

# The Griffiths NHS Management Inquiry: its origins, nature and impact

Edited by  
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Centre for History in Public Health  
London School of Hygiene and Tropical Medicine

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# Witness Seminar

## The Griffiths NHS Management Inquiry: its origins, nature and impact

The transcript of a Witness Seminar held at the Institute of Historical Research, London, on 11<sup>th</sup> November 2008

Chair: Nicholas Timmins, Financial Times  
Organiser: Martin Gorsky, Centre for History in Public Health, LSHTM

With thanks to: Suzanne Taylor for additional research and administrative support  
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Photographs: Anne Koerber /LSHTM, except p.36 Sir Cyril Chantler

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## Contributors

### *Organiser / Introduction*

**Dr Martin Gorsky** Centre for History in Public Health, London School of Hygiene and Tropical Medicine

### *Chair*

**Mr Nicholas Timmins** Public Policy Editor, *Financial Times*, 1996-present; author *The Five Giants: A Biography of the Welfare State*, Harper Collins, 1995

### *Witnesses*

**Sir Michael Bett** NHS Management Inquiry member, 1983; Personnel Director, General Electric Co Ltd, 1972-77; Director of Personnel BBC, 1977-81; Board Member for Personnel, British Telecom, 1981-84; Managing Director, British Telecom UK, 1988-91.

**Sir Cyril Chantler** Professor of Paediatric Nephrology, Guy's Hospital, 1980-2000; General Manager, 1985-88; Clinical Dean, Principal, 1989-92, 1992-98; President British Association of Medical Managers, 1991-97; Chair, Great Ormond Street Hospital for Children NHS Trust, 2000; Chair, King's Fund, 2004.

**Mr Nigel Edwards** NHS manager, Central Middlesex Hospital, Oxford RHA; Director London Health Economics Consortium, 1993-99; Policy Director, NHS Confederation, 1999; Honorary Professor LSHTM.

**Lord Fowler  
(Norman Fowler)** Conservative MP for Nottingham S, 1970-74, Sutton Coldfield, 1974-2001; Secretary of State for Transport, 1979-81, for Social Services, 1981-87, for Employment, 1987-90.

**Ms Christine Hancock** Qualified as a nurse 1962; graduated in economics 1972. Career in nursing, including King's College Hospital and National Heart Hospital; Chief Nursing Officer, Bloomsbury Health Authority; General Manager, Waltham Forest Health Authority 1983-1989; RCN General secretary 1989-2001, President ICN 2001-2005; Director : Oxford Health Alliance, 2006; C3 Collaborating for Health, 2009.

**Sir Graham Hart** Department of Health 1962-1997, apart from three short periods in other organisations. Director of Operations then Deputy Chief Executive of the NHS Management Board, 1984-1989, Permanent Secretary 1992-1997 (KCB 1996). Since retirement he has worked in the

voluntary sector (Chairman of the Kings Fund 1998-2004) and is currently working on a PhD on aspects of 17<sup>th</sup> Century social history.

- Mr Alasdair Liddell** Administrator Tower Hamlets HA, 1976-9; Area General Administrator Kensington, Chelsea and Westminster AHA, 1979-82; District Administrator Hammersmith and Fulham HA, 1982-4; District General Manager Bloomsbury HA, 1984-8; Regional General Manager, East Anglia RHA, 1988-94, Director of Planning DoH, 1994-2000.
- Dr Robert Maxwell** McKinsey & co, 1966-75, consultant specialising in health services; Administrator to Special Trustees, St Thomas' Hospital, 1975-80; Secretary and Chief Executive, Kings Fund, 1980-97.
- Mr Robert (Bob) Nicholls** District Administrator South West Hampshire Health District, 1974; Area Administrator, Newcastle upon Tyne AHA, 1977; Regional Administrator SW RHA;1981; District General Manager Southmead DHA, 1985; Regional General Manager/Chief Executive Oxford RHA, 1988-93; NHS Management Executive, 1993-96. Chair of the Institute of Health Service Management in 1982-3 and President in 1983-4 around the time of the Griffiths Inquiry.
- Dr Peter Simpson** St Thomas's and Northwick Park Hospitals, 1966-78; Lecturer Community Medicine, St Thomas's Hospital, 1974-5; DHSS Senior Medical Officer, 1978-88; Regional Medical Officer Mersey RHA,1988-93.
- Professor Clive Smee** Chief Economic Adviser and Head of Analytical Services in the DHSS and then DH from 1984 to 2002. Visiting Professor of Economics at the University of Surrey since 1995. In 1996 he was made a Companion of the Order of the Bath (CB) for services to health.
- Dr Frank Wells** Under Secretary British Medical Association, 1979-86; General Practitioner in Ipswich, Suffolk; Director of the Department of Medicine, Science and Technology of the Association of the British Pharmaceutical Industry, 1986-96.

## Contributors from the floor

- Professor Tony Cutler** Honorary Visitor at the ESRC Centre for Research on Socio-Cultural Change at the University of Manchester. Previously Professor of Public Sector Management at Royal Holloway, University of London. His books include *Managing the Welfare State* (1997) with Barbara Waine and *Keynes, Beveridge and Beyond*, with John Williams and Karel Williams. The history of management techniques in the public sector is one of his principal research interests.
- Dr Mark Exworthy** Reader in Public Management and Policy at Royal Holloway University of London. His research interests focus on health policy and management. He (and Fraser Macfarlane, Surrey University) was funded by the Nuffield Trust (2007-2009) to conduct a study which examined how NHS managers have coped with changes in the external policy environment. The spur to this project was the 25th anniversary of the Griffiths Report, and the study interviewed 20 managers whose NHS careers pre-dated Griffiths.
- Professor Hugh Freeman** Consultant Psychiatrist. Honorary Visiting Fellow, Green College, Oxford; Honorary Professor at the University of Salford; Consultant Psychiatrist to Salford Mental Health Trust; Editor of the *British Journal of Psychiatry*, 1983-93; held posts at Bethlem Royal Hospital and Maudsley Hospitals, London, Littlemore Hospital, Oxford
- Dr Mark Learmonth** Associate Professor of Organization Theory at the University of Nottingham. He worked in a variety of posts in health services administration/management between 1981 and 1997.
- Professor Nicholas Mays** Professor of Health Policy, London School of Hygiene and Tropical Medicine. Previously worked in the National Health Service, in academic health services research (at the Universities of Leicester and London (St Thomas' Hospital Medical School), and the Queen's University of Belfast), at the King's Fund, and as a policy adviser with the New Zealand Treasury).
- Professor Martin Powell** Professor of Health and Social Policy, Health Services Management Centre, University of Birmingham. He has research interests in current and historical health reforms in Britain, and is currently working on a NHSSDO project on 'talent management in the NHS managerial workforce'.

**Among those attending the meeting:**

Mr Geoff Berridge  
Professor Virginia Berridge  
Ms Sally Brearley  
Professor Celia Davies  
Mr Nigel Edwards  
Mr John Eversley  
Ms Christine Hogg  
Ms Paula Kanikandan  
Dr Stephanie Kirby  
Professor Rodney Lowe  
Dr Fraser Macfarlane  
Professor Susanne MacGregor  
Mr Graham Martin  
Dr Annie Nixon  
Dr Jennifer Lynn Nicholas  
Ms Marcia Saunders  
Ms Suzanne Taylor  
Dr Julie Walabyeki  
Dr Ivan Wells  
Ms Micky Willmott



## **Instructions for Citation**

**References to this witness seminar should follow the format below:**

[Witness name], in ‘The Griffiths NHS Management Inquiry: its origins, nature and impact’, held 11<sup>th</sup> November 2008, Centre for History in Public Health, London School of Hygiene and Tropical Medicine, January 2010, <http://history.lshtm.ac.uk/witness-seminars.html>, [page number of reference].

## Further Reading

Roy Griffiths, 'NHS Management Inquiry', 6 October 1983

Sir Roy Griffiths, *7 Years of Progress: general management in the NHS*, Audit Commission, Management Lectures No 3, (1991)

S.Harrison, *National Health Service Management in the 1980s: Policymaking on the hoof?*, (Aldershot: Avebury, 1994)

R.Klein, *The New Politics of the NHS: from Creation to Reinvention*, (Oxford: Radcliffe Publishing, 2006)

P.Strong and J.Robinson, *The NHS: under new management*, (Oxford: OUP, 1990)

C.Webster, *The National Health Service: a political history*, (Oxford: OUP, 2002)

# The Griffiths NHS Management Inquiry: its origins, nature and impact

## Witness Seminar Transcript

### Introduction

**MARTIN GORSKY:** We're drawing now towards the close of the sixtieth anniversary year of the NHS, and this witness seminar comes as part of two days at the London School of Hygiene where we're going to be discussing the history of management, administration and structure within the NHS. We chose today's theme, on the one hand because 2008 also marks the twenty-fifth anniversary of the Griffiths Inquiry, but also because there now seems to be something of a head of steam building up in academic research on management of the NHS. It has also been very interesting to note how the legacies of the Inquiry have figured in the discussion around the sixtieth anniversary. For example when the *Health Service Journal* compiled and listed the sixty most influential people in the history of the Service, it placed Roy Griffiths at number twelve, dubbing him the father of modern NHS management. The management inquiry also loomed large in the recent publication of the Nuffield Trust, which marked the anniversary with a collection of interviews with movers and shakers in the NHS's past who not only noted the significance of an Inquiry, but also reflected on the extent to which the aims that were set out had yet to be fulfilled.<sup>1</sup> So this seems an appropriate moment to gather together policy makers, civil servants, people who had a first-hand view of events, but also those with careers in management who felt its impact to discuss its place in history.

The key features of the inquiry can be quickly summarised. It was appointed in 1983 by Norman Fowler, and consisted of a small team of businessmen led by Roy Griffiths, the managing director of Sainsbury's supermarkets. Two quotations from the report nicely capture its essence, first of all to 'instil a more thrusting and committed style of management', in contrast to what was seen as the consensual approach hitherto dominant, but also clearly to establish at all levels a single

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<sup>1</sup> N.Timmins, ed. *Rejuvenate or retire: views of the NHS at 60*, (London: Nuffield Trust 2008).

individual, the general manager with whom responsibility and accountability lay. In the words of the report's most famous sound bite: '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'.<sup>2</sup>

The main conclusions, I won't go through in detail, because they're set out in the briefing sheet, but I think the top two are of particular importance. First of all the decision to create in the DHSS a Health Services Supervisory Board to oversee policy and strategy, and a new NHS Management Board, which would then implement this. And then the recommendation to appoint general managers at regional, district and at unit levels; and various other things: management budgets in which clinicians were to be involved, a new personnel and property function. And finally, that the views of users, of patients and communities, should now be more actively sought and acted upon. It was the first two of these which most immediately affected the organisation of the service between the publication of the report in 1983 and 1985.

Now, we suggest taking the discussion in four sections. First of all kicking off with pre-1983 situation, and reflecting on the origins of the Management Inquiry and the subsequent report. Should we set it in the context of the long history of the problem of management in the NHS, arguably something going right back to 1948? The Bevan<sup>3</sup> settlement had in a way been a retrograde step, because the Medical Officers of Health<sup>4</sup> who had previously had a quasi chief executive role in local government, now found that much reduced. The situation which the Thatcher Government<sup>5</sup> inherited was the management structure established in Keith Joseph's reorganisation of 1974.<sup>6</sup> This was premised on the notion of consensus management, by which committees of doctors, administrators, nurses, finance officers, and also

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<sup>2</sup> Roy Griffiths, 'NHS Management Inquiry', 6 October 1983, p.12

<sup>3</sup> Aneurin Bevan (1897-1960): Welsh Labour politician and Minister of Health, 1945-51; introduced the National Health Service Acts in 1946/7, leading to inception of the NHS in 1948.

<sup>4</sup> The right of local authorities to appoint a public health doctor, the Medical Officer of Health (MOH), dates to the Public Health Act of 1848, and such appointments were made compulsory in 1872. By the interwar period the county and county borough MOHs managed large departments and had considerable powers over a range of preventive and curative services. The NHS Acts significantly reduced their role, removing the provision of hospital and primary care from local government.

<sup>5</sup> Baroness Thatcher (Margaret Thatcher): Conservative Prime Minister, 1979-1990.

<sup>6</sup> Sir Keith Joseph: Conservative politician and Secretary of State for Social Services, 1970-74. His proposals for the re-organisation of the NHS were introduced in a White Paper of 1972 and incorporated into the National Health Service Reorganisation Act of July 1973, implemented the following year.

community physicians at district level, reached decisions. It will be interesting to hear comments of the panel and audience on how this functioned.

Or should we set the inquiry more in the short-term context, particularly of the tight financial settlements faced by the NHS during most of the 1980s? Indeed this is something which really goes back to the mid-seventies and the Wilson/Callaghan era. This was in Rudolf Klein's <sup>7</sup> words an era of 'the politics of value for money', so should we see Griffiths as one of a series of reports from this period, intended to raise outputs while inputs were constrained?

Or should we instead put the emphasis on the proximate cause? The trigger, at that time was the industrial action which occurred in 1982, and which seems to have been the direct prompt for the establishment of the inquiry.

The second area of discussion on which we might focus is conduct of the Inquiry itself and its distinctive nature. Unfortunately Sir Kenneth Stowe,<sup>8</sup> who was the Permanent Secretary who really oversaw the inquiry, is unable to be with us today, but I'm hoping that nonetheless we can piece together some elements of the story. And another huge absence of course is Roy Griffiths himself, who died in 1994, but again it would be very interesting to gather some recollections from people here of his personal attributes and the approach which he took to the Inquiry and its consequences.

The Inquiry itself differed in significant ways from prior investigations into the NHS, not least in its short timescale, the brevity and form of the report itself, as a twenty-four page letter addressed to the Secretary of State, and the lack of published evidence. So, again, it would be interesting to learn more about why it took this form, and perhaps glean something of how the inquiry reached its conclusions. Another important absence today is Cliff Graham, also now dead, the civil servant who led the support team, and who is credited in some of the records with influencing the draft of the report. Again, his role could perhaps be brought into focus to learn something more about how the Griffiths recommendations chimed with existing thinking within the department.

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<sup>7</sup> Rudolf Klein: Emeritus Professor of Social Policy, University of Bath. Founded the Centre for the Analysis of Social Policy at the University of Bath, where he was Professor of Social Policy, 1978-97. His study, *The Politics of the NHS* is an acclaimed political analysis of the NHS.

<sup>8</sup> Sir Kenneth Stowe GCB, CVO, KCB, CB: senior British civil servant; Principal Private Secretary to the Prime Minister, 1975 to 1979; Permanent Secretary of the Department of Health and Social Security, 1981-87.

Next we might move on to the reception of the report and its implementation in the early phase, up to the introduction of the internal market. The written records certainly suggest a hostile reception initially from the BMA,<sup>9</sup> the RCN,<sup>10</sup> and other groups, although the Institute of Hospital Administrators<sup>11</sup> was supportive. So why was this and how should we now appraise the objections that were advanced? Related to this, what were the factors that persuaded government finally to endorse the implementation of general management at all levels, in spite of the objections which had been raised?

And then coming on to implementation itself: what can we make of how this turned out? Griffiths himself reflecting in the early Nineties asserted that he felt it really had had a slow start. Could it be said that the tendency to what the team called the slow or lowest common denominator decision-making in the NHS had been halted? And what about the other aspects of the report, management budgets, and their underlying rationale of making doctors more cost-conscious? Or the Griffiths aim of greater attentiveness to the user? He seems to have looked particularly at the Community Health Councils as a suitable channel for this. Then at the top of the Service, what of the plans for the Supervisory Board, which had only a short life, and of the NHS Management Board? Memoirs from this period do suggest that this had a difficult beginning.

Finally, twenty-five years on, we can conclude by taking the long-term perspective, and asking whether Griffiths' aims have been achieved? The criteria for assessing this, I think, are those which the team themselves set out: better control of expenditure; setting more precise management objectives; improved measurement of health outputs; better evaluation of clinical practices, cost-effectiveness; and again, greater responsiveness to patients and their communities. One reading of the Griffiths Report sees it as beginning a shift in the balance of power between clinicians and administrators, a process which has continued to this day. Is this a reasonable reading? And if so, this would be somewhat at odds with Griffiths' own hopes, that doctors themselves would be the natural managers. So what's happened to this aspiration? And lastly, can we say that there has been a downside? The *Health*

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<sup>9</sup> BMA: British Medical Association.

<sup>10</sup> RCN: Royal College of Nursing.

<sup>11</sup> Institute of Hospital Administrators: a professional organisation for administrators/managers within the healthcare sector. The Institute was formed in 1942 and until 1944 was known as the Incorporated Association of Hospital Administrators. It is currently known as the Institute of Health Care Management.

*Service Journal* article I referred to at the beginning also suggested that one legacy had been a ‘them and us’ culture in which managers were sometimes demonised. So that again is perhaps something to reflect on.

A final point, just to say that we are recording the seminar and people who contribute, either on the panel or the audience, will have a copy of the transcription sent to them to approve. One important thing arising from that, please could you identify yourself when you speak, particularly the first time you contribute? If you could say your name, so that we can keep a record for transcription purposes that would be helpful. And at this point, other than to say we’ll pause for a tea break at about twenty past three, I’ll now hand over to Nick to begin the discussion.

**NICHOLAS TIMMINS:** Thank you Martin and thank you all very much for coming. This should be fun. We’ve got two and a half hours plus. But we’ve an awful lot of ground to cover.

So we’ll try and break it into the four issues: the origins, and the conduct, then the implementation and the fall-out, into two sections like that. There’s a lot of people here, so if you could try not to talk for too long if possible, in imparting everything you want to say,



that would be fantastic. [laughter] So we should start with the origins. I suppose the question is should we see management inquiry as the continuation of what Bevan said at the very beginning of the Health Service, that administration will be the biggest headache for years to come? It was simply part of that? Or should it fall more shortly into the outcome of the longest industrial dispute that the Health Service ever faced? Norman?

**NORMAN FOWLER:** No, I don’t think it should. Well certainly not the latter. I mean the strike went on in 1982, it was a very long strike, but I don’t think it had a tremendous impact on the setting up of the Griffiths Inquiry. I think a better context

is that there was undoubted tension at the time between two visions of the National Health Service. One vision was, as you remember, a private health insurance system, which I suppose was epitomised by the CPRS<sup>12</sup> report which came out in 1982, was leaked in *The Economist*,<sup>13</sup> and that set out one way that you could deal with it. And there was a great battle ... there wasn't a *great* battle, there was a discussion in Government. There wasn't actually very much support for it. No one actually knew



that the CPRS review was taking place, which didn't exactly help the decision-making process, and certainly no one had been told inside the Department of Health. But, putting that to one side, that was quite significant in as much as at that moment, or there and shortly afterwards, the Government emphatically said, I said, Margaret Thatcher said, that there was no question of going down the private health insurance route; we were going to have a publicly-funded national health service free at the point of delivery, and all that took place. That's something that I personally believed in.

And so, you then came to the next stage, if that was what your process was, if that that was what your aim was, if that is what your vision was, then it obviously followed from that, that what you really wanted to do was to make the Health Service as effective and as efficient as it possibly could be. I think, several of us came to the view that consensus management wasn't working, that at times decisions being taken were woolly, there was no leadership. The worst example of this came actually a year

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<sup>12</sup> The Central Policy Review Staff (CPRS) was established by Conservative Prime Minister Edward Heath in 1971. Based within the Cabinet Office its role was to review the effectiveness of policies and develop broad strategic objectives. The 1982 report advanced radical ideas for welfare expenditure, such as curtailing public funding of higher education and replacing the NHS with private insurance. Cabinet objections and a leak to the press halted this line of policy development.

<sup>13</sup> *The Economist*: weekly magazine providing analysis on international politics and finance; its editorial stance champions free trade and free markets.



after: the Stanley Royd Hospital Inquiry,<sup>14</sup> where I think something like nineteen, twenty people were actually killed because of food poisoning. We had an inquiry into that, and what that showed was that really no one was taking responsibility for it. No one had ever heard an angry word ever used inside the kitchen, although the kitchen was by any standard a total and utter disgrace. So, it was really from that point of view that we went.

And so, and from my point of view as Secretary of State, it was a sensible way of moving the National Health Service forward, but at the same time it also answered the other issue of people, not least Margaret Thatcher, who were saying, ‘You know, we’re spending a great deal of money on this service, we want value for money.’ So it in a sense ticked both, both of those particular boxes.

**NICHOLAS TIMMINS:** Right. But wasn’t the initial impetus for it the agreement at the end of the strike, there would be an inquiry into manpower, into the management?

**NORMAN FOWLER:** I think that they... I don’t think ... that was manpower. I think that there was a whole range of issues kind of coming together at that stage. I mean, most people, most services, certainly one of the biggest employers in Western Europe, would expect to have information on manpower, which we didn’t have, that was certainly absolutely true. But there were other issues as well round about that time. Again one’s got to understand of that period, I’m not sure how much it’s changed, but everything was extraordinarily political. I mean if you wanted to contract out services, if you wanted to have generic prescribing, you faced certain opposition. My memory of the period of the Health Service is actually fighting opposition on sort of every one. I remember, you’ll remember this probably, we had a small circular to the Health Service about better cooperation between the National Health Service and the private sector. This was characterised as the biggest assault on the National Health Service by Michael Foot<sup>15</sup> that the Health Service had ever

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<sup>14</sup> Stanley Royd Hospital Inquiry: a committee of inquiry into an outbreak of food poisoning at the Stanley Royd Hospital, Wakefield, in 1984. It identified deficiencies in the management of the outbreak and urged that lessons be learnt by health authorities. Department of Health and Social Security. *Report of the committee of inquiry into an outbreak of food poisoning at Stanley Royd Hospital*, (London: HMSO, 1986.)

<sup>15</sup> Michael Foot: British politician and writer; leader of the Labour Party in opposition, 1980-1983.

known. And, it is now Government policy I'm glad to say. Mr Blair<sup>16</sup> very conveniently has kind of underlined it as such, but, I mean you've got to have a kind of slight understanding of the political and public background for everything that was taking place.

**NICHOLAS TIMMINS:** Bob Nicholls.

**BOB NICHOLLS:** I was the Regional Administrator for the South-West at the time, and I'd like to hear from Sir Michael Bett, who was a member of the Inquiry, as was my then chairman, Brian Bailey.<sup>17</sup> I was also, and I want to come back later chairman, the President of the Institute of Health Service Administrators at the time of the inquiry, giving evidence to Roy's Inquiry. But on the specific origins, my memory is yours, and actually well written up in your excellent book (*The Five Giants*). Which is that it was

triggered, I think, by concerns about rapid expansions in NHS staffing. While I couldn't disagree with what Norman said about background, but this Michael may be able to confirm, I thought there was a row because Maggie wanted Roy Griffiths to look at the burgeoning manpower issue, particularly the administrative people, that had followed in the wake of the '74 reorganisation, and



that Roy Griffiths said, 'I can't look at manpower, and how many, and whether you've got too many of this and too many of that, unless I look at management.' And that is well recounted in your book, so it may be that I've read that, and that triggered my memory, but my memory was that he was asked to look at manpower and he said he wanted to look at management in which the manpower must follow.

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<sup>16</sup> Tony Blair: Labour Prime Minister, 1997-2007.

<sup>17</sup> Inquiry member Sir Brian Bailey was Chairman of Television South West (1980-93). Prior to this he was chairman South West Regional Health Authority (1975-82), then chaired the Health Education Council (1983-87) and the Health Education Authority (1987-89).

**NICHOLAS TIMMINS:** Michael, you were part of the process. Sir Michael Bett.

**MICHAEL BETT:** Well, let me say that I was not in any way involved in the triggering or starting off this inquiry. I was landed upon, [laughter] and that was that.



Perhaps I ought to explain, or give you some explanation of why. I had been Director of Industrial Relations at the Engineering Employers<sup>18</sup> I had been Arnold Weinstock's<sup>19</sup> personnel director for five years. I had been at the BBC as personnel director for three and a bit years, and in all of those occupations I had had a great deal of time devoted to countering the trade union strengths on behalf of the employer. And then I was at BT<sup>20</sup> where we had a quarter of a million, as we had quarter of a million people at GEC.<sup>21</sup> And it was possibly because of the size and the nature of my personnel, industrial relations

experience and so on that I was chosen, because I think the 1982 strike had left a great deal of impact on the public consciousness. And so, I think I was just drafted in. But I wasn't anything to do with setting it up.

**NICHOLAS TIMMINS:** Are there any views on the origins, different from anything we've heard about how it came about? Graham Hart.

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<sup>18</sup> The Engineering Employers Federation, where Michael Bett held the post 1970-72.

<sup>19</sup> Arnold Weinstock: (1924-2002). British industrialist; in 1954 he joined his father-in law's electronics company, Radio & Allied Industries Ltd., and in 1963 orchestrated its merger with General Electric, becoming the largest shareholder of GEC. Member of the Board of Directors from 1961 to 1963 and Managing Director from 1963 to 1996; under his leadership it developed into a major company and was listed on the FTSE 100.

<sup>20</sup> BT: British Telecom.

<sup>21</sup> GEC: General Electric Company.

**GRAHAM HART:** Yes. I wasn't involved right from the beginning, I came into the story in September of '84, I think. But as with all big historical events, it's not simple is it? I mean there are a lot of different factors, and the Secretary of State. I mustn't call you Secretary of State must I? It comes naturally! [laughter] Lord Fowler's obviously right about the background. Certainly this point about manpower, that the NHS didn't even know how many people it employed, had a wide currency, and was regarded as a kind of thing that presumably Mrs Thatcher or somebody had picked up as a horrendous story and evidence of a lack of management and grip which needed to be addressed. But I would also have thought that Roy Griffiths' answer, if the story you recount is correct, was absolutely predictable. I don't see how you can look at manpower control, which is as we all know, by far the biggest resource involved in the NHS, without looking at management.



**NORMAN FOWLER:** I think actually, going back on this again, on these factors, as you've put that particular point, I mean, a great deal, much of the finding of Roy Griffiths, because there was a range of managers we could have asked to do the job, though not many of them would have agreed to do it, was down to Ken Stowe. Number 10 obviously had an impact, but manpower, I have to say, was only one of a

list of complaints from Margaret Thatcher about the efficiency of the national health service.

**GRAHAM HART:** That's true

**NORMAN FOWLER:** She would not, she would not wish in any way to confine herself to manpower. And manpower was quite right, is a prime example. I remember the day that I announced, you know, we were counting people, the *Guardian* had a front page story about kind of, tremendous, tremendous cuts in the Health Service, which was complete nonsense. And I went to a conference in Sheffield, and, which was just my luck [laughter], and, they, actually had placards which had 'Down With Norman Tebbit'<sup>22</sup>, and they'd scrubbed out 'Tebbit'. [laughter] And that was the actual day itself. We were under no illusion, which is fair enough in a sense, that we had to demonstrate to the Prime Minister, and to the rest of the Cabinet for that matter, that this amount of money being spent on the Health Service was being well spent. I think there's nothing particularly controversial in that, because at that time public spending was under constraint and so if you happened to be running another department, which you also regarded as particularly important, I mean it was bound to raise the temperature a bit if you saw newspaper reports that the Health Service was wasting this and that. And Margaret also, it has to be said, did want to, the last consultant who spoke to her tended to be the agenda. [laughter]

And just one last point on Roy Griffiths. Roy Griffiths, one has to understand, he was a very great man, but he was a considerable politician himself, and at the end, the only time I threatened to resign, at the end in 1986, he wanted to be the Prime Minister's adviser on the Health Service, and he jolly nearly got that job. And in fact, I think because of various things, we managed to make him my adviser on the Health Service, which avoided the Lawson / Alan Walters<sup>23</sup> thing later on. So, Roy was

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<sup>22</sup> Norman Beresford Tebbit: Lord Tebbit of Chingford, CH, PC, born 1931, British Conservative politician and former MP for Chingford; Secretary of State for Employment, 1981-3, Trade and Industry 1983-5, Chairman of the Conservative Party and Chancellor of the Duchy of Lancaster 1985-7.

<sup>23</sup> Nigel Lawson: Baron Lawson of Blaby, PC, born 1932, British Conservative politician and journalist; former MP for Blaby, Chancellor of the Exchequer, 1983-1989. Sir Alan Walters: economic advisor to Margaret Thatcher, 1981-1984, and in 1989. Lawson resigned as Chancellor of the Exchequer in 1989 when Thatcher refused to dismiss Walters over advice concerning the Exchange Rate Mechanism (ERM).

quite a politician in his own right, and actually would love to have been a minister, but we might come to that.

**MICHAEL BETT:** Sorry. I was only going to say, you've got to remember the management heroes of the day, Arnold Weinstock was described as the greatest *unemployer* of them all. For five years I did his bidding. John Sainsbury<sup>24</sup> was no pushover, and he dominated, and I have to say this, he dominated Roy. I observed that relationship and I remember all sorts of things about the impact of John Sainsbury on Roy. I don't think the word 'union' appears in the whole letter does it?

**NICHOLAS TIMMINS:** No

**MICHAEL BETT:** Management heroes of the day were seen to be the guys who reduced the numbers, who fought the strikes, who put the responsibility on individuals. All these things were part of what I think was going round in Margaret Thatcher's head. There's presumption for you.

**NICHOLAS TIMMINS:** Yes, but just picking up from what you said, Norman, you set the inquiry up and, as Michael is saying, set it up in response to what was going on about manpower and having these troubles with manpower and the strike. But a lot of the pressure was coming from Number 10.

**NORMAN FOWLER:** Well I'm not sure it did actually come from Number 10. We were certainly under pressure to demonstrate to the rest of the Government, actually Number 10, that we were managing the shop well and that we were... But I don't actually remember pressure being put on me to set this up. My memory was, and I'd have to go back to my diaries and papers, but my memory was that this was in essence a sort of, something which came out of the Department. Both Ken Stowe and I were firmly in favour of it, and obviously Number 10 were not opposed to it. But I don't... it was certainly not a Number 10 initiative, you know, handed down to the Department, that, it just wasn't it.

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<sup>24</sup> John Sainsbury: Baron Sainsbury of Preston Candover, KG, born 1927. He joined the family firm Sainsbury's, a British grocery chain, in 1950, becoming a Director in 1958 and Vice-Chairman in 1967. He served as Chairman and Chief Executive from 1969-92, taking the company public as J.Sainsbury plc in 1973.

**NICHOLAS TIMMINS:** No, but there was deep interest.

**NORMAN FOWLER:** What there was deep interest in was actually... You've got to remember that Margaret Thatcher took this view, which I personally regarded as fairly eccentric, that the Health Service had won a hell of a lot of money, and that, you know, we had to actually use that money to best effect. She would have put it rather more strongly than that. [laughter]

**PETER SIMPSON:** The metamorphosis from manpower into broader aspects of management would have come as no surprise to Roy. When he applied at Sainsbury's, he applied to be the personnel director. At the end of the interview, he was told he would have to wait till the next day for an answer. The phone call the next day said, 'Sorry, don't want you for personnel; want you to be the MD.'



**MICHAEL BETT:** That was his Monsanto<sup>25</sup> experience wasn't it? Certainly, he had management experience; American style, again significant.

**MARTIN POWELL:** One more element as well to throw into the mix. It's been said already that consensus management was seen as the enemy. Or was it also the idea which was current at the time, that public sector management, or public sector administration, was seen as the problem? Therefore you needed some successful people from the private sector coming in to show how successful management techniques would revolutionise the NHS.

**CLIVE SMEE:** This was exactly the same point I was going to make. I wasn't involved directly on the health side at all at this time until 1984, but, before that I'd

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<sup>25</sup> Monsanto: originally a US agricultural, chemical and plastics company; since 2000 an agricultural and biotechnology company best known as leading manufacturer of genetically modified (GM) seeds.

been working in DHSS,<sup>26</sup> and you could begin to see what is now seen in retrospect as the new public sector management thinking getting into the Department. I was probably the first civil servant in the country to have an MBA,<sup>27</sup> I got mine in the sixties, and for twenty years nobody showed the slightest bit of notice. But when you compare the Social Security and the Health sides, my memory is that the Social



Security side was much more on the ball with things like performance indicators and performance targets. Health felt this would be far too precise, would put up too many peoples' backs, particularly the medical and nursing professions, so we

would have to touch it with a very light touch indeed. And I think what in a sense Roy Griffiths did was accelerate that process, a process that was going on in some sense in every Whitehall department.

**NORMAN FOWLER:** Could I say that in my view that is an absolutely vital point, because at that stage we had the Department of Health and Social Security, and it was quite clear sitting where I was that, obviously Social Security had come from the National Assistance Board<sup>28</sup> and all this, had a vast amount of experience at actually running things. The Health Service, and the Health Service inside the Department didn't have that experience. So a lot of very good advisers, no names and numbers, just didn't have that experience. I think in a way, just to go back to that question, it's certainly true that we wanted the private sector skills in, but one of its aims of that was to actually move away from, what I think was a bad kind of administrator, to sort of public sector managers, and to have the skills there.

**ROBERT MAXWELL:** This is more in the nature of a question than a point of view. My memory is that, in 1979 when Margaret Thatcher came in, we were

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<sup>26</sup> DHSS: Department of Health and Social Security.

<sup>27</sup> MBA: Master of Business Administration.

<sup>28</sup> National Assistance Board: in 1948 the National Assistance Act led to the formation of the National Assistance Board. The Board established means-tested supplements for the uninsured, funded from national insurance contributions.



expecting change on all sorts of fronts, but she studiously kept off health in her first administration.<sup>29</sup> It was clear she was going to get round to health at some point. She had to because of its importance in public expenditure terms, and in public life. And



probably the industrial dispute also emphasised that. And, I think I agree with what Norman was saying, that, really there were only two options, either you changed the whole NHS system into something totally different, insurance-based for example, or you had to make the existing system work better.

**NICHOLAS TIMMINS:** Christine Hancock.

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<sup>29</sup> Margaret Thatcher's first term, 1979-1983.



**CHRISTINE HANCOCK:**

Right, two things. One, following Robert's comment. One of the things I remember really strongly from the early Thatcher days is that the Prime Minister wasn't interested in health. And I can remember interview after interview, watching how she would spark on education and some other things, but on health she'd answer correctly, but her face dulled over, there was no real passion. I'm sure Lord Fowler might argue against that. But secondly, I'm intrigued, not so much at the decision, but why Roy? I've spent many years going

round the world explaining the British way of doing things, and that when we're worried about our Health Service, we bring in a leading grocer to tell us how to run it. And I probably wasn't approved of by the diplomatic effort of the day. But why, why Roy, as opposed to many others?

**NICHOLAS TIMMINS:** Well one answer to that is in Ken Stowe's words, when he says, 'When we settled the strike, on the basis there'd be a manpower inquiry that was down to me. Norman Fowler, who in effect said, deliver it, who were we going to get? So I phoned up some of my chums, and I phoned up John Sainsbury. And I said, "John, who's the man you can tell me to get hold of to chair this inquiry?" He said, "Well if you can get him it's my deputy, Roy Griffiths." So I asked to see him and I went along. So I went along with that, saying where I was going, visiting with Roy Griffiths in his office at Stamford Street.<sup>30</sup> And I spent the most uncomfortable forty minutes of my career. He didn't say a word. He just glowered at me for forty

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<sup>30</sup> Sainsbury's headquarters, Stamford Street, London.

minutes [laughter], while I was trying this way and that, and persuaded him this was an important job, and he was the person to do it. What I didn't know of course was, he had two children who were doctors and he was more than willing to take it on.'

**GRAHAM HART:** Could I add a sort of contextual point, which I think is very important, this point about public sector management. It's true that the marriage of Health and Social Security was always a somewhat misconceived one, some people thought. And the two Departments were very different in their traditions and indeed in the job they had to do. I joined the Department of Health in the early Sixties, and I think even until the reorganisation in '74, and even possibly after that, if you discussed with my colleagues what the job of the Department was in relation in relation to the NHS, the word 'management' wouldn't have appeared anywhere on that agenda.

The Department did not see its responsibility, not historically, as to manage the NHS. It had inherited from pre-1948 a tradition of handling the field authorities as it handled the local authorities, which were, if you like the arm of government that delivered services. And it only slowly came to accept over a really long period of time that it had to assume a more forward role in managing, and it started after '74. I know you can regard '74 in the context of this discussion as a step back, because of consensus management. In other ways it was a step forward, in the sense that, and Robert and others were involved in helping the Department to gear up for this change, the Department did have a leadership role in relation to the NHS which was even stronger. But even so, even in the 80s, I don't really think it felt like that.

And so there are two elements in the Griffiths Report that were a tremendous shock to me. I wasn't involved at the time, though I was heavily involved later, a tremendous shock. And one was, the one we all talked about, which is, the NHS services out in the field have got to be managed better. But also, the Department had this management role, and what does that mean? And actually my first involvement with Griffiths was in '83 I think it was, I was at a loose end, because the CPRS, which Lord Fowler mentioned, which I'd been in was brought prematurely to an end. So I was at a loose end, and Ken asked, Ken Stowe asked me to, to write a report, which I did, on how the Department itself should reorganise itself to respond to the challenge of Griffiths, which it was then accepted was going to be implemented. It said there's going to be this management board, this supervisory board and so on. How the heck

would we organise ourselves to discharge this new remit? And I can remember sitting in a room with a wet towel round my head, and it was a very strange question actually, and it needed a lot of work.

**NICHOLAS TIMMINS:** And just to pick up on that. I mean, prior to Griffiths it would still certainly be my impression, that the regional authorities were sort of baronies in their own right.

**GRAHAM HART:** Oh absolutely.

**NICHOLAS TIMMINS:** And the Department sort of sent them guidance, nicely asking them to do things ... I mean, I'm exaggerating ....

**GRAHAM HART:** Yes. Well...

**NICHOLAS TIMMINS:** And that they were really powerful organisations where the chairs could more or less run it the way they wanted to, and ministers, in a sense, had to use that as their mechanism.

**GRAHAM HART:** Oh, I didn't get the impression that they were powerful. They were there, they were present, but, power implies that they were wielding something purposely, and I don't think we saw very much of that. [laughter]

**MICHAEL BETT:** But just an anecdote, and a final comment. We had dinner with Ken Stowe one night, four of us, and Cliff. We asked: 'Ken, who is managing the Health Service?' And he said, 'What do you mean?' 'Is it you?' 'Oh no. My job is to advise ministers and to run the Department. I'm not...' 'So is it...' Graham's equivalent, or someone else? And we went round and round. 'No, no, no.' 'Well how is the Health Service managed?' It was a question that absolutely flummoxed me, and of course Roy. And, he said, 'Well,' Ken said, 'Well, we civil servants get together and we create some policies, and we take them to ministers, or ministers stimulate us into thinking along certain lines, and eventually a policy emerges. The ministers take it to the House of Commons, it gets through, maybe with amendments here and there, it comes back. We have an army of circular letter writers. Circular

letter writers get hold of the Act. They then commit it to circular letters, which are instructions; they go out to all units. What other management do you need?' You received a circular letter, and you complied with its terms, and that was that. That was regarded as management. Now, the word 'manager' you say was not used Graham. Well, frankly it wasn't in BT when I got there either. This was not peculiar to the Health Service, no. This was quite common elsewhere in state enterprises.

**NORMAN FOWLER:** The difference was because I came from Transport <sup>31</sup>, to the Health Department. If we had, when you had British Rail, I mean I had a chairman of British Rail, <sup>32</sup> back then, and the other chief executives, they were running the railway system, regardless of how well they were running it, but they were doing the running. We were hands-off. The difference was that in the Health Service we were very much hands-on. There wasn't that kind of separation at all. A point we might come to.

**MICHAEL BETT:** Well, that dinner we said to Ken Stowe, 'Why can't we just get the Health Service out from under, and then ministers would be able to say in the House of Commons when a question arises, "That is not a question for me, that is a question for the management."' And he chuckled, [laughter] because, he did not have faith in the ability of a minister not to try and answer the question. <sup>33</sup>

**NORMAN FOWLER:** Ministers would love to do it. I would. But what one doesn't have faith in is the faith in Members of Parliament not to want the answers.

**MICHAEL BETT:** He just thought ministers would want the credit.

**NORMAN FOWLER:** No, Members of Parliament would want the answers to their question. I think, that's a very interesting road to go down, and there's no question that there are problems there and you put your finger on one, it's the old Enoch

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<sup>31</sup> Department of Transport. Norman Fowler (Conservative party) was Minister of Transport, 1979-1981.

<sup>32</sup> British Rail: British Railways (BR), operated most of the railway system from 1948 when the 'Big Four' railway companies were nationalised until it was privatised between 1994 and 1997. Sir Peter Parker was chairman 1976-83.

<sup>33</sup> For a recent discussion, see Brian Edwards, *An independent NHS: a review of the options*, (London: Nuffield Trust, 2007)

Powell<sup>34</sup> thing, with so much tax money going in, can it be ... it must be accountable in some way.

**GRAHAM HART:** Sorry, can I just finish? I seem to remember Ken telling me that he discussed with Roy, because Roy's initial idea to set up this management board outside the Department and it would become, as Lord Fowler says, almost like a nationalised industry board. And, so Ken then explained that, whether that was desirable or not, it was not going to be easily achieved because it would require legislation and that had very considerable political implications of accountability and so on and so forth. And that is why it was that it ended up with an NHS management board inside the Department, which proved to be, let's say, an interesting experience.

**NORMAN FOWLER:** The least successful part.

**MICHAEL BETT:** I think your recollection of Ken's recollection is quite right. We did actually think that the NHS should be separated out and made into a nationalised industry. We were told that that would require legislation which was unlikely easily to be put through Parliament.

**NICHOLAS TIMMINS:** Right. We're jumping ahead a bit, and we'd better move on to the next bit. But is there anything you feel we should have covered which we haven't covered?

**MARTIN GORSKY:** I just wonder if there are any more responses on the nature of consensus management? Lord Fowler has tied it down to the findings of the Stanley Royd Inquiry, but it seems to me slightly more open. I mean the Royal Commission just earlier had given a slightly more open verdict, on whether it needed more time to bed in.

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<sup>34</sup> John Enoch Powell, MBE (1912-1998) was a controversial British politician, linguist, writer, academic, soldier and poet. He was a Conservative MP, 1950-1974, Ulster Unionist MP, 1974 and 1987. Powell was dismissed from the Shadow Cabinet for his 1968 "Rivers of Blood" speech opposing mass Commonwealth immigration to Britain. As Minister of Health, 1960-1963, he was associated with the Hospital Plan, a programme of hospital modernisation, and with the trend in psychiatric care away from institutionalisation and towards community care. His book *A new look at medicine and politics* (London: Pitman Medical, 1966) stimulated debate about the possibility of an independent medical corporation to administer the NHS. Powell argued this was impractical because tax-financing meant the NHS had to be publicly accountable through Parliament.

**NICHOLAS TIMMINS:** Right. Alasdair, you wanted to add a point.

**ALASDAIR LIDDELL:** Yes. First I can't resist just pointing out that the only copy of the Griffiths Report I could find on the Net was from the Socialist Health Association.<sup>35</sup> [laughter] Very briefly, I want to go back to Michael Bett's point about 'management by circular', just to reaffirm that point. I was actually working for an area health authority prior to 1982. But it did rather feel like a rain of circulars issued by the mighty hand of the Department. And reflecting a little bit more on that, there was a very distinct separation between policy and implementation, which I think actually has been a feature of

later years as well. So that when I went subsequently into the Department, the prevailing sense was that the Department did policy, and any failure was a failure of the health service to implement; while I brought with me an equivalent prejudice,



about those unrealistic people in the Department developing policies without any regard for the implementation challenge they posed. By the time I joined the Department, the rain of circulars had turned into priorities, and while these had perhaps started to provide a clearer direction, in 1994 I remember counting ninety-seven individual priorities. And there was no sense in which people out there were going to deliver on all of those, so they ended up doing pretty much what they wanted to do, what they felt was right.

On consensus management, I don't know whether you want to talk about that now, or that comes later, but I'm sure there are plenty of views around the room, and I have some, on both the successes and failures.

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<sup>35</sup> The Socialist Medical Association was founded in 1930, the successor organisation to the State Medical Service Association formed in 1912. The SMA's initial programme called for a preventive health service, in which hospital care was the right of all citizens, without economic barriers to access. It later campaigned for a national health service in the United Kingdom. It changed its name in 1980 to the Socialist Health Association to reflect increased interest in public health. The Griffiths Report is accessible on its website at <http://www.sochealth.co.uk/history/griffiths.htm> (accessed 22 December 2009)

**NICHOLAS TIMMINS:** Well we're going to do a bit shortly on that now. Right, hang on

**ALASDAIR LIDDELL:** Shall I... Can I just very quickly?

**NICHOLAS TIMMINS:** Yes, do.

**ALASDAIR LIDDELL:** When you're in a management situation, you normally can't just change the structure or the decision-making process so you do try and make it work. And my experience in several different places was that people did really try and work as a team. But consensus management did have some very deep flaws in terms of avoiding potentially contentious issues, and reinforcing a sort of functional rather than a coherent, organisation-wide perspective. And ultimately this led to a lack of clear accountability, subject to what emerged as the implicit leadership role of the administrator. And the problem with that was how can you be accountable for an implicit role? And therefore, consensus management worked where the rest of the team were happy with it and the implicit leadership role of the administrator, and where you had the skills to carry the team with you. But it didn't work well in every case or on every subject. And so, I think it was deeply flawed as a process.

**BOB NICHOLLS:** Just to answer Martin's question directly. I don't think that there's any evidence, there's no evaluation of consensus management being good bad or indifferent. And it wasn't obvious to me then, and although Lord Fowler clearly had a different, national perspective and he was nearer to it than me, I don't think consensus management as a big failure was writ large in '82, '83. I think there were question marks, but there was not an analysis I have seen, looking back. So, to me it wasn't a major trigger. A much bigger trigger if you're looking for it, which has been mentioned, was the, the burgeoning bureaucratic burden of too many tiers. I remember being an author of a paper with John Hoare and others, saying that in the '74 reorganisation, though it had some merit as Graham was saying, it had just too many tiers, the region, the area, the district, and the unit. In fact I was in a teaching district with an area manager; very, very happy with my role, except for the bloody area!



**NICHOLAS TIMMINS:** But areas had gone by 1983 hadn't they?

**BOB NICHOLLS:** Only just. But if you're looking for a general 'not doing a good job' it's not so much consensus management, it's more the increase in bureaucrats to run the service.

**NORMAN FOWLER:** But that's another reason why he wanted to get into management and not into structure.

**NICHOLAS TIMMINS:** Right, Frank Wells.

**FRANK WELLS:** I was working as Under Secretary of the British Medical Association at the time, and I have to say that, now that I've been away from BMA management for twenty-odd years looking back on the years before the Griffiths Inquiry, consensus management was actually perceived by the BMA as working quite



well. Alasdair says there was an implicit role for the manager and leader at the top, but many of the doctors would challenge that. And they actually said that although they felt that the leader of the team should be a doctor, that didn't particularly work

well. The manager was the person who was at the top of the tree as it were. But, at the time of the Griffiths Inquiry, one of the reasons for the initial concern, though not hostility, of the BMA to the Griffiths Report was that they felt that consensus management could, and indeed was, working and that something different was therefore coming as a bit of an upset, finding that there was another concept laid on. We will talk about the implementation of it in a minute, but at the time I think the medical profession saw consensus management as working quite well, and dealing with the issues.

**CHRISTINE HANCOCK:** I think that the debate about consensus management was often naïve, as was the debate about general management. I think there was a view that consensus management meant no decisions were taken, and general management meant some sort of really competent, important person who would make a decision. And actually management only works by consensus. But there were issues around the system, and like Alasdair, and actually with Alasdair at times, I was very fortunate, the people I worked with were really bright, there were good debates, arguments. There was a real discussion. These were complicated issues and things, but I heard that there were other places, where I think it was the clinical professionals who didn't engage in the debate, and, and we often forget I think, there was a veto as it were written in. Now I don't ever remember working anywhere where a veto, even the word, was mentioned, it never happened. But I think there were some places where there was very little debate, and then somebody one or more said, 'Oh, I'm not going to allow that, it won't happen.' So I think there's a lot of naivety about management processes, both about the older and what was to come, but also there were some bad practices in the way that so-called consensus management was actually formally and rather rigidly interpreted I think.

**NICHOLAS TIMMINS:** I'll take one or two more on this and then we'll move on to the actual conduct of the inquiry. Peter.

**PETER SIMPSON:** I was at the King's Fund in the consensus management years and I had an opportunity with several teams coming into the College to see how things were going. It was very difficult, for many teams. It was a great pleasure to listen to a team where all six could keep up with the discussion. In fact some team

members fell so far behind the discussion as to be truly embarrassing. One other thing was very percipient I thought. In a letter Tony Grabham<sup>36</sup> asked Henry Yellowlees,<sup>37</sup> about the consensus principle, saying first of all ‘Do, you have the managers who can do these jobs?’

**ROBERT MAXWELL:** I wanted to go back very briefly to the Grey Book of 1974<sup>38</sup> when Brunel<sup>39</sup> were involved and McKinsey<sup>40</sup> were involved. I was with McKinsey at the time when actually we were advising the Department rather than the Service, but I did attend a number of the steering committees meetings of the NHS study. Single districts were a much better operation than multi-district areas, and behind that difference was the relationship with the local authority, very important, but not a good reason for an over complex structure. The managerial structure was also complicated. My memory is, but I may be wrong, that consensus is not a word used in the Grey Book. The concept is one of multi-professional management, and the thought is, and that must be right, that you must have the doctors fully involved as Roy, as well as the team, the Griffiths inquiry team often said. And you must have the nurses involved, and they have their own managerial structures, more straightforwardly hierarchical than those of the doctors.

So the concept was one of, though the term wasn’t used, one of general management. The question was, how do you lead in a multi-professional situation? In some places I think it worked well. The problem is it doesn’t work at all well where you don’t have a functioning team. I think it’s also relevant, and not yet mentioned, that, at the time of the Grey Book and indeed for a long time after that, George Godber<sup>41</sup> was a very powerful figure in the Department. Nobody else may have known how the National Health Service was run, but George knew. And it was

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<sup>36</sup> Sir Anthony Grabham, chaired the Central Consultants and Specialists Committee, 1975-79, chair of the BMA’s Council, 1979-84, chair of the Joint Consultants Committee, 1984-90.

<sup>37</sup> Henry Yellowlees: Chief Medical Officer (CMO) at the Department of Health 1973-83.

<sup>38</sup> Brunel University: The Health Services Organisation Research Unit of Brunel University was involved with the committee on the re-organisation of the NHS which led to the production of the ‘Grey Book’.

<sup>39</sup> DHSS, *Management arrangements for the re-organisation of the NHS*, (London: HMSO, 1972) known colloquially as the Grey Book.

<sup>40</sup> McKinsey and Co.: management consultancy firm, founded in Chicago in 1926. It participated in the Management Study Group established in 1971 by Keith Joseph, Conservative Secretary of State for Social Services, 1970-74

<sup>41</sup> George Godber, CB, KCB, GCB (1908-2009) was Deputy Chief Medical Officer, 1950-1960, and CMO 1960-1973. He gained his Diploma in Public Health from LSHTM in 1936; working at the Ministry of Health in the 1940s he was closely involved in the establishment of the NHS.

very much on a professional line. And he had all sorts of ways of making people do things, even if they weren't under his direct command. I don't dispute for a moment that there were good reasons why consensus management had to change.

**NICHOLAS TIMMINS:** Right.



**NIGEL EDWARDS:** In a highly unscientific poll of people who were around, thinking back over the history of the sixty years, the Grey Book and the '74 reorganisation stands out as a pinnacle of mismanagement and its legacy in terms of setting off the idea that the NHS was highly bureaucratic was very significant. Brian Edwards,<sup>42</sup> if he was here today, actually nominated the author of the Grey Book as one of the villains of the NHS. [laughter] But since the others were Harold Shipman<sup>43</sup> and Beverley Allitt<sup>44</sup> [laughter] that's probably slightly, slightly extreme! But I do think, its legacy of

creating this impression of a hugely bureaucratic service, and the thing that really persists today, is that the NHS is full of bureaucrats, I think has its roots in that document and particularly the BMA's response to it, which was very hostile. I was quite interested that we didn't pick up, though it was alluded to, some of the mess that

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<sup>42</sup> Brian Edwards: Emeritus Professor of Healthcare Development at the University of Sheffield. Edwards held various hospital posts 1958-69, lecturer in health service studies University of Leeds 1969-71, deputy group secretary Hull Hosp Management Committee 1971-73, district administrator Leeds District Health Authority 1973-76, area administrator Cheshire AHA 1976-81, regional general manager Trent RHA 1984-93. He is the author of *The National Health Service: A Manager's Tale 1946-1992*, (London: Nuffield Provincial Hospitals Trust, 1993).

<sup>43</sup> Harold Shipman (1946-2004) was a convicted serial killer and former doctor. The Shipman Inquiry (2000-2002), chaired by Dame Janet Smith, decided there was enough evidence to suggest Shipman had probably killed about 250 people and prompted reform of legal structures regulating health care and medicine.

<sup>44</sup> Beverley Gail Allitt, born 1968, was a serial killer who murdered four children and injured five others while working as a State Enrolled Nurse (SEN) on the children's ward of Grantham and Kesteven Hospital, Lincolnshire.

was left behind. So although the tiers have been cleared away, there was still this feeling of a very rigid system.

**NICHOLAS TIMMINS:** Yes. And that's also where the issue of 'how much manpower have we got?' came from as well. Cyril Chantler.

**CYRIL CHANTLER:** Yes, my memory of what led to the difficulties was the gap that was widening year by year between what medical technology could do and wanted to do, and what money was available to do it. And, certainly consensus management at Guy's Hospital was not working in the early eighties, and we seemed to have most of our conversations with the hospital management in television studios. [laughter] And I went to Johns Hopkins<sup>45</sup> as a visiting professor in paediatric nephrology in 1982, and was struck by the way they managed there, which was



decentralised into clinical teams that had real management responsibility, authority and accountability. And there the doctors took it as part of their duties to make sure that they operated within an efficient system. And, and Nick, when you wrote about

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<sup>45</sup> Johns Hopkins Hospital, Baltimore, Maryland, USA.

the Guy's system later on, you talked about the 'quisling' factor. Could, was it possible for a clinician to take responsibility for expenditure, and also take responsibility for care of patients? And that was the big question that then came up at Guy's, because I came back, the Griffiths Inquiry was just starting then, and I think, it must have been Mr Graham came, because Roy didn't come. And, I think Cliff Graham did.

**MICHAEL BETT:** I did. With Cliff

**CYRIL CHANTLER:** With Cliff. And we were just beginning to talk about it. And the Inquiry then came out. We had a serious debate in the medical and dental committee at Guy's, culminating in August 1984 in a decision that we would actually cooperate with a system where the clinicians took responsibility. But the key philosophical issue, if I can put it that way, was how do you deal with quisling factor? It was my contention that in a cash-limited system it becomes an ethical responsibility on the part of clinicians to manage a good deal of the resources available, because profligacy in the care of one patient can lead to poor care for another. And that was when clinical budgeting came in. I didn't get a huge amount of support from the BMA, but I didn't get absolute obstruction either. Paddy Ross<sup>46</sup> was very supportive of it, and so was Tony Grabham. But there wasn't huge enthusiasm behind it. But we, we made progress, and it's a matter of history that it worked very well. What happened after that in '92 is another story.

**FRANK WELLS:** At that time, there were some of us who were, at that stage, becoming extremely supportive of the Griffiths concept; we can look at that later. But there were many people who we couldn't get on board, as it were, who were very supportive of that illustration of the way it could work at Guy's which you exemplified and which Tony Grabham supported.

**NICHOLAS TIMMINS:** Thank you. Yes.

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<sup>46</sup> Patrick Ross: Chairman of the BMA Joint Consultants Committee.



**HUGH FREEMAN:** I'm a psychiatrist and was a member of the Area Management Team in Salford. The consensus in our team worked extremely well, except that the nursing member had been promoted somewhat beyond her capacity, and that weakened it somewhat. The consensus worked as well as the people who

made it up and in our case the leadership from the administrator was largely a reflection of his personal capabilities rather than his job. In practice leadership emerged and it functioned very well. Consensus did not lead to a lack of initiative or innovation.

**NICHOLAS TIMMINS:** Right. Peter.

**PETER SIMPSON:** Iden Wickings' <sup>47</sup> work on budgeting put the management teams under considerable stress and made those who were having most difficulty coping at odds with their colleagues. They did not wish to be committed to things that they felt they personally would not be able to defend. They didn't quite understand the nature of the programme. It was a terrific relief when we were working at Guy's where for the first time there were people who could cope.

**NICHOLAS TIMMINS:** So conduct, we're moving into. Michael, you're the one here that can talk about Roy's conduct of the Inquiry.

**MICHAEL BETT:** Roy was not always an easy man, but he was a good leader, and having read this report again, I realised that he had a pretty fair overall grasp, and he was certainly committed. I will say that is entirely written by him, mainly because Cliff was uneasy about the pure Roy Griffiths' line, and Roy realised that he was

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<sup>47</sup> Iden Wickings: NHS manager, later worked at the Kings Fund, becoming deputy secretary, 1986. Worked on clinical budgeting in the late-1970s and early 1980s, directing the Fund's CASPE Research (Clinical Accountability, Service, Planning, and Evaluation in the NHS), which piloted clinical budgeting arrangements in hospitals. Relevant publications include: 'Incentives, budgets, and planning arrangements for clinical teams' in: *Hospital costing and the clinician*. (London: DHSS, 1978), 23-6, I.Wickings, J.Coles, R.Flux, L.Howard 'Review of clinical budgeting and costing experiments', *BMJ*, 286 12 Feb 1983, 576-8; *Rents, rates and performance indicators for the NHS estate*, (London: King Edward's Hospital Fund, 1983)

going to have his report diluted if it was written in the usual way with the civil servants. So Roy wrote, Roy wrote it all.

**NICHOLAS TIMMINS:** Right. And was the famous phrase Roy's?

**MICHAEL BETT:** Yes.

**NICHOLAS TIMMINS:** Nightingale?

**MICHAEL BETT:** Yes. And that isn't the only striking phrase I think, the mobiles ... there's all sorts of bits and pieces of light among the darkness. He was however not very easy with consensus, that's to say, he ... [laughter] he didn't like to be disagreed with, and so he wrote the report. And I for one was never given any other impression.

We travelled around, we met all sorts of people, we learnt all sorts of things. We met nurses who weren't interested in pay, we met all sorts, who were more interested in nursing. And all sorts of refreshing things like that we met. But this consensus thing, it may have worked here and there. However, it does require, and I think this has come out of the discussion so far, it does require four, five or six people of relatively even or good talent, and then maybe they can achieve something through consensus because they are men and women of good will. But it was failing all over the place, and there were all sorts of problems. Vetoes were used. Christine, it may not have been with you, but the reason why consensus was actually appealing was not that it got you somewhere, but that it enabled a tribe, one of the NHS tribes, and that's really what they were, to say 'no', if whatever was being proposed didn't suit the tribal interest. And so, Roy was absolutely adamantly against perpetuating anything like that.

And, and then of course with the examples that I mentioned with people like John Sainsbury, Arnold Weinstock, the chap who ran United Biscuits,<sup>48</sup> the people who were heroes of the time, were great individualists, and did not run with collectives. I mean Arnold Weinstock's board meetings ... he even read the

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<sup>48</sup> Manufacturer of biscuits and snacks founded in 1948 following the merger of McVitie & Price and MacFarlane Lang. Hector Laing chaired the company from 1972 to 1990. Jim Blyth, Group Finance Director at United Biscuits, was the fourth member of the Griffiths Inquiry team.



newspapers! [laughter] I mean that was not how GEC was run. These men were outstanding individuals who made decisions and of course that was a refreshing change for a lot of people.

But we, we had a, a lot of criticism. How was a grocer to know how to run a health service? Well the fact is, he wasn't a grocer; he just happened to be grocerying at that time. [laughter] He was a manager. He was a professional manager, and he had come from a, a chemical company.

**CYRIL CHANTLER:** Also a lawyer wasn't he?

**MICHAEL BETT:** And, and...

**CYRIL CHANTLER:** By background he was a lawyer.

**MICHAEL BETT:** Yes, but he wasn't a grocer. I know that when I chaired the Armed Forces Independent Review<sup>49</sup> people in the forces kept telling me that, 'You can't run the armed forces like Marks & Spencer's.'<sup>50</sup> I virtually had to respond that 'I never worked for Marks and Spencer's!' [laughter] 'I've no idea what Marks and Spencer's ...'. But people get ideas like that fixed in their minds, and Roy did suffer in that respect.

**NICHOLAS TIMMINS:** The passions were immensely strong. I mean, I remember going to an RCN meeting in Bloomsbury quite early on and Roy appeared on the platform, being jeered and screamed at and shouted at and 'What's a supermarket director doing running the Health Service?' And he ... he was really shaken by that.

**MICHAEL BETT:** Of course he was. He didn't recognise himself.

**BOB NICHOLLS:** It's very interesting to hear Michael's interpretation of that team because from my regional administration perspective there was Brian Bailey, my RHA Chair, as a member of the team, and as an administrator in the field, (unlike my

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<sup>49</sup> M. Bett, *Managing people in tomorrow's armed force. Independent review of the armed forces' manpower, career and remuneration structures* (London: HMSO, 1995).

<sup>50</sup> Marks and Spencer's: leading British clothing and food retailer, founded 1884.

colleague on the right), I felt that there were some really bright people in the Department of Health, I'm sure Graham was one, but Graham, Cliff Graham <sup>51</sup> was a bit of a hero to us in the south-west, partly because he was idiosyncratic, he would challenge the circulars all pouring out. I think he was in charge of capital or something at one stage, and we had to make our mark, but Edith Korner, <sup>52</sup> Brian Bailey, Trevor Rippington <sup>53</sup> of RAWP fame, <sup>54</sup> all thought Cliff Graham was a real mover and shaker, and that if we wanted to influence the Inquiry we had a route through Brian Bailey, but we also had a route through Cliff Graham.

**MICHAEL BETT:** There was such an influence. So in the end, Roy wrote the report himself.

**BOB NICHOLLS:** Yes, I entirely accept that. Could I just finish the thing about the grocer? I think that was grossly over-exaggerated. I was giving evidence. We were summoned at one point, I suppose because I was in the Institute's party, and we met, and I remember, yes, a robust discussion, and I thought slightly too much 'private good, public bad'. One striking thing though, I think he said, but it may have been Cliff Graham, is, that he was struck by the fact that, the shop floor workers in Sainsbury's were rather different from the shop floor workers in the NHS, which were essentially highly trained consultants, nurses, very well educated, making amazingly big investment, resource decisions, which was the complete reverse of Sainsbury's. So I think, and what I suppose the Institute was trying to get over was that actually there were big differences, and we weren't sure that we would get very far if he didn't manage to carry the doctors and the nurses with him, with whatever he proposed. By then we agreed that consensus management wasn't working in many places. But he

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<sup>51</sup> Clifford Graham (1937-1994), Higher Executive Officer, Ministry of Health 1965-68; Principal, DHSS (later DH) 1969-74, Assistant Secretary 1975-82, Under-Secretary 1983-94; provided support to the Inquiry and as Under-Secretary was instrumental in the introduction of general management in the NHS

<sup>52</sup> Edith Korner, CBE: An influential figure in the development of the information and statistics system used by the National Health Service. She was chair of the South Western Regional Health Authority in 1976, and in 1980 she chaired a full-scale review of health service information. The Körner Committee sat for four years and produced six reports. The Committee examined the way the NHS collected and used its data and paved the way for comprehensive computerization of the health system.

<sup>53</sup> Trevor Rippington: ex-regional treasurer of South-West Regional Health Authority.

<sup>54</sup> RAWP: the Resource Allocation Working Party was appointed in 1975 to devise a new formula for distributing funding within the NHS 'objectively, equitably and efficiently to relative need', and thus to correct the historically uneven pattern of resource allocation. Its formula, first applied in 1976/7 assessed expenditure needs according to population weighted by mortality indicators.

needed to carry the, if you like, the big tribes with him. Otherwise we weren't going to get very far.

**MARK LEARMONTH:** I wonder whether it's worth putting all this in a sort of wider political and intellectual context, because, it's worth reflecting, I'm kicking myself, I can't remember the name of the report, in '68, in Scotland I think it was, that recommended general management of the Health Service, and it was just politely ignored and forgotten about.<sup>55</sup> And one of the things that's very impressive that it did say, is that it would take fifteen years for this to come in, and it got it almost right on the nail. But you know, I remember in '82, '83, *In Search of Excellence*<sup>56</sup> and all these management heroes that were popular in the public imagination. The denigration of public administrators I think is another great important thing. And myself, I, I don't think Griffiths' report is a particularly impressive document; it seems to me what it did was give the excuse, or way, of doing something radical-ish in the Health Service that's very similar to privatising BT and various other Radical Right initiatives that were, you know, what Thatcher, I presume, wanted to do. So I think we might be giving too much credit to Griffiths himself, in spite of one or two rhetorical flourishes.

**NICHOLAS TIMMINS:** Ri-ight. [laughter]

**MICHAEL BETT:** Maybe there wasn't a great difference between privatising BT and tackling the Health Service's management. We didn't have anybody called 'managers', they were all called senior staff.

**NICHOLAS TIMMINS:** In BT?

**MICHAEL BETT:** Yes. And so the comparisons were very close indeed in many, many ways.

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<sup>55</sup> Farquharson Lang, *Report of the Committee of the Scottish Health Services on Administrative Practices in Hospital Boards*, (Edinburgh: HMSO, 1966). For a contemporary response to this report, see J. Blundell and J Lowry, 'Managing the Hospitals' *BMJ* 9<sup>th</sup> December 1967, p.617, who read its proposals to be 'the idea of a "super manager," who would in most cases be a lay administrator'.

<sup>56</sup> T.Peters, R.H. Waterman, *In Search of Excellence*, (New York: Harper & Row, 1982); the book claimed to illustrate successful management techniques of leading firms and was widely read.

**NORMAN FOWLER:** The fundamental difference is that BT went into the private sector and was owned by shareholders, and what we wanted to do was to keep the National Health Service as publicly-funded.

**MARK LEARMONTH:** Yes. But my point is that, you know, you wanted to do something radical, shake it up in some way which, you know...

**NORMAN FOWLER:** I don't think we wanted to shake it up, speaking for myself, shake it up just for the sake of it. I mean one only wanted to shake it up because some of the things were demonstrably not working. At the time there wasn't any justification for ...



**MARK LEARMONTH:** But surely that wouldn't be widely accepted across the political spectrum, in a way? I mean surely not?

**NORMAN FOWLER:** Well nothing ... Well that's a very good point, because actually, nothing was widely accepted. [laughter] Because you were wading through blood to get anything done at all!

**MARK LEARMONTH:** Yes. Yes. But with all due respect, I don't really think you can say it's a technical decision that, you know ....

**NORMAN FOWLER:** No, I wasn't... No, I think it was a profound decision, I don't really think it was a technical decision. It was a political decision. But I think that actually any administration would have arrived at that conclusion at some, at some point.

**MARK LEARMONTH:** What, even if Foot had won the '83 election?

**NORMAN FOWLER:** Well he might not have done! [laughter] But, any reasonable administration would have arrived at it! [laughter].

**MARK LEARMONTH:** Yes. The other thing that's interesting that comes out of this discussion is really the defeat of the Left, and that's, that's a very distinct change since the early Eighties, I mean it's probably the miners' strike that did it, but you know, now everybody agrees that management is a good thing now I'm not sure that would be true in the early eighties.

**NICHOLAS TIMMINS:** It certainly wasn't true..

**MICHAEL BETT:** No.

**NICHOLAS TIMMINS:** Thank you for that. Graham Hart.

**GRAHAM HART:** Yes. There was a point that Mike Bett may be able to help with. I haven't refreshed my memory, unlike a lot of you, of exactly what Griffiths said, but, certainly my understanding was that Roy Griffiths right from the beginning understood extremely well that what we were really talking about was how to manage what are essentially professional and clinical services. He understood that very well. And, of course the kind of giveaway from that is he certainly did say on the record that he was very keen to have professional staff, doctors, nurses, consultants, in general management positions, and it's one of the great tragedies I think of the implementation, which we may come on to later, that that didn't happen more. It may be because people didn't want to do it, I don't know, but certainly that was very much in his mind.

So I think he understood very well the nature of the business that was going to be done. Whether the report was in fact structured and written in the best way to produce that outcome, I'm less certain, actually. Because certainly the way it was interpreted, it got very much seen as, you know, managers, and it got associated with the supermarket idea; that somehow this was going to be about professional

managers, often businessmen, people like that, coming in and managing these wretched professionals who couldn't do the business themselves. Now, I don't think that was ever in his mind, but whether, as I say, the report could in hindsight have been structured better, or written better, to, to produce that outcome, who knows? I don't know.

**CYRIL CHANTLER:** Can I just say one or two words about Roy. He was enormously helpful to me. I became the general manager of Guy's in April 1985, and was tasked with doing something that I had never been actually trained to do. I never thought it was the task of my job to provide management expertise; I was there to provide an element of leadership. And I worked very closely with a man called Nigel Smith who was the chief administrator, very experienced and very good, and with the chief nurse, and the finance director. And there was a great deal of consensus, but it was a consensus which was driven by a need to achieve certain aims. And we had originally twelve and later fourteen senior clinical colleagues alongside us, and it's a matter of record that we took out fifteen per cent of the running costs over three years and ended up treating as many patients as we had at the beginning of this period.

What Roy said to me, and I got to know him very well during that period and afterwards, when I used to go along to Stamford Street, and he was, I suppose, my mentor, I remember him saying to me before he died, that he had never intended to invent a new profession called management. He said management is not a profession, it is an activity, it's a responsibility. Doctoring is a profession, law is a profession. Dare I say it, hospital administration is a profession, which I have profound respect for. Nursing is a profession. Management is an important task, as is leadership. He taught me what general management is as opposed to line management. In a professional bureaucracy, like in a hospital or in university, where I also have experience of management, you have to have a different style and way of doing things, you have to move forward with consensus, and you have to engage in general management and you need to provide leadership.

Roy I'm sure would be terribly upset now to see that two tribes have developed namely doctors and managers. Children used to play doctors and nurses [laughter] soon they will be playing doctors and managers. I get upset when I hear doctors or managers talking about each other as though they are not colleagues. because in fact the doctors, the nurses, the administrators, the finance people, all need

to be involved in management, and respect each other. It was not what he intended. I can't stay to talk about the long-term perspective, but I think, I think that's one unfortunate consequence. But it is not irretrievable. I think if we can understand where we are now and how we got here, and that's why we're all here today, then maybe we can move forward more positively.

**GRAHAM HART:** I can agree that Roy would have been terribly disappointed by what happened. What he thought could happen, and perhaps he was a bit naïve on this, was that more doctors, more consultants would wish to get involved in management. I don't want to start quarrelling with you about the definition of management.

**CYRIL CHANTLER:** No, quite.

**GRAHAM HART:** But, but he was very disappointed that more did not come forward and see it as a part of their vocation as a good consultant to manage consultants' resources, rather than spend them.

**CYRIL CHANTLER:** Yes.

**GRAHAM HART:** And that, I think he would accept that he was a bit naïve on this.

**CYRIL CHANTLER:** Nick and I have had a previous conversation about this. I can tell you about my conclusions. I think it did actually progress quite well between '85 and the early Nineties, and it had potential. It is my hypothesis, that what stopped progress was the creation of NHS Trusts,<sup>57</sup> and the Treasury rules that NHS Trusts needed to balance their books year on year, indeed had a legal obligation to do so. It brought all the authority and responsibility back to the centre of the hospital, and meant that they no longer encouraged decent decentralised management accounts, which are tools that clinicians require in order to manage. And it's interesting to me now that foundation trusts, which are free to create surpluses for strategic investment

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<sup>57</sup> The proposal that major hospitals might opt out of the control of district health authorities and become NHS Trusts with powers of self-government was made in the White Paper *Working for Patients* in 1989. This was implemented in the National Health Service and Community Care Act, 1990, which marked the introduction of the 'internal market' in the NHS.

and not bound by the same Treasury rules, are now promoting very actively service line costing and quality measures at the decentralised level. And that is one of the reasons that I am optimistic that we can actually build on this experience.

**NICHOLAS TIMMINS:** I'll take one more over there then I've got a couple more questions, Mike, about conduct, and then have a break for tea.

**VINCE SUDBERY:** I was at the time working for the NHS as an accountant. I'd just be interested, because I'm not hearing it very clearly, it might be myself being slow, but whether you might feel inclined before we break now, between you just to sum up what the key issues, and I know it's been discussed at some length, but what the key issue was that Griffiths was, was addressing. I say it partly in the sense of, with a private limited company or a quoted company, quite clearly one object is to be profitable. What were the, the problems in terms of the aims of the National Health Service that Griffiths was going to solve for us, so we can judge how well it did later on?

**NICHOLAS TIMMINS:** OK. Just, on conduct, he didn't formally take evidence, did he?

**MICHAEL BETT:** No.

**NICHOLAS TIMMINS:** And, so, it was unusual in that respect.

**MICHAEL BETT:** We had formal meetings I can remember some meetings with the unions about Whitley, and so on. We had an agenda, we just didn't bowl up and say: 'Hello what are you doing for the Health Service?' We did have prepared



meetings with different, I'll call them 'factions' for the moment, but I don't mean anything pejorative by that. And, yes, one of us would say, I think we ought to explore this topic or that topic or this reaction. I can remember Roy wondering about



the grocer reaction that you mentioned earlier and so on. So, we had some order for what we were doing, but it was not a minutely ordered exercise.

**NICHOLAS TIMMINS:** And I, I don't know if this is right ... I have the impression that you spent quite a bit of time going to hospitals and talking to doctors and nurses rather than talking to organised bodies of people.

**MICHAEL BETT:** Yes. But we did both

**NICHOLAS TIMMINS:** Instead you went around and had a look.

**MICHAEL BETT:** We did both. We talked to organised bodies, we talked to people, who I've rudely called the tribes and their leadership, and that was fine, and we talked to the unions. But Roy did actually have a lot more time for the people actually on the ground.

**NICHOLAS TIMMINS:** He's, he's also on record as saying that he thought what he'd been whistled up to do in the first place was deliver a bit of advice. He wrote a short note which then went to Downing Street, and Margaret Thatcher then said, 'I want a report.' At which point Roy said, 'Well I'm managing director of Sainsbury's, I'm quite busy.' And she wanted him to take a week off and write the famous letter. Does that sound ... ?

**MICHAEL BETT:** I think that makes a good story. [laughter] But I do think that Roy was quite good at politics, and he would have used that trip to Number 10 to suss out what it was that he might get away with writing, in the way of the Report.

**NORMAN FOWLER:** And he wasn't actually reporting to Number 10.

**NICHOLAS TIMMINS:** No.

**NORMAN FOWLER:** As I say, he might have had access to Number 10, and he certainly would have liked more access. [laughter] But that wasn't where he was meant to be going. [laughter] I've never heard that story before.

**MICHAEL BETT:** Nor have I. [laughter] I'd never done an inquiry before, I've done one or two since, but I'd never done one before, so I didn't come to it with some preconception of the way we should go about our business.

**NICHOLAS TIMMINS:** Right.

**BOB NICHOLLS:** Brian Bailey, I think it was Brian, said that he felt the investigations team was like four not very good golfers, driving off the third tee all in completely different directions. And with a bit of luck, which he then said happened, they might arrive at a green more or less at the same time at the end. I have to say, reading the report again it does feel a bit like that, which Michael has confirmed, that there was a really strong overlay of Roy himself. So nothing like the normal sort of report process, and that's why some of us were very shocked, and I'm sure the BMA and RCN were, that no proper evidence was collected. And as for consultation? Ha! "No, we haven't got time for that!" I mean it was a completely different process from most other reports, the Royal Commission and other reports for the NHS.

**MICHAEL BETT:** If you think of the volume of evidence we would have attracted merely by saying, 'Come and tell us what you think.' I mean, it was absolutely deliberate. We were not going to invite huge waves of paper, which we would then have to wade through.

**BOB NICHOLLS:** Right.

**MICHAEL BETT:** And that would have been to Roy the culmination and utter condemnation of the consensus approach.

**NORMAN FOWLER:** Also you didn't have too much time either. You were appointed in February, and I asked you to report, advise on progress by the end of June. So that put you on a pretty tight timetable.

**MICHAEL BETT:** He was doing his job. I was personnel director of BT, he was managing director of Sainsbury's. Jim Blyth was certainly a finance director of somewhere or other. And Brian Bailey ...

**BOB NICHOLLS:** Brian was doing his television chairing by then.

**MICHAEL BETT:** [laughs] So, quite honestly, I mean we did it in our spare time.

**CHRISTINE HANCOCK:** I was a Director of Nursing at the time, and I had no real idea it was going on. And I think that probably accounted ... I can remember my predecessor saying he was really worried about something that was happening, and I was busy, and I didn't and yet I would have read the *HSJ*,<sup>58</sup> and the medical journals. I was at the Bloomsbury meeting and I knew Roy quite well, subsequently and liked him, I met him frequently, but he was shocked rigid by that meeting. That was like a spontaneous outburst of people, who were the ministering angels, yet just absolutely baying for him. And I think part of that was because nobody had any idea what was coming. In the longer-term, now that's, maybe good or bad, but I'm not at all sure that he'd thought that one through, he might have not gone to a public meeting for a while until the shock had died down. [laughter].

**NICHOLAS TIMMINS:** Right. Two more and then we'll break.

**ALASDAIR LIDDELL:** Just one other memorable phrase, from the report, was 'planning, implementation and control of performance', if I've got that right. And what's quite interesting is that I don't think he had really defined in any great depth what performance was about. Perhaps he felt actually the NHS should do that for itself. I think the word 'output' is mentioned in the report, I don't believe the word 'outcome' is, although I could be wrong about that. I think he thought more about outputs. And, I don't think it's unfair to say that the NHS hadn't really defined what performance was really about, beyond financial regularity and so on, until quite a bit later. And even now I think it really struggles to find real measures of outcome which

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<sup>58</sup> *Health Service Journal*.

go beyond simply the clinical effectiveness, into measuring things like equity, access and responsiveness.

**CYRIL CHANTLER:** Could I just intervene? This is interesting, I thought we would take that in the second part, but one of the first things the Guy's management board did was to set out the information that would be needed in order to manage, and outcomes is very much part of that. And that was a clinically dominated board, of nurses and doctors, saying if we're going to manage, this is what we have to know.

**PETER SIMPSON:** I picked up the impression that he was very concerned with what he had seen, and that there was a really big chance to improve what was happening in the Health Service. And I thought that the brevity of the report was aimed at giving you, Lord Fowler, the opportunity to move to action rather than consultation, and that the doing was what had to come out of the report. And others picked up the chance to actually perform differently, as a result of what he had said.

**NORMAN FOWLER:** Yes I agree with that. I mean I think it was very much a report which was very much, you know, action this day. Action should follow. There was an impatience about it, and, I think that was probably the right description of what government of the time felt as well.

**NICHOLAS TIMMINS:** Which is the perfect point to start off the next bit, so we'll have a quick break for ten minutes and then we'll reassemble.

**[BREAK]**

**NICHOLAS TIMMINS:** Right, we're now we come to reception and implementation. And you were saying that it was delivered with a sense of urgency, but there was quite some thinking about it before it was published.

**NORMAN FOWLER:** That's true. And I mean it was delivered, what, in June? I made my statement in October, so yes, there was a lot of thinking on that. I mean, in précis my view would be that at the health authority level, and around that, below that, I thought that it went well. Others may have a different view.

I think where we didn't do so well was at the top of the organisation, at the top of the Health Service. In a sense one was back to the Enoch Powell thing, of how do you have an effective management, and at the same time you are politically answerable to Parliament for everything that takes place? Roy Griffiths, interestingly, his way of squaring that circle was to make Roy Griffiths himself the minister in charge. That's really what he would have liked to have done. He would have liked to have been in the House of Lords, minister in charge of management of the Health Service. And actually that wasn't a bad idea, and I remember running round the track on this particular issue. It was vetoed, as we used to say, in the Lords, on the grounds that, as opposed to the Commons, in the Lords ministers were expected to do other things, and not just one thing. They are meant to, quote, 'muck in'. And so you might find yourself answering questions on other subjects as well. Roy Griffiths didn't really like that idea one little bit, and so these embryonic negotiations sort of broke, broke down.

**NICHOLAS TIMMINS:** Was that before or after publication?



**NORMAN FOWLER:** That was after publication, and it was at a time when... The difficulty, with having a management line and having a policy line, in a sense is, Graham would know more about this than me, but there's obviously a potential for

tension between the permanent secretary on one side and the general manager, the manager, chief executive, call it what you will, on the other. I thought it at the time, that the only way really, or perhaps I thought it by the time I left the Health Service in my last year, that the only way really that to actually reconcile this was to have, if you like, a National Health Service Commission which was a step apart from the Department of Health. And I remember putting this to Margaret Thatcher, and again it was a badge of the time, her immediate response to that was, 'We can't possibly do that, they'll say, this is just a step to privatising the whole of the Health Service.' And there's no question at all that in the kind of public debate that there was on the National Health Service, that that's exactly what did it.

I'm intrigued to see now it tends to be an argument from the Left as opposed to an argument from the Right, which I think is rather encouraging. So, perhaps we're getting to a bit of consensus here. I'm not saying there aren't problems in doing it, but I think this, I think it's about time we actually managed to, able to, divide in a sensible way management policy, rather than having the environment rather like the old Post Office used to be, run, with all lines ultimately kind of going back to the Secretary of State. So I'm a kind of, I'm a National Health Service Commission man, and I think that if we did that, then you would get a sensible culmination of the Griffiths Report.

**NICHOLAS TIMMINS:** Looking back, particularly in the light of what happened, what is slightly odd is that the report was published, the idea of the Supervisory and the Management Board was accepted, and then there was quite a long period of consultation about general management out in the Health Service. If you look back, the Supervisory Board's long dead and the Management Board has become something different and yet general management is still out there. It seems odd it was that way round, particularly when the history of the Board in the Department is considered. Why did you say yes to the bit at the top but have to think about the bit at the bottom?

**NORMAN FOWLER:** I don't think we saw the problems. We were optimistic that they could be done. In a sense as well, we were slightly hoist, weren't we? I mean, you know, we had asked for the report. [laughter] This was the findings. If I started going out there saying, 'I'm not going to do this,' and, do you think that the rest of the Health Service would have actually said, 'Oh well that's all right, they're not doing

it.' But of course we would do everything it said. So we were slightly opposed on that. It didn't work. I always feel guilty about poor Victor Paige<sup>59</sup>, who I recruited, I waved in and I waved out, as the kind of first sort of general manager, because he didn't really have the power and the authority to do what we asked him to do.

**PETER SIMPSON:** Do you really think he had the ability? [laughter]

**NORMAN FOWLER:** Well he had the ability...

**PETER SIMPSON:** Ability.

**NORMAN FOWLER:** Well I'm not sure... I mean, I liked Victor, Victor was a kind of good ...

**PETER SIMPSON:** I'm not saying that. I'm saying the ability. [laughter]

**NORMAN FOWLER:** I'm not sure if there's any man on this earth probably who had the ability to do the job that we actually gave him. That's not to say that you couldn't have someone. I think quite a number of people could do the job, if it was organised in the way, in a commission way. But to actually be both a manager and a Whitehall warrior, and actually deal with these skilled people in the top Civil Service, I mean that requires a degree of knowledge and background and skill that only very rarely people have. So I wouldn't say that. I don't think it was a matter of lack of ability.

**MARK EXWORTHY:** Could I just take a step back before publication, and then it comes to this point about the Supervisory Board, because, was there ... there has been some discussion, but was the ground prepared by the inquiry team within the Department about, as it were, the art of the possible? Because, clearly if you were accepting the Supervisory Board almost *fait accompli*, had that been discussed as a possibility? Had the Inquiry team briefed? Had you had briefings? Had there been much interaction?

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<sup>59</sup> Victor Paige, previously deputy chair of the National Freight Corporation, became chair of the National Health Service Management Board in 1985 and resigned a year later in 1986.

**NORMAN FOWLER:** Before it was published?

**MARK EXWORTHY:** Before ... Yes, between the February and the July.

**NORMAN FOWLER:** Not in ... certainly not with me. I mean, almost certainly Ken Stowe would have had a, might have had a few words.

**GRAHAM HART:** It wouldn't have gone near the minister, I can tell you that.  
[laughter]

**MARK EXWORTHY:** Not the minister, but, but others. To ask, as it were, what's the art of the possible?

**NORMAN FOWLER:** Well I mean there's a question in the areas for discussion which says, words to the effect, was he an independent actor or essentially a compliant appointee? Well I think anyone who knows Roy Griffiths, or remembers Roy Griffiths, would not describe him as a compliant anything. And he was certainly not a compliant appointee. So, he was going to do his own thing. What I'm not saying is that he might ... I mean, he did want this job himself, so I'm not entirely, dissociating that from whatever ambitions he may have had to have done it. Because in a way it could have squared the circle. And there's a piece in the report which I was reading, which basically says, what you're going to be quoting, if you wanted to have a commission, then you would need legislation, and it would be long time in the House of Commons. And so, if you wanted action today, that wasn't the way to go. So all that conspired to get us to that position, but it didn't work.

**NICHOLAS TIMMINS:** Just before I come round here, the Civil Service is cast as the sort of, resistant ...

**GRAHAM HART:** No, I don't think that would be right at all. I was trying to come in on the point about the NHS Commission. I am very interested to hear what Lord Fowler says about that, and I can certainly remember discussing it with a successor of yours.



**NORMAN FOWLER:** And he was in favour was he?

**GRAHAM HART:** Well, I'm not saying which one. It's actually a very difficult issue which I've wrestled with over the years. Whether that would be the right answer. And I think that, we have to remember again, context. The 1980s. I don't think the nationalised industry model was in favour, and I think that there'd been difficulties over the years in relationships between nationalised industry boards and ministers. I mean methods had been devised for setting them up at arm's length from Government and in practice it didn't always work very well, because ministers, with the best will in the world, from time to time want to pull on the reins, and nationalised industries don't like it. So, it wasn't a straightforward thing. And the other danger I think from politicians' points of view about having a body which is genuinely arms length, is that you're talking about this hugely, and even more now, hugely expensive public service. What is it? Fifteen per cent of public expenditure now? Or something like that. And, you don't really want these guys out there lobbying publicly because they can't build up the service because they're not getting enough money.



So, it's, it's not at all a simple thing. And maybe the conclusion that Roy came to, partly on the grounds of legislation, was, well certainly it's understandable. And maybe even the right answer, if you think, and everybody's assuming this, that we were then moving, and have moved, further in the right direction, so far as the Department is concerned. In other words, we were taking on then the beginnings of a sort of management role in relation to the NHS which we've seen develop even more strongly as the years have gone by. These things have a way of being pendulum-like, and one day people will turn round and say, well, actually this is a blind alley we're going up, and maybe we need to go back. I worked very closely with Victor Paige, I was one of his helpers for the whole of the time that he was in the Department, and I agree with everything that's been said about him, I think he had a very difficult job... I just want to say, I've never done the job

myself, but I've worked for three people who have done it, and then as a colleague with others since, and this is an immensely difficult job.

I do think that, whatever you call it, Chief Executive of the NHS, whatever you call the job, it's probably the most difficult and challenging management job in the public sector. I don't know that much about the private sector side, I couldn't say that, but it's a very, very challenging job. And getting it started, with all this uncertainty around, is the other contextual point. I established this with one or two colleagues in the tea break, none of us really understood what this was all about. This is a very, very hard thing, you know. You can read the words in the Griffiths Report, but kind of operationalising them, turning them into practice. What did it actually mean? What have you got to do, to implement this? We were all fumbling around. I think I was. And I think a lot of other people were. We were finding our way, feeling our way with it.

**MICHAEL BETT:** Well I think this was at the root of the difficulties that Roy and Cliff were having. Cliff would listen and would understand what you and others were saying to him. And Roy was either not understanding it or not willing to understand it, because to do so would reduce the force of his thrust. The word 'drive' appears in his report again and again.

**GRAHAM HART:** Yes. Absolutely.

**MICHAEL BETT:** Just analyse how that's written. And Roy just believed that too much of this stuff would slow it all down. And, you know, if you slowed it down, it would never get done with such an enormous organisation and such a complex organisation.

**ALASDAIR LIDDELL:** Just briefly, to Graham's point about whether we could understand what he was about. I think it's very deceptive when you read it now, because, this seems clear as anything doesn't it? But we're seeing it through the spectacles of twenty-five years later and all the history that's gone before. But it did have enormous impact, and I do remember a lot of us, who would be quite capable of understanding these kinds of concepts, sort of scratching our heads a bit, on how do you operationalise this, in this very complex environment in which we were

managing? So it did take us a bit of time to get our heads around what it really meant, and how to move away from a very literal interpretation of it, to something that was much more about what he was actually driving at. And how could we best operationalise what he was actually driving at, rather than necessarily meticulously following the precise words he used.

**NICHOLAS TIMMINS:** And do you ... Sorry, I will come back round. Do you ... One of the things that struck me remembering that is that there was also, I mean it wasn't in Roy's report, but certainly Ken Clarke was very good on this, and probably you Norman, was this desire to bring in private sector managers as part of the new general management cadre.

**MICHAEL BETT:** We said it in the report.

**BOB NICHOLLS:** But it may be, thinking back, that the nine months or however long, to actually give us to think about and challenge was insufficient. How would the BMA deliver about general management, how it was going to be introduced, where were all these managers going to come from? That's a very good point. Actually, it was the right way, and we had the impression that there wasn't any preparation for what was going to happen at the centre. So Victor Paige didn't have a chance. He just came into something where management was a new concept. .

**FRANK WELLS:** I was very much on the receiving end of the report, as the Under-Secretary responsible for actually handling the Griffiths Report within the British Medical Association, and, and, so I, it was one of the things of course, what slowed it down was immediately the reaction of the BMA. It's not surprising, it often does, this kind of thing. [laughter] First of all it produced a letter which is almost, it's in single space, and that's in double space, it's almost as long as the report itself. [laughter] It's not quite true. But it also asks twenty-seven questions of the Secretary of State. Now, Norman, needless to say, relied very heavily on his Chief Medical Officer at the time, who was Sir Henry Yellowlees, a great guy. But, the thing was that in fact we neither welcomed nor condemned the report. We actually said, there are so many unanswered, so many questions we need answers to, we can't actually comment on it quickly. And we didn't.

But I have to say, and I so share the views of Cyril Chantler, that, being the guy who was actually responsible for advising the BMA team on what their responses should eventually be, I had a number of personal meetings with Roy Griffiths at the Sainsbury's HQ, and got to know him very well. And he certainly convinced me beyond all peradventure that the principles of general management absolutely made sense. Now, one of the reasons why the BMA did in fact delay was because, as I said



earlier, consensus management was perceived by many of the doctors who were actually doing it as working quite well. And we agreed that there were some places where consensus management wasn't working out, but they felt they didn't need to change. On the other hand, they also recognised quite quickly when we talked to them that consensus management could throw up the right person to be the general manager. It could be the nurse, it could be the doctor, it could be the administrator.

I was then actually deputed, for the next thing was that the annual representative meeting of the BMA which was some seven months after we received the report, did

actually welcome, it did actually support the concepts of, of the report. And I was then sent on a mission to actually go and talk to hospital consultants, because GPs were really quite at the edge of this, they were marginal actors in this in a way, because they still had their FPC<sup>60</sup> structure, and their local medical committees were the ones that were responsible. John Horder<sup>61</sup>, who was the chairman of the GPs at

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<sup>60</sup> FPC: Family Practitioner Committees were introduced in the 1974 reorganisation as successors to the Executive Councils which oversaw primary care. The administrative boundaries of the FPCs were the same as those of the Area Health Authorities, and medical professionals were well represented, holding 15 of the 30 seats on each board. They were replaced in 1991 by Family Health Service Authorities, smaller, more managerial committees with only one GP representative.

<sup>61</sup> John Horder: President of the Royal College of General Practitioners (RCGP), 1979-1982. He is particularly associated with efforts to raise the status of general practice in the early NHS and with restructuring vocational training for GPs. He chaired the small group that wrote and published *The Future General Practitioner: Learning and Teaching*, (London: RCGP, 1972) and was a founder and later chair of the UK Centre for the Advancement of Interprofessional Education.

the time, joined with Morris Burroughs who was the chairman of the consultants in saying, 'We actually do support the concept of general management.'

I then went round the country, and I looked, I've brought my three diaries which were from the two years in which I was actually doing this. I actually went to sixty-three different locations. The nadir, as I was telling Christine earlier, was, well first of all, towards the end of this exercise, we actually, through the seminars which we, we promoted in the various hospitals all around the country, to other disciplines of the work including the nurses, Christine reminded me the RCN didn't have the same activity at that time that the BMA had. The nadir of our, of my experience was when I went to Scunthorpe, I had an audience of one nurse. [laughter] And I have to say, that nurse did actually become a general manager. [laughter] So in some ways it was successful.

But, but the tragedy, looking back on it, and I do think it's a tragedy, was that, that there weren't enough doctors who actually did grasp the nettle and decide to become general managers. And those that did had a difficult time. Most of them did have a difficult time for whatever reason. And, I think that, had all the things that Roy Griffith wanted in the concept of general management actually been taken on board by the doctors in sufficient numbers, a lot of things that have happened since wouldn't have needed to have happened. That's my, my view of the situation now, from where I sit, which is outside. Well actually I'm chairman of the retired members forum of the BMA, but that's, that's what I see at the moment.

**ROBERT MAXWELL:** I wanted to talk a bit about the reception in the field. After the Secretary of State had come out saying that he accepted the recommendations so far as the Department were concerned, (and I think he said, in broad terms, the rest of the report also) in the period of consultation that followed, there was a series of hearings by the Social Services Committee<sup>62</sup>. Tom Evans<sup>63</sup>, then the Director of the

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<sup>62</sup> See *First Report from the Social Services Committee, Session 1983-84, Griffiths NHS Management Inquiry Report*, (London: HMSO, 1984); the committee was chaired by Renee Short (1916-2003) and included politicians such as Michael Meadowcroft and Conservatives Nicholas Winterton and Edwina Currie

<sup>63</sup> Tom Evans was appointed Director of the King's Fund College in 1981 having trained at the LSE then lectured in public sector management at the London Business School. Evans oversaw the expansion of the College, with increasing numbers of Fellows, more extensive fieldwork and consultancy and the introduction of action learning within management training. He died at an early age in 1985. See F.K.Prochaska, *Philanthropy and the Hospitals of London: The King's Fund, 1897-1990*, (Oxford: Clarendon Press, 1992), 236-7

King's Fund College, with me as chief executive of the Fund, gave evidence to that committee and we came out very definitely in favour of the report. We said whether it is good or bad, depends entirely on how it's used by the NHS and the government. If it's well used this could prove to be the most helpful document yet written about the management of the National Health Service. But, we said, this is much more than about structures; it's about whether the service is going to be run in a different way. Different by government, different by those in the field.



Tom, in a separate paper, pointed out that there were a series of different ways in which at the unit and the next level up, the change to general management could be implemented. One was nominal, that is, one of the existing members of the team gets the role added to his existing, or her existing, responsibilities. Another was supernumerary, in which one of the team is appointed to the role and then is replaced in their existing role. And the third was an executive board in which the DMT<sup>64</sup> is changed into an executive board with CEO and a distribution of responsibilities, which

reflect management functions rather than professional representation. It gradually became accepted in the Service that it was the last of those three options which was the one that needed to be followed. It wasn't always an easy message for the professions to accept, I think particularly for the nursing profession. But few people would want to go back to the previous situation. Maintaining a healthy balance between authority and freedom of action is crucial at the local level and between government and the NHS.

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<sup>64</sup> DMT: Departmental Management Team

**MARTIN POWELL:** A question about who these general managers were. From what we've heard, we've seen the different logics of the old administrators, doctors and nurses, the private sector. But any idea from anyone why we had relatively large numbers of ex military personnel? [laughter] Because the army had the archetypal management structure, of command and control while the NHS has what's most inaccurately called 'command and control' and you can't imagine a bigger contrast. But then did anyone envisage why we would have that system?

**BOB NICHOLLS:** A very interesting point.... I read Tom's and Robert's article about implementation, which rings the right bells. It was an interesting, quick, very challenging report of how we were going to implement all this at the top. Very interesting, the first thing that regions did was to appoint their general managers and it could be, be argued that this set the scene for the rest. The smart regions got up quick to, I think it was normal for regional chairs to say, 'We want X to be our general manager.' Tick or no tick. And the ones that got in early, six out of seven, were administrators. It happened that my region was a bit slow, and nationally there was only one doctor at that point, Rosemary Rue in Oxford.<sup>65</sup> No nurses, and lo and behold, my region ended up with a nurse general manager, and I was dispatched to the boondocks. But there was no process, no explicit or agreed process. Later, bearing in mind that Roy didn't say anything about the military, but he did say 'outside', and he did say doctors and nurses should be in, there were bigger attempts and a more systematic approach, more, as Robert described, about how to attract a broader range, what the skills sets for all those jobs were, and there were proper processes as you might have expected.

**NICHOLAS TIMMINS:** My memory is that initially there was a fair bit of ministerial pressure for outsiders.

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<sup>65</sup> Dame Rosemary Rue (1928–2004): Assistant County Medical Officer, Hertfordshire 1960-65; hospital doctor, Oxfordshire 1965-73; Assistant Regional Medical Officer, Oxford Regional Hospital Board (later Oxford Regional Health Authority) 1965-71, Senior Assistant Medical Officer 1971-73, Regional Medical Officer 1973-88, Regional General Manager 1984-88; . In 1972 Rue was one of the founders of the Faculty of Community Health (the Faculty of Public Health from 1989), and was President 1986-89. She was President, British Medical Association, 1990-91.

**NORMAN FOWLER:** Well, there was quite a lot of pressure for doctors and for nurses.

**NICHOLAS TIMMINS:** Yes.

**NORMAN FOWLER:** It wasn't a lack of pressure on our part, a lack of suggestion on our part, but, obviously at times it was taken up, but often it wasn't.

**BOB NICHOLLS:** Well, answering that, I don't think the percentage of outsiders was very high.... There were some spectacular failures of service personnel who were brought in, and one or two successes but very few. But not big numbers. And unfortunately, big disappointment, very few nurses and doctors were coming forward.

**CHRISTINE HANCOCK:**

Getting ... we're not yet where I got to the RCN, although I can speak a bit about the RCN. Interestingly enough the RCN's archivist is appropriately in the audience, but we are getting close to my personal experience. But Mike ought to have answered the one about why so many military, because the answer was pay. Military men of late forties and fifties have a pension. So what was seen by some as big salaries, were nowhere near going to attract these big captains of industry, but there was some myth that a few were going to come charging in on white horses and save the NHS. They didn't appear of course.





But my own experience I think also, and certainly if Jane Robinson<sup>66</sup> was here she would add to some of this, Alasdair and I competed for the same job, and Alasdair got it, and initially I thought, I'm very happy being Director of Nursing at Bloomsbury I'll just stay. But a combination of, when you start looking for another job often you start leaving the old one, but also a real sense of outrage of how nurses felt they were being treated. So I applied to the great St Thomas', and I still have the letter from the management consultants, that said, 'We are at the moment looking for somebody whose background and experience equips them to do the job', and I have a degree in economics and a business qualification.' And my application was quite good. [laughter] And I thought, well, that's that. And then, a few weeks or months afterwards somebody came up from the Department of Health sort of shrouded in a cloak, secretly, with dark glasses, came up and said, 'I've come to beg you to think about applying to be a general manager, because ministers are so bothered that no nurses have applied.' So I gave them the letter, which I believe was on Ken Clarke's desk fairly quickly.

I continued to apply for jobs. And I've always been very successful in applying for jobs, and, for some reason I continued to interview well, and I was either not shortlisted or turned down on a significant number of occasions. My partner believed that was because I was a woman. I believe it was because I was a nurse. But the issues are actually quite similar. And at that time, out of something like 200 posts, there were six women and six nurses appointed; half the nurses, including your Scunthorpe colleague, were men. And, I think that that was significant. I was actually appointed to a very famous London teaching hospital, Ken Clarke signed the appointment, and the medical committee met. And they didn't know me. Well, I had worked there as a staff nurse, long, long, ago, but the medical committee met and said they weren't having me. And a rather embarrassed regional manager phoned up, and said of course my appointment was perfectly legal, and of course I had the job, and I was entitled to go there, but it would be very difficult. [laughter] Somebody who had been a registrar with me when I was a ward sister told me subsequently that he had not realised this, and said it's a pity nobody asked the people that knew him. And he

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<sup>66</sup> Jane Robinson: Emeritus Professor in the Postgraduate Division of Nursing, Medical School at Queen's Medical Centre, University of Nottingham. Practised as a nurse and health visitor before entering academia to work on health policy research, and co-authored one of the major studies of the implementation of general management: J. Robinson, and P. Strong, *The NHS under new management*, (Buckingham: Open University Press, 1990).

said, and it comes back to that last question, he said, 'Of course we then appointed a brigadier. Unfortunately we didn't get one out of a fighting regiment.' [laughter]

And, and so, that, I think, gives you some personal but also some fairly general views, because Jane Robinson's article, which is quoted, which you quote, talks about nurses being older, not being graduates. Somebody many of you will know, Catherine, is very similar to me, background, age, experience, but didn't have a first degree, which is not uncommon for women, and particularly nurses of our age, and she never got on a shortlist. I usually got on shortlists and then didn't get appointed, because I'm sure the criteria said 'must have a first degree'. Which is perfectly reasonable, unless you want to attract, recruit people who usually haven't got first degrees and then you're failing to do that. And I think that was quite a significant type of issue.

**NORMAN FOWLER:** Is there an issue there as well in that people like you were applying for these jobs, at the same time as the RCN was running a £250,000 advertising campaign saying that the NHS was to be run by people who don't know their coccyx from their humerus?<sup>67</sup> Saying that this was the end of nursing.

**CHRISTINE HANCOCK:** I think there were ... I mean ...

**NICHOLAS TIMMINS:** A quarter of a million pounds was a hell of a lot of money in those days.

**CHRISTINE HANCOCK:** Absolutely. It was worse than that, because I, and, some of you may know them, Liz Winder and Ray Rowden,<sup>68</sup> went to the RCN's annual congress, to speak against a resolution to have general managers thrown out of the RCN because they were no longer nurses. And we were both, all three, fairly articulate and the thing bombed, but it's quite significant that it got on the agenda. And nurses were angry, and very angry. I don't think it affected a decision about me though.

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<sup>67</sup> The RCN campaign 'Why is Britain's nursing being run by people who don't know their coccyx from their humerus?' followed changes in the role of District Nursing Officer to the status of adviser, with some authorities trying to remove nursing posts altogether at District level.

<sup>68</sup> Liz Winder: later Director of Nursing Policy and Practice at the Royal College of Nursing and Ray Rowden, RCN member, later Chief Executive Officer, Institute of Health Services Management.

**NICHOLAS TIMMINS:** No, no.

**CHRISTINE HANCOCK:** But ... Or, or other nurses. It may have affected other nurses applying, as indeed had I talked about my experience, that may have done, but I don't think I did.

**NIGEL EDWARDS:** I just wonder whether it's worth picking up the other tribe here, which is the administrators? Because I thought Bob's point was an interesting one. My impression was that where the administrator didn't get the job, then they did



have to leave. I wonder if that reflects the, the assumption in many places that the administrator was the mainstay of the management team? Quite a lot of their job may have been symbolic especially the external facing bit of it, because the other two had other, other time-consuming

things to be doing. But my recollection is that, in cases, because of course, quite a lot of incumbent administrators were not necessarily appointed, in the year and a half prior to that there was an awful lot of churn, so quite a lot of people had risen to what was then the giddy heights, to scale 23 of the Whitley Council, or to scale 27, who had only just got there. Once you didn't get the job, you had to move.

And the administrators went through a period of self-examination. I remember sitting in a lecture theatre at Northwick Park, listening to Ken Jarrold<sup>69</sup> talk about whether the Institute, he then would have been the president of the IHSA, the Institute of Health Services Administrators, arguing that it should become the Institute of Healthcare Management, the IHSM, and, and a real big challenge. I think

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<sup>69</sup> Kenneth Jarrold: Sector Administrator, Nottingham General and University Hospitals, 1975-79; Assistant District Administrator, South Tees HA, 1979-82; District Administrator, 1982-84, District General Manager, 1984-89, Gloucester HA; Regional General Manager, Wessex RHA, 1990-94; Director of Human Resources and Deputy Chief Executive, NHS Executive, 1994-97; Chief Executive County Durham HA, 1997-2002, County Durham and Tees Strategic HA, 2002-2005; since 2007 Director, Dearden Consulting.

in a way that whereas nurses and doctors have self-identity drawn from their professions, managers did not. The IHSAs had been running a sort of campaign for a few years before to say that you couldn't get to above a certain scale, fourteen or nineteen or whatever (scales were very strange because of large numbers of missing components), without passing their rather strange exams. And it's quite interesting, I thought that the administrators then flipped very quickly into 'Of course we should do this'. It was probably the first death knell of that particular organisation, which has struggled ever since, because it means that there's then no way of controlling entry to it.

There was quite a lot more support amongst the administrators, but many of them, particularly junior ones like I was at the time, it looked like the ladder was being pulled up. The career ladder was disappearing. And there were a lot of people suddenly had greatness thrust upon them in these new jobs and suddenly forgot that they were administrators and started behaving in rather odd and caricatured ways. Like how they imagined people in business did. And that's a recurring theme of a number of reforms over the years. [laughter] The sound of ladders being pulled up and then there's this kind of redefinition of what we are and how you get to be one of us.

**NICHOLAS TIMMINS:** Yes, because there is the paradox that while not many clinicians got appointed initially, there was a worry amongst administrators that they would be out of a job. Doctors and nurses would take over.

**GRAHAM HART:** I got involved in this in September of '84, when we were halfway through, Bob, appointing the RGMs.<sup>70</sup> Quite a number had been appointed by then, David Kenny<sup>71</sup> and others, but quite a number hadn't been resolved. My impression was, under Lord Fowler's supervision, it was actually Ken Clarke<sup>72</sup> and Cliff who were the duo who were orchestrating this in the Department, with Cliff obviously very much the leg man. Point two. You said some of the regions were

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<sup>70</sup> Regional General Managers.

<sup>71</sup> David Kenny: General Manager of North West Thames Health Authority

<sup>72</sup> Kenneth Clarke: Conservative MP for Rushcliffe, appointed Minister for Health in 1982. He joined the Cabinet in 1985 as Paymaster General and Minister for Employment, and following the 1987 general election became Chancellor of the Duchy of Lancaster and Minister for Trade & Industry. He subsequently held the posts of Secretary of State for Health, Education & Science and Home Secretary before becoming Chancellor of the Exchequer in May 1993.

quicker off the mark than others. I think that was probably a bit about the relationship between ministers in the Department on the one hand and the regional chairs on the other. And when there were fourteen regional chairs, the degree of confidence that was held about them will obviously have been a bit different from one case to another, let's put it that way. So that would have been a factor I think. You're absolutely right that there was a kind of presumption that it couldn't just be an administrator's kind of, set piece. There had to be a mix of people which is why some of the difficulties arose.

The final point I want to make about this is that, another thing that we now forget is that the jobs that people were being invited to take on, were not only new in conception, they were new in their terms. You were not being offered a permanent appointment of the kind that was normal in the public sector. You were being offered a term contract. And I can remember, and I will not name names, but I can remember some very difficult negotiations that I had with someone who the region in question wished to appoint as a regional general manager, and he found it difficult to accept the terms. It wasn't the money. It was the idea that if it's a term contract he would be out of a job, or could be out of a job very easily, which in the light of subsequent events was a rather laughable position.<sup>73</sup> But, at the time you can understand why people were nervous about this. So, once again, for them this was all new and different and very challenging.

**FRANK WELLS:** I have to say, as far as superannuation is concerned, it was your colleagues who told the BMA consistently that it was nothing to do with them, and that they had to do separate negotiations elsewhere for superannuation purposes. And all of this correspondence would be bogged down with buck-passing on who should actually deal with the superannuation. Fascinating. [laughter]

**NORMAN FOWLER:** It reminds me so much of what I was doing. [laughter] At that point, can I apologise and disappear? Because as you know nothing changes in my life, I have to go and vote in the House of Lords. I think that it is also probably best that I should leave before your item four, the impact and the long-term perspective. I think I'd better go. But thank you very much. [applause]

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<sup>73</sup> Graham Hart adds: "laughable" because as events turned out, the average length of tenure of general managers proved to be much shorter than initially expected.

**MICHAEL BETT:** I think we've got to recognise that, Griffiths did have slightly starry eyes when it came to businessmen as managers. And this statement here which I think was true. 'Businessmen have a keen sense of how well they are looking after their customers.' [laughter] In retrospect somewhat exaggerated. And then it goes on, 'Whether the NHS is meeting the needs of the patient and the community and can prove that it is doing so, is open to question.' If he hadn't over-egged the businessman side of that equation, he'd have been absolutely right, but he over-egged. He had this feeling that you just had to get some businessmen who really knew what being a general manager was about.

Incidentally, it's as difficult to find good general managers in industry as it is in the Health Service or any nationalised industry. I mean it's a myth that these things grow on trees in orchards that are called 'private sector', and will refuse to grow on trees elsewhere. I witnessed two people running the Health Service, just to come back to this, when I was first commissioner for the Civil Service. I helped them with a lot of appointments, Alan Langlands<sup>74</sup> as the manager, and Chris Kelly<sup>75</sup> as the



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<sup>74</sup> Sir Alan Langlands began his career as a NHS graduate trainee and after several administrative posts succeeded David Kenny as General Manager of North West Thames Regional Health Authority in 1991. Between 1994 and 2000 he was the Chief Executive of the NHS Executive then served as Principal and Vice-Chancellor of the University of Dundee, 2001–2009. In 2009 he became Chief Executive of the Higher Education Funding Council for England.

<sup>75</sup> Sir Christopher Kelly, Permanent Secretary at the Department of Health, 1997-2000; appointed Chairman of the NSPCC in 2002, and in 2007 Chairman of the Committee on Standards in Public Life

Permanent Secretary. Now there were two men of goodwill and ability. And I'm not saying there weren't any difficulties, because I know there were, but if two men could run that bifurcated outfit they did seem to be able to do it. And so it wasn't an impossible task, but it was a damn difficult one that was contemplated.

Now, Roy wrote a polemic. A polemic which was, as you've heard from Lord Fowler, designed to set up a regime which he would be quite happy to run himself. That sounds terribly catty, but, you really do have to understand what the human motivations are behind all of these things, if you're going to try and understand what's going on.

Of course Christine's absolutely right. Servicemen had pensions, but they also retired earlier, and they were available. Businessmen weren't available for salaries that were less than the ones that they were getting already. So who was available? Businessmen who were redundant, businessmen who were out of a job, they were available. But were they these specimens who had a keen sense of how they were looking after their customers? I doubt it. And so, quite honestly it was an extraordinary task that was taken on for the Health Service as a whole. I was involved earlier on and used to get calls from Cliff or somebody, to come and be on a panel. I interviewed all sorts of people. I couldn't believe what was being paraded in front of me. And it was quite extraordinary what you were served up as a shortlist of potential managers. We wouldn't have touched most of them in private industry. But some of them were very good.

**BOB NICHOLLS:** I mean that's very useful, but I'd love to go back, in order I think, to go forward, to what people were regretting before tea. Was this the watershed between administrators who might have been coordinators of consensus teams and doctors and nurses? And if they worked together, I had two really positive, exciting experiences, I'm afraid a lot of people didn't. But why wasn't the ground prepared better, using that phrase? Why weren't there more, particularly doctors applying, and we're hearing actually a very small number of nurses were actually applying? They hadn't been prepared. Well I think there was a resistance, certainly amongst doctors, who you could see were the people who could do it just as well as some of my administrative colleagues, and better than others. But they didn't come forward. ...

**FRANK WELLS:** I think, there's a hopeful reason for this, although I've said there clearly were doctors involved in consensus management, because there were DMTs all over the place ...

**BOB NICHOLLS:** Yes.

**FRANK WELLS:** But they, they had not been trained to do the job of management at all. Cyril so rightly said that, that you're a doctor or you're an accountant or you're an administrator or you're a nurse. You weren't a manager. You did need to be trained in management. The number of doctors who actually felt that they would have been competent at the challenging role of actually being a general manager, that I think was what actually put them off, and the few shining examples of those who did become general managers, largely had a very difficult, challenging time. Cyril's a very good example of perhaps the exception that proves the rule in a way, but I think of the guy, Russell Hopkins who was a consultant, who was a manager in Cardiff. And he had an incredibly difficult time.

**NICHOLAS TIMMINS:** From his colleagues?

**FRANK WELLS:** From his colleagues. Absolutely from his colleagues. And he didn't feel that, retrospectively he said he had not really had the time or the ... it was a time, to be, to be trained to be a general manager and at the top, as opposed to being part of the consensus team. Which is why I say retrospectively, where the management consensus teams were working well, they didn't feel that it would take much to fix it.

**NICHOLAS TIMMINS:** But, can I just pursue that. There was a sense among some doctors that if you became a manager, you were a quisling. You were turning your back on ....

**NIGEL EDWARDS:** Yes. Cyril, if he was here, would tell a story of how he was rung up on his first day by the chairman of what would then have been the South East Thames Distinction Awards Committee, to tell him he was no longer eligible for an



award. And the level of pleasure indicated that this wasn't just personal but that he objected to the role and to him taking it.

**PETER SIMPSON:** I believe that after 800 appointments had been made at district and unit level there were about 100 doctors, almost all of them at unit level. But having heard of these difficult testing, initial times, did this cause you to say 'Oh whoops, this is beginning to look tricky'?

**ROBERT MAXWELL:** I think we always realised that it was tricky. The question was, where was it going in the longer term? It's not just a question of the individual doctor trained as a clinician becoming part of a management board. That requires a tremendous change in thinking and skills which not all, or even many, clinicians have. And it also is only do-able in the sense of bringing the whole institution together, if the rest of your colleagues and those who provide clinical leadership in the place, not the weaker ones but the strong colleagues, support the proposition that the whole institution should be run in a new way. It's only then that it can work. Now, I've seen it work, and I expect all of us have, or most of us have, but it's still not an easy thing to bring off. And it doesn't just depend on one person.

**MARK LEARMONTH:** Can I, can I just ask, why does it matter? I mean, about the doctors being general managers or whatever they became called? I remember at DMT level was a medic telling me that he thought ninety per cent of the time they were talking about things like, contracts for domestics and things like that, which he didn't think he could contribute to anyway. So why should it matter?

**CHRISTINE HANCOCK:** I think you've answered your question. [laughter] And it's my principle about management generally. I mean I actually believe the car industry is better run when it's run by people who spent ... I don't believe you can be helicoptered from Monsanto to Sainsbury's automatically; I don't believe there's something generalist called management. And if the Health Service is about caring for patients, providing for patients, it's a whole range of things which will include the traditional administrative functions. They're not just medical, but they are about people who know the business and care about the business. And that's why that

whole principle that you could helicopter people in, I believe, passionately, is fundamentally wrong.

If I could just come back to something at the very beginning that you quoted, Nick. I always quoted that comment of Roy's about, 'If Florence Nightingale were in a hospital now, she'd be asking ...' And I always said, she, if Florence Nightingale were there, she would expect to see a nurse in charge! And she would put a nurse in charge. And that Johns Hopkins experience that Cyril talked about, the chief executive used to say, 'This hospital is a hospital run by nurses.' Because that's why people are in hospital. If they don't need to be in hospital, they don't need to be nursed, that's the rationale. Doctors can be seen in outpatients, all sorts of places, but a hospital is an institution where you're not fit enough to do ordinary things by yourself and you have to be nursed.

Now I'm not saying that I think nurses should be in every management role, but what I am saying is, come back to Florence Nightingale, what have we struggled with since? Hospital-acquired infection. If Florence Nightingale wasn't about hospital-acquired infection, I don't know what she was about. The basics of feeding, caring, ventilation. In fact, Roy I think, to my way of thinking, shot himself in the foot with that very comment. Because analysing that, it's actually saying you'd have to give a stronger managerial leadership role with people who really know the business and want to see the important things happening.

**MICHAEL BETT:** Can I, can I ... ?

**NICHOLAS TIMMINS:** Yes, sure, I saw you nodding in the middle of that.

**MICHAEL BETT:** Oh, yes, very much so. One point only. For five years I worked in GEC. When we were in our heyday I had eighty-one managing directors that I served as group personnel director. They were all managing directors of engineering firms. And I think seventy-nine of them were engineers. We believed exactly in what Christine has just said, and we were in the private sector.

**MARK LEARMONTH:** So, lots of parallels, but Griffiths obviously, his career showed that he didn't believe that.

**NICHOLAS TIMMINS:** Well I'm not sure about that.

**NIGEL EDWARDS:** We should pick up the issue of why it matters there are doctors when we get to the long-term impact, but my recollection is in the eighties, following Griffiths, there was a general view amongst quite a lot of managers that management was a generic skill. And in fact I remember as a junior manager, being sent off to manage things I knew nothing about. Often clinical things I knew nothing about. Laundries, sterile ... sterilising departments, thoracic medicine, radiology departments. And this belief that management was a generic and exportable skill which could simply be moved around without any real technical knowledge, I think became quite firmly embedded in quite a lot of organisations. I don't have a feel for how far that was just an NHS phenomenon. I think it probably was wider than that.

**MICHAEL BETT:** It wasn't just the NHS at all. It was widespread in industry and in other parts of, of the public sector.

**NIGEL EDWARDS:** But in the NHS I think, it had its roots in this idea of general, the word 'general' in general management, was exported into an idea that this was just a generic set of, of transportable skills, and it's caused some significant damage which we might look at when we get there.

**NICHOLAS TIMMINS:** I think we're moving into that territory anyway

**ROBERT MAXWELL:** There are ways in which the management of a hospital or a combination of health services is an unusually complex management task. It's one where a great variety of different things are going on in terms of clinical activity, each of them with a group of people who know a lot about that activity, who give it very high priority, but who don't, typically, worry too much about the choices that have to be made between their activity and others. Now, if you're going to be competent as a management group, to weigh where the resources are most needed, where things are going well, where things are going less than well, and what questions you need to ask, and how you get changes made, you must have a depth of understanding and sympathy for what is going on, and scepticism. All of which require, I agree with Christine, a substantial feeling for what is going on. I don't think it's something you

can easily come into. I don't mean to say it can't be learnt, but it requires certain characteristics.

**ALASDAIR LIDDELL:** Just so that we don't get too polarised around this discussion, let me say I'm somewhere in the middle. I don't believe that managers can be helicoptered in anywhere. I think they do have to have some real sympathy and understanding. But I don't think managers have to be nurses or doctors. But they have to be good at certain things. And one of them is being able to understand a huge variety of skills and perspectives which are in any organisation that's got to do with health. They've got to be very good at wading through treacle, because, previous to Griffiths and post-Griffiths, that's what the job is about. And about how do you actually make things happen in that sort of complex environment?

And I think the other thing is that there are different skills sets involved in different situations, and perhaps that came up a bit more a bit later. That, the management skills required to run a hospital are quite different from the management skills required to exercise what later became the purchasing and now the commissioning role, where it's much more about influencing people who are outside your organisational control. And that I think is less true of the sort of rather more operational management role, such as managing a big institution. So I think the most important requirement is that the people who manage in these situations do have a sympathy and an understanding and an ability to learn about the organisation, and all of its perspectives and limitations, as well as bringing certain skills to bear which are more general management skills.



**NICHOLAS MAYS:** Alasdair's comment exactly dovetails with this question really to the panel. I'd be interested to hear some reflections about, a) the implementation of general management, and b) its consequences for exactly that distinction between the

operational management tiers in the, in the system, and the, what we would now call purchasing, commissioning. i.e. What was the planning role and what the effect of that was, given that under the 1974 structure there was a purposely divided separation in the sense that regional health authorities were essentially planning organisations, they didn't deliver services. So I wondered whether, what the impact of general management was seen from, from our contemporary view about purchasing, planning and needs assessment and orchestration versus the delivery side. We talked rather a lot I think about sort of, what I call operational management.

**PETER SIMPSON:** I wanted to follow up on what Robert was saying, because, Lord Rayner<sup>76</sup> and his Scrutinies took up those points as to what makes a hospital service: the clinical services and the hotel services. Do you really want to try and be expert as managers of both the clinical and the hotel services? Lord Rayner felt we were very slow and had some of our greatest defeats when we tried to run things that were



nothing to do with our core business of patient care. Also picking up the point about, the generic manager, can he actually be helicoptered in? I believe Lord Rayner made an offer of one of the people who was comparatively young in Marks & Spencer's organisation, who they nevertheless thought was going to be on the main board. Would it be possible for him to work in the Health Service as a general manager, provided he remained on Marks & Spencer's books. His terms, conditions and salary were a matter for the company who would review his performance rather than the Health Service? [laughter] I don't think that was ever taken up. [laughter]

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<sup>76</sup> Lord Rayner was joint managing director of Marks & Spencer, 1984-1991, and Mrs Thatcher's 'efficiency adviser', 1979-83. Rayner Scrutinies were conducted in different spending departments with a view to achieving efficiency savings by opening public sector activities to the critical appraisal of private sector management. Norman Fowler announced the first Rayner Scrutiny of the NHS in April 1982.

**TONY CUTLER:** It's really just a sort of observation. I mean I'm struck by the kind of parochialism of British private sector management, because, you know, something you said that, that generic management to some extent this is slightly contradictory. [INAUDIBLE] Now, one of the things that strikes me about that is that if you look at American management in the eighties there's a massive reaction against general managers, there's leveraged buyouts and so on,. So at the very point at which possibly these generic conceptions of management are being brought into the public sector, they're rejected in supposedly the leading capitalist country in the world. But anyway, this may be something to do with the public sector being vulnerable to management fashions.<sup>77</sup>

**NICHOLAS TIMMINS:** We need to move into the longer term stuff. But just one final point. We've talked a lot about who would be the general manager, whether the doctor or nurse or otherwise, but I've always felt there's a very important thrust in the report that you wanted doctors to be involved in management at all levels, not just at chief executive. Roy kept going on about the quote from a consultant that he used in the report: 'Your use of resources is my denial of resources', saying 'we need doctors to manage budgets', which is not the same thing necessarily as doctors being the general manager.

**MICHAEL BETT:** No.

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<sup>77</sup> Tony Cutler adds: It is a paradox of Griffiths that implicit in it was a managerial ideology which was effectively regarded as outmoded in the United States. Griffiths' assumption was that 'business' methods were applicable to the NHS and thus that 'management' was a completely transferable skill across industries. However, in the US support for the notion of transferable management skills was starting to wane. It had its highpoint in America in the trend to conglomerates since the assumption was (like Griffiths) that diversified corporations could be managed by 'numbers'. Mary O'Sullivan argues that 'by the 1960s the ideology of the 'general manager' had become conventional wisdom in the nation's business schools. The reaction against this ideology is reported in a much cited study by the leading management guru, Michael Porter, which argued, on the basis of data from 33 large US corporations, 1950-86, that the 'track record of such 'strategies has been dismal' with 'most' of the companies divesting more of their acquisitions than they retained.

Thus Griffiths was effectively endorsing an implicit concept of transferable managerial skills which was in process of being repudiated both as a managerial ideology (e.g. Porter) and as a corporate practice (divestment of businesses which senior corporate management found it impossible to manage effectively). See M O'Sullivan, *Contests for Corporate Control: Corporate Governance and Economic Performance in the United States and Germany*, (Oxford: Oxford University Press, 2000), 111; M. Porter, 'From competitive advantage to corporate strategy', *Harvard Business Review*, 65, 3, 1987, 43-55.

**NICHOLAS TIMMINS:** And that sort of, well, did that happen?

**FRANK WELLS:** Nick, can I comment on this and Alasdair, to your point? When I was going around talking to, to doctors, it's significant that the seminars we ran were not well attended, which meant even though the BMA had gone on record as saying it was supportive of general management, involving doctors, and actually wanting consultants to be involved. Doctors chose medical students, youngsters choose to be doctors because they want to actually be people persons, and working in healthcare, and it is a very real, barrier is perhaps too strong a word, but it's a very real factor that if you become more involved in management as a doctor, you would inevitably be doing less doctoring. Now, that, that's fine if you're happy to do that, and I changed career in mid-career because I actually wanted to do something different, having done twenty years of general practice I actually wanted to do, to do something different. But the majority of people who choose to do doctoring, actually want to still spend a majority of their professional life doctoring. Well I think that's actually a factor which needs to be taken into account.

**CHRISTINE HANCOCK:** Just to, this picks up what Frank said, and the previous speaker talking about the American experience. In my experience, we are almost the only country where doctors don't manage the health service, and in most countries, and that's developing and developed, they're often health ministers, they're always hospital managers, and, and there's something about our doctors, I don't know whether it's good or bad, I don't think it means they're better doctors or worse doctors, but there's something about this country that, and Frank's absolutely right, doctors don't want to do it.

**NICHOLAS TIMMINS:** And New Zealand.

**CHRISTINE HANCOCK:** And New Zealand. Thank you Nick.

**MICHAEL BETT:** This is something that Roy just did not expect or anticipate.

**CHRISTINE HANCOCK:** No he didn't.

**MICHAEL BETT:** He thought that one way or another, the medical profession would become far more involved in managing the Health Service. In various ways, maybe more budgets. He got rebuffed by consultants quite strongly and nastily in fact, who said, they didn't want to push paper, they had trained for years and years and years, had an expertise which saved lives. Pushing paper was not their idea of having a fulfilling career. Quite crude statements like that. But I would like to say something for Roy. In the last sentence, he says there can be no single bullet solution for the whole of the NHS, and I just want to emphasise that Roy did not seek a one-size-fits-all solution. He realised that it was a very complex organisation, and he realised that there would be difficulties, but he was taken by surprise by the medical profession, as individuals. Not as the BMA but as individuals, not actually wanting to take personal responsibilities in the management context.

**FRANK WELLS:** I think one of the things that did follow on from that, which possibly we're going to mention in part four, is, is, at least I like to think that the profession had a greater grasp of what management is all about, even though they no longer, even though they didn't particularly want to be involved with the top of the tree themselves. So I think that the time, the effort that we put in to explaining the principles of general management, didn't go amiss, though it's gone awry.

**NICHOLAS TIMMINS:** Yes. We're into the long-term perspective, and I think it's a question, and a very good one, what's the long-term impact been?

**PETER SIMPSON:** You've only got to look at the television programme with Geoffrey Robinson. He saw that same, exactly the same hospital problems as Roy saw twenty years previously. The same pointless mobile action that Roy Griffiths described, and that's why doctors don't go into management, because they too often see it going nowhere. [laughter]

**ROBERT MAXWELL:** I've just finished six and a half years as chairman of a Mental Health Trust and, I do believe there's been a very substantial change out there in terms of the strength of what Roy would describe as 'general management'. The will to try to set the agenda locally, and take things forward in a constructive way, taking account of what the local population thinks and what the performance



measures such as there are, are telling. And so, while I think that progress on some things that the report fought for are very disappointing, for example, I don't think the central changes that he envisaged have really taken place, I do think there's been a real change, a degree of energy down there, and there's been a degree of setting agendas locally.

**CLIVE SMEE:** I'd like to comment on two things in relation to the longer term perspective. First of all, a comment on the slow development of clinicians as managers. I don't think the example being set by the Department was very impressive in that respect. My memory is that there was a three or four year period when we went round talking about how we must get more clinicians into management. Then we forgot that idea, for the next ten years, if not fifteen. Part of that was related to the views of the senior medical officers in the Department at the time. It really wasn't until, in my experience, the mid-1990s under Professor Calman,<sup>78</sup> that the idea that policy decisions on health should be constrained by costs, and opportunity costs, was accepted by the majority of senior medical advisers in the Department. So, until then they were not really practising what, in my view, Griffiths was trying to preach.



And if one asks why, well I think there have been so few doctors in this country relative to other countries per head of population that the attractions of being

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<sup>78</sup> Professor Sir Kenneth Charles Calman, KCB, DL, FRSE. Calman was appointed Professor of Oncology at the University of Glasgow in 1974. He became Chief Medical Officer at the Scottish Office from 1989 and then Chief Medical Officer for England 1991-98, succeeding Donald Acheson. He served as Vice-Chancellor and Warden of the University of Durham from 1998 then as Chancellor of the University of Glasgow from 2006.

just a doctor were sufficient to outweigh the attractions of being anything else. Going back to America, if I might for a moment, when I did my MBA in the early sixties, there was a special sub-school of the business school that I was in which was devoted to health sector management, where they were doing an MBA in health sector management. Now, with that kind of background, there was a large cadre of managers, of doctors, managers coming forward. They were all doctors doing it, and maybe one or two nurses, I can't remember, but they were all health professionals anyway, with that kind of background. It's not surprising that if you go now, and I've gone for the last twenty or thirty years to the States, you find most of the top jobs there in the Health Service are taken by either doctors or nurses.

If I might very quickly turn to the question here of what has been the achievement in the light of the goals which Griffiths set out. First, it's interesting looking back now, that Griffiths' goals would today be said to be at most intermediate outputs and means to ends. None of them actually mention the health or the healthcare, directly, of patients. They are all seen as means to that end presumably, but nowadays that would be said to be a rather limited approach.

If you take them in order, my view would be that they are all moving areas, they're all areas where we can do better. My quick judgement would be, when did we achieve control of expenditure in the NHS? Well, the first time I remember we thought we had it under control was with Sheila Masters<sup>79</sup>, around 1990, we then lost it again and gained it again, and we lost it again under Nigel Crisp,<sup>80</sup> and we've got it back again now hopefully. Setting of precise management objectives? Nothing I would say was precise about the objectives being set down by the Department until 1997. Up until then, there were times when I would go round, and the Under-Secretary responsible for primary care would say: 'GPs are self-employed, small businessmen. We have no right to set them targets or precise objectives, and we certainly have no right to measure what they're doing.' So that was the kind of

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<sup>79</sup> Sheila Masters (Baroness Noakes). Masters joined KPMG in 1970, qualifying as a chartered accountant in 1973. She specialised in public sector issues and was seconded to the NHS as Director of Finance (1988-91) and to HM Treasury (1979-81)

<sup>80</sup> Edmund Nigel Ramsay Crisp, (Baron Crisp), KCB, is a British former senior civil servant in the Department of Health and Senior Manager in the NHS. He joined the NHS in 1986 and was Chief Executive of the Oxford Radcliffe Hospital NHS Trust (1993-1997), then South Thames Regional Director of the NHS Executive from 1997 and London Regional Director in 1999. Crisp was appointed Chief Executive of the NHS and Permanent Secretary at the Department of Health on 1 November 2000, holding the Chief Executive post until his resignation in 2006.

culture against which, in a sense, it seemed to me, that Griffiths was trying to push water uphill.

Then improving in the measurement of health outputs? Well, the Management Executive <sup>81</sup> tried to get progress on that in the 1990s, but again I don't think we made very much progress until well into the 1990s. At least ten years after Griffiths. As to evaluation of clinical practices, well that again has been continuing. But a milestone perhaps was the establishment of the Standing Committee on Health Technology Assessment. That again was ten years later in 1993, and you could say that NICE was a continuation of that, but that was another five or six years after that. Greater attention to the needs of patients and the community? I was asked to advise on how we could assess patients' views of the NHS, in '92 and '93, and the NHS Management Board at the time said: 'We might not like what they would say.' [laughter] So, we again had to wait until 1997, when a minister came in, Milburn, well he was a minister then, not Secretary of State, and said, 'We will have regular patient surveys.'

So it seems to me that we have moved a long way in all these areas. I think the question in my mind is, in a sense, why did it take so long? And the answer in part is because Sir Roy Griffiths was wanting to go far further in the NHS than the Department was willing to go in relation to itself. It always seemed to me, and if I learnt nothing else in the civil service, that civil servants are much better at doing things to other people, than they are at doing them to themselves.

**GRAHAM HART:** Well, can I respond to that, Clive? [laughter] First by pointing out that by the time you're speaking of, the people in the Department who were trying to run the NHS if we can use that word, were largely not career civil servants at all. They were people from the NHS, including some present company, possibly. And I don't think you can just blame the Civil Service culture. What you can legitimately point out are two things. I think we could spend a long time on this. Two things you could point out. One is that Civil Service culture is a code for a subset of a political culture in which ministers have long-term objectives, they do want things to get better and so on and so forth, but not necessarily today in the way we thought was

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<sup>81</sup> The NHS Management Executive was established in 1991 as the successor to the NHS Management Board which had followed the Griffiths recommendations. Its first Chief Executive was Duncan Nichol, who held the post until 1994.

appropriate yesterday, if you see what I mean. So, there may be some kind of political direction to the organisation, but that and a consistent development of management objectives over a period, step by step, don't necessarily go together very readily. That's point number one.

Point number two is, that nobody's yet mentioned, is that in 1988, on the 25<sup>th</sup> of January, Mrs Thatcher said she was going to review, or 'We are reviewing' the NHS, she said. And a year later there was a little thing called *Working for Patients*.<sup>82</sup> And that was actually, if I may say so, quite a big agenda, which didn't necessarily conflict, but it certainly wasn't on the same territory as a lot of this, and which certainly took up a huge amount of energy and resource in the Department of Health and indeed in the NHS subsequently, to implement it. So, I just think it's wishful thinking to think that you make this steady, stately progress with no external factors making a difference.



I've got something more to say on the question you actually asked as well. Shall I do that now?

**NICHOLAS TIMMINS:** Do that now.

**GRAHAM HART:** OK. My perceptions of the NHS today are very limited, although I have had some recent exposure to it, not as a patient. And I think that you have to make a mental jump from the world of the 1980s to the world of 2008, there is a huge difference actually. And one of the things that I would single out is that while

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<sup>82</sup> Department of Health, *Working for Patients*, (London: HMSO, 1989). The White Paper *Working for Patients* was the outcome of a review of the NHS initiated by Mrs Thatcher in January 1988. It included *inter alia* the principles of the internal market, with a purchaser/provider split, GP fund-holding and the creation of hospital trusts, and directly informed the legislation which introduced these reforms.

I'm not saying the NHS is necessarily better managed now - that's a very big question, is it better managed? But certainly, the centre has been, to my surprise, I never thought it would happen, has become very much more effective at getting its way. At getting things done.

And I mean, I can recollect, others in the room can recollect I'm sure, rather pessimistic discussions with ministers over the years about waiting lists for example. They're like the weather, you know, they're just there, with us, all the time. Well actually that issue, I won't say it's disappeared, but it's largely ... it's had an enormous amount of effort, an enormous amount of money and resource, probably misguidedly, put into it. And the fact is, that bit of the NHS territory, geography, has been changed out of all recognition. And it's been done by people just going on about it a lot, and linking managers' performance targets and all that sort of thing to it, and making it plain to everybody that in the end this is the overriding, or pretty well the overriding, priority for the organisation. And the NHS hasn't done in the end what, you know, it would have done twenty, thirty, forty years ago, just kind of sidetracked it and got on with what they were doing at the moment.

So, and I've seen it in my local hospital, I've gone into the A&E with the chief executive, and you find consultants and medical staff there who understand very well what they've got to do. They understand about the four hour targets and all that sort of stuff, and things are done differently. Maybe not better, but differently. Because somebody in an office in Whitehall at some point said, 'We're going to have a target on this, and it's jolly well going to happen.'

And, so, I think in terms of the sense that one had in Whitehall twenty, thirty years ago, you pulled a lever and nothing happened, because it wasn't connected to anything, that is different now. It's not hugely different, but it is different, it's different in quality. And I don't say that, that is entirely down to Griffiths, I don't think it is. I don't even necessarily think it's down to general management, I don't know. But what I do think is that the Griffiths Report, with the huge shock it delivered to the system, and with the changes that he undoubtedly did make, was a kind of milestone on the way to changing the nature of the organisation. Who knows, as Chou Enlai said the French Revolution was only just last year, so it's too early to say whether it's a success or not. It may all change, but, it certainly has moved very substantially.

**BOB NICHOLLS:** There's a lot we can discuss and argue about with this point, and I'm somewhere between Clive and Graham. Because, subsequently around the time of later reforms and I certainly recall it being said, the Secretary of State claimed, I think off and on the record, we couldn't have attempted the Working for Patients reform in the time available if general management hadn't been there. The downside of that was what we've been referring to as being the growing gap between managers and professionals, and that acerbic but very interesting book by Raymond Tallis,<sup>83</sup> has a disturbing phrase, which is that the general managers, which were by a vast majority ex-administrators, became the 'government's enforcers'. Which goes to what Graham says, that the government could therefore get more done.



Now, in one way, whether as a taxpayer or a carer, rather than a manager or anything much to do with any of this, I think that's rather good, and that we pay a lot of tax, and we had a lot of money put in, and some, but by no means enough, is now getting done. And if it wasn't for general management I suspect it wouldn't. What we've lost, and I don't agree with my esteemed colleague Dr Simpson, I think that any general manager or chief executive allowing a television programme in to expose its faults was probably not a very good one in the first place. [laughter] And as Cyril

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<sup>83</sup> The philosopher, doctor and writer Raymond Tallis was Professor of Geriatric Medicine at the University of Manchester and consultant physician in Health Care of the Elderly in Salford. He retired from medicine in 2006 to write full time, but remains Visiting Professor at St George's Hospital Medical School, University of London.

gave us an optimistic note, unfortunately I can't. I think that the best Foundation Trusts, ironically have general managers working very closely with clinicians, nurses and doctors, on service-line accounting but not enough other health organisations do.

And the one thing I really agree with Clive about entirely, is that we are still totally useless at finding out what patients really want. I was talking at tea to my chair colleague in the second row, and actually we could have made CHCs do that, but they got abandoned before we got there. And we've since invented about five new patient representative bodies, I've lost track of the letters they use for them, and we still can't do it! So, I think what is the result really is, that Griffiths started a lot, and he made some of it work better. There's a lot of other influences, and we have a long way to go, not least on outcomes and engagement with the public.

**ALASDAIR LIDDELL:** Just very briefly, because I agree with a lot of what Bob has said. One observation that I would make about engagement with patients and the public is, it's always struck me as slightly bizarre that all of us in some way or another are patients, and yet we seem to be unable to translate that experience into enriching the way we manage the Health Service. It's always amazed me that generally we seem to be unable to do that. It's certainly been a driving force for me in terms of understanding what people want. I think engaging with the public and patients is one of the most difficult challenges still facing the NHS, and people are trying to do it in all sorts of different ways with very mixed success.

But of course the world outside of us has moved on quite a long way, and this whole thing about public expectations and the way people are involved and have more control over their lives, also means they have much higher expectations of the NHS and their ability to influence it. And their experience of the quality of service in other fields is such that they are demanding higher standards. In terms of being involved with the clinicians, I think we have made some progress. But again expectations are rising all the time, and experience elsewhere is rising, and, the complexities aren't getting any less in terms of the totality of what has to be in this hundred billion pound organisation and. So, I think the longer-term impact needs to be looked not just in isolation but also in a wider context, of the world outside moving on.

**NIGEL EDWARDS:** I agree with, with all of that, and, I think one sees it in the power to make things happen, and in particular the emphasis on accountability, and

outcomes and everything else, that shows that there's alignment in the organisation. All of that's true.

I think, you do hear anecdotally, and when the consultants' contract was voted down the first time it was negotiated, there was a little bit of feeling that this is payback for the way we've been disenfranchised. It's a little bit like the long memories that one associates with Northern Ireland, I don't know how credible that is, but certainly anecdotally there's a feeling that that was at the beginning of the rot among some of the clinicians about how they became disenfranchised. I'm not sure that that's really legitimate or indeed that you can really blame that on Griffiths. I mean as one could see, taking a long-term view of this, you could see Griffiths more as a response to Christine's point which is the failure of clinicians to step up to lead.

A couple of other observations that are interesting in taking this long-term view. Interesting how Griffiths is used to define a move from administration to management, and we're sort of now at a point where the rhetoric has moved on a stage, so we now talk about needing less management and more leadership. Well of course, we need all three of those different types of activity. And in all of that, and I think over all of this period, one of the things that's struck me is that the focus on the top of the organisation, on the general manager or on the leader has meant that we've paid far too little attention to supervisory line management, middle management roles, the people who actually make things happen. And very often they're the people who become neglected by the top management, who are privileged in this account as the thing that makes the difference. We've missed the point that actually many peoples' very poor experience of health care is due to bad basic systems and bad basic management. And I think while we can't blame Griffiths for that, we can see him as part of a trend to this [an over emphasis on top management] perhaps.

And thinking about what he had to say and his background, and I'm not unsympathetic to the way it's been interpreted, but it illustrates the way the NHS picks up ideas and then strips away some of the subtlety that goes with them. I'm not just speaking to his ideas about management and leadership, it happens elsewhere. In fact that seems to me to be where we got to. And in the kind of growth of the leadership and management industry, which some could say he started, perhaps the other theme one started to see was an attempt to try to define the ideal 'one of these' in ways that again strips away some of the more interesting, innovative, creative characters, particularly the industry of assessment centres, leadership competencies.



And it means that if you're not very careful you're going to get a 'cookie-cutter' manager. Who is a leader, who isn't totally crazy, but who actually doesn't have any ideas about where they're going to lead you, but has all the competencies to do leadership. [laughter].

I thought Clive's observation that actually the Department has not applied many of the lessons of Griffiths to itself is really insightful. I was thinking something similar, but not nearly as well formed as Clive put it. Perhaps the other legacy is one we've seen particularly today, which takes us back to some of the comments Graham made there, which is how does the Department see the NHS? Is it a system, or is it an organisation? Systems don't have chief executives. And they don't have directors of operation and directors of finance, so the clue's in there. But that continued tension persists. So maybe it was right that Griffiths wasn't applied to the Department, but they didn't then take the next conceptual step and then say, OK, well if it's not appropriate that we are the management in the system, or the management of the organisation, then what does it mean to be, sort of, the co-ordinator of the system? And what leadership and management bits do we need to be able to achieve that? So while I think it was a good solution from Griffiths for individual organisations, it was an incomplete bit of the puzzle that no one quite ever managed to answer.

**NICHOLAS TIMMINS:** Right, now we've reached five o'clock which is our time to stop. I saw three more hands. If I take those three, and then we'll break.

**PETER SIMPSON:** The first time I met a senior doctor, a vice-president of his college, who had lost his enthusiasm, was when I was an SHO in surgery at Kingston Hospital. I said, "Great to have the promise of a new surgical block-isn't that terrific." "Well, I hope so." was the reply. "You're not very enthusiastic." I commented. "It's the fourth time they have promised me." Talking round and round gets people down.

But it need not ever be thus. Later I worked for a chap who some might describe as an intermediate man in Don Wilson, and I was really surprised how far chasing today with enthusiasm and showing people that things were going to change, made a difference. What's more he had a reserve to draw on as Regional Chairman so that if he came upon a good idea he offered funding on a 50-50 basis. Suddenly we had the doctors interested in a way that was new and they were eager to be on the

major regional committees. They kicked their has-been men out of the door. And what's more, they then decided to go to Manchester Business School in order to sharpen up their proposals.

So, coming to the problem with the Department, it's very difficult for people with experience of doing things in the field and who have a natural touch for it, when they come into the Department's craw. I saw it with performance indicators and John Yeats. Brian Rayner converted his ideas into huge timetables of various statistics hoping that somewhere the decisive figures would be captured. Brian did not spot that John used only sufficient numbers to identify those he should talk to about the nature of their practice: were the clinical problems and/or circumstances unusual or was there an opportunity for their practice to be improved?

Secondly I mentioned before Iden Wickings work to which Roy refers in the inquiry report. He found three districts were struggling with Clinical Budgeting but that Guys was successful. What were the differences between these districts and what are the abilities needed to make budgeting a success? The Department did not undertake this analysis but tried to roll out the programme extensively but to little benefit. A disappointing result for an essential idea.

One of the things that I think we have to ponder is that we have had no end of reports from 1970 onwards, in which some bits have gone forward but others hardly moved at all. And we've got to ask, why is that? What has been the problem with doing these things? I would say that some of them have been incredibly difficult to do, even when the description seem simple. Sometimes, the task is obviously complex such as Victor Paige's job as the first Management Board supremo. Was it recognized at the time how difficult the job would be, that it needed very great ability? If you thought scarce anyone could do it then why did you send that poor man down the track heading inevitably to failure? You need to look at such initiatives as ask "How difficult are they? What are the talents that are required, and can you get them from somewhere?" And if you can't, you're going to have to think again. That would help us to perform better.

**MICHAEL BETT:** Yes. I was heartened to hear what Graham had to say, though I didn't mean the pun. I do think things have moved on. I would like to finish by being a voice from the grave if I may. I'll just read three or four very brief bits out of the report. It says, 'The centre is still too much involved in too many of the wrong things

and too little involved in some that really matter.’ I think things have improved in that area, but I still think the statement has some validity. I think the centre is too involved, and here I speak as an ‘expert’ who hasn’t had anything to do with it for years [laughter] I come from a part of the country in which they are on their third head-hunt for a new chair. They’ve rejected the second head hunter’s choice, because he was too ‘commercial’. That worried me. Although my local hospital is known as the Kent and ‘Snuffit’, [laughter] I do perceive the sort of improvements that Graham mentioned.

The next bit I want to quote is, ‘The units and the authorities are being swamped with directives, without being given direction.’ Now I think that’s a terrific statement. In a very short sentence, it draws a distinction between lots of circular letters telling me what to do, but no real leadership and direction. And I think he got that right. I think we’ve moved a bit on that, even though Roy would suggest I think that too much of the overt direction was coming from the centre and not enough from within the localities, whatever the localities might be.

And then he says, another sentence, ‘Real output measurement, against clearly stated management objectives and budgets, should become a major concern of management at all levels.’ Now I think there’s evidence that that is, that’s happened to a great extent. Though at the same time, I get criticised by an ex-colleague, still a friend, who blames me as part of Griffiths for everything that’s gone wrong with the Health Service ever since. But, I do agree you can overdo targets. I’ve done it myself; you can stick with certain targets and distort people’s behaviour, forgetting that the targets you focus on mean that there are targets you don’t focus on. You really have to be very careful how you play targets, it’s not a simple, put a number on the board game and, and follow it slavishly. It’s a very subtle thing, using targets to improve management.

Finally, he says, well, finally as far as I’m concerned, ‘The NHS is so structured as to resemble a mobile, designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction.’ I think that’s changed. But actually, he hit on something. And, partly as a result of Griffiths kick-starting, some new thinking or different thinking, there have been improvements. There are still far too many managers that are non-experts, and there are too many layers. If you really got down to it, you could thin out and improve the quality of the management of the NHS, but it would be one hell of a task to tackle.

**NICHOLAS TIMMINS:** Well, on those final words from the man himself so to speak, it's a very good point to end. Can I thank you all very much for coming, and thank you all for contributing. For those of you who asked questions of the panel and failed to get answers I apologise. But thank you very much indeed.

[applause]



**MARTIN GORSKY:** Can I add my thanks to all the participants and contributors on behalf of the Centre. There should now be some wine about to be wheeled in and I hope people will be able to stay on for some refreshments.

[End of Recording]