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Government policy and the people who work for the NHS

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MANAGEMENT CONSULTANTS CONSISTENTLY inform those of us with the misfortune to be exposed to them that the Chinese symbol for crisis also represents opportunity. I have never confirmed this with a Chinese speaker (it would be deeply satisfying to discover that the Chinese symbol for crisis didn't also mean opportunity at all but did stand for, "the tissue box is fragmenting"). Presumably such management consultants (few of whom work in the public sector) would say that the NHS has been saturated with opportunities for the last 25 years.

Crises, opportunities and stress are now synonymous with public service work. There are no shortages of ordinary stressors in the public sector: patients and clients want help quickly, our employers demand standards and efficiency, society expects nurses to be always caring, social workers to be better parents than real parents and family practitioners to relieve all ordinary human misery. The recent environment of the modern NHS has exacerbated these stresses as people fear for their jobs or for their futures. Litigation looms large in the eyes of many: psychiatrists are frantic that they will be accused of both prescribing dangerous drugs and *refusing* to prescribe these same drugs; GPs are awaiting the next Shipman revelation; and management of risk, both corporate and clinical, is a hallowed shibboleth. Despite the election of a second Labour government there remains a climate of computerization, competition and fear that mirrors the desperation of a war-zone street market.

What was experienced of Tory values in a Tory health service might be described as the New NHS. New Labour has inherited this legacy and shows every sign of continuing rhetoric whereby cuts and "efficiency savings" are seen as inevitable features of reality rather than imposed by government. The New NHS reflects society's love of high technology and information overload. For example, unsolicited e-mails, newsletters and other material arrive on most managers' desks every day of the week. In the mid-1990s, one morning's post regularly brought the *Health Service Journal, The NHS Trust Service Review, Health Manager*, *The Nabarro Nathanson Carewatch, Grass Roots, VFM Update Plus, The IHSM Network, The NHS Trust Federation News* and the *NAHAT Newsletter*. Far from decreasing paperwork as promised the National Health Service Executive has actually added to it with the publication of its own good news journal, *The NHS PLAN magazine*, no less. Ironic in the extreme in what is supposedly a market led culture is that I would not willingly pay for one of these publications. There is a kind of relentless optimism about them so far removed from the experience of those who work in the NHS that to read them is to feel utterly adrift from the reality they present.

The New NHS has also embraced a culture of militarism, business jargon and meaningless sound bites. The militarism is typified by a language of targets, objectives and sometimes more pointedly; in one NHS marketing seminar group leaders discuss "Principles of Offensive Marketing Warfare", "Attack strategies (including guerrilla attacks)" and "Principles of Guerrilla marketing warfare". And all of this presented to nurses and other staff quite explicitly pacifist in their politics or nature. Nor should we kid ourselves the revitalised Labour Party is so very different in its approach. A message to members from General Secretary Tom Sawyer before the 1987 election included two statements of party needs: "outstanding campaign management and leadership through one central command with high flexibility" and "the capacity to predict and rebut the Tory attacks quickly and

effectively". (For an analysis of the New Labour approach to NHS policy see: Beresford and Croft, 2001).

The business agenda was reflected in a preoccupation with business plans and service level agreements and similar documents concerned with tendering, purchaser risk and efficiency improvements. Whether by accident or design we were left fully prepared for privatisation and partnership. Now, the competitive culture is further spurred on by an upsurge in press releases and adverts for awards for fulfilling various quality criteria. Bring on the Charter Mark, the Investors in People award, the UK Quality award, the Golden Helix Award and the Benefit Agency quality award. All of this started with the market rhetoric of Tory policy.

Miller Mair (1988) has argued:

The language of marketed care degrades people and contributes to a cruder understanding of ourselves. Everything presented is positive, eye catching, simplified, up-beat. We have begun to lose any sense of values other than cash values.

His concerns are reflected in the publication of magazines with titles such as *Value for Money Update Plus*. In Wilde's terms the organization has come close to being become dominated by cynics: "A man who knows the price of everything and the value of nothing" (*Lady Windermere's Fan*). Once you have a business ethos, then the idea of mergers and takeovers follows quite naturally. Partnership Trusts, PCTs and Mega Mental Health Trusts are now springing up in England. Like many other Trusts our own has still not fully recovered from our last merger; yet here we are again on the merry-go-round from which numerous board members will be sent spinning. Rather than efficiency the outcome is chaos. Worse, the process itself is chaotic. Chief Executives, Chairs and directors are supposed to guide merger and reorganization agendas while unsure of their own futures. In the case of Trust dissolution their future is, in part, certain: their jobs will end. Clinging to a scuttled ship is a lot to ask and it is hardly surprising that many board members leave to find other jobs during all this upheaval. Then middle managers will be seconded to specific merger tasks, thus abandoning their normal work to already overworked colleagues. Little of this directly impacts on clinical activity but clinicians will find that the changes in finance and personnel departments can have significant effects on the infrastructure on which we all depend.

The NHS remains burdened with centralized, rather loosely framed, visions of the future, small (but expensive) local projects, pump-priming money to start but not complete schemes, and a liking for short-term employment contracts. Curiously, many of the latter are given to the very people supposedly important to the new culture in the NHS, i.e. audit and quality facilitators. The NHS Plan and National Service Frameworks promise much but, again, money and resources do not necessarily follow these ideas and, again, projects like Assertive Outreach Teams are kick-started with little real idea of how they will be different or even what they will do. There remain insufficient resources to maintain existing services while starting new ones. One feature of the 20th century was the increased ability of the State to monitor its subjects. In the NHS monitoring seemed to have become an end in itself. Numerous systems still exist for computerized recording of the minutiae of patients' lives and the everyday, not to say every minute, activities of clinical staff. It is possible to equate the number of bed sores to be found on the bodies of older persons with the number of computers on any given geriatric ward as nursing staff spend more time manipulating keyboards than they do turning patients or helping them be more comfortable. The destruction of language and the use of computers has also combined to make the work-force ready for a codification of all activity — our own ordering system can turn a six letter word into a 14 symbol

code (pencil = MA 166 215 01-02-04). Curiously, this monitoring has resulted in chaos rather than control — it is easy to spell pencil and even pencib or pensil might be understood but get one of those numbers wrong and you will have ordered a fax machine. Get something wrong on one of our HR (PRISM) forms and a member of staff is over- or underpaid for months. The end of Körner seems to have brought confusion rather than relief as some clinical psychologists still collect Körner data a year since the system was stopped by the NHSE. Information is still collected, some is collated, some is sent to contracts departments, none of it is consistent within, let alone between, Trusts and no doubt PCTs will want to invent whole new systems of data gathering. So much of what is collected is, in any case, meaningless taken out of context. Zappa's Cyborg (1988), paraphrasing T.S.Eliott would be happy to remind us that, "Information isn't knowledge and knowledge isn't wisdom". As David Boyle (2000) says:

This is the paradox. If we don't count something, it gets ignored. If we do count it, it gets perverted. We need to count yet the counters are taking over our lives. (p. 14)

Much of this change is heralded as bringing about a new culture of accountability and cost consciousness. There is a constant implication in all of this that the old NHS was marked by inefficiency, untrustworthy staff and unaudited conduct or activity. Of course it may seem necessary to some that in order to bring about a new order the old should be vilified. But in fact many of the apparently non-cost conscious managers retain their positions in any new structure and the new monitoring systems simply confirmed what we knew already (that NHS staff work hard). One clear outcome of the attacks on the old NHS (and by implication its staff) has been a demoralization of those staff and, ironically, an increased likelihood in employees cynically taking "mental health days" when they are not sick, simply fed up. And is it more efficient to expect clinical staff to obsessively monitor their own activity and record it for computer databases via weekly keying-in rituals? The public are unaware that much data gathering in the NHS is not performed by efficient, computer literate clerks, but by nurses, occupational therapists, clinical psychologists and other highly paid, but keyboard inefficient, clinicians. No doubt a government spokesperson would claim these activities take "minutes". In the next breath these NHS staff would be praised for their dedication and in the next told to be more competitive and efficient.

The role of staff counselling services

The degree of disillusionment can be inferred from the rise in staff support and employee counselling schemes in the new NHS. It can of course be argued that such schemes are an indication of a new caring approach from our employers but the comments of staff being counselled might indicate otherwise: "there are too many tasks, no sense of completion", "today's NHS doesn't seem to care about anyone any more", "I spend more time being accountable than getting on with the job", "Flavour of the month demands leave no time for planning", "I'm not going to do work for people who treat me so badly". There are cheerful people still to be found (I recently met an obstetrician who would conjure a smile from a stone) and there are those for whom the NHS provides a good enough salary and have few obvious complaints. Yet, the constant promotion of the concept of a "fitter, leaner" NHS, a kind of healer-athlete, has a particular meaning for longer-serving employees: "My skills are in my bones. Experience doesn't count: things come automatically to me: new people have to learn — that takes time, then they're gone"; "I'm too old at 48. It's pathetic isn't it wanting to survive a couple of years and going at 50. What a way to think." I think the same way. As we have remarked elsewhere (Holmes, Newnes and Dunn, 2001), many psychiatrists we know also look forward to early retirement: why do clinical psychologists and others imagine we are being courted as arbitrators of the new Mental Health Act? Psychiatrists, sensibly, no longer want the hassle.

Employee Assistance Programmes are on the rise and many offer services to NHS and Social Care staff. There are many in-house schemes: our own staff-counselling service has now been going for over ten years (Newnes, 1992). In that time it has grown from a group of qualified and supervised volunteer counsellors to a service employing four counsellors who provide counselling to two local Trusts and the Health Authority. We also provide a psychotherapy service to Shropshire GPs. Referrals have risen from one or two a month to anything up to ten a month from a workforce of 4300. During our last merger a counsellor was specifically employed for a six-month period to help people who felt overwhelmed by the organizational change. This was a shortsighted move. The effects of that change have rumbled on for two years with some people finding that their job changes left them in meaningless roles or others finding that the frustration of attempting to integrate accounting, clinical, cultural and others mores from the two merged organizations has been too much.

The role of counselling in times of organizational upheaval is paradoxical. It may offer some comfort and clarification of workers' concerns. A counsellor might be able to reassure a worker that colleagues are also (silently) suffering. As Smail (1995) and others often point out, however, counselling has a tendency to offer the hope that people crushed by distal powers well beyond their own control can somehow pull themselves up by their own psychological bootstraps. Ideas like personal responsibility and notions of how we can control thoughts and feelings, as if these are entirely internal matters, are used by the counsellor to attempt to make the client feel better. Some counsellors might suggest that the client change jobs but this is not easy in our current economic climate and, in any case, for many NHS workers, their work feels a great deal more than just a means of paying the mortgage: public service is, in more ways than one, a political activity. In these circumstances staff counselling becomes a band-aid, allowing the organization to appear caring while preventing real change in workers' circumstances. Some would go further. Baritz (1960) has argued that occupational psychology and its poor relation, counselling, have been the means by which industry learned how to control its work force. Psychology has been systematically used by big business to develop means of rewarding and controlling workers just sufficiently to prevent rebellion while maximizing production. In doing so, psychology has been a significant weapon in the fight against unionism.

A further paradox for counselling is presented by the role of confidentiality. It is pretty much standard practice to offer a confidential conversation to clients (with some notional discussion about what the limits of that confidentiality might be). This probably enables clients to say more than they would normally say to a stranger and in the context of staff counselling might be seen to be particularly important. In some ways, however, this arrangement protects the organization, and in this case the government, from a detailed account of what its practices do to its workforce. Counsellors hear stories of disempowerment and disillusionment with NHS organization and reorganization again and again. They may share some of these with colleagues but the tendency to internalise the causes and ways out of distress can stop us seeing the wood for the trees. Staff turn to counselling where once they turned to union solidarity and their stories are made invisible by the cloak of confidentiality. For the counsellor who feels bound by this contract it is not necessarily normative to even compare the origins of their clients' distress so no coherent account will be made of why people keep seeking help. Records of non-humanistic counsellors may go no further than categorizing distress as depression, anxiety, obsessionality, burnout and so on. A less clientered approach might reveal: "bored by meaningless new job", "overwhelmed by change in computer technology" or "sick of constant changes in data gathering". Indeed external factors may be so much part of the counsellor's own job that they are denied in case the counsellor recognizes that they are in *exactly* the same predicament as the client.

A surge of referrals from a particular department might prompt a staff counselling service to respond at a management level. Our own contract enables us to give confidential feedback to the Human Resources department about areas of high stress. What this cannot do is capture the ways in which staff are frustrated and crushed by the everyday bureaucracy and boredom of their work or the seemingly pointless energy poured into regular organizational change. Counsellors are not in much of a position to ask whether this combination of chaos and control is actually designed, as Baritz might suggest, to create a confused and malleable work-force.

And……..

What arises from this is a challenge for health service policy-makers. Quite simply the government of the day needs to have the people who work for the NHS on its side. This will only happen if policies make sense, if their implementation is humane, and if people are treated as people not, in the new NHS argot, as "our greatest asset". The well being of public service employees would be enhanced by a variety of environmental and personal factors that were at one-time common in health and social service work. Factors like a sense of belonging, a reasonable degree of trust, straightforwardness (if only in the rigorous negotiations between management and unions) and an environment that assured workers of continuing employment. Politicians who have five-year terms of office can be very critical of workers wanting guarantees of longer careers. The essence of health-care is relationship, however, and the public can only benefit from relationships with people who are reasonably secure (see Goodwin, 2001). This assumes that any given government *wants* the NHS to help people who are ill or otherwise distressed by enabling NHS staff to do good work. Governments can probably drop the idea that they need to continually meddle with the people who work for the NHS in order to keep us under control. We're mostly too busy to plan a revolution just yet.

Dedication

I find that I have worked in the NHS, on and off, since 1970. This is for all those who have survived it longer than me and for Dorothy Rowe, who had the good sense to offer me a job in 1978. Good onya.

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