CENTRE FOR ECONOMIC PERFORMANCE

DISCUSSION PAPER NO. 216

November 1994

THE IMPACT OF THE LAW ON INDUSTRIAL DISPUTES IN THE 1980s: REPORT OF A SURVEY OF MANAGERS IN THE NATIONAL HEALTH SERVICE

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ABSTRACT

This paper reports the results of one part of a research project which investigated the nature and extent of the impact of the labour legislation enacted between 1980 and 1990 on the conduct of industrial relations and the processes by which this came about. Interviews were carried out with managers at national, regional, district and unit or trust level in the National Health Service. Although there had been major national disputes and industrial action in the 1980s, local issues were the most likely source of disputes and possible industrial action. The experience of the 1980s therefore had a continued relevance after the 1990 reforms encouraged extensive devolution of industrial relations issues to unit level. The only notable legal ingredient in management responses to industrial action was deductions from the pay of staff who were not working normally, but on this as on other issues there were notable variations in practice in different areas. In general the law did not seem to be a central component in management thinking on how to respond to disputes.

This paper was produced as part of the Centre's
Programme on Industrial Relations

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The Centre for Economic Performance is financed by the Economic and Social Research Council. The research which is reported here was financed by a grant from the Leverhulme Trust.

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The second part of our research project on the impact of the law on industrial disputes in the 1980s focused on surveys of management and union negotiators. On the union side the survey was carried out by questionnaire. Managers were the subject of structured interviews. The aim of this part of the research was to provide a picture of the range of experience of those with responsibility for overseeing industrial relations in a selection of companies and public services. While the surveys of management do not claim to be representative of any industry or area of the public sector as a whole, they have highlighted a number of important issues relating to the role of the law in industrial relations in general and industrial disputes in particular.

This report presents the results of interviews within three regions of the National Health Service (NHS) in England and in the NHS Wales. There were ten respondents. Two had responsibilities at Regional level, one at District level and five in newly created Trusts.[1]
One of the other two respondents was from an ambulance service; the other was from NHS Wales. The interviews were carried out between February and April 1993. The information was supplemented by an earlier interview with the Executive Director (Personnel) of the NHS Management Executive.

1. The Changing Structure of the NHS

The organisation of the NHS has been modified on a number of occasions since it was established in 1948. Major reorganisations took place in 1974, 1982 and again in the early 1990s as the provisions of the National Health Service and Community Care Act 1990 (the 1990 Act) were progressively implemented. In England the NHS Management Executive is responsible through the Policy Board to the Secretary of State. The Service is divided into Health Regions (RHAs) within each of which are a number of Districts (DHAs) and Family Health Service Authorities (FHSAs - replacing the Family Practitioner Committees which existed from 1974 to 1990). In the 1974 reorganisation an intermediate tier was introduced between the regional and district levels but these Area Health Authorities were abolished in 1982. In Wales the Service is part of the responsibilities of the Welsh Office. The Executive Committee chaired by the Director of NHS Wales is responsible to the Secretary of State for Wales through the Health and Social Policy Board. There is no regional tier of Health Authorities but some of the functions of the Welsh Health Common Services Authority (WHCSA), a special Health Authority, are similar to those of English RHAs.[2]

Health care services are delivered by units all of which were up to April 1991 part of a DHA or FHSA. This date marked the start of the radical changes made by the 1990 Act, implementing proposals first made in the White Paper *Working for Patients* in January 1989. The overriding objective of these proposals was to curtail the spiralling demand for, and the costs of, health care. To this end a completely new ethos was imposed on the NHS. At its core was the intended creation of

commercial-style controls and incentives through contract based relations between `purchasers' and `providers' within the service. The role of RHAs was significantly modified. Their operational functions were reduced but initially they retained a broader strategic and monitoring role in relation to training, workforce planning and labour utilization. It was later announced that staffing at regional level would be limited to a maximum of 200. One respondent felt that regional managers might retain a role in helping to resolve difficulties between purchasers and providers without those having to be referred to the Management Executive.[3]

The 1990 Act required DHAs to delegate operational functions to hospitals and other local management units. As the `providers' of services, these units were encouraged to apply for independent status as self-governing `trusts', managed by boards of equal numbers of executive and non-executive directors plus a chair. It was envisaged that trusts could vary in size and the range of services provided. Some might be single acute units, others organisations providing fully integrated services including community care. DHAs, FHSAs or independent fundholding general practices were to act as `purchasers' of health services from these `providers', with this `market' generating, it was hoped, a more efficient system for the provision of these services. By April 1994 there were some 400 trusts in existence.[4]

There was a clear view among our respondents that a major effect of these changes was to devolve a lot of management decisions to unit level even where units did not become trusts or part of a trust. In their opinion the 1990 Act reforms would make development of the personnel function at unit level a universal practice so that trusts would be self-sufficient in industrial relations matters. As the number of trusts increased it was evident that the need for personnel staff within DHAs would be reduced and it was possible that ultimately there would be no personnel function at DHA level. The development of personnel expertise at unit level had not necessarily taken place after the earlier management reforms which followed the 1983 Griffiths report. This report heralded some of the more important management changes in the 1980s. These included the introduction of general managers at regional, district and unit level. This posed a serious potential challenge to the predominance of clinical practice in the management structure of the NHS.[5]

In Wales the rather different organisational structure with no regional authorities meant that the introduction of trusts and fundholding general practices which are directly accountable to the Secretary of State had considerably increased the involvement of the Welsh Office in strategic management.

Numbers employed

The major changes under way in the early 1990s make it difficult to provide a clear picture of trends within the workforce in those parts of the NHS covered by our respondents. The total numbers employed within each of the three RHAs and NHS Wales ranged from 45,000 to 65,000. There had been a pronounced decline in the numbers working at regional level, in one case from some 1800 in 1980 to 330 in 1993. The numbers employed within the units where interviews were conducted ranged from just under 1500 to just over 4500. A distinctive feature of the NHS is the extent of part time employment and these gross figures translated into significantly lower numbers of full time equivalents.

For most respondents at district, trust and unit level the biggest single group of staff was, as it is in the NHS as a whole, nursing and midwives who made up just

over half of the numbers employed. Increases in numbers were identified by some respondents among nurses, professions allied to medicine (PAMs), professional and technical staff and clerical workers. All respondents at unit level reported a decline in the numbers of ancillary staff as a result of two or three rounds of competitive tendering for the delivery of these services. Closures of smaller hospitals had led to some reduction of staffing in one unit and in another, a planned drop in mental health staff resulted from the `care in the community' initiative.[6] One trust referred to the removal of a layer of management `in common with other trusts'.

Changes in working practices

With a single exception respondents reported improvements in labour productivity; two referred to productivity gains from capital investment. Measured by reference to the Department of Health criterion of `patient throughput' - numbers treated, shorter stays in hospital, greater use of day surgery - gains were significant. Competitive tendering for the delivery of ancillary services, which started in 1984,[7] was also identified as a major source of productivity gains. This had been accompanied by a change in management attitudes over two or three rounds of this process from initial cooperation with unions to try to keep services in-house to a willingness to accept contracting out as a legitimate part of management strategy. This meant that management had become prepared to press harder for changed working practices and reduced staffing levels in in-house bids.

A number of respondents identified changes in the `skill mix' of staff as a way of reducing costs and enhancing `flexible working' practices. In some clinical areas staff were seen to be overqualified and steps were taken, for example, to reduce the proportion of qualified nursing staff in particular areas, supplementing them with non-professional care assistants. At the same time the clinical role of nurses was extended. One respondent at regional level, however, felt that while the issue of changing skill mix was an important one, it had not yet had a major impact on the number of nurses, medical and professional staff employed.

In the ambulance service a change which was said to have increased the difficulties for management was the introduction of annual salaries for operational staff in 1986. Loss of enhanced overtime payments made it more difficult for management to cover nights and weekends, exacerbating existing staff shortages, difficulties which contributed to and continued after the 1989-90 national dispute.

2. Industrial Relations Framework

Trade union membership

In the early 1990s there were some 39 trade unions and professional associations representing NHS staff.[8] Respondents commented that professional associations had extended their industrial relations functions. In particular the 1988 regrading of nurses had provided a stimulus for this side of the work of the Royal College of Nursing (RCN) and the introduction of trusts had led to increased membership among doctors and consultants of the British Medical Association (BMA). Although, with the exception of the RCN, numerically quite small, membership density among professional staff was said to be high.[9] Membership of the National Association of Local Government Officers (NALGO) - from July 1993 part of UNISON - among clerical and administrative staff and of Manufacturing,

Science and Finance Union (MSF) among technical staff was variable, with membership often concentrated in particular pockets. On the nursing side the respective strengths of the National Union of Public Employees (NUPE), the Confederation of Health Service Employees (COHSE) - from July 1993 both part of UNISON - and the RCN varied as between units. NUPE was the dominant union in the ambulance service respondent where the overall level of trade union membership was very high.[10]

Negotiating arrangements

For some 35 years the terms and conditions of most groups of workers in the NHS were determined by collective negotiations within the framework of the Whitley Councils.[11] The main exceptions were doctors and dentists. In 1962 a `Review Body' was set up to make recommendations on their pay to the government.[12] In 1983, in the aftermath of the 1982 national dispute, a similar Review Body was set up for nurses and PAMs. From this time the pay of some 60 per cent of NHS staff was, therefore, settled outside the Whitley structure, although other terms and conditions for these groups were determined through joint consultative committees.[13] One of the central objectives of the creation of trusts at unit level was to break up this system of national bargaining.[14]

With the exception of the ambulance service, all respondents had seen changes in negotiating arrangements. Union recognition was a key and, at the time of the interviews, often unresolved issue in the new trusts. One respondent had offered recognition for consultation only, another recognised all unions with a significant membership but in the context of single table bargaining, which had also been introduced in one of the other trusts. Since existing staff whose employment was transferred from DHAs to trusts retained the right to maintain their Whitley terms and conditions, it was generally acknowledged that Whitley would remain important for some time.[15]

Locally initiatives had already been taken to secure agreed variations on Whitley conditions, for example in one case buying out call out payments for pathology workers. The precedent for a more radical move away from the Whitley framework had been set at national level by the creation of the post of Health Care Assistant in 1991. It was also clear that there were other issues, for example shift working, where respondents intended to press for changes as a matter of principle. Two respondents referred to the introduction of individual performance related pay for some managers in recent years and this was seen as a far reaching change likely to affect wider groups of workers in the future.[16] It was, however, notable that two respondents referred to flexibility which had been achieved in the late 1980s within the framework of Whitley to resolve particular problems within some workgroups.

3. Disputes in the 1980s

In 1982 there was a major national dispute over pay which affected most groups of NHS workers. A prolonged national dispute over the pay of ambulance workers took place in 1989-90. Respondents provided some information about the local impact of these disputes but they were not over issues which it was within the power of local management to resolve. One other major national issue was the clinical regrading of nurses in 1988. This led to widespread protest action by nurses which affected some of our respondents. A more lasting impact had resulted from the length of time taken to process appeals against regrading. This varied markedly between authorities but in one region it was expected that these would not be completed until 1994.[17]

The one issue which led to disputes at local level affecting several respondents was the process of competitive tendering for the provision of services. This began in 1984 with catering, domestic and laundry services and had more recently extended into other areas. While disputes over the loss of contracts to outside bidders, or the job losses necessary for competitive in-house bids, were common, they rarely gave rise to anything more than token industrial action. It was more common for protests to be channelled into lobbying Authority meetings and organising demonstrations. Other local disputes reported were over a range of issues: withdrawal of premium payments for working on statutory holidays, moving all staff to monthly pay, reduction of shift overlap for nurses, the introduction of a job evaluation scheme for PAMs, and proposals to change rotas, annual leave and the length of the working day for ambulance staff.

In 1980 a new disputes procedure was agreed in the General Whitley Council - the section 33 procedure - but the extent to which Health Authorities had complied with this was variable. All respondents bar one believed that this procedure was generally ineffective as a means of avoiding industrial action. Indeed they had been reluctant to use it because it had introduced an independent disputes panel and managers apparently resisted the involvement of outsiders in decisions which they thought should be left to their discretion. Another criticism related to the status quo clause. Two of our respondents each had a single experience of use of the procedure in the early 1980s. The only respondent to agree that it had been effective, reported that a number of collective grievances had been raised through it, all resolved by local management or at district level. As far as use of procedures was concerned there was no clear perception of the circumstances when use of the section 33 procedure would be appropriate, at what level and what the likely outcomes might be. Respondents had a much clearer perception of section 32 of the national agreement which dealt with regrading issues. This was in particular because of the various nurses regrading issues which were being processed through it. Section 32 also had the advantage from their perspective that it did not involve reference to an independent chair.

The creation of trusts meant that the section 33 procedure was becoming a matter of historical interest. Respondents reported that the new procedures already in place or in the process of being concluded would provide for all appeal stages to be completed within the trust with, in some cases, the possibility of reference to an outside body only if both sides agreed.

General experience of industrial action

The nature of the NHS means that most industrial action stops well short of an all out strike. The information provided by our respondents was consistent with this with just one report of indefinite strike action by ambulance workers in one region in 1982. The national disputes, in 1982 and 1989-90 were generally seen as involving issues which could not be resolved locally. For most respondents, therefore, their work in these disputes was directed at minimizing the impact on local services, which evidently varied. The ambulance service respondent was a key participant in the 1989-90 dispute. One of the regional respondents said, however, that while throughout the 1980s there had been considerable, mostly shortlived, industrial action in its ambulance service over a range of issues - staffing levels, overtime, rotas, time off, radio procedure - by 1989 management had `won back control' to the extent that the service was maintained throughout the 1989-90 dispute.

The nurses regrading dispute in 1988 gave rise to demonstrations and meetings in one unit, `working to grade' in another. More clear cut industrial action occurred in two areas in the dispute over medical secretaries' national claim for regrading in 1987 and in one of these the threat of strike action was said to have led to an ad hoc locally negotiated settlement which was then used as a model for local agreements elsewhere. Competitive tendering was, in a sense, another national issue which gave rise to some local action and support for national days of action, but, as already noted, meetings, marches and lobbying of authorities' meetings were reported to be a more common form of response.

There were three reports of industrial action at unit level in local disputes in recent years. Similar action had occurred more frequently in local disputes in the early 1980s. Among the issues which gave rise to these disputes were proposed service or hospital closures, staffing levels, rotas and overtime. More recently there were reports of short-lived walkouts by ambulance staff in 1990 after the 1989-90 dispute ended. In the ambulance service covered by the survey threatened action had caused proposed changes to rotas and annual leave to be withdrawn in 1992.

Management responses to industrial action

A crucial factor in determining the nature of management's responses to industrial action in the NHS has been a concern to maintain patient services. One respondent said that this had become less of a constraint in recent years since during the 1982 dispute management had discovered that it could provide adequate cover for some services. Nevertheless it was generally reported that where a national dispute led to industrial action, part of the response at local level would be to seek agreements limiting its impact on local services. It was also a matter of concern to local management to avoid taking measures which might lead to an escalation of the dispute.

In the 1980s a key feature of national policy was to recommend the practice of making deductions from the pay of workers who were taking action short of a strike. This can be seen to reflect the advice in the Department of Health's 1979 Circular *If Industrial Relations Break Down*,[18] although one respondent questioned its relevance in the changed circumstances of the 1990s. Regional respondents said that in the early 1980s advice on deductions was sought by DHAs, which in turn were approached by units, with a view to establishing some consistency of approach. In

practice there were, nevertheless, considerable variations as to the amount of the deductions and whether, for example, they should be made for `go slows'. Particular difficulties over pay and deductions from pay arose in the 1989-90 ambulance workers dispute; in one unit the unions set up their own freephone emergency service. One of the regional respondents highlighted the problems associated with the provision of an emergency service in relation to deciding which workers would provide the service and therefore be paid.

Threats of dismissal or other disciplinary action were far less common - just one report of each. Pay deductions apart, the management response would not normally involve any legal dimension, both because of the short-lived nature of most action and a concern not to risk making relations at local level worse. The evidence that the individual worker was the primary focus of management responses to industrial action might perhaps be seen as the negative side of the development of direct communications with individual members of staff; three respondents said that this had occurred, although others said that they had not developed any such strategy.

4. Disputes and the Law

Industrial action ballots

Five respondents reported that ballots on industrial action had been held within the last five years, but for only one of these was this other than an isolated occurrence. The exception was the ambulance service where it was recognised that the unions had been increasingly using ballots as a negotiating tactic in recent years. All seven respondents at unit or district level said that they would monitor ballots, generally with an eye to seeing that they were fair rather than looking for compliance with every legal detail; one respondent also provided facilities for ballots to encourage a high turnout. Three respondents, including the ambulance service, reported that they had experience of unballoted action. In general management favoured ballots but as in other sectors where unballoted action occurred this did not necessarily elicit a legal response. In one case where industrial action was threatened but no ballot had been held, no issue had been made of this because management were aware of the strength of feeling among the workgroup on the matter in dispute. In another area, however, senior managers had insisted on ballots being held on industrial action during the nurses regrading dispute, even though the ballots only took place after the action had begun. Two respondents thought that NHS unions had found some difficulty in coming to terms with the balloting obligations. For example in one case the unions failed to ballot members of different groups separately; had this ballot not produced a vote against industrial action, management would have been prepared to threaten legal proceedings in the expectation that the threat would have been effective; actual use of the law, it was said, would have caused a strike.

Other areas of law

A total of three applications for labour injunctions were reported. No court proceedings were actually begun over ballots. One respondent reported that labour injunctions were obtained in respect of unauthorised use of vehicles in the 1989-90 ambulance disputes and another said that this had been seriously considered. A

third respondent said that an injunction had been obtained to restrain union officers from trespassing on hospital premises in a local dispute and another noted that an injunction had been secured to prevent demonstrations at disciplinary hearings. All these were said to be exceptional occurrences. As already noted, greater use of the law was made by way of action against individual workers. But this in turn was largely limited to deductions from pay and there were only two reports of threats of dismissal or disciplinary action.

5. Picture of the 1980s

In addition to questions focused on use of the law (if any) in relation to particular disputes, respondents were asked some more general questions on their perception of the climate of industrial relations in the 1980s and the role of the law in this context.

With a single exception respondents agreed that employers had become more hardline in dealings with trade unions; the respondent who did not agree with this said they had become more sure of their ground. All respondents disagreed with the suggestion that personnel specialists had become less important than they used to be. Some perceived a change in the personnel function linked to a more clearly defined management role which enabled managers to be more proactive.

Only one out of the ten agreed that the law had been the most important factor affecting industrial action. But there was a range of responses on the importance of the law in their own dealings with trade unions: three said that it had been very important, two important, four fairly important and one that it had not been important. One commented that the recession had been more important than the law.

Six agreed and one disagreed that industrial action ballots had been a good thing for trade unions; three others offered no view on this. Four agreed and four disagreed that union officials were now more accountable to their members. Two said that they did not know.

6. Conclusions

The early-mid 1990s were a time of major change in the organisation of the NHS. The developments which followed from the 1990 Act had implications for most if not all aspects of the provision of health services, including industrial relations. The interviews on which this report is based took place at a time when most respondents had recently experienced a major change in their role within the NHS or were about to do so. The experience of industrial relations in the 1980s was clearly a relevant factor in management strategies for the formulation of new structures for the future. In particular, while the NHS would remain `national', government pressure for terms and conditions of employment and other industrial relations matters to be devolved predominantly to unit level, can be seen to reflect a desire to avoid circumstances which could lead to national disputes of the type that occurred in 1982, 1988 and 1989-90. It was clear from the interviews, however, that disputes and actual or threatened industrial action in the 1980s were equally if not more likely to arise over local issues. The extent to which the legal environment

assisted or influenced management responses would, therefore, clearly be relevant to the reorganised NHS of the 1990s.

In all disputes, whether national or local, there was an evident concern to ensure that the impact on patient services was minimised. Experience of the major disputes where industrial action occurred in 1982 and 1989-90 had, however, assisted management by demonstrating that it was possible to maintain acceptable levels of some services even in face of industrial action. Managers believed that this increased the room for manoeuvre in responding to the threat of industrial action. Since the concern to maintain services was largely shared by NHS unions as well as the professional associations, it appeared that there was a degree of cooperation between management and unions in relation to industrial action. That is not to say that all the industrial action with which respondents had been concerned was largely token gestures. It was clear that on a number of occasions in both national and local disputes management had had to respond to industrial action in ways other than just seeking to minimise its potential impact on services.

It was difficult to find a coherent pattern in the nature of the responses made. In general, the only legal ingredient in these responses was the issue of pay deductions from staff who were not working normally. While this could be seen to reflect the approach in the Department of Health's 1979 Circular *If Industrial Relations Break Down*, there were conflicting views on the continuing relevance of this circular and there were wide variations in practice both in relation to when deductions were made and their amount. Other instances of more direct resort to legal remedies through legal proceedings against the organisers of industrial action were more ad hoc and described by respondents as exceptional. They were nevertheless indicative of a willingness to seek legal remedies, usually some form of labour injunction, when these were judged to be likely on balance to produce positive results. It was notable that the legal issues in the cases reported by respondents, most commonly one of the trespass torts, were not part of the mainstream of civil law restraints normally invoked against those who organise industrial action.

The evidence of a pragmatic response to local disputes can also be seen to reflect the conflicting pressures brought about by the process of devolving management decision making. There was an apparent paradox in this process in that increased responsibility for decisions at unit or trust level was accompanied by increased controls through the need to meet `contractual' obligations within fairly tight limits, thereby restricting management's room for manoeuvre. These pressures related to industrial relations issues just as much as any other. In this environment the absence of any consistent approach on matters such as pay deductions in response to industrial action was perhaps unsurprising. It seemed clear that while in the 1980s the personnel function had not developed consistently at unit level, this was increasingly likely to happen in the 1990s. It was possible that with increased experience of dealing with industrial relations at that level, a different and less erratic, though not necessarily more consistent, pattern of responses to disputes and actual or threatened industrial action might emerge.

In the 1980s and at the start of the move away from the Whitley procedures to a more unit based industrial relations environment in the early 1990s, the law did not seem to be a central component in management thinking on how to respond to disputes. The practice of making some deductions from the pay of workers taking action short of a strike did, however, become widespread and there may have been

a belief that this would operate as an effective constraint on workers pressing industrial action beyond certain limits. Management responses only rarely involved resort to the Whitley disputes procedures, and overall these responses could perhaps be characterised as ad hoc. Managers were, however, generally influenced by a concern to maintain patient services at all times and also, it appeared, a belief that a cooperative approach with unions, professional associations and a workforce which, maybe for pragmatic reasons, shared something of the same concern, would be likely to be most productive.

ENDNOTES

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1. Two of these were in one trust; all except one had previously been managers at unit level within Districts.

2. There are also different organisational structures in both Scotland and Northern Ireland. (See Levitt and Wall 1992, ch 6).

3. In October 1993 it was announced that the number of RHAs would be reduced from fourteen to eight as an interim step to their becoming regional offices of the Management Executive, a change which could only be made after further legislation.

4. 57 trusts were established in April 1991, 100 in April 1992, 153 in April 1993 and 99 in April 1994. A number of mergers between trusts took place during this period.

5. The recommendations of *The NHS Management Inquiry* (the Griffiths Report) October 1983 were implemented by Department of Health and Social Security Circular HC (84) 13 *Health Services Management: Implementation of the NHS Management Inquiry* June 1984.

6. The 1990 Act also implemented the proposals of the November 1989 White Paper *Caring for People* which imposed the primary responsibility for community care on local authorities' social services departments..

7. The process was initiated by Department of Health and Social Security Circular HC (83) 18 *Health Services Management: Competitive Tendering in the Provision of Domestic, Catering and Laundry Services* September 1983.

8. This figure relates to organisations represented on Whitley Councils.

9. It is notable that in the early 1990s the Society of Radiographers and Chartered Society of Physiotherapists both affiliated to the TUC. The Health Visitors Association merged with MSF in 1991, retaining its separate identity within that union.

10. Up to the mid 1980s there had been a closed shop. One of the rare ballots held on maintaining a `union membership agreement' for the purposes of the law on unfair dismissal and action short of dismissal under amendments made to the law by the Employment Act 1982 failed to produce the requisite

majority - 85% of those voting or 80% of those eligible to vote - in favour of this form of closed shop arrangement.

11. On the origins of the NHS Whitley Council system and its working up to the beginning of the 1980s see TUC 1981, ch 2.

12. In practice, before the Review Body was set up, the terms and conditions of these two groups were negotiated direct with the government. This remained the case for non-pay related issues after 1962.

13. Craft workers and other maintenance staff, including building operatives, were covered by negotiations outside the Whitley Council system. On negotiating arrangements in the NHS generally see McCarthy 1976 and TUC 1981.

14. *Working for Patients* paras 2.17-2.22, 3.12 .

15. While the Whitley Council arrangements are under review, in 1993 the NHS Management Executive announced that they would continue in existence until at least March 1995.

16. While performance related to pay was introduced for managerial staff in 1986 with the intention of applying it also to other groups, its extent was uncertain. A possible future development was the introduction of performance related pay on a group basis.

17. In 1993 ACAS was asked by the Nursing and Midwifery Staffs Council for help in identifying chairs for grading appeals committees working under a new procedure agreed by the Council with the object of clearing all outstanding cases by March 1995. See ACAS 1994, 46-47.

18. See Morris and Rydzkowski 1984.

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