

‘Searching for the People in Charge’: Appraising the 1983 Griffiths NHS Management Inquiry

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Abstract: This is the first of two related articles in the present volume which examine the recent history of health services management using the case of the British National Health Service (NHS). In the historiography of the NHS the 1980s is widely seen as a watershed, when public policy first sought to introduce market disciplines into its operation. Administrative and managerial reforms were central to this process, and their origins and impact have been the subject of continuing debate. This article examines and evaluates one of the key events in this history, the Griffiths NHS Inquiry of 1983, which put in place the principles of ‘general management’ in the NHS. Drawing on both documentary records and oral evidence it offers fresh perspectives on the reasons why the Conservative government embarked on this reform, on the workings of the inquiry team under the leadership of the businessman Roy Griffiths, and on the uneven course of the implementation of his recommendations. While its initial impact arguably did not meet the expectations of its supporters, it is suggested that several of Griffiths’ key concerns have grown, not diminished, in importance as aspects of subsequent health politics. These include: the need for clinician involvement in NHS management and financing; the conundrum of how to depoliticise the central direction of the service while retaining political accountability; the desirability of measuring and improving performance; and the question of how best to incorporate the wishes of patients and public in the decision-making arena.

Keywords: NHS, Hospitals, Health Systems, Health Policy

Preface

This is one of two articles in the current volume tackling the contemporary history of health services management. Though perhaps not the most glamorous subject, it is none the less of considerable importance to the practice of medicine in contemporary society, and one which merits scrutiny. Regardless of their level of economic development, governments across the world have been concerned to maximise the efficiency of their health systems. The challenge of providing effective medical care at affordable cost is

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rarely one they have left to market discipline. Rather, it has been a process enacted daily in the hospital, the clinic, the insurance office or the health ministry. Here, usually within a regulatory framework set by legislation, doctors, bureaucrats and administrators negotiated the problems of achieving optimal health outcomes with limited resources. In the high-income countries with mature welfare states this challenge has become progressively more acute. Demand is fuelled by ageing populations, steeped in consumerist expectation. Clinicians and scientists champion new technologies and therapies to the benefit of patients, but these come at a cost. Meanwhile, supply is determined by economic capacity, and this is vulnerable both to short-term fiscal crises and to the longer term unbalancing of productive and dependent populations.

The two articles here focus on a group at the sharp end of medical organisation within this context: health service managers. They concentrate on the case of the British National Health Service (NHS), a health system characterised by its aspiration to universal and comprehensive provision funded principally through general taxation. In its recent historiography considerable attention has been devoted to the ‘continuous revolution’ undergone by the NHS, since the ‘crisis’ of the welfare state sparked political action under the Thatcher government of the 1980s.¹ Within this account of a significant rupture the issue of the ‘new public management’ has loomed large. In terms of sheer numbers, there was a marked increase in administrative personnel; for example, in the late 1960s there had been 50,000 clerical and administrative staff in the hospital service but, by 2005, 280,000, representing a rise of eight per cent to twenty-three per cent of the NHS workforce.² In political discourse, though, the figure of the manager was associated with the more stringent disciplines government sought to impose, purportedly administering a dose of reality to spendthrift clinicians, and making the NHS more business-like in its planning and delivery.

This is the background to the two articles that follow. They address the history of policy making, which repeatedly reconfigured the environment in which managers functioned, and reconstruct the lived experiences of those who sought to implement the politicians’ goals. Stephanie Snow’s discussion provides a long-run, regionally grounded study of the post-war professionalisation of health services management. In the process she raises important questions about familiar caricatures of the manager’s role, particularly with respect to lay/medical hostility and the degree of discontinuity that the Conservative reforms really signified. First, though, the event often treated as the harbinger of the NHS’s managerial revolution is brought into view.

Introduction: the Griffiths Inquiry

In June 2008, on the sixtieth anniversary of the National Health Service, the *Health Service Journal (HSJ)* published its list of the sixty most influential people in its history.³ Several places behind Bevan, Beveridge and Blair was an apparently unlikely figure: Sir Roy Griffiths, best known as the managing director of the supermarket chain Sainsbury’s. Why was a leading businessman among the pantheon of politicians and medics? Griffiths’

¹ Charles Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2002), 140–207; Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford: Radcliffe Publishing, 2006); Rodney Lowe, *The Welfare State in Britain Since 1945*, 3rd edn (Basingstoke: Palgrave Macmillan, 2005).

² *Office of Health Economics, Compendium of Health Statistics*, 20th edn (London: Office of Health Economics, 2009), Table 3.3.

³ ‘NHS 60: Diamond Sixty’, *Health Service Journal, NHS60 Anniversary Supplement* (3 July 2008), 70.

prominence arose from his advisory role to the Thatcher government in its programme of reform of the administrative structures of the NHS. He produced two significant reports, one in 1983 on management in the NHS and one in 1988 on community care. It is the NHS Management Inquiry on which his reputation principally rests, and which is the subject of this article.

The inquiry was appointed by Norman Fowler, Secretary of State for Social Services in the first Thatcher administration. It was undertaken by Griffiths and three other businessmen, Brian Bailey, Chairman of Television South West, Jim Blyth, Group Finance Director of United Biscuits and Michael Bett, Board Member for Personnel at British Telecom. It was conducted swiftly and without open consultation, producing a succinct report with far-reaching recommendations. The result was a shake-up of NHS management, from the heights of the Department of Health and Social Security (DHSS) to the ordinary hospital, where the existing system of 'consensus management' was replaced with 'general management'. Griffiths' diagnosis was institutional stagnation: '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'.⁴ The solution was to instil a 'more thrusting and committed style of management' where now it was absent.⁵ In the words of its best-known phrase: '... 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'.⁶

As with much of the Thatcher programme for the welfare state, evaluation of Griffiths is mixed. For some historians the *HSJ*'s epithet, 'the father of modern NHS management' is fully merited. Thus Timmins argues that Griffiths' installation of a managerial chain of command was 'the most important single change to the NHS since 1948, allowing a service which was cracking under the strain to survive into the twenty-first century'.⁷ Lowe similarly sees the Griffiths 'managerial revolution' as essential modernisation, preserving the welfare state by ensuring 'the more efficient delivery of traditional goals'.⁸ Others reject this judgement. Clinician historians deplore the treatment of health care 'as a commodity like cars, shoes, or baked beans'.⁹ More critical still is Pollock, for whom Griffiths fired the starting gun in the baleful march of privatisation, first facilitating outsourcing, then erecting the costly administrative edifice on which the internal market could be built.¹⁰ But whatever their standpoint, admirers and detractors alike agree that the inquiry was a transitional moment. The historiography now routinely depicts a binary divide in the development of the NHS, pivoted around the mid-1970s crisis of financing and legitimacy.¹¹ Before this the service had typified the technocratic planning and deference to expertise characteristic of the 'classic' post-war welfare state. Afterwards it reoriented towards consumers and increasingly sought to achieve efficiency and effectiveness through market mechanisms.¹²

⁴ Roy Griffiths, 'NHS Management Inquiry' (London: Department of Health and Social Security, 1983), 12.

⁵ *Ibid.*, 19.

⁶ *Ibid.*, 12.

⁷ Nicholas Timmins, *The Five Giants: A Biography of the Welfare State* (London: Harper Collins, 1995), 409–10.

⁸ Lowe, *op. cit.* (note 1), 372.

⁹ D. Morrell, 'Introduction and overview', in I. Loudon, J. Horder and C. Webster (eds), *General Practice Under the National Health Service, 1948–1997* (Oxford: Clarendon Press, 1998), 1–19, 16.

¹⁰ Allyson M. Pollock, *NHS plc: The Privatisation of Our Health Care* (London: Verso, 2004), 36–8.

¹¹ Lowe, *op. cit.* (note 1), 318–21.

¹² Klein, *op. cit.* (note 1); Lowe, *op. cit.* (note 1), 433.

A quarter of a century on and the NHS is facing another pivotal moment of shrinking resources and pressure on productivity. This is therefore an opportune time to reappraise the Griffiths Inquiry and its impact. A novel feature of the analysis which follows is the incorporation of evidence from a recent witness seminar on the inquiry which convened the leading politicians, mandarins, doctors and NHS managers who had participated in or been affected by the event. The ensuing discussion is structured around four issues. First, how should we understand the reasons for the inquiry's appointment? Second, how was it conducted, and how were its recommendations arrived at? Third, what was the reception of the inquiry in the years immediately following its publication? Finally, viewed in the longer term, to what extent has Griffiths' original vision been fulfilled, and how should his report be positioned within the diverse readings noted above? To begin, though, some preliminary contextualisation is necessary, as well as further exploration of the historical and policy literature.

Context

The economic backdrop to the inquiry was the tough environment of the first two Thatcher administrations as government determined to rein back expenditure. The average annual real percentage change in NHS spending was 1.4 in 1979–83 and 1.41 in 1983–7, well below the Wilson (4.86) and Heath years (4.59), and less than the Wilson/Callaghan governments (2.02). And from 1982–3 spending on the NHS as a percentage of gross domestic product fell, a situation not substantially reversed until 1989–90.¹³ This imperative of parsimony coincided with ongoing concern in policy circles about the organisational structure of the NHS. Keith Joseph's 1974 reorganisation had sought to improve on the 'tripartite system' of the original legislation, but there were soon concerns that instead of greater integration the principal outcome was excessive bureaucracy. There were now 14 Regional Authorities, 90 Area Health Authorities and 205 District Management Teams, with decision making at all levels through multi-disciplinary 'consensus management', with representatives of doctors, nurses, administration and finance each holding the power of veto. First the Thatcher government removed the area tier (1982), though this was regarded as a temporary fix.¹⁴ Its second strategy was to enhance efficiency, for example with the Körner reports into health services information, the Salmon review of NHS auditing arrangements, the Davies inquiry into NHS property, and annual performance reviews to hold regional chairs accountable.¹⁵

These concerns with organisation, financial efficiency and effectiveness were all central to the work of the Griffiths team. First, they asserted that, notwithstanding its distinctive social goals, the NHS should, like any other business, attend to productivity, cost control, improving service and incentivising staff. Judged in these areas it was failing. It had little idea of how well it performed, nor of the cost-effectiveness of clinical practices. Nor did it gauge the needs of its users, variously described as 'the patient', 'the community' and 'consumers' (though not 'customers').¹⁶ Indeed Griffiths was the first to deploy the

¹³ J. Appleby, 'Government Funding of the UK National Health Service: What Does the Historical Record Reveal?', *Journal of Health Services Research and Policy*, 4, 2 (1999), 79–89; the average annual real percentage change in spending rose under later administrations: Thatcher/Major: 2.63, Major: 1.88.

¹⁴ Webster, *op. cit.* (note 1), 160–2.

¹⁵ 'Sir Derek Rayner to Advise on NHS Performance', *BMJ*, 284 (17 April 1982), 1208; Sir Kenneth Stowe, *On Caring for the National Health* (London: Nuffield Provincial Hospitals Trust, 1989), 44–6.

¹⁶ Griffiths, 'NHS Management Inquiry', *op. cit.* (note 4), 10, 21.

rhetoric which became a New Labour staple, that the NHS should shake off the 'utility labels' of post-war austerity.¹⁷ Crucially, the absence of general management meant that no one provided leadership and bore ultimate responsibility. Instead the consensus model led to 'institutionalised stagnation' and 'lowest common denominator decisions'.¹⁸ Griffiths had utter faith in his prescription: it would be 'almost a denial of the management process' to suppose existing services could not be delivered at lower cost.¹⁹

His recommendations began at the top, with the advice that the DHSS should establish a Health Services Supervisory Board to oversee policy and strategy, and an NHS Management Board with responsibility for implementation, chaired by a chief executive, ideally from outside the public sector. In place of consensus teams, general managers with clear accountability were to be appointed at all levels. In the region and district this might mean importing new blood from the business world, while within units (hospitals) a clinician manager was desirable. All doctors were to participate in resource allocation through the introduction of 'management budgets' linked with workload and service targets. A Personnel Director would improve training and staffing procedures, introduce pay incentives for general managers, and review manpower levels. A 'property function' would be introduced, so that capital schemes and sales of property were given a 'commercial reorientation. Finally, the views of users should be more diligently sought, then incorporated in policy formulation.

Although public reactions were somewhat sceptical, government accepted the proposals for the DHSS supervisory and management boards, which were established in 1983 and 1985 respectively.²⁰ Fowler then announced a period of consultation on general management whose principal forum was the hearings of the Social Services Committee.²¹ Here the report was scrutinised by members such as Renée Short, Michael Meadowcroft, Nicholas Winterton and rising star Edwina Currie. Professional opinion was almost uniformly hostile, with the British Medical Association (BMA) arguing that if managerial decisions went against the patient's interest it 'would neither accept nor cooperate'.²² The Royal College of Nursing (RCN) believed consensus management remained viable, and viewed the proposals as barely veiled demotion of nurse managers.²³ Only the Institute of Health Service Administrators gave unqualified approval for Griffiths' promise of 'cultural change', though they conceded their own self-interest.²⁴ The committee's report fairly reflected this negative evidence but Fowler nonetheless proceeded to approve general management, and the appointments were duly made.

¹⁷ Sir Roy Griffiths, '7 Years of Progress – General Management in the NHS', *Audit Commission Management Lectures*, 3 (1991), 10.

¹⁸ Griffiths, 'NHS Management Inquiry', *op. cit.* (note 4), 14, 17.

¹⁹ *Ibid.*, 13.

²⁰ *First Report from the Social Services Committee, Session 1983–84, Griffiths NHS Management Inquiry Report, Annex A: Statement by the Secretary of State for Social Services on National Health Serviced Management Inquiry: Tuesday 25 October 1983* (London: HMSO, 1984), 158; B. Edwards and M. Fall, *The Executive Years of the NHS: the England Account, 1985–2003* (Oxford: Radcliffe Publishing, 2005), 9, 27.

²¹ S. Harrison, *National Health Service Management in the 1980s: Policymaking on the Hoof?* (Aldershot: Avebury, 1994), 80.

²² *First Report, op. cit.* (note 20), Letter to the Secretary of State from the Chairman of the Council of the British Medical Association, 2.

²³ *Ibid.*, Memorandum submitted by the Royal College of Nursing, 13–17.

²⁴ *Ibid.*, Evidence of D. Nichol, D. Kenny, L. Akid, 74, 80.

Historiography

How have the major historians of the NHS treated the episode? Rivett is overtly critical. Echoing the contemporary hostility of clinicians, he depicts Griffiths as a ‘newcomer’ to the service, oblivious of its peculiar multi-professional environment.²⁵ Thus private sector prescriptions had a deleterious effect, particularly for the nurses, whose loss of clinical leadership presaged a decline in quality control.²⁶ Only the administrators profited, entering the ‘promised land’ with ‘gleeful shouts of triumph’, while doctors watched in ‘wry amusement’ as an incompetent appointments process elevated those ‘who had raised the inability to take decisions to an art form’.²⁷ A quite opposite view is taken by Klein, who argues that Griffiths accurately diagnosed the ‘institutional stalemate’ besetting the NHS. Stasis and fractious labour relations marked the 1970s, Klein suggests, because the ideological standpoints of the various interest groups had hardened just as resources were constricting. Griffiths was therefore justified in condemning the consensus-oriented structures of the NHS as inadequate.²⁸ Klein also depicts general management positively, choosing contemporary quotes to illustrate the beneficial impact of the ‘more assertive . . . style’.²⁹ His thesis is that the organisation needed to adjust to broader social currents in which Griffiths marked the ‘shift from producer to consumer values’.³⁰ No longer was the ‘secret garden of professional autonomy’ to be sacrosanct; instead the service would have to ensure that it actually met the needs of users. Who better to drive home the message than a supermarket man, for whom customer choice was paramount?³¹

For Webster the Thatcher-era reforms were not a product of underlying social change but of an ideologically driven agenda, marked by ‘erratic’ policy making, ‘political opportunism’, and the absence of an electoral mandate.³² For him the focus on efficiency was not consumer driven, but the inevitable outcome of the failure properly to resource the service.³³ However, he also depicts Griffiths as a complex, independent player, sympathetic to the principles of the NHS.³⁴ Nor is he hostile to the key recommendations of an independent central board to run the service, and general management throughout. Indeed, such solutions might have been implemented in the 1974 reorganisation had Joseph not botched the reform.³⁵ Ultimately the inquiry was ineffective, since general managers were no better at handling clinicians than their predecessors, though its weakening of regional and district authorities did pave the way for the internal market (of whose merits Webster is doubtful).³⁶

This same diversity of opinion is discernible in the policy and management studies literature. The key historical works are those of Harrison and Edwards, both of whom were

²⁵ Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS* (London: King’s Fund, 1998), 353–4.

²⁶ *Ibid.*, 355.

²⁷ *Ibid.*, 355–6.

²⁸ Klein, *op. cit.* (note 1), 76–104, especially 101.

²⁹ Klein, *op. cit.* (note 1), 118.

³⁰ Klein, *op. cit.* (note 1), 121.

³¹ Klein, *op. cit.* (note 1), 121.

³² Webster, *op. cit.* (note 1), 144–5, 148.

³³ Webster, *op. cit.* (note 1), 153.

³⁴ Webster, *op. cit.* (note 1), 167–8.

³⁵ C. Webster, *National Health Service Reorganisation: Learning from History?* (London: Office of Health Economics, 1998), 18; *idem*, *The Health Services since the War Volume II. Government and Health Care: the National Health Service 1958–1979* (London:HMSO, 1996), 496–504.

³⁶ Webster, *The National Health Service*, *op. cit.* (note 1), 174.

also actors in the events. Edwards is a retired NHS manager, whose own distinguished career developed under the Griffiths reforms, while Harrison is a political scientist who in 1984 argued before the Social Services Committee that consensus decision making had been 'basically successful', and that general management would 'at best ... make no difference'.³⁷ Broadly Edwards endorses the Klein/Timmins reading, in which the 'liberating new spirit of Griffiths' introduced 'respectability' and accountability to NHS management and thus allowed later reforms to be delivered.³⁸ He argues for the deleterious impact of the 1974 reorganisation, with consensus management failing because the absence of clear responsibility meant weak or tardy decision making.³⁹ The upheaval also prompted experienced administrators to retire early, leaving the field to 'fresh faced' incomers who lacked the skills to manage consultants.⁴⁰ Despite early teething troubles and some poor quality appointments Griffiths inspired improvement. Hospital boards functioned better 'now that they had a clear leader' providing 'purpose and accountability', while clinicians broadly welcomed the clarity.⁴¹ Moreover, the best managers began tackling key issues like performance measurement, the effectiveness of middle management, integrating hospital care with preventive medicine and relations with the media.⁴²

Harrison's analysis is set within a conceptual model of the healthcare arena in which doctors, patients and third-party payers represent different interest groups, locked in a struggle to calibrate supply and demand under limited resources.⁴³ Before 1982, he argues, NHS managers behaved as 'diplomats' whose role was to create a smoothly functioning environment for clinicians, with whom they were in 'passive alliance'. Essentially they were reactive, eschewing objective setting, performance evaluation, and consumer satisfaction.⁴⁴ Griffiths marked the start of the new dominant trend, of a 'shifting frontier' of power away from the doctors and towards managers, who increasingly functioned as 'agents of the state'. Drawing particularly on political economy theory he presents Griffiths as the solution to a dilemma: how to rein back spending as demanded by macro-economic policy while not being seen to damage a popular service whose existence had a legitimising effect.⁴⁵ Unlike Edwards he regards the Griffiths reforms as initially of limited impact, with no clear infusion of new personnel and little restraint of medical autonomy.⁴⁶ Only after 1991, when hospitals adopted independent trust status and adjusted to the internal market were general managers more able to curb clinician sovereignty, a

³⁷ Brian Edwards *The National Health Service: A Manager's Tale 1946–1992* (London: Nuffield Provincial Hospitals Trust, 1993), 85; after posts in district and area administration Edwards was regional general manager of Trent Regional Health Authority, 1984–93; *First Report, op. cit.* (note 20), Memorandum submitted by Keith Barnard and Stephen Harrison, Nuffield Centre for Health Service Studies, University of Leeds, 129; Examination of Witnesses, 1 February 1984, 137.

³⁸ Edwards, *ibid.*, 86, 102, 122.

³⁹ *Ibid.*, 25, 43, 56.

⁴⁰ *Ibid.*, 48–51, 194.

⁴¹ *Ibid.*, 88, 100, 120–1.

⁴² *Ibid.*, 99–108.

⁴³ Stephen Harrison, *Managing the National Health Service: Shifting the Frontier* (London: Chapman and Hall, 1988), 3–5.

⁴⁴ S. Harrison and J. Lim, 'The Frontier of Control: Doctors and Managers in the NHS 1966–1997', *Clinical Governance*, 8, 1 (2003), 13–18; S. Harrison and W. Ahmad, 'Medical Autonomy and the UK State 1975–2025', *Sociology*, 34, 1 (2000), 129–146, 132.

⁴⁵ Harrison, *National Health Service Management, op. cit.* (note 21), 138–45.

⁴⁶ Harrison and Lim, *op. cit.* (note 44).

process furthered under New Labour with the aid of devices such as the National Institute of Clinical Excellence (NICE) guidelines on clinical effectiveness.⁴⁷

In sum, two lines of interpretation emerge from the literature. The first locates the inquiry within a critical phase when the NHS reoriented towards the consumer society of late twentieth-century Britain. Griffiths injected a new self-awareness into ‘a monolith ...preserving powerful professional empires’, making it more efficient, responsive to users and competent at assessing its performance.⁴⁸ The second emphasises the policy framework of tighter social spending espoused by the Western economies following the long post-war boom. Griffiths offered a mechanism for restricting expenditure without incurring a political backlash. Not only could the business prescription ‘make the NHS more efficient, or, more precisely ... make it *seem* more efficient ...’ it also provided a means of restraining clinicians’ power over resources.⁴⁹

Methodology

The witness seminar has developed over the last two decades as a novel source for contemporary history, though one which as yet has generated more raw data than analytical application. The two institutional drivers have been, since 1986, the Centre for Contemporary British History, whose interests emphasise high politics and, from 1993, the Wellcome Trust History of Twentieth-Century Medicine Group, where the focus is on medical science.⁵⁰ The technique is essentially group oral history, though the participation of eminent politicians or scientists sets it apart from mainstream oral history practice which concentrates on the testimony of non-elites.⁵¹ While such ‘history from below’ is often gathered through a life-story interview from which theory may be generated, the witness seminar generally explores a carefully delineated research question through concentrated discussion. The technique has done much to rescue elite oral history from the charge that it is merely the “debriefing” of the Great Men before they passed on’.⁵² Instead it has introduced a novel means of understanding the policy process at pivotal moments.⁵³

The limitations of the method reflect those of oral history more broadly. Participants may have inaccurate recall, may rehearse the received wisdom, may grandstand for posterity, may be tempted to settle scores, and so on.⁵⁴ Retired civil servants also tread the shifting sands of government tolerance towards public utterances by ex-employees.⁵⁵ The group setting carries additional pitfalls in that individuals may be less candid than in a one-to-one interview, particularly if former social hierarchies reassert themselves.⁵⁶ The agenda is preset, and once underway is circumscribed by the Chair, thus excluding

⁴⁷ Harrison and Ahmad, *op. cit.* (note 44), 134–6.

⁴⁸ Edwards, *op. cit.* (note 37), 189.

⁴⁹ Harrison, *National Health Service Management, op. cit.* (note 21), 141.

⁵⁰ E.M. Tansey, ‘Witnessing the witnesses: potentials and pitfalls of the witness seminar in the history of twentieth-century medicine’, in R. Doel and T. Soderqvist (eds), *The Historiography of Contemporary Science, Technology and Medicine: Writing Recent Science* (Abingdon: Routledge, 2006), 260–78.

⁵¹ Paul Thompson, *The Voice of the Past: Oral History* (Oxford: Oxford University Press, 1978), 2–7.

⁵² Michael Fritsch, ‘Oral history and Hard Times: a review essay’, in R. Perks and A. Thomson (eds), *The Oral History Reader* (London: Routledge, 1998), 29–37, 32.

⁵³ V. Berridge, ‘Hidden from History? Oral History and the History of Health Policy’, *Oral History*, 38, 1 (2010), 91–100.

⁵⁴ Thompson, *op. cit.* (note 51), ch. 4, 91–137.

⁵⁵ Public Administration Select Committee, *Mandarins Unpeeled: Memoirs and Commentary by Former Ministers and Civil Servants* HC 664 (London: The Stationery Office, 2008), 11–12.

⁵⁶ H. Slim *et al.*, ‘Ways of listening’, in Perks and Thomson, *op. cit.* (note 52), 114–25: 118.

some conceptual and empirical dimensions.⁵⁷ Validity also hinges on representativeness, and inevitably some witnesses will be absent, whether through death, disinterest or misadventure.⁵⁸ It should therefore not be supposed that the seminar will produce a consensual account which inevitably surpasses that revealed by the documentary record.

Nonetheless, when carefully triangulated with other sources the methodology has several virtues. The direct testimony of influential actors can generate valuable new insights which the official records occlude. In particular it can illuminate issues such as individual motivation, interpersonal dynamics and intellectual and cultural influences. Group interaction cannot aspire to generate a collective memory, but it has other attributes, prompting recollection, and exposing areas of consensus or dissent.⁵⁹ With this in mind, the 'problems' of lack of representativeness and collusive construction of historical narrative may also be viewed as strengths. A transcript reveals how participants make their vision of history, replete with their ideological and theoretical assumptions; the point is not simply to look for the facts, important as these may be, but also to treat the witnesses as 'bearers of culture' who can reveal much about these assumptions.⁶⁰

The roster of participants at the Griffiths witness seminar was: Lord (Norman) Fowler; inquiry member Sir Michael Bett; three leading civil servants from the DHSS, Sir Graham Hart, Peter Simpson and Clive Smee; doctors' leader Frank Wells, policy experts Robert Maxwell and Nigel Edwards, the clinician-manager Sir Cyril Chantler, and three other prominent managers who later went on to hold national positions: Christine Hancock, Alastair Liddell and Robert Nicholls.⁶¹ There were several key absences. Griffiths has died (1994), as have Cliff Graham, the inquiry Secretary, and Renée Short; Sir Kenneth Stowe, the Permanent Secretary who recruited Griffiths, has long retired and could not attend; other key informants unable to come on the day were Edwina Currie and Jane Robinson, an academic who assessed the initial impact. The Chair was Nicholas Timmins, whose admiration for Griffiths has been noted. The questions were therefore not framed from a position of critical neutrality, but rather provided an encouraging platform for candid discussion, though this did not preclude disagreement and conflict. The discussion draws both on full text of this seminar and on primary and secondary literature to explore the four research questions.⁶²

⁵⁷ Alessandro Portelli, 'What makes oral history different', in Perks and Thomson, *op. cit.* (note 52), 63–74: 71–2.

⁵⁸ Tansey, *op. cit.* (note 50), 266–8.

⁵⁹ Tansey, *op. cit.* (note 50), 270–1.

⁶⁰ Ronald J. Grele, 'Movement without aim: methodological and theoretical problems in oral history', in Perks and Thomson, *op. cit.* (note 52), 38–52: 44–8.

⁶¹ Hart: Director of Operations then Deputy Chief Executive of the NHS Management Board, 1984–9; Simpson: Senior Medical Officer, DHSS, 1978–88; Smee: Chief Economic Adviser, then Head of Analytical Services, DHSS, 1984–2002; Wells, Under Secretary of the BMA, 1979–86; Maxwell, Secretary, later Chief Executive of the Kings Fund, 1980–97; Edwards: Manager in the Oxford region and from 1999 Policy Director of the NHS Confederation; Chantler: Clinician and General Manager of Guys Hospital, 1985–8; Hancock: General Manager of Waltham Forest Health Authority 1983–9, then RCN General Secretary 1989–2001; Liddell, General Manager Bloomsbury, 1984–8, East Anglia Regional Health Authority, 1988–94, then Director of Planning, Department of Health, 1994–2000; Nicholls: President of the Institute of Health Service Management 1983–4, General Manager, Southmead, 1985–8, Oxford (later Chief Executive) 1988–93; NHS Management Executive, 1993–6.

⁶² Textual references are to 'Witness Seminar: The Griffiths NHS Management Inquiry: its Origins, Nature and Impact' (hereafter WS), held 11 November 2008, at the London School of Hygiene and Tropical Medicine; Available online at <http://history.lshtm.ac.uk/Griffiths%20Inquiry%20Witness%20Seminar%20final%20versionsecure.pdf>, web link consulted on 19th November 2012.

Causes

Existing accounts do not fully explain how management reform arrived on the agenda. The direct influence of Margaret Thatcher, the 1982 industrial action by healthcare workers, and the machinations of DHSS mandarins all vie for consideration as the proximate cause. Stowe claims that the idea of an ‘NHS manpower and management’ inquiry evolved in discussions between Fowler and union leaders during the strike, to tackle the underlying problem of uncontrolled growth in the hospital workforce.⁶³ Griffiths’ own account credits himself with extending his brief after Stowe’s initial request, in January 1983, that he investigate manpower issues. He retorted that these must be symptomatic of management failings, which should be the main focus.⁶⁴ In support of this, Fowler’s first public announcement (October 1982) alluded only to ‘the better use of manpower’, with ‘management issues’ not appearing in the terms of reference till February 1983.⁶⁵ However, management controls were already in the DHSS’s sights. Civil servants had been angered when some NHS administrators colluded with striking unions, reaching local deals which undermined the DHSS negotiating position.⁶⁶ Thatcher, meanwhile, influenced by Conservative backbencher Ralph Howell, had also voiced concern about ineffectual NHS management systems.⁶⁷ Despite this, the Minister of Health, Ken Clarke, lobbied for a narrow report on manpower, out of concern that Griffiths might encroach on his own remit. Another Thatcher intervention, in February 1983, finally tilted the review towards ‘a searching look at ... general management issues’, as favoured by Griffiths, Stowe and Fowler.⁶⁸

How do key players now view its inception? Fowler minimised the importance of the strike and manpower, emphasising instead the larger political and economic context. Public expenditure was tight, and two policy options presented themselves, either to change the funding base or to maximise efficiency.⁶⁹ The former was abandoned in late 1982 following a leaked report by the Central Policy Review Staff which had considered adopting private health insurance. The ensuing negative publicity had bounced Thatcher into a declaration of support for a publicly funded NHS, a position Fowler ‘personally believed in’.⁷⁰ If increasing inputs was impossible, the only alternative was to raise outputs through efficiencies, not least if the NHS was to compete with other spending departments.⁷¹ The backdrop to this was the ‘extraordinarily political’ ferment created by the press and opposition in response to proposals such as competitive tendering, generic prescribing and even ‘counting people’.⁷² Thus implicitly an independent inquiry would deflect heat and build an alternative consensus. Fowler claimed the management issue was always uppermost, and that the impetus had come from his department’s concern ‘that consensus management wasn’t working’. Number 10 exerted general pressure but was

⁶³ Stowe, *op. cit.* (note 15), 50–1.

⁶⁴ Timmins, *op. cit.* (note 7), 408.

⁶⁵ Fowler, Speech at the Conservative Party Conference, 1982, DHSS press release, February 1983, cited in Harrison, *National Health Service Management*, *op. cit.* (note 21), 69, 71.

⁶⁶ Edwards and Fall, *op. cit.* (note 20), 14.

⁶⁷ *Ibid.*, 14–15; Harrison, *National Health Service Management*, *op. cit.* (note 21), 59.

⁶⁸ Edwards and Fall, *op. cit.* (note 20), 17–18.

⁶⁹ WS Fowler, 15.

⁷⁰ *Ibid.*

⁷¹ *Ibid.*, 20.

⁷² *Ibid.*, 16, 20.

neither consistent nor instrumental: 'Margaret ... it has to be said ... the last consultant who spoke to her tended to be the agenda'.⁷³

Not all agreed that industrial relations were peripheral. Bett understood his co-option onto the inquiry as a direct result of the 1982 strike and its public impact. Indeed, it was his experience in 'countering the trade union strengths on behalf of the employer's which explained his involvement'.⁷⁴ '(P)art of what ... was going round in Margaret Thatcher's head', he speculated, was the need to involve the managerial 'heroes of the day', figures like Arnold Weinstock of General Electric Company (GEC), Hector Laing of United Biscuits and John Sainsbury, 'the guys who reduced the numbers, who fought the strikes', 'were great individualists, and did not run with collectives'.⁷⁵ Of course, Thatcher's determination to bring business leaders into government, such as 'efficiency experts' Derek Rayner of Marks and Spencer and Robin Ibbs of Imperial Chemical Industries (ICI), is well known, as is her resolve to curb trade union power.⁷⁶ Thus Bett located his role within this project, and stressed that prevailing ideals of tough, charismatic leadership also influenced Griffiths.

The civil servants, by contrast, saw the inquiry as evolving from internal debates about management reform. Techniques of public sector management such as performance indicators and target setting were slowly infiltrating the DHSS from the more progressive social security arm, and Griffiths' role was to 'accelerate the process'.⁷⁷ This tardiness owed much to the prevailing ethos of decentralisation, a legacy of the pre-1948 'tradition of handling the field authorities' as an 'arm of government that delivered services'.⁷⁸ Direction still continued to come through a 'rain of circulars issued by the mighty hand of the department', with insufficient regard for implementation.⁷⁹ Nonetheless, the change was underway, kick-started by the clearer leadership role forced on the DHSS by the 1974 reorganisation. Thus the shift from manpower to management was 'absolutely predictable'.⁸⁰

So was the inquiry's establishment evolution or revolution? Pushed on whether he was arguing that this was essentially a technocratic decision, Fowler argued that it was by necessity a *political* decision, given the charged atmosphere in which NHS policy making took place. However, ultimately 'any reasonable administration ... would have arrived at that conclusion'.⁸¹ Essentially then, the 'efficiency' policy route was inevitable, given the political roadblocks to reform of income mechanisms in the teeth of rising demand: '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'.⁸²

But would 'any reasonable administration' really have arrived at the general management reform? The question hinges largely on whether consensus management was genuinely failing. Here the witness evidence was both conflictual and inconsistent with

⁷³ *Ibid.*, 15, 19, 20, 21.

⁷⁴ WS Bett, 18; he previously worked with GEC then the BBC.

⁷⁵ *Ibid.*, 21, 39.

⁷⁶ Though her preference was for self-made entrepreneurs, rather than more established figures like Weinstock. Hugo Young, *One of Us: A Biography of Margaret Thatcher* (London: Macmillan, 1989), 360, 364.

⁷⁷ WS Smee, 23.

⁷⁸ WS Hart, 26.

⁷⁹ WS Liddell, 30.

⁸⁰ WS Hart, 19, 26.

⁸¹ WS Fowler, 43; by 'reasonable' he meant to exclude a putative Labour government under Michael Foot.

⁸² WS Chantler, 36.

the documentary record. Fowler's smoking gun was the Stanley Royd hospital scandal, where nineteen patients died in a food poisoning incident with poor management the culprit. This, though, significantly post-dated Griffiths.⁸³ Others recounted horror stories of incapable team members who were 'truly embarrassing' and of boards in which doctors and administrators were bitterly opposed.⁸⁴ However, just as the contemporary evidence to the Social Services Committee had found doctors and nurses content with the status quo, and the government and administrators less enthusiastic, so were memories divided.⁸⁵ Medical professionals recalled that, in practice, 'leadership emerged' in consensus teams, while BMA concerns lingered at the 'upset' of further reform.⁸⁶ Managers confirmed that there was no overwhelming sense of failure, though there was bad practice with the use of veto, lack of accountability and a structural tendency against adopting a 'coherent, organisation-wide perspective'.⁸⁷

Nor had contemporary research furnished definitive evidence that consensus management was unsuccessful. In 1978 Brunel University reported a survey based on interviews with 519 respondents from health services and government bodies, supplemented by several NHS case studies.⁸⁸ There was great diversity of opinion, and the problems of fudged compromises and personality dominance acknowledged, yet the principle was broadly endorsed and the difficulties interpreted as the necessary concomitant of multi-professional working.⁸⁹ The 1979 Royal Commission on the NHS duly concluded that consensus management was an acceptable model, which might be improved through better guidance from health authorities on the allocation of responsibility.⁹⁰ Snow's companion article in this volume provides further new evidence of the fruitful experiences of consensus management in the Manchester region, which seems broadly consistent with this assessment.

On balance, then, these contradictory perceptions weigh against the argument that the inquiry proceeded inexorably from the failings of consensus management and a momentum for change within the DHSS. Instead, the conjunctural factors loom large: the policy goals of curbing the power of organised labour and of finding new ways to enhance productivity in the face of Treasury demands for spending restraint.

Conduct

Existing knowledge of how the inquiry team conducted their work is robust, thanks to interview data collected by Harrison. The members limited their preliminary reading to a digest of relevant official documents prepared by Cliff Graham, including an earlier report which had recommended introducing general management.⁹¹ The team did not

⁸³ WS Fowler, 16; the salmonella outbreak occurred in August 1984 in an ex-Poor Law psychiatric hospital. Fowler announced an inquiry into Stanley Royd in September, and the culpability of management was exposed during 1985: 'The Stark Lessons of a Scrapheap Hospital', *Sunday Times*, 19 May 1985.

⁸⁴ WS Simpson, 33, Chantler, 36.

⁸⁵ *First Report*, xxi-xxiv, Evidence of D.K. Nichol and D.J. Kenny, 25 January 1984, 78-80.

⁸⁶ WS Freeman, 38, Wells, 32.

⁸⁷ WS Hancock, 33, Liddell, 31, Nicholls, 31, Edwards, 35.

⁸⁸ Royal Commission on the National Health Service (RCNHS), *The Working of the National Health Service, Research Paper Number 1* (London: HMSO, 1978), 4; Maurice Kogan led the research team.

⁸⁹ *Ibid.*, 44-9.

⁹⁰ RCNHS, *Royal Commission on the National Health Service*, Cmnd 7615 (London: HMSO, 1979), 314-5.

⁹¹ Harrison, *National Health Service Management*, *op. cit.* (note 21), 73; the earlier report was Farquharson Lang, *Report of the Committee of the Scottish Health Services on Administrative Practices in Hospital Boards* (Edinburgh: HMSO, 1966).

invite detailed written evidence, engendering much consternation amongst observers: 'And as for consultation? Ha! "No, we haven't got time for that!"'⁹² In part this was pragmatic, since the members were working in their 'spare time' within the tight schedule requested by Fowler.⁹³ It also mirrored the managerial philosophy Griffiths embodied: '(w)e were not going to invite huge waves of paper, which we would then have to wade through ... that would have been to Roy the culmination and utter condemnation of the consensus approach'.⁹⁴ Instead the process was threefold: first, the team undertook a series of visits to NHS institutions and met representatives of organisations; second, they commissioned 'unit studies' of management in five general hospitals; and third, they contracted consultancy firms to develop a new method of preparing management budgets.⁹⁵ Griffiths had been keen to use the visits to meet 'people actually on the ground', and was impressed particularly by the nurses' altruism.⁹⁶ Tellingly, Bett conceptualised the more structured meetings as encounters with 'the NHS tribes', each with its own interests.⁹⁷ This tribalism underpinned the failure of consensus management, since the veto allowed factional concerns to outweigh the common good. Confirming the supposition in the literature that the inquiry team was always predisposed against the consensus approach, he noted that 'Roy was absolutely, adamantly against perpetuating anything like that'.⁹⁸

One question that remains unresolved is the precise role and influence of Cliff Graham. As the senior DHSS participant in the inquiry and later as under-secretary with responsibility for introducing general management he was a central figure. Obituarists described him as 'almost a caricature out of Yes Minister; the silky-tongued senior civil servant, charmingly dynamic, but totally bamboozling,' yet also someone who 'made things happen' in the NHS.⁹⁹ Others hint that he was proactive, Edwards and Fall suggesting the 'Nightingale lamp' phrase was his, and noting the 'strong coincidence' between Graham's views and the content of the report.¹⁰⁰ He was remembered as 'a bit of a hero ... a real mover and shaker ... if we wanted to influence the inquiry we had a route through ... Cliff Graham'.¹⁰¹ Bett, though, played down Graham's role, noting that the civil servant was unhappy with 'the pure Roy Griffiths line'. The issue 'at the root of the difficulties that Roy and Cliff were having' was strategic, for where Graham wanted to give clarity on implementation, Griffiths was 'either not understanding it or not willing to understand it, because to do so would reduce the force of his thrust'. Thus, while the report did represent the team's views, 'Roy wrote it all', including the celebrated soundbite.¹⁰²

Indeed, Griffiths emerged in memory as the dominant figure and 'a considerable politician' in his own right.¹⁰³ He was 'not always an easy man, but he was a good leader',

⁹² WS Nicholls, 49.

⁹³ WS Bett, Fowler 50.

⁹⁴ WS Bett, 49.

⁹⁵ Harrison, *National Health Service Management*, *op. cit.* (note 21), 75–6.

⁹⁶ WS Bett, 39, 48.

⁹⁷ *Ibid.* 39, 47.

⁹⁸ *Ibid.*, 39; Harrison, *National Health Service Management*, *op. cit.* (note 21), 75.

⁹⁹ Harold Baum, 'Obituary: Clifford Graham', *The Independent*, 6 September 1994; Peter Simpson, 'Obituary: Clifford Graham', *The Independent*, 17 August 1994.

¹⁰⁰ Edwards and Fall, *op. cit.* (note 20), 19.

¹⁰¹ WS Nicholls, 40–1.

¹⁰² WS Bett, 38–9, 57; Nicholls 49.

¹⁰³ WS Fowler, 20.

and in the mould of the day's management heroes, 'he didn't like to be disagreed with'.¹⁰⁴ As to the 'famous letter', Griffiths had apparently not intended a detailed report but instead wrote a short note for Mrs Thatcher. Only when Downing Street demanded something fuller was the report produced.¹⁰⁵ Given that he had no formal reporting line to Thatcher this may have been a manoeuvre to 'suss out what it was that he might get away with writing'.¹⁰⁶ Bett confirmed that 'Roy wrote a polemic ... designed to set up a regime which he would be quite happy to run himself'.¹⁰⁷ Fowler's view was that Griffiths had ambitions to become Thatcher's adviser on the NHS. Indeed, he revealed that in 1986 he had threatened resignation to avert this situation, which he believed undermined his own position.¹⁰⁸ Another option was for Griffiths to be appointed to the Lords as minister with responsibility for managing the NHS, though this foundered on his reluctance to shoulder the attendant party obligations.¹⁰⁹ In the event he became Deputy Chair of the NHS Management Board with an office in the DHSS.¹¹⁰ Although Timmins claims he 'was promoted' to be Mrs Thatcher's 'personal adviser', the political memoirs are equivocal, Thatcher making no mention but Lawson recording Griffiths' advisory role on the 1988 ministerial committee which preceded the internal market reforms.¹¹¹

Memories dwelt, finally, on the motif of the 'supermarket man', and the bitterness engendered by a 'grocer' sitting in judgement on the NHS. In Griffiths' defence it was stressed that his expertise lay primarily in management, 'he just happened to be grocering at that time'.¹¹² Chantler recalled this philosophy, which Griffiths expressed while mentoring him as medical manager at Guy's:

He said management is not a profession, it is an activity, it's a responsibility. Doctoring is a profession, law 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 ... you have to move forward with consensus ... and you need to provide leadership.¹¹³

Griffiths also clearly appreciated the distinctive nature of the NHS workforce, and his strong hope was that clinicians would step up to general management.¹¹⁴ Indeed, for him medical cost-consciousness was a question of social justice: 'in a cash-limited system it becomes an ethical responsibility on the part of clinicians to manage ... the resources available, because profligacy in the care of one patient can lead to poor care for another'.¹¹⁵ However, these nuances were lost to popular perceptions, which interpreted the members' commercial backgrounds and the report's blunt presentation as signifying 'private good, public bad'.¹¹⁶ General management was thus read as private sector incursion: 'coming in

¹⁰⁴ WS Bett, 38–9.

¹⁰⁵ WS Timmins, 48.

¹⁰⁶ WS Fowler; Bett, 48.

¹⁰⁷ WS Bett, 70.

¹⁰⁸ WS Fowler, 20.

¹⁰⁹ *Ibid.*, 52.

¹¹⁰ This later became the NHS Policy Board; *Civil Service Yearbook* (London: HMSO, 1987–1994, *passim*).

¹¹¹ Timmins, *op. cit.* (note 7), 417, 460; Margaret Thatcher, *The Downing Street Years* (London: Harper Collins, 1993, pp. 47, 609; Nigel Lawson, *The View from no.11: Memoirs of a Tory Radical* (London: Bantam Press, 1992), 614.

¹¹² WS Bett, 40.

¹¹³ WS Chantler, 45.

¹¹⁴ Griffiths, 'NHS Management Inquiry', *op. cit.* (note 4), 6, para 8.2; WS Hart, 46.

¹¹⁵ WS Chantler, 37.

¹¹⁶ WS Nicholls, 41.

and managing these wretched professionals who couldn't do the business themselves'.¹¹⁷ When this reaction was articulated at a hot-tempered RCN meeting Griffiths was 'shocked rigid by ... a spontaneous outburst of ... the ministering angels ... just absolutely baying for him'.¹¹⁸ He had not expected this response and 'didn't recognise himself'.¹¹⁹

The discussion of the inquiry therefore elicited some unexpected insights about its leader. Although the occasion itself may have encouraged undue concentration on the individual, these reflections underscored the dominance of Griffiths' personality over the report. Particularly striking was the claim that he intended its recommendations to create for himself a position close to the centre of power. There was also evident respect for the energy and lucidity of his managerial philosophy, along with a sense of the political naiveté which prevented him anticipating the reaction to the report.

Implementation

One of the questions surrounding the implementation of the report is why reform within the DHSS itself was so limited. As Fowler put it: 'at the health authority level, and ... below that, I thought that it went well ... where we didn't do so well was at the top...'.¹²⁰ The Supervisory Board was appointed in October 1983, chaired by Fowler and including Griffiths as 'independent member', but its remit for strategic planning was weaker than he had envisaged, and it was more a 'high level sounding board' than a decision-making body.¹²¹ Its initial business was the implementation of the report, alongside issues such as efficiency studies and competitive tendering for support services; from 1986–7 it met infrequently and was finally scrapped in 1988.¹²² The Management Board lasted longer (albeit with modifications and retitling), though its terms of reference similarly diluted Griffiths' intent: instead of functioning as a quasi-autonomous corporation the Secretary of State would retain ultimate authority over the regional chairs and hence the lower tiers.¹²³ The first appointee as its Chief Executive was Victor Paige, who lasted only a short time in the post, finding the tensions between the political and organisational elements of the role impossible.¹²⁴

Indeed, this problem of reconciling independent oversight at the centre with political accountability had perplexed the team from the outset. Bett recounted how one of the first policy options it explored was setting up an independent governing body for the NHS, on the model of the BBC or the nationalised industries.

We had dinner with Ken Stowe one night We asked: 'Ken, who is managing the Health Service? Is it you?' 'Oh no. My job is to advise ministers and to run the Department...'. 'So is it ... 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. ... [W]ell ... 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, because he did not have faith in the ability of a minister not to try and answer the question.¹²⁵

¹¹⁷ WS Hart, 44–5, 47.

¹¹⁸ WS Hancock, 36.

¹¹⁹ WS Timmins; Bett 40; Hancock, 50.

¹²⁰ WS Fowler, 51–2.

¹²¹ Edwards and Fall, *op. cit.* (note 20), 22.

¹²² *Ibid.*, 22–3.

¹²³ *Ibid.*, 23–4; the board underwent various changes and was wound up by Alan Milburn in 2001.

¹²⁴ Klein, *op. cit.* (note 1), 118.

¹²⁵ WS Bett, 27–8.

In the end they abandoned the idea when Stowe pointed out that an independent corporation would require legislation, which would be ‘intensely politically sensitive’ and ‘far too delaying’.¹²⁶ Thus the inherent contradiction in the new executive boards remained, and was confounded by Griffiths’ cavalier desire for immediate action, coupled, presumably, with his expectation that a leading role for himself would ‘have squared the circle’.¹²⁷ He made no attempt to prepare the ground by assessing ‘the art of the possible’, so that the civil servants ‘were all fumbling around’ as to how to implement the report, while Fowler received no prior briefing.¹²⁸ The result was that the post of Chief Executive proved to be the ‘most difficult and challenging management job in the public sector’, demanding a combination of both ‘manager and ... Whitehall warrior’.¹²⁹ Fowler again expressed regret at Paige’s unhappy experience, caught in this ‘no-man’s land between the department and the service’.¹³⁰

Why though were ministers so reluctant to delegate power to an executive board? Fowler articulated this as a longstanding political conundrum: ‘the Enoch Powell thing’.¹³¹ This referred to Powell’s classic statement of the impossibility of divorcing management from accountability in a tax-funded NHS; an independent corporation would simply blame all ills on funding levels while the public would have no means of redress.¹³² Civil servants also advanced counter arguments. As with the old nationalised industries, ministers did sometimes need to ‘pull on the reins’, and Whitehall would not want ‘these guys out there lobbying publicly ... because they’re not getting enough money’.¹³³ Nonetheless, there was serious discussion of the option, which Fowler divulged was scotched by Thatcher, who believed it would be seen as a step towards privatisation and thus a public relations disaster.¹³⁴ Noting the recent convergence of left/right support for reviving the ‘National Health Service Commission’ idea, Fowler reiterated his view of this as ‘a sensible culmination of the Griffiths Report’.¹³⁵

Confusion and uncertainty also characterised implementation at the lower levels. If amongst the mandarins ‘none of us really understood what this was all about’, the unit level administrators too were ‘scratching our heads ... on how do you operationalise this’.¹³⁶ Influential guidance was offered by the King’s Fund on different transitional models from consensus to general management, with the preferred option emerging as the creation of boards under a chief executive with members representing the different management functions.¹³⁷ But who should take the executive positions? The report gave ambiguous signals, favouring on the one hand more clinician managers, but also emphasising that appointments should be ‘regardless of discipline’ and invigorated by ‘outside catalysts’.¹³⁸ Moreover, the determination to press forward regardless of agreement with the professions

¹²⁶ Griffiths, ‘NHS Management Inquiry’, *op. cit.* (note 4), 15, para 11.

¹²⁷ WS Fowler, 55.

¹²⁸ WS Exworthy; Fowler, 55; Hart, 57.

¹²⁹ WS Hart 57; Fowler 54.

¹³⁰ Norman Fowler, *Ministers Decide: A Personal Memoir of the Thatcher Years* (London: Chapmans, 1991), 196; Stowe, *op. cit.* (note 15), 54.

¹³¹ WS Fowler, 28, 52.

¹³² Enoch Powell, *A New Look at Medicine and Politics* (London: Pitman Medical Publishing, 1966), 11–3.

¹³³ WS Hart, 56.

¹³⁴ WS Fowler, 53.

¹³⁵ *Ibid.*, and cf. Fowler, *op. cit.* (note 130), 197.

¹³⁶ WS Hart; Liddell, 57.

¹³⁷ WS Maxwell, 61; Nicholls, 6.

¹³⁸ Griffiths, *7 Years of Progress*, *op. cit.* (note 17), 6, para 8.2, 19, para 21, 20, para 27, 4, para 4.

led to discord. The BMA demanded further clarity of Griffiths' intent, and doctors did not accept the case against consensus management.¹³⁹ Nurses' anger at the threat to their professional status prompted a hostile publicity campaign, which taunted politicians with not knowing 'their coccyx from their humerus'.¹⁴⁰ Even administrators worried that there was 'no explicit or agreed process' for making the appointments.¹⁴¹

Against this difficult backdrop the regional appointments began, with existing administrators first to seize the opportunities, setting a precedent for the lower tiers. Ultimately about two-thirds of the appointments went to existing administrators, some twelve per cent to outsiders, with about fifteen per cent to clinicians and ten per cent to nurses, these latter principally at unit level.¹⁴² However, this was not necessarily the 'promised land' for junior administrators, already adjusting to the abolition of the area tier. The incursion of 'other disciplines' into their career paths meant the 'sound of ladders being pulled up'.¹⁴³ Opening the field to incomers also undermined efforts by the Institute of Health Service Administrators to introduce a system of certification, thus slowing the progress of professionalisation.¹⁴⁴ Amongst the outsiders ex-military personnel were prominent, some of whom proved to be high-profile failures.¹⁴⁵ Their presence illustrates the problem that public sector salaries were too low to attract the business talent Griffiths envisaged, and fixed-term contracts were another disincentive; retired soldiers, with the cushion of forces' pensions, were more tempted.¹⁴⁶ Bias in the process was most glaring in the tiny numbers of female managers, attributed by contemporary researchers to the persistence of cultural assumptions about the nurse's subordinate role both within and outside nursing.¹⁴⁷ In a striking anecdote Hancock recalled how, after rejection by St Thomas's, she was finally appointed to another London teaching hospital, only to be advised by the region that she should decline because the medical committee had refused her. 'My partner believed that was because I was a woman. I believe it was because I was a nurse'.¹⁴⁸

The aspiration of creating a cadre of medical managers therefore went largely unmet. Griffiths was personally 'rebuffed by consultants quite strongly and nastily', and although the hostility of the BMA abated, its efforts to encourage active participation were poorly received.¹⁴⁹ Enthusiasm within the DHSS is also questionable.¹⁵⁰ There were some success stories, however, notably at Guy's Hospital, where a clinician chaired a board of clinical directors, each of whose directorates was run by a doctor, nurse

¹³⁹ WS Wells 58–9, 71.

¹⁴⁰ Harrison, *National Health Service Management*, *op. cit.* (note 21), 91–2; Timmins, *op. cit.* (note 7), 410; WS Hancock, 65.

¹⁴¹ WS Nicholls, 63.

¹⁴² Harrison, *National Health Service Management*, *op. cit.* (note 21), 104.

¹⁴³ WS Edwards, 67.

¹⁴⁴ *Ibid.*, 67; S. Davies, 'Health Services Management Education: Why and What?', *Journal of Health, Organisation and Management*, 20, 4 (2006), 325–34.

¹⁴⁵ WS Powell; Nicholls, 63; Hancock, 64–5.

¹⁴⁶ WS Hancock, 63; Hart, 69.

¹⁴⁷ P. Strong and J. Robinson, *The NHS: Under New Management* (Milton Keynes: Open University Press, 1990), 36–41.

¹⁴⁸ WS Hancock 64–5.

¹⁴⁹ WS Bett, 79, Wells, 59–60.

¹⁵⁰ WS Smee 80.

and business manager.¹⁵¹ In addition to Griffiths the catalyst for this was the financial crisis faced by the London teaching hospitals as resource allocation diverted funds away from the south-east.¹⁵² Guy's successfully maintained levels of care and developed capital projects while trimming running costs by fifteen per cent precisely by medical managers focusing on clinical efficiency.¹⁵³ This example and those furnished by Snow in the accompanying article warn against any over simplistic conclusions about medical disengagement. Nonetheless, they do underscore the question which concerned Griffiths, and others since, of why so many British clinicians do not consider NHS management a part of their vocation.¹⁵⁴

However, Griffiths ought arguably to have anticipated this reluctance. Clinician management was comprehensively examined five years before by the Royal Commission, which had demonstrated the '... considerable novelty and difficulties of this role'.¹⁵⁵ First, the status of doctor-managers was ambiguous: were they representatives or delegates of clinicians? Neither role was comfortable: a fiercely autonomous profession was not easily represented, while a 'delegate' acting independently risked being seen as 'the "administrator's man"'.¹⁵⁶ Chantler dubbed this the 'quisling' phenomenon, where clinician-managers were regarded as betraying their primary obligation to the patient.¹⁵⁷ Second, doctors contemplating managerial roles faced practical impediments such as pressures on time and lack of secretarial support.¹⁵⁸ Third, their professional culture aligned job satisfaction with the clinical encounter, not committee work: 'they want to actually be people persons'.¹⁵⁹ Fourth, in contrast to other countries, medical training provided no grounding in management skills.¹⁶⁰ Beyond this, a possible explanation of the slow advance since the 1990s is that Treasury book-keeping requirements for NHS Trusts undermined the devolved budgeting which had aided clinician decision making.¹⁶¹

Over time, then, the experience of participants and the judgement of researchers has tempered triumphalist assessment of the implementation of general management. Griffiths had 'over-egged' the capacity of private sector knights to ride to the rescue, and many who did were of poor quality.¹⁶² The lack of clinician engagement was another 'unforeseen failure', and nurses' morale had suffered as they felt their career map threatened.¹⁶³ The major academic studies of the new general managers through the 1980s, based on substantial interview programmes, gave similarly downbeat readings. The tight spending settlements had narrowed the scope for local initiative and greater engagement with users,

¹⁵¹ C. Chantler, 'Historical background: where have clinical directorates come from and what is their purpose?', in A. Hopkins (ed.), *The Role of Hospital Consultants in Clinical Directorates* (London: Royal College of Physicians of London, 1993), 1–11.

¹⁵² *Ibid.*, 1–2.

¹⁵³ WS Chantler, 37, 45.

¹⁵⁴ WS Hart 47; N. Timmins (ed.), *Rejuvenate or Retire? Views of the NHS at 60* (London: Nuffield Trust, 2008), interviews with Dorrell, 63; Stowe, 90–1; Nichol 98–9; Black 128; Catto 131–32.

¹⁵⁵ RCNHS, *op. cit.* (note 88), 70; again the Brunel University multi-interview study was the source.

¹⁵⁶ *Ibid.*, 66–8.

¹⁵⁷ WS Chantler, 38; Wells, 71; Edwards, 71–2.

¹⁵⁸ RCNHS, *op. cit.* (note 88) 68–70.

¹⁵⁹ WS Wells, 79.

¹⁶⁰ RCNHS, *op. cit.* (note 88), 69; WS Smee 82; Timmins, Hancock 78; Bett 79.

¹⁶¹ WS Chantler, 46–7.

¹⁶² WS Bett 70–1; Hancock 63.

¹⁶³ Timmins (ed.) *op. cit.* (note 154), interview with Stowe, 90; Griffiths, *7 Years of Progress, op. cit.* (note 17), 11.

while status asymmetries and the continuing lack of appropriate information systems meant that clinician autonomy remained: 'Doctors still gave orders, nanny still knew best'.¹⁶⁴ Yet for all the shortcomings of the process, general management was put in place and rapidly bedded in. Research findings also revealed that there was no appetite for a return to consensus management, that nurses appreciated speedier decision making and that managers felt unshackled.¹⁶⁵ And if their impact was not to be felt immediately, it soon would be. As Thatcher herself argued, without general management 'the later reforms would not have been practicable'.¹⁶⁶

Conclusion: The Long-Run Verdict

At the outset two alternative narratives of the management inquiry and its place in the history of the NHS were suggested. One celebrated it as a pivotal moment in the march towards greater effectiveness and consumer responsiveness. The other suspected it was a device for implanting government 'enforcers' to control UK health expenditure, which in this period remained markedly lower than comparable industrialised nations.¹⁶⁷ The purpose of the witness seminar was not to refute or confirm these, nor to produce an alternative collective account. Indeed, many of the earlier uncertainties and dissensions about the inquiry's causation, diagnosis and impact were rehearsed. Nor was it necessarily to find new facts, although some did emerge, in Fowler and Bett's emphasis on how Griffiths' personal ambition shaped the report, and in Fowler's discussion of Thatcher vetoing the independent corporation model. Rather, the aim was to understand the perceptions and assumptions of influential actors as they formulated their historical accounts.

That said, a measure of agreement did emerge among participants, which drew elements from both narratives: it found some truth in the 'enforcer' notion, and from the taxpayers' perspective this was no bad thing, but also accepted that the quality of management had been slowly raised.¹⁶⁸ The Griffiths goal of setting clear objectives, for example, had become a distinguishing feature of the Blair era, where central targets were a key policy driver.¹⁶⁹ Measurement of outputs was also slow to improve, both in terms of the diversity of clinical outcome measures and of indicators for 'equity, access and responsiveness'.¹⁷⁰ Again it was only in the 1990s that advances were made in assessing clinical effectiveness, first in the area of health technology assessment, then through the more far-reaching NICE.¹⁷¹ And although the goal of separating policy and management responsibilities within Whitehall proved a chimera, by the mid-1990s the NHS Executive was dominated by ex-managers, not career civil servants, and had become more adept at setting and monitoring performance objectives.¹⁷² Thus the management reforms did

¹⁶⁴ C. Pollitt *et al.*, 'General Management in the NHS: The Initial Impact 1983–88', *Public Administration*, 69, 1 (1991), 61–83; Strong and Robinson, *op. cit.* (note 147), 164.

¹⁶⁵ *Ibid.*, 31–61; Pollitt *et al.*, *op. cit.* (note 164), 61–83.

¹⁶⁶ Thatcher, *op. cit.* (note 111), 47.

¹⁶⁷ WS Nicholls, 85.

¹⁶⁸ WS Smee, Hart, Bett, Nicholls, Maxwell, Liddell, 79–90 *passim*.

¹⁶⁹ WS Smee, 81.

¹⁷⁰ WS Liddell, 50–1; Smee, 82.

¹⁷¹ Clive Smee, *Speaking Truth to Power: Two Decades of Analysis in the Department of Health* (Oxford: Radcliffe Publishing, 2005), 82–4.

¹⁷² P. Day and R. Klein, *Steering but not Rowing? The Transformation of the Department of Health: A Case Study* (Bristol: Policy Press, 1997), 4–16, 35.

ultimately alter the situation in which ‘you pulled a lever and nothing happened, because it wasn’t connected to anything. That is different now’.¹⁷³ Recent comparative analysis of the performance of the four countries of the UK since devolution provides empirical support. England consistently had the lowest rates per capita of expenditure, nurses and hospital medical staff, 1996–2006, yet also the shortest inpatient and outpatient waiting times and best ambulance response rates. The most plausible reason is that, unlike Wales, Scotland and Northern Ireland, it made use of targets backed by public reporting and performance incentives for managers.¹⁷⁴ In the long term, then, ‘the Griffiths Report, with the huge shock it delivered to the system ... was a kind of milestone’ on the way to better delivery of health services.¹⁷⁵

However, the persistence of structural divisions between the interest groups within the healthcare arena also shaped perceptions. Despite the demands of a more informed and discriminating public, Griffiths’ goal of greater consultation with patients was repeatedly deferred, not least because this might generate unwelcome findings.¹⁷⁶ Griffiths’ favoured vehicle for articulating patient viewpoints was the Community Health Councils, set up in 1974 to permit grassroots representation. However, policy remained stalled and some suspected their abolition in 2002 was because their oppositional views were politically inconvenient.¹⁷⁷ Subsequent attempts to develop ‘Patient and Public Involvement’ have not arrived at a stable organisational model, and there is as yet only modest research evidence that managers are becoming better at incorporating local opinion into decision making.¹⁷⁸ The long-standing theoretical assumption that the patient’s demands tend to remain a ‘repressed interest’ seems to be borne out.¹⁷⁹

So too does the theory that the ‘two tribes’ of doctors and managers are bound to regard each other adversarially, because they represent the divergent interests of third-party payers and producers.¹⁸⁰ The demonisation of managers as ‘enforcers’ or obstructive pen-pushers has popular currency, and there remains a sense amongst some doctors that Griffiths began a process of disenfranchisement.¹⁸¹ Any mutual decline of respect and collegiality is an outcome about which ‘Roy ... would be terribly upset. It was not what he intended’.¹⁸² Griffiths’ optimistic assumptions about general management as a generic skill, through which an inspirational figurehead would knit the organisation together, also appear time bound. Experience showed instead that in the NHS a level of technical knowledge was essential, while the emphasis on leadership led to the neglect of mid-level, functional management skills.¹⁸³ By the 2000s this was most evident in the difficulties

¹⁷³ WS Hart, 84.

¹⁷⁴ S. Connolly, G. Bevan and N. Mays, *Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution* (London: The Nuffield Trust, 2010), xi–xiii, 95.

¹⁷⁵ WS Hart, 84.

¹⁷⁶ WS Liddell, 86; Smee, 82; Smee, *op. cit.* (note 170), 142; A. Coulter, *The Autonomous Patient: Ending Paternalism in Medical Care* (London: The Stationery Office, 2002).

¹⁷⁷ Webster, *The National Health Service, op. cit.* (note 1), 245.

¹⁷⁸ T. Milewa, J. Valentine and M. Calnan, ‘Community Participation and Citizenship in British Health Care Planning: Narratives of Power and Involvement in the Changing Welfare State’, *Sociology of Health and Illness*, 21 (1999), 445–65: 461–2.

¹⁷⁹ R. Alford, *Health Care Politics: Ideological and Interest Group Barriers to Reform* (Chicago, IL: University of Chicago Press, 1975).

¹⁸⁰ *Ibid.*; Nicholls, 85.

¹⁸¹ WS Edwards, 87.

¹⁸² WS Chantler, 45–6.

¹⁸³ WS Bett, 73; Edwards, 74, 87; Maxwell, 74–5; Cutler 77.

over hospital hygiene, giving rise to the riposte to Griffiths: 'if Florence Nightingale were there, she would expect to see a nurse in charge! And she would put a nurse in charge'.¹⁸⁴ Thus if the Griffiths episode had suggested that outsiders could not unproblematically be 'helicoptered in', then the case for fostering a professionally skilled health service management cadre became all the stronger.¹⁸⁵

Writing in 1991 Griffiths gave a mixed and rather wistful verdict on the progress of general management, invoking (inaccurately) 'Chairman Mao' on the historical impact of the French Revolution: 'Give it time'.¹⁸⁶ Twenty years on, he would probably take more satisfaction, particularly as the 2012 Health and Social Care Act incorporates some of his key themes. At the centre, new powers will be held by a NHS Commissioning Board and by the economic regulator, Monitor, and these should go some way to distancing the Secretary of State from day-to-day managerial responsibility. At local level the abolition of Primary Care Trusts and their replacement by GP-led commissioning consortia will forcibly create a new tier of clinician managers, willing or otherwise. Meanwhile, the establishment of local Health and Wellbeing Boards is designed to give voice to patient and public representatives in commissioning processes, rather as Griffiths envisaged. However, as in the 1980s, the backdrop to these structural reforms is financial stringency which, ironically, is now accompanied by hostile rhetoric towards 'endless layers of bureaucracy and management' and a programme of £20 billion of 'efficiency savings' to be found from 'cutting bureaucracy'.¹⁸⁷ In this context there are fears that the reforms may backfire, and thus that the 'Enoch Powell' problem of political accountability may arise with a vengeance. As implementation of the 2012 act proceeds, then, it seems unlikely Griffiths' final legacy will become clear in the very near future.

¹⁸⁴ WS Hancock, 73; Nick Black, 'Rise and Demise of the Hospital: A Reappraisal of Nursing', *BMJ*, 331, (2005), 1394–6.

¹⁸⁵ WS Liddell, 75; Davies, *op. cit.* (note 144).

¹⁸⁶ Griffiths, *7 Years of Progress*, *op. cit.* (note 17), 24. This is both a misquotation and a misattribution. The observation 'It is too early to tell' was purportedly made by Zhou-en-lai in an interview with Andre Malraux: Elizabeth J. Perry, *Patrolling the Revolution: Worker Militias, Citizenship, and the Modern Chinese State* (Lanham: Rowman and Littlefield, 2006), 306.

¹⁸⁷ Conservative Party, *Invitation to Join the Government of Britain* (London: Conservative Party, 2010), 45; Department of Health, *Equity and Excellence: Liberating the NHS*, Cm 7881 (London: The Stationery Office, 2010), 5.