THE AEGIS CAMPAIGN TO IMPROVE STANDARDS OF CARE IN HOSPITALS: A CASE STUDY OF THE PROCESS OF SOCIAL POLICY CHANGE

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CONTENTS

		Page
Abstract		1
CHAPTERS		
ONE	CONTEXT, AIMS AND METHODOLOGY	2
TWO	THE CASE FOR A CAMPAIGN	29
THREE	TOWARDS THE LEADING PRESSURE GROUP IN MENTAL HEALTH	52
FOUR	SANS EVERYTHING AND A CASE UNANSWERED	86
FIVE	ELY AND FRIENDS	120
SIX	THE END OF THE OSTRICH ERA	141
SEVEN	SCRUTINEERS, COMPLAINANTS AND INVESTIGATORS	166
EIGHT	A PARTIAL VICTORY	192
NINE	A 92% VICTORY	219
TEN	EVALUATING THE REFORMS	243
ELEVEN	COMPLAINTS MACHINERY	281
TWELVE	POLICY CHANGE IN MENTAL HEALTH: INPUT POLITICS	319
THIRTEEN	POLICY CHANGE IN MENTAL HEALTH: THE STATE'S RESPONSE	351
Appendix 1	List of people interviewed for research	389
Appendix 2	A Postscript	390
Appendix 3	Selected mental hospital scandals	399
Appendix 4	Detailed cost and activity data	405
Bibliography		418

Abstract

This study explores the process of decision-making in central government health policy. It also documents the history of the pressure group Aid for the Elderly in Government Institutions (AEGIS) and thus the career of its Chairman Mrs Barbara Robb as a social reformer. There are two major arguments in the thesis.

Firstly, the study demonstrates that AEGIS played the key role in initiating and sustaining the extraordinary succession of scandals in the mental hospital service between 1965 and 1975 and that these were one of the major determinants of policy between 1970 and 1980. There are two broad areas of policy. The establishment of mental illness and mental handicap as priority services. Empirical evidence is presented to support the argument that the policy has achieved a considerable measure of success. The second area is the redress of grievances in the NHS through the development of formal complaints procedures, special inquiries and the Health Commissioner, where the conclusions are that reforms have been largely cosmetic and largely unaffected the established autonomy of the medical profession to investigate allegations of performance failure brought against its members.

Secondly, none of the major competing models of state activity gives a complete understanding of the process of change in the study. The policy process in mental health thus emerges as an example of the professionalised state thesis in neo-pluralism, set within an ideological framework which establishes medicine as the dominant profession.

CHAPTER ONE

CONTEXT, AIMS, AND METHODOLOGY

> "Social Policy is easier to describe than to define." (Francois Lafitte)

> "Now what I want is, Facts. Teach these boys and girls nothing but Facts. Facts alone are wanted in life. Plant nothing else, and root out everything else. You can only form the minds of reasoning animals upon Facts: nothing else will ever be of service to them." (Thomas Gradgrind, Hard Times, Charles Dickens)

> "A person does not exist without a social context. You cannot take a person out of his social context and still see him as a person, or act towards him as a person. If one does not act towards the other as a person, one de-personalises oneself." (R.D.Laing)

On the 21st of January 1965, Mrs Barbara Robb, of 10 Hampstead Grove, London NW3, visited an acquaintance in Friern Barnet Psychiatric Hospital in Southgate. Mrs Robb was accompanied on subsequent visits by her friends and associates, David (Lord) Strabolgi the Labour Peer and later Minister, and Audrey Harvey, the poverty campaigner.[1] For these three people, the first visits to Friern were their initiation into the shabby, twilight world of the back wards of British Mental Hospitals in the 1960s. As a result of her experiences at Friern and beyond, Mrs. Robb, with the assistance of her two friends and a number of other influential people, had, within 6 months, founded the small, elite pressure group, Aid for the Elderly in Government Institutions (AEGIS). Within a year she was spearheading a national media

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[1]MacGregor S, The Politics of Poverty,(London:Longman, 1981) pp.138-9 and Banting, K.G., Poverty, Politics and Policy, (London: Macmillan, 1979) p.24

campaign on conditions in psychiatric hospitals and was engaged in a protracted wrangle with the Ministry of Health about changing them. Within three years she had published a book called Sans Everything[2] setting out her case, and within five had been instrumental in restructuring the political agenda in mental health and health policy generally. By the time she died of liver cancer in 1976, the political history of psychiatric services and health service complaints machinery had been altered irreversibly.

Sans Everything was the first in a wave of mental hospital scandals which lasted beyond Mrs Robb's death and into the 1980s. During her lifetime, inquiries at Ely, Farleigh, Whittingham and South Ockendon Hospitals and the events which gave rise to them made front-page news. What is less well known about these events is the critical role AEGIS played in instigating and sustaining the press interest, and by thus raising the issue of care in mental hospitals, inspired the principal complainants at Ely and Whittingham to pursue their grievances. The South Ockendon Inquiry would never have taken place without the efforts of Barbara Robb over three years beginning with the first serious injury to a patient there in 1968.

This study documents Barbara Robb's political career as a social reformer between 1965 and 1976. It also examines in detail the career of policy reforms which concerned AEGIS, up to the present day. But the fundamental objective is to use a case-study to analyse the process of policy change in health policy in England and Wales.

In this introductory chapter, the context of the study in academic social administration is established. The aims are then set out and followed by a review of the major schools of methodology from which a framework for analysis is distilled and discussed in the

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[2]Ed. Robb, B. Sans Everything: a case to answer, (London:Nelson, 1967)

context of the source material used. Finally, the structure of the study is outlined.

Context

The study has been conceived of and researched within the academic tradition of social policy and administration. This originated in a number of empirical investigations in the 19th and early 20th centuries into the lot of groups in society whose state of material, physical and social well-being troubled the conscience of the elite groups from whom the investigators were largely drawn.[3] In addition to documenting the plight of the 'submerged 10th', studies also advocated government action to remedy the evils unearthed. Pre-dating this work, utilitarian philosophers such as Jeremy Bentham had developed moral theories of what was beneficial to individuals both in isolation and as members of society and formulated and promoted elaborate prescriptions of government intervention to foster welfare as defined.[4] Bentham himself even designed a technical device to implement some of his prescriptions. Just as the contemporary steam engine was forming the technological base for the development of mass industrial production, so the Panopticon served as the blueprint for the workhouse and the insane asylum which facilitated mass social engineering.[5] Then in the late-1920s the Webbs embarked upon

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[3]See Simey, T.S. and M.B. Charles Booth:Social Scientist (Oxford: Oxford University Press, 1960)

[4]Klein argues that the first example of policy analysis in social administration was the work of the Benthamite Poor Law reformers, See Klein, R., The rise and decline of policy analysis: the strange case of health policy-making in Britain, Policy Analysis, Vol. 2, No.3, (1976) pp.459-476

[5]Evans, R. Bentham's Panopticon: an incident in the social history of architecture, Architectural Association Quarterly, Vol. 3, Jul. 1977, pp.21-37

their epic English Poor Law History[6] and pioneered a historical perspective to the emergent discipline.

When the first Chair in social policy was created in 1950, these three traditions, the philosophical, the empirical and the historical were the core approaches of the discipline. However, its focus, the social services had by now become so extensive and elaborate that whole texts were required simply to outline the major elements of health, housing, social security, and local authority welfare services[7], and a fourth descriptive approach had emerged. Then later in the decade, the discipline attracted two young Cambridge academics, Brian Abel-Smith, an economist and Peter Townsend a sociologist. With the research which the former did on the cost of the National Health Service[8] and Townsend's study into the elderly poor of east London[9], social administration had acquired economic and sociological perspectives.

If one was to draw up a comprehensive list of the literature at the core of the discipline written before the 1970s, it would be possible to classify studies by this six element typology - philosophical, historical, descriptive, economic and sociological. Since the categories are not mutually exclusive, the concern in this hypothetical allocation would be to identify the primary aim of a study. Indeed, it has been the express aim of social administrators to develop, and transmit to students, a theoretical

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[6]Webb, S. and Webb, B., English Poor Law History, (London: Frank Cass, 1963 (reprint)

[7]Hall, M.P. The Social Services of England, (London: Routledge, and Kegan Paul, 1952)

[8]Abel-Smith and Titmuss, R.M. The Cost of the National Health Service in England and Wales, (Cambridge: University Press, 1956)

[9]Townsend, P., The Family Life of Old People, (London: Routledge and Kegan Paul, 1957)

versatility. Titmuss is perhaps the most brilliant exponent of this approach.

> "As a subject in the field of further education, it can ..be argued that Social Policy and Administration constitutes a synthesis - an interdisciplinary way of studying certain social institutions, problems and processes in society. This subject area does not, therefore, rest to the same extent as, for example, economics on a comprehensive body of theoretical knowledge. Nor does it exist to describe a technical body of information for professional training - as do, for example, most law faculties in Britain. It does not claim to be a distinctive, separate discipline. For some of its theory and some of its concepts, Social Policy and Administration draws on economics, and political science, on sociology, on psychology, on moral philosophy and related disciplines. For its methods of study it leans heavily on statistical theory, social survey techniques and history."[10]

His study of the policy and administration of blood transfusion stands out as a seminal work. The Gift Relationship examines and compares the mechanics of meeting a particular individual and social need and draws on extensive statistical, documentary, field study and financial evidence to support a policy prescription for the best means of meeting that need.[11] The book works at many levels in the discipline of social administration, but like much of Titmuss' literary output, the primary aim of studying blood transfusion becomes one of supporting a moral position involving contentions about the nature of human welfare, the supremacy of altruism over individualism, and the importance of collectively-financed and -administered social services in promoting and

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[10] Titmuss, R.M. Social Policy, (London:George Allen and Unwin, 1974) pp.57-58

[11] R.M. Titmuss, The Gift Relationship, (London: George Allen and Unwin, 1970)

fostering these moral values throughout society. Within the typology, therefore, the book is written from the philosophical perspective.

In the mid-1970s, the national political climate began to change and call into question the cross-party, 'Butskellite', welfare consensus which had dominated social policy development since the early part of the second world war. As the profile of 'new-right' politics grew, so did dissatisfaction with established explanations of policy and service development written from a 'whiggish' perspective presenting the process as a progressive, inevitable and natural social movement encapsulating the triumph of enlightenment and humanitarianism over nineteenth century demons such as unrestrained, laissez-faire capitalism and less-eligibility. At the same time, the growing influence of decision-making techniques developed by American political scientists on policy-makers in the United States during the 1960s chimed with a reaction against the theoretical pragmatism of Titmuss and a pursuit of a foundation in theory unique to social policy; although it remains contentious whether the greater emphasis given to theory over the last fifteen years has isolated and established a distinct social administration theoretic.[12]

Aims of the study

The concern with greater theoretical depth has unquestionably yielded one valuable by-product; the re-examination of the major fields of social policy from a political perspective to seek to explain the process of policy change and its impact on the nature of policy outcomes.

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[12]Mishra, R. Society and Social Policy, (London:Macmillan, 1977) pp. 4-5
See also, Carrier, J., and Kendall, I., Categorisations and the political economy of welfare, Journal of Social Policy, Vol.15, 1986, No. 3, pp.315-335

It is the aim of this study to develop such an explanation. In so doing, issues such as the rights of the clients, concepts of need, the historical development of services, and empirical evaluation of implementation emerge. However, the primary mode of inquiry will be political analysis.

Studies of policy change in social policy

This methodological objective is shared with a number of important studies which began to appear in the mid to late 1970s. Donnison[13], Hall et al.[14], Hall[15], Banting[16] and others have focussed on the process of political decision in social policy rather than evaluating or making prescriptions in the programmes considered. This work has added much to the field whilst remaining in many ways problematic and limited.

Hall, Land, Parker and Webb's, Change, Choice and Conflict in Social Policy, constructed a framework for analysis of the political process based upon three theoretics. Firstly they employed Easton's characterisation of politics as a coherent system with inputs, outputs and a constant imperative to maintain equilibrium. The conventional pluralist accounts of Lindblom and others were then fused together with Miliband's functionalist Marxist conception of state activity to produce the notion of 'bounded pluralism'. This holds that although decision making is pluralistic, it takes place within boundaries of perceived legitimacy determined by class-based, power relations. Hall et al. accordingly carried the analysis of social policy-making into new 'macro' realms of debate about the location of

[13]Donnison, D., Social Policy and Administration Revisited, (London: Allen and Unwin, 1975)

[14]Hall, P., Land, H. Parker, R., and Webb, A., Change, Choice and Conflict in Social Policy, (London:Heinman, 1975)

[15]Hall, P. Reforming the Welfare, (London:Heinemann, 1976)

[16]Banting, K., Poverty, Politics, and Policy (London: Macmillan,1979)

institutionalised decision-making within wider contexts of the structure of power.

They also drew on the evidence in six case studies across a wide spectrum of policy fields to derive criteria against which the likely 'success' or 'failure' of new policy proposals being transformed into material policy initiatives, and implemented, could be assessed. They argued that throughout the history of a proposal, varying degrees of legitimacy, feasibility, and support can be ascribed to it which determine its fate at the hands of decision-makers. These criteria are largely self-defining. 'Legitimacy' is defined in terms of the recognition given by political elites. 'Feasibility' refers to the prevalence and extent of practical barriers to innovation and reform. 'Support' seems a particularly circular analytical concept:

> "Since the case studies are all concerned with actual changes in social policies, they satisfied, as it were, the criterion of support."[17]

Although as explanations of change the criteria in Hall et al.[18] repeatedly generate the question 'so what?'[19], they reflect a recognition on the part of the authors that there is an intermediate level to which the detailed mechanics or 'blow by blow' evidence in the case studies can be distilled, but below the more abstract macro-level discussion about the structure of power from which 'bounded pluralism' emerges.

Hall et al. restricted their choice of macro theories of state activity to pluralism and marxism, begging the question of why other schools had been omitted. More fundamentally the final chapter of the book fails to return to the debate about the

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[17]Hall et. al. op.cit. p.485

[18]Hall et al. op.cit.

[19]I owe this point to colleagues in the postgraduate student seminars in the Department of Social Science and Administration at the London School of Economics

structure of power and draw any conclusions from the case studies, and throughout, builds at best, only tenuous vertical links between the horizontal levels of analysis. The added unconcern of the authors to structure their empirical material within their conceptual framework is one of Ham's principal criticisms.[20] Of course whether to sacrifice the momentum of chronology in presenting case study material is one of the most challenging methodological dilemmas - which Ham himself seems not to have resolved entirely in his own study of decision-making in the Leeds Regional Hospital Board.[21]

Banting however, is more successful in presenting his case study material within his analytical framework in his book on the politics of poverty policy and its interface with housing and education. But then the framework is far less ambitious. Firstly the value of macro-level of abstraction is completely swept aside with only cursory debate about the merit of contending theories[22]:

> "Our understanding of policy determinants can be refined further by abandoning the assumption that there is a single policy-process operating identically throughout an individual policy change and over all policies. The balance of forces at work seems to differ systematically in different phases of the process and in different types of policies."[23]

Ostensibly, then, his analysis operates at only two horizontal levels. Firstly he is concerned in the content of his case

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[20]Ham,C. Approaches to the Study of Social Policy-Making, Policy and Politics, Vol. 8 No.1 (1980), p.60

[21]Ham, C. Policy-Making in the National Health Service, (London:Macmillan, 1981) Ham avoids the problem by presenting a descriptive account divided into themes corresponding to the organisational concerns of the RHB.

[22]Banting, op.cit pp. 2-4

[23]ibid p.10

studies with the dynamics within the institutions of policy making - Parliament, the Executive, Whitehall and local authorities - and their interaction and response to inputs from the wider political environment, thus pressure groups, the media and public opinion. Second at a more abstracted level, he seeks to formulate 'emergent patterns' which he contends add up to a comprehensive picture of the social policy process. These patterns are structured into two 'continually interactive' categories of process; intellectual and institutional.

However, having earlier eschewed grand theories, he implicitly proceeds from within an acceptance of the work of American pluralists such as Lindblom and Heclo and Wildavsky who argue that in the face of intense issue complexity, uncertainty and constantly changing circumstances, policy-making both in practice and normatively is bound to be incremental.[24]

> "The image of policy-making that emerges is of a continuous learning process, in which policy-makers are constantly adjusting their interpretations of problems and changing their policies in response to steady flow of signals from their environment."[25]

Banting sees policy-makers as highly receptive to (even dependent on) those individuals most capable of replenishing the 'flow of policy intelligence' who are academics and professionals in the social services.[26] The political institutions digest and interpret the new ideas penetrating their world. The primary institutions here are political parties, the civil service, and pressure groups.

Two major limitations of Banting's approach allow corresponding conclusions to be drawn about the aims of a more satisfactory policy analysis. To begin with it should operate at three levels.

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[24]See section on pluralism, pp.353-54

[25]Banting op.cit. p. 4

[26]Banting op.cit p.141

There is the primary level 'blow by blow' account of issue identification, campaigning, lobbying, consultation, negotiation, Ministerial action and legislation. There is a secondary level which aggregates this work into an analysis of the broad ranges and sources of demands place upon the state which Dunleavy and O'Leary term 'input politics'.

> "This phrase is a piece of systems theory jargon which has become a synonym for studying who makes demands upon the state, what these demands are, and how these demands are made."[27]

The third level is the highest tier of abstraction which is concerned with broader sociological issues such as the role of the state and its implications for the structure of power in society. As noted above, although dismissive of the relevance of a tertiary level analysis, Banting writes from a wider construct which assumes that policy-making is pluralist. A more satisfactory approach needs to be explicit about these issues and evaluate the appropriateness of all the major, competing, theories of the state. It needs also to address the limitations of the work of Hall et al.[28] by forging vertical links between the three levels and drawing conclusions about the process in the case study material at each level of analysis.

Banting is sensitive to the second problem with his approach. Policy analysis must also avoid the hazard of using the specific content of case study material to draw general conclusions which detailed study in other fields may not substantiate. Banting discusses this issue in the context of his own work, yet seems to fall into his own trap nonetheless, since the significance he ascribes to the role of academics whom he sees as central to the process of change appears partly tunnelled by his choice of subject.

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[27]Dunleavy, P. and O'Leary, B., Theories of the State, (London:Macmillan, 1987) p.11

[28]Hall et al. op.cit.

The programmes he analysed were directed by Labour politicians such as Richard Crossman and Anthony Crosland who were academics themselves and in common with many ministers in Harold Wilson's Cabinet, suspicious that in-house advice was biased towards conservatism. They therefore brought in outside experts who supported change consistent with the Government's party political persuasions. The receptivity of these politicians to like-minded academics is therefore unsurprising but may not be typical. McCarthy, for example, draws more cautious conclusions about their role in making poverty policy in the mid-1960s. He also makes the further important point that having limited their role to problem definition and the specification of alternative policy proposals (for which role their academic qualifications particularly recommended them) they then found that the government was initially unsympathetic and accordingly became political campaigners.[29]

Banting's analysis is further limited in the role he ascribes to professionals which is essentially as organised interest groups or lobbies. This appears problematic in those fields of policy such as health and social services, where professionals directly implement policy in the course of professional practice. Indeed, there is evidence against Banting's view here in at least one of the three policy fields he reviewed. Dunleavy's study of urban renewal programmes in Birmingham identifies a much more extensive role for professionals in making housing policy than Banting would suggest.[30] Therefore, rather than demonstrating that his emergent patterns can be applied comprehensively to all social

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[29]McCarthy, M., Campaigning for the Poor, (London:Croom Helm,1986), pp.38-61

[30]Dunleavy, P., Urban Political Analysis, (London: Macmillan 1980) pp.112-119 or more fully set out in Dunleavy, P., The Politics of Mass Housing, 1945-75 (London:Oxford Clarendon Press, 1981)

policy areas his work tends to indicate that, at least at the intermediate level, the nature of political analysis can be specific to the field of policy under review.[31]

Public administration has a longer tradition in the analysis of decision-making and has consequently built up a more wide-ranging body of theory and extensive literature of case studies at central and local government level. Political scientists who are not also social administrators would, in the main, consider that limiting the analysis of the policy process to social policy issues places an artificial boundary around the enterprise.[32] They would contend that there is no single policy process specific to social policy and that one must consider public policy as a whole. Indeed some of the most instructive policy analyses of social policy change have been undertaken by generalist public policy analysts, such as Dunleavy and Heclo.[33] [34]

The definition and delineation of 'social services' through legislative and administrative political institutions is the product of complex, multivariate historical political processes which are dynamic. This evolutionary development produces a differential extent and rate of expansion of state intervention within different sectors, and a fluctuation of issues which fall

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[31]Compare this with Allison's findings in that different theoretical perspectives can colour the findings from the same case study material. Allison, G.T., Essence of Decision, (Boston, Mass.: Little Brown, 1971)

[32]"...our argument is that the separation of the disciplines of politics, social administration and economics has prevented an understanding of the real world phenomena, such as government policy, which cut across their artificial boundaries." Cawson, A. Corporatism and Welfare, (London:Heinemann, 1982) p.59

[33]Dunleavy, P, op.cit.

[34]Heclo, H., Modern Social Politics in Britain and Sweden (New Haven: Yale University Press, 1975)

under the social policy umbrella at any point in time. In this context, it would be highly challenging to attempt to synthesise a coherent and specific 'analysis-of-change-in-the-social-services'. One may also ask why social administrators who have tried to meet that challenge have drawn extensively on political science theory developed from studying other policy areas. For there is a certain lack of logic in searching for a process of change exclusive to social policy using tools of analysis from defence, economic, environment and transport policy.

Since this study focuses on highly specific policy areas, it is too narrow to draw general conclusions on such wide-ranging issues. Its objectives are simply to elucidate the process of change in mental and other health policy areas as a contribution to the wider debate. The first stage is to construct a framework encompassing the three levels of analysis earlier delineated.

An analytical framework.

The primary level of analysis, encompassing Chapters Two to Nine, is an exposition of the case study. This presents the major events chronologically, but also focuses on four major political arenas or spheres of input politics, during successive phases of the story. Firstly, the construction of a pressure group is examined, including the crystallisation of its promotional issues, its support-building, and entry into the political arena. In the second phase, the analysis moves closer to Ministers and the internal mechanics of central policy-making. In the third, the focus moves out of Whitehall to the mobilisation of 'public opinion' by the media, in opposition to professional (largely medical) political organisation. Lastly, the passage of legislation through Parliament is analyzed, highlighting the interactive roles and influence of the pressure group, the profession, Ministers and the Opposition.

The second analytical section encompasses chapters Ten and Eleven and begins by evaluating the impact of the policy reforms up to

the present day, from the perspective of the aspirations of the various partisans. In the final two chapters, the case study and the impact of the reforms are taken into the intermediate and tertiary levels of political analysis. An exposition of the characterisations of 'input politics' is taken as the starting point. This is drawn from Dunleavy and O'Leary's categorisation of five major interpretations[35]; pluralism, elite theory, public choice theory, Marxism and its variants, and neo-pluralism. Just as this typology includes the literature in policy analysis and political sociology, so the social policy literature can be so categorised. This intermediate analysis examines whether the case study material confirms the interpretation contained in each of these five models of the major spheres of input politics within the policy process. These are pressure groups, the mass media and Parliament. The tertiary analysis then draws on this work to test the appropriateness of the five models in interpreting the responses and outputs of the various administrative and political arms of the state and identifying the determining parameters in mental health policy change.

Methodology

A requirement of rigorous study is a considered structure for the process of research. Methodology like so many other areas in social science is contentious. On either side of the field stand the positivists, who contend that natural scientific method must be applied, and the subjectivists, who argue that the objectivity needed to apply positivistic approaches cannot be brought to bear by people studying society. A number of other schools have also sought to bridge the gulf between these two poles by attempting to draw on the best elements of each. Most prominent among these are Marxist and Weberian social theories. The following is a necessarily brief discussion from which some conclusions are drawn about an appropriate method for studying modern political history in England and Wales.

[35]Dunleavy P. and O'Leary B. Op.Cit.

Positivist approaches developed from an aspiration for the study of social phenomena to achieve the status of a fully-accepted science. If the social study was to claim to be a real science, it needed to adopt the methods used by natural scientists.

> "Most social scientists were agreed that the social sciences should model themselves on the natural sciences, especially physics, since it was these disciplines that represented the peak of achievement in human knowledge."[36]

Briefly, scientific method involves the development of theory by positing hypotheses about an objective reality and submitting them to empirical test by observation, data gathering and analysis. In applying these techniques, social investigators were required to set aside value judgements and conduct the exercise objectively.

The most influential positivist, Karl Popper, developed the doctrine of 'falsification'. According to this, it is the task of the analyst to put forward systematic theories from which hypotheses are deduced which pertain to empirical facts and which in turn can be falsified through observation. Scientific advance then proceeds through the accumulation of unfalsified theories and hypotheses and the rejection of falsified ones.[37]

There are several problems with the positivist approach. Firstly, Rein argues that in social science, the range and number of variables in social events are only partly known and it is often difficult to be definite about causal links or whether an unknown extraneous variable is at work. Not least, the data which exists or can be derived to investigate these problems are often incomplete or of poor quality.[38]

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[36] Hughes J., The Philosophy of Social Research, (London:Longman, 1980) p.35

[37] See Johnson, T., Dandeker, C., and Ashworth, C., The Structure of Social Theory, (London:Macmillan,1984) pp.192-193

[38] Rein, M., Social Science and Public Policy, (London: Penguin,
Continued on following page

Equally importantly, Kuhn and Weber[39] have both pointed out that natural science does not necessarily follow these strict criteria of falsification. According to Kuhn, the Popperian method underestimates the extent to which natural scientists abandon some theories before they have been falsified and retain others which have been shown to be false but which continue to have a pragmatic application in certain situations.[40] Positivist method is merely one paradigm or system of interpretation about what constitutes useful data, and what form 'scientific' theories should take. He argued that there is a range of competing paradigms in natural science and that the grounds for chosing one or another were often social or psychological.[41]

Both these two categories of criticism, complexity of the field of study versus the inadequacy of the information base and the subjectivity of choice of scientific method in certain situations, apply equally to fields of study in natural science. Therefore, the third criticism is perhaps the most useful to a discussion of social science method since it is specific to studies of human activity and organisation. Positivists deny any legitimate role for the active interpretation of observed phenomena on the part of the observer. They presume, therefore, that people can experience an event in a neutral fashion. According to subjectivists, this is a fallacy.

Continued from previous page
1976) pp. 53-54

[39]For a summary of Weber's position see Giddens, A., Capitalism and Modern Social Theory, (Cambridge: University Press, 1971) pp.138-139

[40]See Johnson et al., op.cit. pp.193-194. Examples which spring to mind include Newton's Laws of Motion, and Boyle's Law on the relationship between pressure and temperature in gases.

[41]Kuhn, T.S., The Structure of Scientific Revolutions, (Chicago: University Press, 1962)

Subjectivism shares with positivism the view that knowledge is based in human experience but diverges by claiming that that experience is an _interpretative_ process. Society is conceived of as a complex of 'socially constructed meanings' comprised of the ideas and interpretations its members hold about it. Accordingly, treating society as a pre-determined order involves the fallacy of regarding a subjective product as an objective thing, or, put another way, confuses _ideas_ of reality with reality itself.

Subjectivists, deny that social science can be value-neutral. Objective reality exists, yes, but human beings interpret it through perception and consciousness. Since such constructions placed upon reality are usually shared with others and conveyed by socialisation, they are also shared by social scientists. Thus, social researchers cannot place themselves in some unique position of having stepped outside socially-constructed reality.[42]

In its most reduced form, subjectivism poses a problem for social analysis since if social scientists are unable to escape commonsense assumptions and constructions on reality, how are their findings to be validated? Subjectivists respond to this by asserting that the most that can be achieved is to establish the kind of agreements about reality upon which the functioning of society is dependent and the ways in which these are constituted.

As positivists and subjectivists stand in opposition to one another, Weber and Marx have tried to harness the tensions of this dichotomy to build bridges.

Weber shared the positivist distinction between normative statements, which could not be established, and factual ones which could. He also accepted that subjectivist contention that human beings interpret reality. He tried to resolve the tension between the two perspectives by contending that a major task of social science was to make intelligible the subjective basis of social phenomena through techniques which are scientifically verifiable.

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[42]Johnson et al. op.cit. p.102

The range and complexity of reality was to be managed by selection of a set of events or 'problem of interest' from the totality. However since, according to Weber, the process of selection is subjective, it is incumbent on social investigators to make known their own values.

Once selected, the problem of interest should be studied through the process of constructing 'ideal types'. Neither descriptions nor hypotheses, ideal types are abstracted frames of reference or models of reality. They are the delineation of the most important and distinct aspects of the problem of interest, distilled from empirical observation, from the perspective of the analyst. They are thus the interface between the real world and research. They are judged by the criterion of how useful they are in organising our understanding of the world and are refined through observation. Scientific method is applied to estimate the extent to which these unreal 'idealisations' have grasped aspects of the real events.[43]

The construction of ideal types is for Weber the mechanism for achieving the principal objectives of social research which is to understand how social phenomena come to be as they are. This requires the establishment of causal relationships which involves positive answers to two principal questions. Firstly, is the causal relationship verifiable by others and not valid for one person only? Secondly, would the outcome of the social process under study be different if the facts or specific events identified as causal were modified?

The Marxist approach is based in 'materialism' which starts from the premise that objective, material reality constrains the limits of human action and social relations. Johnson et al. use the

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[43]See Giddens, op.cit. pp.133-151, Johnson et al. pp.84-85, Bottomore, T.B., Elites and Society (London:Penguin, 1964) p.38 and note 17. p. 45 (which quotes Weber's own explanation) and Cawson, A. op.cit. pp. 61-73

analogy of a book to distinguish materialism from subjectivism. Subjectivists would stress that the physical makeup of a book does not determine its meaning. This is conveyed by the author and interpreted by the reader and of course the one may differ from the other. Materialists would argue that no meanings could exist without the manuscript which remains a constraint upon possible interpretations. Materialism departs from positivism in its conceptualisation of reality. As noted above, positivists contend that reality can be explained by direct experience and observation. For materialists, the accumulation of facts and knowledge about their inter-relationships is purely descriptive. Explanation in social science requires the uncovering of underlying causal mechanisms which are not given to direct observation but which can be constructed or abstracted from it.

> "Marx .... believed that external reality did exist and that human consciousness could understand it. But doing so required a process of theoretical labour in which the analyst abstracts from a mass of empirical observations in order to detect the underlying order beneath the appearance of bewildering variety, and works on the fundamental causal processes in operation."[44]

For Marx, objective reality and human construction of it are not distinct concepts, since reality is not external to people. Reality is both the product of human activity and the condition of that activity. Strategic amongst human activity is sustaining the means of existence or productive action on the material world. The material world is not universal and determined by abstract nature, it is acted on by and transformed by people in society through the social relations of production.

> "This history of the relations between man and his natural environment is one in which nature is progressively transformed from an alien force determining our actions into

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[44]Dunleavy, P. and O'Leary, B. Theories of the State (London:Macmillan, 1987) p.217

a socially-constructed reality reflecting our socially constructed needs.... Human beings not merely reflect upon the natural order of things, they act upon it, control it, give it social meaning."[45]

Hence knowledge about the social world cannot be obtained by passive observation, only through action. Knowledge is one consequence of 'being-in-the-world'.

For Marx, then, there is an objective reality which is the product of human action, but also, human beings place interpretative constructions upon it through their direct experience of it. These constructs are based in ideology or a coherent set of ideas about the world. Ideologies are founded in relations of material production which in capitalist society are class-based and in conflict. Ideologies, like classes, exist in antagonistic relation to one another. At any one time, the ideas of the ruling-class constitute the dominant ideology in society, through which reality is interpreted. By internalising the major value assumptions in the dominant ideology, the subordinate class, which is exploited - that is has surplus economic value expropriated from its labour-power - aligns itself, contrary to its own objective interests, with the exploiting class: a state of being which Marx called 'false consciousness'.

In summary, the methodological problem in Marxist social theory is to explain social reality, not through empirical observation, but by uncovering hidden causal relations which pre-determine the process of change and development which observation describes. Such 'structural' determinants can be political, cultural or ideological in character but fundamentally are based in the economic structure as defined by the social relations of production. For Marxists, structural determinants are features of objective reality. They therefore differ from Weberian 'ideal types' which are merely models contrived to represent aspects of reality to assist explanation.

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[45]Johnson et al. op.cit. p.138

For Johnson et al., there are methodological problems with all these strategies whose resolution is a long-term goal of social scientists who expose the failures or one strategy or another. They have most sympathy with Marx's dialectical approach, in turn inspired by Hegel, to set the two 'fundamental axes' of social theory, object and subject, in opposition in order to expose the limitations of each and synthesise more satisfactory approaches.[46]

Four key issues arise from this brief review of the major methodological approaches. Firstly, positivist method is both problematic and contentious. Secondly, it is alone in denying the involvement of the researchers' own values in the entire research endeavour of issue identification, data collection, and analysis. Weber warns us that the selection of research topic is a value-biased process. Rein and others consider the empirical evidence available to social science to be inadequate to the procedures of scientific method. Thirdly, subjectivists see active interpretation of observed evidence as an inescapable human characteristic and therefore inevitable in social research. Fourthly, Johnson et al. after Marx, advocate using empirical and interpretative approaches in parallel and in opposition, one to the other, in order to synthesise method which addresses the limitations of each.

In general, my own view accords with the majority of approaches presented above and therefore rejects the purist, positivist method as mechanistic, limited and limiting. In the course of the foregoing study, a wealth of data has been gathered and analysed using standard empirical approaches where the evidence allowed and this endeavour has undoubtedly added enormously to understanding; although the search is unlikely to have been exhaustive. Moreover, any student of policy-making in contemporary Britain cannot get access to all the necessary evidence since key parts of the public record remains secret for thirty years. Hence,

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[46]Johnson et al. op.cit. pp.225-6

interpretation of poor data is inevitable on occasions. More importantly, I would argue that interpretation is an illuminating and creative intellectual faculty in research even where the empirical data is plentiful.

So both positivist and subjectivist techniques are employed in the ensuing study. It also tries to explore the utility of the respective methods of Weber and Marx, in seeking to abstract from complex, observed, empirical data, frameworks of reference or structural determinants which aid the task of explaining why events turn out as they do.

Weber's requirement that the value judgements made in choosing a research topic should be made explicit is both a challenge and an opportunity. After all, some of the events which are reviewed in the course of this study of the impact of mental hospital scandals are not amongst the most attractive incidents in modern social history, so it is interesting to explore one's motives for chosing it.

There are intellectual and 'non-rational' motives. Certainly the choice accords with major interests in health and the relationship between the process of change and the nature of major policy outcomes. Curiosity also demands an understanding of why human conditions which manifest themselves as an inability to function personally and socially, are conceived of as the purview of medicine and why policy should reflect this; particularly since despite the determined efforts on the part of somatic research psychiatrists over the course of more than a century, mental disorders are yet to reveal themselves of a demonstrable, somatic aetiology.

But the roots of this study also go back to adolescent memories of immediate family members admitted to a large psychiatric hospital during the period when AEGIS was active. There are resonant images: of two-hour bus journeys to visit; of a massive, sprawling institution whose ostensibly benign name was terrible and fearful; of the shame of the patient and of the family and the consequent

imperative to lie to neighbours and relatives; of a locked admission ward; of nurses locking doors behind them with bunches of keys swinging from steel chains; of cavernous, high-vaulted wards with long, shining floors, rows of beds with starched counterpanes and no basic privacy. At an intuitive level, it all seemed so remote from the personal suffering of the individual and felt very wrong at the time and perhaps the story of AEGIS allows one to explore the validity of that intuition.

At an academic level, my own approach to social welfare follows a former teacher, Francois Lafitte who contends that it should be unsentimental.[47] This implies a rational approach, which stresses technical assessment rather than moral judgement and paternalism. It is however, perfectly conceivable that one's implicit value-system can colour judgements otherwise presented technically; particularly since the definition of need blurs the boundaries between these categories.[48] Beyond this, Weber's challenge is too demanding. It is for others to say whether the study in the succeeding pages is unduly value-biased. An honest, and thorough attempt has been made to approach the material with as open a mind as I have available at the moment.

Sources

The material for the case study is drawn from five major sources. The primary, original source is the record left to the British Library of Economic and Political Science by Barbara Robb's executors. This is an extensive and remarkable collection of correspondence, briefing and policy papers, structured evidence to Ministers, and the two committees of inquiry she was involved in,

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[47]An unrecorded speech given on the occasion of his retirement from the Chair of Social Policy at the University of Birmingham in July 1988.

[48]Forder, A., Concepts in Social Administration, (London:Routledge and Kegan Paul, 1974) pp.40-57

as well as her own observations and notes of phone calls. The AEGIS record fills over 120 A4 ring binders. In the last few months of Mrs Robb's life, she began a detailed classification of her papers to trace the step by step events of her campaign and support her own interpretation of events. She managed to finish about twenty percent of this enterprise before she died, and the major initial methodological task was to complete her work by cataloguing and classifying the papers into broad themes and writing them up.

The second major source was the official, publicly available documentation and relevant statistics. Apart from all the standard Parliamentary, Departmental and quasi-government agency documentation, and professional and other interest group material, this included internal records of the interface between Ministers and civil servants and the health service drawn from the archives of South West Thames Regional Health Authority.

The third source was material obtained from semi-structured interviews with participants. These are listed in Appendix 1. The approach adopted was to forward a questionnaire which focused on both general issues and the specific role and concerns of the individual participant. The individual was then interviewed and a record was written up and agreed with the participant as evidence for the thesis. The events and issues surrounding AEGIS have also been discussed with a number of former and current senior civil servants and senior health officers who wished to remain unnamed.

Although this evidence has been extremely useful and in the case of some individuals opened exciting fields of inquiry which might otherwise have been missed, it has its limitations. Firstly, the ability of participants to recall detail 15 years or more after the event was variable and in individual cases, people remembered more about some issues than others. Moreover, good practice in the use of participants as sources requires that they should be allowed to comment on aspects of content. The result can be inhibiting in areas where substantive evidence is less than

comprehensive or conflicting and where interpretation is required.

Fourthly, extensive use was made of Richard Crossman's unedited Diaries in the University of Warwick Modern Records Centre. The complete Diaries are several times longer than the published version and are a far richer source of evidence on health care; the process of editing for publication having clearly focused on the parliamentary and inter-cabinet politics. However, as with the AEGIS record, an extensive cataloguing and write-up was required before the data was usable. Dictated to tape every Sunday and covering the previous six days, this record places historians in unique proximity to the centre of formal decision-making. Wherever possible, alternative evidence on the same events is presented alongside Crossman's account. In all fairness to Crossman, this cross-checking largely corroborates his description of events. His perspective and interpretation were singular to him and provided they are not confused with 'hard facts', they are critical evidence in themselves since he was personally involved and highly committed to his initiatives in the areas of policy of interest to AEGIS.

Fifthly, the research has involved an extensive, although probably not exhaustive trawl through national, local and specialist press covering 'hospital scandals' and AEGIS promotional issues from 1964 to the present day. A comprehensive and detailed content analysis over this entire period would have required more resources than were available and has therefore not been attempted.[49]

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[49]Golding and Middleton required a team of coders to analyse the national and relevant local press and broadcasts on the Deevy social security fraud case, over a six month period. See Golding,P. and Middleton, S., Images of Welfare, (London: Basil Blackwell, 1982) pp.67-8
Waves of massive media coverage of mental health scandals occur over a 10-year period during the history of the AEGIS campaign.

As intimated above, these sources are not the entire story. Access to the full record in modern political history in the United Kingdom is impossible. Finding corroborative evidence at the level of detail in Mrs. Robb's papers is therefore extremely problematic. There is one fascinating internal DHSS meeting between Barbara Robb and Crossman which both parties recorded in considerable detail. The content is the same, but the interpretation very different - an account is given in Appendix 2. The chronicling of events which emerges from her files has been largely corroborated by participants where they have been involved and where memory permits. One can also trace the story which her records describe through the voluminous official documentation. Nevertheless, there are events where her records and interpretation are the only sources. In these cases they are presented as such. To the extent that this is not 'scientific', the researcher can only plead that evidence is evidence even if corroboration is impossible. Besides, two years spent reading, cataloguing and interpreting Mrs. Robb's records leaves at least one student with firm grounds for believing her a reliable source; a view also shared by some now very senior and prestigious journalists.

It is feasible, therefore, that a future student might write a significantly different version of the political history of AEGIS and the hospital scandals of the late-1960s and 1970s once the public record becomes available from the mid-1990s onwards. For the time being, the following is an attempt written from one, individual perspective to get as close to the reality of events that the above listed sources permit.

CHAPTER TWO

THE CASE FOR A CAMPAIGN

In the autumn of 1963, Miss Amy Gibbs, a retired seamstress in her mid-70s, was admitted to Friern Barnet Psychiatric Hospital at Southgate in North London. Her condition deteriorated and she was transferred to a longstay ward for confused elderly people (then classified as psychogeriatric) and, apparently in anticipation of her remaining there, her furniture and household possessions were "sold up". Miss Gibbs' case was unexceptional in all but two characteristics, without which her quality of life would have probably reduced to the meagre existence afforded most of the 180,000 elderly people in longstay hospitals at the time[1]; a personal tragedy left unrecorded. However Amy Gibbs was a member of the Hampstead Artists' Society and, unrelatedly, had in her past been counselled and befriended by Mrs. Barbara Robb. Her admission and subsequent retention in Friern became as a consequence what Carr terms "an historical fact"[2].

Barbara Robb was a middle-class woman then in her early fifties. She had no professional career and lived at number 10 Hampstead Grove, Hampstead with her husband Brian. The house is a small early-Victorian terrace, just behind the "village" high street of Hampstead where, in the 1960s, dwelt those affluent and fashionable people who preferred fresh air and greenery to the smog and terraced townscapes of Mayfair, Knightsbridge, Belgravia and increasingly then, Kensington and Chelsea. The Robbs were not rich but with Brian's salary, her inherited, unearned income, and no children to drain the budget, they lived comfortably enough.

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[1]See Townsend, P. The Last Refuge, (London: Routledge and Kegan Paul, 1962) There were a further 115,000 elderly people in other longstay hospital care, much of which was ex-poor law infirmary pavilion ward accommodation. See Townsend, P. A national survey of old people, in Ed. Freeman, H., Psychiatric Hospital Care: a Symposium, (Balliere, Tindall and Cassell: London, 1965) p.225

[2]Carr. E.H. What is History (London:Penguin, 1961) p.12

She was born an Anne of Burghwallis just before the 1st world war. The family were part of the squirearchy in Yorkshire and they had a family seat at Burghwallis Hall just outside Doncaster.[3] Her father pursued a military career and the family were devout Roman Catholics. She had no title but the Annes were important people in the area and her lineage was a source of great self-esteem to a degree that there were those of her acquaintance who concluded from her bearing that she had been born into the high aristocracy. Her upbringing was conservative and gave her no great aspirations to transcend traditional gender roles and train for the law or some similar profession. Her Catholicism gave her a profound if at times paternalistic compassion. She also learned the 'old school' values of loyalty, decency and, perhaps from her father, fastidiousness in her work and formidable organisational skills. Indeed, her records of meetings demonstrate such a capacity for the recall of detail, even down to extensive verbatim quotes of conversation, that one would be forgiven for presuming she must have carried a tape recorder in her handbag.

At the same time she was far from conventional, since her primary interest in her early life was the theatre. In her youth, Mrs Robb trained for the ballet but her aspirations to a dance career were reversed by an ankle injury. However it is said of her that she carried this unattained ambition throughout her life, wearing her hair up as if always prepared for class. After the injury she changed course somewhat and entered the Chelsea College of Art to study theatrical design. At Chelsea she met Brian Robb who pursued a distinguished career and became head of the department of book illustration at the Royal College of Art. The Robbs were devoted to each other and Brian was a source of great moral support to his wife. His loyalty inspired him to bear without complaint the disruption and inconvenience that AEGIS brought to his life. They frequently ate out and Barbara Robb followed a punishing schedule which confined her to the basement study for

[3]It was ironically later turned into a home for the elderly.

weeks on end. He also provided financial support when her own resources were stretched.

She did not pursue any career as such but contented herself to keep house and engage in voluntary work through the Catholic church. Working with young offenders during the war generated her interest in Jungian psychoanalysis which she developed by reading widely. She then began to practise as a part-time psychotherapist counselling people referred primarily, if not entirely, through the local church networks. In this way Barbara Rob met and counselled Amy Gibbs in 1943. Miss Gibbs subsequently remained in contact with the Robbs and on her retirement, she was encouraged by Brain Robb to take up art and became a proficient collagist. It was a mutual acquaintance in the Hampstead Artists Society who approached Mrs Robb at the old lady's request during her second year in Friern.

Barbara Robb had the self-confidence and grandeur characteristic of an aristocrat. She feared no-one regardless of status or social position and in her work as Chairman of AEGIS was as assertive with the Secretary of State for Social Services as with the nursing auxiliaries at Friern. As suggested earlier, her self-image was further sustained by strongly-held personal and religious convictions. She is variously described as 'high-minded', 'idealistic', 'a woman of the highest principles'. She was a staunch, but liberal Roman Catholic who would cheerfully write to the Pope to criticize any church policy (such as the Encyclical on birth control) with which she disagreed. If her compassion is added to this formula, her commitment to AEGIS emerges as the expression of her sense of moral rectitude in the cause, and sudden discovery of a vocation in later life.[4] Her commitment was total. By the middle of 1965, she was devoting sixteen hours a day to her work and sustained this pace before illness overtook her ten years later. She brought to the task a penetrating intellect, a critical, analytical mind, expressive

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[4]Prior to embarking on the AEGIS campaign she had been considering the cause of prison conditions.

lucidity (not to discount wit) in the written and spoken word, and a considerable latent talent for political bargaining which became highly developed through experience.

She had a powerful personal presence, complemented by a striking appearance - with large facial features which she magnified further with high-fashion clothes and the broad-brimmed hats which became a talking point at conferences on mental health during her active years. The care and attention she devoted to her appearance were no mere vanity, however, since her files reveal an assiduousness to ensure that she was so-dressed for any occasion to project a functional image. There were those on the circuit of symposia, press conferences and public inquiries who found her clothes rather incongruous, even ostentatious for a social reformer in late middle-age. However it was all part of her self-presentation as an imposing, rather theatrical, figure. Barbara Robb was a 'power-dresser' before anyone dreamt up the term.

If this image seems hardhearted, her close friends and associates would be anxious to emphasise that her resolution was tempered by personal warmth, humour, great enthusiasm and immense charm. These qualities were also highly functional to her in engaging the support of influential people. Journalists in particular seem to have found her approach refreshing and attractive in that 'she managed to preserve a degree of freshness and naivety which made her appear vulnerable in the hard world of political bargaining'.[5] Although most of them knew that she very quickly developed into a keenly astute, highly organised and extremely efficient lobbyist, she never lost her 'old world charm'. She was personally generous, offering unsolicited gifts to associates <u>after</u> they had helped her. She would send champagne or flowers to raise the spirits of ailing supporters or more incongruously, sweep into the shabby long-stay wards at Friern laden with fine hand-made chocolates and vintage brandy for the otherwise deprived residents.

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[5] Interview with Hugo Young

She ran AEGIS virtually single-handed from the basement of the house, consulting her advisers by telephone and motoring around London in mini-cabs delivering copies of the latest AEGIS paper to potential allies, up-to-date fully-referenced information to journalists and briefing documents to politicians and lawyers. As the workload swelled, she engaged part-time secretarial assistance. Throughout the campaign, her private income and savings constituted the principal source of finance and came under considerable pressure at times when, as will be documented, her legal fees grew. Despite this, she would decline offers of money from supporters, although members of the public sent her small sums from time to time which she did accept. Encouraged by associates to register AEGIS as a charity to attract funding, she aborted the application anxious not to compromise her contentious, campaigning approach.[6]

This picture of Barbara Robb contrasts markedly with a reputation she acquired amongst certain politicians, civil servants, and some other professional and lay lobbyists in mental health. Barbara Robb was widely perceived as an irresponsible complainer and trouble-maker who was interfering in an area of which she had little knowledge or experience. This reputation was in part a symptom of frustration with her political effectiveness and sheer dogged persistence, however it was undoubtedly, if unconsciously, encouraged by Barbara Robb herself. Her chosen modus operandi involved a certain amount of mud-slinging in the columns of the press. There were the inevitable inter-personal and -group rivalries which she aggravated because her cause was paramount, and she took a dim view of anyone whom she saw as obstructive or even less than wholly committed to it. This left little scope for understanding of expediency and compromise which were second

[6]Mrs Robb aborted an application for charitable status after reading of the removal from the Charity Commissioners Register of the British Humanist Association for engaging in political campaigns, The Times, 3.1.68 and Robb Files, Record of a Campaign vol.IV section 1.

nature to most other members of the political spheres she moved in and consequently put her at odds with some potential supporters and gave rise to periodic distancing from some of her closest allies who, however, usually forgave her before she forgave them.

Furthermore, the case that AEGIS initially presented had two connotations which alienated some people. Firstly it seemed so incredible as to be indicative of exaggeration and sensationalism. AEGIS appeared to be spoiling its case through overkill. Again she reinforced this impression when, following the publication of Sans Everything[7], she refused to cooperate with the formal inquiry; a decision which convinced some that she lacked substantive evidence. Secondly, by focusing on the deficiencies in the service, AEGIS appeared insensitive to the genuine dedication of and enormous demands upon staff caring for long-stay elderly and mentally disordered patients. The presentation of the case in the press emphasised the more extreme forms of neglect and maltreatment and so fuelled what was essentially a misconception about her which opponents were only too ready to exploit.

This is a snapshot of the elegant woman who on the 21st of January 1965, made the first of many expeditions up the immense and dingy main corridor at Friern Barnet hospital to what contemporaries referred to as the 'back wards'. She kept a diary of this and subsequent visits which resulted in Amy Gibbs being escorted out of Friern and moved to a Convent Home for elderly people where she eventually died. The diary appeared in print, and was the subject of public controversy. However one fact is indisputable - Barbara Robb was profoundly shocked and outraged by what she saw and experienced at the hospital.

Friern Barnet had first opened its doors in 1851 as the Middlesex County Asylum at Colney Hatch. It was featured at the Great

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[7]Ed. Robb, R, Sans Everything: a case to answer (London:Nelson, 1967)

Exhibition of the same year as the pinnacle of achievement in scientific lunacy administration. Indeed, interested sight-seers were ferried out to Southgate on daily trips to marvel at the results of the ratepayers' philanthropy. Built to house 1000, it was the second great Middlesex County Asylum. Yet its size and emphasis in design on economies of scale were the despair of some commentators.[8] [9]

In 1965 the mental health services were largely based in the large hospitals which had evolved from an interplay of four social movements: moral treatment theories formulated during the late eighteenth century and introduced to pauper lunatic asylums by John Connolly[10]; Benthamite imperatives to segregate the unproductive in society who were excused the rigours of less eligibility[11]; the energy of a number of social reformers[12]; and professional empire building by asylum doctors of the mid-19th century.[13] Not least, changes to the financing of poor law

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[8]Martin Granville, J., The Care and Cure of the Insane, Reports of the Lancet Commission on Lunatics, 1875/7 Vol.1

[9]Extract from the Asylums Quarterly of 1851 cited in Hunter, R,. and Macalpine, I., Psychiatry for the Poor, (London: Dawsons, 1972) p.136

[10]See Digby A., Moral Treatment at the Retreat, 1796-1846, in Ed. Bynum W.J., Porter, R., and Shepherd, M., The Anatomy of Madness, Vol.I (London:Tavistock, 1985), pp.2-51, Connolly J., Treatment of the Insane without Mechanical Restraint, 1856, Re-published Ed. Hunter R. and Macalpine, I., (London:Dawsons, 1968) and Scull, A.T., A Victorian Alienist: John Connolly, FRCP,DCL (1794-1866) in Ed. Bynum W.J., Porter, R., and Shepherd, M., The Anatomy of Madness, Vol.II (London:Tavistock, 1985), pp.103-150

[11]Cochrane, D.A., The Colonisation of Epsom, (London:SWTRHA, 1988) pp.3-4

[12]Jones, K., A History of The Mental Health Services, (London:Routledge and Kegan Paul, 1972) pp.132-149

[13]Scull, A.T., Museums of Madness (London:Allen Lane, 1979) pp.146-163

administration in the 1860s and 1870s produced a rapid expansion in the numbers certified as insane and a consequent mass production of lunatic asylums with 2000 beds in 'barrack wards'.[14] This policy of mass segregation of lunatics and then mental defectives continued well beyond the end of the Great War.[15]

Insulin was a great wonder drug of the 1920s. It was administered in ever-increasing doses to the mentally ill in asylums until insulin-coma-therapy (ICT) was invented. The treatment was dangerous and occasionally fatal. It required intensive medical and nursing care in special units where, due to their success, high staff morale and comradeship contrasted with the purposelessness and rigid hierarchy sadly typical of the rest of the service.[16] A second major innovation arose from flawed epidemiological analysis which concluded that dementia praecox (schizophrenia) and epilepsy were aetiologically incompatible. With a simple conceptual leap it was concluded that the administration of a convulsive agent would be therapeutic. Electricity was finally chosen because its effects were immediate. ECT remains in limited use, modified by muscle relaxants and anaesthesia. The third innovation was the use of surgery to intervene in the frontal lobes of the brain and thereby eliminate some of the more distressing, self-destructive and 'florid symptoms' of acute psychosis.

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[14]Cochrane, D.A., Human, Economical and Medically Wise: The LCC as Administrators of Victorian Lunacy Policy, in Ed. W.J.Bynum and Porter, R., The Anatomy of Madness Vol.III, (London:Routledge , 1988) pp.248-253

[15]Ibid p.261

[16]When it was finally proven in the 1950s that insulin could not have been the effective agent and ICT was abandoned, the growing band of social psychiatrists attributed the therapeutic success to the intensive group experience enjoyed the units by formerly neglected patients. See Clark, D.H. Administrative Therapy, (London:Tavistock, 1964)

Titmuss records in his history of the social policy in the second world war, that of the 140,000 people discharged from hospital to provide space for the Emergency Medical Service, a substantial proportion were mental hospital residents.[17] Some institutions were used as military hospitals, but the beds were also emptied as government officials heeded the advice of psychiatrists that if modern warfare produced acute psychiatric disturbance in soldiers[18], mass bombardment would have a devastatingly distressing effect on the civilian population. The predicted mass hysteria never materialised, however the post-war administration of mental hospitals continued to discharge the more able, long-stay hospital residents.

The impact of the next major therapeutic development is contentious in the literature. Phenothiazines were originally synthesised for use in rheumatology. When they were found to have potent tranquilising effects, they were taken out of use in this specialty and introduced in psychiatry. Jones, who herself worked in the service at the time, claims that they transformed it and contributed to the decline in hospital resident populations with began in 1955 and has since continued.[19] Scull accepts that the drugs were perceived as performing this role, but argues that the attrition in hospital residents began before phenothiazines were widely used since average length of stay declined steadily between 1948 and 1954.[20] Indeed, since the number of residents in

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[17]Titmuss, R.M., Problems of Social Policy, (London:HMSO and Longman, 1950) p.193, See also House of Commons, 32nd Annual Report of the Board of Control for 1945, Retrospect for 1939-45, (London: HMSO, 1946)

[18]See Stone, M., Shell Shock and the Psychologist, In E. Bynum, W.J. et al, Vol.II op.cit. pp.248-257

[19]Jones, Op.cit, pp.291-293

[20]Scull, A.T., Decarceration, (New Jersey: Prentice Hall, 1977) pp. 79-87
The view that the impact of phenothizines on hospital rundown in the 1950s has been exaggerated has become a recurrent theme in the
Continued on following page

hospital is simply an outcome of the balance of discharges and deaths against admissions, for the populations to peak and decline there would have needed to be a trend increasing the rate of discharges and deaths, relative to admissions which predated the peak.[21] Moreover, in the Edwardian era the administration of the London asylums (which provided 25% of the national asylum bed stock) indicates that they were largely quiet places, with up to 40% of wards unlocked and staffed by a comparatively small establishment heavily supplemented by patients. There were refractory or disturbed wards, true, but the great majority of asylum residents must have been compliant and easily managed.[22]

The belief in government in the late 1950s that the phenothiazines were transforming the service was their significant political attribute which helped cement the medical model of mental illness in policy.[23] The 1930 Mental Treatment Act had tentatively begun this process by allowing the treatment of the insane in public hospitals without the legal certification procedures prescribed in the 1890 Lunacy Act, and formally re-designating asylums as Mental Hospitals. However, the majority of patients remained certified in the 1950s; perpetuating the stigma of being mentally ill.

Again before the widespread use of the new drugs, a Royal Commission was established in 1954 to re-examine the legislative base of the psychiatric and mental deficiency services. It

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Continued from previous page
literature: see Ramon, S., Psychiatry in Britain: Meaning and Policy, (London: Croom Helm, 1985), Goodwin, S., Community Care for the Mentally Ill in England and Wales: myths, assumptions and reality, Journal of Social Policy, Vol.18 No.1, pp.29-31

[21]For evidence of this in certain parts of the United States see Lancet Editorial, 1944, ii, pp.147-8

[22]Cochrane, D.A. op.cit. pp.261-2

[23]See Goodwin, S., Community care for the mentally ill in England and Wales: myths, assumptions and reality, Journal of Social Policy, Vol. 18, 1989, no.1 pp.30-31

reported in 1957. Its major assumption was a parallel between mental and other forms of ill-health:

> "Mental disorders are forms of ill-health and care and treatment are usually based on medical diagnosis and advice."[24]

Leaving aside its provisions for mentally disordered offenders, its key recommendations for mainstream services were:

(a) the abolition of legalised certification procedures[25] and their replacement for a minority of specified cases by compulsory detention at the discretion of doctors[26];

(b) to shift the administrative base of psychiatric and mental handicap services from large institutions to 'community care' with responsibility divided between the NHS which would provide medical treatment and local authorities, who would provide preventive services "...and all types of community care who do not require in-patient hospital treatment or training or who have had a period of treatment or training in hospital and are ready to return to the community".[27]

Although what Jones refers to as 'revolutions'[28], were actually continuities of established administrative and policy reforms,

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[24]UK, Royal Commission of the Law Relating to Mental Illness and Mental Deficiency, 1954-1957, Cmnd, 169, (London:HMSO) para. 86

[25]Ibid paras. 287-307

[26]Ibid paras.319-358

[27]Ibid para.603

[28]Jones, K., The History of the Mental Health Services, pp.283 - 305. Goodwin op.cit. pp. 37-41 posits an alternative 'big bang' account of policy change in the 1950s which implies a conceptual leap from a victorian model of incarceration in 1950, to community care in 1959 and is thus simply an unhistorical analysis.

policy emerged from the 1950s, medically-inspired and looking to develop small-scale, local services in the NHS and local authorities leading to the eventual demise of the asylums[29]. The 1959 Mental Health Act implemented most of the Royal Commission's recommendations for legal changes, the 1962 Hospital Plan[30] set out a programme to develop a national psychiatric service based on general hospitals and the 1963 Health and Welfare White Paper set 10-year targets for the development of complementary local authority support services.[31] The actuarial projections of Tooth and Brooke, which underlay the Hospital's Plan's targets, suggested that half the large hospitals could close in only fifteen years if contemporary admission, discharge and death rates were maintained.[32] This was seized on by the then Minister of Health, Enoch Powell who with his characteristic, graphic rhetoric passed a death sentence on the isolated, and feared, Victorian madhouses in his address to a startled 1961 Annual Conference of the National Association of Mental Health (NAMH).[33] The hospitals then housed 134,000 people.[34] By the mid-1950s, when the population of mental hospitals peaked in England, Friern housed over 2000.

The 1950s was also a period when social anthropologists began to penetrate these institutions. Their studies uncovered rigidly

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[29]See Ramon, S., Psychiatry in Britain, (London: Croom Helm, 1985) pp.285-6

[30]National Health Service: A Hospital Plan for England and Wales, Cmnd 1604, (London:HMSO, 1962)

[31]Ministry of Health, Health and Welfare: The Development of Community Care, Cmnd 1973 (London:HMSO, 1963)

[32]Tooth, G.C., and Brooke, E.M. 'Needs and Beds: Trends in the Mental Hospital Population and their effect on Future Planning, Lancet 1961 (i) No. 7179, 1.4.61, pp.710-13

[33]Report of the Annual Conference of the National Association of Mental Health, 1961 (London:NAMH, 1961) pp.4-10

[34]Jones op.cit. p.358

hierarchical social relations, institutional goals dominating therapeutic goals, and systematic processes of what Goffman termed 'depersonalisation', 'deculturisation', 'role-dispossession' and 'batch living'.[35] The impact of the institutional routines was interpreted as responsible for much of the symptoms attributed to illness.[36][37][38]

The Services in 1965

What was the life like for longstay patients in a typical mental hospital by the mid-1960s? In its second annual report the Hospital Advisory Service, established in 1969 following a proposal by AEGIS, was to report the widespread practice in many large psychiatric hospitals of "dumping" chronic and other longstay patients on back-wards. A passage headed The Waiting Syndrome, describes the daily routine.

> "Observation of such wards shows that patients are woken and dressed often at an early hour ....the day is punctuated by meals and toilet but otherwise there is no purposeful activity. The patients have no social stimulation, no variety and are not involved in any activity which has hope for the future, or promises an improvement in their lot.
>
> "..relatives and others who have known the patients in the past are often aghast at the obvious loss of individuality and of interest in life. When such patients are spoken to they do not as a rule complain, do not ask for anything and produce stereotyped answers to queries. They may be looked on as "good patients" by the staff, while those who resent

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[35]Goffman, E., Asylums (London: Penguin, 1961) pp.23-65

[36]Caudhill, W., The Psychiatry Hospital as a Small Society (Cambridge, Mass.: Harvard University Press, 1954)

[37]Goffman, E. op.cit. pp.123-155.

[38]Martin, D.V., Institutionalisation, Lancet 1955(ii), No. 6901, December 3rd 1955 pp.1188-90

or object to the way of life imposed on them and try to run away are regarded as "difficult". On this type of ward the television set may be left on all day, sometimes poorly adjusted and it may be obvious that not one of the patients is actually watching...."[39]

Similar findings were to emerge from a major empirical study of the country's mental handicap hospitals, conducted during the mid-1960s by Pauline Morris.[40] Of the 34 hospitals visited, two-thirds were based on Victorian buildings many in poor physical condition, frequently designed for other purposes such as workhouses and functionally ill-suited. Overcrowding was endemic with one third of patients in wards of sixty or more (my emphasis) and beds crammed in to leave little or no space between.[41] Still more seriously, the survey highlighted the absence of observation points and noted "..the impossibility of supervising let alone nursing patients under these conditions, especially at night".[42] Sanitary facilities were old, inadequate in number and often constantly malodorous. Although most patients had some personal items saved for special occasions, in the generality clothing came from a communal supply and was characteristically dull, unimaginative and ill-fitting. Staffing levels were low, and the distribution of qualified staff and nursing assistants varied widely across the country. Morale was low, particularly amongst the front-line nursing staff.[43] Acute shortage of domestic staff added considerably to the workload of the nurses. Mental subnormality institutions were closer to prisons than hospitals because the curative function was "effectively

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[39]DHSS, National Health Service Hospital Advisory Service Annual Report for 1969-70, (London:HMSO, 1971) paras. 40-41

[40]Morris, P., Put Away, (London:Routledge and Kegan Paul, 1969)

[41]69% of patients had two feet or less between their beds; ibid p.86.

[42]ibid p.85.

[43]Morris, op.cit. p.211

neutralised".[44] Their inmates were less fortunate, however, in having to serve indeterminate sentences which often turned out to be for life.

When Mrs Robb first crossed Friern's elegant main portal, its population had reduced to just over 2000, and some 200 people lived in wards of more than 70.[45] It was functioning as a "dump for geriatrics".[46] Although Mrs Robb kept a diary of her visits to Friern, it contains no graphic description of the scene with confronted her on E3. However it is not difficult to piece together from the many thousands of words subsequently written on conditions in the psychogeriatric wards of large mental hospitals in the 1960s and early 70s. Drab pavilion wards with high-vaulted ceilings were crammed with beds which almost touched in rows along the walls and down the centre 'aisle', even spilling out onto corridors. In the day-rooms, their elderly occupants, hair cropped and dressed in ill-fitting clothing, deprived of teeth spectacles and hearing-aids, gazed unoccupied into unfocussed space, while the ward radio or television entertained if not the staff then nobody.

During the first month of her visits to Friern she enlisted the support of Mrs Audrey Harvey and Lord Strabolgi. Mrs Harvey was a close neighbour who was known in Hampstead village as a person involved in 'social affairs'. She was suggested as a possible ally by the local newsagent who supplied some of Mrs Robb's books and introduced the two women whose friendship quickly took off.

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[44]ibid p.293

[45]It was the only NWMRHB hospital with wards of this size. Nationally, 43 out of 101 psychiatric hospitals had at least one ward of this size. 16 had more than 300 in such wards and Winwick and Rainhill in Liverpool, housed over 1000 people each in this way. See Ministry of Health, The facilities and services of psychiatric hospitals in England and Wales, (London:HMSO, 1966)

[46]Ministry of Health, The Findings and Recommendations Following Enquiries into Allegations Concerning the Care of Elderly Patients in Certain Hospitals, Cmnd 3689, (London: HMSO, 1968) para.117

Audrey Harvey worked at a citizens advice bureau in the East India Dock Road. She had developed a special concern for the housing conditions and unscrupulous landlords in this locality. Her determination to get public recognition of these problems, along with her membership of the Fabian Society brought her into contact with Prof. Brian Abel-Smith and C.H. Rolph, then legal correspondent of the New Statesman. They both encouraged her to put her criticisms into print and her subsequent Fabian Pamphlet was one of the early documents in the 'rediscovery of poverty' in the early 1960s.[47] She then became a founder member of the Child Poverty Action Group which was launched in December 1965 with the publication of The Poor and the Poorest.[48] Mrs Harvey's support was crucial in the early stage of the AEGIS campaign. She gave advice, provided practical help and introduced Mrs Robb to some key individuals. She also commended her to C.H. Rolph, Abel-Smith and Prof. Peter Townsend as someone worthy of support and help.

Lord Strabolgi was one of the Robbs' oldest and closest friends. He had been a student of contemporary art at the Chelsea College of Art and acted as best man at their wedding. By 1965, he was a prominent Labour politician in the Lords and destined to hold office in the 1966 Labour Administration. He was to act as AEGIS spokesman in Parliament in the early days, pressed its concerns during the passage of relevant legislation and gave the whole thing kudos and weight by agreeing to have his name on the letterhead as 'President'.

Both Lord Strabolgi and Audrey Harvey shared Mrs Robb's feelings of profound shock and outrage at the plight of Amy Gibbs, her fellow patients and the condition of the ward. It was the first

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[47]Harvey, A., Casualties of the Welfare State, (London:Fabian Society, 1960), the inspiration behind the influential TV documentary, 'Cathy Come Home'.

[48]Abel-Smith, B. and Townsend, P., The Poor and the Poorest, (London:Bell, 1965)

time either of them had been inside a mental hospital. Mrs Harvey subsequently described what they found.

> "The old ladies sat listlessly about in their State-issued pinafores... And with hardly any exceptions (their) spectacles, like their dentures their hearing aids and all their small possessions, had been taken from them." Their hair was "cut off.... to a hideous uniform shortness on admission."[49]

This practise of cropping hair and removing spectacles, dentures and hearing aids was usually justified by staff as a precaution against possible injury. However on wards full of frail elderly people, it could only have had its roots in established institutional routines. Whatever its explanation it was totally unacceptable to Barbara Robb and her associates. Initially they brightened up Amy Gibbs' life with spectacles and a few personal possessions but they decided very quickly that any substantial general improvements were beyond the capacity of the hospital. Indeed, the constant suggestions and reminders by these rather grand people seem to have been interpreted as complaints and to have invoked defensiveness in some of the staff which did little to make the old lady's life more bearable.

So by March 1965 Barbara Robb was intent on moving Amy Gibbs as soon as alternative accommodation could be arranged. But she had also determined to take up the case of all the hospital's elderly patients, the majority of whom she believed to be inappropriately hospitalised. She had also begun to see the problem on a national scale thanks to an article in <u>The Guardian</u>[50] and subsequent correspondence.[51] The article, written by an unnamed consultant psychiatrist, described a hospital in the London area which he claimed was "...typical of the physical conditions under which

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[49]Harvey, A. 'The Unknown Prisoners', <u>The Guardian</u>, 10.8.69

[50]<u>The Guardian</u>, 9,3,65

[51]<u>The Guardian</u>, 30.3.65

psychiatry is practised today."[52] Drab, barn-like wards with primitive washing and lavatory facilities housed up to 90 long-stay patients. Staff were extremely short relative to the work-load, and some of them were poor quality. Subsequent correspondence came in the main from various staff members and fell into two firmly opposed camps: strong support and vehement rejection.

At the beginning of April 1965 Barbara Robb approached Kenneth Robinson, the Minister of Health, through the intermediary of Lord Strabolgi. The Robbs and the Robinsons were acquainted (although how closely is difficult to determine) and Amy Gibbs was a constituent of the Minister in St. Pancras North. This direct approach, was therefore, understandable and presumably expectant of a sympathetic response. Mrs Robb sent her Diary completed to March 26th with an appendix of comments and recommendations of which she was also the author, signed by all her associates.[53] This appendix introduced a range of issues which were to become familiar AEGIS themes. She argued that most of the elderly patients in Friern were not mentally ill at all and that living alongside those who were, together with receiving electro-convulsive therapy was detrimental to their health; this problem appeared widespread. She demanded their immediate transfer into more suitable accommodation.

Kenneth Robinson had come to office with a substantial record in campaigning on behalf of the mentally disordered. Throughout the 1950s he was a pioneer and principal parliamentary advocate of reform in mental health. In 1954 he used the opportunity gained by his first win in the Private Members ballot to lead a debate on "... the serious overcrowding in mental hospitals and mental deficiency hospitals," and staff shortages in the service. This was the first general debate on the mentally disordered since the passage of the 1930 Mental Treatment Act. Mr Robinson's speech demonstrated a keen awareness of the position. The Victorian

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[52] ibid.

[53] Robb, B. (Ed.) op.cit. pp.112-3

heritage constituted the mental hospital accommodation. These institutions "... contain vast, unmanageable wards, they are badly designed, the sanitation is often inadequate and they are practicably impossible to heat properly." The wards were crammed with beds which spilled into corridors, and patients' recreational space. "In the main, it is the chronic, long-stay .... patients who suffer from the grim institutional atmosphere of these Victorian barracks, and it is on their behalf that I am making my main plea."[54] This debate was instrumental in the establishment of the 1954 Royal Commission whose report outlined the philosophy which structured the 1959 Act, and the commitment to District General Hospital psychiatry and community care given by Enoch Powell in 1961.

Mr Robinson's insight was gained through his service as a member of the North-Western Metropolitan Regional Hospital Board and more directly, as chairman of its Mental Health Committee until he resigned to take up his Ministerial post less than two years before the approach from Barbara Robb. He was also a leading Parliamentarian in the National Association of Mental Health, (later MIND), then the leading voluntary association and lobby in the field.

Since the 1959 Mental Health Act had abolished the Board of Control, one of the major roles of the Mental Health Committee was to visit the region's hospitals. Thus Robinson presumably had first-hand experience of the long-stay wards at Friern Barnet which was the Regional Board's largest mental illness hospital. In the decade or so between that debate and the arrival of Barbara Robb on E3, the resident populations of psychiatric hospitals had been declining and staffing levels had improved. However, apart from reductions to the most severe overcrowding, conditions could not have radically changed since the mid-1950s and barely since Robinson resigned from the Board (to assume Ministerial office) in 1964.

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[54]House of Commons Official Report, Vol. 523, cols. 2293-2307 (19.2.54)

He should not have been greatly surprised by the general conditions described in Mrs Robb's Diary, and was certainly concerned about the specific allegations of neglect and inappropriate use of ECT. According to Mrs Robb, he expressed strong concern and promised an investigation into the old lady's case.[55] The signatories of the Diary had hoped that the Minister would conduct an inquiry of some sort and interpreted his response that he would indeed do so. In this connection Mrs Robb was invited to the Ministry for an interview with a senior official. The content of this meeting was to become a matter of argument between Mrs Robb and the Ministry. An assiduous recorder, Barbara Robb 'retired to a cafe immediately afterwards' and produced a highly detailed, 20-page report.[56]

According to this account the official introduced her to the term 'stripping' for the removal of patients personal effects and possessions which had so appalled her at Friern. The Ministry recognised and deplored its continued practice but could not intervene even in the case of non-violent elderly patients since it had delegated its powers of control over hospital practices in 1959 and had greatly reduced the size of his department reducing it to an advisory role. The Ministry had long been concerned about the poor condition of the capital stock and standards of care in the mental hospital sector but did not have the resources for comprehensive rebuilding. Mrs Robb had her own scheme for selling off the land around the hospitals in order to finance their reconstruction but the official doubted that it could ever be got off the ground. In the particular case of Miss Gibbs, the Official had on Ministerial request sent a visitor to Friern who had found her 'not noticeably worse than all the others'. He also offered to use his influence with the Court of Protection with which Mrs Robb had been negotiating on the matter of Amy Gibb's

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[55]This letter has apparently not survived, but Mrs Robb separately recorded its content in <u>Robb Files</u>, Record of a Campaign, Vol.1 'p.57'

[56]ibid 'pp.61-7'

savings and belongings, apparently sold up without her knowledge. Otherwise Mrs Robb claimed that he did not dissent from her conclusion that:

> "The government of my country is powerless to protect the old and helpless from unnecessary hardship and cruelty known to be inflicted upon them in its own institutions."[57]

The Ministry insisted on restricting itself to advice and guidance, but some hospital boards simply ignored it.

Although the reported special pleading has the ring of truth, the quote is Mrs Robb's and hardly sounds Civil Service in tone or connotation. The precise accuracy of her account is less important than the impressions the meeting left on her. Firstly, she sensed that the official had divulged more than he should have and therefore doubted that he would corroborate her account in any negotiation with the Minister. Secondly, she feared she had been fed with false information on the Ministry's powers. In fact this was not the case given that following the abolition of the Board of Control in the 1959 Mental Health Act, central responsibility for visiting hospitals passed to health authorities and was the primary responsibility of Hospital Management Committees. Similarly, the Ministry had indeed conceded its remaining controls over resource allocation at regional level in favour of an advisory role.[58]

Formally, health authorities acted as the agents of the Minister under the provisions of the 1946 National Health Service Act.[59]

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[57]ibid 'p. 26'

[58]One of the pre-Appointed-day circulars, RHB (47)1 declared that RHBs should "...enjoy a lively sense of independent responsibility..". Subsequent development of this centre-periphery relationship is documented in Ministry of Health, Committee of Enquiry into the Cost of the National Health Service, Report, Cmnd. 663 (London:HMSO, 1956)

[59]Specific reference The National Health Service Act 1946,
Continued on following page

However, since 1948, succeeding Ministers had developed a policy of minimum intervention. Not surprisingly as a former authority member, Kenneth Robinson considered health authorities to be competent to manage their own affairs. He viewed central direction as appropriate for extreme contingencies only and generally outside the protocol governing relations between centre and periphery.[60]

As far as Barbara Robb was concerned, the Minister had the power to direct if he chose to invoke it and she felt she was uncovering a situation which urgently warranted such action. Her interview with the official had strengthened her view that a national campaign was called for. She finally resolved to embark upon it in June when through Audrey Harvey, she learned of further evidence of the widespread practice of the stripping and neglect of elderly mental patients from a national survey of social service provision for the elderly led by Peter Townsend of LSE. According to this survey nearly 60% of the 60,000 people aged over 65 then resident in psychiatric hospitals had only slight to moderate personal incapacity, and less than half were severely mentally impaired.

> "On the whole, this national evidence supports the conclusion that rather fewer elderly patients in psychiatric hospitals than is commonly supposed, are physically and mentally incapacitated to a severe extent. A considerable number possess capacities and skills which are held in check or even stultified. Staff sometimes do not recognise their patients' abilities, though more commonly they do not have time to cater for them. Modern aids and appliances are

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Continued from previous page
section 12 "... it shall be the duty of a Regional Hospital Board, subject to and in accordance with regulations and such directions as may be given by the Minister generally to administer on behalf of the Minister the hospital and specialist services." (London: HMSO, 1946)

[60]Interview with the Rt. Hon. Sir Kenneth Robinson

sometimes not provided when they could be. All this gives empirical support to the arguments in favour of developing alternatives to institutional care in the community.... But it also supports the arguments for introducing greater occupational and social opportunities in psychiatry hospitals or departments, as well as a large measure of comfort...."[61]

Of the twenty psychiatric hospitals visited ten had more than 1,000 beds. 34 of the 168 wards (or 4,456 beds for the elderly) averaged 40 beds and provided no other furniture. In a further sixty, only one article, such as a bedside mat, a chair, a locker or wooden box was provided per patient. 60% of the wards provided 'dismal surroundings' in a 'military atmosphere and spartan dormitories'.[62]

Once aware of this evidence, there was no longer any question of Barbara Robb restricting her efforts to Friern. She therefore set herself the task of converting her small caucus into a pressure group with a national profile.

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[61]Townsend, P., A national survey of old people, in Freeman H., Psychiatric Hospital Care: a Symposium. (London: Balliere, Tindall and Cassell, 1965 p.229 See also, Townsend, P. Prisoners of neglect: psychiatric hospitals in Britain, in Ed. Townsend, P., The Social Minority (London:Allen Lane, 1973) pp.131-135

[62]ibid p.231

CHAPTER THREE

TOWARDS THE LEADING PRESSURE GROUP IN MENTAL HEALTH

Having decided to embark on a campaign, Mrs Robb set about building her band of supporters and early networks of influence. These were to weave together prominent individuals, other pressure groups, key figures in the national press and in the nursing profession. She then spent the first two years to the middle of 1967 trying vainly to get the Ministry of Health to recognise the problems she was gradually uncovering. Before documenting these developments, and by way of context, some common typologies of pressure groups and analyses of their methods are set out and discussed.

The anatomy of a pressure group

What is a pressure group? For Mackenzie it is something more easily recognised than defined[1], and as Bell and Millard emphasise, no agreed conceptual boundaries have been drawn which encompass all the associations we would recognise as pressure groups.[2] Determining characteristics include some level of cohesion and shared attitudes, and purposeful action to influence state activity and policy. They can be large or small, highly organised or inchoate.

The word 'group' requires at least two individuals. Membership need not be formal or fixed over time. AEGIS and Barbara Robb are sometimes thought to be synonymous, in which case AEGIS could not be described as a pressure group but merely a front for an individual social reformer. Yet Barbara Robb never worked alone but engaged the active support of one or more of a range of sympathisers, some of whom allowed their names to be used against formal-sounding titles such as 'President' (Lord Strabolgi) or

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[1]Mackenzie, W.J. Pressure Groups in Government, in Ed. Rose, R. Studies in British Politics, (London: Macmillan, 1976) p.343

[2]Bell, A.R. and Millard, F., Pressure Politics in Industrial Societies, (London: Macmillan, 1986) p.34

'Sociological Adviser' (Audrey Harvey). Barbara Robb had an AEGIS letterhead printed which presented these 'offices' as if there was a formal structure, which of course there was not. Although they were merely contrived to project a functional and legitimate image, AEGIS was nonetheless a pressure group since at any one time it represented the joint activity of more than one person with shared objectives aimed at changing government policy.

The pressure group literature is also replete with discussions about typology. The emergent consensus divides groups into 'sectional' or 'interest' groups which seek to promote the economic needs or demands of their members, and 'promotional', 'causal' or 'attitude' groups who promote a cause without apparent, vested interest. The typology is useful because it informs the analysis of group strategies, the delineation of appropriate spheres of activity, and the receptivity of the state agencies in those spheres.

Although AEGIS served a number of Mrs Robb's psychological needs, it was conspicuously detrimental to her economic circumstances and therefore was a promotional group. Promotional groups have characteristic traits. Firstly, their constituencies are likened to a series of concentric circles with an inner-most core, an intermittent membership and a wider, non-activist support which at the broadest level is bracketed with public opinion. Secondly, what Potter terms 'the propensity to support causes'[3] means that leading individuals are often associated with more than one group. The continuity of membership between several promotional groups of the 1960s are facetiously referred to by Davies as 'Hampstead Worthies.'[4] Thirdly, such groups are often small and therefore less dependent upon horizontal mobilisation and organisation (say of a group of workers or of a profession) than on the prestige or perceived quality of their members. The leading figures must be recognised by state agencies as 'authorities'. They are therefore often leading academics and other experts and/or share the values

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[3]Potter, A., Organised Groups in British National Politics (London: Faber and Faber, 1961) p.139

[4]Davies, M., Politics of Pressure, (London: BBC, 1985) p.4

and social background of those who staff the political and administrative arms of the state. In other words, promotional groups tend to be 'elite pressure groups'. Fourthly, groups who campaign over a long enough period to span the different political administrations will generally construct a party-neutral platform.[5]

Much of the literature on pressure groups accords a privileged position to a core of sectional groups, trade unions, industrialist organisations, professional associations, within a corporatist framework of policy-making. Exerting effective influence is seen as more problematic for promotional groups. They have no automatic access to the political and administrative executives, characterised as Whitehall, and are reliant on indirect methods such as lobbying in Westminster and mobilising public opinion through media campaigns. Alternatively, Marsh has suggested that whether the relationship is corporatist or pluralist depends on the policy area and changes over time.[6] Economic and industrial policy tends to be corporatist and social policy, pluralist. The history of the AEGIS campaign provides an opportunity to test the validity of these broad contentions. For the moment, an examination of the strategies employed by all types of groups to bring pressure to bear on all the major arenas of political battle is required. Whitehall, Westminster and the mass media will be considered separately.

In terms of their relationships with the Executive, groups are re-classified as insiders and outsiders[7] or 'legitimate' or

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[5]Alderman, G. Pressure Groups and Government in Great Britain (London: Longman, 1984) p.123

[6]Marsh, D. Introduction in Ed. Marsh,D. Pressure Group Politics, pp.3-6

[7]Grant W. and Marsh, D. The Confederation of British Industry, (London: Hodder and Stoughton, 1977) p.16

'illegitimate'.[8] A major theme in the analysis of the insider group activity is reciprocity.

> "The relationship between some lobbies and the Ministry are very close, each side having something to offer the other. The civil service often rely on a lobby for advice; they work through it to obtain consent; and sometimes they rely on it for smooth administration. For its part, the lobby relies on the civil service to smooth out administrative tangles, hopes to get it to adopt policies in its interests, and needs information about official intentions."[9]

The communication channels are; formal and informal consultation on new policy initiatives; group representation on standing or ad hoc advisory committees or inquiries; and informal dialogue. Most of the major professions are also represented in the permanent Civil Service organisational structure, particularly in a welfare Ministry such as the Department of Health. Pressure groups provide Ministers and officials with expert knowledge and opinion and are a source of information on the demands of the interests they promote, and likely impact of proposals.[10] Conversely, as problems arise which Ministers judge to be in need of political response, groups are also a source of policy proposals. Recognition of a group's legitimacy in this role includes appointment of its members onto standing committees, Royal Commissions, awarding honours to senior post holders, and the appearance of Ministers at its annual conferences.

Consultation is open ended and public, but it can also be limited to a select group of interests. Civil servants maintain lists of organisations considered as legitimate to comment on given areas

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[8] Guy Peters, B. Insiders and outsiders, the politics of pressure group influence on bureaucracy, in Ed. Mecgrew A.G. and Wilson, M.J. Decision-Making: Approaches and Analysis, (Manchester: University Press, 1982) pp.261-290

[9] Finer, S.E., Anonymous Empire, (London:Pall Mall Press, 1966) p.22

[10] Eckstein, H., Pressure Group Politics, (London: George Allen and Unwin, 1960) pp,23-24

of policy.[11] Confidential proposals and drafts are placed on restricted circulation although, inevitably, leaked still further. At its most informal level, consultation takes place through person to person contact over the phone, or over a meal 'at the Club'. In these situations, both sides are off the record and can come out from behind their public positions and address a problem frankly and directly. In a political system which some see as obsessed with secrecy[12], these informal networks become critical channels of influence. With Cabinets and senior civil service recruited largely from a limited number of social strata[13], those groups whose members are of similar social origins are strategically placed.

As Finer implies, the relationships between groups and the Executive are governed by codes of ethics or 'rules of the game'. Vested interest provides both sides with incentives to maintain the other's goodwill and avoid mutual embarrassment. Confidences must be honoured,[14] and the groups should not make demands which are radically at variance with the departmental view.[15]

A consequence of these rules is that those groups whose concerns are radically at variance with current departmental perspectives are unlikely to form allegiances with officials and therefore bring pressure to bear elsewhere. These are the so-called outsider or illegitimate groups. At the outset outsider groups are often voicing claims, previously unregistered, and accordingly pursuing aims which are redistributive.

Similarly the greater the propensity of a group to move into the public arena to further a dispute, the less likely it will be part of the internal consultation network.[16] But outsider groups can

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[11]Alderman, G. Op.cit p.136
[12]Ponting, C., The Right to Know: The inside story of the Belgrano Affair, (London: Sphere Books, 1985)
[13]Guttsman, W.L. The British Political Elite (London: Macgibbon and Kee, 1963) pp.328-320
[14]Eckstein, op.cit. p.158
[15]See Finer op.cit p.102 and Potter op.cit. pp. 320-330
[16]Coxall, W.N., Parties and Pressure Groups, (London: Longman, 1981) pp.88-90

become legitimate. Relations with the Executive are based in mutual trust which develops only over time. Newly-formed groups cannot expect to be brought into the inner circles of policy-making until they have proved themselves legitimate, authoritative, trustworthy etc. Introduction to the inner circle can be achieved by persistent, effective public campaigning, since the more a group is able to prove itself politically dangerous, the more likely a Ministry will try to buy its cooperation by according it consultative status.[17]

One option open to outsider groups is to develop support amongst MPs. As with the Executive, the basis of the relationship between groups and parliamentarians is usually reciprocal. Groups are sources of material for MPs to make their mark with the Party hierarchy. There are three mechanisms for the representation of group interests by MPs and Peers. Most directly, groups recruit Parliamentary spokesmen who lobby Ministers, present Private Member's Bills promoted by a group, sponsor meetings in the House with other Members, as well as tabling motions, asking questions and tabling amendments to legislation.[18] Secondly, a group can develop support in the wider party political networks, say through the trade unions in the Labour politics, although to so align itself to one party undermines its claims to non-partisanship.

Groups are most active in the corridors of Westminster at the Report and Committee stages of Bills, securing support for proposed amendments.[19] Questions are one means of engaging press interest in an issue. Indeed Wallace sees the fact that Parliament is a central locus for news gathering as a principal justification for pressure groups to be active there.

> "During the Committee stage of a Bill the lobbyists of affected interests and concerned groups, often pitted against each other, haunt the corridors of Westminster, exchanging hurried conversations with 'their' MPs and

[17]Finer, op.cit. pp.44-45
[18]Potter op.cit. pp.285-292

[19]Finer op.cit. p.10

supplying them with briefs from which to speak. .... Ministers and civil servants are well aware of this continued activity and cultivate good relations with groups on different sides of a difficult issue in the hope of giving advanced warning..... Academic writing on the 'decline' of Parliament and complaints by back-benchers about the weakness of the House of Commons should not be taken as implying that Parliament is no longer worth considering as a major target of pressure group activity; it remains one of the most effective means of ensuring publicity for an interest or cause and of exerting pressure of the Government."[20]

Thus Parliament is one route to the second major channel of influence open to outsider groups, the media.

"The government operates in a climate of politics in which responsiveness to opinion is held as a virtue. This virtue is inculcated by the need for the government to seek re-election. But it is more than that. In the same way as an M.P. feels a duty to the constituency, the government feels a duty to opinion."[21]

For the media to be interested in an issue it must be perceived as newsworthy. Criteria of newsworthiness and their application to the promotional concerns of AEGIS on a topic will be explored in some detail in a later chapter.[22] For the time being the concern is the measures used by journalists to identify legitimate sources amongst pressure groups over and above the issue itself.

The primary criterion is the group's facility to help journalists do their job. This involves providing accurate regular source material of proven reliability which is readily transferred into copy, and holding press conferences within easy access of the

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[20] Wallace, W., The Pressure Group Phenomenon, in Ed. Rose, R. op.cit. p.96
[21] Stewart, J.D., British Pressure Groups, (London: Clarendon Press, 1957) p. 93
[22] See below p.335

newspaper office. Until recent years, this meant in Fleet Street. The most trusted lobbyists will be asked to contribute articles directly.[23] Personal relationships are also important and groups need to target the relevant specialist correspondents both in the press and broadcasting and also in the professional and other journals which the dailies use as sources. As with politicians and civil servants, journalists draw a distinction between legitimate sources and others.[24] One further tactic employed by a number of promotional groups in the 1960s was to provide a focus on an issue by publishing an expose book.

As a new group, AEGIS could not expect to achieve a great deal through direct liaison with the Ministry at both political and official levels. Mrs Robb and her advisers therefore used the first year to place themselves in strategic positions to exploit external avenues. Strabolgi was again well placed to make the small group's concerns publicly known, and found the opportunity when the House of Lords debated community care for the mentally disordered on the 17th of July 1965. He decided to 'take the lid off' during this debate and composed a powerful, emotive speech. It focused on the plight of elderly people inappropriately housed in psychiatric hospitals and summoned up powerful symbols for Labour, Conservatives and Liberals alike. He merged images of the poorhouse with the gothic horrors of the Victorian asylum. He then condemned the State for dealing out treatment to elderly people which was more characteristic of a primitive race, than the civilised British. He condemned "stripping" and described the rapid deterioration of patients in the face of the inertia of the institutional regimen. He claimed that enormous workloads shouldered by staff perpetuated neglect and in some cases engendered ill-treatment. He urged the Government to expand provision of alternative forms of care for patients who were merely enfeebled and incontinent, making anonymous references to Friern by way of illustration. Finally, he shocked and startled the House with the following conclusion:

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[23]Potter, op.cit. pp.349-353
[24]Wallace W., op.cit. p.106

"In olden days primitive tribes used to turn their old people into the cold to die. We are more civilised, we allow them to rot in mental hospitals. So far as a great many people are concerned, especially old people, the Welfare State is little more than a sham and a mockery."[25]

On the whole, his fellow peers were incredulous, outraged and interpreted his speech as an attack on hospital staff. Indeed it proved so unpopular that he was grateful to have Barbara Robb along to give moral support.[26]

This reaction was unsurprising in the context of the general tenor of the debate. By the mid-sixties, the image of a modern, curative service transformed by phenophiazines was firmly established. The previous March, the Commons had carried the motion:

"That this House welcomes the progress made in the provision of services for the mentally disordered and urges H.M. Government to take steps to encourage further development."[27]

There were occasional, passing references to 'AEGIS' concerns. The services were still the 'Cinderella' of the NHS; there were instances of intolerable overcrowding and elderly people in hospital because there was nowhere else. But no-one dissented from the Minister's view:

"We all know that there are bad patches in the Mental Health Services, but I think it a remarkable achievement that in the face of the kind of difficulties that have been described, the devoted staffs of these hospitals are able to

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[25]See House of Lords Official Report Vol. 267 Cols. 1396-9, (quote cols 1398-9) 17.7.65
[26]Interview with Lord Strabolgi
[27]House of Commons Official Report Vol.708, Col. 1645, 19.3.65

maintain standards as impressively high as they are in so many cases."[28]

Maybe the buildings were old and dysfunctional, but the service as a whole, like the rest of the NHS, was the "best in the world".

Whatever the reaction of the House of Lords, Strabolgi's speech was a huge public relations success and aroused enormous interest in Fleet Street.[29] He and Mrs Robb were approached by several social service correspondents anxious to discover the name of the hospital. Such was the Daily Mail's interest in the story, that Barbara Robb persuaded its correspondent to undertake a national survey of mental hospital conditions. The signatories of the Diary had agreed not to identify the hospital, to avoid singling out one institution and because the Minister could give the name to the press if he felt it proper. Lord Strabolgi therefore issued statements describing their approach to the Minister, Mrs Robb's meeting at the department and the Ministry's 'powerlessness' to intervene.

The sudden appearance of these issues in the press took the Ministry of Health off guard. While a spokesman assured correspondents that action would be taken if the allegations were substantiated[30], the Minister wrote to Lord Strabolgi to defend himself against the charge of powerlessness.[31] This letter presented a rather different version of Mrs Robb's meeting with one of his officials.[32]. According to the Minister, she had been told that the Ministry proposed a full inquiry by the regional board into the case of Amy Gibbs but Mrs Robb had been opposed as she feared that the old lady would suffer as a consequence.

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[28]House of Commons Official Report, Vol. 708, col. 1708 (19.3.65)

[29]See Daily Telegraph, Guardian, Times (18.7.65)

[30]The Daily Telegraph, 9.7.65

[31]This letter was evidently a reaction to the press coverage since it was dated 19.7.65. It was confidential to Strabolgi but Mrs. Robb obtained a transcript, see Robb Files, Record of a Campaign, Vol 1. p.107

[32]See Chapter 2

Of course there was no question in Mrs Robb's mind of her ever having been offered a full inquiry. Her responses to the Minister's points were listed in an endpaper attached to a copy of her account of her meeting and forwarded by Lord Strabolgi who added his own inquiry as to what the Minister intended to do about the problem of 'stripping'. Mrs Robb rejected the claim that she had discouraged the instigation of an inquiry and suggested that had he made such an offer, he should not have allowed her to influence him in the discharge of his duties. As for the question of powerlessness, she asked why the Ministry had failed so far to stop the practice of stripping if he had the requisite powers.[33]

The Minister accepted his official's account but none-the-less decided to issue guidance that patients should only be deprived of personal effects if it was in their own interests; claiming that going beyond this would have intruded on clinical judgement. He also wished to put the Diary before the regional hospital board concerned to give it a chance to answer the case. Lastly he refused a request from Strabolgi for a formal visit to Friern to show one of his Lords critics, Lord Taylor, the substance of the case (and which would have seemingly included Peter Townsend in the party).[34] According to Mrs Robb's account, Lord Strabolgi felt that having obtained an inquiry at regional level, they should now cooperate with it. But Barbara Robb had grown suspicious of the Ministry's motivations. She retained little confidence in the impartiality of a regional board inquiry conducted in camera and she and her friends were now attracting a great deal of publicity and seeking action on a national basis. The parochial concerns of the Diary were no longer the primary

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[33]Letter Lord Strabolgi to Kenneth Robinson 15.7.65 and Mrs Robb's endpaper in Robb Files, Record of a campaign, vol.1, pp.108-115

[34]According to the correspondence in Mrs Robb's files, the visit had been organised following a demand from Lord Taylor, that Strabolgi should substantiate his allegations. Peter Townsend had accepted an invitation for Strabolgi to accompany them. Audrey Harvey felt that with all Townsend's experience of the longstay elderly care, the suggestion that he would come along had frightened the Ministry off. See Robb Files, Record of a Campaign, Vol. 1 pp.123-125

concern. She therefore hardened her position, informed the Minister that they no confidence in the Ministry's complaints procedures and had formed other plans for the Diary which was now to remain confidential.[35]

Leaving the Ministry to proceed with the inquiry, the group kept the issue of stripping before the public. Peter Shore MP was persuaded to table a written question seeking the Minister's view of the practice. In his reply, Kenneth Robinson accepted that it existed in a 'minority of hospitals where it was rarely in the patients best interests' and announced his intention to issue guidance.[36] Then early in September, the Daily Mail published the findings of its survey, initiated by Barbara Robb. Its staff had visited seven hospitals which although chosen 'at random' just happened to include Friern Barnet. The hospitals were warned in advance but the reports made grim reading and set the issue resounding amongst Fleet Street correspondents. The Mail reported that thousands of elderly patients were suffering neglect in overcrowded insanitary conditions in hospitals. The capital stock was obsolete and dilapidated. Staff shortages gave rise to over-work which made recruitment difficult; moreover expenditure on even the most basic elements of hospital care was lower in mental hospitals than in an average general hospital.[37]

Mrs Robb and her associates had decided to await the Minister's response to these findings. In the event of it proving unsatisfactory, they had resolved to form a small committee and publish a letter in The Times inviting members of the public to report experience of malpractice and general short-comings in hospitals. The Daily Mail published Kenneth Robinson's reply in late October. He conceded that there were 'bad patches' in the service but maintained that the articles had presented an unbalanced picture. It was misleading to compare expenditure between different sectors and in any case, it was up to the regional boards to make the allocations. He accepted that much of

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[35]Ibid p.129-32

[36]House of Commons Official Report Vol.717, Written Answers Col.224, 2.8.65

[37]Daily Mail, 8.9.65 and 14.9.65

the capital stock was poor, and had asked regional boards and local authorities to give priority to the elderly and mentally disordered in reviewing their building programmes. Moreover, his department had issued detailed guidance on improving existing mental hospitals within available resources; however he felt it was too soon for all hospital authorities to have implemented these recommendations.[38]

The specific guidance on improving hospitals had been circulated by Mr Robinson's predecessor in June 1964.[39] Just prior to his Daily Mail interview, the Ministry had issued further guidance on the care of the elderly and on improving services for the mentally handicapped; the latter circular squeezed in a reference to the elderly and mentally ill in discussing joint planning.[40] Now many people would have felt it reasonable that some health authorities had not made major strides in only fifteen months - not so Barbara Robb. She was in any case skeptical about the value of advisory memoranda which could all too easily be ignored. Besides, she and her associates had been seeking direct Ministerial intervention and it had not been forthcoming.

Hence they drafted a letter to The Times. Mrs Robb obtained signatures mainly from prominent people with whom she was personally acquainted.[41] She also secured the name of Prof. Brian Abel-Smith whom Audrey Harvey recommended as an expert who was generous with his advice and time and importantly, prepared to take serious notice of 'lay' reformers. As noted above, small promotional groups need an image of authority and Abel-Smith was the first prestigious professional to be struck by Mrs Robb's character and commitment. His support for the AEGIS case during the ensuing decade was to prove crucial. For the time being his name would lend a considerable degree of legitimacy. He was respected both for his academic work, and as a policy adviser. His name carried prestige and authority in Whitehall, with the

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[38]Daily Mail 27.10.65
[39]Ministry of Health, Circular, HM (64) 65 'On Improving the Effectiveness of Services for the Mentally Ill, June 1964
[40]Circulars HN(65)77 and HM (65) 104, Ministry of Health, 1965
[41]Including Baroness Beaumont and Lord Heytesbury

various professional organisations, in the National Association of Mental Health, with the social service correspondents in Fleet Street and in the hospital service itself. Without this, Barbara Robb and her friends would have been susceptible to dismissal as interfering amateurs. Moreover, Brian Abel-Smith was, at that time, an adviser to the Child Poverty Action Group, a pressure group about to embark on a media campaign with the publication of a book which challenged and aimed to overturn the conventional wisdom that poverty had been eliminated.

The following is the text of the letter which appeared in The Times of the 10th of November 1965 and was reproduced in other newspapers:

> "We the undersigned have been shocked by the treatment of geriatric patients in certain mental hospitals, one of the evils being the practice of stripping them of their personal possessions. We have now sufficient evidence to suggest that this is widespread.
>
> "The attitude of the Ministry of Health has merely reinforced our anxieties. In consequence, we have decided to collect evidence of ill-treatment of geriatric patients in mental hospitals throughout the country, to demonstrate the need for a national investigation. We hope this will lead to the securing of effective and humane control over the Ministry which seems at present to be lacking.
>
> "We shall be grateful if those who have encountered malpractice in this sphere will supply us with detailed information, which would of course be treated as confidential."

The letter carried Mrs Robb's home address at 10 Hampstead Grove; from then on the postal address of Aid for the Elderly in Government Institutions, AEGIS.[42] Mrs Robb ordered a supply of

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[42] Who thought up the name is contentious. Mrs Robb Files says
Continued on following page

headed note-paper which presented herself as 'Chairman', Lord Strabolgi as 'President' and Mrs Harvey as 'Sociological Adviser'. There was no committee, no formal organisation nor membership but Barbara Robb had a keen sense of the importance of image.

This letter led immediately to a response from within the service which manifested Ministerial involvement as The Times published a letter from the Chairman of the North-West Metropolitan Regional Hospital Board, Mr Maurice Hackett. To anyone 'in the know', this was a coded reference that the mysterious unnamed hospital was somewhere in Hackett's region. Now, not only did he have ultimate accountability to the Minister for Friern, of course, he had been until recently, a colleague of the Minister on the RHB and was also his brother-in-law. Indeed, the content of the letter suggested that it had been drafted in consultation with the Ministry. Mr Hackett claimed that he had first learned that Strabolgi's House of Lords speech referred to Friern when approached by a journalist from 'a reputable Sunday Newspaper' who was in possession both of the patient's name and that of Lord Strabolgi's informant. Anxious to investigate something affecting one of the hospital's patients, and concerned for staff morale the Board asked for 'a public - or private - independent inquiry' into the matter. This had not been possible since Lord Strabolgi had refused to release his information: accordingly the Board was conducting its own inquiry.[43] In its reply, AEGIS denied Hackett's implication that it had prompted his press visitor, and affirmed that had the Minister conducted a proper investigation into the report when "he had full permission to use it for any action" there would have been no need to raise the matter in Parliament.[44]

Continued from previous page
she dreamt it up in a taxi on the way to visit Amy Gibbs in Friern (Robb Files: Record of a Campaign vol.II, p.11), Lord Strabolgi thought it was Brian Robb (Interview) and Audrey Harvey attributed it to her husband (Interview)

[43]Letter to the Editor from Maurice Hackett, The Times, 1.11.65

[44]Letter to the Editor from Barbara Robb and Lord Strabolgi, The Times, 24.11.65

At this time, AEGIS enlisted the support of C.H. Rolph, then legal editor of The New Statesman. Rolph knew Audrey Harvey. He was also acquainted with Charles Clark, a publisher, and committee member of the Patients Association, who in turn knew Barbara Robb. Rolph was a former policeman turned writer and journalist. He was already a mental health lobbyist as a member of the NAMH Council. At the time, he was also an active member of the the Albany Trust which campaigned for the implementation of the Wolfenden Report on Homosexual Law Reform: in this way he had worked alongside Kenneth Robinson amongst others.[45] Rolph's support provided AEGIS with a national platform through his weekly column in The New Statesman from which he would launch issues and promote them through his excellent and senior press and publishing contacts. He was an invaluable source of advice on public relations and and not least had extensive experience in a pressure group campaign.

Once was Rolph was recruited, AEGIS had its core membership and began to diversify its activities and expand its support networks. Through this process it further crystallised its promotional issues and formulated its strategy.

Widening the Support

If AEGIS was to be effective in an area of policy with as low a profile as mental health, generating support amongst individuals and organisations in its active political world was essential. This world was relatively small in the mid-1960s. The potential support for AEGIS was diffused and located in isolated pockets of various groupings whose major concern was not conditions in long-stay hospitals. Psychiatry had no Royal College at the time. The Royal College of Nursing had a Psychiatric Sub-Committee. The National Association of Mental Health was a broad coalition of lobbyists and professionals which was operated largely as an 'insider group'. A major task confronting AEGIS was therefore to locate, focus and mobilise influential and sympathetic people and

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[45] Interview with C.H.Rolph

arenas. This process also further developed issue definition and strategy formulation. The major categories of support were well-connected experts, other pressure groups, Fleet Street, and Parliament.

Barbara Robb was to enlist prominent members of the medical, nursing and legal professions. She corresponded with numerous geriatricians and psychiatrists, however, two were to identify themselves most closely with AEGIS. Russell Barton and Dr. J. Anthony Whitehead were prominent critics of mainstream clinical practice in psychogeriatrics and the conditions in hospitals and politically active, largely outside the established channels of medical representation.

Russell Barton's critique of the regimen and standards of care in large hospitals was well-established by the beginning of 1966 when he was first approached by Barbara Robb.[46] He was outspoken and contentious in his approach and was not averse to making public attacks on the service.[47] His condemnation of conditions at Whittingham, at the 1966 Annual NAMH conference brought him up before the BMA Ethical Committee. His forceful personality undoubtedly alienated people and he became quite a controversial figure. When he met Barbara Robb, he was a consultant psychiatrist at Severalls Hospital, near Colchester. He had been the medical superintendent and like many who held the post, had seemingly had difficulty in adjusting to a multi-disciplinary management structure which was introduced after the 1959 Mental Health Act. Following a prolonged battle with his regional hospital board over the extent of his authority at Severalls to influence the practice of consultant colleagues, he resigned. He then joined a number of prominent, British anti-establishment psychiatrists who emigrated to the United States where he became a Professor at Princeton University, New Jersey.

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[46]Barton R.W., Institutional Neurosis, (London: J.Wright and Sons, 1959)

[47]See Nursing Times Vol. 61, no. 51, of 17th December 1965, p.1740

Although a member of the BMA, Barton had little faith in established representative, consultative, and complaints channels. He felt that they served to emasculate radical and progressive initiative from within the service. He used them strategically, to legitimate his case, but concentrated efforts combining direct pressure and public campaigning in the mass media.

This opinion was certainly shared by Tony Whitehead, who had worked with Barton at Severalls. Indeed it was at a symposium held at the hospital that Dr. Whitehead and Barbara Robb first met in April 1966. Unlike Barton, Whitehead was not a member of the BMA. He has always been a prominent proponent of alternative views in medical politics and is now highly respected as such. He is prolific medical journalist.

There was undoubtedly a personal affinity between Barbara Robb and each of these doctors. It is easy to dismiss this as 'all trouble-makers together', but after a year as a lobbyist, she had accorded with their view about the potential of organised medicine to further her cause. Moreover she felt that the model of care which they had developed at Severalls was a prime example of how good practice could survive the low resource-base and Victorian capital stock of psychogeriatrics. They contended that confusional states symptomatic of dementia were due to relatively minor physical disorders in the majority of cases and, consequently, admitting the elderly to psychiatric hospitals was usually inappropriate. Moreover, Barton's thesis of institutional neurosis held that life on a longstay ward compounded the original psychiatric conditions, such as senile dementia.[48] In the mid-1960s these views were contentious (they are now, of course, central to policy).

However, by so closely identifying her campaign with these two clinicians, Barbara Robb was consciously setting herself in

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[48]See Barton, R.W., Institutional Neurosis, (London:Wright, 1959), Barton, R.W. Developing a service for elderly dementing patients, in Ed. Freeman, H. op.cit. p.244-251 and Whitehead, J.A., Myths of mental illness in the elderly, Nursing Mirror, Vol. 153, No.7, August 27th, 1971. pp.18-20

opposition to the BMA with all its access to and influence over Ministry policy.

In the mid-1960s the profession of psychiatry was represented by the Royal Medico-Psychological Association which was a division of the Royal College of Physicians. Its major preoccupations at that time were to complete the task of gaining recognition for the profession as a true medical specialty, fully represented in general hospitals and medical teaching, and to achieve that status by establishing the Association as a Royal College.[49]

AEGIS developed extensive contacts and support amongst the nursing profession. This operated at three levels. Firstly following the publication of The Times letter and particularly once Sans Everything was published, Mrs Robb's address was widely circulated amongst psychiatric nurses and large numbers wrote to her about problems in their own hospitals: she became, in Crossman's words, "...a kind of clearing house for all complaints about cruelty and torture in the hospitals".[50] Through these reports, Barbara Robb began to identify a previously unrecognised and rather disturbing problem. Considerable discontent within the service never came to the attention of Management Committees or Regional Boards because it was stifled by suppression of complaints and victimisation of complainants.

As Barbara Robb became more well-known through the press and by word of mouth within the service, her post-bag swelled with correspondence from nurses supporting her and asking for her support for campaigns they were fighting to change things in their own hospitals. Any information given to her in confidence was scrupulously respected and she would always seek prior permission

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[49]See Curran, D., Teaching or Therapy', (Presidential Address to the RPMA 123rd Annual Meeting) in British Journal of Psychiatry, Vol.110, (1964) pp.2-3. Also Address by Prof. K. Sottowe, President of the RMPA, 1964/65, to the Royal Medico-Psychological Association and American Psychiatric Association Meeting, 16.7.65 in British Journal of Psychiatry, Vol.111 (1965) Supplement, November 1956 pp.21-22

[50]University of Warwick Modern Records Centre, Crossman Diaries, JH 69/39

before passing it on even to her closest collaborators. She acquired a reputation of someone to trust, and 10 Hampstead Grove became the focus for defracted, atomised discontent throughout the service. She supported and promoted the cases of some individuals who decided to fight victimisation and patient neglect, sometimes paying their legal fees.

Secondly she developed links with the Royal College of Nursing. The publicity for Lord Strabolgi's speech precipitated an approach by the Reverend Bill Kirkpatrick, a member of the Psychiatric Committee of the Royal College of Nursing. Initially anxious about the motives and methods of AEGIS, he was soon reassured upon meeting Mrs Robb and recruited to her cause. His experience both as a Registered Mental Nurse and as a nursing representative had led him to share the concerns to effect improvements in standards of care for long-stay psychiatric patients. He also corroborated the acute and disturbing dissatisfactions with the working conditions in some areas of psychiatric nursing that were emerging as common themes in the letters arriving at Hampstead Grove. Like Barton and Whitehead, he was not afraid to speak out and his close association with AEGIS as designated 'Nursing Adviser' caused difficulties when he became Regional Nursing Officer with one of the London Regional Boards, and he eventually resigned his post.[51]

In a campaign critical of nursing care it was crucial to maintain good relations with the profession and, as far as possible, carry nurses along; particularly as Mrs Robb believed there was little chance of support from organised medicine. Bill Kirkpatrick played a central role as AEGIS brought the conditions in psychiatric hospitals to the top of the College's agenda. Firstly he was instrumental in persuading it to organise a special conference on the impact of the 1964 Ministerial Circular, Improving the Effectiveness of Psychiatric Hospitals which took place on December 7th and 8th 1965 and was addressed by Russell

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[51]interview with Rev.Bill Kirkpatrick

Barton.[52] Secondly, Bill Kirkpatrick set up a series of meetings with the Professional Secretary of the RCN, Keith Newstead, which took place during 1966 and 1967.

The first meeting was attended by Mrs Robb, Rolph, Kirkpatrick, Newstead, a prominent officer of the NAMH, the liberal MP Eric Lubbock and two journalists and took place on the 9th of November 1966 in St. Bride's church Fleet Street. By this time, Mrs Robb had over 400 complaints from nursing staff on file and AEGIS was seriously considering publishing a selection of them. The second was held in March 1967 at the London School of Economics and chaired by Abel-Smith. This meeting was attended by the College's deputy president, Phyllis Rowe. As an insider, professional group, the RCN could not have been expected to side publicly with AEGIS's contentious methods; although by allowing Kirkpatrick to serve as a member of its psychiatric sub-committee, the College was helping her aims. There were two views in the College about AEGIS. Older members saw the case as an attack on the profession, whilst others considered that there was a case which needed investigating.[53]

A direct result of this second meeting was the decision by the RCN to organise its 1967 conference around the themes to be raised in Sans Everything which AEGIS briefed the College on during the course of the meeting. As time went on, Kirkpatrick won more and more of his colleagues over until the College was itself lobbying Ministers on the issues of conditions in hospitals and the victimisation of nurse complainants.[54] By July 1968, the RCN was petitioning the Prime Minister on Standards of Care in mental hospitals and demanding a redistribution of health spending to fund the improvements.[55]

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[52]See Report in The Nursing Times, Vol.61, No.51, 17.12.65, pp.1739-40

[53]See Robb Files Record of a Campaign Vol. III pp.70-73 and Record of Campaign Vol. XX for full correspondence and transcripts of meetings.

[54]Interview with Bill Kirkpatrick

[55]See letter from John Andrews, Chairman of the RCN Psychiatric Sub-Committee to The Sunday Times, 6.10.68

The third channel of nursing support was the professional press and particularly The Nursing Mirror. There existed a similar relationship between The Nursing Times and Mirror as that between the two major medical journals. The Nursing Times was close to the Royal College's public view and whilst generally supportive of AEGIS remained reserved in its reports and editorials. The Nursing Mirror, was more of a campaigning journal and became a great ally. As well as sharing common viewpoints on most of the major issues, Barbara Robb developed a close personal rapport with Yvonne Cross, who was its editor for many years until killed in a yachting accident in the early 1980s. She was ever ready to give AEGIS maximum publicity at each key moment in the campaign and provided practical help such as the survey timed to correspond to the publication of Sans Everything, which demonstrated widespread lack of confidence amongst nurses in established complaints channels and which was used against the Minister in Parliament.[56]

Hence, although she was often to be accused of insensitivity to the complexities of the issues in psychiatric and geriatric nursing, Barbara Robb used these three channels to ensure that she was as closely in touch with real nursing opinion as anyone.

The support AEGIS generated in Fleet Street was remarkable. Under Rolph's guidance and instruction, Mrs Robb mobilised and maintained support throughout Fleet Street and in some specialist journals. Within about six months of the founding of AEGIS, conditions in mental hospitals became national news and remained so for 15 years - often making lead story in the national papers. Prior to Barbara Robb's arrival on the scene, the issue seldom surfaced and then usually in the form of articles contributed by specialists from outside Fleet Street.

She kept her contacts in Fleet Street fully up-to-date with accurate, fully referenced, synopses and analyses of any given

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[56]Nursing Mirror Vol. 124, 16.6.67, p.241, 23.6.67, pp.287-288
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issue. Transforming her documents into copy involved minimal work. This rapidly gained her a reputation as a totally reliable source. Influential correspondents face a constant assault from lobbyists of all kinds, and are therefore discriminating in whom they support. Barbara Robb merited it for three reasons. Firstly, journalists take have a cynical view of people promoting causes, whereas it was evident that she had no ulterior motives. Secondly, she also avoided a professional slickness. As one of her closest Fleet Street allies put it, 'throughout she retained the style of the typical English middle-class do-gooding lady who did not know her way round very well. She never acquired the outward skin of the worst kind of professional lobbyist.' Thirdly, she extended the warmth and friendship she showed her advisers to her press supporters.

For the newspapers involved, there was more at stake than the gathering of stories to sell copies. Key correspondents and their editors were convinced that here was a cause worth promoting. The Minister of the time described the issue as 'ideal grist for the journalist mill'.[57] It was undoubtedly true that it had sensational overtones and some newspapers certainly made full use of them. Neglect and ill treatment, particularly of 'deserving' elderly patients was 'hot news', 'a real human interest story'. We will examine the newsworthiness of these issues in the final chapters. Two of AEGIS closest allies in Fleet Street were Hugo Young on the Sunday Times and David Roxan on the News of the World and represent the polarity of newspaper types attracted by mental hospital scandal.

Hugo Young was chief leader writer and social services correspondent when the AEGIS case first came on to his desk in 1966. Having met Barbara Robb he was convinced that she was revealing a scandalous situation of which newspapers were, in the main, unaware; she presented a new issue which had been previously 'swept under the carpet'. With the appointment of Harold Evans as Editor in January 1967, Mr Young enjoyed full support in promoting the AEGIS campaign. Evans was a campaigning journalist and under

his editorship, the paper was to fight a number of celebrated campaigns: thus the case very much appealed to him. The political influence of The Sunday Times has always been proportionately greater than its readership (three and a half million in the mid-1960s).[58] It was read by the middle-classes and, of course, members of the political community where it served as a forum for debate and opinion within national politics. As chief leader writer and subsequently Political Editor, Hugo Young was a powerful ally.[59]

Writing on The News of the World with a circulation of six and a half million and thus a readership of around sixteen million,[60] David Roxan was no less powerful a supporter in presenting the case to a much wider public. He was one of the few journalists who was familiar with the problem having fought a campaign on behalf of a Rampton patient in the late 1950s consequently freed from wrongful detention. Having met with obstruction and hostility in official circles and witnessed the conditions in Rampton at first-hand, he approached Barbara Robb to offer his support in February 1966. Mr Roxan argued that Fleet Street's massive support for AEGIS reflected a collective guilt complex about an issue of which it was distantly conscious but 'which had been kept under wraps'. Unlike Hugo Young, he had to persuade an editor not generally inclined to campaigning to promote the case. It was a measure of his success that the News of the World was to be instrumental in the establishment of the Ely Hospital Inquiry.[61]

Other journalists whom Barbara Robb recruited included John Roper on the Times, Anne Shearer on the Guardian, Anne Allen on the Daily Mirror, Helen Mason on the Sunday Telegraph, John Prince on the Daily Telegraph. The Sunday Telegraph and Daily Telegraph carried articles also authored by Barbara Robb herself. Although

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and 7.7.67, pp.320-323

[57]Interview with Rt.Hon. Sir Kenneth Robinson
[58]Seymour-Ure, C., The Press, Politics, and the Public, (London:Methuen, 1968) p.52
[59]Interview with Hugo Young
Continued on following page

these papers were probably closest to her own political views, getting direct access to their pages was particularly useful in maintaining for AEGIS an image of political neutrality. Without this and with supporters such as Rolph, Audrey Harvey and Able-Smith, AEGIS could have been perceived (rather like CPAG) as a Labour Party lobby.

Press contacts were maintained and developed by sophisticated press relations. AEGIS issued press releases, held press conferences in the library of St. Brides Church, Fleet St., entertained correspondents over dinner, and invariably secured maximum publicity for significant events in the campaign. This also took Barbara Robb into the studios of television and radio. In return, the press gained a new issue for mass publicity and open access to mental hospitals, previously unavailable to them. By the late 1960s representatives from national and local newspapers were scouring the service in search of 'scandals' and when they found them, maintaining the pressure on the Department. Public opinion, which may well have been indifferent at the outset - at least it was thus seen by journalists - was being mobilised against two presenting images: a mental hospital service which neglected and ill-treated its patients; a Ministry which refused to recognise the problem.

Other Pressure Groups

By the end of 1966, AEGIS' primary concerns were standards of care in long-stay hospitals and complaints procedures in the hospital service. None of the other major pressure groups was promoting standards of care as a predominant issue, although the Patients' Association(PA) had had a long-standing preoccupation with the pursuit of complaints generally in the Health Service. Barbara Robb liaised with the PA, the NAMH (later MIND), the Disablement Income Groups and the National Old People's Welfare Council (later Age Concern).

The Patients Association was a small group run essentially by two or three women of whom its then Chairman Helen Hodgson was the most active. She supported the AEGIS case from the outset and although not a greatly significant figure politically was important to Mrs Robb as a source of encouragement and advice in the early stages of her career. The PA supported the AEGIS case on complaints throughout the campaign.

In the mid-1960s the National Association for Mental Health (NAMH) was the most significant lobby in the field. This organisation was effectively a broad coalition of views and interests mostly from within the service with psychiatry highly prominent. A number of key actors in the AEGIS story were active members of the Association. Rolph, Russell Barton and Kenneth Robinson were all members of the Council, the latter resigning his Vice-Presidency to take up his office as Minister of Health. Rolph had become a member of the Advisory Committee in 1957 and Brian Abel-Smith contributed to the occasional Annual Conference.

These conferences served as a forum for the debate of contemporary issues in the field.[62] Before AEGIS came on the scene, the predominant concerns at the NAMH conferences were the implementation of the 1959 Mental Health Act and the problems created for community care by the relative poverty of the services.

Thus when Barbara Robb approached the NAMH General Secretary for advice and support there were pockets of sympathy within the organisation but predominant concerns with other issues. Her intention to use the press to disseminate a picture of neglect of elderly patients conflicted with the NAMH policy to overcome public fear of mental institutions. NAMH worked as an insider group and its political coalitions would have undoubtedly become strained if Mary Applebey, the then Secretary, had thrown her weight fully behind Barbara Robb.[63]

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[60]Seymour-Ure, Op.Cit

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However, Mary Applebey recognised Mrs Robb's conviction, and sympathised with her cause, and privately welcomed her radical strategy to motivate public opinion. Mrs Robb believed that Mrs Applebey and the Press Secretary of the NAMH, Joyce Emmerson, wanted to give whole-hearted support but encountered internal opposition.[64] Certainly, they were privately supportive in the early days of AEGIS but the groups never became close allies. However in the wake of Sans Everything the subject for the Annual Conference in February 1968 had become, "What's wrong with the Mental Health Services" and was to become a recurrent theme in subsequent years.[65] With the appointment of David Ennals as campaign director in 1971, and subsequently through the work of Larry Gostin and Tony Smythe over the reform of the 1959 Act, MIND, as it became known, had rather borrowed a leaf out of Barbara Robb's book and moved on the public offensive. But in 1965, the NAMH was regarded as 'part of the psychiatric establishment'.[66]

Although approaches to other organisations generally resulted in expressions of support[67], they revealed that AEGIS would be filling a void in two respects. No group was promoting standards of care as a primary concern, or using a media campaign in mental health which the press was clearly ready for. The road was open for AEGIS to take the initiative, and it is perhaps one explanation of the NAMH ambivalence to AEGIS that Mrs Robb was very quickly able to establish AEGIS as the prominent mental health pressure group of the late-1960s and early-1970s and dominated the policy agenda over that period.

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[61]Interview with David Roxan
[62]Interview with Mary Applebey, then Secretary of the NAMH
[63]Interview with Mary Applebey
[64]Robb Files, Record of a Campaign Vol. VIII
[65]NAMH, Report of the 1968 Annual Conference, (London:NAMH, 1968) Addresses included one by Abel-Smith on the lessons of Sans Everything, for complaints machinery, a very defensive speech by Kenneth Robinson, and one from Dr. Alex Baker of Banstead Hospital, itself pseudonymously referred to in the book, proposing an inspectorate of hospitals similar to the Scottish Mental Welfare Commission. See also Annual Reports for 1969 and 1973
[66]See Smythe, T. 'MIND'- an assessment, British Journal of Psychiatry, Vol. 129 (1976) Vol.129, Supplement May 1976 pp.16-18
Continued on following page

Lastly, AEGIS canvassed support in the House of Commons. It is not certain what Mrs Robb's personal politics were, although her friends believed they were initially conservative and moved left as her career as a reformer progressed. She collaborated closely with senior figures in the Labour Party but was never associated with Labour to the exclusion of support from other parties. Mental Health is a cross-party issue which serves as a vehicle for backbenchers to get themselves noticed. Hence Barbara Robb obtained the support of MPs from all sides of the House, including those with particular interest in mental health, such as Eric Lubbock (Liberal and active in NAMH) and Eric Moonman (Labour), Mervyn Pike, then Conservative Opposition spokesman on Health, and her strongest ally in the Commons, Ben Whittaker who was Labour MP for Hampstead until 1970. As with the press correspondents, Mrs Robb kept them up to date with events and supplied questions prepared by her advisers to pressurise, embarrass or squeeze information out of the Minister or Secretary of State.

Finally, because the issues of complaints procedure and victimisation took AEGIS into issues of administrative law, Barbara Robb recruited legal advice. Although the letterhead presented Rolph as 'legal adviser' to AEGIS, this role was restricted to reading her pre-publication copy for possible libel. Otherwise Barbara Robb consulted a number of legal experts in the first few months before settling on Theo Fitzwalter-Butler. He came into the campaign through Mrs Robb's social contacts. He was a judge, the recorder at Newark, and for many years edited the law reference book Archibold's Criminal Pleadings. If he personally did not have the expertise on a given problem, he had direct access to a barrister who did. Barbara Robb's legal bills were considerable throughout her reforming career. Without Fitzwalter-Butler's generosity with his time, she may well have had to abandon the enterprise due to bankruptcy. Moreover his consultancy and inside information greatly enhanced the quality of AEGIS submission documents. The small intimate team of advisers which Mrs Robb gathered around her and constituted her 'organisation' as it was presented in the public sphere, was thus complete. Most of them became friends as well as advisers.

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Having once enlisted their support for the cause, she used them wisely and economically. They also enriched her life.

Liaison with the Ministry and Definition of issues and policy proposals

On receiving her invitation to the regional board inquiry into her Diary, Mrs Robb had decided not to attend and wrote to the inquiry and also to The Times and setting out her terms for cooperation:

(a) the tribunal would be chaired by a barrister totally independent of the Board or its management committees;

(b) secondly all witnesses would be legally represented;

(c) thirdly AEGIS would be permitted to call any witnesses as necessary.[68]

Having despatched this letter, she learned that Lord Strabolgi had been invited independently and accepted on the grounds that having pressed the Minister to establish it, it would have been unreasonable for AEGIS to ignore it.[69] Hence, despite being informed by the inquiry's chairman that it was to proceed as planned not withstanding AEGIS' objections, Barbara Robb attended somewhat unwillingly in order that her group should not appear divided.[70] She also secured the appearance of a letter in The Times, on the morning of the inquiry. This declared that her former willingness to allow the Minister to use her report in April had been replaced by a complete lack of confidence either in the Ministry's ability to take effective action or in the procedures established for investigating complaints about the hospital service.[71] She arrived at the inquiry clutching her

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[67]Robb Files, Record of a Campaign, Volume VIII 'Organisations in touch with AEGIS'
[68]Letter from Barbara Robb to the Inquiry's secretary dated 8.12.65 in Robb Files, Record of a Campaign, Vol.II p.22

[69]Robb Files, Record of a Campaign, Vol.II pp.24-37
[70]Robb Files, Record of a Campaign Vol.V
Continued on following page

Diary to her breast just in case the Regional Board had decided to meet AEGIS conditions. As the majority of the Committee's membership turned out to be members of the RHB, Mrs Robb sat through the hearing with the report unopened on her lap, repeatedly demanding an independent inquiry, and orally listed her dissatisfactions with the treatment of Miss Gibbs and conditions on ward E3.[72]

The Committee conceded shortage of resources and asserted that the adverse publicity was demoralising staff. When its findings were eventually communicated to Lord Strabolgi by the Minister, it had clearly adopted a defensive if carefully worded position. It accepted that the buildings were antiquated and that staff and facilities were insufficient, but denied the suggestions of unkindness and ill-treatment. It similarly rejected the allegation of routine stripping: "The Committee went into this very carefully indeed, and closely questioned everybody concerned. Patients who are confused may have their dentures removed at bedtime - as is done on E3 - but there is no routine stripping of those possessions."[73] However this was not to be the last word on Mrs Robb's Diary.

Shortly afterwards, it became clear that AEGIS was beginning to penetrate the Minister's armour. Abel-Smith informed her that Kenneth Robinson had consulted him about AEGIS, 'stripping', and hospital complaints. Abel-Smith was at the time a member of a team of outside experts used by Kenneth Robinson to supplement the advise from his officials.[74] He felt the Minister could not be expected to start issuing directives in favour of patients while engaged in the difficult negotiations with the BMA about the remuneration of GPs. However Enoch Powell had devised an intermediate mechanism between direction and ordinary hospital memoranda which were all too easily ignored; the so-called 'pink circulars'. These documents listed the recommendations and also

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[71]The Times, 18.12.65
[72]Interview with Lord Strabolgi, Mrs Robb's detailed account of the hearing is in Robb Files, op.cit. pp.38-60
[73]Letter Kenneth Robinson to Lord Strabolgi, 16.5.66 in Robb Files Record of a Campaign, Vol.II pp.65
Continued on following page

required the hospital authorities to report back on the action taken. Abel-Smith suggested that hospitals could be advised that patients should be deprived of their possessions only following certification by a consultant that it was essential on grounds of safety; it was the intention to prevent nursing staff having discretion in this area.[75] With Mrs Robb's support, Abel-Smith sent this proposal to the Minister who immediately replied that he would consider it.[76]

In February 1966, AEGIS learned that the suggestion had been adopted although not through a pink circular. Mrs Robb was contacted by two women who had respectively petitioned the Queen and the Prime Minister's wife about the 'stripping' of elderly relatives in hospital. They had each been duly informed by the Minister of Health that although he had no evidence of this practice, he had sent out appropriate guidance to hospital authorities.[77] This was news to Mrs Robb and even to Abel-Smith; there had been no public announcement or circular. So she mobilised Brian MacArthur of the Daily Mail who asked the Ministry directly, and she also arranged for Eric Lubbock to put down a Written Question. The Ministry confirmed that hospitals had been advised at the end of the year to review practices to ensure that patients retained their personal possessions whenever possible. The Minister's Written Answer confirmed that they had also been advised to remove aids and belongings only on medical advice. Kenneth Robinson had decided to adopt the less public procedures of a letter to the Secretaries of the Regional Boards.[78] So AEGIS had scored its first success.

Meanwhile Rolph had been mobilising the press campaign. He published an article criticising the limits on the power of the Court of Protection and advocating that the Court conduct an

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[74]Interview with Kenneth Robinson
[75]Robb Files, op.cit. pp.70-74
[76]Letter Brian Abel-Smith to Kenneth Robinson, dated 7.12.65 in Robb Files, op.cit. p.76
[77]Letter E.B.S.Alton (Ministry of Health) to Geraldine Richardson, 31.12.65 in Robb Files, op.cit. 'p.137'
[78]House of Commons Official Report Vol.725, Written Answers Cols. 184-5, 28.2.66

investigation into conditions on wards for the elderly.[79] Subsequent articles and correspondence dealt with variation in standards of care between institutions and defensive attitudes adopted by staff in the face of criticism.[80] Rolph's article had brought with it approaches by Brian MacArthur of The Daily Mail, who had introduced Eric Lubbock to AEGIS, by The Sunday Telegraph, and by David Roxan on The News of the World. All three papers pressed AEGIS concerns with the Minister. Mr Roxan obtained information from the Ministry and agreed both to allow Rolph and Barbara Robb to read his article before he went to press and to print extracts from reports gathered by Barbara Robb from her contacts in the service.[81] The pressure was building up.

It was therefore timely when, at the beginning of March the Ministry issued a 'pink circular' giving specific advice to hospital authorities on handling complaints. Mrs Robb's copy arrived through Brian Abel-Smith whose advice lay behind this Ministerial initiative. The circular, HM(66)15, broke new ground in detailing procedures for handling complaints according to two principles; promptness; and that the complainant should be made aware that his complaint had been 'fully and fairly considered.' The circular prescribed a hierarchical procedure starting at ward level and graduating to higher authority if the complainant remained unsatisfied. The patient was to be fully informed of his rights and assisted in drafting a written complaint which could then proceed to senior level. All written complaints were to be seen by the Secretary of the Management Committee or the Board of Governors - or a senior member of staff designated by this official - who would then agree with the complainant and the head of the hospital department concerned on the action to be taken. If there was still no satisfactory outcome, the complaint would go to the HMC or Board of Governors who would conduct an investigation with an informal hearing at which the complainant and the person complained against would appear but without compulsion.

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[79] New Statesman, 11.2.66
[80] New Statesman 4.3.66, 11.3.66, 18.3.66
[81] Robb Files, op.cit. pp.82-89

The most important section considered what were envisaged as a small number of cases serious enough to warrant an 'independent inquiry' at Regional Hospital Board level. AEGIS had criticised existing health authority inquiries on the grounds that members of a board could not be considered independent when investigating a complaint about a service for which they were responsible. They were 'judges and juries' in their own cases. The new guidance went some way to meeting this criticism by moving the Regional Board Inquiries towards more formal legal procedure.

> "The general rule should be that an independent lawyer or other competent person from outside the hospital service should conduct the enquiry, or preside over a small committee set up for the purpose, whose membership should be independent of the authority concerned and should include a person or persons competent to advise on any professional or technical matters. The complainant and any persons who are the subject of the complaint should have an opportunity of being present throughout, the hearing, and of cross-examining witnesses, and should be allowed to make their own arrangements to be legally represented if they so wish."[82]

In all cases, this formal procedure was not to be invoked without consultation with the Minister himself. Lastly, hospital authorities were asked to keep systematic records of written complaints graded according to importance and subject.

With the Ministry now beginning to respond to its concerns, AEGIS had to sustain the pressure. Hence it ensured that letters and articles sympathetic to its cause appeared throughout the next six months; in the columns of the Lancet and the Guardian in March, the Daily Telegraph in April, Mental Health and the magazine Nova in June, the New Statesman in August, and the Sunday papers in September.[83] This was a chain reaction as the national dailies

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[82]Ministry of Health, Circular HM(66)15 para.(iii)b

[83]The Guardian 18.3.66, 23.3.66., 26.3.66, Sans Teeth, Sans Eyes, Sans Everything, in Lancet 1966 (i) no. 7430 p. 646

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picked up on stories appearing in the specialist journals constantly encouraged by Barbara Robb and Rolph both by approaching journalists and direct contributions in the form of letters and articles.

By the Spring of 1967, AEGIS had synthesised two major promotional issues. Firstly, it claimed that thousands of people were inappropriately housed in long-stay psychiatric wards where standards of care were poor, and in many cases amounted to nothing less than neglect and ill-treatment. Secondly, it alleged that anyone trying to remedy the position through complaint encountered obstruction and denial, if a member of the public, and also risked victimisation, if a member of staff. Both contentions were publicly disputed by the Ministry of Health.

In early January 1967, Barbara Robb finally determined that AEGIS would follow the example of Abel-Smith and Townsend and go into print with a politically-motivated book, and so told the press.[84]

Continued from previous page
Daily Telegraph, 26.4.66, article by Helen Mason in Nova, June 1966 (also of the Sunday Telegraph and married to Hugo Young), and Mental Health, June 1966 (article by Rolph), Mrs Robb appeared on Granada TV on 1.6.66, New Statesman 26.8.66, The Observer 4.9.66, and The Sunday Telegraph, 26.9.66

[84]The Times, 5.1.67

CHAPTER FOUR

SANS EVERYTHING AND A CASE UNANSWERED

".... some of the mental hospitals are very near to a public scandal and we are lucky that they have not so far attracted more limelight and publicity."(Aneurin Bevan 1950)[1]

When the good fortune referred to by Bevan ran out, the resultant adverse publicity cast a shadow over a Minister of Health who had devoted much of his career in public life to pressing for improvements in services for the mentally disordered. Kenneth Robinson was unfortunate that the issue burst into the public domain during his period of office since he could have hardly been blamed for the back-log of neglect which he inherited in 1964, still less have expected to have made up the deficiencies in only two and a half years. However, when Sans Everything appeared in June 1967, his Department's posture was to evince a marked degree of insensitivity, a fatal underestimation of AEGIS as a political adversary and not least ignorance of what was happening at hospital-level. The book opened the floodgates to a torrent of discontent and deficiencies which stranded the Ministry.

The launch of the book on the 30th June was the spearhead for an assault on three fronts. There would be widespread, favourable press publicity, attacks on the Ministry in Parliament, whilst the pressure so created fortified AEGIS in its negotiation with the Minister to obtain independent inquiries into the book's allegations. The outcome was a White Paper[2] purporting to

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[1]Public Records Office, CAB 129/38, NHS, Control of Expenditure, Memorandum by the Minister of Health, 10.3.50, quoted in Klein, R., The Politics of the National Health Service, (London:Longman, 1983) p.36

[2]Ministry of Health (MOH), National Health Service, Findings and Recommendations Following Enquiries into Allegations Concerning the Care of Elderly Patients in Certain Hospitals, Cmnd 3687, (London:HMSO, 1968)

answer the case which satisfied very few, became widely viewed as a whitewashing exercise, and amplified the impact of events precipitated by the publicity. Firstly, some of the inquiries were unsatisfactory answers to the AEGIS case, and raised questions of procedure and content. Secondly, the Ministry was completely out-manoeuvered by Barbara Robb in managing the press. Thirdly, by presenting the White Paper as a total refutation of the allegations, the Ministry prepared the way for an enormous backlash when obliged comprehensively to answer the case at Ely. Fourthly, it precipitated the Minister to propose a major extension to complaints machinery in a Green Paper.

Hugo Young opened Mental Health Week with a foretaste of the book in the Sunday Times of June the 4th.[3] Two of the accounts[4] from the book were reproduced side by side with a powerful supporting article explaining that AEGIS hoped ".. to create the sort of public shock which alone seems capable of stimulating a better psycho-geriatric service."[5] The great majority of elderly residents of mental hospitals were " ... vegetating amid the despair if not the cruelty .." described in the reports.[6] Problems created by staff shortages were aggravated by poor-working conditions and the low-status of mental nursing. Nurses, patients and relatives faced reprisals if they complained whilst regional boards and management committees were often either unaware of the situation or unable to change it. Mrs Robb was reported as proposing the re-deployment of available resources according to the system of care at Severalls and the establishment of a lay commissioner for hospital complaints.[7]

In response the Minister issued a press statement condemning "distress caused to patients' relatives and to hospital staff", asserting that none of the allegations was supported by particulars which would have made it possible to pursue inquiries

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[3]Sunday Times, 4.6.67
[4]Robb, R., Sans Everything: a Case to Answer, (London: Nelson, 1967) p.18 and p.37

[5]Sunday Times Op.cit.
[6]Ibid
[7]ibid

and rejecting the suggestion that specific complaints or evidence about ill-treatment or neglect of patients would lead to reprisals.[8] The response from other parties did not share this confidence. There was strong support in the newspaper's letters column from Mary Applebey of the NAMH and from Yvonne Cross.[9] The Nursing Mirror endorsed AEGIS' claims that nurses faced reprisals if they publicly aired their complaints, and asked its readers to write in with their own views and experience.[10] The Nursing Times reserved judgement in anticipation of the forthcoming RCN Conference on standards of care, which AEGIS had inspired.[11] Even the voice of hospital administration felt that the possibility that the reports were substantially true gave cause for concern.[12] The reports went largely unnoticed in the medical press.

The Sunday Times continued the theme the following week, June 11th, replying to a demand from the Chairman of the South-East Metropolitan RHB that AEGIS reveal its sources[13], by endorsing Mrs Robb's mistrust of in-house inquiries.[14] Meanwhile, Government front-bench spokesman in both Houses faced a barrage or questions partly due to the publicity and partly from Mrs Robb lobbying her supporters in Parliament.[15] Kenneth Robinson told Nigel Fisher that he believed existing methods of dealing with complaints were adequate for all concerned, and raised cheers when he assured Bernard Braine that he was "... only too ready and anxious to investigate anything which can be investigated .." but that he deprecated " ..these generalised smears against the

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[8]Ministry of Health, Conditions of the Elderly in Hospitals, Press Release, 6.6.67

[9]See Sunday Times Letters Column 11.6.67
[10]Nursing Mirror, Vol. 124, p.241, 16.6.67
[11]Nursing Times Vol.63 p.777

[12]British Hospital Journal and Social Services Review, Vol.777 No.4027 p.146, 23.6.67
[13]Letter from Sir Ivor Julian, Sunday Times 11.6.67
[14]Sunday Times Editorial, 11.6.67
[15]See House of Lords Official Report, Vol.283, Col.1263

psychiatric hospital services".[16] Hence the battle-lines had been firmly drawn when Sans Everything appeared on June 30th.

The content of the book corresponded closely with AEGIS promotional issues. Mrs Robb's Diary together with accounts from six pseudonymous nurses and two social workers presented the case on standards of care and ill-treatment.[17] Tony Whitehead described his alternative model of psycho-geriatric care.[18] Bill Kirkpatrick claimed that victimisation was a major problem for nurses.[19] Brian Abel-Smith developed this theme in a chapter on complaints machinery. He maintained that fear of victimisation or ignorance of procedures prevented nurses from pursuing complaints. Doctors were hesitant to interfere in what they saw as nursing matters or were simply unaware of deficiencies at ward level. Hospital authorities, however well-meaning in their attempts to do justice to complaints that did reach them, were still acting as judge and jury in areas of their own responsibility. Hospital visits by authority Members were ineffective and crowded out by officers and senior staff. Reviving a proposal abroad at the time of the establishment of the Parliamentary Commissioner for Administration, he proposed an office of Commissioner specifically for the hospital service to handle complaints[20], and to visit hospitals as part of a national hospital inspectorate service.[21]

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[16]House of Commons Official Report Vol. 74, cols.69-70

[17]Ed.Robb, R. Op.cit. pp.13-48 and 69-114

[18]Whitehead, J.A., A comprehensive psycho-geriatric service, in Ed. Robb. op.cit. pp.115-123

[19]Kirkpatick, W.J.A. Conscience and Commitment: a commentary, in Ed.Robb, B., op.cit. pp.48-57

[20]Action taken on or on behalf of the Minister of Health (including that of health authorities) had been specifically excluded from the powers of the PCA, against the wishes of some MPs. See Chapter 11

[21]Abel-Smith, B., A hospital commissioner, In Robb (Ed.), op.cit. pp.128-135

The book's reception in Fleet St. was predictably favourable.[22] The professional journals were also supportive. The Lancet found no fault in the AEGIS case.[23] The editor of The Nursing Times accepted it in part and called for more staff, more money and a reduction in overcrowding. The press also reported that the RCN and the National Council of Nurses supported the case, with the former launching a national investigation into the extent of ill-treatment in hospitals.[24] The Nursing Mirror firmly endorsed the book's claims in regard to conditions, bad nursing practice, and the fear of reprisals and proposed a statutory committee to guarantee anonymity to nurses pursuing complaints.[25] The hospital administrators journal criticised the emotional presentation of the accounts but accepted their substance and the case for a hospital commissioner.[26]

Mrs Robb appeared on national radio[27] and the BBC's 24 Hours programme where she was filmed with Amy Gibbs at the Catholic home, attacked existing complaints machinery and defended the anonymity of her collaborator's. Following a supportive appearance by Yvonne Cross, Desmond Wilcox, the programme's presenter, introduced the Minister of Health.[28] Apparently, AEGIS had not been warned of this and was completely taken off guard. Kenneth Robinson declared that the book contained no evidence which enabled investigation and reminded viewers of his primary interest in mental health prior to taking office. He further asserted that Mrs Robb's charges arising from the patient in Friern had been fully investigated and found to be

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[22] The book and related issues were major daily themes, commanding Front Page space, in the press throughout the whole of July, See The Sunday Times, The Times, The Guardian, 26.6.67, and 30.7.67

[23] Lancet 1967 (i) No. 7505 pp.85-6

[24] The Times, 22.7.67 and The News of the World 25.6.67

[25] Nursing Mirror, Vol.124 p.296 30.6.67

[26] British Hospital Journal and Social Science Review, Vol.77 No. 4031, July 21st 1967, pp.1346-7 and 1373

[27] BBC The World at One, Transcript in Robb Files Sans E. Vol. VI 29.6.67

[28] BBC 24 Hours, 30.6.67, Transcript in Robb. files, Sans E Vol.VI

unsubstantiated. He then retreated significantly from this position, adding "... if any of this is true, and to the extent that it is true, I am sure that it was far truer 10 years ago".[29]

The Minister was losing the argument. The Nursing Mirror published a selection of responses from nurses to their questions on victimisation which without exception, confirmed that there was a widespread fear of and frequent experience of reprisals.[30] The most significant coverage was to prove to be David Roxan's review in The News of the World. On the 25th of June, with the book due out the following Friday, he had asked his readers in the hospital service with similar experience to approach the paper.[31] As a result of this appeal, he received a number of disturbing letters. Having interviewed the authors, Roxan forwarded five accounts to the Minister, and published extracts from them on August 20th, including one from a former nursing assistant at Ely Hospital in South Wales.[32]

Not surprisingly, the Minister had been one of the first recipients of a copy of the book. On the 29th of June, a Private Secretary wrote to Mrs Robb hoping that she would identify the pseudonymous contributors or at least, the hospitals referred to, so that a 'full enquiry' could be held. Mrs Robb's hand-delivered reply requested details of the envisaged procedures, and was immediately informed that they would be conducted by legally-qualified, independent chairmen. She was asked to disclose the identity of the hospitals, in confidence and the following day she informed the press that the form of investigation proposed seemed satisfactory and would now be asking her fellow contributors if they would consent to her informing the Ministry, confidentially,

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[29]ibid

[30]Nursing Mirror Vol 124, 23.6.67, pp.287-322 and 7.7.67, pp.320-322

[31]The News of The World 26.7.67,

[32]News of the World, 20.8.68

of the names of the hospitals.[33] Two days later she wrote to the Minister listing the institutions: Banstead, Cowley Rd., Oxford, Friern, St James, Leeds, St. Lawrences, Bodmin, Storthes Hall, Huddersfield and Springfields, Manchester.[34]

Mervyn Pike, Conservative Opposition spokesman on health, had planned with AEGIS a Supply Day debate on Sans Everything. AEGIS briefed a number of Members by suggesting over forty questions drafted by Mrs Robb, Russell Barton, and Bill Kirkpatrick in the weeks before the book was published.[35] In her opening speech, Miss Pike drew attention to and elaborated on the major themes of the book. She expressed her support for the Commissioner proposals and a hospital inspectorate. She then asked the Minister whether the inquiry chairmen were to be advised by medical and nursing staff and demanded an assurance that the members of the committees would have no connection with the hospitals or regions concerned.[36]

Robinson's reply was more reserved than his previous parliamentary references to AEGIS. The Nursing Mirror survey had caused him to revise his view on reprisals, although he added that he could not conceive of such practices being widespread. He said he had been given the names of the hospitals in the book and merely awaited information relating specific complaints to specific hospitals before "... the hospital board chairman can arrange for inquiries to be carried out by a legally qualified chairman from outside the NHS assisted by other persons unconnected with the hospital service".[37] Finally, in winding up the debate, the Government

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[33]Correspondence with R.S. Matthews , the Private Secretary at the Minsitry of Health, in Robb Files, Sans E. Vol.5 section i.

[34]Letter Barbara Robb to Kenneth Robinson, 3.7.67 in Robb Files op.cit.

[35]See correspondence to with Mervyn Pike, Ben Whittaker, Eric Moonman, David Owen, David Kerr, Bernard Braine, Lord Balniel, Douglas Houghton, Hugh Gray in Robb Files, Sans E. Vol.3

[36]House of Commons Official Report Vol.750, Cols. 431-7

[37]ibid. cols. 451-4

announced its intention to make public the findings and recommendations of the tribunals.[38]

AEGIS was disturbed to learn that the tribunals were to be established by the Regional Board Chairman and not directly by the Minister himself. For this took them beyond the scrutiny of the Council on Tribunals.[39] On the 21st of July, Mrs Robb issued a press statement explaining that she had identified the hospitals referred to in the book on the assumption that the Minister would himself appoint the Chairmen. AEGIS had to be satisfied that the inquiries would be both thorough and impartial or no further assistance would be forthcoming.[40] For its part, the Ministry was only prepared to grant 'qualified privilege' to the testimony of witnesses and declined to answer specific questions posed by AEGIS on the aims and procedures of the inquiries.[41]

AEGIS wanted its case examined according to formal legal procedure covering all aspects of administration. The Ministry preferred a less formal procedure focussing on specific allegations in the accounts. Findings and recommendations would then be published to answer the case in the public sphere. As the press carried blow by blow accounts of the argument, the need to find a compromise became increasingly apparent. Again it originated with Brian Abel-Smith, who proposed in the course of a television debate with Maurice Hackett that the Lord Chancellor should appoint the members of the committees of enquiry who should be drawn from outside the service to guarantee their independence.[42] This proposal was welcomed by the Minister and incorporated into a formula announced to the press on the 9th of August.[43]

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[38]Ibid
[39]see p.96
[40]Letter Barbara Robb to R.S.Matthews, released to the press, copy in Robb Files Sans E Vol.5
[41]Letter to C. Wade of Oswald Hickson, Barbara Robb's solicitors, to L.R.Warner, Private Secretary, in Robb Files, op.cit.
[42]BBC 24 Hours 28.7.68, Transcript in Robb Files Sans E. Vol.VI
[43]Press Statement in Robb Files, Sans E. Vol. 5, reported in The Guardian 10.8.67

The Chairman of each committee of inquiry was drawn from a list of QCs prepared by the Lord Chancellor, all of whom were experienced in medical litigation cases. Each committee would also comprise a doctor, a nurse and one lay member. All members would be unconnected with the regional board concerned. Each committee was to sit in private, the precise details of procedure left to the discretion of its chairman within the department's guidance. Although this still excluded any statutory role for the Council on Tribunals, Mrs Robb and her advisers felt obliged to cooperate if they were not to lose face in the public sphere.

From this point of apparent accord, relations soon deteriorated again. In informing the Minister of the willingness of the Sans Everything contributors to cooperate with the inquiries, AEGIS took the precaution of reminding him that information so far conveyed to the Ministry had been on a basis of strict confidentiality and AEGIS reserved its position on allowing it to be made public.[44] This issue then blew up into a major dispute. The Minister replied that, regardless of AEGIS view, he intended to publish the findings and recommendations together with the identity of the institutions involved.[45]

Given the enormous publicity, it seems reasonable that the Minister should publish the reports. He had a dual responsibility; allegations of ill-treatment had to be investigated thoroughly and independently; the service was also to be protected from generalised smear campaigns which damaged staff morale and hampered recruitment. As he explained to AEGIS through one of his officials, when he had asked for the names of the hospitals 'in confidence' the phrase meant that there would be no publicity until an inquiry had made its findings known to him. The inquiries were to be held at the hospitals concerned and inevitably rumours would circulate, not least to the press. The

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[44]Confidential Letters Barbara Robb to Kenneth Robinson, 3.7.67 and 9.8.67 and to R.S.Mathews, 19.7.67 and 21.7.67 in Robb Files, Sans E. vol. 5

[45]Two Letters R.S.Matthews to Barbara Robb, both dated 21.7.67, in Robb Files, op.cit.

book's allegations reflected on all hospitals caring for the elderly and the identification of those involved would avoid this general implication. Moreover, failure to publish would arouse the suspicion that serious shortcomings were being concealed. Besides, this the Government had committed itself to publish in the House of Commons and such was the usual practice.[46]

AEGIS privately accepted some of these arguments, but it feared a whitewash.[47] Yet no Minister in his right mind was likely to concede what the group was demanding. AEGIS was seeking the right to see the enquiry reports and approve them for publication on the basis of its assessment of fairness, thus giving AEGIS an effective veto over the reports. The Minister could reasonably argue that he was responsible both for the establishment of the committees and for the hospitals under investigation, and could do with the reports whatever he considered in the best interests of the service and the public. That responsibility rested upon electoral accountability whereas Barbara Robb was a self-appointed guardian of public interest. So Mrs Robb elected to take her chances and cooperate with the committees on the Minister's terms. At the same time she decided to monitor their procedures closely in case she would need to appeal to the Council on Tribunals.

She duly lodged an appeal on the 7th of June the following year, roughly a month before the committee reports appeared. The Council on Tribunals had been established following pressure from administrative lawyers both in and outside Parliament for standardisation and regulation of the adjudication by standing tribunals which proliferated in the Government sphere after the second world war. The 1957 Report of The Franks Committee recommended the creation of a council to advise on procedural standards for tribunals. The Conservative Government extended Franks' proposals to bring statutory ad hoc committees of inquiry

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[46]Letter From L.R.Warner to C. Wade, Mrs. Robb's solicitor, Robb Files, op.cit.
[47]note of discussion between Mrs Robb and Rolph, in Robb Files op.cit.

into the Council's remit.[48] As far as inquiries were concerned, the 1958 Tribunals and Inquiries Act empowered the Council to consider and report on matters referred to it by the Lord Chancellor concerning administrative procedures involving the conduct of an inquiry by or on behalf of a Minister of the Crown.[49]

The Council's judgement was to be governed by principles of natural justice which Franks summarised as openness, fairness, and impartiality.

> "In the field of tribunals openness appears to us to require the publicity of proceedings and knowledge of the essential reasoning underlying decisions; fairness to require the adoption of a clear procedure which enables parties to know their rights, to present their case fully and to know the case which they have to meet; and impartiality to require the freedom of tribunals from the influence, real or apparent, of Departments concerned with the subject-matter of their decision." [50]

The restriction to mandatory inquiries was intended, as Wraith and Lamb[51] point out, to exclude private investigations in administrative departments, however in practice it excluded inquiries, such as those into Sans Everything, established by agents of the Minister at his request. The Council itself was critical of this and an amending Act of 1966[52] provided that Orders could be made designating discretionary inquiries to be brought within the Council's jurisdiction. However, the discretion was exercised following consultation between the

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[48]Harlow C. and Rawlings R., Law and Administration, (London: Weildenfield and Nicolson, 1984) pp.166-181

[49]Wraith, R.E. and Lamb, G.B., Public Inquiries as an Instrument of Government, (London:George Allen and Unwin, 1971) pp.220-229

[50]Report of the Committee on Administrative Tribunals and Inquiries, Cmnd 218 (London:HMSO, 1957) para.42

[51]Wraith and Lamb op.cit.

[52]The 1966 Tribunals and Inquiries Act, (London: HMSO, 1966)

Department concerned and the Lord Chancellor's Office.[53] It was following an order made under this Act that section 70 inquiries were designated as statutory. Given that there was no such process prior to the establishment of the Regional Board Inquiries, the Council on Tribunals had no authority to monitor their procedures.

Despite having no direct jurisdiction over non-statutory inquiries, the Council accepted the complaint from AEGIS. It found grounds in the Minister's decision not to make use of his powers to appoint directly under section 70 of the 1946 NHS Act. This, it argued, would have been more satisfactory for the complainants without prejudicing the interests of the hospital authorities.[54] More generally it took the view that Franks' three principles should apply and that it should have the authority to ensure that they do.[55]

Equally important, as the 1976 Annual Report makes clear, the Council has always interpreted its brief widely where it is satisfied that an omission or defect of a procedural or administrative nature may have prejudiced a complainant.[56] An examination of the procedure of two of the Sans Everything committees together with a detailed analysis of the published reports suggests that this last condition obtained to a marked degree.

The Ministry seems to have issued only the most general guidelines on procedure. These were not made public, however, it can be safely assumed that they corresponded closely to those provided for the Ely Inquiry and published in its report.

> "(a) the Inquiry was to be conducted in private, with evidence being given in confidence, except in cases where

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[53]Ibid
[54]Council on Tribunals, Annual Report for 1968, (London:HMSO, 1969) paras.48-52
[55]Harlow and Rawlings, op.cit.
[56]Council on Tribunals, Annual Report for 1975/6, (London: HMSO, 1976)

witnesses wished to make serious allegations against named individuals, in which circumstances they had to be prepared to give evidence in the presence of the person accused, who were to have opportunities to question the evidence;

(b) the committee were to have no power to summon witnesses, to take evidence on oath or to make any recommendations in respect of the award of costs;

(c) the Chairman .... was to decide whether any persons should be represented ..... legally or otherwise;

(d) the Committee's investigation was to include;

(i) inspection of the accommodation and equipment in the part of the hospital concerned;

(ii) interviews with all members of staff (current and former) who worked in the relevant parts of the hospital during the relevant periods;

(iii) interviews with persons who were patients...."[57]

This procedure extended the guidance in HM(66)15 and gave the committee chairman considerable discretion with the risk that each committee might follow a different procedure.

AEGIS envisaged that the chairmen would adopt a strictly judicial approach, affording full rights of cross examination, and representation. It was the variation in the extent to which the six chairmen interpreted their roles that formed the general case in AEGIS' complaint to the Council. So profound were Mrs Robb's disagreements with the Chairman at Friern, that she became convinced that her case would not get a fair hearing and withdrew all cooperation.

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[57]DHSS, National Health Service, Report of the Committee of Inquiry into Allegations of Ill-treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff, Cmnd 3975, (London:HMSO, 1969) para.5

The AEGIS complaint to the Council on Tribunals fills two large folders and contains an enormous amount of detailed evidence, prepared by Mrs Robb's lawyers, She had it read by six barristers. There are five general dissatisfactions beginning with the 'breach of confidence issue'. Secondly it was claimed that holding the inquiries at the hospitals concerned made a nonsense of Ministry claims that they took place without publicity given that word soon got round each hospital, within range of any local journalist in search of a story. Thirdly, potential nurse witnesses sympathetic to the AEGIS case were, it was claimed, deterred from testifying by the prospect of being recognised going into the hearings and thereby running the risk of reprisals. Fourthly, although the hospital authorities were legally represented, presumably out of the region's budgets, no public money was provided for those complaining who, if proved justified, were risking their own careers to render a valuable public service. Indeed, Mrs Robb met all the legal costs of presenting AEGIS' case at each inquiry. Lastly, the 'lay' member of four of the six committees was either a current or former member of a regional hospital board or hospital management committee and not, in Mrs Robb's view, independent of the service.

Mrs Robb's refusal to give evidence to the Friern Inquiry was interpreted by some as an indication that she did not after all have a case. This view was mistaken. Barbara Robb was advised that the inquiry did not meet AEGIS's strict interpretation of procedural impartiality. This fuelled her already fiercely burning suspicion that it was merely a whitewashing exercise to emasculate her politically.

Early in October, Mrs Robb was asked by the committee's secretary for details of the complainants.[58] He re-stated that legal representation would be according to chairman's discretion but legal expenses not be met. He assumed that the information would

[58]Letter H.Roberts to Barbara Robb, 9.10.67, in Robb Files, Sans E. Vol 7B. Vol I.

be forthcoming by the 23rd of October and gave notice that she herself was scheduled to give evidence on the 30th. This gave her only three weeks to prepare her case, and given that she was still embroiled in the confidentiality dispute with the Ministry she telephoned the Chairman for a postponement. Mrs Robb recorded that although agreeing to read her correspondence with the Department on the dispute, he seemingly offered no hope of a delay. He declined to give a decision on whether she would be allowed representation until she had submitted all her allegations plus the names and addresses of witnesses.[59]

A principal complainant, Mrs Robb was evidently expected to make accusations and divulge all her confidential information without any guarantee that she would be allowed a lawyer. Mrs Robb pointed out that this contravened the Ministry's most recent guidance which stated clearly that in cases serious enough for referral to an independent inquiry, "... the complainant and any persons who are the subject of the complaint ... should be allowed to make their own arrangements to be legally represented if they so wish."[60] According to her note of the conversation, this circular 'was all news' to him though he suggested that the passage referred to a departmental inquiry.[61] He was determined that there was to be no delay, Mrs Robb was to give her evidence as scheduled, and he would make no decision on representation before seeing her complaint.

Prophetically, Mrs Robb presumed that, in the likelihood of her legal advisers opposing the release of her information before she was guaranteed the right to be represented, she and the inquiry would be at deadlock, and he seemingly agreed.[62] So she put her concerns into writing adding her request that all her supporting

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[59]Correspondence between Barbara Robb and D.G.A.Lowe, also Mrs. Robb's detailed notes on telephone conversations with Mr. Lowe. in Robb Files, op.cit.

[60]Letter Barbara Robb to D.G.A.Lowe, 16.10.67 in Robb Files, op.cit, section iv Reference to Circular HM(66)15, para.7 (ii) b

[61]Note of telephone conversation on 10.9.67, in Robb Files, op.cit.

[62]Ibid

witness also be legally represented.[63] The Chairman's reply was the same: there would be no decision on representation until he had seen her submission, she was to appear on the 30th, although a subsequent appearance might be allowed.[64] She next handed the correspondence to her solicitors who explained to the chairman that there was no prospect of their completing her case by the date specified, particularly in the light of new problems which had come to light.[65]

Mrs Robb had by now discovered that the 'lay' member of the Friern committee was the Chairman of the Oxford Regional Hospital Board.[66] Now not only was the Oxford RHB itself holding an inquiry into the chapter on Cowley Road Hospital, Mrs Robb had information that one of its senior officers had condemned Sans Everything as 'sensationalist' at a Board meeting at the time of the book's appearance. It seems that the Chairman was not present to witness this assessment, however it had gone into the minutes, had been reported in the local press[67] [68] Hence AEGIS argued that this person could not be regarded as neither lay, nor strictly impartial. Mrs Robb did not evoke a sympathetic reaction from the inquiry's chairman when she brought the matter to his attention.

So her solicitors wrote to the Minister informing him that AEGIS were refusing to cooperate with the inquiry at Friern giving their reasons. AEGIS was however, "... anxious to cooperate with a newly appointed committee which has a lay member in the true

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[63]Letter Barbara Robb to D.G.A.Lowe, 16.10.67, Robb Files, op.cit.
[64]Letter D.G.A.Lowe to Barbara Robb 17.10.67 in Robb Files, op.cit.

[65]Letter from Mssrs. Young and Jones dated 19.10.67 to D.G.A. Lowe in Robb Files op.cit.

[66]Mrs I. Graham-Bryce

[67]The Oxford Mail 17.6.67
[68]Robb Files, Undated, hand-writtten note by Mrs Robb with content expressed by her solicitors in letter from Mssrs. Young and Jones and Co. to Kenneth Robinson 27.10.67, both documents in Robb Files, op.cit.

sense, and on condition that confidence will be strictly observed at every stage, that reasonable time is allowed for the preparation of the case, and that permission for representation by Council is granted at the outset."[69] This greatly irritated the Ministry who wrote back refusing to intervene either in the matter of time allowed for the preparation of the case or to remove the member objected to. The inference that 'lay' implied no connection with the hospital service was rejected. Apparently the Chairman of the Oxford board had been on holiday when the offending remarks had been made and had remained unaware of them "...Until your client chose to make an issue of the matter."[70] The reply overlooked the issue of representation.

On the advice of Barbara Robb, her three co-authors also withdrew.

The issue of representation arose in the case of the St. Lawrence's inquiry together with a second problem of whether AEGIS' lawyer was given sufficient time to read transcripts in which witnesses were questioned about the book's allegations at a session of the inquiry to which he was not invited. The St. Lawrence's Inquiry was in two parts. The first part investigated allegations of ill-treatment against two members of staff sufficiently serious to warrant their suspension from duty from June until the committee reached its verdict in November.[71] It came to light that witnesses were being questioned about the Sans Everything contributor at this first part.[72] Having apparently raised objections, her lawyer received transcripts of the earlier proceedings in a stack some ten inches high. Occupied with the day's hearing he was unable to give them the necessary attention and was refused any other opportunity to read them. Moreover one

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[69]Letter Mssrs Young and Jones, 19.10.67 to Kenneth Robinson op.cit.
[70]Letter, V.J.M.Poole, Asst. Secretary, to Mssrs Young and Jones, 29.11.67 in Robb Files op.cit.

[71]See The Times, The Guardian, and The Daily Telegraph of 4.11.67

[72]She was seemingly telephoned by a local MP, Peter Bessel, See Robb Files, Vol.7B Vol.II

of the two suspended nurses turned out to be the sister who was the subject of the book's allegations. This was confirmed the following April by the Secretary of the South Western Regional Hospital Board.[73] The exact nature of the other complaint against the sister was never made known as no extracts from the first part of the hearings were ever made public.

AEGIS claimed that its author was effectively denied full rights to cross-examine witnesses giving relevant testimony at the first part. To be fair to the committee, it had probably not intended this. It had a tight schedule, and the delay caused by AEGIS' dispute with the Ministry necessitated last-minute adjustments. Never-the-less, it did cast a margin of doubt over the fairness of the procedure since the right to cross-examination or audi alteram partem is one of the fundamental tenets of natural justice in English Law.

Unfortunately such technical concerns took no account of the politics involved. The book's allegations and the attendant publicity was gnawing away at the Ministry and raising serious questions about the mental hospital service and the longer the delay in answering the charge, the greater the harm done.

Kenneth Robinson presented the White Paper to Parliament on the 9th of July 1968.[74] Several hours earlier, his Department had issued a Press release which seemed a reasonable summary.[75] It will have been gathered that AEGIS had not expected the document fully to support the allegations in Sans Everything. Hence Mrs Robb immediately set to work compiling a detailed analysis of the reports using her own evidence and that of her fellow authors. Some of this material has appeared in sympathetic newspapers in abbreviated form, but the bulk of it has never been reproduced. There is no space within the confines of this study

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[73]Letter H.White, Secretary of the South Western Regional Hospital Board, 29.4.68 in Robb Files op.cit.
[74]House of Commons Official Report Vol. 768, Col.214-5, 9.7.68

[75]Ministry of Health, Press Release: Cmnd 3687, Notes for lobby correspondents, 9.7.68

to present Mrs.Robb's case in detail. However some brief comments on the White Paper are presented since the validity of the White Paper Reports are pertinent to an historical judgement on AEGIS and Barbara Robb who vehemently rejected them as adequate answers to Sans Everything.[76]

The White Paper consisted of seven reports from six committees: the Leeds Regional Hospital Board was responsible for two of the hospitals.

Each committee had the same terms of reference:

> "(i) to investigate so far as available evidence permitted the allegations contained in the relevant sections of Sans Everything (emphasis added);
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> (ii) to examine the current situation in the wards of their respective hospitals; and
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> (iii) to make recommendations."

The Command Paper's foreword indicates an amendment to the composition of the committees as originally announced to the House.[77] Perhaps in response to the dispute with AEGIS over the meaning of the word 'lay', the Ministry merely deleted it and replaced it by "not professionally qualified in medicine or nursing but experienced in the administration of hospitals or other public concerns".[78] Although these were the reports of

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[76]The most recent discussion of the period makes the following comment about Sans Everything: "Because the pamphlet contained articles by a well-known consultant psychogeriatrician and an academic, it was given a degree of respectability which later evidence proved to be unjustified." Korman, N. and Glennester, H., Hospital Closure, (Milton Keynes: Oxford University Press, 1990) p.15

[77]House of Commons Official Report Vol. 750, Col. 441-454 (11.7.67)

[78]MOH, Cmnd 3687 op.cit. p.1

seven inquiries, the entire White Paper comprised a mere 83 pages.

Friern Barnet hospital was the subject of four contributions to the book including that of Barbara Robb herself. The report is the longest of the seven and deals with her contribution, The Diary of a Nobody, in particular detail despite the fact that it took no evidence from Barbara Robb. Although consistent with its brief to "investigate as far as available evidence permits", it was unlikely to produce a balanced appraisal.[79] The report stated as early as paragraph three that the authors had refused to attend but gives no details of their reasons. It becomes difficult not to believe that the protracted and unresolved dispute coloured the committee's approach to AEGIS in reading the report.

In paragraph 34, Mrs Robb's account is described as "...based sometimes on misquotation, misrepresentation and serious distortion of facts, and in other instances on almost willful disregard of medical opinion". Noting that the qualifications contained in this statement could denote that the great majority of the account was accurate, an interpretation not apparently intended, the paragraph continued with a personal attack on Barbara Robb.

> "The Committee accept that for some obscure reason Mrs Robb had a genuine desire to help the anonymous patient, who is virtually a stranger to her, and that she is possessed of an almost fanatical zeal to further the interests of geriatric

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[79]The Minister took the view in Parliament and in correspondence that he could not count the accounts of Sans Everything as evidence without full disclosure of both the names of the complainants and those complained about. The Friern Committee for its part stated that it was "...unprepared to accept that any statement by Mrs Robb that has not been admitted or corroborated either in evidence given or in documents placed before them. The Committee observed, of course, the assertion in the book's preface that Mrs Robb's Diary was "true down to the smallest detail" but the claimed that the evidence the committee was able to obtain established the falsity of this unsubstantiated claim". (Emphasis added) MOH, Cmnd 3687 op.cit. Friern Report para.34

patients in mental hospitals but the Committee deplore the flamboyant and exaggerated style in which she presents her case in the Diary, a case which - if it has substance - would be more impressive if stated factually....." (emphasis added)

No evidence was offered for the incorrect assertions about the relationship between Mrs Robb and Miss Gibbs. Given that Mrs Robb made no appearance at the tribunal, its only grounds for concluding that her reasons for intervening in the Amy Gibb's case were obscure or that she was motivated by near fanaticism in her advocacy of the elderly in hospital, were presumably the uncontested statements of those evidently hostile to her. The use of such language appears to discredit Mrs Robb's allegations by casting doubts on her reliability. If the Committee deplored 'exaggerated and flamboyant' literary style, it should have avoided it in its own report. It is also interesting to note how the final clause in the extract contains a parenthesis which suggests that the Committee were unsure whether the Diary's case had 'substance'. This contrasts sharply with a categorical refutation later in the report "... that none of the allegations of cruelty towards or ill-treatment of Miss Wills (Gibbs) in particular of of other identified patients in general is justified..."[80] The latter was selected for the Ministry's press release.

AEGIS' general case against the Friern report was put by Rolph when he accused the Committee of "... commenting confidently on what it had never heard ....full of blind guesses about the information of which it had stupidly deprived itself".[81]

The Committee's attempts to refute the allegations in Sans Everything of neglect and maltreatment at Friern, particularly its implied criticism of Mrs Robb and her fellow authors would not -

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[80]MOH, Cmnd 3687 Friern Report op.cit. para.90
[81]Rolph, C.H. Whither the White Paper, New Statesman, 13.7.68

and indeed did not, as we shall see - command general credence if published alone. They appear still more incongruous preceding, as they do, what amounted to one of the most complete indictments of the general standards of care, staffing arrangements, and other aspects of administration of a hospital, to have appeared in formal report published on behalf of a Ministry of Health.

In the course of its assault on the Diary, the Committee had stated that although there were patients in Friern who were "merely old", they were very few in number, yet in its general findings[82] Friern is described as "overburdened with patients who ought not to be there ...".[83] The wards were seriously overcrowded, providing "substance in a criticism that Friern is a "dump for geriatrics"".[84] There was "an acute shortage of nurses, particularly trained nurses" on all shifts but so critical was the position on nights that "....several of the wards are virtually unstaffed save for an hourly visit by a charge nurse or sister".[85] This shortage was aggravated in its impact both by the overcrowding and by the "serious shortage of domestic staff" resulting in even trained nurses doing domestic work on top of all their other duties.[86] The provision of occupational or diversionary therapy was inadequate.[87] Much of the patients' clothing was "of poor quality and appearance". [88] There was "no satisfactory or adequate social work department".[89] In the committee's view, the administration side of the hospital required "drastic overhaul".[90] The report even admonished the Regional Board for discounting if not disregarding the particular needs of Friern.

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[82]MOH, Cmnd 3687 Friern Report op.cit. para.58
[83]Ibid para.105

[84]Ibid para.117
[85]Ibid para.121
[86]ibid
[87]Ibid para.128
[88]Ibid para.113
[89]Ibid para.128
[90]Ibid para.127

The Report of the Committee of Inquiry at Cowley Road considered the complaints of a nurse and a nursing assistant[91] who appeared with representation paid for by Barbara Robb. The Report contains no attacks on the authors however there was once again an apparent dismissal of the complaints which is difficult to justify in the light of ensuing paragraphs. The substance of the complaints was low standards of care rather than ill-treatment or misconduct, rough handling of patients, neglect of cleanliness and hygiene, rudeness and other symptoms of poor nursing care. Both authors argued that inadequate training and supervision of nursing assistants and staff shortages were at the root of the problems.

Paragraph 24 of the report begins by asserting that, the allegations,

> "in so far as they are allegations of general or frequent unkindness, ill-treatment, cruelty and disrespect, have not been established; indeed .... they have been disproved."

This is to be compared with the following:

> "...there have been few occasions when patients have been treated auxiliary nurse, and sometimes nurse or male orderly, has spoken crossly, rudely or improperly to a recalcitrant or annoying patient':

> "... there have been few occasions when patients have been treated roughly, but only on two occasions has this been done deliberately....;

> "... The occasional misconduct which has been proved was due to either (i) lack of adequate supervision ... (ii) lack of training and day-to-day instruction of auxiliary nurses... (iii) the unsuitability of individual nurses under stress and strain....'[92]

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[91]Ed.Robb R. Sans Everything op.cit. pp.27-37
[92]MOH, Cmnd 3687 Cowley Road Report, op.cit. para.24

Thus the discrepancy between the complaints and the Committee's findings seemed to be a matter of degree.

One of the most significant aspects of the Cowley Road Inquiry was a reported dispute between the Committee's chairman and the Region and Ministry over the nature of the report to be published. According to Theo Fitzwalter Butler, who was apparently a friend of the Chairman, the Minister directed the committee not to set out the evidence alongside its findings. Butler did not think that this directive had been general given that the Friern Report had included a certain amount of evidence.[93] The Committee's review of the evidence was indeed omitted from the report producing what the chairman saw as a most unsatisfactory document which although rejecting the allegations, lists recommendations which appear to establish them.[94] The omission of the evidence distorted the report and, of course, both conflicted with the principle of 'openness' and rendered impossible, judgements about 'fairness'. Barbara Robb also argued that any committee of inquiry which had bowed to Ministerial pressure, had thereby compromised its impartiality.

The report of the Committee at St. Lawrence's Bodmin reflects a similar but unresolved dispute between the Committee and a Ministerial directive on the non-publication of evidence. This report is the shortest of the seven and comprises only a list of conclusions which do not carry the signatures of the Committee members. Here again there was a confrontation between the Committee and this time, the regional board presumably acting under Ministerial instruction. The Committee was unwilling to provide a summary in the form required and what appears in the White Paper was presumably written either by the Board or the Ministry. It was unsigned but then given qualified approval by

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[93] Letter Barbara Robb to C.H.Rolph, 4.8.68 in Robb Files Sans E.Vol. 7C

[94] Memorandum from Sir Geoffrey Howe to the Bar Council, NHS Committees of Inquiry, March 1969

the committee in exchange for a concession by the department that the full report be shown to certain named people.[95]

Both Storthes Hall and St. James were administered by the Leeds Regional Hospital Board who accordingly established one committee to investigate the allegations against the two hospitals. In the case of St. James these were made by a nursing sister and related mainly to staff shortages, insufficient and inappropriate supplies, unreliability and poor service from ancillary departments and irresponsibility, carelessness and incompetence on the part of nurse colleagues. The comment on the allegations is extremely brief and comprises three brief paragraphs[96] which fill less than half a page. The first two simply introduce the charges and point out that none of them relate to ill-treatment or cruelty. The entire article is judged in one paragraph consisting of ten lines of imprecise, qualified, ambiguity. The third of its three sentences most warrants careful attention.

> "We concluded that if the Nursing Sister who had made the allegations had demonstrated a little more determination and initiative, the Psychiatric Unit of this hospital would never have been pseudonymously referred to in "Sans Everything".[97]

In her account, she described numerous occasions upon which she determinedly complained and pressed the hospital's ancillary services to provide her with the equipment and supplies necessary to run the ward.[98] The last clause of the sentence in the above comment is particularly enigmatic in its apparent implication that the state of affairs described by her contained sufficient truth to warrant the Unit's inclusion in a book devoted to, amongst other things, the exposure of intolerably low standards of care in mental and geriatric hospitals. Although the Committee had been unable to uphold her charges against other members of staff, they

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[95]Ibid
[96]MOH, Cmnd 3687 op. cit. para.5-7
[97]Ibid para 7
[98]Ed. Robb, B., Sans Everything, pp.18-27

had not even challenged the rest of her account. Hence raising the question whether, if the Committee felt that the hospital warranted inclusion due to her lack of determination and initiative, was it also referring to the deficiencies in administration which she described and the Report did not contend?

The allegations against Storthes Hall were made by a nursing assistant and included grave charges that staff had cruelly assaulted and generally maltreated patients.[99] These were dismissed by the report in only six lines in the absence of any documentary or other corroborative evidence. According to the AEGIS lawyer at the hearing, the ward book covering the relevant period, which could have provided documentary evidence, was missing: once more, there is no mention of the fact in the report.[100] The complainant had also reported that unqualified staff were left in charge of wards of 80 or 90 patients, thus implying overcrowding and shortages of trained staff. The committee did not believe him, although it did not indicate why he lacked credibility.

The same author wrote the section of the book on Springfields. The Committee here found him 'highly emotional' and 'prone to exaggeration'. However, it was prepared to believe some of his account including an incident in which an elderly patient with a colostomy bag had been dragged from his bed and thrown onto the floor.[101] It also established that around six other incidents of ill-treatment had occurred between 1962 and 1966, that "...at least two charge nurses showed themselves prone to outbursts of ill-temper which expressed itself in violence" and that the HMC's disciplinary procedures were inadequate.[102]

The complaints against Banstead Hospital were brought once more by one of the Friern complainants and concerned alleged incidents during his training at the hospital between 1958 and 1961. These

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[99] Robb,B.(Ed.) op. cit. pp. 43-7
[100] The lawyers report to Mrs Robb is in Robb Files, Sans E Vol.7C
[101] MOH, Cmnd 3687 Op. cit. Springfields Report para.5.

Continued on following page

related to physical and verbal cruelty, the improper sale of hospital beverages, and his general view that nurses could be socialised into accepting brutal methods and exploitation as students through fear of victimisation[103]; complaints remarkably similar to those subsequently upheld by the Whittingham Report.[104] The Committee made extensive efforts to contact former members of staff as well as relevant official bodies and organisations.[105] None of this evidence seems to have corroborated the article and the AEGIS author withdrew his allegations.

However, the Committee did not reject the allegations but restricted itself to finding the case unproved due to inability to investigate the truth, adding that it had no reason to doubt the complainants good faith.[106] Mrs Robb's records state that her witness had tried unsuccessfully to persuade three former colleagues to support him but all three had declined for fear of reprisals.[107] Interestingly, faced with this assessment, the Ministry was extremely selective in publishing an extract in its press release which excluded the unproven verdict and suggested that the allegations were refuted. The White Paper also omitted large tracts from the Chairman's original report which drew attention to overcrowding and staff shortages on the long-stay wards.[108]

It was in the preparation of the published reports that the fairness, openness and impartiality of these committees seems most in question. As Wraith and Lamb put it:

> "The point that emerges most strongly from these inquiries and from a study of the reports, is not that some committees did their work well and others badly, but rather that in

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[102]Ibid para.4
[103]Ed. Robb, B., op.cit.
[104]See below pp. 241-17

[105]MOH, Cmnd 3687 op. cit. Banstead Report, para. 1-9
[106]Ibid para.5(a)
[107]Note by Barbara Robb in Robb Files, Sans E Vol. 7c

some cases the public has ample opportunity for evaluating the worth of the Committee's conclusions and findings (although not as full an opportunity as if the evidence, or a summary of it, had been published) and in other cases virtually none at all."[109]

They were constrained by the Department in terms of resources, procedure, timetable and control over publication. In some cases, the committees seem to have reacted to the complainants with a degree of hostility. Due to the timetable, some complainants, including Mrs Robb, were denied adequate opportunity to arrange counsel. It was assumed that the complainants would themselves meet their own costs while the hospitals used taxpayers money. Some were denied adequate opportunity to cross-examine important witnesses. To be fair to the committees, these inquiries were unprecedented in the health service and followed a procedure which had only recently been laid down by the Ministry. Their nature and prescribed function were ambiguous, oscillating between legal hearing and administrative review. It is difficult not to conclude that they were conducted with undue haste demanded by the Minister's political needs. Some of these procedural issues were addressed in forthcoming years. However, it is fair to assert that Mrs Robb's book did not get a thorough and thus fair hearing. This was to be widely accepted as the battle for public opinion was fought.

When the White Paper was published in July 1968, the Ely Inquiry was preparing its report, and its likely content known to departmental officials.[110] Barbara Robb had whipped up a 'moral panic' in the press since the appearance of Sans Everything[111]. Mental hospital scandal had become hot news, sold papers and made reputations for journalists. Fleet Street correspondents were despatched to all parts of the country looking for them, while their colleagues on local papers were only too willing to oblige. Appendix 3 lists some of this remarkable coverage. In the midst

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[108] South West Metropolitan Regional Hospital Board, Report of a Committee of Enquiry, Banstead Hospital, 1967
[109] Wraith and Lamb, op.cit. pp.209-210
[110] See Chapter 5
Continued on following page

of this torrent of adverse publicity, the Ministry learned of the death of 24 elderly patients in a fire at Sheldon Psychiatric Hospital, near Shrewsbury at the beginning of March. It made banner headlines. With the Chairman of the Ely Inquiry making known his dissatisfaction with the procedure he was commissioned to follow[112], with the Council on Tribunals having accepted Mrs Robb's complaint, the Minister was obliged to instigate an inquiry direct under section 70 of the 1946 NHS Act.

The White Paper's impact was important in three ways. Firstly, it was presented by the Government as refutation not just of specific allegations but of AEGIS general case. This amplified the shockwaves created by subsequent inquiry reports. Secondly, and relatedly, by mishandling the press, the Ministry infuriated interested correspondents, set itself up for attack on the issue of conditions in psychiatric and mental handicap hospitals and motivated journalists to trawl the country for mental hospital scandals. Thirdly, it brought the British Medical Association, the Medical Protection Society and the Confederation of Health Service Employees to countervail pressure for reforms in complaints machinery by their advocacy of the status quo.

Kenneth Robinson presented the White Paper to Parliament on the 9th of July. He declared that the book's allegations had been found to be "....totally unfounded and exaggerated" and that he regretted "...the anxieties which have been caused to patients and their relatives, to hospital staff and to the public generally by the publication, which I believe the whole House will deplore, of so many allegations which are now authoritatively discredited."[113] He reminded MPs that he had been "very willing and ready to investigate thoroughly any allegations of ill-treatment", that "in general, the committees did not have a great deal of co-operation from the authors of the book", adding that the cost of the inquiries had been "not inconsiderable".[114] Most MPs who rose to speak shared the Minister's view. Laurence Pavitt "...a member of

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[111]See Chapter 12
[112]Chapter 5
[113]House of Commons Official Report, Vol.768 Col.213-4
[114]ibid

one of the regional hospital boards...concerned" beseeched the Minister to prevent the press running "sensational anti-National Health Stories"[115] while Dr Summerskill asked that the publication of similar books be prevented. Another backbencher sounded the only note of dissent by pointing out that if most of the allegations were unfounded, then it followed that some of them were not and he felt this justified a re-consideration of the proposal for some kind of inspectorate.[116] In reply, the Minister suggested the matter could be considered when he published his Green Paper on NHS structure and advised Members to read the White Paper "in order to get the matter fully into perspective".[117] This was indeed sound advice, given that the Ministry had by no means offered a balanced view. It scored an initial success by dominating the early press reports, all based on the highly selective press release which went out several hours before the White Paper's publication.[118]

Barbara Robb's reaction was predictable. She told the Sun that the reports were a 'shocking whitewash', the Daily Express that many of the findings were valueless, and the Evening News that she had been expecting a general denial (but was pleasantly surprised by the extent to which the reports uncovered faults in the service).[119] As the various correspondents had time to read the reports, and Barbara Robb had had time to brief them on the AEGIS position, the clumsiness of the Minister's attempts at media management became apparent and his Press became hostile. Rolph described the chain of events in Fleet Street.

> "The ministerial hand-out business is getting older, and it is no use getting old unless at the same time you get artful. Last week when the Minister of Health was ready to issue the White Paper ....its press service first put out a typed 'summary' and then let several hours go by before anyone got sight of the White Paper itself. The newspapers

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115Ibid Cols. 214-5
116ibid
117Ibid
118Daily Telegraph and The Guardian 10.7.68
119Editions 10.7.68

and radio men went to town on the typed summary. Everyone, after the interval, could see how they had been misled. I don't remember hearing pressmen so angry".[120]

It was poor press management. Journalists felt that the Ministry of Health at least failed to appreciate the value and power of the press and was even contemptuous of them. Hence when confronted by the misleading summary, correspondence felt they were being deceived or 'conned'. They were resentful and angry.[121]

Therefore, within forty-eight hours, their editors were devoting enormous column space to AEGIS' objections to the committees' procedure and details of its complaint to the Council on Tribunals.[122] Mrs Robb told the Daily Telegraph that she intended to publish a sequel to Sans Everything to "expose the reluctance of some hospital authorities to act after they have been given evidence of irregularities involving patients in geriatric hospitals".[123] The Sunday newspapers launched a corporate attack on the Minister, spearhead by Hugo Young who accused him of giving a 'totally misleading impression' of the reports whose recommendations implied fundamental criticism of the hospitals investigated. The Minister ".... has allowed his responsibility for the Health Service totally to engulf his duty to the public".[124] The News of the World disputed the claimed independence of the inquiries and accused them of grilling the AEGIS authors as if they were on criminal charges.[125] The Observer reported widespread criticism of the Minister including Mary Applebey for the NAMH who felt that he should have been 'very disquieted'. The Sunday Telegraph felt the public feared that the reports and particularly their presentation by the Ministry were part of a 'whitewashing operation'.[126] All the Sundays listed

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[120]Rolph, C.H. Whiter than White Paper, New Statesman, 19.7.68
[121]Interview with Hugo Young
[122]Editions of 11.7.69
[123]Daily Telegraph of 11.7.68

[124]The Sunday Times 14.11.68
[125]See Editorial 14.7.68
[126]Editions of 14.7.68

AEGIS' disatisfactions with the inquiries and called for an inspectorate or a health service commissioner or both.

In the New Statesman, Rolph attacked both the White Paper and its presentation and defended the integrity of those responsible for the book.[127] In an unsigned editorial by Prof Townsend, New Society described the Minister as 'shockingly complacent'.[128] The British Hospital and Social Science Review published a detailed analysis of the reports by Brian Watkin. He was especially critical of the Friern Report for conveying "a sense of bias that is out of place in a report that was from the first expected in some quarters to be a piece of "whitewashing". He viewed the recommendations in the reports as suspect and supported Prof. Abel-Smith's call for reforms in complaints machinery.[129]

Opinion amongst the various interest groups was divided. The Nursing Mirror supported AEGIS and attacked the Department.[130] Although the Nursing Times produced the Minister's press release virtually verbatim, the RCN were unhappy with the Minister's statement to the House.[131] For the NAMH, Mary Applebey was shocked at the Minister's attitude, and the President, Lord Balniel joined the lobby for an inspectorate.[132] The Patients Association, made a direct appeal to the Prime Minister to establish an independent investigation into hospital conditions for the elderly given the unsatisfactory nature of the Sans

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[127]New Statesman 2.8.68

[128]New Society Vol. 12 No.303, 18.7.68, p.75

[129]Watkin, B., Sans Everything - the White Paper, British Hospital and Social Services Review, Vol. 88, No. 4083, 19.7.68 pp.1338

[130]Nursing Mirror Vol. 127, No. 2, p.10, 12.7.68 and Vol. 127, No.3, 19.7.68, pp.12-13

[131]Nursing Times Vol. 64, No. 28, 12.7.68, p. 918 and p. 943, and report in Nursing Mirror, Vo. 127, No. 22, 29.11.68 p.11, of the an address by the Secretary of RCN's Psychiatric Division to the Student Nurses Association, Mrs Harrisson: Keith Newstead, who had attended AEGIS early meeting with the RCN, was on the Platform. (See Chapter 3)

[132]NAMH Mental Health, Autumn 1968, and Annual Report 1967/68 "Aims and Achievements" (London: NAMH, 1968) , which stated that "...we cannot accept the Minister's interpretation of the reports."

Everything inquiries and the Minister's 'complacent attitude' to their reports.[133]

The Lancet supported AEGIS and called for a health service commissioner.[134] The publicity and particularly, the demands for a health service commissioner galvanized the BMA, as the British Medical Journal declared two weeks after the publication that "the hospitals concerned and their staff have been cleared of imputations that should never have been made."[135] Most enthusiastic in welcoming the White Paper, the Confederation of Health Service Employees, who had represented some nurses at the inquiries, proclaimed that the book had greatly damaged morale and recruitment and asked Barbara Robb to now withdraw her allegations.[136]

When the criticism of the Minister reverberated in Parliament, he appeared to have shifted his position a little. He told Maurice Macmillan on the 16th of July that the report had made many criticisms on such matters as over-crowding, staff shortages and antiquated capital stock; matters which were being dealt with within 'available resources'. When pressed to establish an inspectorate publishing reports, Kenneth Robinson expressed doubt that the proposal would provide 'absolute protection' but repeated his intention to introduce the matter as part of the discussions to surround his imminent Green Paper.[137] But it was not all uphill for the Minister at this stage. The day of this debate the BBC staged a programme on the White Paper which was watched by Richard Crossman then preparing the new Department of Health and Social Security which was shortly to be announced. He records it as follows:

> "Now I was very anxious to have this programme staged. One reason being that I was disgusted by the programme the BBC

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[133] Daily Telegraph and The Times 3.8.68, Patients Association, Bulletin October 1968
[134] Lancet(ii) No. 7561, 27.2.68, pp.202-3
[135] British Medical Journal 1968 Vol. 3, No. 5611, 20.7.68, p.135
[136] Reported in British Hospital and Social Services Review, Vol. 88, No. 4083, 19th July 1968, pp.1334
[137] House of Commons Official Report, Vol 768 col.1245 16.7.68

had put on for the 20th anniversary of the Health Service, something for nothing. And everybody had panned it as a very bad programme and I knew there was a chance now that Kenneth Robinson would be forced to write to Charles Hill, who after all is a doctor and we should get some amends. And sure enough we did. On this evening clearly the BBC directors were under control from the top to give fair play to Kenneth Robinson and fair play to the hospital system. And the whole programme was strongly biased in favour of the hospitals and very much cut the critics down to tape and also gave very small prominence to Mrs Robb and much more prominence to the Minister.....It was a splendid programme from Kenneth's point of view."[138]

The Green Paper appeared on the 23rd of July and its major concern was NHS management structure. However, it showed that AEGIS had succeeded in shifting the Department's position on complaints machinery. The Green Paper outlined a new office of Health Service Commissioner. It envisaged that many types of complaints would be open to investigation. However, complaints involving allegations of negligence which could be pursued by the courts, or clinical matters would be excluded.[139] Even at this early stage, some of the major bones of contention were being uncovered,

The structural reforms in this document were very quickly confined to the shelves of the Ministry of Health when it merged with the Ministry of Social Security in October to form the Department of Health and Social Security (DHSS). The new Secretary of State for Social Services, Richard Crossman had taken a dim view of Robinson's insistence on going into print with his proposals just before the change. However, the health commissioner idea lived on.

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[138]University of Warwick Modern Records Centre, Crossman Diaries 151/68/SW to 152/68/SW

[139]Ministry of Health, The Administrative Structure of the Medical and Related Services in England and Wales (London:HMSO, 1968)

CHAPTER FIVE

ELY AND FRIENDS

> "Sans Everything will only be a precursor to the explosions and implosions that will rock the conscience of the community, unless the community becomes alive to the danger and takes crash-action to re-think and plan ahead."(Monica Stewart)[1]

> "There is no political capital to be made out of the needs of the mentally handicapped, and the goodwill and sincerity of those who try to bring about reform is unquestionable." (Kathleen Jones)[2]

Crossman was the most senior politician to head up the NHS since Aneurin Bevan. As a Cabinet minister he could form allegiances with senior colleagues gaining their support for his proposals in exchange for his. Moreover, until he was involved in a major row over prescription charges, Crossman's standing in the Parliamentary Party was such that he was seen by a significant number of MPs as the natural successor to Harold Wilson. He was also strong willed and personally very forceful. Whereas Robinson would negotiate and mediate, Crossman often chose head-on confrontation even bullying. He was an adept political operator and not averse to manipulating people to serve the desired end; earning himself the title 'Tricky Dicky' or as Barbara Robb called him 'Double-Crossman'.

His style of working was coloured by his extra-political, professional experience as both an academic and a journalist. Like other ministers in the Wilson Government he involved academics in policy formulation; part of a general suspicion that

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[1]Stewart, M. My Brothers Keeper, (London:Tavistock, 1968) p.9

[2]Jones K. et al. Opening the Door, (London:Routledge,1975) p.15

the Civil Service was conservative and lacking in expert knowledge. Crossman enjoyed bringing academics in to work with his officials in seminars to examine problems and generate policy options. Of enormous importance to AEGIS he appointed Brian Abel-Smith as Senior Adviser.

Crossman had also been a journalist and served in the wartime Ministry of Propaganda. He had a keen sense of the importance of public image and ensuring that his version of events should be prominent in the press. He was highly critical of his department's existing press management arrangements and determined to modernise and overhaul them.

Crossman's main concerns as Secretary of State were the introduction of a new plan for pensions intended as a major vote-winner, and the reorganisation of the health service. Unlike Robinson, he had no special expertise or experience in mental health so it was in some ways ironic that at the end of his period of office, he viewed his mental handicap policy as his major success.[3] Throughout his office he toured psychiatric and mental subnormality hospitals and his Diaries contain detailed accounts of these visits and his reactions to the patients and the conditions. He shared the view that the improvement in conditions since the war was revolutionary. His attitudes to mental disorder and old age were otherwise ill-informed and paradoxical. He was disgusted by the degenerations of old age, and despaired at the severely mentally subnormal whom he thought beyond hope, but they generated great compassion within him. Consequently, he admired those who cared for them. Mental illness, or 'mental disease' as he often termed it, interested him little and he was content to allow his doctors full scope to deal with it. Reading Crossman's accounts of his visits one senses a patrician's physical repugnance and discomfort rather like that of George Orwell leading the working class lifestyle among miners in the Lancashire coalfield in the 1930s.[4]

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[3]UWMRC Crossman Diaries CD 250 1970

[4] On the elderly: "really old age is ghastly, and old age when
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David Ennals was originally appointed Minister of State for Health but was moved to Social Security when the holder of that office, Stephen Swingler died suddenly of a heart attack in February 1969. At the PM's suggestion, Baroness Serota came in as Minister of State for Health. Baroness Serota was a former neighbour of Barbara Robb in Hampstead, and although the two women were only vaguely acquainted, Mrs Robb felt she had a second direct access to the centre of power. Brian Abel-Smith had already been at the Elephant and Castle for some months. These contacts were to prove crucial in getting her views across to government.

Hence the climate at Alexander Fleming House changed markedly for AEGIS. Having been resisted and obstructed for three years, Mrs Robb was to be involved both formally through the official consultation process and informally through her contacts. Moreover, Crossman's view of the value of exposing deficiencies in

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you are incapacitated is singularly unpleasant, And reminded me of my mother , sitting there in Shepherd's Bush in that dark room, Heavens its disgusting. I could still almost smell the stale smell again, and think how odious it is...." UWMRC Crossman Diaries 152/68/SW and

On the profoundly mentally handicapped: "Obviously my main feelings were "couldn't we find some way of destroying them" because these were the rock bottom cases these were the people who are kept alive year after year and you know that they will get no better. And there were 50 fully trained nurses looking after these corpses. They really are more on the level of animals than human beings". UWMRC Crossman Diaries JH/68/40-41 see also JH/68/40-41, and 249/69 JH

the services and of persistent, effective campaigners like Mrs Robb was very different from his predecessor's.

Crossman came into the job well aware of AEGIS. When making his plans in July, he had invited Brian Abel-Smith and Richard Titmuss out to dinner with the chairman of the Supplementary Assistance Board to discuss reforms to the national pensions scheme. After, eating they watched the BBC programme on the Sans Everything White Paper.

> "there was trouble last year with a book called Sans Everything, published by a certain Mrs Robb with a number of contributors to it, attacking cruelty in our geriatric hospitals. This was indignantly repudiated by Kenneth Robinson who immediately told the six regional hospital boards concerned to set up an inquiry under an independent QC .... and he published the week before last the report of the six QCs...together with a brief forward by him. He told me the thing would be completely uncontroversial because it would simply demolish Mrs Robb. Well he himself made a very short statement, very complacent, saying that everything was justified, a saying briefly that the six reports denied all allegations. This was obviously untrue. In fact the reports didn't by any means deny all the allegations and if he had had the common sense to say they deny all the...gravest and most serious allegations, well there are of course a number of criticisms and welcomed them and said that of course they were not fully met and he was going to meet them, that was right. But he didn't. He gave a sense of complacency and complete defending which he does as a bureaucratic Minister. So there was a great comeback for Mrs Robb in the Sunday press ...."[5]

The first ramification for AEGIS of the new political team was Mrs Robb's decision to withdraw her campaign on the Sans Everything White Paper. It had been her intention to use her dossier as part

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[5]UWMRC Crossman Diaries, 151/68/SW

of a general campaign to reform the complaints procedure and oblige the Ministry to withdraw the offending document. She did not release her evidence to the press until the spring of 1970 and explained at that time:

> "The fact is that shortly after the publication of the iniquitous White Paper on the Sans Everything inquiries, when Mr Crossman was preparing to take over the health service, I was asked by one of his associates to "preserve a dignified silence" about the white paper's defects - in the interests of the Department's aims to implement vital reforms. It seemed a great deal to be asked but the cause appeared a good one and I was assured that "friends" would look after AEGIS' interests. So it was decided that AEGIS should not demand an inquiry into the White Paper until a later stage." [6]

The exact nature of this arrangement is not specified in Mrs Robb's files but she must have had strong assurances from people she trusted. The only likely intermediary whom she would have trusted and who was in a position of sufficient influence to give such an assurance would appear to have been Prof. Abel-Smith.

Although AEGIS refrained from publicising its disatisfaction with the inquiries, it pursued the complaint through the Council on Tribunals - submitted in June 1968. Mrs Robb heard from the Council's Secretary in late July and, as she expected, it was unable to entertain her complaints about the specific constitution or conduct of the inquiries. Nevertheless the Council had noted her suggestion that the Minister should have appointed the committees directly and thus brought them within the Council's jurisdiction. Although unable to comment on this suggestion, it had agreed to take up the general question of hospital complaints with the Ministry. The following January, Mrs Robb learned that the Council had indeed consulted the Secretary of State and expressed the view that statutory inquiries should be the usual

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[6] Robb Files Sans E. Vol.11

procedure for 'certain types of complaint'. The Council also expressed the hope that the health commissioner proposals would be implemented.[7]

In its Annual Report for 1968, the Council drew special attention its disatisfactions with the Sans Everything inquiries:

> "The division of responsibility between the Minister and the Regional Hospital Boards clearly made it difficult in some cases for him to decide whether or not to hold a statutory inquiry under section 70. But the nature of some of the complaints which had been made to us about the Sans Everything inquiries made it, in our view, unfortunate that we had not the right to consider them. We therefore told the Secretary of State for Social Services....that for this reason we felt that a procedure which fell within our jurisdiction would have been more satisfactory , both in the interests of the complainants and of the hospital service".[8]

Soon afterwards David Ennals, when still health minister, announced that the idea of a health commissioner raised in the Green Paper had been 'well received'.[9] The following week, the Nursing Mirror observed that the Minister's remarks were being interpreted by MPs as an indication that whatever the reaction to the main body of the Green Paper, "....the Ombudsman plan has received general approval and is likely to be the subject of early government action".[10]

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[7]Correspondence with the Secretary of the Council on Tribunals 13.1.69 to Mrs Robb, 17.1.69 to Mrs Robb, Robb Files Sans E. Vol.9

[8]Council on Tribunals Annual Report for 1968 (London:HMSO, 1969) para.52

[9]Speech by David Ennals to Reigate Labour Party reported in The Times 25.1.69

[10]Nursing Mirror Vol. 128 No. 5, 31.1.69, p.8, see also Vol. 128 No.4, of 24.1.69, p.7.

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The Ely Report

Soon after the arrival of Baroness Serota at the DHSS something of a crisis arose within the Department which brought the mentally disordered and particularly the specific concerns of AEGIS to the very top of the Secretary of State's agenda. Indeed, although not directly involved, AEGIS had been instrumental in the events which gave rise to the crisis.

The Report of the Committee of Inquiry into Ely Hospital[11], arrived in the Department following protracted negotiations between the committee's Chairman, Sir Geoffrey Howe and the Welsh Regional Hospital Board. Established by Robinson in September 1967, the committee's report was not formally submitted until a year later. According to Crossman, the Department were aware of it in September 1968. It appears not to have been passed to the political head until March 1969 when Crossman was told he would have to publish the report before the Welsh Office assumed responsibility for the NHS in Wales, to be effective from April 1st. Crossman reported that he was first told that something controversial was in the pipeline as early as October 1968. The Diaries say that he had been so advised by Prof Abel-Smith, a friend and Cambridge contemporary of the inquiry committee's chairman.[12] The delay was due to the inability of the committee and the regional board to agree a publication draft before December 1968. The Department's role in these negotiations is difficult to ascertain; for its part the committee dealt directly with the regional board. However Crossman's Diaries state clearly

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[11]DHSS, National Health Service, Report of the Committee of Inquiry into Allegations of Ill-treatment of Patients and Other Irregularities at Ely Hospital, Cardiff, Cmnd 3975 (London: HMSO, 1969)

[12]Crossman R.H., Diaries of a Cabinet Minister Vol.II, (London:Jonathan Cape, 1975) p.408

that the Department was involved, presumably advising the regional board in its deliberations.[13] In any case, given the Ministerial interest in the Sans Everything Reports and the adverse publicity it faced, it is inconceivable that Ministry officials did not take a direct interest.

The Ely committee was established by the Welsh Regional Hospital Board acting as the Minister's agents in September 1967. This followed the appearance of an article in the News of the World of August 20th of reports by two nurses alleging neglect and ill-treatment of patients in their hospitals. These and three others had been selected by the paper from postal responses to the invitation it had published as part of David Roxan's review of Sans Everything. The paper had interviewed respondents to check the validity of their complaints. Five reports were then forwarded to the Minister of Health who judged one, from a nursing assistant at Ely Hospital, near Cardiff, sufficiently serious to warrant formal investigation.

The complainant had not read Mrs Robb's book, but he had, of course, responded to an appeal by the paper precipitated by the book. He was encouraged to do so by the favourable publicity which her book attracted in the national and the nursing press.[14] As the report was to affirm, to complain as this individual did was a courageous act. The publicity was evidence there were others in the service working in similar conditions, facing similar difficulties in effecting positive change. The consequent moral support was a major factor in 'XY's' decision to put his complaints into writing.[15]

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[13]Crossman R.H. op.cit.

[14]Interview with Sir Geoffrey Howe

[15]The News of the World was also well known as the champion of the 'little man' against bureaucracy through the John Hilton Bureau which it staffed and financed as legal and welfare rights agency.

The Ely allegations arrived in the Department at the height of the controversy over the AEGIS book and the media discussion of the issue of independence of inquiries in the health service led by The News of the World[16], the original source of the complaint. As in the case of the book, the Minister asked the regional board to set up the inquiry to be chaired by a barrister with relevant expertise from a brief short list prepared by the Lord Chancellor's office. Robinson was concerned to avoid any suggestion of partiality by the inquiry, and therefore personally supervised the final choice of Chairman.[17] Geoffrey Howe was a distinguished barrister with special expertise in medical litigation working with the Medical Defence Union, and, as he practised on the 'Welsh Circuit', was professionally known to the regional board involved. He was also no stranger to the field of mental disorder having written on the subject for the Bow Group Study Group. His wife also served on the management committee of a large mental handicap hospital in Surrey, having been appointed to that position upon recommendation by Prof. Abel-Smith, a member of the South-West Metropolitan Regional Hospital Board at the time. Howe was thus ably qualified.

He had also been emerging as an important figure in the Parliamentary Conservative Party, until he lost his seat in the 1966 Labour landslide. He had served as Opposition spokesman on Health and Social Security during the Government's first term. From the Minister's point of view, therefore, this appointment could not be seen by the public as anything other than independent of the Government.

The membership of the committee of inquiry was similar to that of the Sans Everything committees. The 'lay' member was on the Birmingham Regional Hospital Board, the nursing member was a retired nursing officer with the South-Western Regional Hospital Board, and the psychiatrist was D. Russell Davis a 'radical' Professor of Mental Health at Bristol University and an active

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[16]Editorial 14.7.68

[17]Interview with Kenneth Robinson

campaigner through the NAMH. The quality of the report's analysis of conditions, patient care and working relationships at Ely was a tribute to the three of them; however the chairman's influence was to be crucial both in adopting a rigorous approach to investigation and securing full publication of the report.

Howe placed the inquiry firmly on a judicial footing. Without specifically mentioning the Franks Report, the Ely committee considered the administration of natural justice where personal and professional reputations were at stake to be paramount.[18] The three principles of openness, fairness and impartiality were strictly upheld except where limitations of resources made this impossible. In such cases, the committee was at pains to highlight the limitations on the findings or avoided a judgement at all.[19] Not only did it interpret its brief widely, it reported on its dissatisfaction with the ordained procedure and the resources provided by the Department.[20]

The committee was also sensitive to the criticisms currently levelled against the Sans Everything Inquiries[21]. The Ely committee asked the regional board if it could announce the inquiry to the public, and although this was initially refused by the Department, direct application to the Minister resulted in his authorisation of the necessary announcement.[22] This public announcement was supplemented by personal invitations to over sixty current and former staff and over 250 relatives and friends of patients. The Ministry's guidance as to general procedure, left the granting of legal representation to the Chairman's discretion and Howe exercised it widely. All witnesses who answered charges or allegations were represented. The committee disapproved of its inability to compel witnesses to attend and

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[18]MOH, Cmnd 3975 op. cit. para.8

[19]Ibid para.9

[20]Ibid paras.6 and 9

[21]Sir Geoffrey Howe's Memorandum to the Bar Council, National Health Service Committees of Inquiry, 1968

[22]ibid

documented examples when unwillingness of corroborating witnesses to attend rendered it unable to pursue an allegation. In contrast to some of the Sans Everything inquiries, the Ely committee did not dismiss allegations which could not be corroborated in this way, but merely stated its inability to reach a judgement.

The committee's major disatisfaction was the Ministry's refusal to provide a solicitor to sift and prepare the evidence. After the inquiry Howe expanded on the summary of the problems this refusal generated published in the report.[23] The committee had no advance knowledge of testimony. Evidence was given in a random order, necessitating the recall of witnesses which was not always possible. It proved impossible to warn all those facing allegations of their nature. Allegations were examined on occasions when the inquiry had no prior knowledge, or it was considered unsafe to adjourn as their was no certainty that the witness would return for cross-examination. Those bringing allegations and those facing them could not always be organised to appear together before the committee. Howe was particularly unhappy that in his dual role of 'prosecutor and judge', he often had to cross-examine witnesses on the basis of premises which later proved to be false.

There were other more general criticisms voiced after the inquiry but first it is important to look at the report's findings on standard's of care. It will be recalled that how some Parliamentarians had greeted the Sans Everything allegations with disbelief, and that the Minister had refuted AEGIS' case that the existing complaints machinery was inadequate. In the light of this, and her treatment at the hands of the Ministry - including obstruction and repeated denials of her case - Barbara Robb must have read the Ely report with great satisfaction and, after the attacks upon her in the Friern Report, with a sense of complete personal vindication. For here was a formal report from within the National Health Service publicly acknowledging so many of her contentions.

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[23]Sir Geoffrey Howe's Memorandum op.cit.

Ely hospital was grossly overcrowded and understaffed. Nursing care was often crude, backward and instances of cruelty and neglect went far beyond anything alleged in Sans Everything. The Hospital Management Committee (HMC) was out of touch, its members ill-qualified and ill-informed. Staff were inhibited from complainant by realistic fear of victimisation. Lastly, the report advocated an independent inspectorate and replacement of existing complaints machinery.

Ely Hospital was a designated psychiatric hospital which had come to serve as a repository for chronic, incurable cases, living bleak lives, crammed into wards of up to 70.[24] It was significantly understaffed mostly on the male side.[25] This was aggravated by acute shortage of domestics so that much of the cleaning was done by nursing staff aided by 'higher-grade' patients. The guidelines issued by Kenneth Robinson in 1965 on personal clothing were judged to be beyond the bounds of possibility by the Ely staff.[26] The laundry service was chaotic and foul linen was sluiced on the wards, in one case in the room used for sterilising implements. Once again, Ministerial guidance was not put into effect.[27]

In assessing the character and credibility of the principal complainant 'XY' there is a much more dispassionate approach than in some of the Sans Everything reports. He was described as a 'natural outsider' without enthusiasm for hard work and resentful of being given low-status work-tasks. Yet the committee believed him to be motivated by a genuine concern for patients and the public interest whilst understanding the problems facing those staff he complained of. The committee was also highly sensitive to the process of victimisation,[28] and throughout, was disposed

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[24]MOH, Cmnd 3975 op. cit. paras. 16-17 and 88

[25]Ibid paras.18-20

[26]Ibid paras. 316-7 Reference to MOH Circular HM(65)104

[27]Ibid para.324-33

[28]Ibid paras.24-27

to give credence to XY's evidence "except where it was substantially refuted by other evidence".[29] Again this is markedly different from the Sans Everything inquiries where the prevailing attitude to most of the complainants seems to have unsympathetic.[30]

When the Ely Report was published, it was single incidents of ill-treatment which made banner headlines. Some of these were indeed horrifying and profoundly disquieting even to those members of the Lords who, three year's earlier, had greeted Lord Strabolgi's remarks in the Community Care with outraged disbelief. For example, one-seven year old boy, removed from the hospital by his parents, was discharged in clothes which were wet and covered in excrement.[31] His genitals and thighs 'raw and caked with faeces.' He had been kept on a ward for severely subnormal older men which was overcrowded, stinking and dotted about with patients in various states of undress. A second boy was discharged at his parents' insistence from a ward described by his mother thus:

> "Most of the children .... did not have a thing and (my son) never seemed to be without bruises and sores and cuts, which I was terribly upset about because of the filth that went with it."[32]

Whilst on the ward, the boy was sedated with the major tranquilliser chlorpromozine at six times the dosage he had been on at home.

In another case, an elderly man, visiting relatives had asked the duty-nurse to furnish his dentures to enable him to eat fruit they had brought, only for to her to emerge with a bowl of various unmarked sets, some of which belonged to dead patients, and proceed to fit them by trial and error into the old man's mouth.

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[29]ibid para.28

[30]See Chapter 4

[31]MOH, Cmnd 3975 op. cit. paras.147-9

[32]ibid para.153

Elsewhere, a complaint by the mother of a middle-aged subnormal patient that the hospital provided him with nothing to do was judged by the committee to be "symptomatic of the inactive monotony of the atmosphere which seemed to to us to characterize Ely".[33] Failure to provide patients with recreation or occupation is a recurrent theme in the critique of standards of care.

A crude authoritarian approach survived characterised by verbal abuse and rough handling. Furthermore, because of an inter-professional hierarchy inherited from the 'Poor Law Tradition', and the old asylum system of supreme authority vested in the senior doctor, there was no multi-professional management and the senior nursing staff were not accorded their proper authority or appropriate status. Combined with lack of attention to induction and in-service training and the amount of cleaning work undertaken by nurses, the nursing role was relegated and devalued. The outcome was poor standards of nursing care.[34]

Apart from specific criticisms levelled at clinical decisions, the committee judged the medical staff to be concerned almost exclusively with the patients physical health and ".... betrayed a low order of expertise..." as far as behaviour and training requirements were concerned.[35] Once more professional isolation was the root cause of narrow attitudes to treatment. The Physician Superintendent failed to perform his administrative duties in particular neglecting to inform the HMC of the conditions in his hospital.

It was in its indictment of channels of communication between the centre and the hospital service that the Report was most embarrassing to the Ministry since it consistently conflicted with the Minister's position over AEGIS' critique. For example, Robinson's circular, HM(65)104 arrived on the senior doctor's

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[33]Ibid paras.49-57

[34]Ibid pp.266-71

[35]Ibid para.386

desk, but he took no steps to ensure that the HMC saw it, leaving the HMC in ignorance of the Minister's policy.[36]

The committee's placed primary responsibility for the overall standards and facilities at Ely squarely on the shoulders of the Hospital Management Committee.[37]

Officers and members each looked to the other for initiatives so nothing happened. The HMC was often left in ignorance of ministerial guidance often .Specific instances of this included the failure of the Medical Staff Advisory Committee to inform the HMC of the contents of HM(65)104, and HM(64)45 its predecessor. HMCs were required to abide by each of these circulars. Neither of the senior nurses, male and female sides, submitted reports to the HMC.[38] HMC visits were totally inadequate as sources of reliable information and major deficiencies such as patient inactivity went unnoticed. Importantly, just as Barbara Robb contended elsewhere, the visits were crowded out by senior staff.[39]

Another acute embarrassment for the Ministry was the committee's findings on the victimisation of individual nurses at Ely which confirmed the Nursing Mirror's own survey. Two qualified nurses made well-intentioned complaints and were driven out of the hospital service as a consequence. It is a measure of the perpetrators lack of concern for subtlety that in one case this happened whilst the inquiry sat. Also, after the publication of Mrs Robb's book, the Permanent Secretary to the Ministry of Health had written direct to Group Secretaries to ensure that there were no such goings on in their hospitals. The senior medical and nursing staff at Ely met to discuss the subject late in October and decided that there were no grounds for disquiet on the grounds of 'undiscovered inhumanity' at Ely. In this context Nurse 'B'

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[36]Ibid para.389

[37]Cmnd 3975 paras.400-43

[38]Ibid paras.425-7

[39]Ibid paras.433-438

who was known to be a corroborating witness of 'XY' was dismissed.

More generally the report argued:

> "There must be all-round confidence that complaints which arise from within "the system" will be fairly handled. ...In the absence of this confidence the complainant may feel obliged - as XY did - to resort to the Press, whose important role as a "long stop"...cannot be denied."[40]

Thus, by inference, it not only substantiated the claims by AEGIS that existing complaints procedures were ineffective, it also contradicted the Minister's view that it was unnecessary and irresponsible to use the press to air grievances.

This was the committee's justification for proceeding beyond its brief which restricted findings to the hospital. In making recommendations for national policy reform, the Ely committee, again by inference, recognised the validity of the case previously promoted only by AEGIS (and to some extent the Patients' Association). The problems at Ely arose primarily because the staff and management committee were unaware of how far Ely had lagged behind accepted standards. In this context, the report observed:

> "It is plain that the Minister, with overall responsibility for the standards of service provided at Ely, as at other hospitals, cannot be satisfied with the persistence of such a gap between the standards allowed and those suggested and amplified in many circulars and instructions. It is equally plain that the gap is not bridged by the distribution of such circulars. Complaints from the patients or staff have not been effective to draw attention to deficiencies. And the hospitals "customers" are, of course, seldom free to provide an unconscious, but automatic, value judgement by

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[40]Ibid para.470 (d)

transferring their needs to another purveyor of hospital services. Standards of performance thus clearly need to be checked from time to time by somebody who is not responsible for day to day management of a hospital like Ely".[41]

It therefore concluded that there was a clear need for some system of inspection within the service to ensure that the responsible management was made aware of what needed to be done to bring standards up to ministerial targets. (The proposal advocated by Abel-Smith in Sans Everything.) The Ely committee proposed three options: the regional board, a body acting on behalf of the Minister or an independent inspectorate. It further suggested that the inspectorate could perform the investigatory function of the inquiry and also supported the hospital commissioner proposal.

This summary is of course drawn from the published report. It was published in full under the directive of Richard Crossman, who did not see it until the 10th of March 1969. Crossman had only two days to decide which of three available drafts to publish as his Department was scheduled to hand responsibility for health services in Wales to the Welsh Office on the 31st. The Regional Board had originally instructed the Ely committee to prepare a 'summary of findings and recommendations' alongside their report. However they had unanimously agreed [that] to recommend publication of their full 83,000 word document on the grounds that a 'summary' would not explain their reasoning and run the risk of unfair treatment of individuals. Howe began liaising with the RHB Chairman who it appears agreed to consider a slightly shortened version. The committee then took out 7000 words and submitted again only to have this rejected by the RHB Chairman on the grounds that it did not comply with his instructions.[42]

The members of the committee of inquiry then met with the Regional Board in December to try and resolve the disagreement, Howe taking

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[41]Ibid para.461

[42]Sir Geoffrey Howe's Memorandum op.cit.

along an amended 'summary' of conclusions and recommendations which, at 20,000 words was roughly twice the length of the published 'Friern Report'. This seems to have been a difficult meeting. Howe had included in the new draft reference to editorial pressure on those preparing the report. He and his committee made it clear that they were concerned to preserve public confidence in the integrity and independence of such inquiries. Their experience had persuaded them that there was a need for a review of procedure in such inquiries regardless of the particulars of the Ely case. They eventually agreed to the deletion of the reference to editorial pressure, substituting a compromise phrase. The committee then disbanded assuming that the three versions were submitted, and that the Secretary of State would publish in consultation with the RHB.[43]

However Geoffrey Howe did not leave it there. He immediately submitted a memorandum to the Policy Committee of the Bar Council which outlined his procedural dissatisfactions, gave an account of the Ely committee's negotiations with the RHB and went on to make some pertinent points. The committee felt that abbreviation had affected the balance of their report.

He drew the parallels with the Sans Everything inquiries referred to in the previous Chapter, and drew the following conclusions:

i) that the existing procedure failed to adequately assure the independence and integrity of Committees of Inquiry;

ii) that the public were also doubted this independence and integrity (doubtless a reference to the publicity fuelled by Barbara Robb);

iii) that his colleagues on the committee had been frequently impressed by the fact that some of their opposite numbers on the Sans Everything inquiries were regarded as

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[43]Ibid

having joined the 'white-washing wing of the Establishment'.

The submission of this Memorandum may well have been a discreet way of putting pressure on the DHSS and Crossman not to publish the shortened Report. Written by so significant a national figure, its contents would have filtered through legal channels to the Lord Chancellor's Office. There is no evidence that Howe intended to go public with his complaints. Indeed, he seems to have been motivated purely by a concern to reform future procedure. Nevertheless the potential threat was there for Crossman who could not read Geoffrey Howe's mind, assumed he was an ambitious politician and did not take any chances. The Secretary of State also knew that Barbara Robb, The News of the World, and the rest of Fleet Street were waiting in the wings.

In electing to publish the complete version Crossman shocked his Civil Servants:

> "If I published any less, Geoffrey Howe would be entitled to go on television and talk about suppression....I think I put the fear of God into them."[44]

Having read the Report he was convinced:

> "The report completely vindicated the News of the World story and I might as well make the best of it by outright publication. But I was also clear in my mind that I could only publish and survive politically if in the course of my statement I announced necessary changes in policy....[45]"

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[44]Crossman R.H.S., The Diaries of a Cabinet Minister, Volume Three, Secretary of State for Social Services, (London: Hamilton and Cape, 1977) p.408

[45]UWMRC Crossman Diaries CD 250 1970

Although it appeared that Crossman was making a rod for his own back, the decision makes sense in the circumstances and Crossman's personal style. He was a dynamic, high profile politician who mistrusted civil servants. Indeed he saw them as resistant to radical reforming initiatives. He was a journalist and both had an 'instinct to publish' and fully appreciated the pressure which the media coverage would create. He was a shrewd politician who respected Howe both as a lawyer and not least as a potential political adversary. Moreover he understood the dangers inherent in suppressing the full report with the risk that the truth would emerge and do him great damage as the Sans Everything affair had damaged his predecessor. He was committed to the cause advocated by the Ely Report and surrounded by colleagues who shared that commitment. Publication would create shock waves in the Department which he would use to carry through reforms in mental handicap, thus raising its political importance in health policy.

The publication of the Ely Report was a milestone on the road to the Priorities documents of the 1970s and a major impetus to changes in hospital complaints machinery. As he formulated his embryonic Post-Ely-Policy (PEP) Crossman was also acutely aware of the political ramifications. He decided fully to enlist the support of Geoffrey Howe. Crossman intended that he and Howe would appear on television together to discuss the Report and possible policy responses. However, Crossman records that Howe refused on the grounds that he wished to avoid any compromise of his committee's work. He was not concerned with political capital. He was purely motivated to illustrate the defects in the health service complaints machinery[46] and for this reason had widened the brief so that the reverberations would be felt in the Ministry. He was, of course, greatly relieved that Crossman was publishing in full and rather surprised. He agreed to involve himself in reforming measures in the wake of the Report.[47] Perhaps he also declined to be too closely associated with

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[46]UNWMRC Crossman Diaries 177/69/SW

[47]ibid

Crossman who was clearly intent on using the Ely Report to his own political advantage.

As the tidal wave of publicity flooded the DHSS, Barbara Robb kept a discreet low profile. Some commentators have concluded that AEGIS 'disappeared' at this time[48]; rather AEGIS withdrew from public arguments for three reasons. First, they had sensitised the press to conditions in long-stay hospitals, laid the foundations for the Ely inquiry, raised the issues which were its central concerns and at least indirectly influenced the inquiry's outcome. Mrs Robb's friends in Fleet Street were now fully capitalising on the Report as they would of those which followed it. After all they did have a score to settle with the Department.

Secondly, AEGIS 'disappeared' because Mrs Robb had put aside her public campaign in return for consultative status as an 'insider group'[49]. She now directed her energies to influencing the policy initiatives, set in train by AEGIS, in the Department of Health and then at Westminster. Thirdly, she could now leave the scandal-making to the Department of Health under Crossman and his successor. AEGIS was to go back onto the public offensive again in 1972. For the time being, Mrs Robb, upset and disturbed at the content of the Ely Report, could nonetheless derive satisfaction from the irony of the Department doing her 'dirty work' for her!

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[48]Jones, K. Ideas on Institutions, (London: Routledge, and Kegan Paul 1984) p.108

[49]See Chapter 3

CHAPTER SIX

THE END OF THE OSTRICH ERA

Crossman carefully stage-managed his presentation of the Ely Report to Parliament. He informed Cabinet on the 23rd of March.

> "They thought My God another Bloody scandal, but the only real interest to the PM was the fact that it was being announced on Thursday the day of the by-elections. It appalled him...he thought how was it possible that one could ruin the chances of people voting Labour by having all this terrible story blurted out on the six o'clock news...."[1]

Crossman countered that the Government would appear courageous in revealing the truth and taking firm action. Less confident, other Ministers were anxious to implicate the previous administration. So he checked the Ministry's record under Robinson and found improvements in the levels both of staffing and capital investment in mental handicap hospitals. He next organised pointed supplementary questions from the Labour benches for the debate. Thirdly he briefed Barbara Robb's close allies Yvonne Cross of the Nursing Mirror, and David Roxan of the News of the World, to whom he gave an exclusive interview[2] [3]. He also briefed both the

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[1]UWMRC Crossman Diaries, 178/69/sw

[2]UWMRC Crossman Diaries 160/69/SW Crossman refused to comment to other journalists who had picked up the scent.

[3]This interview took place on the train to Crossman's constituency in Coventry the day after the debate (Interview with Mr Roxan). Interestingly, Roxan's subsequent article stated that the Secretary of State would be proceeding with the Health Service Commissioner indicating that Crossman had been more definite with the journalist than with the House of Commons. News of the World 30.3.69

BMJ and The Lancet, in order to reassure the medical lobbies.[4] Having lastly put the RHB Chairmen on notice[5], he went to the House on the 27th March.

> "I felt a great gulp in my throat when I started because I think I really do care about this. I do feel righteous and indignant about it, and launched it out and read it and within 30 seconds I knew I'd gripped the House..."[6]

He summarised the main findings. At the broadest level, the existing procedures for dealing with complaints were inadequate and a system of hospital inspection was needed.[7]

Crossman gave a firm assurance that remedial action would be taken. This would include a survey of conditions in all long-stay hospitals, the establishment of a special working party to examine this evidence and its implications, and the creation of a "new system of regulation and inspection" independent of the Department and reporting directly to him.[8] Early discussions would also be held with the regional boards to begin redistributing of resources in favour of hospital services for the mentally subnormal.[9]

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[4] "...I had to carry them with me and say to them, this disclosure, this sensational report, this is something which is not going to break the morale of the service because the Minister is on your side, because we are going to keep the professions with us..." UWMRC Crossman Diaries 180/69/SW

[5] At the monthly meeting on the 18th March. UWMRC Crossman Diaries 159/69/SW

[6] UWMRC Crossman Diaries 183/69/SW

[7] House of Commons Official Report Vol. 780, cols.1810-1819

[8] Ibid.col 1809 and 1812

[9] Ibid col.1810

He received a favourable response from MPs on all sides. For the Opposition, Lord Balniel welcomed the new inspectorate, called for the publication of its reports, and clarification of its role in complaints procedures.[10] [11] Crossman replied that the new department for scrutiny would not handle complaints - a function which might have to be vested in a Health Service Commissioner. Although he would not be drawn on publication, he expressed the hope that the independence of the new service from the health service would overcome the fear of victimisation amongst nurses.

Putting the lid back on

Crossman stressed that the findings of the Ely inquiry applied only to one part of one hospital and were therefore no basis for general conclusions.[12] However, this was less than extravagant with the truth for he had plenty of evidence that the problems were not restricted to this hospital. Indeed, at the end of the debate, three MPs raised the spectre of events at South Ockendon Hospital[13] of which the Secretary of State was already fully aware. The two most disturbing aspects of this affair to date had been an assault on one patient the previous June and the death from injuries of another on February 22nd, 1969. The press picked up South Ockendon after the debate. The Times of the 29th March reported that Norman Atkinson was to ask for a full-scale inquiry into the death of patient Robert Robinson and quoted a

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[10]Ibid col 1810-11

[11] Mrs Robb's files do not indicate that she briefed opposition MPs for this debate, although of course Tory MPs were in regular contact with her.

[12]House of Commons Official Report, op.cit. col. 1808.

[13]Ibid cols.1815-1819. Arthur Lewis had put down a written question on the fatal incident (House of Commons Official Report, Vol.780 Written Answer Col. 16, 17.3.69) and had also written to him about it.

Departmental statement to the effect that Crossman was determined that there would no attempt to whitewash any hospital but was not contemplating a statutory inquiry at South Ockendon.[14]

Crossman had also been touring mental subnormality hospitals. In January he had visited Harperbury following criticism of the children's unit by Anne Shearer in The Guardian[15] and found gross overcrowding and staff shortages. In February 1969, the inquiry into the fire at Shelton Hospital had reported, and revealed grave shortcomings in fire precautions.[16] More widespread evidence came to Crossman's attention in March 1969. Pauline Morris had recently obtained her Ph.D which comprised an extensive, empirical study of half the country's subnormality hospitals. Though not published until the following September, it came to Crossman's notice early because Brian Abel-Smith had acted as her external examiner; her supervisor having been his close associate Prof. Peter Townsend.[17]

Morris' findings also supported Mrs Robb's contentions about the quality of management of these hospitals. The Ministry and the Regional Boards were remote. The HMCs were inactive, concerned only with finance, and effectively dominated by the Physician Superintendent, perpetuating the "tradition of personal autocracy established before 1948".[18] Members were spoon-fed all their

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[14]In May, the BMA lobbied the Chief Medical Officer over the Department's order that all admissions to South Ockendon be suspended: British Medical Journal 1969 Vol. 2, no. 5652, 3rd May 1969, Supplement p.69

[15]UWMRC Crossman Diaries 249/69 JH Crossman notes that Anne Shearer was reported to the Press Council over her article, presumably by the hospital authorities, however the complaint was not upheld giving rise to yet more unfavourable publicity.

[16]24 people had died in the fire and the event was front-page news in the press. See Appendix 3.

[17]Morris, P., Put Away, (London: Routledge, 1969)

[18]ibid p.214

information by the senior staff and only visited on a formal basis accompanied by their senior staff "minders". From the point of view of the staff on the ground, the central department was a very remote entity whose advice comprised abstract thinking with the semblance of a pipe dream.[19] Hence it was clear that the mere issuing of circulars, however well-intentioned, did not tackle the essential problems of hierarchy, lack of communication and autocratic decision-making.

Over the next few months the catalogue was to grow and maintain the pressure for reform. Firstly, in December 1968 the police had been called into Farleigh hospital to investigate serious allegations of ill-treatment. Following completion of the police investigations, Crossman set up a Committee of Inquiry into conditions at the hospital.[20]

The following August, he visited Monyhull, Coleshill and Chelmsley hospitals, close to his Coventry constituency, near Birmingham. The background to these visits was apparently leaked to the national press by prominent local Labour politicians who were also Members of the RHB. According to Eric Jacobs in the Sunday Times, the DHSS published a report on investigations into conditions at these hospitals by the RHB which had been edited to take out recommendations on accommodating the elderly at ground level to facilitate evacuation in case of fire, and the Board's estimates that nearly £300,000 would have to be spent to raise fire precautions to acceptable standards; over three times the amount

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[19]Reference to Ministry of Health(MOH), HM (65) 104 On Improving the Effectiveness of the Hospital Service for the Mentally Handicapped: ibid p.218

[20]UWMRC Crossman Diaries CD 74/69 entry for 4.9.69 The exact date that Crossman knew about Farleigh is unclear; this entry was precipitated by a lunch date with Lady Serota in which she told him that the officials had not made her aware of the report for some weeks after they had received it.

budgeted. The reporter also claimed that the full survey had revealed the hospitals to be endemically overcrowded (by up to 50%), unheated, underspent on food and with staff ratios that were even worse than at Ely. At Monyhull hospital there was severe overcrowding in an environment of bare, unplastered walls. In several wards at Coleshill, beds were so crammed as to be touching. At both Chelmsley and Coleshill "...the general atmosphere was very depressing. There appeared to be general apathy, and inertia amongst the higher grades of staff and there was virtually no leadership of any description."[21]

Crossman's Diaries confirm these reports. At Coleshill he found "appalling overcrowding" and at Chelmsley, " ghastly buildings, ghastly overcrowding...I have never seen overcrowding like it, beds absolutely jammed together...".[22] On the 7th of August, the day after his visit, he described the conditions to the press and promised a five-year programme of development at long-stay hospitals. In the meantime he would consider erecting prefabricated buildings to relieve overcrowding.[23]

Organising for Change

In the face of all this evidence, it is significant that the Secretary of State who had revealed all about Ely was anxious not to publicise the scale of the shortcomings throughout the longstay hospital sector. Yet, Crossman's guarded remarks to the House of Commons were perfectly comprehensible. The Ely Report provided sufficient ammunition to sustain internal pressure and browbeat officials and the regional boards as required. He could do without added scandals which risked worsening morale on the ground still further and certainly showed up the Government in a

[21]Sunday Times 13.7.69 Also Guardian 14.7.69

[22]UWMRC Crossman Diaries CD 2/69 Visits took place on 6.8.69

[23]The Times 7.8.69. In one ward designed for 36 he found 72 occupied beds.

disfavourable light at a time when it was trailing behind in the opinion polls.

Whether or not he could be criticised for his attitude to further revelations, Crossman could not have been accused of hesitating to reform the subnormality service radically. Furthermore, the case presented by Barbara Robb, who was now commanding respect at Ministerial level, confirmed by the Ely Report and by Put Away[24], demonstrated the need for effective action beyond the hospitals themselves.. Crossman wanted wholesale change effected by a high profile, sharply politicised approach and he was clear in his mind that his permanent officials were not up to the task:

> "You can't get thorough impartial analysis followed by a striking political statement out of civil servants, they can't write it. They can't do anything so polemical, so controversial, the whole instinct is to flatten things out...."[25]

Indeed, the civil servants were in a predicament. Their instincts would have been to respond in a way consistent with their approach prior to the Ely Report. For the previous three years, this had been characterised by defensiveness, public assertions through their Minister that there were no serious deficiencies in the long-stay hospital sector, that standards were monitored through visits by hospital management committees, that the complaints procedure was perfectly fair and adequate, and that anybody, such as Barbara Robb, who suggested the contrary was an irresponsible complainer. Squaring this with the reforms Crossman wanted would have overtaxed the most skilful drafter in the Department so that a degree of dilution would have been inevitable.

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[24]Morris, P., op. cit.

[25]UWMRC Crossman Diaries 70/SW/69

Furthermore, not only did Crossman mistrust his officials, he did not rate their competence. He compared them disfavourably to those at the Ministry of Housing and Local Government where he appears to have spent two years fighting to assert his policy against an obstructive Permanent Secretary.[26] He reports that he was unclear what the four thousand people in DHSS were doing apart from sending out endless streams of paper, circulars and other guidance which served, so he believed, only to choke the filing cabinets of the lower-tier authorities.[27] At one stage, Crossman wrote to his Permanent Secretary asking him if the hospital division was trying to frustrate his policy. He was informed that they felt excluded and reduced to relying on the press to learn of his intentions. In return, Crossman accepted that he was often difficult to approach, however he felt it was they who failed to communicate with him: "they don't hear what they don't want to hear and they try and get a Department view against mine."[28]

This kind of problems arose partly out of a fundamental difference between the perspective and operational policy of the new, and most recent administrations. Under Kenneth Robinson and Sir Arnold France the Ministry's primary role had been to <u>manage the NHS</u> by allowing the regional boards considerable discretion in policy. Following the debates of the early fifties about the future of the service, largely resolved by the Guillebaud Report, the continuation of the NHS had become part of the 'welfare consensus'. Now it was proven that there were serious faults in the system, Crossman judged that the political head, particularly a senior Cabinet Minister, had to "get hold" of and politicise the Centre thereby to become in his words "the first <u>Minister</u> of Health since Aneurin Bevan"(my emphasis).[29] It was an approach which his officials certainly found uncomfortable and probably resented.

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[26]UWMRC <u>Crossman Diaries</u> SW69/1-4

[27]UWMRC <u>Crossman Diaries</u> CD 92/69

[28]UWMRC <u>Crossman Diaries</u> SH/69/36

[29]UWMRC <u>Crossman Diaries</u> CD 1099 1969

This resentment could only be reinforced by Crossman's ill-disguised preference for the views of "outsiders". He had immediately brought in Brian Abel-Smith to advise on policy; a role Crossman described as partly a private secretary and partly a permanent secretary (emphasis added).[30] Moreover, Crossman's academic background made him predisposed to the 'objective' expert, and persuaded him that ideas could be synthesised from debate and discussion in seminar-like meetings which he liked to chair. Hence when embarking on a reforming campaign in subnormality, what better way for him to proceed than to set up a working party of expert outsiders, selected both to provide political balance and independent advice in fields of expertise which corresponded to the policy areas where action was required?

There were six components:

to improve conditions;

to change established spending patterns in the regions to ensure that improvements and development were sustained;

to change the conventional relationship between the centre and the regions;

to develop a coherent strategy for mental handicap;

to reverse the policy, established in the late fifties, of locating the responsibility for visiting and monitoring conditions in hospitals at local level by setting up a central agency to monitor conditions and proselytise good practice;

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[30] UWMRC Crossman Diaries SW/69/6

to reappraise complaints procedure, to produce a code of practice, tighten up the procedure for special inquiries, and introduce legislation to implement the Health Commissioner proposal.

The Post-Ely Policy Working Party (PEP) involved a number of people chosen to address these issues and also facilitate professional and party political support. Firstly there was the professional expertise and involvement; an administrative doctor, John Revans the Senior Administrative Medical Officer at Wessex RHB, an authority advanced in its thinking on mental handicap, who was also seconded to the Chief Medical Officer's department and impressed Crossman; a psychiatrist, John O'Gorman who had struck Crossman as dynamic and innovative on a visit to Borocourt, where Gorman was medical superintendent; and the senior nurse at the Maudesley Hospital, Eileen Skellern, who appears to have been Abel-Smith's recommendation. To tackle standards of care and the strategy, Pauline Morris and Prof. Townsend were invited in; Townsend brought both his academic kudos and his Labour Party connections. The party politics were balanced by Geoffrey Howe who came in to look at complaints and inquiry procedures. They were the core group of PEP, however Crossman also brought in Dr Alex Baker, a consultant psychiatrist at Banstead Hospital, and then seconded to the Department, and an architect, John Weeks who worked on design for temporary buildings to relieve overcrowding in the hospitals.[31]

Baroness Serota and Crossman himself gave the group its political leadership. Part of this function consisted of consulting the

[31]The only name on the list of which Barbara Robb fully approved was Geoffrey Howe. She was most unhappy to see Prof. Townsend involved as she believed him to be prejudiced against her and would therefore limit her influence on events. She and her immediate advisers were also doubtful whether professionals whom ran excellent hospitals would have insight into the function of the bad ones.

lobbyists both professional and otherwise. Crossman's style here was fairly informal. He would invite them to his office or to lunch, and brief them on his policy. The aim was to allay unwarranted anxieties, test opinion and, of course, identify opposition and measure its potential strength. His officials were given some tasks which PEP were also engaged on and provided secretarial support to the Working Party.

The elements of the Post Ely Policy divide into those aimed directly at improving standards and those which would bring indirect pressure to bear to ensure that improvement was sustained. The latter group, comprising the Hospital Advisory Service, and complaints procedure, directly involved AEGIS as a powerful, respected lobby. Work on these policies under Crossman is examined in the next chapter. For the time being, the concerns are standards of care, resource allocation, centre-periphery relations and the mental handicap strategy.

Interim Standards in Hospitals

The aim of this policy was to establish quantitative indices to serve as measures of the current position, objectives to be achieved and yardsticks for monitoring progress. Of course, this approach was not entirely novel; minimum standards were as old as the health service itself. These were first issued in 1948 and comprised qualitative indices of ward size, and dormitory and floor space.[32] The maximum ward size for mental hospitals was set at fifty, or 20 for "disturbed and excited" patients. In subnormality hospitals, the maximum ward size was set at 60. Moreover, subnormality hospitals were to avoid dormitories with two rows of beds or more. These crude indicators were supplemented in 1964 and 1965 with the two, 'On improving the effectiveness of hospitals' circulars.[33]

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[32]MOH, NHS Standards of Accommodation in Mental Hospitals and Mental Deficiency Institutions RHB(48)4 (London: MOH, 1948)

[33]See above p.66

Crossman's policy was new in its detail and comprehensiveness, its degree of realism and, not least, the ministerial determination to ensure that the lower-tier authorities made the necessary finance available.

Pauline Morris was the key adviser and Crossman first met her on the 25th of April, just prior to a meeting with RHB Chairmen to brief them more fully on the Post Ely Policy.[34] Morris handed him a list of suggestions including improved occupational therapy, and a service from GPs and paediatricians to the residents of subnormality hospitals. Administrative reforms included the recruitment of younger, more vigorous people onto HMCs, and the fostering of communication between the Committee and ward levels through increased visiting; open communication; changing attitudes within hospitals to the outside world would encourage voluntary help through Leagues and friends and relatives. The culture of custodial care would be eroded if staff were given in-service training, and encouraged to develop links with community-based professionals such as social workers. Lastly to combat institutionalisation, transfers form admission to long-stay wards should become a rarity whilst long-stay residents would be provided with active rehabilitation programmes.

These suggestions, together with others which had resource implications, were presented to the Chairmen on the 30th. Crossman asked them to investigate the spending on food, overcrowding, personal clothing, lockers, and nurse and domestic staffing levels in their own hospitals. He encountered some resistance, as Chairmen argued that the size of HMCs was limited and prohibited the inclusion of all interested parties; and of course, as far as conditions in hospitals were concerned, earmarked funding would be needed from the centre. Crossman reminded them of the Ely Report's comments on management. He remained firm that current patterns of spending would have to be

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[34]UWMRC Crossman Diaries CD 1141-42/1969

reviewed. Privately, he apparently took the view that he would have little chance of persuading Cabinet to provide additional funds so had no choice but to enforce a redistribution from acute hospitals.[35]

Some Chairmen protested that they were careful how they allocated revenue and besides, concentrating resources on existing hospitals reduced what was available to build new community services. They were supported in this by the Chief Medical Officer arguing that it was important not to lose sight of the main objective of changing the pattern of residential care. The Secretary of State seems to have got quite angry at this point and demanded to know how they, as the responsible authorities, could defend keeping the mentally handicapped in such poverty that they were even fed at a lower standard than anybody else.[36] There was no intention to change policy direction but it had to be recognised that there were large numbers of people for whom the hospitals constituted home; conditions, standards and the approach of staff had to reflect this reality.

It was finally agreed that the Department would issue a list of standards to be achieved in the interim as well as those to be met in the longer-term. Crossman accepted that they should have the status of guidelines and would therefore not be mandatory.[37] For their part the Chairmen agreed to report back by July on what action they thought feasible.

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[35]I owe this point to Prof. Abel-Smith.

[36]"...I had to impose my will on them and it was a fascinating meeting......there were 15 Chairmen and 16 members of the Department plus myself and Serota in the middle of the table and this formal confrontation."(emphasis added) UWMRC Crossman Diaries CD 1162 1969. Also the personal recollection of Prof. Abel-Smith.

[37]DHSS RHB Chairmen 3/69

The work on finalising the indices continued throughout the next six months. In June, the Department sent out returns which asked for specific information on overcrowding, day space, number of lockers available and the extent of personalised clothing, in both psychiatric hospitals and those for the mentally handicapped.[38] Thus the policy was widening. When Chairmen reported back at the July meeting, they accepted a standard for expenditure on food equal to the current cost per patient in mental illness hospitals.[39] However they pointed out the difficulty of recruiting sufficient staff due to the isolation of many institutions. The number of patients cared for by supervisory staff was linked to their remuneration. Increasing staff ratios would financially disadvantage them. Crossman argued that overcrowding and physical conditions in a hospital also hindered recruitment. The nursing division was working on a system of remuneration which broke away from bed numbers, to be incorporated into the next pay settlement. On the management side, the Department would be producing a paper with proposals to amalgamate psychiatric and subnormality hospital groups with general hospitals, and would be issuing guidance on the recruitment and training of volunteers.[40]

The final list of Interim Standards, which went out for discussion at the December meeting, was in three sections.[41] Better care and amenities for patients set specific levels of ward capacity, (to eliminate those housing more than fifty) day space per patient, medical, dentistry and chiropody staffing, and spending on food and kitchen staffing. It also required the provision of personalised clothing on a daily basis, the upgrading of poor standard wards to provide a domestic environment, and the

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[38]DHSS, DS Letter 6.6.69 (from Statistics and Research Division)

[39]Spending on food in mental subnormality hospitals was 24s compared with 29s in mental illness units and 34s in the acute sector.

[40]DHSS, Circular HM(69)58, 1969

[41]DHSS, RHB Chairmen 10/69

provision of adequate recreation, occupational therapy, education and training and social work support. Improved conditions and support for staff specified nurse patient ratios by dependency, the level of domestic staff also by dependency, and also covered, accommodation, inter-disciplinary working and staff training, to include nursing assistants, aimed at ensuring a permanent commitment to high standards of care. Voluntary Services confirmed the list of improvements the Chairmen already had.

The indices were based on the detailed returns on subnormality hospitals which RHBs had sent in July. These had confirmed Dr. Morris's own findings. Over 34,000 hospital residents had less than the required level of bed space; 22,500 had no personalised clothing; 18,000 had no cupboard space. The Department used standard costing information to estimate the total cost of reaching these standards at nearly £13 million capital and £11 million recurrent revenue. The Secretary of State expected the standards on food, kitchen and personal clothing to be achieved within two years and for a start to be made on domestic staffing and ward space the coming financial year. In order to help meet this cost, Crossman had found an additional £3 million in revenue to be earmarked for the coming financial year and distributed to reflect the number of beds per region. For their part, the Regional Boards would be asked to prepare detailed programmes to implement these standards and submit them to the Department no later than Mid-January 1970.

The only complaint raised by the Chairmen was about Crossman's timetable for their reports back. A subsequent letter to Regional Board Secretaries put this back to March but now included revenue and capital costing estimates. This letter also confirmed the success of Crossman's campaign in Cabinet by informing the Boards that a further £1 million in capital was to be earmarked on top of current allocations for 1970-71.[42]

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[42]DHSS, DS Letter 10.9.69

The last practical advice for the improvement of hospital conditions arose directly from Crossman's visit to Birmingham RHB and the appalling overcrowding he found at Chelmsley. In order to relieve this problem, he commissioned a design team headed by John Weeks to come up with a scheme for low-cost temporary ward units requiring the minimum of planning time. The recommendation in Week's Report "Buildings for Mentally Handicapped People" was a prefabricated building housing 30 patients at a cost of £25-30,000 and took only 20 weeks to erect.[43] A number of these units were built around the country including South Ockendon and Coleshill, where they are still known as the "Crossman Huts".

Priorities and Reallocation

The Department estimated that extending minimum standards to the psychiatric and geriatric sectors would have cost an extra £40 million in revenue alone.[44] Clearly then, although the centre could make very modest additional finance available, the Government were restraining public expenditure and therefore, the conventional discretion allowed to the regions in allocating money had to be challenged to achieve a sustained policy. Now although everyone was happy to see extra money coming in, Crossman was to encounter resistance to his attempt to shift only 1.25% from the rest of the service to the subnormality hospitals.

This began immediately the suggestion was put to senior officials in the Department. The Chief Medical Officer warned that as the money for long-stay hospitals would have to come from the acute sector, Crossman risked a confrontation with the medical lobbies. For their part the Regional Chairmen pointed out that in some parts of the country acute services were already underfunded and further reductions would be impossible. Moreover, they were keen to know how far the centrally-funded teaching hospitals had been

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[43]DHSS, DS Letter 8.5.70

[44]UWMRC Crossman Diaries JH 69/19

pressed to play their part in the programme.[45] Crossman was sympathetic to this last point. After all Boards of Governors received three times the per-patient capital allocation given to the regions, and teaching hospitals were one and half times as expensive to run as ordinary acute hospitals. Because of the sensitivity of powerful medical interests, this issue was left unaddressed until after NHS Reorganisation.[46]

It took four months to get the priorities policy accepted within the Department. The regional boards were even slower. At the meeting on April 30th 1969 they were asked to report back by the following July on the amount of money they could redistribute in favour of psychiatric and geriatric hospitals. The total for all regions was just £1.8 million, a figure dwarfed by the extent of the need and described by the Accountant General as "disappointing". Crossman then seems to have decided to leave these sectors and settle for establishing the precedent in the subnormality hospitals.[47]

By the December meeting, the Chairmen accepted that the finance needed fully to meet minimum standards in subnormality hospitals over and above the earmarked funds, would have to come from reallocation within existing budgets. It was to need further scandals and considerable effort by Crossman's successor to extend the policy throughout the long-stay hospital sector.[48] [49]

Relationship between the centre and the regions

Crossman's campaign to assert the political control of the centre over the NHS, of which the priorities policy was but one element,

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[45]DHSS, RHB Chairmen, Report of Pre-Meeting 2.6.69

[46]UWMRC Crossman Diaries CD 39-40/69

[47]UWMRC Crossman Diaries JH 69/19

[48]RHB Chairmen 10/69

[49]DS Letter 10.12.69

necessitated a more interventionist approach to the regions. This required reorganisation of the central department to establish a clear and identifiable chain of command and accountability. Crossman not only concluded that DHSS was a vast amorphous bureaucracy, he believed that the Regional Boards were "self-perpetuating oligarchies"[50] who had grown accustomed, under the previous Minister, to running things their own way.[51] His first encroachments into the power base of the Boards was to Chair the monthly meetings with RHB Chairmen at Alexander Fleming House, on a regular basis, and to establish periodic reviews of their performance on agreed objectives.

> "Here is a great floppy department, which is there in a vaguely advisory capacity, which is constantly issuing bumf...I am not just content to issue some bumf about subnormality, I am going to get out and see that the programme is actually carried out and I have done that conscientiously through monthly meetings with the RHB Chairmen....They used to see the Minister two or three times a year, now they know.....I am taking over direct personal responsibility of contact with them, teaching them the policy."[52]

At the first Post-Ely meeting on April 3rd, it had been agreed that the relationship, as the Secretary of State saw it, should be clarified formally. Hence Pink Circular HM(69)59 emphasised that the role of RHBs was as agents of the Secretary of State, directly responsible to him for administration and standards of care in hospitals. Moreover, during Crossman's Office, the nuance of

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[50]UWMRC Crossman Diaries CD 92/69

[51]interestingly, a view apparently shared by Barbara Robb's old adversary, the Chairmen of the North West Metropolitan RHB, Maurice Hackett (also George Brown's brother-in-law): UWMRC Crossman Diaries SW/69/132

[52]UWMRC Crossman Diaries SW 69/5

drafting in Ministerial guidance began to change from polite requests to firm expectations of action.

Establishing the precedent of a centrally-directed priorities policy was another important step forward. Yet Crossman feared that the situation would slip back once he left the Department, an eventuality which appeared likely given the Government's standing in the opinion polls throughout 1969. Therefore, his view that the regions were oligarchic was reflected in his proposals for NHS reoganisation which aimed to break up their power-base. The idea was to replace them with much smaller Regional Councils mainly limited to advisory functions and responsible to a Central Advisory Council. Some of the RHBs' functions would transfer to 90 new Area Health Authorities, coterminous with proposed new local authorities, and directly accountable to the Secretary of State for policy, priorities and efficiency. They would have effective authority for budgeting planning and running an integrated health service which included the teaching hospitals.[53]

The Regional Councils would comprise nominees from the AHAs, (including some professionals), and universities, and from the Secretary of State. They would retain some executive functions such as running the Blood Transfusion and Ambulance services, deploying medical and dental staff, organizing postgraduate teaching, and would be responsible for service planning of the hospital and other specialist services. Importantly, they were to have no direct authority over the Areas.[54]

The Central Department, reorganised into strengthened regional offices, would take over the remaining functions of the Regional Boards; including the planning, design and implementation of major building schemes within a national programme. The responsibility

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[53] DHSS Green Paper: National Health Service: The Future Structure of the NHS (London: HMSO,1970)

[54]Ibid Paras 83-89

for minor schemes including health centres would rest with the AHAs. The Secretary of State would be directly responsible for these functions and be advised in carrying them out by the Central Advisory Council with a membership from within and outside the professions.[55]

Much of the motivation and thinking behind this Green Paper originated in Crossman's frustrations with both the Department and the Boards as he pushed through his Post-Ely Policy. The proposals for the replacement of the RHBs by much weaker advisory councils and to locate the major management functions with authorities coterminous with local government aroused firm opposition from the medical profession. Doctors were thus both reiterating the profession's longstanding determination to avoid greater local government involvement in the NHS and voicing misgivings about the demise of the regional professional advisory committee structure; a source of professional influence.[56] Clearly Crossman, or more probably his Labour successor[57], would have had a battle on his hands to convert the Green Paper into legislation had not the defeat of the Labour Government in June confined its ideas for ending the reign of the Regions to the dusty shelves of the DHSS.

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[55]DHSS, NHS, The Future Structure of the National Health Service in England, (London: HMSO, 1969)

[56]Leading Article:British Medical Journal 1970 Vol. 1 no. 5693, 14th February 1970 p. 379

[57]Crossman signed up to become editor of the New Statesman in February 1970. At the time, Labour were trailing in the opinion polls, however, later in the year, when the party's prospects appeared more favourable, he remained resolved not to accept another Cabinet post and recommended to Wilson that Barbara Castle should succeed him at DHSS. UWMRC Crossman Diaries JH/69/3, CD/206/70

A Strategy for Mental Handicap

The development of community care had been central to policy for mental handicap since the consensus established by the recommendations of the Percy Commission in 1957.[58] Although reforms of the late fifties and early sixties had established a philosophy for service development, they did not constitute a coordinated strategy for the mentally disordered as a whole. Services were delivered by the NHS and by two separate departments within local authorities. The 1962 Hospital Plan had forecast a marginal increase in hospital beds for the mentally handicapped, which, it was stated, should be in units of no more than 200 beds.[59] Otherwise the care group was passed over as unsuitable for sharing the campus of the new-style district general hospitals. Within the NHS at least, the emphasis remained on separate provision.

The 1963 White Paper Health and Welfare[60] purported to give substance to the assumptions of developing community services within the Hospital Plan. It envisaged that these services would comprise, social work support, training, residential and day care, all to be provided by local authorities.[61] The document contained detailed listings of the ten-year plans submitted by local authorities. However, it conceded that without precise knowledge of the incidence of mental disorder "any estimate of the proportion of the population likely to need these services in the future must be extremely tentative".[62] These plans had been revised twice, most recently in 1966 under the previous Minister,

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[58]See Chapter 2

[59]National Health Service A Hospital Plan for England and Wales Cmnd 1604 (London: HMSO,1962) para.42 and Appendix B Col. 12.

[60]Minstry of Health, Health and Welfare. The Development of Community Care, Cmnd 1973, (London: HMSO, 1963)

[61]MOH, Health and Welfare: The Development of Community Care Cmnd 1973 (London: HMSO,1963) paras. 83-99

[62]ibid para 81

when a steady increase in service levels was reported, but the policy lacked focus.[63]

The only other central government initiative in mental handicap prior to Crossman's administration was the 1965 Circular[64], which gave advice on the location of hospitals within a future pattern of service for the mentally subnormal in the community. Although a step forward, there were no quantitative guidelines for staffing levels, or number of places per head of population of the kind included in its earlier equivalent on mental illness.[65] Then as the Post-Ely Policy developed, the Department published the Report of the Bonham-Carter Committee on the functions of the District General Hospital. Reversing the conclusions of the Hospital Plan this Report argued in favour of subnormality assessment wards on the DGH campus. This would be part of a three-tier system which included community care and the large hospitals. The earlier optimism about the demise of the large hospitals was beginning to give way to recognition that they would be required for some years to come.[66]

What was evidently lacking, therefore, was a coordinated and systematic plan for mental handicap, based on a considered philosophy which identified the likely extent of need, clarified the respective roles of the health service and local authority health and welfare departments which were soon to merged into social services departments, and set realistic objectives for the quantity and level of provision in each sector. As Townsend commented at the time:

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[63]MOH Health and Welfare The Development of Community Care:Cmnd 3022 (London: HMSO,1966)

[64]MOH, HM(65)104

[65]MOH, HM (64) 45

[66]DHSS Central Health Services Council The Functions of a District General Hospital Report of the Committee (London: HMSO, 1969)

"The Ministry's tentative excursion into planning in 1962 seems to have been regarded as too daring by Ministry officials and subsequent Ministers. When one hoped for intelligent development of the general ideas expressed in 1962....there was only an embarrassed silence."[67]

Crossman, advised by leading figures in empirical social administration, was seeking to reverse this tendency and produce a national plan, tailored to the needs of mentally handicapped people and their families, which carried the authority of a Government White Paper.[68]

Although Crossman did not wish to decelerate what was somewhat optimistically referred to as the "closure programme", a major element in the strategy was the recognition of the role of large hospitals for the conceivable future. He regarded proposals for a service based entirely in the community as futuristic. The establishment of the care group as a priority for spending was another central component. A third was an open presentation of the facts and political developments leading up to policy.[69] The omission of this appears to have been the main reason for his rejection of the Department's draft white paper and his decision to ask Abel-Smith to rewrite it.

"She doesn't even mention the Ely Report, it doesn't mention Pauline Morris Book, all the evidence about the scandals, the terrible things......She has not put it into the report. All flattened out so there is no crisis really. Just smooth civil service officials."[70]

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[67]Townsend P., New structures; a critical review; needs and leadership in the planning of the Mental Health Services. NAMH Report of the Annual Conference, (London: NAMH, 1969)

[68]UWMRC Crossman Diaries JH 64/70

[69]House of Commons Official Report Vol. 795 Written Answers Col.888-9

[70]The draft prepared by the head of the hospital division
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A fourth was to encourage the Regions to plan jointly with local authorities. At the time there were wide variations across the country with the regular joint discussions in the Manchester RHB at one end of the spectrum and no dialogue whatsoever in some areas at the other.[71] The final element was funding for research into alternative patterns of care whose findings would be built into the strategy. Firstly, Alex Baker and John Weeks were commissioned to weigh the relative advantages of putting the money into local authority building or relieving overcrowding in hospitals.[72] The second strand was the epidemiological work of Dr. Albert Kushlick, John Revan's colleague at Wessex RHB. Thirdly the Department set up pilot projects such as the development of alternative services to Powick hospital in Worcester, and the Sheffield Mental Health Service aimed at reassessing the division of responsibility between the hospital service and local authorities.[73]

Of course, the resulting white paper never appeared in Crossman's time. Abel-Smith presented the draft to Crossman just before Harold Wilson called the June election.[74] As he cleared his desk on the 19th of June, Crossman asked his officials to put the document before his successor.[75] He described it as "magnificent" suggesting that once he was gone, the officials

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UMWMRC Crossman Diaries CD 70/SW/53

[71]DHSS, RHB Chairmen 6/69

[72]UWMRC Crossman Diaries 70/SW/195

[73]UWMRC Crossman Diaries CD 59/69 Finance also went to the project to build up local mental illness services to replace Powick Hospital (still open 21 years later) and to build up mental handicap services in Sheffield.

[74]UWMRC Crossman Diaries JH 70-34 entry for 5.5.70

[75]UWMRC Crossman Diaries CD 1264 1970

succeeded in "flattening out" the draft of the White Paper published the following year.[76]

Crossman must have left office with a sense of enormous frustration at seeing so much work left at the pre-White-Paper or pre-legislative stages. Yet his was a most intellectually fruitful period of office which largely established the ideas which were to structure policy for the next fifteen years. As the procession of scandals continued unabated in the 1970s, minimum standards, priorities, care group strategies and, eventually, closer central supervision of the regions emerged as key issues in health policy.

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[76]DHSS Better Services for the Mentally Handicapped Cmnd 4683 (London: HMSO, 1971). The sections referring to the HAS, the priorities policy, interim standards and history service development to the White Paper all make no mention of the Ely Report.

CHAPTER SEVEN

SCRUTINEERS, COMPLAINANTS AND INVESTIGATORS

Crossman's administration was to be only partially successful in implementing measures to monitor standards and reform the complaints machinery, although the groundwork was laid for future developments. In these fields, AEGIS figured as one of the most important lobbies by maintaining external pressure, and feeding ideas directly into the centre of power as an 'insider' pressure group.

Crossman's Eyes and Ears

The 1957 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency resulted in the abolition of the Board of Control as an inspectorate. The debate had then pivoted on the ability or otherwise of the Minister and his agents to adopt a critical stance towards the standards of a service for which they were directly accountable. The Royal Commission had been confident both that there was no conflict of interest and, additionally, that this authority, as the controller of resource allocation, was the best agency for the job.[1] However, Crossman now had ample evidence that this confidence had been misplaced.

The Ely Report identified a "clear need" for a system of inspection to ensure that those responsible for management were aware of what was needed to bring a hospital up to the Ministerial minimum standards.[2] Together with Put Away, it had also demonstrated both that the distribution of circulars was no

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[1]House of Commons, The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1954-57, Cmnd 169 (London: HMSO, 1957) paras.37-42

[2]Ministry of Health (MOH), NHS Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and other Irregularities at Ely Hospital Cardiff: Cmnd 3975 (London: HMSO 1969) para.467

safeguard, and that HMCs were often poorly informed in mental health, visited rarely and, when they did, were frequently crowded out by senior hospital staff. Crossman was also clear in his own mind, that the objectivity of the Department had been called into question by its wrangling with the Ely Committee over the published version of its Report. This too was reinforced by his belief that the inquiries into Sans Everything had verged on a "whitewashing" exercise.[3]

The Diaries indicate that Crossman was convinced by the case for separating inspection, from management and accountability.

> "The key to the inspectorate in my mind is that it is an organisation completely separate from the policy-making, the administrative organisation of the Ministry.....it is an independent group of people inspecting and reporting directly to me......the only way we ever got anything working in the war, was to keep intelligence and inspection independent of policy."[4]

Opinion amongst his officials mirrored the debate in the Percy Commission; the medical division supported him and the administrators were vehemently opposed.[5] Once again he used the Ely Report as "an exposure of their failure" to "get the whip hand" over the internal opposition.[6] Uncharacteristically

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[3]A view possibly reinforced in a general sense by Abel-Smith as one of Mrs Robb's advisers, and by Geoffrey Howe whose criticisms of the procedure of those inquiries and account of the pressure brought to bear on their Chairmen, as they prepared reports, had been made known in legal circles.

[4]UWMRC Crossman Diaries 158/69/SW

[5]UWMRC Crossman Diaries 158/69/SW

[6]Although when Crossman was given his pre-prepared answers for questions prior to the Ely Debate, it appeared that the Administrators had not given up hope. "I noticed something interesting which was in the supplementaries on the nature of the new advisory service. It was said to be mostly in the regions, there was no mention of a director directly responsible to me. I rang up Brian Abel-Smith. And he said, very interesting, I was present at the meeting and (a senior official) said that in view of what you said to the regional hospital board Chairmen she said
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anxious to appear mindful of his officials' advice, he conceded the term inspectorate in favour of advisory service and also agreed to a two-tier system comprising a central service reporting directly to him and a similar one at regional level.

Otherwise, the new Hospital Advisory Service (HAS), was to function as a direct communication line between the hospital service and the Secretary of State or, as the catch phrase termed it, his "eyes and ears". Crossman was keen to play down the inspectorial function of the service, and emphasised its role in offering constructive criticism and the proselytisation of good practice. Importantly, and conflicting with what Crossman had told the House of Commons, the initial consultation proposals envisaged that as a safeguard against victimisation, a staff member with problems and complaints would bring them to the attention of a visiting team.[7]

When Crossman outlined the policy to the RHB Chairmen, they accepted the need for a centralised service to keep the Secretary of State informed, provided firstly that the reports were made available to them and secondly that they should not be published. This was agreed once the RHB Chairmen had given an undertaking to cooperate fully with advisory service visits.[8] For their part they saw no need for further local machinery and would rely on existing arrangements.

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that she thought your enthusiasm for a director responsible to you had waned and we could put the emphasis back in the regions where it belonged. Now this is the kind of way civil servants work. She still had hopes of getting a blunting at the edge of what I did. So I had her in at the briefing and said; There is some mistake here. Oh yes, she said, a little mistake. I must have got it wrongly phrased and I said; Well, let me assure you that when I answer the supplementaries on that the key point will be Directors responsible to me, as an independent service not mixed up with the administration either at regional or national level." UWMRC Crossman Diaries 179-180/69/SW

[7]DHSS, Paper 69/12 Proposals for a new National Health Service Advisory Service

[8]DHSS, RHB Chairmen 3/69

Having cleared the policy with the regions, Crossman then tested it out on the lobbies. Although they all supported the general thrust, most of them criticised the de-emphasis of inspection and the apparent inability to enforce recommendations. He began with the Joint Consultants Committee whose membership included the Chairmen of the Royal Colleges, whom he met on the 29th April. According to the Diaries, they came with the impression that the new service would be staffed by ill-qualified civil servants interfering in areas of professional practice.[9] The consultants argued that the new service should be completely independent of the DHSS, and that the Director should be a doctor with a minimum status equal to that of a deputy chief medical officer. They went away reassured firstly that the Secretary of State would fully consult the profession in formulating the policy[10] and secondly that staff would be seconded on a short-term basis directly from the NHS. Other medical opinion, also felt that Crossman's proposals did not go far enough.[11] The psychiatrists' body, the Royal Medico-Psychological Association, contended that in preference to an "information service" for the Secretary of State and RHBs, the function should be that of a pressure group to ensure that action was taken and therefore that standards improved.[12]

The RCN was concerned about victimisation. It held that when teams visited, any staff member should be free to raise matters of concern with them without any member of staff present. Nurses should also have direct access to the central authority, when the local complaints machinery failed to give satisfaction.[13] [14]

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[9]UWMRC Crossman Diaries CD 1153 1969

[10]Report of the Meeting of the Central Committee for Hospital Medical Services BMJ 1969 Vol. 2, 5th July 1969 Supplement 5.7.69 p.5

[11]The one exception was the Society of Clinical Psychiatrists, a body very secondary to the RPMA, who argued that the Board of Control had not guaranteed high standards in mental hospitals and that the function of inspection was best carried out by RHBs. Nursing Mirror Vol. 128 No. 25, 20th June 1969, pp.8-9

[12]Ibid

[13]This meeting had taken place on May 15th 1969. Nursing Standard July/August 1969

The National Association for Mental Health supported a still tougher policy in a paper by Russell Davies who had served on the Ely Committee. It advocated an inspectorate, whose independence was assured by separate administration through the Lord Chancellor's Office. It would also serve as a complaints channel to reflect the fact that conditions of work were often inseparable from the incidents giving rise to complaints.[15]

AEGIS was not directly consulted prior to the appointment of the first director of the HAS. However Mrs Robb made known her views in the national press, having first informally consulted Abel-Smith on the draft proposals. She feared that if the service was attached to the Secretary of State rather than to a hospital commissioner's office, its independence would be compromised. She was also appalled to learn that the reports would be unpublished yet fully available to the regional boards; thereby, in her view, removing any chance of the HAS preventing victimisation. She felt that "only a fool or an office seeker" would take the directorship, that the whole thing was a complete sell-out and she would so inform the Council on Tribunals.[16]

Abel-Smith seemingly did his best to allay her concerns. He countered that if attached to the Secretary of State, the HAS would be more effective in getting its views across. He felt that the HM Inspectorate of Schools was an exact analogy, in that its reports were not published. The HAS could make it known that it had submitted an unfavourable report and that the Minister had given an assurance that certain action would be taken. Thirdly the function of the service was to "prosecute" and not "decide": these should be kept separate and the latter was the legitimate

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[14]Andrews, J., Psychiatric nursing: Today and tomorrow, <u>Nursing Mirror</u>, Vol. 129, No.16, 17th October 1969, pp.19-20

[15]<u>Nursing Mirror</u> Vol. 128 no. 25 20th June 1969 pp. 8-9

[16]Robb,B.Note of a telephone conversation with B.Abel-Smith, 6.5.69 in <u>Robb Files</u> Sans E Vol.6A

concern for an ombudsman. The teams could then collect evidence on which they could decide whether referral to the ombudsman was appropriate. Fourthly, the HAS could proceed immediately to hospitals about where allegations had been made and directly brief Ministers. Its Director was to be expert in the functioning of hospitals; Russell Barton's name had even been suggested.

Barton's name did not appease Barbara Robb. She saw no reason why attachment to the ombudsman's office need give rise to delay. She did not accept that the schools inspectorates were analogous given that the Secretary of State for Education has a supervisory role with regard to local authority provided schools, whereas the Social Services Secretary was under statutory responsibility to provide the hospital service. She also stressed that in order to overcome the fear of victimisation, complainants initially required a confidential, informal channel to make their grievances known. Fourthly, she was aware that the Ministry already knew that conditions in many of its hospitals did it little credit. It would therefore be surprising if it did not have strong views on the extent of publication. This was an issue to be decided by an impartial body. Lastly, in her view, there was little chance of anyone of Barton's calibre accepting the post in such circumstances.[17] Her press article reiterated these points, however it was more conciliatory with regard to Crossman himself. Direct attachment was acceptable so long as he was in office, however, she feared the future under a "lesser man".[18]

The following October, Mrs Robb submitted a formal view to DHSS.[19] This was the outcome of two meetings convened by Mrs Robb to discuss her principal concerns at that time: the HAS, the health service commissioner proposal and South Ockendon. The

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[17]Ibid

[18]Robb.B., Detecting those sins of the Health Service <u>Daily Telegraph</u> 18.6.69
Mrs Robb had been invited to write this article by a senior reporter on the paper, Colin Welch

[19]The document was sent to Prof.Abel-Smith with a copy to Baroness Serota. Letter B.Robb to B.Abel-SMith in <u>Robb Files</u> Op.Cit.

first meeting was held over dinner on the 30th September, at Abel-Smith's house and comprised Mrs Robb, the Professor and Russell Barton. According to Mrs Robb's account, Prof Abel-Smith explained that it was too late to change course on plans for the HAS, although Crossman was looking at the possibility of keeping certain confidential information from the Regional Boards. Abel-Smith also reported that the administration had run up against "obstacles" in developing a policy to protect nurse complainants from victimisation, and that there had not been enough suitable applicants for the director's job, which partly confirmed Mrs Robb's expectations. She then advised that the HAS teams should restrict their investigations to general conditions, and leave the investigation of complaints to teams attached to a health service commissioner.[20]

The theme of the complaints procedure was the major item of discussion at the second meeting on October 7th this time held over lunch at the Royal Society of Medicine; the participants on this occasion being, Mrs Robb, Dr.Barton and Dr.Whitehead.[21] The major recommendation to emerge was in the area of terms of organisation and relevant expertise. The teams should comprise practising professionals and administrators served by a small core of full-time staff; they would thus have clear ideas about what could replace malpractice and malfunctioning administration. This proposal had been put to the Department by Dr. Barton and Mrs Robb. Finally, they agreed that whatever happened it was essential, in order to keep up the pressure for reform, that the series of scandals should be continued.[22]

The discussion at these meetings was sythesised into a brief document which Barbara Robb forwarded to Baroness Serota on the 14th of October.[23] AEGIS had concluded that the proposed attachment of the service to the Secretary of State rendered it most unsuitable for the reception of complaints and believed that

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[20]Note of this meeting in Robb Files Sans E.Vol 6A
[21]Transcript of this meeting in Robb Files Op.Cit.
[22]ibid
[23]Mrs Robb's favourite pseudonymous reference to Abel-Smith

this would be remedied by dividing the advisory service into two sections:

> (1) An "advisory section" existing to help hospitals with their problems...Apart from very exceptional circumstances it would act with the approval of the hospital authorities concerned and often we would hope by their invitation. When desirable it would stay to support a hospital in its attempts to introduce improvements.
>
> (2) An "inquiry section" which would, on request, obtain information from within a hospital for either the "advisory Section" or for the Commissioner and his representatives....

Each section would have a semi-permanent nucleus of staff engaged for two to three years assisted by others brought in for special circumstances. Complaints would be dealt with by the Commissioner.[24] [25] [26]

As AEGIS continued lobbying and feeding ideas into the Department at the highest level, Crossman proceeded with his plans. Having tried unsuccessfully to persuade John Revans to accept the director's post, he eventually appointed Dr. Alex Baker.[27] [28] As AEGIS had recommended, the other members of the service would

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[24]AEGIS, the Hospital Advisory Service, and the Hospital Commissioner, Robb Files, Sans E Vol.9

[25]Mrs Robb received a prompt reply to her letter form the Minister of State thanking her for her proposals and assuring her that the Department were searching for a solution to the problem of victimisation. Letter B.Serota to B.Robb 24.10.69 in Robb Files in Sans E Vol.9

[26]The same document was also sent to the Secretary of the Council on Tribunals who duly promised to circulate it amongst members particularly interested in NHS matters. Letter B.Robb to A.MacDonald 14.10.69 and his reply 15.10.69 in Robb Files Sans E Vol. 6A

[27]UWMRC Crossman Diaries CD 76/69 and SW/69/46

[28]Dr Baker's connection with Banstead, a hospital featured in Sans Everything, did little to assuage Mrs Robb's anxieties about the HAS.

be recruited from NHS working professionals and it was not to serve as a complaints mechanism for patients. Inquiries were to be discreet and private. The teams would initially concentrate on long-stay and mental subnormality hospitals. However, disappointingly for Mrs Robb, the service was still intended at this stage to serve as the channel for nurses to raise their own grievances.[29]

In the weeks leading up to this announcement, Crossman had developed increasing awareness of and respect for Barbara Robb as a lobbyist. In so doing, he recorded that he was following Lady Serota's lead, who had also been liaising directly with Mrs. Robb about her evidence on events at South Ockendon.[30] As the press carried the announcement of Dr.Baker's appointment, Crossman invited him and Mrs Robb to lunch at the House of Lords on the 12th of November.[31] At first Mrs Robb, by now convinced that the new service would be ineffective, felt disinclined to meet its Director. She changed her mind, for reasons explained in her account:

> "But I now heard that (consequent of my letter of 14th October) he (Dr.Baker) would not after all be receiving any complaints (David Roxan of the News of the World, told me that Dr.Baker was pleased with me for getting him off the hook)."[32]

Hence she accepted the invitation for the 12th of November.[33] According to Mrs.Robb's account of this luncheon, she hardly spoke to Crossman and spent most of the time in conversation with Alex

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[29] The Times 16.11.69 It was also reported that Dr.Baker had signed a three-year contract on £7,500 per year.

[30] UWMRC Crossman Diaries JH/69/39

[31] Mrs Robb had already accepted an invitation from Lady Serota to be her guest at the mental health debate to take place on that afternoon.

[32] Note in Robb Files Sans E Vol.6A. Mrs Robb does not disclose her source for this information, however, when the details of the HAS were formally published, there had indeed been a change in the original intention.

[33] Ibid

Baker. He tried unsuccessfully to persuade her to reveal the names of the hospitals about which AEGIS had complaints so that he "would know where to start". Mrs. Robb could not make this information available. Anxious not to criticise the service directly on this polite occasion she explained that she always respected the confidentiality of her informants, and besides she felt that there was no reason to suppose that those against which she had had complaints were any worse than others. She had known nothing about Farleigh, for example, prior to the story breaking in the press. Dr.Baker seemingly accepted this and spoke of his plans for the HAS. Mrs Robb congratulated him on his work so far and proceeded to give him some advice:

> "I said I was sure he realised how important it is that however painstaking the preparations, theory should always give way to experience wherever that shows it to have been wrong. The HAS is pioneering. It can't hope to get all its planning right from the very start. As I see it, whether it sinks or swims will largely depend on its ability to make adjustments in its plans wherever practice is proving this to be necessary."[34]

Crossman's account of this meeting is somewhat more colourful:

> "Mrs Robb...has always been a terrible danger to us because Kenneth Robinson mishandled her....Kenneth Robinson set up some .... committees of investigation into her charges, and then published the White Paper as a non-controversial document which was supposed to answer Mrs Robb and it didn't. And it left a very dirty impression. Since then she has become a kind of clearing house for all complaints about cruelty and torture in the hospitals and she is always collecting ammunition for an attack on us. And I knew I must try and defuse this time bomb. There is no doubt what we have been doing has helped. This setting up of an advisory service, the Ely Report....But this lunch was partly

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[34]Report in <u>Robb Files</u> Sans E Vol 6A

important because there I got her to meet Alex Baker and to meet me....She was gratified at seeing us and then she spent a whole day in the House of Lords hearing...the debate on ... mental health and I think we have taken some of the danger out of Mrs Robb by that meeting."[35]

Certainly, AEGIS and Mrs Robb had come along way politically in only four years.[36] Indeed, when details of the plan of operation of the HAS were published in March 1970, it was clear that some AEGIS ideas had found favour. Teams comprising a consultant, a senior nurse, a ward sister, an administrator and social worker would be drawn from staff on secondment for periods of <u>one or two years</u>. The service would not investigate complaints but would advise on deficiencies of management, organisation, and resources that gave rise to them. Any member of staff wishing to see teams in private could do so, if necessary away from the hospital. Emergency teams would also be formed for urgent visits.

At first, the HAS's programme was restricted to longstay hospitals. Teams would consider how far a given hospital conformed to norms or minimum standards and other national policies, and in so doing be as much concerned with human relations as physical conditions. The Director would report to the Secretary of State and produce an annual report for publication.[37] Crossman's policy was that the submission of the report would be high profile Ministerial concern; the Secretary of State or his deputy, meeting with the RHB Chairman involved to discuss the report and reach agreement on action to follow from it[38]; another policy imposed against the advice of officials.[39] Interestingly, and confirming Mrs Robb's fears, almost immediately

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[35]Diaries JH/69/39.

[36]See also Appendix 2 on the second meeting between Barbara Robb and Crossman

[37]DHSS, Circular HM(70)17, <u>National Health Service Advisory Service: Initial Plan of Operation</u>, March 1970

[38]Letter H.M.Hedley to Sir Desmond Bonham-Carter 16.3.70 SWTRHA Archives

[39]"The hospital division wanted to send the recommendations out individually to the RHBs for comment. Crossman wanted "direct confrontation" between the top , the RHB chairman and the SAMO.

on taking office, Keith Joseph delegated this to senior officials in the department; although Boards were still required to send in reports on action within three months of the meeting in the Department.[40]

Handling Hospital Complaints

The Ely Report had listed four criteria for a satisfactory complaints procedure: fairness and promptitude; the identification of deficiencies of organisation and in individuals; confidence of staff; and absence of victimisation. The report felt that the existing system denied the likelihood of an organisation resisting complaints made against it.[41] The object of this critique was HM(66)15 which had prescribed a hierarchy of procedures working up to regional level and left the hospital authorities and Regional Boards to ensure that this was effectively administered.[42]

The lack of preventive measures against victimisation was a principal concern for AEGIS. Crossman's Diaries indicate he was of a similar mind. There was also other external pressure for reform in this area, in which Mrs Robb had had a hand.

In April 1969, the Council on Tribunals published its Annual Report for 1968 including criticism of the previous Minister for failing to use section 70 of the 1948 NHS Act as the mechanism for establishing the Sans Everything Inquiries: thereby taking them out of the Council's jurisdiction.[43] The Report also called for radical improvements in the machinery for investigating complaints against hospitals and medical professionals, arguing that any investigation conducted within an organisation could not be satisfactory unless it was "clearly seen to bring an independent mind to bear on the matter."[44] As things stood,

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[40]DS Letter 24.7.70
[41]NHS:Cmnd 3975, Paras. 469-470
[42]see above pp.
[43]Council on Tribunals, Annual Report for 1968 (London: HMSO, 1969) paras.48-52. Also see chapter 4.
Continued on following page

those complained against were backed by a competent, closely knit organisation, with "a strong sense of solidarity".[45] Recommendations for change included standard rules of procedure and assistance to applicants to prepare their cases.[46] The Council also asked the DHSS to bring these comments to the attention of the Working Party[47] engaged on drawing up a complaints procedure and it was assured that this would be done.[48]

Medical opinion disliked these proposals, as the BMJ explained:

> "...certainly independence is an essential feature of natural justice, but the Council on Tribunals seems to have missed the point of investigations within a service like the NHS. No member of the public is deprived of his rights by the present regulations. If he is dissatisfied by the investigation of his complaint he can still sue his doctor or the hospital in the civil courts, and he can also complain to the General Medical Council. The medical profession has a long tradition of strict surveillance of the professional standards of its members."[49]

Evidence available to the NAMH did not support this confidence. A paper by Russell Davis, which was sent in to Crossman, reported a constant stream of letters from patients and relatives complaining of neglect or lack of consideration in particular hospitals at a rate which had increased since the publication of Sans Everything.[50] That nursing staff needed better protection was accepted throughout the profession.

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[44] ibid para.38
[45] Ibid para 38
[46] Ibid paras.43-46
[47] PEP and thus, Geoffrey Howe
[48] Council on Tribunals, Annual Report for 1969, para.17
[49] Editorial BMJ 1969 Vol. 3 no. 5661 p.3 and Supplement p.2
[50] Nursing Mirror Vol. 128 no. 25, 20th June 1969 pp.8-9

Crossman assigned the task of drawing up a more satisfactory procedure to one of his senior officials. PEP was not happy with the first draft submitted in July:

> "Just the kind of routine stuff departments put forward. Howe thought it was so frightful he was thinking of resigning".[51]

The official was sent off to think again and reported back in October recommending the setting up of working party to re-draft this. Crossman overruled this suggestion and decided to submit the second document for consultation with a view to introducing a procedure as soon as possible.[52] This second effort was largely based on a report published by the Scottish Office the previous July.[53] Its components were similar to those of HM(66)15 but included the provision of information booklets on procedures for relatives and patients.[54]

When Crossman made it known that the ideas in the report were contained in the document he too was consulting on[55], the BMJ marginally shifted its position. Although it accepted the need for some provision, it dismissed the proposals as a "bureaucratic edifice" and "..little more than a placebo for the public and a source of irritation and anxiety to doctors and nurses in the hospital service".[56]

The document went out on limited circulation in January 1970.[57] It stressed that many complainants had little confidence in the

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[51]Diaries CD 697 1969
[52]Diaries SW/69/81
[53]Disclosed by Crossman the following February, House of Commons Official Report Vol.796, Written Answers Col.24
[54]Scottish Home and Health Department, Report of the Working Party on Suggestions and Complaints in Hospitals (Edinburgh: HMSO, 1969
[55]House of Commons Official Report Vol. 796, Written Answers, Col.24
[56]BMJ 1970 Vol. 1 No. 5693 pp.380-1
[57]RHB 70/3

ability of hospital management to take an impartial view of a complaint, and that this "crisis of confidence" was the motivation for a more uniform and better publicised machinery.[58] For the first time, it was announced that a Code of Practice was to be drawn up which would include the main principles in the memorandum now being issued as an interim measure.[59]

Unfortunately, the recommendations which followed were hardly commensurate or even consistent with this laudable analysis of the problem area. The major responsibility for the initial investigation was to remain with hospital authorities through a Member designated as "Adviser". This "adviser" would see copies of all complaints received, offer advice on procedure and participate in investigating any requiring special attention. He would ensure that answers given to complainants dealt adequately with all the points raised and that serious complaints were made known to the Chairman.[60] The document then constructed the by-now familiar hierarchy of channels through which a complainant would proceed; from ward sister, to Group Secretary, to the adviser, thence to the "higher authority"; envisaged as the Regional Board or the Department at least until such time as a health service commissioner was appointed.[61]

It conceded that the fear of victimisation should not be underestimated, but effectively denied such fears were real and rational and asserted that the widespread belief that hospital staff closed ranks against criticism was unfounded (emphasis added).[62] Hence, it followed that any member of the nursing staff wishing to complain could confidently approach his direct superior, or, if nervous of this, a nurse manager. This complacent document finally performed a complete volte-face by addressing itself to possible cases of victimisation when a staff member might approach the HAS. However, in such cases, it was to

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[58]Ibid para. 4
[59]Ibid para.4
[60]Ibid para.8-14
[61]Ibid paras.19-22
[62]Ibid para.23

be made clear that nothing could be done if the complainant insisted on anonymity; the involvement of the HAS was assumed to act as a safeguard against possible victimisation. Otherwise the principles of HM(66)15 were to apply.

There was very little in this document which would have given comfort to Barbara Robb and it is therefore, perhaps understandable that the Department refused to send her a copy.[63] She therefore relied on a detailed summary published by Chapman Pincher, in the Daily Express, to whom a copy had evidently been leaked, in preparing her comments for the Department.[64] Although welcoming the recognition of the present "crisis of confidence" AEGIS politely dismissed the interim guidance pointing out that in those hospitals where complaints were badly handled, the mere existence of an officer designated to deal with them would not encourage staff who were fearful of victimisation. A solution to this problem lay outside the sphere of the hospital authorities.[65]

Apart from the odd logistical suggestion, and some cosmetic drafting which paid lip-service to the findings and recommendations of the Ely Report, the memorandum was largely a repetition of existing Departmental guidance and machinery. As an answer to critics of the existing system, therefore, it was hardly adequate.

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[63]Mrs Robb approached Abel-Smith and was told that the paper was confidential. However she did learn that it was interim guidance in advance of the preparation of a Code of Practice. Abel-Smith also informed her that the Secretary to the Council on Tribunals had had a hand in its preparation. Robb Files: Letter B.Abel-Smith to Barbara Robb 13.3.70. in Sans E Vol.5

[64]Daily Express 31.1.70

[65]Aegis's comments on the Secretary of State's proposed Guidance on Principles and and Code of Practice for Hearing Complaints". Robb Files Sans E Vol.6A

The Conduct of Special Inquiries

The Ely Committee and its Chairman had gone on record with a number of criticisms of the procedure they been obliged to adopt in conducting their inquiry. These were the denial to the Chairman of the services of a solicitor, and the practice of the health authority or the Ministry to edit a Committee's report - thus calling into question the independence and integrity of the Committee and thereby eroding public confidence in its findings.

Other criticisms now before the Department included those from the Council on Tribunals, and Mrs Robb's own catalogue of dissatisfactions with the Sans Everything inquiries. Added to this was the transparent unfairness of hospital authorities employing lawyers from public funds, whilst complainants were obliged to meet their own legal fees. As the Royal Commission on Tribunals of Inquiry had said:

> "It is a great hardship that a witness should be left to bear the very heavy expenses often incurred in being legally represented before the Tribunal. After all, the inquiry is in the public interest, the witness is the Tribunal's witness, it is usually just that the witness should be represented, and his solicitor or counsel are assisting the inquiry at arriving at the truth. It is manifestly unfair that such a witness should be left to face what in a long inquiry is sometimes a crippling bill of costs."[66]

Crossman's decision to publish the complete Ely Report arose, in part from his preference, as a journalist, for full disclosure following a high profile event such as an inquiry. Secondly, the very fact that he asked Howe to assist in developing a better alternative is also evidence that he was impressed by some of the other criticisms.

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[66]House of Commons, Report of the Royal Commission on Tribunals of Inquiry, Cmnd 3121, (London: HMSO, 1966) para.60.

Support for a more formal, legalistic approach to the investigation of serious complaints was also voiced by the Chairman of the Welsh Regional Hospital Board in a memorandum which was widely circulated. This document listed a number of dissatisfactions with inquiries at HMC level. Firstly, they lacked thoroughness. Secondly, the Committee of Inquiry often failed to follow up allegations made at the hearing during the course of the inquiry. Thirdly, and perhaps most disturbingly, the findings conveyed to the RHB did not always reflect the transcript of the evidence. The document then made a number of recommendations. All complaints should go directly to the RHB as the procedure under HM (66)15 gave too much discretion to the HMC and Group Secretary to decide what constituted a serious complaint. Investigating committees were currently crammed with representatives of all major departments and would operate more effectively if restricted to three, one of whom should be a lawyer who could bring an impartial mind to bear and avoid the criticism that findings favourable to a hospital were a "whitewash". This committee should not be specially convened to consider a particular complaint but should be more or less a permanent standing committee. The final representation related to the standard of proof, which, as has been shown, was a point of controversy in some of the _Sans Everything_ Committees. The document recommended that a strict requirement to prove allegations should be applied _only_ in cases where complaints, if established, would lead to disciplinary proceedings. In all other cases, complaints were to be accepted on the balance of probability.[67]

Despite all this pressure the Department once again succeeded in passing a document which made only cosmetic proposals.[68]

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[67]_Investigation of Complaints_ memorandum by the Chairman of the Welsh Regional Hospital Board, June 1969

[68]The status of this document is somewhat ambiguous. It was evidently intended both to give guidance, and stimulate discussion to inform the drafting of the code of practice. It was therefore not a consultation document as such. Indeed, the only follow-up arising from it was a brief Dear Secretary Letter issued in June. Continued on following page

Firstly, the procedure in HM(66)15 was largely unchanged. Committees of inquiry into serious allegations would remain at Regional Board level and comprise "authoritative persons" not themselves members of the Board, under an independent chairman. Decisions on procedure would be matters of chairman's discretion. Included in this was the granting of rights to be represented. It claimed that informality, rather than a more legalistic approach, was "suited" to hospital inquiries and that Section 70 inquires would only be invoked "exceptionally", when powers of subpoena were needed. Finally, it was stated that guidance on matters such as witnesses' expenses and participants' legal costs would be given in the code of practice, "in due course".[69]

This document and the memorandum on handling hospital complaints have all the marks of drafts by Ministry officials struggling to maintain the appearance of consistency in policy. It is therefore curious that the Secretary of State allowed them to go out. Perhaps this was merely a political expedient which, although unsatisfactory would at least diffuse the mounting pressure on the administration to be seen to be doing something. Alternatively, Crossman himself may not have taken a keen direct interest in either document. As they contain only two references to the code of practice, and none to the procedure of inquiries, his Diaries would support the latter explanation. However, it was significant, that having decided that the misdemeanors committed by individual nurses at Farleigh warranted a inquiry into conditions throughout the hospital, Crossman was not prepared to put his trust in the much vaunted existing procedure, and invoked Section 70 of the NHS Act - a decision which met all the criticisms. Other committees of inquiry were to become increasingly formal. For the time being, however, those amongst Departmental officials whom Mrs. Robb called the "ostriches with

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This letter once more endorsed HM (66) 15, adding only a request that charge nurses should familiarise themselves with the circular and that booklets be made available to patients and relatives giving details of persons to whom written complaints should be addresses. DS Letter RHB Secretaries 70/23, June 1970.

[69]A familiar civil servants term to convey lack of urgency.

their heads buried deep in the sand"[70] had won a temporary victory.

A Health Service Commissioner

The Ely Report added its voice to the established campaign to secure this office originally launched by Abel-Smith in Sans Everything. [71] The Professor had informally secured Barbara Robb's agreement that she should lie low for a period in exchange for assurances that an effective health commissioner would be established and that the Sans Everything Inquiry Reports would be reviewed. The Secretary of State told David Roxan in March 1969 that the Government would be proceeding to legislation on it.[72] The Minister of State for Health was a strong supporter.[73] Indeed, the Prime Minister himself was enthusiastic[74] and told Mrs Robb's principal ally in Parliament in July that Health Ministers were ironing out the remaining problems prior to going ahead.[75] Now the likely form of this office had been apparent for some time. Firstly the Parliamentary Commissioner for Administration (PCA) had been appointed in 1967 to deal with complaints against central government departments. A complaint was handled only if referred through a member of Parliament or "MP filter". Evidently, on the evidence of the Department's documents on complaints procedure, a parallel role was envisaged for a health ombudsman who would not intervene unless the complainant had failed to gain satisfactory redress through other channels.

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[70]Robb B., Detecting those sins of the health service. Daily Telegraph June 13 1969
[71]Cmnd 3975 para.480
[72]News of the World 30.3.69
[73]Interview with Lady Serota. She was of course subsequently appointed Commissioner for Local Government.
[74]Crossman warned Wilson that he could not expect to appoint an ombudsman for the NHS without running up against medical and nursing opinion and therefore advised the PM to reserve his position. However Wilson saw it as part of the Government's preparation for the Election. UWMRC Crossman Diaries CD 673 1969
[75]Reply to Ben Whittaker MP for Hampstead, House of Commons Official Report Vol.787, Written Answers 22.6.69

Of course, one of the primary functions anticipated for the office by AEGIS was to prevent victimisation by providing a confidential channel for complaints for staff and patients alike. This was the major theme of a document which Barbara Robb had forwarded to Baroness Serota in October 1969.[76] It argued the case for the ombudsman to handle all complaints which the complainants preferred to be heard independently of the hospital concerned. To render the Office readily accessible, the central office would need regional representatives. These posts required individuals who could be trusted implicitly to respect confidence amongst nursing staff. This trust would not be forthcoming at first but would develop provided experience demonstrated that cases were dealt with impartially, and without undue formality. In the case of numerous less serious complaints against the same hospital, the Commissioner should have discretion to institute a general inquiry if judged advisable.

In his announcement to the Commons in July, Harold Wilson had disclosed that the final form of the new office would be so devised as to complement the functions of the HAS, protect the clinical freedom of doctors and fit in with the future structure of the health service. Hence, the Government waited until the beginning of March 1970, when the full reorganisation proposals were ready, before going out to consultation on the health service commissioner.[77]

This time AEGIS received a copy of the consultation document and an invitation to comment.[78] As expected, it was intended that the great majority of complaints in the hospital service would continue to be dealt with by the responsible hospital authority. The Commissioner would be there as an independent person to whom a complaint of maladministration could be taken if - and only if -

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[76]AEGIS, The Hospital Advisory Service and the Hospital Commissioner Robb Files: Sans E Vol.9
[77]NHS The Future Structure of the National Health Service: DHSS 1970 paras 95-98
[78]DHSS Proposals for a Health Commissioner Enclosure with DS Letter 26.2.70

satisfaction had no been obtained from the health authority itself. This "filter" would, it was argued, both recognise the the authority's responsibility for dealing with complaints as an integral function of management, and avoid grievances going to the Commissioner unnecessarily. As with the Parliamentary Commissioner, complainants with the right of appeal to a tribunal or remedy through the courts would not be eligible except in circumstances where it was unreasonable to expect the complainant to have resorted to it.

Again echoing the terms of reference of the PCA, investigations would be conducted into allegations that maladministration had caused hardship or injustice" to those using the NHS[79]: this function would be widely interpreted, but generalised complaints about alleged deficiencies would not be included. The Commissioner would work mainly through correspondence and interview, but would be given the power to arrange hearings and compel anyone with evidence to attend. Findings would be presented as reports to the complainant and the authority which would be published on the Commissioner's discretion.[80] Complainants would be patients, or individuals such as staff, relatives and friends acting on their behalf.

It was also proposed that the Commissioner should review some aspects of the work of doctors, not their clinical judgement as such but "....in so far as it was necessary for him to form a view on whether the professional person concerned had put himself in a position to make a reasonable judgement and had acted upon it". In such cases the Commissioner would seek the opinion of a professional adviser or panel of advisers. Finally the appointment would be for a fixed term "to provide the necessary measure of independence". Some of AEGIS' suggestions had evidently found favour. Firstly local offices and, possibly, regional assistants, were envisaged.[81] More importantly, the

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[79]Ibid para.6
[80]Ibid para 9
[81]Ibid para.4

HAS was to be empowered to refer cases ".. since it is not intended that the Advisory Service should itself investigate individual complaints and the reference of a complaint to the health authority might sometimes be inappropriate".(emphasis added)[82]

The proposal to give the Commissioner jurisdiction over aspects of the conduct of doctors might have been expected to run into a united opposition front from the profession. In fact, medical opinion was divided. The BMA's Central Committee for Hospital Medical Services (CCHMS) rejected the idea out of hand.[83] However, the Association's primary policy-making body, the Central Council, introduced a note of qualification into its otherwise hostile reaction to the scheme; a reaction at least partly precipitated by anger at the Government's failure to involve it at an earlier stage.

> "As with the extensions of the advisory service , a decision appears to have been taken on undisclosed grounds. The only information the Council had received is that contained in outline of the Secretary of State's proposals...which ...nowhere states the grounds upon which such an appointment is considered necessary. Reference is made in the outline to relatively trivial matters... (which) can perfectly well be dealt with by other means. In more serious matters the present system already provides for an independent inquiry to be held..." [84]

Despite the document's clear exemption of matters of clinical judgement, the Committee sensed a veiled threat. If the proposals were adopted:

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[82]Ibid para 10
[83]Lancet (i), no. 7650, 10.4.70, p.759
[84]The first annual report of the HAS revealed that it may visit general hospitals once it had covered the longstay sector. NHS Hospital Advisory Service Op.Cit. The Council made known its strong opposition to this without full discussion and consultation in the light of experience of the Service. BMJ 1970, Vol. 2, No. 3402, 11.4.70, Supplement p.14

"... the trust respect and mutual rapport which should characterise doctor/patient understanding will be damaged. Working under suspicion can be destructive of the best effort and when tragic and irrecoverable illness is ascribed to medical incompetence, the doctor's work becomes impossible...

" For all these reasons, the Council ...cannot accept the proposal unless and until stronger arguments are forthcoming."[85]

This view was attacked as "occupational obscurantism" by The Lancet and as "the usual biased, illogical and eccentric claims" in a letter from Dr.Whitehead, published in the same edition.[86] Another leading voice of hospital doctors accused the Central Committee of alarming the public and reinforcing reliance on ".. their unofficial ombudsman, the press and television..".[87] The press also cited an unnamed SAMO to the effect that Regions would cooperate provided the doctor's role was not undermined.[88]

The Royal College of Nursing declared itself firmly in favour in a report to the Secretary of State which, although supporting the proposed authority filter, argued strongly that the Commissioner should be as available to staff as to patients.[89] The Institute of Hospital Administrators, although not altogether enthusiastic, nevertheless informed Crossman that it would not specifically oppose the proposals.[90]

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[85]British Medical Journal 1970 Vol. 2 No. 5701, 11th April 1970 Supplement p. 28
[86]Lancet 1970 (i) No. 7550, 11th April 1970 p.759. Whitehead's letter in same edition p. 774
[87]Medical News Tribune Editorial 17.4.70
[88]The Daily Telegraph (4.4.70) argued that the resistance of organised medicine would seriously impede the government, whereas The Observer (19.4.70) took the view that with the representatives of nursing and hospital administration cooperating, Crossman could easily override the doctors.
[89]Observer 19.4.70
[90]Report of their annual conference in British Hospital Journal Continued on following page

Mrs Robb decided to call together her close advisers. On this occasion, Barton and Whitehead were joined by Theo Fitzwalter Butler once more at the Royal Society of Medicine. Mrs Robb then drafted the response and Fitzwalter Butler amended it before it was submitted on April 14th 1970. To ensure that their suggestions were public knowledge, Mrs Robb again secured space for an lengthy article in the Daily Telegraph.[91] Although gratified that regional offices were being contemplated, there was really only one issue for AEGIS.

Direct Access for complainants was essential. Otherwise many would not come forward, as they would have no grounds for expecting anything better than the familiar "whitewash". Many complainants did not have the means to employ legal advice and would therefore not risk the serious consequences of complaining. Equally importantly, giving hospital authorities the effective right to deal with all initial complaints carried the risk that the "wrong sort of hospital" would tamper with the evidence relating to serious grievances before the Commissioner had access to it. No, the Commissioner was the proper agent for the reception of all complaints; there was after all, nothing to prevent there being a registrar attached to the office to to filter out the more frivolous or less serious allegations.

If the Secretary of State refused to recognise this and went ahead as proposed he would bring disaster down onto the whole project. Experience had by now amply demonstrated:

> "...that when hospital authorities act as their own judges and juries in respect of complaints about the hospitals for which they are responsible, too often they find that the

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and Social Service Review. Vol.80 No. 4173, 10.44.70 p.653

[91]Robb R., Crossman's Ombudsman Daily Telegraph 29.5.70

cheapest and easiest solution is to sweep the complaint under the carpet."[92]

It also reminded the Crossman administration that the author of the relevant chapter in Sans Everything was now the Secretary of State's Special Adviser.[93]

With the evident isolation of and division within medical opinion the press debated whether or not the Government could proceed with confidence. According to The Observer, the BMA had decided to review its position with a view to adopting a more cooperative line and the paper believed that with the support of the regions, hospital administrators as a whole, and the nurses would allow it to proceed with confidence. In contrast, The Daily Telegraph argued that the resistance of the medical profession would successfully obstruct the Government. This seemed more reliable after Crossman told the Commons in February that he had promised the doctors that he would not finalise the health commissioner proposals until experience had been gained in the working of the advisory service and the complaints procedure.[94] However, such speculations became academic since, as in the case of other policy initiatives instigated by Crossman, the June election curtailed consultation on the health commissioner and it was to require further scandals to precipitate the "stronger arguments" called for by the BMA, before the office became a reality. Even so, it was clear at this stage, that Mrs Robb and her AEGIS advisers faced a dogged, uphill struggle if they were to gain acceptance of their proposals.

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[92]AEGIS' comments on the Secretary of State's "Proposals for a Health Commissioner in the Reorganised National Health Service" Robb Files Sans E Vol.6A

[93]Ibid

[94]House of Commons Official Report, Vol 750 Col. 1360-1361. debate on mental health 11.2.70

CHAPTER EIGHT

A PARTIAL VICTORY

"Most hospital patients are not ill-treated or abused. But when poor conditions prevail it is very likely to happen. Poor conditions still do prevail at most mental hospitals and it is very difficult for nurses to give sympathy if they themselves are being pushed to physical and mental limits. I don't think most people realise how desperate the situation is."

An unnamed nurse at Whittingham Hospital quoted in the Nursing Times of 17th February 1972.

Labour lost the General Election of June 1970, but the issues which AEGIS had championed remained high on the political agenda at DHSS not least because Sir Keith Joseph demonstrated as much commitment to reform as his more publicity-conscious predecessor. This was initially reflected in the endorsement and further development of the priorities and minimum standards policies and the publication of the mental handicap strategy which Crossman had initiated. At the same time, the Hospital Advisory Service turned its attention to services for the mentally ill and the elderly. These developments are documented to 1974, in the first section of this chapter.

Though the campaign for improved complaints machinery, particularly for the health service commissioner, still faced an unenthusiastic medical establishment in 1970, it was reinforced by more official revelations about maltreatment and neglect in Farleigh and Whittingham hospitals, published over the following two years. The procedures of the committees of inquiry in the next phase demonstrated significant success for Howe's campaign to establish due process in procedure. Moreover, the reports were to identify further deficiencies in national policy and expand the debate outside the concerns originally identified by AEGIS. The

second section of this chapter documents these further scandals which led to AEGIS' partial victory when the Secretary of State presented proposed legislation to Parliament to establish a health service commissioner as part of the 1973 NHS Reorganisation Bill.

Priorities, the mental handicap strategy, interim standards and the Hospital Advisory Service

In November 1970, AEGIS was able to welcome the announcement of additional funding earmarked for mental handicap, mental illness and elderly services. The Secretary of State had obtained Treasury approval for accelerating the growth in spending on the health and social services over and above that planned by the previous government from 4.7% to 6% at constant pay and prices.[1]

The extra resources complemented the strategy, largely drafted by Abel-Smith, which Crossman's successor committed himself to publish in the early Spring of 1971[2] - although it finally appeared in June. The significant difference from the earlier draft was apparently the omission of any reference to the scandals. The White Paper *Better Services for the Mentally Handicapped* simply ignored the Ely Report and presented the new policy in seamless DHSS drafting as the natural progression from the 1959 reforms.[3]

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[1]DHSS, Letter A.B. Marre (Second Permanent Under-Secretary) to RHB Chairman, 16.11.70

[2]Repy to Richard Crossman, *House of Commons Official Report Vol. 791*, 4.11.70, col. 1106

[3]DHSS, *Better Services for the Mentally Handicapped*, Cmnd 4681, (London: HMSO, 1971)

Better Services was the first systematic care group strategy formulated for the NHS. For the first time, DHSS provided health and local authorities with a policy framework which listed criteria for a satisfactory service, beginning with prevention and early detection and moving across a range of support services through to local residential and hospital provision. Services were to be based on aggregated assessments of the needs of individuals and jointly planned by health and local authorities. Finally targets for places in education, day care, residential care and NHS hospital beds were set and compared with existing provision. These targets envisaged a huge expansion in day care in the community, and a reduction by half of that provided in hospitals. The level of residential care across the two sectors was to increase marginally, with a parallel shift from hospital to community.

Significantly, the document set no timetable for the achievement of targets. However, the Government was confident that its revised revenue and capital plans would both support the policy to the end of the financial year 1974 and also achieve the minimum standards set by Crossman (although to do so entailed further marginal increase to the mental handicap budget).[4]

The extra money for the mentally ill was linked to supplementary policy guidance issued in December 1971. The Government also extended the minimum standards policy into this and the geriatric sectors. The circular _Hospital Services for the Mentally Ill_ was mainly concerned with administrative arrangements in the large hospitals to facilitate the change to local services and the type of service envisaged in the increasing numbers of district general hospital psychiatric departments both open and planned.[5] Although these developments were widely perceived as the more progressive element in mental health policy, the policy was then entirely devoted to short-stay, acute psychiatric services.

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[4]Ibid pp.205-7 and 230

[5]DHSS, Circular HM(71)97

This guidance was diversified by recommendations on the needs of the elderly mentally ill, issued the following year. Firstly, a DS letter criticised the operational policy in some mental illness hospitals of designating wards occupied by elderly patients as geriatric contrary to departmental policy.[6] The Memorandum on Services for Mental Illness Related to Old Age, issued as a Pink Circular, followed with recommendations for levels of bed and day places for people with dementia.[7]

The close monitoring of RHBs' progress towards achieving Crossman's interim standards continued under Joseph as RHBs were asked to submit their plans up to year-end 1973.[8] The policy was also extended when minimum standards for mental illness and geriatric hospitals were sent out in March 1972, despite complaints in advance from RHB Secretaries that there would be difficulties in finding the resources to meet them.[9] The accompanying letters stressed that these were not optimum desired standards but rather the minimum tolerable. Regions were asked to achieve domestic staffing levels within a year in order to reduce the burden on nurses and allow them more time for direct patient care. All others were to be met by the end of 1974.

The impetus to extend minimum standards into these sectors came from the succession of reports submitted by the Hospital Advisory Service (HAS) during its first two years. In his second Annual Report as Director,[10] Dr Baker singled out geriatric hospital services as requiring the greatest concentration of effort and

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[6]DHSS, Circular, DS/F/G54/48 dated 7.3.72

[7]DHSS, Circular HM(72)71 issued October 1972

[8]Circular, DS 65/71 dated 28.12.71

[9]DHSS, Notes of the Meeting of RHB Secretaries 31.1.72 and Circular DS Letter 95/72 dated 29.3.72

[10]DHSS, NHS Hospital Advisory Service, Annual Report for the Year 1971, (London: HMSO, 1971)

resources. Conditions in geriatric hospitals were often poor and thousands of patients were blocking beds in general hospitals. Specialist geriatricians were hampered by enormous caseloads and inadequate nurse staffing levels.

The HAS completed a survey of all mental handicap hospitals in October 1971, and reported its findings in its second Annual Report which observed that although there was widespread evidence of good practice, conditions in some hospitals remained "appallingly bad". More protracted comment was reserved for the mental illness and geriatric sectors. This deplored the practice in many large psychiatric hospitals of "dumping" chronic and other longstay patients on hospital back wards, whilst the units in general hospitals creamed off the more easily managed patients.

Interestingly, during the HAS' first two years, both the Department and the regional boards became dissatisfied with Crossman's procedure for handling reports. As a consequence, in the spring of 1972, its Director and the senior civil servants agreed some changes which by accident or design seemed likely to blunt the impact of the HAS. Originally, the reports were submitted to the Secretary of State and a meeting held at DHSS between the Department and the Regional Board in which the report's main principles were discussed and decisions reached on responsibility for further action. Crossman had intended senior Ministerial representation at these meetings. The Department now argued that the workload deriving from Advisory Service visits was too excessive to permit involvement of the Secretary of State in the follow-up to every visit. In future, therefore, the Department would restrict its role to writing to RHBs for follow-up reports on specific issues arising from visits, as it considered appropriate. Moreover any strong criticism of HMCs and senior hospital staff was to be forwarded separately to the main report and circulated far less widely.[11] Although it may have

[11]SWTRHA Archives, RHB Secretaries Agenda for Meeting on 11.4.72
Continued on following page

been impractical for a busy Minister to be personally involved in every report, it nevertheless appeared in April 1972 that his "eyes and ears" would henceforth have to function at two or more paces removed, mediated through DHSS officials.

Complaints Machinery

As noted in the previous chapter, Crossman had in 1970 used section 70 of the NHS Act to establish a committee of inquiry into allegations of ill treatment at Farleigh Hospital in Somerset. The report was submitted to the Department in November 1970, but failed to appear until April 1971. The Secretary of State took advantage of the delay to appoint a committee to review the one policy field where Crossman's initiatives had run into the ground: complaints machinery. It is difficult not to deduce that this announcement in February 1971[12] was intended to cushion the predictable response to the overdue publication of the Farleigh Report.

This conclusion seemed still more plausible when it was announced that Mary Applebey, a member of the Farleigh inquiry, was also to serve on this new "independent and authoritative" committee. The Chairman was Michael Davies, a prominent, senior barrister, Recorder of Derby and Chairman of the Birmingham Mental Health Review Tribunal. This was a clear signal that the review was intended to assess NHS complaints procedure on legal criteria. Although the Department reassured regional boards that the Secretary of States wished to achieve "a balanced membership"[13],

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[12] House of Commons, Official Report Vol.810, Written Answers, Col.308, 3.2.71,

[13] DHSS Circular, DS letter headed "Hospital Complaints Procedure" dated 3.2.71

other appointees evidenced that the committee was constructed to produce a sympathetic view of the need for reform. They included included John Revans from Wessex RHA and former member of Crossman's Post-Ely Policy group, Prof. Kathleen Bell, a member of the Council on Tribunals and two prominent campaigning journalists, Anne Shearer, of The Guardian, and Barry Askew the editor of The Lancashire Evening Post who was playing a prominent role in the Whittingham Hospital Inquiry, of which more later. Although there were also six members or senior officers of health authorities, any conservative coalition they might have wished to form was unlikely to dominate the 15-strong committee.

Evidence was collected from all RHBs, Boards of Governors, HMCs, and 57 interested organisations and individuals of the 117 selected by the committee. Printed alphabetically, the list was headed by Brian Abel-Smith and AEGIS, and also included the Chairmen of the Whittingham Inquiry, and the Sans Everything Inquiry at Friern.[14] There was no direct approach made to Sir Geoffrey Howe, now Solicitor General, however he gave his permission for the Council on Tribunals to forward a copy of the memorandum listing his dissatisfactions with the Department's arrangements for the Ely Inquiry and his recommendations for reform.[15] In addition, the committee commissioned its own surveys of 455 former in-patients and 550 former outpatients, interviewed in their homes by questionnaire, and case studies of a mental handicap, a psychiatric, a geriatric, a district general and a teaching hospital. These employed questionnaires and unstructured interviews, to measure the views of staff, patients and relatives on attitudes, procedures, and practices, relating to

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[14]DHSS, Report of the Committee on Complaints Procedure, (London: DHSS, 1973) Appendix 3, pp.112-13

[15]Ibid, para. 9.32

complaints.[16] Davies also took oral evidence from Sir Alan Marre as designate Health Service Commissioner and Dr. Alex Baker as outgoing Director of the HAS.[17]

For once AEGIS and Abel-Smith submitted separate comments, subsequently exchanging copies.[18] Understandably, there was much common ground. Mrs Robb prepared the AEGIS evidence with Dr.Whitehead and Fitzwalter-Butler. It took three months to compile, comprised 3,500 words plus appendix, and was finally submitted in August 1971.[19] She enclosed with it a copy of her survey of the findings of the Sans Everything White Paper to reinforce her case against the existing procedure which made up the greater part of AEGIS' evidence.

AEGIS was highly dissatisfied with the procedures for special inquiries laid down under the extant Circular, HM(66)15 and argued that serious complaints in need of special investigation should be the subject of a Section 70 inquiry and that the decision on whether such a course was taken should rest not with the health authority, but with a health service commissioner, when and if one was appointed.

Assuming a commissioner with adequate powers and whom the dissatisfied complainant could approach directly, AEGIS was content for hospital authorities to handle the less serious complaints and felt that the first point of contact should be the senior ward nurse; patients and relatives having been supplied with literature on how a complaint should be made including instructions for approaching the commissioner.

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[16]Ibid para. 5.3

[17]Dr Baker was succeded by Dr E. Woodford-Williams in September 1973

[18]Correspondance in Robb Files Sans E. Vol. 6b Section 8

[19]Robb, B., Aegis replies to the Davies Committee Proforma in Robb Files Sans E. Vol. 6B Section 8

Abel-Smith's emphasis on this issue was less hostile to hospital authorities. He argued that they should have primary responsibility for the initial handling of complaints, but that complainants should have free access to the commissioner if still dissatisfied. Moreover the commissioner would need powers to override this in certain instances to avoid the 'judge and jury' problem. These included cases when the complainant feared victimisation, where the complaint was sufficiently serious, where the hospital complained against had been the subject of an abnormal number of grievances, and, lastly, where the HAS had a low opinion of the hospital authority or had reported adversely on its standards of care. Submitted prior to the passage of the reorganisation bill, both AEGIS and Abel-Smith set out their criteria for an effective ombudsman.[20]

The Davies Report, published in December 1973. was the first comprehensive review of the entire policy area since AEGIS had brought it to the political fore eight years earlier. Although Davies' criticisms of the existing system and recommendations for change in every sphere did not wholly concur with those promoted by AEGIS, they came as close to so doing as Mrs Robb could have dared expect. As such the Davies proposals were a major development over and above internal thinking in DHSS under the previous government and, ironically, rather vindicated those officials brushed aside by Crossman for advising him that the issue was best referred to a special working party.

The Davies Report was wide-ranging and radical both in its critique of existing arrangements and proposals for change, and was not well received in key centres of influence. It appeared in the midst of the miner's strike and the three-day week which contributed to the defeat of the Heath Government in the election of February 1974. Sir Keith told the Commons that his department

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[20]Abel-Smith, B. Hospital Complaints Procedure Committee (unpublished), Copy in Robb Files Sans E Vol. 6B.

would need to consult widely on the recommendations, some of which were "controversial" and in need of "considerable thought".[21] However he hoped to be able to announce guidance for health authorities soon. Of course the February election of 1974 put an end to any such aspirations.

His successor Mrs Barbara Castle was not destined to introduce speedy reforms. In April 1974, the Council of the BMA told the Secretary of State that although it accepted Davies as a basis for discussion, it needed more time to produce a considered response.[22] With such unsupportive reactions from medical lobbies, it is hardly surprising that even in November, the Secretary of State was still unable to make a statement.In June 1975, the national conference of Hospital Medical Staffs, passed a motion rejecting the report as a "discriminatory document" which would, if implemented, "turn the hospital service into a complaints-oriented organisation".[23] Indeed, the emergence of proposals arising from the report's appearance had to wait until 1976; by which time, most of the more radical recommendations had disappeared without trace. The content of the Davies Report and its destiny are discussed in detail in Chapter 11.

The momentum of scandal

Early in its administration, the Heath Government had appeared to show little enthusiasm for the health service commissioner proposal. As shown earlier, the medical establishment was firmly opposed. However, the pressure which mounted between 1970 and

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[21] House of Commons, Official Report, Written Answers Vol.866 Col. 272, 17.12.72

[22] BMJ 1974 Vol. 2 No. 5911, 20.4.74 Supplement p.21 and No. 5912 27.4.74, Supplement p.38

[23] National Conference of Hospital Medical Staffs report in BMJ 1974 Vol. 2, No. 5291, Supplement 29.6.74, p.133

1972 pushed both the government and the BMA into accepting the case for the proposed new office.

The Farleigh Report, published in 1971, was the first case in the second wave of major scandals. Farleigh in Somerset was part of a group of hospitals which housed some 900 mentally handicapped patients, located 42 miles from the headquarters of its management committee. Problems at the hospital first emerged in the public sphere in January 1969, when the local press reported that police were investigating irregularities at the hospital.[24] With Fleet Street hot on the trail of scandal stories, detailed reports appeared in most of the national dailies in February and March. A former policeman, who was by then a student nurse at the hospital, had complained that he had seen patients punched and ducked in cold water baths. Following initial investigations, the HMC had called in the police. The complainant, Mr Saunders, was suspended on full pay and his wife, a state enrolled nurse, who had also been working at the hospital since the previous August, was dismissed.

In an article in April 1970, The Sunday Times had contrasted the suspension of Mr Saunders with the fact that a nurse whom he had complained against and had since landed in jail was allowed to continue to work until the time of the inquest. A senior member of the hospital staff then wrote to the paper protesting that Mr Saunders' suspension had nothing to do with his complaint but was due to his having "failed to comply with instructions, used bad language, and was generally insubordinate". Having consulted Russell Barton, Mrs Robb sent the Paper a statement arguing that if these allegations had substance and action was needed, Mr Saunders should have been sacked and not suspended on full pay at the taxpayer's expense.

Indeed the Guardian had reported on the 12th August 1969 that Mr Saunders had been awarded an exemplary conduct certificate on

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[24]Western Evening News 29.1.69

leaving the police. As Mrs Robb noted at the time, this was hardly consistent with the hospital's assertion that he was predisposed to insubordination. Moreover, the events at Farleigh having persuaded him against pursuing a nursing career, he was re-employed by the police without any hesitation.[25]

They continued to live in hospital accommodation and made further complaints of intimidation and threats, including having stones thrown at them by local children.[26] Mrs Saunders then alleged brutality by nursing staff against patients. The Deputy Secretary of the RHB referred her to the Chief Nursing Officer who offered her reinstatement on condition that she withheld her allegations. She refused and complained of unfair dismissal but her grievance was not investigated. Following an approach to the Group Secretary, the couple made an official complaint and the police were brought in.[27]

The police ordered the exhumation of the bodies and an inquest into the deaths. The proceedings were closely followed by the press particularly attracted by evidence given by Mr.Saunders that patients were 'used as punchballs'. It made good headline copy.[28] As a result, nine nurses were charged and appeared at

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[25]See also The Times, The Daily Telegraph of 25.8.69 and The Daily Telegraph 28.8.69

[26]See particularly the Reports in The Sunday Mirror 2.2.69 and The Daily Express of 31.3.69; also 20.3.69 editions of The Times, The Guardian, The Daily Mail and The Daily Mirror

[27]DHSS, Report of the Farleigh Hospital Inquiry, Cmnd 4567 (London: HMSO, 1971) para.137

[28]See The Times, Guardian, Daily Telegraph, Daily Mail, Daily Mirror, Daily Sketch, Daily Expresss, editions of 12th, 13th, 14th, 15th, 16th and 18th March 1970 and Observer and Sunday Times of 17th March 1970

Potishead Magistrates Court, where three were cleared and six referred for trial at Somerset Assizes.[29] During March, detailed daily reports of proceedings were carried in the national press. Of the six nurses tried, three were jailed on manslaughter charges. Meanwhile, nursing staff at the hospital wrote to Crossman, protesting at the suspicion cast over them by these events.[30]

When the trial was over, Crossman established a Section 70 inquiry.[31] By so doing, he satisfied the criticisms lodged against previous inquiries by AEGIS, Geoffrey Howe (a member of his PEP working party) and the Council on Tribunals. A Section 70 inquiry had powers to subpoena witnesses, was fully serviced by the Treasury Solicitor and of course, was subject to the scrutiny of the Council on Tribunals. Furthermore, the inquiry was held in public and therefore followed in great detail by the press. Chaired by Tasker Watkins QC, the Committee had included Mary Applebey, General Secretary of the NAMH.

In the first of a what was to become a succession of similar cases, the specific incidents of ill-treatment took place on the hospital's secure ward.[32] These incidents were only symptoms of a much deeper malaise at Farleigh.[33]

The Report provided further evidence in support of the case for granting direct access to a health commissioner. Many of the

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[29]The Times, Guardian, and Daily Telegraph of 11.12.69

[30]The Times, Daily Telegraph of 6.9.69

[31]There had of course been Section 70 inquiries into other issues such as the Sheldon Hospital Fire (see Appendix 3)

[32]DHSS, Cmnd 4567, op.cit. Chapter 2

[33]Ibid paras. 17-34

interests who supported the general proposal argued that a hospital authority should first be given the chance to investigate a complaint. However, the Farleigh Report documented further examples of senior hospital staff resisting complaints by their juniors. The hospital's internal procedure was little more than cosmetic given that the CNO decided whether serious complaints should be handled at hospital level (and thus by himself) or referred to the Group Secretary. The system therefore both deterred staff complaints and militated against participation by members of the HMC. Attempts by junior staff to register complaints were brushed aside by their seniors and the CNO who used intimidation and victimisation particularly against those whose complaints eventually led to the police charges.[34]

It was this kind of incident which led the Committee of Inquiry to interpret its brief widely and to make recommendations about national policy:

> "...the history of complaints made at Farleigh, and the manner in which they were handled, demonstrates to our mind the need for an independent authority to which the unsatisfied complaints by or against staff can be taken. The authority should be armed with the widest possible powers...."[35]

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[34]In 1968 an SEN who had been dismissed from her post complained to the Deputy Secretary of the RHB of staff brutality against patients on North Ward. The RHA referred her to the CNO who offered to her reinstatement on condition that she withheld her allegations. She refused and then complained of unfair dismissal but her complaint was not investigated. In November that year, her husband, a student at Farleigh, was suspended, allegedly for bad language. Following an approach to the Group Secretary the couple made an official complaint and the police were brought in. Ibid para. 137

[35]Ibid para. 150

In the same context the Report called for an urgent decision on the appointment of an independent health commissioner.[36]

When he presented the Report to Parliament in early April 1971, the Secretary of State attempted a low-key response through the medium of a Written Answer which promised consideration of the health commissioner proposal[37], and he was criticised for this tactic across the floor of the House.[38] However, the press and professional journals were by now highly tuned to the issue; AEGIS supporters figuring strongly amongst those contributing articles and correspondence.

As with the Ely Report, the coverage of the findings of the Farleigh Inquiry was enormous. The national dailies were firmly on the side of AEGIS and unanimous in their call for a health ombudsman.[39] The Sunday Times was typical in pointing out that the case for an independent complaints machinery dated back to the publication of Sans Everything and that if the Farleigh Report did not give rise to it then it was difficult to envisage circumstances that would.[40] Professional opinion was somewhat diverse. The Lancet supported the Committee's recommendations.[41] The Royal Society of Health also came out strongly in favour at

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[36]Ibid para. 151

[37]House of Commons Official Report Vol. 815, Written Answers col. 1873

[38]House of Commons Official Report Vol. 815 cols. 181-2 (7.4.71)

[39]See reports, leaders and parliamentary pages of editions of 6th April 1871, The Times, The Daily Telegraph, The Guardian and Daily Mail editions of The Sunday Times and Observer of 11th April 1971

[40]The Sunday Times 11.4.71

[41]The Lancet, 1971 (i) no. 7703, 17th April 1971 pp.790-1

its Annual Congress later in April.[42] Similarly, the official journal of the Institute of Health Service Administrators, The Hospital, drawing parallels between Farleigh and Put Away, strongly supported the health commissioner proposal, although its reaction to the report's other recommendations was rather lukewarm.[43] The Rcn welcomed the Report and called for more staff and better facilities.[44] In its editorial the Nursing Times called for an ombudsman with sufficient powers.[45]

The BMA led the opposition. The BMJ acknowledged that the report's views warranted a thorough airing, however it failed to see what purpose could be served by the appointment of a Health Commissioner.

> "This is a politician's way of remedying defects. If something goes wrong appoint an official. But it will not heal the wound itself, and that is public indifference...It is tempting to shut away a mentally defective person, forget about him, and appoint a Health Commissioner to see he is all right."[46]

In the summer, at the Association's annual representative conference, the Chairman of the General Council dismissed the proposal as a "natural sequence to obsession with lay management".[47] The main argument against was the need to

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[42]Royal Society of Health Annual Congress at Eastbourne, 21.4.71 as reported in The Daily Telegraph 22.4.71

[43]The Hospital, May 1971 Vol. 67 No. 5 p.144

[44]Nursing Times Vol.67 no. 16, 22.4.71, p.466

[45]Ibid. p. 463

[46]BMJ 1971 Vol. 2 no. 5754, 17.4.71, p.119

[47]Held 21 to 24.7.71, BMJ Supplement 31.7.71 no. 3471 p.45-6

maintain the influence of doctors, already subject to four separate complaints procedures (the HAS now having been added to those previously listed). Naturally, the profession maintained it was protecting that influence not for its own sake but for the welfare of patients.

As the world received the Farleigh Report, another committee of inquiry was sitting at Whittingham Hospital, near Preston. To maintain the impetus of the debate until its report was published, both Prof. Abel-Smith and Barbara Robb published articles, prepared after mutual consultation, pressing for a health commissioner. Abel-Smith chose the columns of New Society[48]land Barbara Robb those of the Daily Telegraph[49] - now a more appropriate outlet for pressure on the government given the change in ruling party.

Fleet Street kept up the pressure by hunting down 'scandal hospital' stories. In May 1971, the Morning Star got in on the act by reporting allegations of neglect and ill-treatment at Calderstones Hospital, near the Blackburn constituency of the Opposition spokesman on social services, Barbara Castle.[50] Members of the hospital staff had alleged poor standards of patient care, and specific incidents including patients having their teeth extracted without anaesthetic and still more serious neglect leading to the death of a patient. The Manchester RHB,

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[48]Abel-Smith, B.A. A Hospital Ombudsman, New Society, Vol.17 No. 447, 22.4.71 pp. 672-74

In a subsequent article, Abel-Smith advocated widening the powers of the HAS, renamed the Health Advisory Service, to include giving advice on management and all aspects of the services provided by heatlh authorities. Abel-Smith, B., Managing the Health Service, New Society Vol. 17 No. 448 29.4.71, pp.721-22

[49]Robb, B., The aged in care, quid custodiet, Daily Telegraph, May 26th, 1971

[50]Morning Star 19.5.71

already embroiled in the Whittingham affair, held a day-long inquiry and published an edited version of the committee's report. Dr Whitehead sent it to Mrs Robb who enlisted the support of David Roxan of the News of the World. Between them they made life most uncomfortable for the Regional Board for some weeks until uncharacteristically, they allowed the issue to drop.[51]

The following October, with the publication of the Whittingham Report imminent, other journalists maintained the momentum. A Daily Mail reporter related his experiences as a nursing assistant at Friern Hospital having being appointed to the post without revealing his true identity to the hospital authorities.[52] His graphic description of the "mental health problem" mobilised the Nursing Times to abandon its usual reticence and attack the "the monstrous inhumanity of authorities and administrators, not only to their patients but to their nurses as well, in allowing the disgraceful conditions to persist".[53] It was indicative of current editorial policies on this kind of story that any attempt the North-West Metropolitan RHB may have made to deny the substance of the report went unreported as the press merely carried the RHB's complaint about the methods through which the reporter had "deliberately entered the hospital under false pretences with the apparent object of finding grounds for criticism".[54]

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[51]Correspondance in Robb Files Some Events Vol. C Section A

[52]Daily Mail 19.10.71

[53]Nursing Times Editorial Vol 67 No.43 29.10.71 p.1357

[54]Following up this story, a reporter from The Observer followed in Mrs Robb's footsteps down the main corridor at Friern, This time with the approval of the HMC and accompanied by its Chairman since the Sans Everything Inquiry, Mrs Peggy Jay. She conceded that the publicity engendered by the book had bought extra resources albeit in her judgement at the expense of staff morale. The Observer nevertheless found enough in her replies to accuse her of a recalcitrant attitude to criticism. Observer 6.2.71

The inquiry at Farleigh did not end the troubles of this hospital. In early January 1972, the press reported that a wheelchair-bound patient in the hospital had sustained two black eyes and that two nurses had been suspended as a result. A report was again sent up to the DPP and the nurses were charged and found guilty of assault and given sentences of six and nine months. Although this judgement was subsequently overturned on appeal, the damage of the adverse publicity was done. Even 'wrongful detention', a preoccupation of late Victorian Lunacy reform, emerged as an issue in the press following the discharge from St.Catherine's hospital, near Doncaster, of two elderly ladies. The papers were captured by the tragedy of their lives. They had been in-patients for fifty years, having been admitted as moral defectives in the 1920s having each had babies outside marriage. The cases led to the NAMH arguing that half the 50,000 residents of mental handicapped hospitals were leading similar "lost lives".[55]

Facing this tidal wave of bad publicity, the Secretary of State informed the House of Commons in January 1972 that the Government was resolved to appoint a health commissioner. After further consultation, the medical profession had come to accept 'the

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[55]The cases were brought to the attention of the press by the Director of Social Services for Dewsbury. See Daily Mail, Daily Telegraph, Daily Express, and The Times 20.3.72. Also articles "The Legion of the Lost" in The Sun 22.5.72, and "How many Lost Lives" in The Guardian of 23.5.72

Interestingly, The Guardian of the 26.5.72 quoted Prof. Kathleen Jones positing an optimistic view of the development of large institutions for the mentally disorded. She argued that under the 1913 Mental Deficiency Act the moral defective was a protective rather than a punitive classification. This seemed to be rather over-stretching the concept of beneficience as the press began unearthing other cases of unmarried mothers whose lives had been similarly ruined by incarceration. Daily Telegraph of 27.5.72

arguments in favour'.[56] It is hardly a coincidence that this announcement was followed swiftly by the publication of the Payne Report on Whittingham Hospital.[57] Again any attempt to de-fuse the backlash overlooked the determination of Barbara Robb to maximise the advantage it gave to AEGIS. Moreover, the content of the Report was so disturbing that it created profound shock waves even in a political climate already somewhat desensitised by Ely and Farleigh.

The precipitating events at Whittingham, near Preston had first surfaced in 1970, when Crossman was still Secretary of State. With 2000 beds, it was the largest psychiatric hospital in the Manchester Regional Hospital Board, widely recognised as one of the most progressive in its mental illness policy, having pioneered the establishment of psychiatric units within general hospitals and inspired departmental policy. It must have been with a degree of dismay therefore that DHSS officials received allegations by the hospital's assistant psychiatrist, Dr Masters, of ill-treatment of patients, fraudulent dealings with their monies and maladministration which included the suppression of complaints.[58] The Department initially sent out a team of auditors who uncovered financial irregularities in the hospital's accounts and also evidence in support of the other allegations. The police were brought in and two nurses were charged with theft.[59] Soon after, a male nurse at the hospital assaulted two

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[56]The Times 27.1.72

[57]DHSS, National Health Service, Report of the Committee of Inquiry into Whittingham Hospital, Cmnd 4861, (London: HMSO, 1971)

[58]The reports first appeared in the national press in February 1970 having been picked up from investigations by the Lancashire Evening Post, 7.2.70. See also Daily Telegraph 9.2.70 and Nursing Times, Vol. 66, no.8 20.2.70, p.227

[59]Daily Telegraph 23.6.70. According to this report, one at least was cleared

patients, one fatally; charged with murder, he was found guilty of manslaughter.[60]

By the time his trial was concluded in 1971, there had been a change of Government and Sir Keith Joseph used his powers under section 70 to set up a committee of inquiry and appointed Sir Robert Payne QC to chair it.[61] A firm of solicitors was appointed to collect and prepare the evidence. All witnesses were given full rights of cross-examination; some were summoned to appear. As at Farleigh, the entire hearing was conducted in public, despite the vehement protests of the Hospital Secretary.

Once more the open hearings provided the papers with an abundance of good copy, especially when the specific incidents of abuse were examined.[62] Loyal to Barbara Robb, The Daily Telegraph led off with a report on the hospital's failure to act on the Permanent Secretary's letter following Sans Everything.[63] In the midst of this publicity, Counsel for NALGO at the inquiry complained at the legal emphasis in the proceedings on the grounds that even those individuals who might be exonerated by the tribunal would not emerge with their characters cleared: "Some of the mud has been thrown and it is bound to stick".[64] The Daily Telegraph leader writer disagreed with the implication in this complaint that

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[60]See The Times, The Guardian, Daily Telegraph and The Sun 5.12.70

[61]First announced in the press of 5.12.70

[62]See The Times, Telegraph and Guardian of April 15th, 16th, 17th, 20th, 21st, 22nd, 27th, 28th, 29th, May 11th, 12th, 13th, 27th, 29th and June 8th and 10th 1971.

The Wet Towel Treatment incidents made headline news in The Evening Standard of the 10th May, and the national dailies on 11th May 1971

[63]Daily Telegraph 15.4.71

[64]Daily Telegraph 10.6.71

inquiries should be in camera. Again the copy was firmly consistent with the AEGIS 'party-line':

> "It has to be admitted that there are disadvantages and possible unfairness in the procedure of any such tribunal of inquiry. Though not a court of law, the need is nevertheless there to ensure that justice is seen to be done. The question is what use would it be to hold an inquiry in private. True, witnesses at a public inquiry may not have the same protection as in a court of law. But at least anyone against whom aspersions are made can give his own version of events. What the tribunal is concerned with is misdemeanours in the human if not legal sense. And it is right that any public institution should be put under proper scrutiny in such circumstances."[65]

What then were the report's findings when it appeared in February 1972 the following year? Formally the hospital provided a comprehensive service. Yet over the two decades prior to the complaints, the regional board's policy of transferring acute patients to general hospitals had changed the hospital's effective role to an institution for longstay patients. 86% of in-patients had been resident for more than two years and 45% were aged 65 or more. Most of this longstay population was housed in three-decker pavilion wards of 80 or more. The wards had not benefited from upgrading and provided grossly inadequate sanitary and other facilities. Their inhabitants were left unoccupied and vegetating under a regimen which the Report notes was largely untouched by any 'revolutions' in care which may have taken place elsewhere.

The complaint to Crossman had arrived at the height of the Ely publicity and in the wake of Sans Everything. Again the added courage this gave to the complainants cannot be underestimated. However, Sans Everything played a still more direct role in events leading to the Whittingham inquiry. Discontent with conditions

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[65]Editorial, Daily Telegraph of 10.6.71

had first been voiced by members of staff in a hospital magazine as early as 1965. Neither the HMC nor the nursing administration responded appropriately and the unrest simmered until the summer of 1967, coinciding with the publication of the book and the attendant press publicity. The report attributes no direct role to the book, yet clearly its appearance gave rise to two important events in the lead-up to the complaint. Firstly in mid-June 1967 and at the height of the book's publicity, student nurses met the Matron and Principal Nurse Tutor and made a number of profoundly disturbing allegations.[66]

Secondly, as mentioned earlier the Permanent Secretary at the Ministry of Health responded to the book's appearance by sending out a Dear Chairman letter asking each RHB to satisfy itself that there were no grounds for complaint in any of its hospitals. At Whittingham this was discussed at a meeting convened by the HMC and attended by both these senior nurses, which took place the day after they had received the students. They each kept quiet about the complaints and in July 1967 the Chairman of the HMC wrote to the RHB to reassure it that he had every reason to believe Whittingham free of incident. Once more Kenneth Robinson's satisfaction with existing machinery was shown to have been misplaced and AEGIS proved to have been right. Indeed the Whittingham Report politely censured the former Permanent Secretary for sending out a letter which 'indicated the expectation of a reassuring response'.

The hospital's managers dogged resistance to the complainants is all the more disturbing when placed in the context of the allegations which the Whittingham Committee upheld. The culture of the hospital was steeped in the 1930s. Patients were handled roughly, given little or no occupational therapy and poorly fed. Doors between and within wards were locked and controlled by nurses brandishing large bunches of keys. Airing courts still fulfilled their asylum purpose to air patients in conditions of

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[66]DHSS, Cmnd 4861 op.cit. Appendix II

maximum containment, and a flourishing parole system had survived complete with its variously coloured cards issued to patients to designate the hierarchy of privileges accorded to them for compliant behaviour. The fact that such findings astounded the Committee of Inquiry underlines the extent to which Whittingham challenged the conventional wisdom about 'revolutions' in British Mental Hospitals.

The Report argued that the region's policy of developing acute psychiatric units on general hospital sites had created a two-tier system of psychiatric care which offered only poor conditions in isolated large hospitals for the longstay and elderly. The relative poverty of the latter care groups was aggravated at Whittingham by low staff morale caused partly by the removal of acute services from the hospital and the consequent deprivation of a therapeutic philosophy and momentum.

This was the Committee of Inquiry's only foray into national policy issues. There were no specific recommendations on complaints or monitoring standards. Indeed this was no longer necessary as central government initiatives were at an advanced stage by the time the report was written in 1972 and of course, its appearance reinforced the momentum to the campaign for reforms in these areas.

The impact of Whittingham in the media was as big as any of the hospital inquiries; although as will be seen, it by no means marked the peak of the press interest in mental hospital conditions which Barbara Robb and her supporters sparked off in 1965 and subsequently developed. The post-Whittingham publicity was indeed spearheaded by Mrs.Robb and one of her advisers. In January 1972, this individual received an advance "confidential" copy of the report seemingly sent by an official in the Department. However, it would have taken an extremely naive civil servant not to have assumed that this was merely an indirect route to the press. Mrs.Robb produced her own briefing paper on the

Report linking its findings to a call for an effective health commissioner, and sent it both to the Sunday Times and to Brian Abel-Smith, now advising the Labour Party Front bench spokesmen, Mrs.Barbara Castle and Dr.Shirley Summerskill. Interestingly, editorial staff on the Sunday Times, New Society and even Crossman, by then on the New Statesman, were nervous to carry the leak, and therefore Mrs Robb sent her brief to Pulse, a GP's weekly.[67] It had no such reservations and published the substance of Mrs.Robb's brief on February 12th 1972, three days before the Secretary of State had planned to present the report to the House.[68] With the story due to break, the national press jumped on the bandwagon; although the Telegraph, Times, and Guardian were careful to attribute the source. The Sun led its front page with the banner headline "Horror Hospital Guilty".[69]

Hence there was little point in Joseph attempting a low-key response to Whittingham Report for when he rose to make his statement to the House, in February 1972, most of Fleet Street and interested MPs knew exactly what was in it. He accepted the Report's recommendations and conceded that in previous years the Department might have failed to recognise the danger of dual standards of care inherent in its policy. He had now asked all regional boards to review their services for the longstay mentally ill, paying particular attention to outmoded attitudes and practices. He was committed to his predecessor's policy of improving conditions in longstay hospitals until their eventual closure. Although he refused to make any further announcement on the health ombudsman, he confirmed his intention to remove the large hospitals altogether. To achieve this end, each RHB would be discussing its proposals for the restructuring of its mental

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[67]Correspondance between Barabara Robb and respectively Hugo Young, P. Watson (New Society), R.H.S. Crossman, and C.H. Rolph and Peter Heard (Pulse) in Robb Files Record 10b Some Events Section C

[68]Pulse Vol 24 No.5

[69]All editions of 10.2.72

illness services to ensure a smooth transition to services in general hospitals. Nothing in the report could detract from this objective.[70]

The theme of complaints and the health ombudsman was common to the press reports. Thus The Guardian described the report as "a classic textbook study of how complaints can be suppressed..." and, mixing its metaphors, as "the final straw that clinches the argument for an ombudsman.." The Daily Telegraph recognised "a picture that has become so depressingly familiar since the publication of Mrs.Robb's book Sans Everything..." Keith Joseph was widely quoted, and at one stage promised an inquiry at any British mental hospital if there was any hint of a scandal of the Whittingham type.

The calls for reforms echoing through the nursing press included the voice of another of Mrs.Robb's contacts, John Andrews formerly Chairman of the RCN Psychiatric Sub-committee now grappling with a deteriorating situation as chief nursing officer at South Ockendon Hospital.[71] The Nursing Times castigated the managing authorities:

> "It is no excuse that the 'authorities' were unaware of what was going on. That was the excuse in Nazi Germany. It is the responsibility of the the 'authorities' to know what the situation is at ward level. The patients for whom the hospital exists are in the wards. They are not in the committee rooms and they are not in the conference halls."[72]

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[70]House of Commons Official Report Vol. 831 cols. 246-254. Debate on Whittingham 15.2.72

[71]Andrews, J., Less ignored - but still impoverished, Nursing Times, Vol. 68, no.7, 17th February 1972, pp.217-19

[72]Nursing Times, Vol. 68 no.7 17th February 1972, pp.214-15

Mrs Robb's close ally, Yvonne Cross, was particularly generous to her in the Nursing Mirror's editorial on Whittingham.

> "Barbara Robb, with the publication of the book Sans Everything, lit the fire, and Nursing Mirror and the general press, radio and television fanned it into a flame which illuminated the full horror of the situation. .. Thousands of nurses felt new hope for the future. Thousands more resented the situation saying that Sans Everything was a hotch-potch of unprovable accusations and downright lies. They were unable to see that it was a catalyst which was inevitable if anything was to be done to remove a terrible blot from the nation's escutcheon.
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> "A long-stay hospital is a breeding ground for many undesirable things. Victimisation is high on the list. Hopefully, one day, such hospitals will be no more than bad memories."[73]

The BMJ was by now resigned to the inevitable, however there remained much to fight for in the debate over the final form of the commissioner. It therefore stated the profession's strong opposition to any involvement by the office in matters of clinical judgement and proposed the job title of "Commissioner for NHS Administration". It also expressed concern about the possibility of increasing the number of litigation cases by allowing the ombudsman to function as a "dry run" and warned that the Government would have to reach an agreement with the BMA.[74]

AEGIS' campaign for a health commissioner had succeeded. The battle for an effective office was about to begin. For the time being, however, Mrs.Robb had won a partial victory.

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[73] The Nursing Mirror Vol. 134 No.6 and 7 18th and 25th February 1972 pp.14-15

[74] BMJ 1972, Vol. 1, No. 5795, 12.2.72, pp. 383-4

CHAPTER NINE

A 92% VICTORY

Having won the first battle largely in the press, AEGIS' campaign for an effective Health Commissioner moved to Westminster. On February 22nd 1972. Sir Keith Joseph informed the Commons that the Government was proposing to invest the current Parliamentary Commissioner for Administration (PCA) with the three additional and separate posts of Health Commissioner for England, Scotland and Wales, with powers which largely paralleled those of the PCA. Health authorities would retain responsibility for initial investigation and right of access to the Commissioner would be restricted to those complainants who remained unsatisfied after this stage. Aggrieved persons with recourse to tribunals or litigation would be precluded unless the Commissioner was satisfied that it was unreasonable for the complainants to have thus sought redress. There would be no right of direct access[1] for complainants.

The remit of the new office would differ from the PCA's in two respects. Firstly, although, MPs could act as the channel to the Commissioner, eligible persons[2] would have direct access. Secondly, in addition to actions where it was claimed that an individual had suffered injustice through maladministration, the health ombudsman was empowered to investigate complaints arising through alleged 'failure to provide necessary care and treatment' in hospital-based services. Following investigation, the Commissioner would be required to send a report to complainants, any persons complained against, and to the managing authorities. He or she would also be required to submit statutory annual

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[1]NB direct access throughout used to mean complaining direct to the Commissioner without first approaching the health authority subject to complaint.

[2]The term "eligible persons" refers to those who had first exhausted the internal NHS procedures.

reports to the Secretary of State and also ad hoc reports on special topics according to the Commissioner's discretion.[3] To obtain the agreement of the medical profession, a compromise had been drawn up which simply excluded complaints in cases of clinical judgement and was the principal departure from Crossman's proposals.

For Barbara Robb, the key deficiency was the requirement of an initial investigation by the hospital authority. There was thus no guarantee against victimisation and intimidation of nurse complainants and no safeguard against authorities who were so-minded 'laundering' evidence before the Commissioner became involved.

Prior to the Secretary of State's Common's statement, she sent a paper to Brian Abel-Smith, now advising the Opposition Frontbench, who forwarded it to Mrs Barbara Castle the Social Services Spokesman.[4] Henceforth Barbara Robb became closely allied with the Opposition during the passage of the proposals, as she was in the course of simultaneous events leading to the South Ockendon inquiry.[5]

In her reply to Joseph's statement, Mrs Castle[6] proposed direct access as a safeguard against victimisation, declared the Opposition's hostility to the proposed merger of the offices of PCA and Health Commissioner and criticised the exclusion of clinical judgement.[7] In reply, Sir Keith was confident that the

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[3]House of Commons Offical Report Vol.831, Col.1104-1106

[4]Robb Files Record 10B some Events Section C.

[5]See Chapter 10

[6]It will be recalled from an earlier Chapter that Crossman had recommended her for this portfolio to Harold Wilson. She was of course to retain it into Government, apart from a six month period following a defeat in the elections to the shadow cabinet in autumn 1972.

[7]House of Commons Official Report Vol. 831, Cols.1106-7

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availability of recourse to the Commissioner would deter the suppression of complaints. But when it came to clinical complaints, informed commentators might have been forgiven for believing that the Secretary of State's brief had been written by the BMJ editorial staff; as he argued that it would be intolerable for doctors to face another procedure in addition to hearings before the General Medical Council and litigation.[8]

Barbara Robb also consulted her other advisers on tactics and there was some debate over the extent of direct access which could realistically be achieved as the legislation was finalised. AEGIS decided to limit its demands to cases of complaint about ill-treatment or neglect of patients, and to achieve this by using the pressure created by the exposed, and potential, scandal hospitals.[9]

There was strong support in the press for direct access; as usual the copy echoed Barbara Robb's case and strategy.[10] [11] [12] One notable exception, the BMJ reflected the medical profession's evident satisfaction with its agreement with Sir Keith, and gave the proposals a cautious welcome.[13]

When the NHS (Scotland Bill) appeared in May, The Times reported that the Government was considering appointing Sir Alan Marre,

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A similar announcement was made in the Lords by Lord Aberdare, Minister of State for Health. Baroness Serota confirmed the Opposition's commitment to direct access. House of Lords Official Report Vol. 328, Cols. 419-425

[8] House of Commons Official Report, op.cit. ibid col.1107-8

[9] Correspondence between Barbara Robb, Theo Fitzwalter Butler and Brian Abel-Smith in Robb Files Sans E. Vol 6C section 19

[10] The Times 22.3.72

[11] Nursing Times Vol. 68, No. 9, 2.3.72, p.252

[12] Gould,D. Semi Ombudsman New Statesman 25.2.72

[13] BMJ, 1972, Vol. 1, No. 5797, pp.393-94

former senior civil servant at DHSS and then PCA, as Health Commissioner at least for an initial period.[14] Mrs Robb was appalled by the prospect of the job going to a former senior DHSS official.[15]

Firm Government proposals on NHS reorganisation for England and Wales were published at the beginning of August, traditionally the time of departure on holiday of the British establishment - often chosen by government for initiatives which it wants to remain low-profile and uncontroversial. Whatever her commonality with establishment figures in some respects, Mrs.Robb took her holiday in September and certainly did not consider the White Paper's proposals to be uncontroversial.

The Government's reorganisation package was based on a three-tiered management structure with two higher levels of authority, Regional and Area Health Authorities (RHAs and AHAs), each with its team of officers, and one lower-level district management team responsible for running the hospitals. Although the rhetoric of NHS reorganisation in the 1960s and 1970s emphasised integration of the then existing three sectors, general practitioners were to retain their autonomy in Joseph's proposals through the new Family Practitioner Committees. Some post-graduate teaching hospitals also stayed out and became Special Health Authorities, but most were incorporated within teaching areas where they were to maintain a powerful influence on AHA policy and resource allocation. Apart from a third tier of management, the major difference between the new and Crossman's proposals lay in the

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[14] The Times 13.5.72

[15] Memo from Mrs.Robb to Abel-Smith telephoned 4th December 1972 in Robb Files Sans E Vol 5D.Sect 1. Barbara Robb had strong suspicions that Sir Alan had been involved in the Department's handling of the Sans Everything Inquiries, a suspicion she reports to have derived from press correspondents. See AEGIS first contact with the Health Ombudsman's office. 27.9.73 in Robb Files Sans E Vol 6E section 10

power of the regions. Joseph intended to increase their power over the lower tiers by introducing, a system of strategic planning, alongside the new structure.

The NHS Reorganisation Bill had its first reading on the 15th of November 1972. It was introduced in the Lords partly as a means of managing a heavy legislative programme and partly to appease Peers who had been forced to sit late into the evenings not only during August but also into September of that year.

To brief Opposition front-bench spokesmen on health and social services, Abel-Smith organised a Fabian Society symposium on issues in the Bill. It took place on December 2nd, two days before the Second Reading Debate. Barbara Robb spoke on complaints. Anxious to avoid too close an association with the Opposition, she subsequently sent a slightly amended version to Peers from other parties who had been prominent in the debate on the second reading; and received supportive replies from some of them including the former Professor of Medicine, Lord Platt.[16]

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[16]Copies forwarded on 12.12.72 to two former senior doctors Lord Amulree and Lord Platt (formerly Professor of Medicine at Manchester University) as well as Baroness White, Lord Cottisloe Lord Lichfield, Lord Beaumont, Lord Marysham, Lord Hayter (later to become chairman of the King Edward Hospital Fund) Baroness Summerskill, and Lord Cobbold. See AEGIS' Paper "The NHS Reorganisation Bill and Hospital Complaints" and correspondence in Robb Files Sans E.Vol 6D sect.2

In his speech, Lord Amulree had expressed his support for doctors investigating complaints against their colleagues and expressed his confidence in "his old friend" Sir Alan Marre. House of Lords Official Report Vol.337 Cols 27-32.

In a memo to Brian Abel-Smith, delivered by telephone on the evening of the second reading debate she had this to say of him. "Lord Amulree was just hopeless. He said he's a friend of Sir
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Her paper reaffirmed AEGIS' four primary objections to the Government's proposals and were to structure much of the Parliamentary debate that followed.

AEGIS was dismayed at the omission of direct access. Secondly, Mrs Robb dismissed the decision to appoint Sir Alan Marre as an insult to the public's intelligence. Thirdly AEGIS had no confidence in MPs forwarding complaints as many of them sat on authorities, or had relatives and friends who served in that capacity. Fourthly, AEGIS felt it wrong that availability of redress through a court or other tribunal should preclude access to the Commissioner, again given the prohibitive legal costs. Lastly, AEGIS supported a return to Crossman's proposals on cases involving clinical judgement. As things stood the Government was offering an ombudsman in name only.[17]

Mrs Robb sat in the Strangers' Gallery throughout the passage of clauses 31-39 establishing and prescribing the authority of the Commissioner.[18] Schedule Three of the Bill set out those areas not subject to investigation:

"1. Actions taken in connection with the diagnosis of illness or the care or treatment of a patient, being action which, in the opinion of the Commissioner in question, was taken solely in consequence of the exercise of clinical judgement ...

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Alan Marre's. Did Marre perhaps nobble him (charmingly as "Mr.Crossman" would say) re the Sans Everything Inquiry into Banstead Hospital - on the committee for which Amulree was the medical member?" Robb Files Sans E.Vol.6D Sect 1.

[17]Robb Files Sans E Vol 6D Sect 2 The NHS Reorganisation BIll and Hospital Complaints

[18]NHS Reorganisation Bill Pre-Amendment: H.L. Sessional Papers 1972 Vol. IV

2. Action taken by an Executive Council[19] or Family Practitioner Committee...

3. Action taken in respect of appointments or removals, pay discipline, superannuation or other personnel matters in relation to service under the NHS Acts;

4. Action taken in matters relating to contracting or other commercial transactions;

5. Action that has been or is the subject of an inquiry under section 70 of the principal Act."[20]

In moving this section of the Bill, Lord Aberdare confirmed the press rumour that Sir Alan Marre would initially add both posts to his current one.

The Lords gave the proposals a mixed reception. Although some Tory Peers sided with the Government, there was strong criticism from all benches. Summing up for the Opposition, Baroness White drew these themes together and highlighted the issues which her party would be raising in the course of the bill's passage. Echoing Mrs Robb's paper, she attacked the investiture of Sir Alan Marre with the post and criticised the proposed office for failing to take account of the position of staff in longstay hospitals who identified a need to complain.[21] The Minister did little to allay Mrs Robb's misgivings when he listed the kinds of complaint which the Government anticipated the Commissioner would investigate. Cases such as "..excessive waiting times.. bad food...and.. the failure of an ambulance to arrive on time.."[22]

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[19]The existing management authority for GPs, dentists, and opticians

[20]Ref.to 1946 NHS Act

[21]House of Lords Official Report Vol. 337, Cols. 121-2

[22]Ibid Col 130-3

were hardly commensurate with the serious failings which preoccupied AEGIS.

By the 23rd of January 1973, the Lords was taking amendments to Clauses 31-39 in Committee. Prior to this debate, AEGIS had been lobbying to change one of the Opposition's tabled amendments to the Clause 35. As noted earlier Mrs.Robb and her advisers had been concentrating their efforts on the Labour Front Bench. They had so far succeeded in gaining Opposition support for three major objectives:

1. to ensure that the office would be separately established and not appended to that of the PCA;

2. to bring cases of clinical judgement into its remit;

3. to obtain direct access.

The amendment tabled to achieve the third aim, was too wide in scope in Mrs Robb's view. It would have given the Commissioner power to accept a direct complaint from any member of the public, reserving to them the discretionary power to refer it to the hospital authority complained against.[23] Mrs Robb's was convinced that the Government would never agree to this, as it was unlikely to provide the new office with sufficient resources to cope with the large number of complaints which would be inevitably forthcoming.[24] Equally important, she was anxious that the wording of the amendment should maintain the pressure by association with the hospital scandals. She therefore drafted a compromise amendment which restricted direct access to hospital staff wishing to complain about ill-treatment or neglect of patients: the formula which she and her advisers had earlier devised.

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[23]Amendment 114 :1st Marshalled List of Amendments, House of Lords Sessional Papers 1972/3 Vol.IV

[24]Annotation in Robb Files Sans E.Vol 6D Sect 5

Mrs Robb's files contain the following account of events. As President of AEGIS, Lord Strabolgi agreed to table her draft and canvassed for support.[25] Firstly, he and Mrs Robb obtained that of Lord Beaumont who was himself moving two amendments to the Bill and therefore looking for reinforcements.[26] Having got him on their side, they decided to approach Lord Stow Hill, Strabolgi's colleague on the Labour benches and Lord Platt. Fitzwalter Butler was a close friend of the former and approached him informally only to discover that Stow Hill was the author of the original wide draft and would not entertain any changes. So Strabolgi approached Baroness White who agreed to adopt it on behalf of the Opposition Front Bench. The amendment was then worked up by the Opposition's lawyers and appeared in the final list under the names of of the Opposition Spokeswomen - Baroness Serota, Baroness White, Baroness Summerskill and Lord Beaumont.[27]

Debate moved onto amendments to the Health Service Commissioner clauses. Opposition attempts to prevent the Government vesting the the job in the PCA[28], and to reverse the Government's stance on clinical complaints both failed.[29] However, in withdrawing, Baroness White gave notice that the issue would be taken up again in the Commons.[30] The House was more sympathetic when she moved the "AEGIS" amendment, 114A, together with the original as drafted by Lord Stow Hill, making it plain that she favoured the narrower version restricting direct access to hospital staff. This tactic

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[25]ibid

[26]Annotation in Robb Files Sans E Vol 6D Sect.4

Amendment 114A to Clause 35 subsection 4 granting direct access to "members of staff employed by or under contract to the relevant body". NHS Reorganisation Bill 3rd Marshalled list of Amendments House of Lords Sessional Papers 1972/3 Vol IV

[28]House of Lords. Official Report. Vol. 338 Cols. 229-232

[29]Ibid Col. 370

[30]Cols. 375-376.

of presenting a desired change as a partial retreat gives the Government some manoeuvering space in that it appeared to be conceding less. The themes of Mrs Robb's briefing were well to the fore in Baroness White's argument:

> "The Commissioner may for example have reason to believe that in a certain hospital, conditions are unsatisfactory and he may have apprehensions that if there is not an early investigation what is politely called "erosion" of evidence will take place."[31]

It was crucial that hospital staff should be free from the threat of victimisation which the Ely Report had documented. Lord Strabolgi followed her and immediately declared his interest as President of AEGIS.

> "I think it is highly undesirable that hospital boards should act as judges and juries in their own cases. There will also be great difficulties of staff members if they make complaints to their own employers. Many of these staff members are shy nervous people; I think it would be a great ordeal for them. They would be confronted by a high-powered tribunal. Sometimes they would have to undergo cross-examination by skilled lawyers retained by the hospital board without the benefit of legal representation because they will not be entitled to this. But most important of all, there will be fears of victimisation."[32]

Adding to the catalogue of pressure he cited the Farleigh Report as an example. Support from the Government Benches came from Lady Ruthven of Freeland who recalled an incident whose themes were familiar to Barbara Robb. As a former HMC member she had served on an inquiry into complaints by junior nursing officers against their seniors which had duly reported to the HMC.

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[31]House of Lords Official Report Vol. 338 Col.352

[32]Ibid Col. 354

"One of the three people who were sent from our management committee on this inquiry was a retired civil servant and by chance he met an ex-colleague of his who was then in the Health Ministry. Unfortunately, he talked to this ex-colleague, who went straight to the Minister or whoever it was; and down from the Ministry, as it then was, came a complaint to the Regional Board, and then from the Regional Board to the Hospital Management Committee. The report of our inquiry was absolutely slammed down, and the Ministry instructed the Regional Board to have an inquiry. I, having been on the Hospital Management Committee naturally could not be a member of the inquiry. I protested and said that I knew that these things had been happening.

"When the Regional Board inquiry went down, they never saw any of the junior people. They were told that everything was all right, there was nothing to complain about and that none of these things had happened, although I knew myself that they had happened. If that can happen to a Hospital Management Committee how much more difficult is it going to be for a junior person employed in the hospital to make a complaint against his seniors? Of course it will not go further. i think it will be terrible if these juniors have not the possibility of going direct to the Ombudsman or Health Commissioner."[33][34]

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[33]Ibid Col. 354-355

[34]According to Mrs. Robb's files, she knew about these events.

"I suspect that the retired civil servant mentioned by Lady Ruthven in her speech is ..... a retired under-Secretary at the Ministry of Pensions, and member of mid-Sussex HMC. He came to see me on 22.12.67. He brought with him a report on poor care and ill-treatment in one of his HMC's hospitals (Pouchlands). He consulted me as to how the faults described in the report could be remedied. He planned to table a

Continued on following page

In his initial reply, the Minister of State resisted on the grounds that considerable changes had taken place since Ely and Farleigh, including the establishment of HAS, the appointment of the Davies Committee. Secondly, he echoed the Secretary of State's contention that the Commissioner would act as a last resort and thus deter victimisation. Thirdly he foresaw "practical difficulties" to direct access. It would be resented by staff and probably lead to a flood of complaints from patients. Pressure of work would ensure that most complaints would be referred to the hospital authority thus reflecting badly on the office. He objected to the "AEGIS" amendment on the grounds that it would create an anomaly since complaints from patients and relatives were transmitted in the usual way, while those made by staff, perhaps about the same matters, could be dealt with by the Commissioner.

These arguments were not well received. Lord Hayter felt that victimisation warranted exceptional measures since it could finish a nurse's career. The Earl of Onslow and Lady Ruthven pointed out that nursing staff were responsible, intelligent and loyal and

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Continued from previous page

> report presently to [a senior official] at the Ministry. The whole exercise had been carried out in response to Kenneth Robinson's request to HMC's (made subsequent to the publication of Sans Everything) to investigate the care of elderly patients in their hospitals.
>
> "[He] subsequently notfified me that [the senior official) had passed him over to an under-Secretary .... and that from then onwards (just as I had forecast) the report was supressed."

Note in Mrs Robb's hand in Robb Files Sans E vol 6D sect.5a.

"...not completely made up of barrack-room lawyers and complainers".[35] If the principle of the ombudsman was right, any practical difficulties could be overcome. For the Opposition, Baroness Serota played the third trump card. At Whittingham five years had elapsed between the students' original complaints and the approach to the Department by Dr.Masters. For all they knew there could be similar situations developing while they spoke. She rejected the flood of complaints argument. Even if the Commissioner did refer complaints back to the authority, the complainant would have derived added protection from the knowledge on the part of the authority that the office had been notified of the complaint. All four peers urged acceptance of the "AEGIS" amendment.[36]

In the face of this cross-party disfavour, Lord Aberdare had little choice but to acknowledge the feeling of the Committee. He therefore asked that the amendments be withdrawn to give him the opportunity to reconsider.[37] Although the Labour Bench was unwilling to withdraw the "AEGIS" amendment, it was in a vulnerable position. Clearly it had won the argument, but the Government was evidently prepared to use the Whips to avoid a defeat. Hence, the Earl of Onslow pressed Labour to withdraw arguing that it was preferable to give the Minister a chance and reserve the right to re-table the amendment at the Report Stage (if this response was unsatisfactory) than to lose it altogether on a division. A compromise proposal to adjourn the committee until the beginning of the following week was rejected by the Leader of the House. Baroness White therefore reluctantly withdrew hoping that the Minister's offer had substance.[38]

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[35]House of Lords Official Report, op.cit. Col. 360. Other speeches cols. 359-360

[36]Ibid Cols. 360-363

[37]Ibid Col. 364

[38]Ibid Cols. 364-367. Compromise suggested by Lord Shepherd and rejected by Lord Jellicoe, Leader of the Lords, ibid Col.366

Naturally AEGIS was delighted to meet with such a favourable response and set about trying to ensure that the amendment was accepted on Report. Mrs Robb's record gives the following account of events leading up to the Report Stage debate. In his attempt to counter the arguments in favour of direct access, Lord Aberdare had implied that policy initiatives since the Ely, Farleigh and Whittingham inquiries had rendered the victimisation of nurses a thing of the past. To demonstrate otherwise, Mrs Robb gave Baroness Serota some current case material from her own files - having first obtained the permission of the nurses involved. Should the Minister again have tried the same argument, Lady Serota would have been able to inform him that she had contrary evidence in her possession. Just before she despatched the documents, Mrs Robb heard from Brian Abel-Smith that the Government was "conceding about a 92% victory to AEGIS". Lord Aberdare had himself tabled an amendment which gave members of hospital staffs direct access to the Commissioner when making a complaint on behalf of an individual who is unable to make it for himself.[39]

The next day, she received a copy of the amendment, number 91, from Lord Strabolgi and immediately noted that it granted direct access only to "an officer of the relevant body in question".[40] As the word officer was not defined in the Bill it appeared unclear if the term applied to members of nursing staff. She referred the matter to her advisers who agreed that although things may have been in order, they could not assume so and the Minister would have to be more specific. Moreover, Lord Strabolgi pointed out that in Part II of the Bill, the section dealing with

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[39]Annotations in <u>Robb Files</u> Sans E Vol 6D section 5a subsection ii and iii

[40] NHS Reorganisation Bill Marshalled List of Amendments to be moved on Report <u>House of Lords Sessional Paper !972/4 Vol IV</u>. "Relevant Bodies" was the term used in the Bill to refer to health service authorities in the NHS Reorganisation Bill, Clause 34. subsection 1

the Health Commissioner, the term seemed to imply a member of the relevant body. Lord Aberdare would therefore have to insert his definition in Clause 39 of the Bill, the Interpreting of Part III, and Baroness Serota should be advised to lose no time in asking Lord Aberdare to table another amendment accordingly. Brian Abel-Smith therefore wrote to Lady Serota who, again according to Mrs Robb's files, rang her to ask if AEGIS' legal advisers could interpret Lord Aberdare's amendment. Mrs Robb explained that they could not and also raised Strabolgi's point about further amendment to Part III. Baroness Serota seemingly undertook to consult an expert in Parliamentary drafting.[41]

However, when Mrs Robb arrived at the Lords on the 13th of February, for the Report Stage, no amendment of Clause 39 had been tabled and it appeared that Lady Serota had got no further. According to Mrs Robb's files, when the two women met Lady Serota explained that she had indeed notified Lord Aberdare that she would be seeking definition of the term "relevant officer of the body in question". He was taken by surprise, but suggested that another amendment he had moved earlier that day would clarify things. Lady Serota asked Mrs. Robb if she had any idea which one he was referring to. Mrs Robb was in no doubt that he meant one relating to Schedule One of the Bill in which he had replaced the term "employee" with "officer". However, in her view, it was nonsense to suggest that this had any bearing on Part III of the Bill and amendment 91. He would indeed have to be pressed for the definition.[42]

The ensuing debate was consistent with this version of events. When he rose to move the amendment, Lord Aberdare made sure that the Government's intentions were clear:

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[41]Annotation and Letter from Barbara Robb to Lord Beaumont 13.2.73 in Robb Files Sans E Vol.6D section 5a subsection iii

[42]ibid

"The amendment gives the Health Service Commissioner discretion to investigate complaints made to them direct by members of the staff of Health Service Authorities on behalf of aggrieved persons who are unable to act for themselves, without such complaint having first been brought to the notice of the responsible health authority and without the authority have been given an opportunity to investigate and reply to the complaint....It will enable a member of the staff of whatever status or grade to go direct to the commissioner with a complaint made on behalf of a patient unable to act for himself. I should expect that such patients would be predominantly in the long stay hospitals which is the group of hospitals about which most anxiety was expressed."[43] (emphasis added)

The Labour Bench thanked the Minister. Lord Strabolgi then raised the matter of amending the interpreting of Clause 39 to include the definition of "officer". Members of the public, or for that matter the legal profession, could not be expected to search through Hansard to discover what an Act of Parliament was intended to mean. This could be done during the Bill's passage through the Commons, so for the moment the Amendment was agreed to.[44]

Opposition attempts to strengthen the Commissioner's powers in respect of complaints arising from clinical judgement in hospitals and complaints against the general medical services were again unsuccessful. Although Labour achieved minor successes in persuading the Government to remove the restriction imposed on Voluntary bodies and CHCs from making complaints on behalf of

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[43]House of Lords Official Report Vol.338 Cols. 1524-1526

[44]Baroness White also sought clarification as to whether this implied that a Doctor would be able to go direct to the Commissioner in respect of some grievance. In reply, Lord Aberdare confirmed that the right would be granted to all NHS Staff who were directly employed and therefore GPs were excluded Ibid Col 1526-7

aggrieved persons[45], and ensuring that the Commissioner for Wales had sufficient number of welsh-speaking officials.[46]

Mrs Robb wrote to thank the Peers who had been involved and her attention now switched to the Commons. Four days before the Report Stage, Rolph published a piece on the Bill in the New Statesman;[47] providing the opportunity for Baroness White to give notice, in the correspondence columns of the next edition, that the Opposition would continue the fight on clinical judgement.[48]

Meanwhile, Mrs.Robb was reflecting on what she perceived, perhaps unfairly, as the Opposition's 'muted protest' to the plans to vest the post in Sir Alan Marre.[49] She was also busy preparing a brief for the Labour Front Bench, a copy of which she also sent to the Liberal Sponsor for Health, John Pardoe. The brief advocated separating the posts and focussed on the need to define "officer" in the Bill. The term had had several meanings in company law and the courts rarely looked beyond an Act of

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[45]The 1973 NHS Reorganisation Act introduced community health councils and their was some debate about their role in complaints which has been omitted as these bodies were not promoted by AEGIS and also partly due to space constraints.

[46]Debate on Amendments 88,89, 90 and 92 (Marshalled list of Amendments to be moved on Report, Sessional Papers 1972/3 Vol IV) House of Lords Official Report Vol. 338 cols 1510-1524

[47]Rolph, C.H. Obudsmouse New Statesman 9.2.73
Mrs Robb noted at the time that she pointed out to Rolph that he should have either used language close to AEGIS briefing paper for the Lords, or at least given AEGIS a credit. Robb Files Sans E Vol 5D Sect.5

[48]Letters New Statesman 16.2.73

[49]She notes in her files that a journalist on her local paper, the Hampstead and Highgate Express, had suggested to her that this might be because Lady Marre and Lady Serota were close friends. Robb Files Sans E Vol 6D section 5 c.

Parliament and might indeed refuse to examine Ministerial statements of clarification made in the course of a Bill's passage.[50] She also noted her intention to attend as many sessions of the Commons as she could, As she wrote at the time:

> "I can't help feeling it's a pity that other organisations concerned don't follow such debates in the same way. I'm in no doubt that if they did, Governments would get away with fewer of their cons."[51]

Hence, when the Commons began its second reading on the 26th March, Barbara Robb was seated in the Public Gallery. Shirley Summerskill set the Opposition's agenda for amendments to the Commissioner provisions:

1 it was unacceptable to vest the post in the PCA not least since the current holder of the office, Sir Alan Marre, had recently been a second Permanent Secretary at DHSS;

2 the requirement for complainants to approach the health authority first was a deterrent to complainants, and an encouragement for victimisation and suppression of grievances;

3 the office should be able to investigate complaints against general medical services;

4 the office should not be precluded from complaints arising from clinical judgement.[52]

Following the debate, Mrs.Robb sent further briefing papers to Lord Strabolgi and Brian Abel-Smith. She understood from

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[50]Annotation in Robb Files Sans E.Vol 6D section 5c

[51]Letter to "Mary" dated 2.4.73 in Robb Files Sans E Vol 6 E section ii.

[52]House of Lords Official Report Vol. 853 Col. 1030

Dr.Summerskill's speech that the Opposition was making another attempt at gaining direct access for all complaints. Given that it was doubtful that this could be achieved, it was crucial to that the word "officer" should be defined in Clause 39.[53] She wrote to Dr.Summerskill on these lines, adding her opinion that the Opposition in the Lords had not been particularly effective on the issue of clinical judgement and hoping that the matter would be raised again during the Lords Committee Stage.[54] This last issue was already on the agenda, of course. However, AEGIS' principal concern was to be swamped at the Committee Stage by the Opposition's other priorities.

Standing Committee G on the NHS Reorganisation Bill began work on April 5th[55] and reached the Health Service Commissioner Clauses on May 22nd. In moving the Opposition's first amendment, designed to prevent the two posts being vested in the PCA, Dr Summerskill

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[53]Letters Barbara Robb to Lord Strabolgi 10.4.73 and Brian Abel-Smith 10.4.73 in Robb Files Sans E Vol 6E section 3

[54]Robb Files Sans E Vol 6E section 3

[55]Composition

Conservative	Labour
Bryant Godman Irvine (Chair)	Ernest Armstrong
Michael Allson	Arthur Blenkinsop
Kenneth Clarke	Brynmor John
Patrick Cormack	Alec Jones
David Gibson-Watt	Harry Lamborn
Joseph Hiley	James Lamond
Sir Keith Joseph	Elyston Morgan
David Knox	Eric Ogdon
John Leveridge	Laurence Pavitt
Timothy Raison	John Silkin
Wyn Roberts	Shirley Summerskill
Michael Sherby	George Thomas
Roger White	

condemned the decision to appoint prior to the appearance of the Davies Report. The Secretary of State accepted that the timing could have been better, but rejected the case overall. He had every confidence in Sir Alan Marre to cover the workload.[56] Attempts to give the Commissioner power to investigate complaints where recourse to a tribunal or the courts existed, made no progress.[57] Similarly, Sir Keith refused to give ground on the exclusion of complaints against the general medical services.[58]

The Opposition was more successful in tightening up provision to allow health authority officers direct access to complain on behalf of patients. The existing wording left it to the discretion of the Commissioner to disregard the general obligation on complaints to go through the health authority provided two conditions were met.[59] Firstly the Commissioner was to be satisfied that the officer was authorised to make the complaint. Secondly, the circumstances needed to justify the complaint; thus. they were required to be exceptional. Sir Keith Joseph agreed to delete the discretionary element.

> "The health authorities will know that in the narrow range of cases with which we are now dealing, the Commissioner, once he has decided that the staff member has an exceptional case, would have no discretion but to take that case."[60]

Now although the Secretary of State was again making it clear that the word officer referred to members of staff, the Opposition did not press for definition to be written into the bill. On this issue at least, AEGIS seems to have made no headway with the Labour Front Bench.

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[56]Ibid cols. 830-33

[57]ibid cols. 836-857

[58]ibid cols. 863-873

[59]ibid col. 883 ref to amendment 225

[60]ibid col. 885

Finally, the Opposition's attempt to change the provisions regarding clinical judgement, although unsuccessful, gave rise to revealing discussions. Similar to Crossman's original proposal, the aim was to require the Commissioner to examine the facts of a case before deciding that clinical judgement ruled out an examination.[61] At the same time, the Chairman took two amendments moved by Michael Shersby, but promoted by the BMA[62], which sought to stiffen the existing provision by prohibiting the Commissioner from investigating any professional judgement whether clinical or administrative; a move which served to meet the counter-pressure for incursions into this sacred territory. In defending the existing provisions, Sir Keith demonstrated admirable candidness by reporting how closely the BMA had been involved in drawing them up:

> "The Government had long discussions with the medical profession about the phrase "clinical judgement". The medical profession would have preferred....to have all medical decisions excluded from the Commissioner's remit, and understandably because it feared that if there were anything other than total exclusion of medical decisions, clinical judgement would be shackled. But the profession was most willing to discuss the Government's concern that medical decisions should not rest solely upon clinical judgement - administrative medical decisions - and after long discussions, a formula was reached which is embodied, as best we can, in the first paragraph of Schedule 3."(emphasis added)[63]

The Commissioner was therefore limited to deciding whether a decision involved elements other than clinical judgement, and then

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[61]Ibid col. 889

[62] BMA Letter to the Profession: Progress Report on NHS Reorganisation: BMJ 1970 Vol. 1, No.3540 3rd February 1973 Supplement, page 29

[63]House of Lords Official Report op.cit. col. 893

to decide whether to take the complaint; access to expert advice would be available for such contingencies.

Although pressed from both sides for a strict definition of "clinical judgement", Sir Keith would not give ground. This was hardly surprising given that he had given the BMA Council his personal assurance that the Commissioner would not investigate decisions taken solely in consequence of the exercise of clinical judgement.[64] Even the spectre of Ely, summoned by Brynmor John was to no effect.[65] It is academic to speculate, but the efforts to revive Crossman's proposals may have met with more success had the timing been such that they could refer, for supporting evidence, to the reports of the further committees of inquiry (at South Ockendon, St.Augustines and Normansfield) that were to follow over the next five years.

Three weeks later the Commons dealt with the Report Stage, when the Opposition failed in a last ditch attempt to amend the Commissioner clauses.[66] Hence, as the NHS Reorganisation Bill received the Royal Assent, somewhat belatedly, in August 1973 [67], AEGIS' long, and hard-fought battle was over and the Health Service Commissioner was on the Statute Book.

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[64]B.M.A.Letter to Profession: Progress Report on NHS Reorganisation: BMJ Supplement op.cit. p.29

[65]House of Commons Official Report, op.cit. Col. 895-6

[66]Under Clause 34, Labour sought to place a responsibility on the Commissioner to investigate a complaint unless he is satisfied that the complainant had other means for redress and could avail himself of them. This was a change of emphasis which would have given the Commissioner discretion to refuse such complaints in place of the discretion to accept them in the provisions. House of Commons Official Report Vol.857 col.1435-1438

[67]There was some delay due to a row between the two Houses of Parliament about charging for contraception prescriptions. The House of Lords did not climb down until mid-July.

Mrs Robb issued a press statement bemoaning the new Act's failure to define officer. This was carried in the Times in the form of a letter from her, and in the Nursing Times, which gave AEGIS full credit for achieving direct access for staff members. However, her doubts over whether the intention of Parliament with regard to the meaning of the term officer had been made sufficiently clear, were not lifted even when the Department sent health authorities official notice of the responsibilities of the new office in September. This stated that the term did indeed apply to hospital staff.[68]

Sir Alan Marre took up his additional post as Health Commissioner on October 1st, 1973 in advance of implementation of the main reorganisation measures, effective from April 1st 1974. He held a press conference in September, where he gave notice that his office had produced a leaflet, describing his functions, to be made available to the public at outlets such as Citizens Advice Bureaux.

This turned out to be a verbatim reproduction of the document also sent out to health authorities by the department.[69] Mrs. Robb had four principal objections to it. Firstly, it omitted the office's telephone number which could not be found in the directory. She was unhappy with this aspect because the great majority of dissatisfied nurses who approached her did so by telephone.[70] Secondly, she felt the presentation was confusing, and the official language liable to deter rather than encourage

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[68]DHSS, HM(73)52 para.2 of accompanying paper Health Service Commissioner for England. It was repeated in the guidance sent out on the eve of the commencement of the office DHSS, HSC(1S)10 March 1974

[69]Ibid

[70]Her files report that she engaged Sir Alan's deputy, the Hon.John Scarlett, in a long discussion of this issue. See Memo AEGIS first contact with the Health Ombudsman's office 27.9.73 in Robb Files Sans E Vol 6E Section 10b.

complaints. Thirdly, there was no explanation that the motivation behind Parliament's decision to grant direct access to nursing staff was to protect them against possible victimisation. Fourthly and most importantly, the Commissioner was to have discretion both to decide whether legal representation was appropriate and if so who was to pay the costs, the complainant or his office. For AEGIS, unless complainants were guaranteed representation with costs paid from public funds, many would be deterred.[71] For the time being, however, debate over the powers and nature of the office was at an end. Its subsequent effectiveness is reviewed in Chapter Eleven.

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[71]Robb, R. "Bad things come from poor beginnings." In Robb Files, Sans E. Vol.6E section 10b. It was also contrary to the recommendations of the 1966 Royal Commission on Tribunals of Inquiry which had held that given that a witness was participating in an investigation in the public interest, it was only fair for the public purse to met the costs. See, House of Commons, Report of the Royal Commission on Tribunals of Inquiry, Cmnd 3121, (London: HMSO, 1966), These recommendations were accepted by the Government and DHSS, NHS, Report of the Committee on Hospital Complaints Procedure, (London: DHSS, 1973) para. 9.26

CHAPTER TEN

EVALUATING THE REFORMS

The Report of the Committee of Inquiry into South Ockendon Hospital[1] was the last national mental hospital scandal to emerge during Barbara Robb's active years. It was published in May 1974 by the DHSS under Barbara Castle who, in presenting the South Ockendon Report to Parliament, told MPs that the Inquiry would never have taken place had it not been for the tenacity and sheer hard work of Barbara Robb.

> "I should acknowledge the work of Barbara Robb of AEGIS who made such strenuous and successful efforts to ensure that the events which had occurred were not swept under the carpet."[2]

One would search the Report itself in vain for this kind of acknowledgement of AEGIS's role, but Mrs Castle was entirely correct. Indeed her point could have been equally well made about publication itself which was delayed by more than a year after the Committee submitted its report to the DHSS; Mrs Robb attributing this hiatus to the previous Secretary of State's anxiety to get the Health Service Commissioner on the statute book before publishing more ammunition for those campaigning for more extensive powers for this Office.

The story of the South Ockendon Inquiry began in June 1968, when Barbara Robb was approached by two nurses from the hospital, apparently acting independently. They each made disturbing allegations about the circumstances surrounding an assault, with a ward bath brush, on a patient in the hospital's secure ward, Cypress Villa. This attack was to be one of series of violent incidents

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[1]House of Commons, The Report of the Committee of Inquiry into South Ockendon Hospital, Cmnd 124, (London:HMSO, 1974)

[2]House of Commons Official Report Vol. 873 Col.1294, (15.5.74)

which included two deaths and one manslaughter charge brought against a patient who was subsequently acquitted when Geoffrey Howe was persuaded to act for him on appeal and the police offered no evidence.

Mrs Robb's three-year campaign began soon after The Yorkshire Post of the 7th of June 1968 carried a statement by the Minister of Health given at a press conference held at Storthes Hall Hospital; a significant choice of venue as it had featured in Sans Everything. The press conference concluded his nationwide tour of health services and he declared he had found "no serious deficiencies" in the hospital service - unfortunate timing since the first attack took place at South Ockendon, three days later.

The history of the campaign for the inquiry would be slightly tangential to the major direction of this study, even if space limitations allowed its inclusion in anything like the detail needed to do justice to the story. Suffice it to say that the report continued the sad catalogue of findings during this period when the reality of the Victorian legacy of large-scale institutional care was revealed to a shocked and outraged public by Mrs Robb and her associates. If the volume of press coverage the report received is a measure of that outrage, there was no evidence of desensitisation by 1974 despite the seven-year interval since Sans Everything and the unremitting barrage of press publicity on mental hospitals which had followed in the book's wake.[3]

Had it been available to the Opposition Front Bench, during the passage of the NHS Reorganisation Bill in 1973, the South Ockendon Report would have added powerful support to the case for involving the Health Service Commissioner in matters of clinical judgement. Unfortunately it came twelve months too late. The context of the Secretary of State's assurances to the BMA on this issue may contribute to an understanding of the excessive delay in publishing the report beyond its arrival in the department in March 1973.

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[3]See Appendix 3

In common with Ely, Farleigh and Whittingham, an atmosphere of fear and intimidation prevailed at South Ockendon. The report lists a number of specific complaints by staff, patients and parents which were handled so as to deter others.[4] In the long run, of course such tactics proved wholly counter-productive because the glaring deficiencies they created only served to turn some of the more determined nursing staff and parents towards Mrs.Robb.

Despite this the Committee's findings deeply disappointed Barbara Robb, who suspected that the deaths were not accidental and that the police could have done more find out who was responsible. The report's political implications are reviewed below.

Continued reverberations

South Ockendon was not the last hospital inquiry whose national impact was considerable - there were two others. The first was a non-statutory enquiry established under HM(66)15 by the South East Thames Regional Health Authority into allegations of neglect and ill-treatment at St. Augustine's mental illness hospital in Kent.[5] It was marked for the seniority and experience of some of the committee's membership: notably its Chairman Hampden Inskip who had chaired the South Ockendon Inquiry, and Alex Baker the first Director of the HAS. With certain qualifications, the Report, published in 1976, largely vindicated the case and particularly indicted the hospital's management for having no clear effective complaints procedure.[6] The significance of the report for AEGIS concerns was largely to sustain the pressure to maintain and develop the priorities policy. Its major impact was to fuel an established campaign to reform the 1959 Mental Health Act led largely by the

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[4]House of Commons, Cmnd 124 op.cit. paras. 569-570

[5]Report of the Committee of Enquiry into St. Augustine's Hospital, Chartham, Canterbury, (London: SETRHA, 1976)

[6]House of Commons, Cmnd 124 op.cit. paras.77-80

National Association for Mental Health. By the mid-1970s MIND as it was now known had become a more radical lobby strongly influenced by concerns about civil and legal rights of hospital patients emanating from the United States.[7]

The second inquiry followed a strike by nursing staff at Normansfield mental handicap hospital[8] which took place two months after the St.Augustine's report was published; although the two events appear unconnected. Normansfield was probably the most elaborate, and costly inquiry of any whose reports appeared as parliamentary papers. Its report is the longest and most detailed. However, the primary significance for the concerns of this study is its procedure which are dealt with in more detail in the next chapter. Although there were some government initiatives in the wake of the report, its impact was largely localised. There were major changes in management, staff, and injections of resources which hauled the hospital near to the top of the league of average spend for mental handicap hospitals.[9] As with St. Augustine's, the national impact of Normansfield was to demonstrate that substantial scope for improvement remained and thereby sustained the priorities policy through the change of government in 1979.

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[7]See Gostin L, A Human Condition (Vol 1), London: MIND, 1975, DHSS A Review of the Mental Health Act 1959, London, HMSO:1976 (the consultative document), and DHSS, Review of the Mental Health Act 1959, Cmnd 7320, (London:HMSO, 1978) (The White Paper)

[8]NHS, Report of the Committee of Inquiry into Normansfield Hospital, Cmnd 7357 (London:HMSO, 1978)

[9]For example in 1982, the cost per inpatient week at Normansfield was £284 compared to a national average of £173. This put it well ahead of the field with notably Ely in second place and South Ockendon in fifth each around £220 per week. Two hospitals in the same RHA as Normansfield, Botley's Park and St. Lawrence's had weekly costs of under £150. DHSS, National NHS Cost Accounts 1983 (London: DHSS, 1984)

Policy developments after AEGIS

The publication of the South Ockendon Report in 1974 effectively marked the end of Barbara Robb's career as a political lobbyist in health care. There were two reasons for this. First she resolved at this point that AEGIS had largely served its useful purpose and that she would take up another cause. Second, a year after the report appeared, she began to suffer the symptoms of liver cancer which finally killed her in 1976. Doubtless the lot of the objects of her chosen new crusade, young offenders, is so much the poorer for her early death.

There is little point in dwelling on the months of her demise, since to the extent that this study is biographical it should focus on her political activity. It suffices to record that the strength of character which had sustained her campaign was manifest during her illness. She kept it from all but her most intimate friends and fought the crippling pain and debilitation without recourse to chemical relief which would have blurred her intellect and dimmed her awareness. Her profound mistrust of hospital authorities deterred her even from entering hospital until she simply could no longer cope at home. She passed the time cataloguing and annotating her immense collection of papers, correspondence and notes; a task she left largely uncompleted.

However, the story of the reforms the campaign set in train still unfolds in 1990. In order to review the effectiveness of AEGIS as a lobby, and proceed to develop an analysis of the policy process in mental health, the outcome of the reforms needs to be evaluated to the present day. Four broad categories of reform have been identified in this study:

(a) the development of policy in mental health and the extent to which it has been influenced by the concerns of AEGIS and the numerous hospital inquiries;

(b) the evolution of the priorities policy and its impact on standards of care in mental illness and mental handicap hospitals. This has two elements; the extent to which real spending on these care groups has risen both as an absolute proportion of hospital spending and relative to other sectors; the way standards of care have reflected changing patterns of expenditure.

(c) the impact of monitoring agencies:

(d) the extent to which reforms in complaints procedure have met the criticisms voiced by AEGIS and by the Davies Committee. This has three elements: the procedure adopted by health authorities; the role and impact of the health service commissioner; the evolution of the procedure for special inquiries.

Since evaluative research is not the primary aim in this study, the treatment of each will be relatively brief though the intention is to raise and discuss the major issues under each category. The analysis is presented in two parts with the following chapter dealing with complaints procedures.

Policy developments

The Castle administration began its contribution to policy reform with the publication of Better Services for the Mentally Ill in 1975.[10] The White Paper was noteworthy for its acknowledgement that the movement away from dependence on large Victorian hospitals had not been achieved at the pace anticipated by the 1962 Hospital Plan. In the period immediately after the oil crisis of 1973, it was clear that the necessary capital resources would not be available in the volume needed substantially to accelerate the

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[10] DHSS, Better Services for the Mentally Ill, Cmnd 6233, (London:HMSO, 1975)

programme. Indeed according to the document's own estimates, an annual investment of £100 million (at 1984/5 prices) was required to develop local services and upgrade the large hospitals.[11]

The main objective of Better Services was to provide health and social services authorities with an ambitious blueprint for comprehensive local mental illness services. In so doing, it wove together the strands of policy guidance which had been evolving in the light of the Whittingham Report and the work of the Hospital Advisory Service to the effect that community-based psychiatry needed to include adequate provision for the elderly mentally ill, and sufferers from chronic mental illness: groups largely overlooked in the plans of the 1960s.[12] Better Services took this one stage further and made recommendations for day care, housing and hostel accommodation as well as guidance on more specialist services for alcoholism, drug misuse, forensic psychiatry and child and adolescent care. As in its sister document on mental handicap, quantitative indices of service and staffing levels were cited.

The second major initiative during this period was the consultative document, Priorities for Health and Social Services, which appeared in 1976. This was the first attempt systematically to set out the priorities policy which had been evolving since 1969 and was part of the Castle administration's strategy to redistribute health care spending more fairly both geographically and functionally. To achieve the latter objective, Priorities introduced the mechanism of programme budgets, inaugurated in the USA, which divide the total revenue budget into major care group categories which structure future shifts in spending.[13] Unlike the RAWP formula[14], programme

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[11]Better Services cites a figure of £30 million at 1974 prices, ibid para. 11.8, which has been reflated here using the NHS/GDP multiplier in Table 5 in Appendix 4.

[12]See Chapter 6

[13]Banks, G.T., Programme budgeting in the DHSS, in Ed. Booth, T.A., Planning for Welfare, (Oxford: Basil Blackwell, 1979)

budgets were not an attempt to establish needs-based criteria for allocating revenue. Indeed had it been feasible to calculate targets on this basis (which given the complexity of the task, seems doubtful) and the established patterns of spending proved to be widely at variance with them, then the Government may well have had to tramp across a political minefield in trying to move towards targets. Instead, it took the safer route of beginning with the historically established pattern of spending and adopted a policy of moving incrementally from that base. Within an overall projected annual growth rate of 2% in revenue for the three financial years beginning 1977/78, Priorities set differential targets for the major care groups in health and personal social service spending. Services for the elderly, the mentally ill, the mentally handicapped and children were to grow at a significantly faster rate than acute and general services.[15]

In the next major review of the policy, the 1979 Royal Commission Report endorsed a recent Public Expenditure Committee report which implied that the established planning system and the Department's resource allocation process were uncoordinated and thereby an impediment to the implementation of priorities.[16] In the face of this type of criticism and its own ideological commitment to squeezing the maximum value out of public services, it was perhaps unsurprising that the new Conservative administration embarked upon major restructuring of the planning system and introduced systematic

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[14]DHSS, Sharing Resources for Health in England, (London: HMSO, 1976)

[15]DHSS: Priorities for Health and Social Services, (London:HMSO, 1976) para.11. Acute services were to grow by 1.2% per year. These figures compare to the Government's own estimate that 1% growth was required merely to allow for demographic changes and to make some allowance for medical advances: see House of Commons, The Report of the Royal Commission on the National Health Service, Cmnd 7615 (London:HMSO, 1979) para.6.11

[16]Ibid para.6.17

procedures to monitor and review the performance of health authorities against national policy.

In 1982, the Government implemented the recommendations of the 1979 Royal Commission and combined districts and areas into new District Health Authorities. At the same time it revised the planning system by establishing two phases of the cycle.[17] Every five years, regions and districts were to produce strategic plans for the coming ten years based on given revenue and capital assumptions over the period. Within this framework, they were to publish annual plans which detailed the service and resource changes in the forthcoming financial year needed to move towards strategic objectives. In 1983, systematic monitoring of regions and districts was introduced to complement the planning system and provide the feedback mechanism required to review progress and make appropriate adjustments to existing plans as they rolled forward. The review process has become increasingly quantitative and standardised over the last five years as Ministers and more recently the NHS Management Executive have sought to establish a uniform basis for performance targets and monitoring.

The evolving system of Ministerial and management reviews and quantitative measures of performance such as performance indicators and the Management Accounting Framework have been designed to ensure that health authorities implement Government policy and priorities. They represent a logical development in an age of relatively cheap and accessible information technology, of Crossman's original attempts to assert the supremacy of Ministerial policy over the periphery. In its early days, the Thatcher Government published Care in Action which fully endorsed its predecessor's priorities policy. Through the review process, it has put pressure on health authorities to accelerate the development of local services for

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[17]Glennerster points out that this was partly motivated by the irrelevance of 10-year plans in an era of cash limits, Glennerster, H., From containment to conflict? Social planning in the seventies, Journal of Social Policy, Vol. 10 No.1, January 1981, pp.31-51

people with a mental handicap or illness and develop costed proposals for closing the large hospitals. At the same time, during a period when management resources might otherwise have been channelled into acute services, the Government introduced four major incentives for health authorities to keep mental illness and mental handicap at the top of the agenda.

(a) The 1982 restructuring created district health authorities ostensibly to provide comprehensive health services within their boundaries to their own populations which implied the demise of distant large hospitals serving multi-district catchment areas;

(b) In 1983, the Care in the Community initiative was launched to extend existing joint finance arrangements and more potently, introduced mechanisms for transferring revenue and capital from the NHS to social services and allied agencies[18];

(c) The 1983 Report of the Enquiry into Underused and Surplus Property in the NHS reminded health authorities that property was an important resource in strategic planning. The following year, legislative changes allowed health authorities to seek planning consent for developing redundant sites before disposal thereby greatly increasing their value;[19]

(d) The NHS Land Transaction Handbook which regulates the acquisition and disposal of property by health authorities was revised to require health authorities to re-invest proceeds

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[18]DHSS, Care in the Community, A Consultative Document on Moving Resources for Care in England, (London:DHSS, 1983) and DHSS circular HC (83) 5, Health Service Development, Care in the Community and Joint Finance

[19]DHSS, NHS, Report of the Enquiry into Underused and Surplus Property in the NHS, (London: DHSS, 1983)

from the disposal of mental illness and mental handicap hospitals into the development of new services in those sectors.[20]

Given the strategic location of many of the country's large hospitals, there was substantial potential for regional health authorities to supplement their central capital allocations, provided sites could be vacated and planning consent for development obtained. With the number of old longstay patients in the hospitals finally dwindling to the levels projected for 1962 Hospital Plan, albeit ten years late, it appeared that the long-standing "closure programme" would finally come to fruition. The priority care groups had at last achieved a high profile within the NHS. Even Ramon, a severe critic of the Conservative Government, was obliged to concede that by the mid-1980s it had been more effective in implementing the policy than any since 1948.[21]

It was this precise moment that the House of Commons Social Services Committee[22] and the Audit Commission[23] chose to launch highly

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[20]DHSS, NHS Land Transactions Handbook, (London: DHSS, produced annually)

[21]Ramon, S., Psychiatry in Transition, (London: Croom Helm, 1989), pp.261-287

[22]"it is only now that many people are waking up to the legacy of a policy of hospital run-down which began over 20 years ago. Many of the horror stories of mentally ill people living on the streets or miserably in board and lodging are the results of an earlier era....Putting pressure on authorities to close or run down hospitals without similar incentives of resources to develop alternative services is putting the care before the horse." Second Report from the Social Services Committee HC 13-1, (London:HMSO,1985) para.31

[23]"There are serious grounds for concern about the lack of progress in shifting the balance of services towards community care.
Continued on following page

publicised critiques of the implementation of the hospital closure programme. The former provided ammunition to pressure groups and interests who nurtured grave doubts about the entire de-institutionalisation policy. Adverse press publicity began to play new roles. Media attention in mental illness and mental handicap has switched from conditions in the large hospitals, towards the lot of those discharged from them. With the assistance of orchestrated campaigns by new pressure groups such as the National Schizophrenia Society, and RESCARE, perceived inadequacies in community care became the mental health scandals of the 1980s.[24]

The Audit Commission launched a lobby for major structural change aimed at a substantial expansion in responsibility and resources of local government largely at the expense of the health service. A Government dissatisfied with Royal Commissions as mechanisms for defusing pressure, asked the architect of General Management, Sir Roy Griffiths to review the position and make recommendations.

Griffiths took the critiques of the Social Services Committee and the Audit Commission as his starting point for proposals for change. His report recommended that local authority social service departments should be made responsible for coordinating residential care for those elderly, mentally ill and mentally handicapped people who do not need intensive medical and nursing care.[25] The fact

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Continued from previous page
progress has been slow and uneven across the country; and in the near-term prospects are not promising. In short, the community care policy is in danger of failing to achieve its potential." Audit Commission, Making a reality of community care: A Report by the Audit Commission, (London:HMSO, 1986)

[24]See National Schizophrenia Fellowship, Slipping through the Net, (Surbiton: NSS, 1989) and Wallace, M., Did Edward have to die, Sunday Times Magazine, July 24th, 1988

[25]There are thematic parallels between the Griffiths Report and the
Continued on following page

that it was published with minimum ceremony, the day after the budget led observers to assume that the government were unenthusiastic about the prescribed increase in local authority budgets and responsibilities.

Pre-election adverse publicity about acute services grew to a crescendo in the winter of 1987/8 and was taken by the Prime Minister as justification for a review of the entire structure of the NHS. Proposing the most radical structural reform to hospital services since the 1946 NHS Act, the 1989 White Paper is aimed at introducing an internal market in health care with the separation of the service provider and service purchaser roles. At the time of writing, 66 hospitals have been short-listed by their regions as candidates for self-governance and their proposals currently subject to Departmental scrutiny now that a new Act of Parliament is on the statute book. The first wave of National Health Service Trusts should be in place by April 1991.[26] A number of regions are supporting proposals from mental illness and mental handicap units.

At the same time, the Government has revived interest in priorities, with long awaited developments on the Griffiths Report. The White Paper, Caring for People was published in the Autumn of 1989.[27] It

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Continued from previous page
earlier Report of the Committee of Enquiry into Mental Handicap Nursing and Care, Cmnd 7468 (London:HMSO, 1979) established by Barbara Castle as one by-product of the South Ockendon Report. The Jay Report proposed shifting the philosophy of caring for mental handicap from a medical and nursing model to a social model and also advocated administrative reform to vest major responsibility for care with social services departments. At the time of the 1982 restructuring of the health service, there were widespread expectations that the Government was intent on implementing this recommendation. However, opposition from within mental handicap nursing and nervousness about the resource implications for local authorities caused Ministers to withdraw.

[26] NHS and Community Care Act 1990

[27] DOH, Caring for People, Cm 849, (London: HMSO, 1989)

has three major objectives. Firstly, health and social service authorities are required to define their respective roles by distinguishing between health and social care. Secondly, social services are to become commissioning agencies of social care based on an individual assessment of need. Thirdly, there would be some simplification of income support for people in residential care by transferring the care element of board and lodgings payment to the budgets of local authorities through the Revenue Support Grant. This measure has proved the most controversial as the NHS and Community Care Act has passed through Parliament, not least since Ministers have opposed "ring-fencing" to ensure that the funds would be earmarked for spending on social services for the client groups concerned. In a recent decision to phase implementation of the new social service responsibilities, the transfer of income support responsibilities from DSS has been put back to 1993 amongst rumours that Ministers may not do it at all. Moreover, NHS Trusts will be empowered to offer social care provided the social services authorities will place the contracts. This blurs the distinction between health and social care which Griffiths was keen to draw cleanly and with the delay in implementation appears another in a series of moves which dilute his proposals.

Whilst the Secretary of State for Health was fighting the public relations battle with the BMA and RCN over the merits of the major NHS reforms, one of his junior Ministers was keen that health authorities should not lose the momentum on hospital closures.[28] A new capital loans fund has been created from which regions can borrow to finance capital schemes needed to close large hospitals and free up sites for disposal to generate proceeds, part of which then pay off the loan. The scheme is limited in the first year but will be expanded in subsequent years, but seems unlikely to have a major impact on hospital closure programmes. In the meantime a collapse in property prices in the south-east has halted the capital programmes of the four Thames Regions who between them manage about

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[28]See Department of Health Press Releases 89/298 dated 12 July 1989 and 89/301, dated 13 July 1989.

30% of the country's large hospitals. Any slowdown effect that this might have could be more than counter-balanced once contracting becomes effective from April 1991. Provider hospitals are required to charge at full cost, and districts with responsibility to pay for the care of longstay residents will have a greater incentive to resettle them given the rising unit costs in many of these institutions.

Finally, the lessons of the inquiries have also influenced more detailed management policies. There have been major innovations in nurse training and practice.[29] In mental illness, these have included the Nursing Process, greater autonomy for nurses through the Nurse Therapist innovation, individual patient care programmes and increased sensitivity to the difficulties of managing patients with behavioural difficulties.[30]

Priorities

The campaign spearheaded by the National Schizophrenia Society and RESCARE to review the closure programme has been in harmony with changes in the emphasis in central policy towards slowing the pace of change in mental illness and mental handicap. This appears to support the suspicion now abroad that the priorities policy has been

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[29]These are described in detail in Martin, J.P. Hospitals in Trouble (London: Blackwell 1984) op.cit pp.226-240

[30]DHSS circular HC(76)11 The management of violent or potentially violent hospital patients is another example of the Department resisting a proposal until events overtook it. It appeared after both the South Ockendon and St. Augustine's Reports. However, the idea originated in the 1973 report of a working party set up by the National Association for Mental Health after the Farleigh Report: Guidelines for the Care of Patients who Exhibit Violent Behaviour in Mental and Mental Subnormality Hospitals: A consultative document, (London: NAMH, 1973)

phased out. For the time being, however, it remains formally in place and is the legitimate object of evaluative analysis.

Given the range of services for people with mental illness and mental handicap in the health and social service sectors, a comprehensive analysis of the priorities policy since the 1960s would constitute a substantial empirical investigation. The primary subject matter of this study is the longstay hospital sector and this is therefore the major focus of the empirical evaluation. Evidence on the development of services in the non-hospital services is briefly reviewed later in the chapter.

When the 1976 Priorities document was launched it was greeted with some scepticism. Brown argued that it betrayed a lack of commitment to improving services for the mentally ill and mentally handicapped and was merely another in "a long history of fine policy statements in this area of service area and an equally long history of slow progress in implementing them."[31] Wilding suggested that the initiative has proved largely futile due to opposition from the medical profession.[32] At a superficial level, the evidence supports this pessimism.

The objective of the priorities policy was to improve standards of care in the longstay sector by shifting resources across functional

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[31]Brown, M. "Priorities for health and personal social services" in Ed. Jones K., and Brown M., in The Year Book of Social Policy in Britain 1976, (London:Routledge, 1977) p.29. For a similar pessimistic interpretation, see also, Creese, A., The National Health Service, in Glennester, H., Ed. Labour's Social Priorities, (London: Fabian Society, 1976) pp.18-21

[32]Wilding, P. Professions and Social Welfare, (London:Routledge, 1982) pp.39-40, Klein also viewed the policy as a failure, though for different reasons. See Klein, R., Policy Perceptions and Problems in the NHS, in Policy and Politics, No. 2, Vol. 3, pp.226-7

boundaries within health authority budgets. The policy was first formalised in 1969 after the publication of the Ely Report and subsequently endorsed by successive Secretaries of State. Any worthwhile evaluative analysis must therefore examine trends in relevant indicators in years leading up to the policy as well as those beyond it to ascertain whether it has had an impact. The evidence presented below is drawn from standard DoH returns on revenue spending and staffing from 1964 to the mid-1980s or two decades after Barbara Robb launched AEGIS. Of potential indicators of the success of the priorities policy, such as minimum standards, the revenue and staffing data are the only objective measures which can be standardised for the periods before the policy initiatives of Crossman and the rest. Some discussion of the Department's minimum standards and other quantitative indicators of standards of care is included at the end of the section.

Financial data by hospital service sector was collated from published Ministry of Health and DoH returns and then restructured and analysed using standard computer-based spreadsheet and graphics software. In order to make valid comparisons, the figures were reflated to a 1984/5 price base. This is by no means a straightforward exercise. Since 1971/2, the DoH has published its hospital and community services price index. Prior to then only the standard Treasury GDP deflator is available. The two indices are not consistent on a year to year basis either with each other or in the direction of the variation. Thus in one year the NHS price index exceeds the GDP deflator. In another it is smaller. In a third the two are equal. In order to mitigate if not to solve these problems, a multiplier for each year of spend was calculated using the GDP deflator to 1970/71 and the NHS price index thereafter. Since the aim of the analysis is comparative and the object is expenditure between sectors within a public service, no adjustment has been made to the GDP deflator for relative price effect.[33]

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[33]For a further justification of this approach see Gould F., and Roweth, B., Public Spending and Social Policy, in Journal of Social Policy, Vol.9, No.3, (1980) p.344

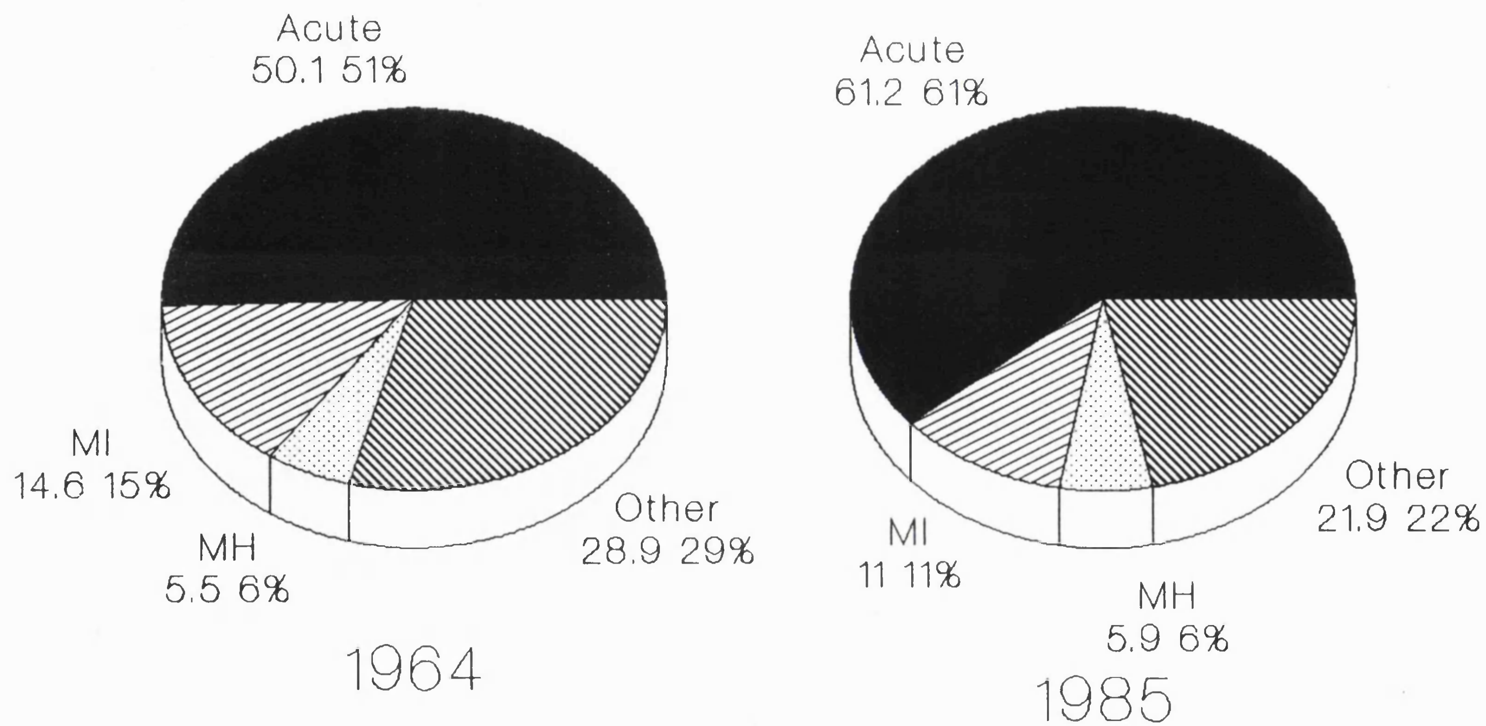
Table 5 in Appendix 4 gives the two indicators and the resultant GDP/NHS multiplier.

Costs in the acute sector are compared with those in mental illness and handicap and those in the remaining longstay hospitals which largely care for the elderly. Direct comparison between service sectors is complicated by differential rates of inflation in acute and longstay hospital costs which arise from the higher diagnostic and treatment episodes per case and greater equipment and maintenance costs in acute care. With this qualification, the figures presented below allow reasonably reliable conclusions to be drawn about the success of the priorities policy. No attempt has been made to consider the list of priority acute services which first emerged in the mid 1980s and which Ministers seem content to increase every year, since these were considered to be outside the scope of this review.

Evaluating the implementation of a policy to shift resources from acute services to the main priority care groups is also problematic. Figure 1 compares the distribution of spend by service sector in 1964 with 1985. Full figures for the period given in Table 2 in Appendix 4 show the percentage distribution of total spend by service sector. By 1975, after six years, the policy had achieved a 1% increase in the share of mental handicap services. Thereafter relative spend on the sector fell back and following a brief period of expansion after the Normansfield report, stabilised at 5.9% or half a percentage higher than in the 1960s. Over the same period mental illness hospitals lost out in absolute terms and show a steady decline until Ministers reasserted the policy in the early 1980s with Care in Action.

In the following charts, the word "spend" denotes recurrent revenue expenditure.

Figure 1: Spend by sector 1964 & 1985
England and Wales

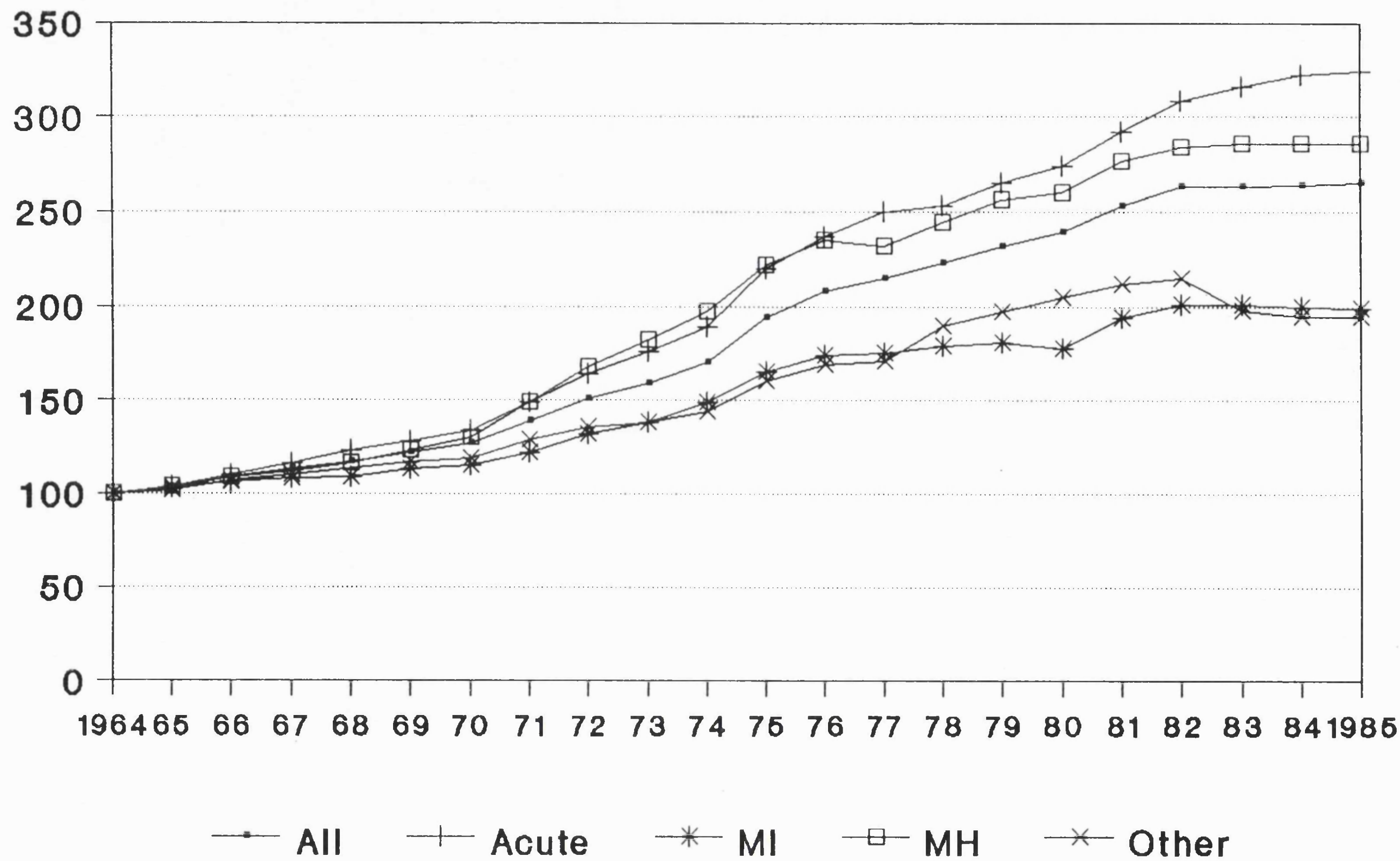


Source:Table 2 In Appendix 3

Figure 2 traces the growth in spending during the period to 1985, taking 1964, the year before Barbara Robb launched the AEGIS campaign, as the base year. Total real spending on hospitals increased by a multiple of 2.65 across all sectors. The acute sector increased the fastest and again in absolute terms, absorbed most of the additional resources; the respective figures for acute, mental illness and mental handicap were 3.25, 1.99 and 2.86.

Figure 2: Net spend by hospital sector 1

Standardised with 1964=100



Source: Table 3 in Appendix 3

A simple comparison of total net spending by care group leads to the conclusion that the priorities policy has made only a marginal impact on established patterns of spending and failed to affect the dominance of acute services in spending decisions.

However, absolute comparisons are often misleading and particularly so in this field. Further probing is therefore required to do full justice to the policy since there are a number of objective reasons why acute services should have maintained their dominant position. Part of the explanation lies in changes in the number of available beds by sector.[34] Although the number of acute beds has fallen it has grown as a proportion of total hospital beds over the period. The number of mental illness beds fell by 42% and mental handicap beds by 25%; the number of acute beds by only 18%.[35] The difference between the rate of decline in mental illness and mental handicap beds is largely explained by the relative age profiles of the old long stay residents in each type of hospital. They are significantly older in mental illness hospitals since the policy of long-term institutionalisation began to decline in the late 1940s in that sector but continued well into the 1960s in mental handicap.

Moreover, it is not simply a matter of beds since workload (the total number of cases treated), and throughput (the number of annual cases moving through a bed) have a proportionate impact on cost; since a large proportion of acute case cost is incurred during the first few days of a hospital stay in that sector. Acute workload has accounted for 90% of total hospital workload throughout the period and although throughput has increased in all sectors, it has done so far more rapidly in acute services.[36] Not least, case costs in acute services are considerably higher for equivalent lengths of stay, due to higher consultant and other medical

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[34]At the same time there has been a steadily increasing shift of workload in acute services from inpatient care to daycases.

[35]See Appendix 4 Table 9.

[36]See Appendix 4 table 10.

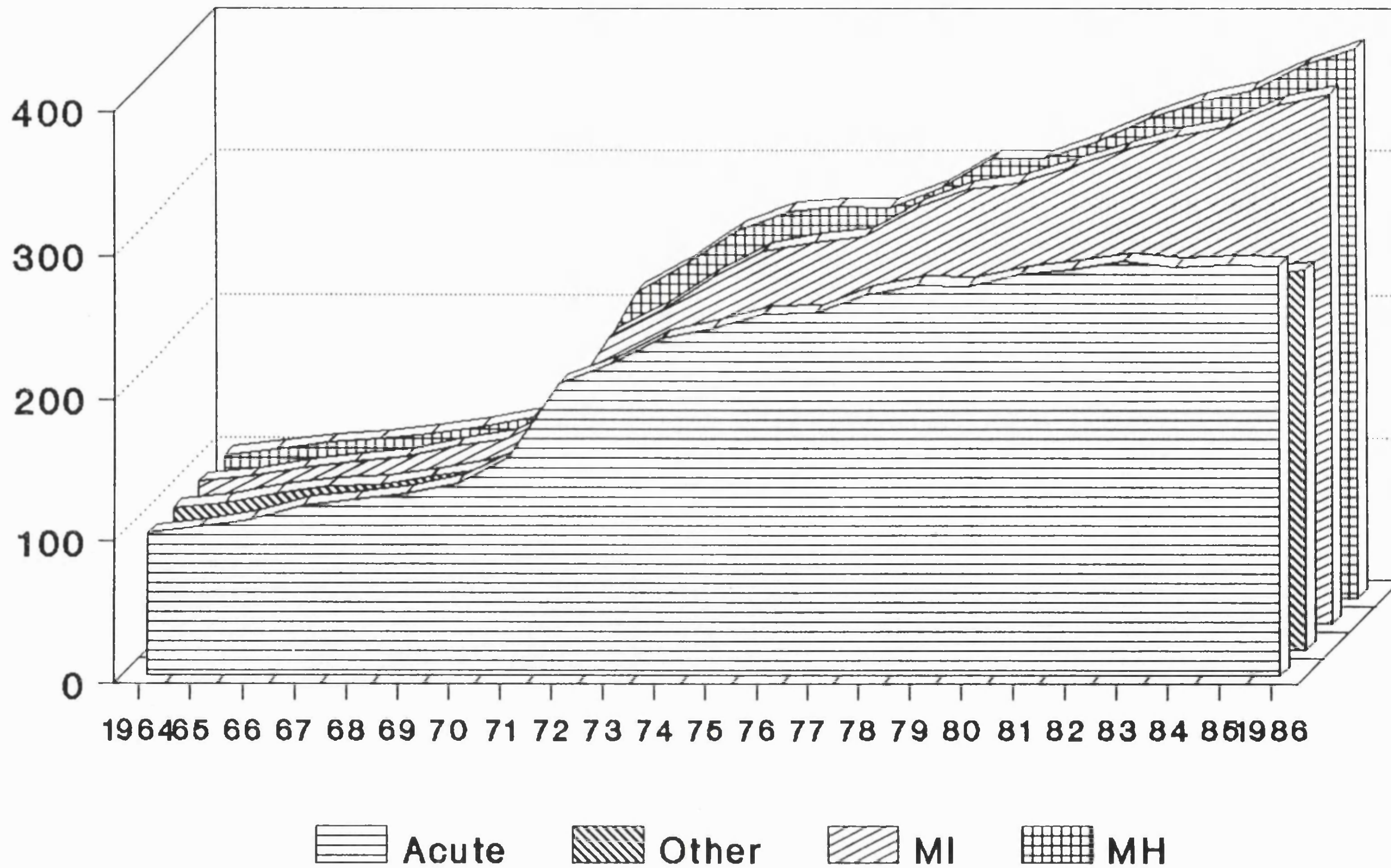
"episodes" and the higher levels of diagnostic investigations and treatment procedures.

Hence higher case costs and the sheer volume of work undertaken by acute hospitals, cloud the issue of the success or failure of the priorities policy if simple comparisons are made between net total spend. Indeed that treatment did and should cost more in acute medicine was never contended by AEGIS, Crossman or anyone else. Their concern was to tackle the relative poverty of the long-stay sectors by improving staffing ratios, access to occupational and rehabilitative therapies and not least hotel services such as the quality of catering.

To investigate whether this has been achieved, evidence is required that spending in the longstay hospitals has accelerated in line with central government policy initiatives. Table 6 in Appendix 4 shows the costs per inpatient week by specialty at 1984/5 prices. It shows how in both the mental handicap and mental illness sectors, spending has been increasing at a faster rate <u>relative</u> to acute spending from the early seventies onwards: following a period of contraction in the mid-to late-1960s. It also illustrates that the 1980s initiative launched with Care in Action and reinforced through the review process has been particularly effective. Over the whole period mental illness and mental handicap costs have grown as a proportion of acute costs from 30% to 40% and from 25% to 36% respectively. Further supportive evidence is provided in table 7 in Appendix 4. which gives the annual percentage increase in each sector, again showing how spending per patient accelerated in the mental illness and mental handicap sectors relative to acute from 1969/70 onwards. Finally, Figure 3 shows the cost per inpatient week by sector standardised with 1964 levels set at 100. Whereas acute spending has increased by a factor of 2.88, mental illness had increased by 3.7 and mental handicap by 3.84.

Figure 3:Cost per inpatient week 1964-86

Standardised with 1964=100



Source: Table 8 in Appendix 3

It is quite clear then that significantly more money has been channelled into the mental illness and mental handicap hospitals relative to acute hospitals since Crossman launched the priorities policy. Even during periods when the acute sector has experienced nil or so-called negative growth, mental illness and handicap spending has accelerated. This trend has been particularly marked during the first five years of the 1980s and indicates the effectiveness of the review process in securing the implementation of ministerial policy.

In this context, more recent commentators such as Allsop[37] and Lee[38] who are critical of the failure to move towards equalisation of total net spend by programme have expected more from the policy than it was designed to deliver. Generally, politicians, administrators and academics alike, have tended to underestimate both the cost and more fundamentally the historical span of transferring all services from the network of large hospitals which took 140 years to create.[39]

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[37]Allsop, J., Health Policy and the NHS, (London: Longman, 1984), concludes that there is no definitive evidence of a resource shift.

[38]Lee, K. Public expenditure, health services and health, in Walker, A., Ed. Public Expenditure and social policy, (London: Heineman, 1982) p. 87

[39]Cost estimates of reproviding the services in one large hospital, Darenth Park, are given in Korman, N. and Glennester, H., Hospital Closure, (Milton Keynes: Open University Press, 1989) pp.152-175. To date, Darenth is the only large hospital which South-East Thames RHA has been able to afford to close.

These shifts in resources within the hospital services have been paralleled by substantial developments in the community services. The Department of Health last undertook a 10-year analysis of progress in the late 1980s. This reported an 80% increase in the number of local authority community residential places for people with a mental handicap and over 180% growth in places in the voluntary and private sectors.[41] Equivalent figures in mental illness were 85% and 143%.[42] Increases in the number of day and training places were of similar orders of magnitude.

Standards of care

To what extent have these additional resources been reflected in standards of care? Since manpower accounts for between two-thirds and three-quarters of hospital costs, these trends in expenditure should reflect increased staffing levels in mental illness and handicap hospitals. To investigate this, data from the Ministry of Health and DHSS statistical reports on the facilities and services in mental illness and mental handicap hospitals has been collated, and restructured on a common basis of the number in major staff group per 100 patients resident. The returns were first published in 1964 allowing the entire period to be represented, however they did not begin appearing annually until 1969. It has not been possible therefore to compile a complete data set for the 1960s, since data for 1964, 1967, the year Sans Everything appeared, and 1969 is not available in the returns. However the trend remains apparent.

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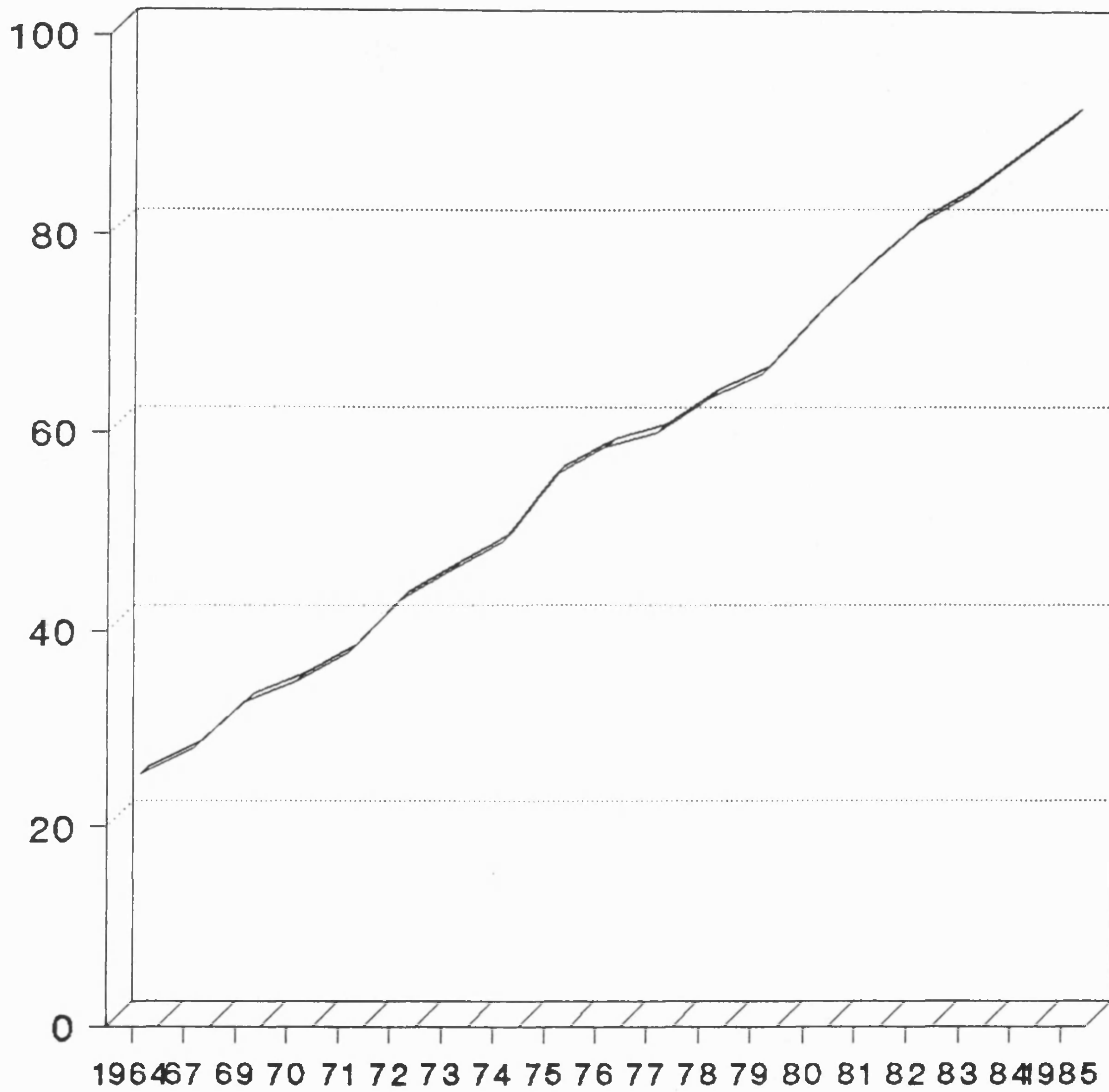
[41]'Personal Social Services: Provision for Mentally Handicapped People in England, 1976-86', Statistical Bulletin, (DoH, London: October 1988) pp.15-27

[42]'Personal Social Services: Provision for Mentally Ill People in England 1977-87, Statistical Bulletin (DoH:London, April 1989) pp.11-17

As Figures 4 and 5 demonstrate, the entire period shows sustained improvements in staffing ratios and, for nursing staff, reductions in the dependency on untrained staff.

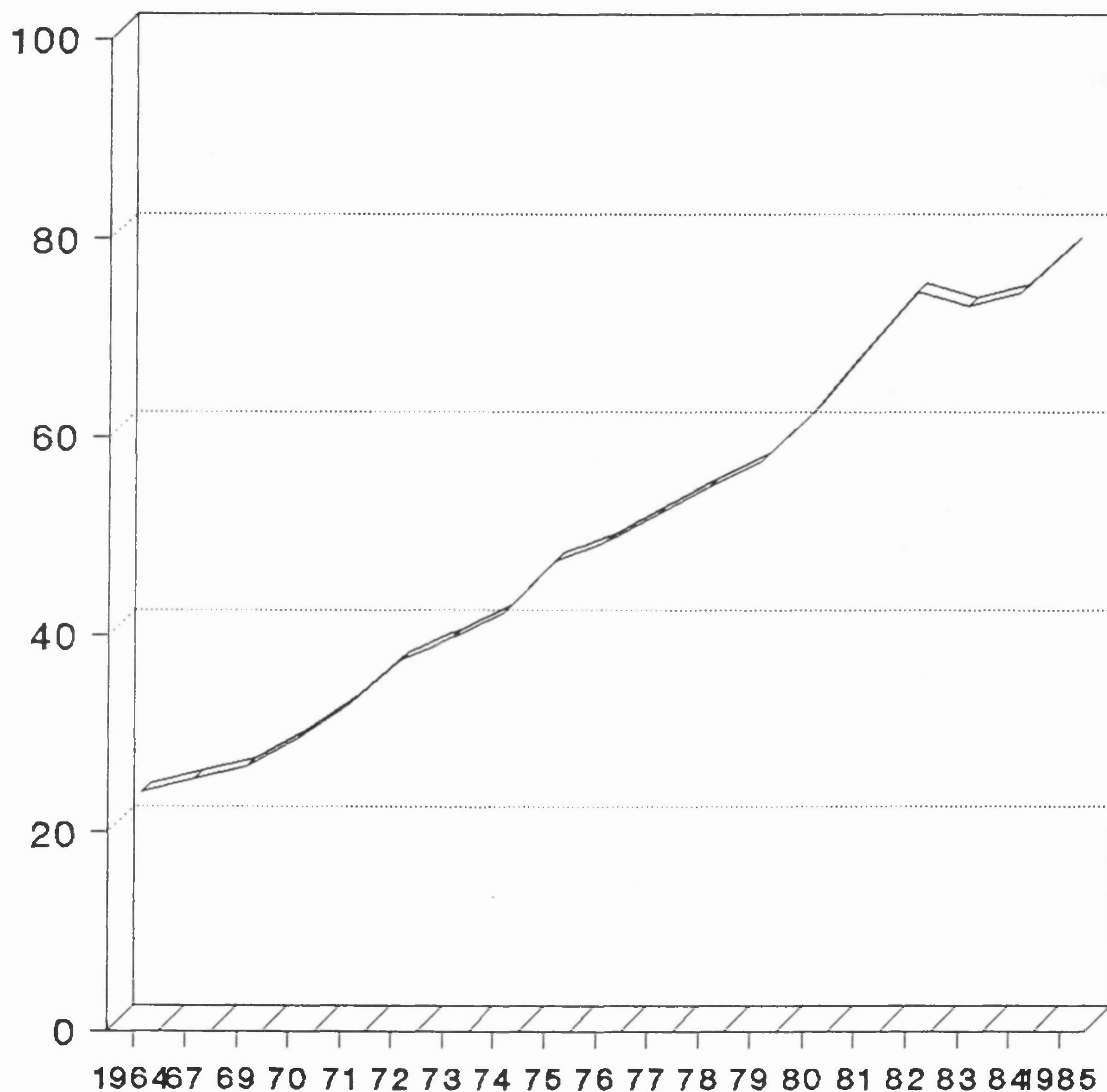
Figure 4: Nurses per 100 pats. 1964-85
Mental Illness Hospitals



Nurses per 100 pat.

Source: Table 12 in Appendix 3

Figure 5: Nurses per 100 pats. 1964-85 Mental Handicap Hospitals



Source: Table 13 in Appendix 3

Minimum Standards

The Department began collating annual returns on compliance with minimum standards in 1970 as part of the Post Ely Policy. The categories included were staffing levels for consultant psychiatrists, nurses and domestics, and patients amenities including minimum provisions of night and day space, of personalised clothing and cupboard space. They have been summarised annually in the statistical reports series headed "The facilities and services of mental illness and handicap hospitals". From 1972[43] onwards, the Department followed the practice of including in the published summaries only those hospitals where 25% or more patients are without the amenity. Given the wide variation in the size of large hospitals, this appears somewhat anomalous since if care for 20% of patients in a 1000 bed hospital does not comply it appears satisfactory despite the fact that twice as many patients are involved than in the case of 400 bed hospital with 25% non-compliance.

In 1973[44] 78 large mental illness and 65 large mental handicap hospitals failed to comply with at least one standard: the respective figures for two or more were 41 and 48. By 1982, only 8 mental illness hospitals failed to meet one standard only and 8 RHAs had attained minimum standards in all such hospitals. Progress in the mental handicap hospitals has been slower. By 1982, 47 of the 65 hospitals with 200 or more beds failed to comply with one indicator (which in all but one case was levels of ward orderly and domestic staff) and eleven with two or more. The collection of this data was ceased in 1986 when the NHS moved over to the Korner information definitions.

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[43]DHSS, DS 86/72

[44]This is taken as the base year since the figures were presented slightly differently from 1973 onwards.

John Yates Indicators

Further evidence that the relative poverty of the mental handicap hospitals should still cause concern has been provided in the data complied by the University of Birmingham Health Services Management Centre on all the country's mental illness and mental handicap hospitals with 100 beds or more.[45] Between 1975 and 1985 John Yates and his colleagues monitored hospital performance against nine quantitative indicators and developed a particular interest in factors which they argued could inform authorities that certain hospitals in their management might be at risk of being subject to enquiry. Yates' work has illustrated that the scandal hospitals were relatively unexceptional in performing poorly on the indicators he has selected. Table 1 includes information covering hospital size, staffing and other indicators relating to performance drawn from the "Facilities and Services" report published for 1967; the year that Sans Everything appeared. Those hospitals which were to be subject to inquiry are included and compared with others which escaped the trauma despite the fact that they were performing as badly or even worse.

[45]See Yates, J.M. Just Visiting - Long-Stay hospitals: Challenge for Health Authorities, University of Birmingham , 1985, Yates J.M and Vickerstaff, Inter hospital comparisons in mental handicap, Mental Handicap, 1982, 10:2, pp.45-47 and Staff-patient ratios and hospital inquiries, Nursing Times Vol 71 No.50 9.12.81, pp.2143-2145

Table 1 Quantitative indicators of performance of large mental illness and handicap hospitals in 1967 (figures for staff show ratios all staff per hundred residents)

Mental Illness Hospital	No patients	% in wards 50+	% working	Consultant	Qual'd Nurses	Other Nurses	Total Nurses	Domestics
Hospitals featured in inquiries								
Banstead	1275	16	77	0.22	13.0	28.0	41.0	5.8
Friern	1948	27	46	0.21	9.5	11.6	21.1	4.7
Storthes Hall	1713	43	65	0.38	7.8	17.0	24.9	4.5
St.Augustine	1325	62	61	0.33	12.0	19.9	31.9	3.7
St.Lawrences	1154	18	56	0.44	10.6	18.3	28.9	4.3
Whittingham	2110	43	72	0.13	7.9	16.9	24.8	2.6
Other selected comparisons								
Bexley	1877	72	62	0.28	11.7	18.2	29.9	5.0
Prestwich	2039	70	79	0.15	8.3	12.0	22.7	1.7
Rainhill	2471	70	52	0.42	15.1	16.5	31.6	4.3
Warley	1695	67	67	0.53	14.0	23.5	37.5	3.8
West Park	1877	55	57	0.28	9.3	11.6	20.9	1.8
Mental handicap hospitals	**No patients**	**% in wards 50+**	**% working**	**Cons.**	**Qual'd Nurses**	**Other Nurs.**	**Total Nurses**	**Domestics**
Hospitals featured in inquiries								
Sth Ockendon	1210	52	43	0.17	7.7	18.5	26.2	5.9
Ely	459	98	37	0.15	7.2	22.7	29.8	5.6
Sandhill Park Group*	854	38	61	0.16	9.4	18.1	27.5	4.0
Other Selected comparisons								
St.Lawrences	2063	76	50	0.15	7.8	12.2	19.9	1.9
St.Margarets	1397	67	48	0.21	7.4	12.5	19.9	1.1
Brockhall	1971	76	44	0.15	7.3	16.7	24.0	2.5
* included Farleigh Hospital								

* included Farleigh Hospital
Source:DHSS Statistical Report Series No.9
The Facilities and Services of Psychiatric
Hospitals in England and Wales HMSO 1967

This data supports the view widely held amongst NHS managers that the inquiry hospitals were, in some respects, unlucky to be singled out.

Agents of scrutiny

Soon after she published the South Ockendon Inquiry Report, Barbara Castle reinforced the existing provision for advising and scrutinising management in the longstay hospital sectors by creating separate agencies for the mental handicap sector leaving the Hospital Advisory Service to concentrate on services for the elderly and mentally ill. In 1975, she established the National Development Group for the mentally handicapped to provide a national policy advisory role and the following year set up the National Development Team (NDT) to visit hospitals and advise individual authorities. The National Development Group lasted only four years before it was wound up as an 'unnecessary QUANGO'. In order to de-emphasise the inspectorial role, the NDT differs from the HAS in a number of respects. When first established, the NDT could visit by invitation only, although after the Normansfield report, this was revised to allow uninvited visits according to the Minister's discretion. Over the period, leaks to the press of confidential reports, and advice to authorities which seemed somewhat unrealistic in the light of their resource constraints have led to criticisms of the NDT and to a certain erosion of its authority within the service.

In contrast, the HAS has maintained a central role in advising Ministers on policy, pressurising authorities to act on unacceptably low standards of care in hospitals and proselytizing good practice throughout the service. There have been two major changes since 1969. First in recognition of the importance of joint planning and collaboration, the services provided by social service authorities were brought within its remit and it was renamed the Health Advisory Service. Secondly, beginning with a highly critical report of the services provided at Brookwood Hospital by North West Surrey Health Authority in 1985 its reports are now published in full.

The HAS has expanded its role in policy advice and produced a number of major reviews whose findings have been adopted as Ministerial policy.[46] Visits to authorities can vary in their impact. Team members from the major disciplines of psychiatry (or geriatrics), nursing, occupational therapy, social work and administration (usually planning) spend two weeks in an district not merely reviewing standards of care and monitoring professional practice, but they also scrutinise local planning relationships between health and social services and established strategies for service development. The impact and helpfulness of HAS visits depends to a large degree on the experience and knowledge of the teams, both objectively and as it is perceived by the authority visited;[47] although the Secretariat will seek to ensure that teams are drawn from professionals whose philosophy of care is known to accord with central policy.

There was understandable apprehension amongst health authorities at the prospect of the HAS publishing its reports in case the media focussed on the more critical aspects. These fears have largely proved unfounded, since ironically the press seems to have shown less interest in HAS reports now that they are freely available than it did when reliant on leaked documents. There has been some perception that the HAS has begun to adopt a more pro-active role and critical position viz-a-viz district health authorities. Certainly its first few published reports have adopted a critical stance with authorities managing large hospitals if standards of care are found not to be good or plans for future services have seemed institutional and unimaginative. For an agency criticised for lacking teeth[48], this is probably a healthy development.

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[46]Health Advisory Service (HAS), The Rising Tide: Developing Services for Mental Illness in Old Age, (London: HAS, 1982)

[47]See Henkel, M, Kogan, M., Packwood, T., Whitaker, T., And Youll, P. The Health Advisory Service, (London: Kings Fund, 1989) pp.68-71

[48]Parker P., 'Faithful Watchdog Barking in the dark', Times Health

Continued on following page

A critical approach has always been in the character of the HAS since successive directors have not recoiled from using dramatic descriptive language in annual reports to focus attention at national level on inadequate standards of care. Over the years, this has made an important contribution to sustaining pressure on Ministers to maintain the priorities policy. There is a case for greater subtlety with district health authorities. The HAS has no brief to consider the resource implications of its recommendations. There are therefore dangers in adopting too critical a stance since if health authorities judge its recommendations to be unrealistic, the HAS could lose some of the credibility it has built up over the years. Although to be fair to the HAS, some authorities so far singled out for strong criticism have responded with major reviews of operational policies and plans for future services.

The Mental Health Act Commission (MHAC)

Established by the 1983 Mental Health Act, which owed something to the South Ockendon and Farleigh Inquiries on the use of seclusion and confusion over dealing with violent patients, the MHAC is empowered to ensure that the Act's provisions on the rights of detained patients are observed. It vets their care and treatment in NHS and special hospitals, including ensuring that second opinions are available for patients who object to treatment, and a right of veto over proposals by clinicians to perform psychosurgery. It was innovative in including lay members and granting them an equal role as Commissioners as professionals. The Commission has more overriding powers than the HAS. Authorities are obliged to implement its recommendations and, like the Health Service Commissioner, it is obliged to produce two-yearly reports which are put before Parliament. It can visit without notice, require that all relevant case notes and files are made available and staff and

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Continued from previous page
Supplement, 11 December 1988.

patients can request confidential interviews with members of visiting teams and Commissioners can select individual patients for interview. In its powers the MHAC comes much closer to the type of inspectorate which Barbara Robb envisaged for the service as a whole. At the time of writing, the Commission has been subject to some press publicity about differences of view amongst Members as to its role, and its relationship to the executive and the legislature.

The future

With the implementation of NHS Trusts, the role of statutory agencies of scrutiny seems set to grow. Recent proposals include the extension of the powers of the Audit Commission to the NHS in England and Wales. More widely, the growing interest in quality assurance, medical audit, and resource management, together with the need to ensure that that Trusts meet standards of care for which the Secretary of State is answerable to Parliament, should expand the role of statutory agencies of scrutiny, monitoring and inspection.[49]

It is crucial that they should develop and be given the powers and resources necessary to be effective. The large hospitals will be closed over the next 10-15 years. Stiff powers will be therefore be needed to ensure that capital and revenue currently devoted to these hospitals stay in the mental illness and mental handicap sectors, whether spent by social services, the private sector, voluntary organisations or the NHS itself. Otherwise it may prove all too tempting for health authorities to divert resources released from closing mental hospitals into the ever-hungry acute hospital

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[49]See Sketris, I., Health Service Accreditation - An international overview, (London: Kings Fund, 1988)
Also the NHS and Community Care Act requires Social Services Authorities to establish inspection of facilties to which they contract for care, including those under their own management.

services. Similarly, as local authorities receive additional resources as a result of the NHS and Community Care Act, monitoring will be necessary to ensure they are spent on Community Care and not the roads, refuge collection and education.

Authorities not mindful of this may be storing up trouble. Neglect, insitutionalisation and ill-treatment can develop in small-scale residential facilities. The history of AEGIS suggests, that when officialdom allows this to go on, it is sitting on a political time-bomb.

Summary

The impact of the reforms set in train and promoted by AEGIS in standards of care have been substantial. Certainly the move away from large hospitals towards more localised services has been reinforced by the negative image of the mental hospital presented in the scandals. However public perception of this was already low and it is debatable whether the publicity aggravated or merely confirmed the reputation. By turning the spotlight onto conditions on the longstay wards, the closure programme has proceeded alongside an impetus to improve standards of care in the large hospitals during the transition period. Consequently, there has been a sustained trend of resource shifts into the mental handicap and mental illness hospitals compared to workload and relative to the acute service sector which ostensibly is more politically powerful. The HAS has added its contribution by sustaining pressure on Ministers. The jury is now out on how the most recent reforms will impact on this trend.

The large hospitals have not been the only gainers since the scandals have had a major impact on policy in all fields of mental health, raising its profile and hauling its concerns up the political agenda. As a result the planning of community-based services became substantially more sophisticated. Care group planning was established and the detail of policy focussed on the

previously forgotten needs of chronic, elderly and other patients with special needs such as the behaviourally disturbed. Also, the inquiries at South Ockendon and St. Augustine's in particular have provided formidable ammunition to the civil rights movement in mental health which lobbied for the 1983 legislative reforms. Beyond mental health, there have reverberations in planning, in the accountability of health authorities and their relationship between Ministers and the central department.

Whether claims of parallel victories can justifiably be made for the campaign on Mrs Robb's second front, complaints, is the subject of the next chapter.

CHAPTER ELEVEN

COMPLAINTS MACHINERY

> "...the first essential in the delivery of good health care is to listen to the complaint of the patient..."(Sir Cecil Clothier)[1]

> "The number of statutes which pass the legislature, or the number of decrees which are handed down by the executive, but which change nothing in the permanent politics of society, is a rough index of the role of magic in politics."(Edelman)[2]

The machinery for the redress of grievances against the hospital services now has three components; the procedures laid down for internal investigation by health authorities; the provisions for special inquiry into serious complaints; the Health Service Commissioner. The activities of AEGIS influenced all three areas and particularly the last two.

Of all the post-Ely reforms, the formulation of an adequate hospital complaints procedure has proved the most problematic. During Crossman's period of office a number of attempts were made by officials but rejected as inadequate by him and his PEP advisers.[3] After the Farleigh Report, Sir Keith Joseph established the Davies Committee to try and resolve the issue. Since it reported in 1973, the saga has continued and the holy grail continues to prove elusive. There have been five attempts, including Davies, and their history can be characterised as a

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[1]Clothier, C., The Patient's Dilemma, (London:Nuffield Provincial Hospitals Trust, 1988)
[2]Edelman D., The Symbolic Use of Politics, (Urbana: University of Illinois Press, 1964), p.195

[3]See Chapter 7

gradual but purposeful retreat from the principles set out in his report.

As befits a Recorder and senior barrister, Davies's approach was legalistic and his report endorses clearly defined and standard procedures underpinned by independent review in preference to administrative discretion.[4] His major objection to the extant procedures in HM(66)15 was that they were almost entirely internal and largely subject to the discretion of individual authorities. Firstly, senior staff over-emphasised the more formal aspects of procedure; most would not consider oral complaints and there was no uniformity across authorities for dealing with similar situations. Secondly, the official procedures were perceived by staff as imposed from above, out of touch with their conditions of work, and therefore informal procedures evolved. Thirdly, there were no clear guidelines as to when Regions should be involved following investigation by the lower-tier authority. Similarly, the question of how and to what extent authority members should be brought into or informed about the investigation of complaints was left uncertain. Fourthly, the guidance did not deal with complaints by members of staff on behalf of patients "or with the related problem of possible victimisation of staff or suppression of complaints".[5]

By implication, at least the report was equally critical of the central Department. According to the circular[6], the DHSS was to act as the convener of complaints and determine the method of investigating the more serious amongst them. The power vested in Ministers to investigate complaints was rarely exercised. Responsibility was fragmented across several branches and no one section to deal with investigation of individual complaints as a specialist subject. When a complaint came in, it was immediately

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[4]DHSS, NHS, Report of the Committee on Hospital Complaints Procedure, (London: DHSS, 1973)

[5]Ibid para. 2.6

[6]Ministry of Health, Circular HM(66)15 para.9

referred to the hospital authority's senior officer and therefore there was no effective independent review.

Davies' prescribed 6 major principles for a fairer and more effective procedure:

(a) It should be well known, easily accessible, comprehensible, and seen to be fair and just;[7]

(b) It should allow the free flow of suggestions and complaints;[8]

(c) Patients should be assisted to complain by providing them with appropriate information;[9]

(d) Oral and written complaints should have the same status[10] and all be recorded;[11]

(e) The various parts of the system should be interrelated;[12]

(f) A standardised system for dealing with complaints to do with medical care and treatment was required;[13]

To achieve the first five, the report set out a code of practice with three main objectives: to reassure patients and others that proper provision had been made; to make it clear to staff dealing with complaints what is expected of them; and to set standards for those reviewing and monitoring the system. The code had three principal characteristics. Firstly it was hierarchical. Complainants who remained dissatisfied with the response at one

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[7]ibid para.6.4
[8] ibid para.6.4
[9]ibid para. 1.10
[10]ibid para. 1.10
[11]ibid para. 1.16
[12]ibid para. 6.6
[13]ibid para. 1.16

tier of management, moved up the structure finally reaching Members in serious cases (but not sufficiently serious to warrant an independent inquiry) before moving to external review.[14] Davies anticipated that the great majority of complaints would be satisfied at officer-level and regarded the Members' role as the first independent check in the system[15]. Secondly, it was based on the provision of adequate information and assistance to complainants, through booklets and prominent notices which specified the recourse open to the dissatisfied. Similarly staff members were to be informed how to complain on their patients' behalf. Thirdly the fairness and openness of the system depended on the existence of effective independent review.

Davies found that investigation of clinical complaints was seriously inhibited by an unwillingness amongst doctors to criticise colleagues.[16] As a result complainants who did not wish to were often obliged to go to law.[17] Davies therefore recommended a system of standing 'Investigating Panels' to be appointed by RHAs, and composed of both professional and lay members, unconnected with the RHA, under a legally-qualified and permanent Chairman. The Panels would assist in the investigation of any complaint which could be the subject of litigation, clinical or otherwise.[18] The Chairman would be a senior barrister or solicitor from a list compiled by the Lord Chancellor. It would be at the panels' discretion whether a hearing was held, in which case it would be in private and without legal representation. In the case of sufficiently complex and serious complaints, the Chairman would ask the RHA to constitute a panel as an independent inquiry.[19]

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[14]ibid para. 7.23
[15]ibid para 7.40
This view was not shared by Barbara Robb and her advisers who felt that authority members could be considered independent in reviewing complaints against their own hospitals.
[16]ibid para. 7.29
[17]ibid para. 8.9
[18]ibid para. 8.9
[19]ibid para. 8.22

In February 1976, Barbara Castle told Parliament that she accepted the Davies proposals for a uniform, written code of practice and issued a consultation draft. The timing of Mrs Castle's announcement could not have been insignificant since it took place just six weeks after the St. Augustine's Report hit the headlines. Despite the clinical aspects of the St. Augustine's complaints, Davies' proposals to introduce an external review of clinical complaints remained contentious. Therefore as she launched the consultation on the Code of Practice, she also announced that she had asked the Select Committee on the Parliamentary Commissioner to review the jurisdiction of the Health Service Commissioner having regard to Davies' recommendations about investigating panels.[20] Of course this was a convenient means of clearing the political path for the less contentious recommendations in the Davies Report. The answer indicated that Mrs Castle both accepted the case for some mechanism of independent review of clinical complaints other than the courts and believed that an extension of the Commissioner's jurisdiction was preferable to Davies' proposals. This was unsurprising since she had led the Opposition attempt to include clinical complaints in the Commissioner's jurisdiction when the 1973 Reorganisation Bill passed through the Commons; not least, as her record as Secretary of State was to demonstrate, she was unabashed by the prospect of taking on the profession.

The draft code of practice produced by her Department, alone amongst the several which appeared after Davies, met most of the principles he set out. Authorities were to provide detailed information to complainants through readily available booklets which included advice on taking a complaint further if local investigations were considered unsatisfactory. Staff were to have equal access to this information and be informed of their right to approach the Health Service Commissioner direct if complaining on behalf of patients. Oral and written complaints were to be given equal status and recorded. Like Davies' recommendations the code

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[20] House of Commons Official Report Vol 905, Written Answers Cols. 85-6, 9.2.76

was hierarchical beginning at ward level but reserving the right of complainants to approach either the district or area administrator at any stage. They were to bring any serious complaint or untoward occurrence to the attention of the area health authority who could take one of four channels: it could leave the investigation to senior officers, set up a member level investigation, refer the complaint to the Health Service Commissioner or establish a formal inquiry.[21]

The draft code placed the responsibility for investigating complaints on health authority officers and members and vested in them considerable discretion over whether to refer complaints to independent review. In any authority less inclined to do this, the onus was left on the complainant to exhaust the channels prior to appeal to the Commissioner. In the light of AEGIS's contentions that authorities could not be trusted with such wide discretion, and that many complainants would never reach the Commissioner since they would exhaust themselves before reaching the end point of local procedures, it is difficult to consider the draft code as a radical document.

Even so, the proposals were criticised by health authorities and the Medical Defence Union.[22] When subsequently the Report of the Select Committee of the Parliamentary Commissioner raised its voice against the draft code, it became inevitable that it would be interred. The Select Committee rejected the judicial preference for standard procedure and argued that the draft code sought to replace the fragmentation of existing arrangements with an unduly complex and formalised system.[23] The DHSS withdrew and

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[21]NHS, Code of Practice for Handling Suggestions and Complaints (other than those about Family Practitioner Services), attached to DHSS Circular HN(76)107, Health Services Management: Health Services Complaints Procedure, June 1976

[22]Brooke Barnett, J.W., 'Standing the test of time, Health and Social Service Journal, Vol. 87, No. 4535, 8th April 1977 p.623. The author wrote in his capacity of Secretary of the Medical Defence Union.

[23]House of Commons, First Report from the Select Committee on the Parliamentary Commissioner for Administration, Independent Review
Continued on following page

issued a new draft in 1978 with three major changes. Firstly, it was substantially shorter and less detailed in its prescriptions for procedures which answered the Select Committee's call for simplification. However, it increased the implied discretion of authorities and therefore ran the risk of generating wide variations in procedure and simply reproducing many of the difficulties which Davies had found in existing arrangements. Secondly, it required a complaint to be put in writing before it could be referred to senior officers or members, risking deterring the less literate or staff fearing victimization. Thirdly the emphasis which the original draft had placed on the need to inform members of staff of their rights to complain on behalf of patients was taken out.

With the 1979 Election there was yet another hiatus until in 1981 the new administration published what seemed to be final proposals in Circular HC(81)5. Its provisions for non-clinical complaints were largely in line with the Labour Government's second draft document. In one minor divergence it re-emphasised the status of oral complaints as formal if the complainant sought an investigation by senior staff.

Its major departure from the previous two documents was its inclusion of guidance on handling clinical complaints. This issue had come to a head when the Select Committee on the PCA recommended that the Health Commissioner's jurisdiction should be extended to cover this field.[24]. However the new Secretary of State rejected this and instead, asked the BMA to devise a procedure which was then transferred virtually verbatim into the circular and remains in force in 1990.[25]

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of Hospital Complaints in the National Health Service, HC 45 (London:HMSO,1978) paras. 16 and 41

[24]Ibid

[25]BMA Joint Consultants Committee, draft procedure for hospitals, British Medical Journal, Vol.281, No. 6252, 22nd November 1980, pp.1442-3,

There is no further review available to complainants who remain dissatisfied apart from the Courts. Whether or not this is adequate is discussed below in the context of the powers of the Health Commissioner. However the 1981 guidance did not end the saga of the fate of the Davies proposals for other types of complaint. In 1986 personal experience of hospitalisation motivated Michael McNair Wilson MP to introduce a private members bill to oblige the Secretary of State to introduce direction to health authorities about a new complaints procedure for the hospital service. There is no prescription on procedure in the resultant two-page act which simply makes the discretionary power in section 17 of the 1977 NHS Act, mandatory.[26]

The Secretary of State duly responded in November 1986 with yet another consultation draft procedure whose provisions were less detailed yet at once more formalised than any of its predecessors. Each health authority would designate an officer to be the recipient of complaints. These were to be made in writing and should the patient be unable to do this, a designated officer would make a record of the complaint which the complainant would be required to sign. Information on making complaints was to be made freely available, however as in the HM(81)5, there was no reference to complaints by staff on their patient's behalf. The draft was confirmed in 1988.[27]

Davies's objections to the situation he reviewed apply to the current draft. It lacks detail. There is no indication of when complaints should be referred to different tiers of the authority, and in what circumstances senior officers or members should be involved. Neither is there any detailed guidance as to the

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[26]The Secretary of State, is required to give health authorities directions to ensure: "(a) such arrangements are made for dealing with complaints made by or on behalf of persons who are or have been patients at that hospital; and (b) such steps are taken for publicising the arrangements so made" Eliz.II c.42, Hospital Complaints Procedure Act 1985, section 1 (1)

[27]DHSS Circular DA (86) 14, and attached booklet, DHSS:Hospital Complaints Procedure Act 1985, Consultation Document, DHSS Circular HC(88)37

circumstances under which a complaint should be referred for special investigation under HM(66)15. As a consequence, it leaves authorities with considerable discretion and in all probability is producing a diversity of local procedures. Those authorities who currently handle complaints fairly and justly will continue to do so and those who are less concerned would remain so. There is no provision for assisting complainants other than the publicity, although CHCs can offer advice.[28]

The absence of any specific guidance on staff complaints is a serious omission given the findings of a survey by the National Association of Health Authorities which reviewed complaints procedures in 80% of district health authorities. There was little evidence either of uniformity of content or widescale comprehensiveness and procedures varied in quality. Significantly only a quarter of the authorities surveyed provided guidance to staff on how to make complaints on behalf of patients.[29] Lastly, discretion is left either with health authorities or the Secretary of State to refer serious complaints to independent inquiry.

As Davies emphasised, the adequacy of a hospital complaints procedure which gives health authorities the first opportunity to review the case, relies on the existence of adequate external checks and channels for complainants to seek alternative redress if dissatisfied with the local response. Since authorities are responsible for the service against which the complaint has been made, a legal perspective sees independent review as the only means of maintaining public confidence in the system by ensuring that 'justice is seen to be done'. The available channels are the

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[28]Although not a agencies for the redress of grievances and therefore a primary focus of this study, community health councils have a statutory responsibility to assist patients pursue complaints. Indeed many chairmen see it a primary role to encourage as well assist people with grievances to pursue through the formal channels.

[29]National Association of Health Authorities, Protecting Patients: Guidelines for Handling Staff Complaints about Patient Care, (London:NAHA,1985)

provisions for special inquiry and the Health Service Commissioner.

Special Inquiries

None of the guidance issued since 1976 indicates when health authorities should refer complainants to independent inquiry. As this study has shown, the road to an inquiry has proved long and difficult and required dogged persistence on the part of the complainant. Although this may be expected to have had a limiting effect, the growth in the use of formal inquiries has been one of the most marked developments arising directly from the AEGIS campaign.[30] It is difficult to be precise about the total, but Davies reported that between 1967 and 1971 there were 11 Section 70 inquiries, plus 16 "independent Inquiries" set up by hospital authorities and Martin lists a further 19 in both categories between 1972 and 1981.[31] Since the great majority of these 46 inquiries have been into allegations about care in mental illness and mental handicap hospitals, it is a remarkable tally of up to 20% of all such hospitals.

Since the six committees which considered the allegations in Sans Everything reported in 1968, these inquiries have similarly become increasingly judicialized. This trend has been driven by criticisms of the approach adopted in the Sans Everything and Ely inquiries. The guidelines which applied were issued by the Ministry of Health in 1966 when already under severe pressure from AEGIS and the press over standards of care in mental hospitals and allegations of cover-up and obstruction to complaints.

The Department then introduced a new type of NHS inquiry as an alternative to the statutory inquiries which section 70 of the 1946 NHS Act (or 84 of the 1977 Act) empowered the Minister of

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[30]Harlow,C. and Rawlings,R., Law and Administration, (London: Weildenfield and Nicolson, 1984) p.64
[31]Martin,J.P. Hospitals in Trouble, (London: Blackwell, 1984) pp.256-257

Health (and subsequently Secretary of State) to appoint at his or her discretion. Since they were not appointed directly by the Minister, HM(66)15 inquiries were non-statutory. According to the circular, complaints serious enough to require independent inquiry at Regional level were to be investigated by a specially-appointed committee chaired by a lawyer 'or other competent person from outside the hospital service' and comprising professional and technical experts. The complainant or any persons subject of the complaint was to be present throughout the hearing. There were to be rights of cross-examination, although legal representation was permitted provided it was arranged personally by those appearing.[32] Following the dispute between AEGIS and the Minister of Health over whether or not Barbara Robb would cooperate with inquiries into the Sans Everything allegations, the Minister conceded that the chairman of the committees would be barristers nominated from a list prepared by the Lord Chancellor. The detail procedural guidance was not published at the time but there is no reason to suppose that it was not identical to that provided to Sir Geoffrey Howe in conducting the inquiry into Ely Hospital and sharply criticised in his report. The hearings were held in private. There was no power to summon witnesses. Considerable discretion was vested in the Chairman to decide who would be legally represented.[33]

The Sans Everything inquiries were widely criticised by the press and by the legal profession in the persons of senior barristers such as Geoffrey Howe, Theo Fitzwalter Butler, as an advisor to AEGIS, Sir Michael Davies and his committee, and the Council on Tribunals. Adding their criticisms and recommendations for change to those of the 1957 Franks Report, and the Report of the 1966 Royal Commission on Tribunals of Inquiry (the Salmon

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[32]Circular HM (66) 15 op.cit. para.7.(iii)b
[33]See Chapter 5

Report)[34] produces a package of seven components for the 'ideal type' of judicial inquiry into serious hospital complaints.

First they should adhere to the two major principles of natural justice. There should be full rights of cross examination. This is the rule of audi alternem partem which prescribes that not only should both parties be heard but also that each should have the opportunity to question the other.[35] There also should be no possibility that the body complained against could be cast in the role of both judge and jury in its own case.[36]

Since the Sans Everything and Ely inquiries were appointed by the Regional boards involved Wraith and Lamb politely censured them on this point:

> "The major responsibility for administration lies with the hospital boards, of course, but it remains to be doubted whether they are the appropriate bodies for organising inquiries in situations where if allegations are found proven, they will be seen to have failed in at least one aspect of their administrative duty."[37]

Second, they should be conducted according to standardised and explicit procedural rules. Imperviousness to review is the principle objection to this means of decision-making raised by senior lawyers[38] and again the Sans Everything inquiries were

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[34]House of Commons, Report of the Committee on Administrative Tribunals and Inquiries, Cmnd 218, (London: HMSO, 1957) and Report of the Royal Commission on Tribunals of Inquiry, Cmnd 3121 (London: HMSO, 1966)

[35]See Elcock, H.J. Administrative Justice, London:Longman's 1969, p.47

[36]See Gregory R., and Hutcheson, P., The Parliamentary Obudsman, (London: George Allen and Unwin, 1975) p.32

[37]Wraith R.E. and Lamb G.B. Public Inquiries as an Instrument of Government, (London, George Allen and Unwin, 1971) pp.210-11

[38]See for example, Griffiths, J.A.G. and Street H., Principles of Administrative Law, pp.155-159. Harlow and Rawlings argue that this distinction is misconceived since administrators prefer to operate by the rulebook. op.cit p.118

criticised for a lack of uniformity of procedure[39]. Third, the inquiry should be open in two respects. The hearings should be held in public and both a comprehensive summary of the evidence and the full findings of the committee should be published. It is noteworthy that statutory Section 70 inquiries do not meet this principle since they impose no obligation for a public hearing or publication either of the evidence or the report submitted to the Secretary of State. Fourth, the chairman should have the right to subpoena witnesses. Fifth, all parties should be legally represented either out of the public purse or as a minimum, legal aid should be available to those without the means to employ counsel. Again this was a bone of contention between AEGIS and certain of the committees of inquiry into the Sans Everything hospitals. Sixth, the committees of inquiry should be adequately serviced. This was the subject of one of Howe's principal criticisms of his given procedure since the absence of a solicitor to collate and marshall and sift the evidence severely restricted his committee's ability to investigate some of the allegations which were left unproven as a consequence.

Lastly, inquiry procedure should be subject to external check or scrutiny. This was the role envisaged by the Franks Report for the Council on Tribunals established by the 1958 Tribunals and Inquiries Act. Initially, and contrary to the recommendations of Franks, all non-statutory inquiries were excluded from the Council's jurisdiction. This was remedied to some extent by the 1966 Tribunal and Inquiries act which vested power in the Lord Chancellor to redesignate non-statutory inquiries as statutory; indeed it was following an Order made under this act that Section 70 inquiries became statutory in the first place.
The role and impact of the Council on Tribunals has been the subject of much discussion by writers on administrative law. On paper it has a wide remit. It scrutinises procedure of all statutory inquiries and tribunals both on its own initiative and by receiving and investigating complaints. It also has an inspectorial role and may visit tribunals to make 'spot checks'.

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[39]Wraith and Lamb op.cit. p.209

In addition it produces special reports on topics as it thinks fit, and advises and is consulted on proposals for legislative change.

However, most writers agree that the Council is ill-equipped to encompass such a wide brief across the myriad tribunals and inquiries which now adjudicate in virtually all fields of public administration. Its impact is constrained by the limitations and ambiguity of its powers, its predominantly lay membership (though its concerns are matters of law) and the limited resources it its disposal. As a consequence Harlow and Rawlings argue that it has come to perform a "firefighting" rather than a "firewatching" role.[40] In reality, therefore any scrutiny role it could perform in hospital inquiries would in all probability be confined to responding to specific complaints rather than actively monitoring procedures.

When Barbara Robb made her complaint to the Council, it criticised the way the Minister had used his discretion not to appoint the Sans Everything committees directly under section 70.[41] Although expressing surprise that the Council should have been concerned at this, the Ministry informally agreed to conform to this practice in future and so it did at Farleigh, Whittingham, South Ockendon and Normansfield. At Normansfield, Michael Sherrard QC conducted the most in-depth and procedurally rigorous investigation of all the committees which sat over the period. He stuck by the letter of the principles in the Salmon Report including meeting legal costs from the public purse and did not 'for one moment regret having done so'.[42]

The majority of committees of inquiry since 1968 have been established by health authorities and therefore remained beyond the Council's scrutiny. They have nevertheless been strongly influenced by the trend towards due process. Indeed this was

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[40]Harlow and Rawlings Op.cit. pp.170-191, also Wraith and Lamb pp.225-6, Street, H. Op.Cit pp.62-4
[41]Council on Tribunals Annual Report for 1968 paras. 45-52
[42]House of Commons, Cmnd 7357 op.cit.paras. 13-14

reflected in Appendix 7 of the draft guidance on complaints issued by Barbara Castle in 1976 which contained guidelines for committee chairmen.[43] As noted above, the presumption underlying the trend is that reliance on judicial procedure is the most satisfactory means of reviewing the validity of complaints and allegations and protecting the interests of all concerned. But this understanding should not go unchallenged since evaluative analysis must examine the arguments for and against the appropriateness of judicial procedure for the issues in question.

What are the advantages? To begin with a clear set of procedures mitigates arbitrariness and clarifies the rights of all parties. Second, all allegations are made explicit and known to all sides. Inquiries of this type appear thorough and independent to the general public and therefore their recommendations carry considerable authority and legitimacy. Thirdly, many of the issues involved seemed appropriate for adjudication. There were factual questions of whether specific incidents took place, whether disputed conditions were present, and whether formal responsibilities had been fulfilled. For the individuals involved, there were questions of personal reputation and future career prospects and the need to guarantee protection against recriminations. Not least inquiries have sought to identify causation and attribute blame to individuals in order to prevent future occurrence. For management they have helped resolve known problems involving personalities and entrenched attitudes which were otherwise proving intractable. They have also attracted resources. For the public the inquisitorial approach has undoubtedly opened up the closed worlds of mental hospitals, revealed their relative poverty and related neglect by politicians, and administrators. The importance of these aspects cannot be over-stated.

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[43]DHSS, HN(76)107 op.cit.

But it has not been without cost. Inquiries have been a traumatic experience for individuals and the hospital as a whole which neither will ever forget. Individuals particularly those volunteering evidence out of a sense of public duty, unused to the adversarial approach of counsel were shocked at the treatment meeted out to them in the gladiatorial exchanges.[44] The St.Augustine's Inquiry seems to have generated particular resentment, as the Kent Area Health Authority put it:

> "No one was obliged to give evidence. Those who did so were motivated by a genuine desire to help the Committee discover the truth about the allegations.... and thus restore the good name and reputation that St. Augustine's has hitherto enjoyed. Many of them regrettably came away from the Inquiry with the feeling, not that they had been willing parties to a fact-finding exercise, but rather as having been looked upon as guilty until proven innocent. The feeling could only have been reinforced by some of the questioning to which they had been subject, which more than once was described as hostile."[45]

In his own defence, the inquiry Chairman, Hampden Inskip, saw this as unavoidable:

> "A thorough inquiry will inevitably upset and anger some witnesses..... One of the saddest but cruel and unavoidable features of inquiries is the exposure of inadequacy in a nice sincere person. The fact that witnesses in a court of law are often much more ruthlessly treated is little consolation."[46]

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[44]Swaffield, L. St Augustine's - a breath of fresh air, Nursing Times, Vol 77, no.48 pp.2062-63
[45]Kent Area Health Authority, St. Augustine's Committee of Inquiry. Report of an Emergency Panel, January 1977 para.2.02

[46]Hampden Inskip, J., and Guy Edwards, J., Mental Hospital Inquiries, The Lancet, 1979, (i), No. 8117, 24 March 1979, p.658

Staff have also felt a deep sense of injustice at being subject to severe criticism since they believed they were doing their best in adverse and often extreme circumstances. The clearest example was the petition to the Secretary of State by staff nursing the behaviourally disturbed patients at Farleigh which manifests the insecurity and apprehension caused by the inquiry to staff struggling to provide some kind of service to people otherwise written off by society under conditions which would strain anyone to the limits of patience and endurance.[47] The hospitals may also have inflicted serious blows to staff morale which can reverberate throughout the service. This became a particular danger under the media spotlight and its focus on the sensational and the blameworthy. The hospitals concerned certainly got a bad name, and a blanket image of longstay institutions was created. This could well have aggravated staff recruitment problems. It could have done little to reduce the stigma for those admitted and may have deterred people needing the service from seeking help. On the other hand, the public esteem for the hospitals was already low and the stigma deeply rooted in the days of the asylum. Similarly it is difficult to imagine that the morale at Normansfield could have sunk any lower than it was in 1976. Not least there is substance to the argument that the recognition of problems previously swept under the carpet restores flagging morale.

Undoubtedly inquiries are protracted and extremely costly. Their approach has also been criticised as inflexible and lacking capacity for compromise on a contentious issue. Allegations are either proven or not proven. In the case of the Sans Everything Inquiries, a not proven verdict was used by the Minister to try and discredit AEGIS and, by association, its general case against conditions in the hospitals. Adjudication may be inappropriate to the more subtle problems. It is one thing to find for or against a specific allegation, it is quite another to adjudicate on the

[47] DHSS, Report of teh Farleigh Hospital Committee of Inquiry, Cmnd 4557, (London: HMSO, 1971)

culture of custodial care. It is significant that in reading most of the reports, one oscillates between rational weighing of the evidence and ill-disguised value judgements.

It is largely because the technique of adjudicating on specific allegations was too tight an approach to encompass the multi-variate problems of the longstay hospitals that the early committees of inquiry felt justified to go beyond their strict briefs and make recommendations for national policy. Politicians found themselves reacting to these policy proposals in the context of a press primed by AEGIS and anxious for stories and it is questionable whether this is a desirable means of making policy. The high public profile can create resource demands which politicians are unable to deliver.

Ultimately the test of the appropriateness of the committees of inquiry is their impact. This has been substantial for the individual hospitals which have variously experienced complete changes of management and authority and benefitted from extra resources, and upgrading.

The Health Service Commissioner

If any one individual could justifiably have taken much although not all of the credit for the establishment of the office of Health Service Commissioner in 1973, it was Barbara Robb. As this study has shown she was both the architect of the 1960s and 1970s hospital scandal era, and also a formidable lobbyist to provide countervailing pressure to the might of the BMA both in getting government agreement to proceed and also in the battle for an effective office.

Barbara Robb believed that the nurses on the ground responsible for delivering care were amongst the best judges of standards and that if only they could be freed from the fear of victimization, the lot of the longstay patient would be greatly improved. She

also placed great store by the mechanism of complaints from the public as a source of constant pressure on government and health authorities to improve standards of care; indeed there can have been no better exponent than she. She campaigned hard for a Health Commissioner to act as the channel for the concerns which nurses raised with her about care in their hospitals, and also to remove the kinds of obstacles to furthering complaints by members of the public which she had encountered at the very beginning and which had motivated her to embark on her campaign.

Her major victory was achieving direct access for nurses complaining on behalf of their patients. Her two major defeats lay in failing to persuade Parliament to bring clinical complaints within the office's jurisdiction from and to allow all complainants direct access, although complainants were spared the further hurdle of the 'MP filter' (obligatory for investigations by the PCA).

The primary concern of academic administrative law has been with the role of the Parliamentary Commissioner and with the exception of Stacey[48], the subject has paid little attention to its younger sibling. Similarly, few commentators on social policy have considered it worthy of attention. These facts alone indicate that the office has made no great impression on expert opinion and to the extent that experts influence the consciousness of the wider public, its impact may well have been limited.

In the one major study of the hospital inquiries to date, Martin is not encouraging about the record of the Health Commissioner as a champion of the longstay hospital service.[49]. In reviewing the cases discussed in the first five annual reports, he concluded that only a small proportion of complaints were about standards of care in the longstay hospitals.[50] The results of a content

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[48]Stacey F., Ombudsmen Compared, (Oxford:Clarendon, 1978) pp. 176-195

[49]Martin J.P. op.cit. pp.154-156
[50]ibid p.161

analysis of all the published cases in the annual reports from 1975 to 1980 seems to confirm this since the mental illness and mental handicap sectors accounted for no more than 16% of all upheld complaints in any year.

Table 1

Complaints upheld : Care Group Analysis					
Year end	Elderly	MI/MH	Acute	Other	Total
Net Figures					
1975	4	8	30	7	49
1976	0	9	32	14	55
1977	6	7	69	18	100
1978	8	13	61	15	97
1979	11	5	70	19	105
1980	11	8	44	10	73
(information not published in these years)					
1986	6	9	19	16	50
1987	3	14	27	12	56
1988	9	7	14	19	49
Distribution					
1975	8.2	16.3	61.2	14.3	100
1976	0.0	16.4	58.2	25.5	100
1977	6.0	7.0	69.0	18.0	100
1978	8.2	13.4	62.9	15.5	100
1979	10.5	4.8	66.7	18.1	100
1980	15.1	11.0	60.3	13.7	100
(information not published in these years)					
1986	12	18	38	32	100
1987	5	27	54	23	56
1988	18	15	28	39	49

Source: Total selected cases reported in HSC Reports 1975/6 to 1980/1 and 1986/88[51]

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[51]The successive holders of the office have followed different policies on the degree of publicity given to cases upheld in their reports to the House of Commons; hence the variation in the proportion of cases discused in detail as shown in table 2 of the total number concluded and upheld between years as shown in table 2. Between 1977 and 1979, when the commissioner published a report every four months including all the cases up held during Continued on following page

Yet it is not surprising that complaints in acute services should dominate the commissioner's work when the care-group analysis figures are compared with the caseload statistics in Table 10 in Appendix 4. The fact that the longstay hospitals account for 20% of complaints compared with only 10% of caseload suggests that the Commissioner has enjoyed some success in targeting these sectors.

However there is no cause for complacency, since in global terms the use made of the Commissioner is limited. According to the figures supplied by DHSS to the Davies Report, between eight and nine thousand written complaints were received annually about the hospital services.[52] By 1986 this had risen to 22,000.[53] Extrapolating from Davies estimate of the numbers who were dissatisfied but did not formally complain, the pool of potential complainants could be over 10 times that number who put pen to paper.[54] In contrast, table 2 shows the number of cases handled by the Commissioner over the ten year period beginning 1975, analysed by course of action taken. Although the figures show a steady increase, by 1985 less than 1000 new grievances were arriving on the Commissioner's desk every year.

Continued from previous page
the year.

In more recent years some of the complaints in mental handicap and illness have been from outraged local residents objecting to group homes being established in their neighbourhood. See Editorial, Nursing Times, July 13 1988, vol.84, no.28 p.60

[52]DHSS Report of the Committee on Hospital Complaints Procedure, op.cit. para. 2.2.

[53]DHSS, Circular DA(86)14

[54]DHSS, Report of the Committee on Hospital Complaints Procedure, op.cit. paras. 5.6 - 5.9

Table 2: Analysis of complaints by action taken 1974-85

Year end	New Complaints	From prev year	Total Considered	Rejected /Discontinued	Referred	Reports Issued	Cases Concluded	Carried to next year
1974	361		361	201	18	23	242	119
1975	493	119	612	293	85	128	506	106
1976	504	106	610	308	69	128	505	105
1977	582	105	687	341	85	120	547	140
1978	584	140	724	319	70	109	499	225
1979	712	225	937	508	88	116	712	225
1980	562	225	787	391	73	106	570	217
1981	647	217	864	462	101	113	676	188
1982	686	188	874	484	114	101	699	175
1983	798	175	973	559	112	115	786	187
1984	895	187	1082	592	178	119	889	193
1985	815	193	1008	446	227	125	798	210

Source: Annual Reports, 1975-1986

Clearly then, the cases investigated by the commissioner comprise the very small tip of a substantial iceberg[55] and support another of Martin's observations that "complaints .... only got as far as the Commissioner if they were pursued by rather determined and well-informed complainants".[56]

On this kind of evidence, Barbara Robb's own aspirations for the office as a complaints channel which is both free and freely flowing cannot be said to have been realised in practice; although once the battle in Parliament had been fought and the office was on the statute book, she did not expect that they would. There are two major reasons for this. Firstly, the restrictions on the Office's jurisdiction oblige the holder to reject the majority referred. Secondly, and less tangibly, there is an inevitable limitation on the possible impact of ombudsmen by virtue of what they are and where they stand in British public administration.

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[55]The iceberg analogy is borrowed from Klein's study of the complaints machinery for GP services. Klein, R., Complaints against doctors, (London: Charles Knight, 1973), pp. 104-120
[56]Martin, J.P., Op.Cit. p.161

The jurisdiction of the Health Service Commissioner is wider than that of the Parliamentary Commissioner since it encompasses complaints that result from 'failure to provide a service', 'failure in a service' as well as those involving maladministration. However the remit is nonetheless restricted as follows:

(a) the Commissioner cannot consider a complaint unless the authority complained against has first been given the opportunity to investigate it, except where a member of a hospital's staff submits a complaint on behalf of an aggrieved person whom the commissioner is satisfied cannot act on his or her own behalf (the provision secured by AEGIS).

(b) All complaints involving clinical judgement are excluded as are;

(c) cases where redress is available through the courts or a tribunal unless the commissioner thinks it unreasonable for the complainant to have sought redress in this way;

(d) complaints against doctors, dentists, opticians contracted to Family Practitioner Committees;

(e) and complaints involving NHS staff personnel issues.

(f) The commissioner cannot investigate a complaint that does not involve "hardship or injustice through maladministration".

The effect of these limitations is illustrated in table 3 which shows, that between 50 and 70% of referred cases are rejected as outside the office's jurisdiction.

Table 3: Rejection Analysis - net figures

Year end	Clinical Judgement	Authority n.g.c.t.a.**	FPCs	Body o/s remit	Others	Total Rejections	% of total considered
1974	36	18	27	54	88	223	61.8
1975	60	85	76	39	94	354	57.8
1976	63	69	81	41	106	360	59.0
1977	91	85	83	30	134	423	61.6
1978	120	70	32	25	117	364	50.3
1979	184	88	73	38	179	562	60.0
1980	115	73	50	32	148	418	53.1
1981	128	101	59	43	186	517	59.8
1982	145	114	70	40	192	561	64.2
1983	220	112	87	49	103	571	58.7
1984	222	176	96	46	230	770	71.2

Distribution of total rejections

Year end	Clinical Judgement	Authority n.g.c.t.a.**	FPCs	Body o/s remit	Others ***
1974	16.1	8.1	12.1	24.2	39.5
1975	16.9	24.0	21.5	11.0	26.6
1976	17.5	19.2	22.5	11.4	29.4
1977	21.5	20.1	19.6	7.1	31.7
1978	33.0	19.2	8.8	6.9	32.1
1979	32.7	15.7	13.0	6.8	31.9
1980	27.5	17.5	12.0	7.7	35.4
1981	24.8	19.5	11.4	8.3	36.0
1982	25.8	20.3	12.5	7.1	34.2
1983	38.5	19.6	15.2	8.6	18.0
1984	28.8	22.9	12.5	6.0	29.9

* excludes "discontinued" in table 2 (above)
** "not given chance to answer"
*** mainly FPC and personnel issues
Source as Table 1

Complaints involving clinical judgement comprise the single largest category of rejections. The case for and against inclusion has been a recurring theme of the debate surrounding the office since the passage of the bill. It is an example of the conflicting perspectives of two of the most powerful professional groups in Britain, the law and medicine. Administrative

lawyers[57], legally-trained holders of the Office, Members of the Select Committee on the PCA (which includes lawyers) and the Council on Tribunals have argued that the exclusion of clinical complaints imposes an unreasonable restriction on the office, not least because it is often difficult to draw a distinct boundary between clinical and administrative aspects of hospital services[58].

The BMA has opposed extending the Commissioner's jurisdiction to include clinical complaints on three grounds. Firstly it has argued that it would place doctors in 'double jeopardy' since complainants already have the option of litigation. It has suggested that complainants would use the office as a test of the likely success of any court action and thereby encourage more people to proceed and this in turn would erode public confidence in the profession. Secondly, it has pointed out that doctors often have to make rapid decisions on the basis of the balance of probabilities, particularly in emergency, life-threatening cases. Inevitably they are bound to be wrong occasionally. If a climate is created which encourages aggrieved patients or relatives to take legal action, doctors would be forced to practise defensive medicine to the detriment of patient care. Thirdly, the profession has vehemently opposed vesting authority for a final decision about a clinical issue in a lay-person (non-medical).

The last argument is the weakest since a judge in a litigation suit is equally lay on this definition and adjudicates on the evidence of expert witnesses. The Commissioner could similarly seek the advice of an expert panel nominated in consultation with

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[57]See Stacey, F. The British Ombudsman, (Oxford: Clarendon, 1971) p.78, Stacey F.,(1978) op.cit., and Street, H. op.cit. The latter argues that including clinical judgement in the list of standard exceptions to the PCA made the Health Commissioner's office unimportant.

[58]The argument that the PCA investigates complaints against clinical judgement in hospitals managed directly by central government departments, including the special secure hospitals and military hospitals, is also often cited by administrative lawyers.

the profession. The remaining issues are more complex. When the Select Committee on the PCA reviewed the question in 1977, it accepted the need to avoid any system of complaints which caused doctors to think first of how to avoid criticism and to place the best interest of patients second. However it could not accept that the courts should be the sole independent review available to any individual worried about care and treatment. It therefore rejected the profession's case in favour of evidence submitted by the Council on Tribunals, the RCN, the National Association of Health Authorities, and RHA Chairmen who all supported the inclusion of clinical complaints in the Commissioner's jurisdiction. The Chairmen argued that once a patient makes a complaint about professional judgement, his confidence in the doctor has already been undermined and that the willingness of doctors to open their decisions to more easily accessible independent review could only strengthen public confidence in their decisions.[59]

When Sir Cecil Clothier reviewed the issue in 1983, he accepted that there could be no guarantee against his office being used as a dry run for the courts. Although it was his practice to obtain a statement from any complainant to whom access to the courts was available to the effect that it was not his or her intention to proceed to litigation, any undertaking given at this stage was not binding in perpetuity. Nevertheless Sir Cecil did not accept that this possibility would place an unreasonable burden on the profession and argued that providing people with an alternative avenue for clinical complaints might indeed prevent some people from suing at all.

Much of the argument rests on the adequacy of the 1981 procedure. It is undoubtedly elaborate and controlled by doctors. It vests responsibility for reviewing clinical complaints with the Regional Medical Officer. There is a three stage procedure. At the first

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[59]House of Commons, First Report from the Select Committee on The Parliamentary Commissioner for Administration, Session 1977/78, HC 45, London: (London: HMSO, 1977) paras. 26-31

stage, the consultant in charge is responsible for investigating the clinical aspects of the complaint and referring any non-clinical element to the district administrator. Where a complainant remains dissatisfied with the reply received at the first stage, the complaint has to be renewed and referred to the consultant or the authority who then bring it to the attention of the Regional Medical Officer (RMO). It is up to the RMO to decide in consultation with the complainant and the responsible consultant whether a second opinion is appropriate. This third stage applies only to complaints of a "substantial nature" which do not seem likely to lead to litigation. The RMO arranges for all aspects of the case to be considered by two other consultants in active practice in the specialty or specialties involved, at least one of whom should be working in a similar hospital in another region. This involves a medical consultation with the complainant who may be accompanied by a relative, friends or general practitioner.

The guidance, emphasises the importance of resolving the complaint at this stage. If the second opinion review finds that the clinical judgement of medical staff concerned has been exercised responsibly, then they are to endeavour to resolve the complainant's anxieties. In "other cases", presumably where there is some doubt about the wisdom of the clinical decision, the second opinions are advised to talk to the doctors concerned to avoid recurrence, and explain to the complainant how it is hoped to overcome the problems identified. They are also to report to the Regional Medical Officer, on any non-clinical elements or circumstances in the case which contributed to the problem. The district administrator makes a formal report to the complainant on behalf of the authority following the advice of the RMO. The matter would remain confidential as far as the authority is concerned, unless it had otherwise had become the subject of publicity.

Clearly there is substantial discretion vested in the RMO. What is more the third stage procedure seems somewhat forbidding.

According to the Department's own figures for the first two years of the system, it was not being widely used. Although 44% of all written complaints are clinical, or about 6,500 in 1982. in the same year only 100 were referred to RMOs, and of these, only 32 were reviewed by second opinions.[60] In contrast the Medical Defence Union paid out compensation to over 300 patients in 1982.[61]

Nobody would wish to see litigation cases mushroom and defensive medicine flourish. Yet, despite the formidable financial barriers to the courts facing potential complainants who do not qualify for legal aid, the number of litigation suits is on the increase; no doubt partly motivated by augmenting damage awards in successful cases.[62] Views differ over whether this trend is giving rise to defensive medical practice. Doctors argued that it is and lawyers that the evidence is ambiguous.[63] The BMA has called for a system of no-fault compensation[64] where patients who suffer medical injury could claim compensation from the state, outside the law of tort.[65] Schemes of this kind operate in New Zealand and Scandanavia.[66]

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[60]DHSS, Report on the Operation of Procedure for Independent Review of Complaints Involving the Clinical Judgement of Hospital Doctors and Dentists. (London:DHSS,1983) p.8

[61]CIPFA (1984) op.cit.

[62]Ham, C., Dingwall, R., Fenn, P., and Harris,D., Medical Negligence, Compensation and Accountability, (London:Kings Fund, 1988) pp.6-12 and Trainor, J., and Appleby, J., 'Health care data briefing: medical negligence', The Health Service Journal, Vol.100, no. 5207, 28th June 1990, p.959

[63]Contrast Fletcher, D., Protection money is the practise, The Times, 18th August 1988, with Ham et al. op.cit. p.14. whe argue that "there is little hard evidence that defensive medicine is on the increase."

[64]See Editorial, Journal of the Royal Society of Medicine, Vol. 82, No. 5, May 1989 p.249-251 and The Times, 5.7.88.

[65]The law of Tort covers ".. wrongful acts and omissions, other than breaches of contract, in respect of which damages can be claimed by the victim from the wrongdoer.." Report of the Royal Commission on Civil Liability and Compensation for Personal Injury, Cmnd 7054, (London:HMSO, 1978) para.45 p.17

[66]See Brahams, D., The Swedish medial insurance schemes; the way ahead for the United Kingdom? Lancet, 1988 (i) No. 8573, 2nd January 1988, pp.43-47, and Brahams, D, No-Fault Compensation Finnish Style, Lancet, 1988 (ii), No, 8613, 24th September 1988,
Continued on following page

Making public money available in this way could mitigate any growth in litigation suits and not least, avoid spiralling insurance costs for doctors[67] and inflationary pressure on their remuneration which the American experience suggests can add substantially to the cost of health care[68]. It would make it simpler for the victims of medical accidents whether due to negligence or not, to get compensation.

But no-fault compensation could be problematic. Firstly, it is questionable that the public would wish to see the separation of damage and fault. As Clothier observes:

> "'Fault' and 'liability for fault' go hand in hand in the estimation of right-thinking people. 'No liability without fault' has as righteous a ring as 'No taxation without representation'....This is no lawyer's subtlety....It comes naturally to think that those who hurt others by their fault should make good the damage, just as it seems unjust that an innocent person should have to pay for injuries caused through no fault of his. This is because both 'fault' and 'liability' have fundamental moral connotations; remove them

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pp.733-736, Smith R., The world's best system for compensating injury? BMJ, Vol.284, No. 6324, 24th April 1982, pp.1243-5, and Ham et. al. op.cit. pp.21-25

[67]Carson records that subscriptions to the Medical Defence Union increased by 60% in 1986, See Carson, D., Complaints Procedure Act that was a waste of parliamentary time, Social Work Today, Vol 18, no.11, 10 Nov. 1986 p.25. This trend is well established. See also, Ed. Harrison, A. and Gretton, J., Health Care UK 1984, and economic, social and policy audit, London: Chartered Institute of Public Finance and Accountancy, 1984 p.119

[68]Although his evidence is 20 years old, Titmuss's case that there is a correlation between the level of litigation suits, the cost of insurance cover for doctors, and the cost of health insurance and the global acute health care budget in the United States is at the heart of this argument. See, Titmuss, R.M. The Gift Relationship (London: George Allen and Unwin, 1970) pp.165-172. However, once again, Ham et al. dispute this claim op.cit., pp.19-20.

and you remove the moral basis for this part of our civil law."[69]

Secondly, the use of public money involves accountability and monitoring to ensure that it is being used appropriately. It is difficult to see how these considerations would avoid review of the validity of the grievance and therefore its cause. Thirdly, the proposal would simply transfer the cost of compensation to health authorities which would add to the cost of health care anyway.

Fourthly, it would be administratively complex since it would require a hearing before a standing tribunal acting under medical advice, and rules would need to be devised to fix the levels of compensation for similar types of case.[70] It is difficult to estimate how much of the savings in legal fees would be offset by fees charged by doctors giving professional advice at no-fault hearings. Fifthly, it may prove difficult to differentiate between injury and inevitable disappointing outcomes of medical treatment. The Report of the 1978 Royal Commission on Civil Liability and Compensation for Personal Injury debated the idea but came down against on the grounds that it would be difficult to discriminate between medical accidents and disappointing outcomes due to acceptable risks in medical treatment and inevitable variations in individual recovery patterns.[71] If, to overcome this, this category of injury were excluded, the Royal Commission held that this would little more than "..convert the negligence of tort into a statutory formula...". Sixthly, the system of tort through the civil courts with all its implications for the career of those found negligent and the costs incurred by the unsuccessful litigant, is believed to act as deterrent both to acts of negligence and frivolous litigation. By removing the

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[69]Clothier, C., (1988) op.cit. p.57

[70]See Clothier C. Medical Negligence and No-fault liability, Lancet, (i) no.8638, March 18th 1989 pp.603-605
[71]Cmnd 7054 op.cit. para. 1304-71

deterrent, a no-fault scheme could give rise to a proliferation of claims which would escalate the costs of administration still further.

No only do senior lawyers have doubts about no-fault schemes, some of them also stand on the other side of the debate about reforms to clinical complaints in advocating increasing access to litigation by introducing the type of contingency-fee arrangements which exist in the United States, wherein lawyers agree to represent plaintiffs with prima facie cases and accept a proportion of any damages as payment (thus running the risk of no fees at all). A pressure group, with Lord Scarman as its President, has been launched to campaign for legislation which amongst other things would introduce a limited contingency-fee scheme. For his part, Sir Cecil Clothier has condemned contingency-fee arrangements for encouraging dishonest lawyers and witnesses, encouraging courts to inflate damages to cover the lawyer's share of the award, inflating insurance premiums, increasing the cost of health care to the public and mitigating against innovative practise by doctors.[72] However, Ham et al. are sceptical on this point on the grounds that there are other aspects of the US health care and legal systems which encourage litigation. Also, since they are understandably anxious to maintain profitability, American lawyers who take contingency fee cases first consult medical advisers and thus filter out 85% of prospective cases.[73]

The Department of Health has responded recently to the pressure for reform in this area by consulting on a range of options including no-fault compensation. Since subscriptions to medical defence societies are largely reimbursed by the Treasury, the Department has decided to indemnify doctors it employs for successful claims against them; thus removing the direct cost of subscriptions to the practitioner. It is currently reviewing the details of the scheme having agreed the principle. However, as

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[72]Clothier (1988) op.cit. pp.50-55
[73]Ham et al. op.cit. pp.19-21

Ham points out, this does solve not the real problems in clinical complaints and negligence.

How can this be resolved? To begin with, not every complainant is seeking financial gain. The Davies Report argued that the great majority simply wish to obtain the satisfaction that a legitimate grievance has been recognised and brought to the attention of the responsible authorities so that they can take action to prevent future occurrence.[74] Although Sir Cecil Clothier was less confident about this[75], he has suggested two mechanisms for people in this group. Firstly, his experience convinces him that many complaints would never arise if an unfortunate double-bind was overcome. In his view, doctors are unwilling to apologise to patients because of an erroneous belief that to do so amounts to a concession of liability which contravenes their contracts with their insurers.[76] For their part, complainants often interpret unwillingness to apologise as evidence that the doctor has something to hide. To resolve this, Clothier proposes that a consultation between doctor and patient or a close relative at the time of an unexpected disappointing outcome, should become a 'privileged occasion' so that any 'unguarded or over-generous concession' made by a doctor to give comfort and reassurance would be inadmissible as evidence in any subsequent litigation.[77] Secondly, where a complaint does arise but no monetary gain is sought, the ombudsman could take the grievance but to avoid the risk of "double jeopardy" for the clinician complained against, a legal bar would be placed on the complainant against proceeding to litigation.[78]

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[74]Op.cit. Chapter 5
[75]Clothier op.cit. p.40
[76]The Medical Defence Union has been at pains to reassure clinicians on this point. See Allsopp, K.M., Saying Sorry, Journal of the Medical Defence Union, 1986, summer p.2.
[77]Clothier op.cit. pp.46-48
[78]House of Commons, Health Service Commissioner Annual Report for 1979-80, (London HMSO 1980) para.33

This would present the public with a choice of avenues and if the majority is genuinely uninterested in monetary compensation would offer a compromise solution, albeit not an uncontroversial one since, according to Harlow, the Courts could be expected to resist any attempt to make what they would see as administrative decisions unchallengeable.[79] However, the system would have a number of advantages over the Investigating Panels advocated by Davies. It would be procedurally less cumbersome and protracted and not least minimise the distress caused to those involved. Those with good cases who sought monetary compensation would proceed to the courts with access improved either through extending legal aid or through contingency-fee arrangements.

Although the profession has so far staved off the measure, the proposal will not go away.[80] Medical opinion is not unanimously opposed. As a Chairman of the Conservative Medical Association has put it: "as long as we adopt a protective attitude, the public will believe we have a lot to hide and the clamour for investigation will continue".[81] The Health Commissioner may be the best channel for providing a respected, but relatively cheap and rapid form of independent review.

AEGIS's original demand for the general public to have direct access to the Commissioner on the model of the Scandinavian office[82] has also surfaced from time to time. This restriction is partly due to the fact that the Health Commissioner grew out of

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[79]See Harlow, C and Rawlings, R. op. cit. p.98. Also Stacey views the Swedish system where the reports of ombudsmen can be used as evidence in court cases as a "sensible arrangement". Stacey, F.,(1978) op.cit. p.10.
[80]See Debate on the 1987 Parliamentary and Health Service Commissioners Bill, House of Commons Official Report, Vol. 109, Cols.1059-1066, 4.2.87, where there was all party support for including clinical complaints. The Act itself was limited and made some minor procedural amendments to the Office.

[81]Lyall, J, "Widening the Ombudsman's role", General Practitioner, 29.2.1980, p.20

[82]See Stacey (1978) op.cit. Chapters 1-3

the PCA; indeed the same individual still holds both offices. The PCA can only proceed on complaints referred by an MP and this largely reflects the constitutional position of the office as a mechanism for parliamentary scrutiny of the executive[83]. The argument in favour of the restriction is that most complaints can be dealt with satisfactorily at authority level. Not surprisingly successive Health Commissioners have been largely content to leave the arrangement as it stands subject to reforms to the hospital complaints procedure.[84] There is no hard evidence either way. Certainly, the great majority of complaints rejected by the Commissioner on these grounds are not subsequently referred back; although this does not mean that the complainant was eventually satisfied since the procedure at health authority level may in some cases deter complainants with a genuine grievance from proceeding further.

The Commissioners have found it difficult to investigate complaints about neglect and ill-treatment in longstay hospitals if the cases are referred a long time after the alleged incidents took place. Since the time-lag between raising a complaint with an authority and exhausting all its procedures can be considerable, this would seem to support the case for allowing all such complaints to be referred direct, such as those brought forward by staff on behalf of patients.

There has been wide criticism of the limitation imposed on British ombudsmen not to investigate complaints which do not involve maladministration on the grounds that this limits concern to procedural issues at the expense of substantive considerations or the quality of decisions. This argument applies less to the health commissioner than to the PCA because of the 1974 NHS Reorganisation Act's precise definitions about failure to provide, or failure in, a service. The cases in the reports also indicate that successive Commissioners have interpreted the term

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[83]See Gregory, and Hutcheson, op.cit. pp. 624-650
[84]DHSS, HC 537 Health Service Commissioner A.R. 1983-4 op.cit para.4

maladministration flexibly. They cover a wide range; AEGIS-type complaints of inadequate care in the longstay hospital sector is a recurrent theme.

The second major category of restrictions on the impact of the Office is its nature. To begin with, it is not in practice equally accessible to all members of the public for two reasons. People have a variety of expectations for a service and therefore vary in their propensity to complain. Second, the NHS enjoys a high regard from the general public and more specifically those treated which may or may not reflect the standard of service provided.[85] Many people, therefore, may simply not appreciate when a service is sub-standard.

Secondly Barbara Robb's faith in a Health Commissioner as an agent of control and change may have been unrealistic. This argument has two aspects. First, much depends on people's ability to complain when they do have a grievance to voice. Thus, Gwyn has argued that the "benefits of an ombudsman reached only on the initiative of the complainant are bound to be enjoyed disproportionately by the affluent and well-educated".[86] He also cites survey evidence that less than 10% of the public would know how to proceed with a complaint through one of the various commissioners and that the likelihood of anyone having that knowledge was proportional to his or her socio-economic status.[87] The "iceberg" effect described earlier indicates that this phenomenon may be widespread.

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[85]Davies P., The public speaks out, The Health Service Journal, Vol. 98, no. 510, May 19th 1988, pp.556-7 A report of the findings of a Marplan poll on the NHS which found that nearly 70% of people thought the service in their area was very good. However, in June of the same year, a Gallup Poll compared results with earlier surveys and noted a substantial decline in public satisfaction over time. See The Daily Telegraph, 4.7.88
[86]Gwyn, G.B., The British Parliamentary Commissioner for Administration: Ombudsman or Ombudsmouse?, Journal of Politics, Vol. 35, No. 1 (1973), pp. 45-69
[87]Ibid

Second, and still more fundamental, the efficiency of complaints procedures as agents for improving public services is questionable. As Gregory and Hutcheson observe:

> "A system of control in which complaints and complaint handling procedures play an important part can never be wholly effective. If, though timidity, alienation or sheer ignorance of what action they should take, large numbers of people with grievances do nothing about them.....it may very well be.....that the problem of alienated or submerged non-complaint is in any case one that will never be completely solved by institutional innovations without far more fundamental changes in society itself."[88]

On the credit side, the commissioners have argued that not only can they improve standards in departments and authorities subject to complaint, they have also claimed that the presence of their Office and its reports have a "tonic effect". Thus authorities and hospitals are toned up and made more vigilant. In their research into the impact of the PCA on attitudes amongst civil servants, Gregory and Hutcheson found inconclusive evidence. Selective perception operated so that the the PCA and his staff found evidence of improvement. For their part civil servants were unwilling to concede that the PCA had changed departmental practices for the better since this was to accept that there was room for improvement in the first place.[89] Both Klein and Harlow and Rawlings are little more positive[90], however, in the absence of any hard evidence on this aspect of the health commissioner's work, the balance of probabilities is that the tonic impact of the Office has been marginal at most.

Finally what of Mrs Robb's great triumph to allow nurse complainants direct access to prevent victimization? The

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[88]Gregory and Hutchinson, op.cit. p. 622
[89]ibid pp.395-397
[90]Klein, R. The Health Commissioner: no cause for complaint, BMJ, 1977, Vol. 1, No. 6055, 22 January 1977, p. 248, and Harlow and Rawlings Op.cit p.209

available evidence is not encouraging. Only a handful of such cases appear in the annual reports. In her study of this area, Beardshaw found that reluctance amongst nursing staff to complain about poor standards of care for fear of prejudicing their career prospects remained widespread after seven years of the Office's existence. Those who did complain faced the familiar problems of victimization by managers, harassment by colleagues and hostility from local union branches. Moreover, few nurses were even aware of the Health Commissioner's jurisdiction in this field[91]. Although more recent evidence is more encouraging about the willingness of nursing staff to proceed with complaints about standards of care, the Commissioner remains relatively uninvolved in this process.[92]

In conclusion, it is only in the case of committees of inquiry where the legal profession has maintained a primary interest that the reforms promoted by AEGIS in complaints machinery have enjoyed notable success. Where the medical profession has felt its autonomy to be seriously under threat, progress has been slower. The changes to hospital complaints machinery and the powers and impact of the Health Service Commissioner are substantially below the hopes and aspirations of Barbara Robb.

However, the relative weakness of the channels for the redress of grievances in the NHS is not surprising if viewed in perspective. They reflect the relative closed nature of British government institutions. Thus the Health Service Commissioner's limited impact is characteristic of the British Ombudsman system. When Barbara Robb first embraced the proposal she was inspired by the work of the Scandinavian Ombudsmen. The Swedish Ombudsmen in

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[91]Beardshaw,v., Conscientious Objectors at Work, London: Social Audit Limited, 1981 See also The Association for the Protection of Patients and Staff (APPS) Vulnerable People (author not attributed), (APPS: London, 1985) which makes the same point somewhat more polemically and graphically.

[92]Nurses are rather turning to the Statutory professional advisory and monitoring body, the United Kingdom Central Council on nursing and midwifery. See Hicks,C. How to betray a profession, The Guardian 16 July 1986

particular have had a major impact across all sectors of public administration including legislation and the courts. Their area of jurisdiction, powers to investigate (and initiate) complaints far exceed their counterparts in Britain, and consequently, the Swedish people use them far more frequently. The Swedish Ombudsmen investigate ten times more complaints from a population of only 8 million. The degree of openness is best illustrated by the fact that journalists have full access to the files![93] In contrast British institutions are preoccupied with discretion. confidentiality and secrecy and the British people at best accept it or at worst are resigned to it. So why should the health service be any different? Stacey's comparative study illustrates how parochial the debate surrounding the British Ombudsman system has tended to be.[94] This and the relative power of the professions is a major concern of the two concluding chapters.

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[93]See Stacey, F. (1978) Chapter 1
[94]ibid

CHAPTER 12

POLICY CHANGE IN MENTAL HEALTH: INPUT POLITICS

The framework constructed in chapter one, was a three-stage analysis of policy change. The case study represented the primary level. The next stage is to take its major conclusions, incorporate the findings of the policy evaluation in Chapters Ten and Eleven and to construct the remaining horizontal tiers of the framework and draw the vertical links between all three levels.

The intermediate level examines how the major theories of state activity, understand 'input politics' or the demands acting on the state from the outside. There are five models, drawn largely from Dunleavy and O'Leary's typology which distinguishes pluralism, new right theories, elite theories, Marxist theories and neo-pluralism[1]. Dunleavy and O'Leary's typology is selected because it provides as comprehensive an exposition and categorisation of the immense, relevant literature on public administration in political science and political sociology as is currently available. It has the further advantages of including discriminating, penetrating comment in the course of exposition, whilst avoiding judgements about the validity of a given approach, save those which concern commonality between the models and which arise from the modicum of comparative analysis in the book's final chapter.

The major demands on the state in the AEGIS case study can be summarised under three headings; pressure group activity (including the professions in their role as interest groups), the mass media, and, less significantly, Parliament which is here seen as a force exterior to the state (and thus excludes the Executive which is contained within the state). The approach will be to set

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[1]Dunleavy P. and O'Leary B. Theories of the State, (London: Macmillan, 1987)

the material from the case study against the explanatory approaches in each model to test appropriateness.

The conclusions about the nature of input politics in the case study are carried forward into the tertiary level analysis, which examines how each macro theory of the state both describes and interprets the responses and outputs of the various administrative and political arms of government and peripheral, quasi-governmental agencies and delineates the determining parameters. This will allow an evaluation of the appropriateness of the five models to policy change in mental health using the results from the case study. This tertiary analysis is the subject of the next chapter.

Pressure groups

Pluralist accounts consider liberal polyarchy to be both necessary and desirable.[2] Central features are a free and competitive media and pressure groups which have a central role in promoting the interests of citizens to government.[3] This optimism about the democratic role of pressure groups stems from two contentions. First, governments assess the relative importance of a preference on the basis of the size of the groups which promote it, their rate of mobilization and the intensity of its expression. Second, interests groups are seen as particularly valuable where interests are difficult to organise formally (for example, the poor or elderly).[4]

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[2]Ibid pp.20-22

[3]Dunleavy, P. Alternative Theories of Liberal Democratic Politics; the Pluralist Marxist Debate in the 1980s; in D.Potter, Society and the Social Sciences, (London: Routledge and Kegan Paul, 1981)

[4]Dunleavy op.cit. pp.33-37

A small minority participate in group activity at any one time, so that the pattern of activity and influence in the group universe is unstable. Equally central to pluralist theory is the view that the universe is permeable by any interests. So that "...the interest group process in polyarchy generates a continual flux in the make-up for the winning coalitions of interests which influence policy." [5]

The evidence from the AEGIS study supports the pluralist model in part only. Certainly groups like AEGIS, and the Patients Association promoted the causes of people who at the beginning of the campaign were amongst the most deprived and neglected in Britain. Whether the public was apathetic is difficult to assess since it was conspicuous by its absence as a participant in the process of input politics in these reforms. The promotional groups and the interest groups such as the medical and nursing professions, together with the mass media as primed by AEGIS, constantly invoked the public interest in support of their demands. But only a handful of non-professional, non-experts who could claim to be members of the lay public, were directly involved. Similarly, debates in the press and in Parliament were largely the articulation of conflicting, professional vested interests. Even where letters columns widened the field of participation in these debates, the correspondence printed came from prominent representatives of the same interests or professionals and other staff working in the service. In response, pluralists would be inclined to infer from the enormous press coverage that the public was interested because otherwise competitive commercial newspapers would not have allocated the column space, a contention challenged in the section on the media below.

There is no doubt that successive governments were responsive to the intensity of demand expression and mobilization which AEGIS achieved. There were also plenty of examples of Ministers and

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[5]Dunleavy P., and O'Leary, B., Op.cit. p.37

civil servants responding, and weighting a variety of pressures. But it would be simplistic to interpret their political responses as the net balance of all demands expressed.

More fundamentally, the AEGIS campaign strongly contra-indicates that the government is permeable by all potential interests. AEGIS rapidly achieved the transition from an illegitimate to an insider group.[6] Even during the transition period, when Robinson was Minister of Health, the social position and contacts of Barbara Robb, and the tentacles of influence which grew out of her initial small core of advisers, served as a network of privileged access to the decision-making process. They are indicative of a policy community which included people in key positions with direct access to the political head. At close quarters, the perimeters of the 'pressure group universe' in mental health were fixed by a score of streets in Hampstead, Westminster, South Kensington and Chelsea. Since access to the arena of debate and to the centre of decision-making was so circumscribed, the idea of policy-making inexorably serving the public interest remains speculative. As Peters observes:

> "So long as access is a scarce and regulated commodity, the possibility of finding the 'public interest' among a set of conflicting pressure groups is remote if not non-existent."[7]

Secondly, Barbara Robb had personal characteristics necessary to found and run AEGIS successfully which were specific to her and not generally available. Her background gave her self-confidence and a sense of belonging in the elite spheres in which she had to move. She therefore perceived the higher echelons of political

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[6]These concepts are discussed in Chapter 3.

[7]Guy Peters, B., Insiders and outsiders, the politics of pressure group influences on bureaucracy, in Macgrew, A.G., and Wilson, M.J., Decision-Making: Approaches and Analysis, (Manchester: University Press, 1982) p.272

power as accessible and saw herself as a legitimate person to gain that access. This perception was shared by all the key participants. She was the 'right type of person'. This is not to deny the importance of her enormous personal talents, her compassion, her persistence and tireless energy which she brought to the task. It is simply to contend that the fact that she was born and raised in a social stratum similar to that from which the majority of the policy community was drawn was material to her success. Not least, the time and financial resources she needed in her work of AEGIS demanded that she was economically independent, that she had no family-ties, apart from her understanding and supportive husband, and, to meet her legal and administrative costs, that she had a sufficient private income.

Public choice theory interprets input politics from the concept of the political market which parallels the economic market in neo-classical economic theory. Interest groups are seen as playing an important but generally pernicious role. Firstly, two or more groups which have separate interests which do not contradict, can trade support - a process know as 'log-rolling'. Interest groups in this role are seen as organised attempts to exploit the system for purely sectional interests whilst sheltering behind a 'public interest' ethic. Hence the policy process becomes dominated by winning coalitions of interest groups. Second, since it is argued that MPs put their own interests first, their primary concern is to secure local electoral popularity; known as 'pork barrel politics'. Hence national policy is biased in favour of those issues which reflect the local interests of those politicians with the most power or those interest groups who are best able to threaten politicians and government security. Thirdly, and relatedly, elected officials become biased towards the demands of interest groups, particularly if they are able to attract media attention which reflects badly on the government; a process called 'atavism'. Neither politicians nor interest groups leaders are seen as having anything to gain by longer-term, coordinated policies and instead are preoccupied with making symbolic gestures

which generate votes for politicians and convince members of the group that it is an effective lobby.

There is some resonance between these contentions and the AEGIS campaign but on balance the evidence is contra-indicative. It is difficult to interpret AEGIS activity on behalf of longstay hospital residents as pursuant of material vested interest since the actors involved cannot be seen as rational economic beings since they extracted no material gain. It is certainly arguable that the legal, medical, nursing and administrative interests involved have fought their own sectional concerns, at least to some extent. But as a generalisation, 'log rolling' cannot be applied to AEGIS.

There was undoubtedly an element of pork barrel politics since Crossman particularly was concerned about the impact of the hospital scandals and media coverage on the Government's standing when behind in the opinion polls in 1969. In general though, mental health is not an issue which determines the future of governments. Although the constant torrent of adverse publicity can reflect badly on individual Ministers, senior cabinet Ministers such as Crossman, Joseph and Castle were too experienced to let the mud stick and simply turned the scandals to their own departmental advantages.

What of atavism? Certainly politicians reacted to the adverse publicity and looked for short-term political gain. But this objective need not be inconsistent with longer-term programmes. The Better Services programmes, and functional redistributive initiatives in health resources were rational, coordinated, long-term programmes, sustained and developed by the Crossman, Joseph and Castle administrations alike.

Elite theories developed after the war as a critique of pluralism. They argued that the areas of state activity which could be controlled by representative input politics were dwindling, in the face of the rapid growth of the state apparatus. Two principal means of exercising power are elite groups (with similar social

backgrounds, education, socialisation and networks) and control of the political agenda which excludes some issues and thus creates the need in analysis for questions about why some decisions are excluded.

Elite theorists argue that there are gross inequalities of political influence between interest groups or that "...the flaw in the pluralist heaven is that the chorus sings with an upper class accent and the voice of the poor are barely audible."[8]

Second, the attitude of government differs towards different groups. Governments opt in selected interests. Also, coopting groups is aimed at compliance to create 'corporatist' institutions. These are coalitions struck between a core of key major interests, such as business, the trade union movement and government, managed and coordinated from within the policy machine to develop mutually convenient outputs. Elite theorists are consequently cynical about consultation with groups as a channel of information to politicians.

The evidence in the AEGIS campaign strongly supports the components of elite theory representations of pressure groups activity. If policy outcomes reflect the demands of groups differentially, then it indicates that in their approach to the various interests, governments are adopting varying positions to different lobbies. In the case of the AEGIS reforms, government attitude has varied within and between administrations both to AEGIS and relatively between AEGIS, other small groups such as the Patients Association, and major professional interests.

There is also plenty of evidence of groups being coopted into compliance. This is intrinsic to the insider group/executive relationship. Mutual interest results in compromise. On the other hand all the group pressures exercised their discretion to dissent publicly from executive proposals at various times. Thus

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[8]Dunleavy P., and O'Leary B., op.cit. p.159

organised medicine came out to fight the Davies Committee proposals and the ideas of Crossman's PEP to bring a health commissioner office into the realm of clinical autonomy. Even when consulted directly through both formal and informal channels, AEGIS went to the media when it perceived that progress was slow and the radicalism of policy ideas was being diluted. Thus insider groups establish their private bargaining position partly by the constant threat of recourse to the public offensive.

What of corporatism? Well clearly there were no direct or apparent corporate business interests in the developing policy for the care of longstay patients during the period under review.[9] However there is clear evidence of a small, exclusive, policy community constructed of inter-connected, smaller spheres of influence. For example, during the Crossman administration these were; AEGIS, the NAMH, key journalists, a core group of QCs practising in medical negligence, and the Bar, a group of empiricist social administrators, the Department of Health officials, organised medicine, and organised nursing. This issue is revisited in the next chapter.

<u>Marxists</u> adopt a distinct methodological approach which poses problems in fitting their perspectives within the thematic framework identified earlier. As outlined in Chapter One, they contend that external objective reality cannot be grasped from empirical observation. Rather it is the role of the analyst seeking to explain the workings of society to abstract fundamental causal processes from the bewildering variety of observable phenomena. Second and relatedly Marxists adopt a structuralist approach to analysis. Therefore analysis of input politics and interpretations of decision-making processes take place within broader constructs about the state and have one basic contention in common, according to which all political mobilization is class based.

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[9]If AEGIS had been fighting in 1990, this element may well have been prominent.

Differing models of Marxism place differing emphases on the role of pressure groups. Either they are acting from a position of class consciousness and therefore representing their objective economic and political interests, or their view of the world is structured by the pro-capitalist dominant ideology. Their access to the legitimated policy process is therefore determined by the extent to which their demands are consistent with the objectives of the state. They will either be excluded or incorporated. Incorporation may simply amount to a legitimation of the state's claim to be pluralist or so-called repressive tolerance wherein interests are involved in decision-making to provide a flow of information on the spheres of opposition and where possible, emasculate them.

In general, the mechanics of access and incorporation are of less concern and interest to Marxists who are relatively unrepresented in the pressure group literature. Two broad themes can be identified nonetheless. Marxists differentiate the processes of inclusion and exclusion in terms of the policy elite's perception of the legitimacy of the group. This is defined by the extent to which a group's demands correspond to the elite's interests and related construction of appropriate policy outputs.

During its career, AEGIS oscillated between insider and outsider status. Once the Labour Government was out of office in 1970, AEGIS gradually perceived that the new political administration was more sympathetic to the views of organised medicine than its predecessor. The group reverted to aiding the media pressure (which had by now developed a powerful momentum of its own throughout the Ely, Farleigh, Whittingham and South Ockendon reports). It also became much more closely associated with the Parliamentary Labour Party and abandoned its ostensive political neutrality. Although for her part, Mrs Robb relied on Abel-Smith to do the direct liaison and continued her input to the Tory press to keep the pressure on the government from its own 'constituency'.

The wider issue is the extent to which a demand accords with the conventional wisdom about the nature of the social problem which policy is directed at. An acceptance by the policy communities of two primary assumptions is relevant here. Firstly, the nature of policy outcomes for the psychiatric services are largely consistent with a medical model of mental illness. The solutions in mental handicap are more socially-oriented. The debate in complaints machinery pivots around the legitimacy of clinical autonomy and belief that only doctors can assess the performance of other doctors. These issues are explored in more depth in the next chapter.

Neo-pluralist accounts have elaborated conventional pluralist theory in the face of criticism from elite, public choice and Marxist theorists to explain the increasing role of corporate business interests and other powerful interests in policy-making.

Firstly neo-pluralist argue that there has been a marked shift away from class-based politics due to three developments. The growth in the non-manual workforce is perceived as reducing class polarisation. Trade union power is diminished as multi-national corporations have developed and both caused unions to involve themselves in class compromise and not least introduced non-unionised workplaces. Class disalignment, or the association of socio-economic status and voting behaviour has been on the decrease. Secondly, the growth of the state has reduced the significance of representative politics as a means of controlling public policy. This gives rise to a shift of power to the Executive which focuses on strategic issues and is less concerned with the details of policy and its implementation. Thirdly, neo-pluralists concede that business occupies the position of special importance which more orthodox pluralists deny; the polyarchy is thus deformed. Fourthly, and particularly in social welfare agencies, the state has become 'professionalised'.

Any tendency for the policy-process outputs to be distorted by vested-interest is countervailed by two factors. Firstly, it is argued that liberal, caring and public interest values are now widely socialised within the middle-classes and therefore penetrated the managers of large corporations and of course professional organisations. Secondly, along with conventional pluralism, the mass media is seen as promoting the public interest by scrutinising the activity of politicians and business interests alike.

Neo-pluralists also share elite and Marxist perspectives on the limitations of pressure groups to guarantee representation to all citizens. Neo-pluralist accord a key role to professions both as pressure groups but also as central components of the government machine. Professionals occupy privileged positions in input politics. There was certainly evidence of distorted polyarchy in in the outcome of the reforms in the AEGIS campaign, although the distorting influence was not the corporate business sector. Rather, policy outputs, such as the Health Service Commissioner and reform of health service inquiry procedure indicate that the demands from the organised medical profession and senior figures in the legal profession have emerged as predominant. Similarly, in the early days of AEGIS, when the critique was radically at variance with the conventional wisdom about the psychiatric services and policy outputs of the Ministry of Health, AEGIS was not allowed access. It took Sans Everything and particularly the Ely Report to change the conventional wisdom and legitimise the group.

Their role as implementors gives professionals substantial discretion over the real impact of policy and therefore renders policy-makers highly dependent upon them. On key issues, policy-makers preferred professional opinions over those of the 'amateurs' such as Barbara Robb. Equally, the AEGIS case also highlights a tension within medicine, between psychiatry and the rest of the profession over complaints and the priorities policy, and between medicine and the law over the scope of an effective

complaints machinery. The way policy outputs reflect these multi-dimensional professional cleavages implies support for the neo-pluralist 'professionalised state' thesis. This is considered in more detail in the next chapter.

The mass media

The AEGIS campaign was fought against a background of enormous press and media interest which was generated from the moment Lord Strabolgi spoke in the Lords debate in July 1965.[10] The press was critical to the ability of AEGIS to extract a recognition of its case and relevant policy initiatives from civil servants and Ministers whose early reaction was denial and obstruction. The role of the press in the AEGIS campaign is one of its most striking features. The volume of press coverage, the duration of the period when this was at its height, and the closeness of Barbara Robb's working relationship with so many and such diverse journalists was exceptional. Therefore detailed attention needs to be devoted to this issue in order to explain why.

The questions are both general to the politics of change and specific to the issues in the AEGIS campaign. These two categories are of course inter-related, but it is important to draw the distinction to ensure that general conclusions are not drawn from highly specific evidence. A framework for analysis can be distilled into three questions.

> What determined press interest in AEGIS concerns and sustained it over a 10-year period?

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[10] See Chapter Three

What was the impact of press coverage on public opinion?

What was the impact of press coverage on politicians?

A free and competitive news media is a major component of pluralist input politics. Pluralists argue that a source of full and accurate information to voters is essential if polyarchic competition is to control decision-making. Further, in the period between elections the press is seen in the role of guardian of the public interest directing public attention to issues and scrutinizing government against corruption, incompetence and despotism. To fulfil this role, the press needs to be a reliable source and act with both neutrality and a sense of responsibility. In a free market under capitalism, reliability, responsibility and neutrality are guaranteed by competition. The rule of consumer choice should ensure that diversity of opinion in the electorate is translated into demand preferences resulting in a diversity of editorial opinion addressing the full range of the market. Also, entry into the supply side of this market would need to be relatively easy to ensure that large groups of less affluent citizens could get their opinions into the press. Neutrality is guaranteed in the broadcast media by public regulation to prevent monopoly, enforce neutrality and countervail any imbalances in the press. A further critical assumption underlying this liberal democratic model is that the readership is discerning in these areas and actually uses the press as a source of relevant information.

Similarly, neo-pluralist theorists see the media "...as an increasingly specialist and distinct social interest whose structures and market make it serve a key overview function".[11] It is an ample source of information on political issues which increases the sophistication of the voter.[12]

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[11]Dunleavy and O'Leary, op.cit. p.297

[12]ibid p.290

A characteristic of the literature on the mass media is the almost unanimous rejection of this model to explain the role of the press in political life. This is not to say that there is not fierce competition between newspapers and broadcasting channels. Even with the trend of increasing concentration of ownership and reducing number of titles since the second world war, which has been identified as a possible threat to alleged press neutrality, the two broad coalitions of political interest in British society have continued to be represented in national newspapers with mass circulations. Indeed, as Seymour-Ure contends, so long as people are free to make choices in the newsagents, there need only be two newspapers of opposing political perspectives to guarantee competition.[13] Not least, the extensive empirical evidence collated by Seymour-Ure indicates that the press is valued more for its entertainment value than for its contribution to healthy democracy.[14]

Elite theorists point to the dominance of corporate interests both in the ownership of the press, and through advertising, as one of its primary sources of revenue. Moreover the mass media now play a crucial role in politics both in setting the political agenda and, increasingly, selecting politicians since a favourable media profile is fast becoming essential for advancement. Consequent collusion between the mass media and politicians leads to the exclusion of issues termed the mobilisation of bias.

> "In any liberal democracy a mobilization of bias is cumulatively created by the outcomes of political and social conflicts. Victors accumulate new resources for use in future battles. The scope of debate is limited or shifted over time in particular directions, but always in a direction which consolidates power into more permanent forms, which in time may become almost invisible to

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[13]Seymour-Ure, C., The Press, Politics and the Public, (London:Methuen, 1968), p.23

[14]ibid pp.26-94

citizens, accepted as uncontroversial, 'natural' features of the landscape."[15]

It is a point of agreement amongst analysts that the press plays a crucial role in selecting issues and setting the agenda. To begin with constraints on news content are set by newspapers' organisational routines or bureaucratic procedures. Rock identifies two primary constraints, column space and time.[16]

The criterion governing selection is newsworthiness. At one level this can be defined through content analysis of press coverage of a given issue into recurrent themes. Thus in her analysis of media coverage of health issues, Karpf, herself a journalist, singles out 'the medical breakthrough', 'the disaster', 'the ethical controversy', 'the scandal','the epidemic', 'the official view' as commonly occurring themes.[17]

More fundamentally there are a range of criteria or news values routinely used by journalists to decide newsworthiness and the relative importance of stories. They are shared by all journalists and editors, although differently clustered by the latter according to the paper's editorial policy. They are part of the tools of the trade. Journalists will tend to highlight news values in a story to raise its newsworthiness and improve its chances of selection by the editor. Hence aspects of stories become highlighted and exaggerated. Similarly, events which score highly on a number of news values in a given story, are more likely to be covered.

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[15]Dunleavy p. and O' Leary B.,op.cit. p.158

[16]Rock, P. News as eternal recurrence, in Ed. Cohen S. and Young J., The manufacture of news (London: Constable, 1981) pp.64-69

[17]Karpf, A. Doctoring the Media, (London:Routledge, 1988) pp.28-29

This analysis begs the question of why certain themes reoccur and relatedly why they have passed into professional journalistic practise as news values. As noted above, elite theorists would anticipate that the press is bound to be biased due to proprietorial interest (argument employed to explain the latter-day dominance of right-wing perspectives across the national press) and that there are coalitions between politicians and journalists. The evidence from the AEGIS campaign supports neither of these two contentions. Firstly, apart from selling newspapers, the proposition that one could abstract a wider, material proprietorial interest from the wholesale support by newspapers of mental health reforms is improbable. Moreover, the strongest allegiances that existed between AEGIS and the press were largely hostile to politicians.

Ironically, it is a prominent school of Marxist sociologists who have been most concerned to discount such conspiracy theories. In so doing they have developed the idea that the scope of debate is circumscribed by selected issues, which in time may become accepted as uncontroversial, 'natural' features of the landscape.

The approach derives from a conceptualisation of the press as the major channel for communicating ideas which serve the interests of 'dominant classes'. A major problem for Marxists is the continued compliance of the working class, under universal suffrage, with its objective exploiters, as manifested in the mass support for liberal democratic forms of political organisation. How have the dominant classes managed to restrict 'class consciousness' to safe levels?[18] There are two answers offered to this dilemma: one materialist and one ideological. The former argues that the short-term material interests of the workers are too closely

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[18]Class consciousness is awareness of 'objective' exploitative relationships and determination in the proletariat to overthrow the exploiters. It is contrasted with 'false consciouness' which does not recognise this objective position.

linked to those of the capitalists. In short, capitalists have been successful in buying off key groups of workers.

The second is founded in Gramsci's concept of hegemony.[19] Just as Marxist theory interprets capitalist society as characterised by economic and political cleavages, so Marxist cultural theorists contend that differing cultures and respective ideologies exist and conflict with each other. Pro-capitalist parties therefore preserve their power-base because sufficient members of the working-class accept and share the 'dominant' ideology.

The dominant ideology is " a set of ideas about political and social questions which privileges capitalist interests and insulates the status quo from criticism by making existing social arrangements appear 'natural' or 'inevitable'".[20] Marxist sub-cultural theories of the media have developed from this idea.[21]

Detailed studies of media coverage of two social policy areas have been undertaken from this perspective. The work of Hall et al.[22] on 'mugging' (robbery of the person) and Golding and Middleton's[23] study of social security fraud concerned issues

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[19]See Chapter One

[20]Dunleavy and O' Leary op.cit p.232

[21]Clarke, J. et al, Subcultures, cultures and class , in Ed. Hall S., and Jefferson T., Resistance Through Rituals, (London:Hutchinson, 1976) p.2. See also, Hall S., et al., Politics and Ideology: Gramsci, in On Ideology, (authorship unattributed), (London:Hutchinson, 1977) pp.9-32 and Parkin F., Class, Inequality and Political Order, (London:Granada, 1978) pp.79-97

[22]Hall, S., Critcher, C., Jefferson, T., Clarke, J., Roberts, B., Policing the Crisis: Mugging the State and Law and Order, (London: Macmillan, 1978)

[23]Golding, P., and Middleton, S., Images of Welfare, (London:
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which like psychiatric hospital scandals, attracted intense coverage. They also focus on the early to mid-1970s and are contemporaneous with the later years of the AEGIS campaign.

The type of intense media fixation with an issue, such as that seen during the late-1960s and early-1970s in mental health press coverage, and the reaction engendered in public opinion and in decision makers are symptomatic of a 'moral panic'. Cohen defines it as follows:

> " A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests, its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnosis and solutions; ways of coping are evolved (or more often) resorted to; the condition then disappears, submerges or deteriorates and becomes more visible....Sometimes the panic passes over and is forgotten, except in folk-lore and collective memory, at other times, it has more serious and long-lasting repercussions and might produce such changes as those in legal and social policy or even in the way society conceives itself."[24]

Hall adds:

> "When the initial reaction to a person, group of persons or series of events is out of all proportion to the actual threat offered, ... when the media representations universally stress 'sudden and dramatic' increases (in numbers involved or events) and 'novelty' above and beyond

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Basil Blackwell, 1982)

[24]Cohen S., Folk Devils and Moral Panics, (London:MacGibbon and Kee, 1978) p.9

that which a sober, realistic appraisal could sustain, the we believe it is appropriate to speak of the beginnings of a moral panic."[25]

For Hall and also for Golding, selection of issues with news value goes beyond professional judgement and is part of a more fundamental process of structuring events for inclusion and presentation, according to "a socially constructed set of categories.".[26] The social construction has its foundations in a 'consensual' view of society based in the dominant ideology.[27]

The components of this consensual view are a set of paradigms, themes, premises, assumptions, questions presuming answers within a coherent matrix of ideas. Hall terms these 'image clusters', or 'core images' of society which add up to a sense of Englishness which he contends is fundamental to the consensus view. Firstly, there is the notion of respectability defined by thrift, decency, self-reliance and conformity to social standards set and embodied by those high up in the social hierarchy. Secondly there is the centrality of work which on the one hand allows the middle-classes the material lifestyle which befits respectability and on the other protects the working-class from poverty which brings with it a descent from respectability. Third there is the need for social discipline defined as the aggregate effect of individual self-discipline. Hierarchy and authority are two further related values. Society is seen as naturally hierarchical and therefore presupposes deference to authority. Discipline is engendered in the family, which therefore becomes the focus for social anxieties about the supposed breakdown of discipline in society which 'mugging' is identified to be symptomatic of. A seventh important

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[25]Hall, S. et al., op.cit. p.16

[26]Hall et al. op.cit.p.53 See also, Molotch H. and Lester, M, 'News as purposive behaviour', in Ed. Cohen, S. and Young, J. The Manufacture of News (London:Constable, 1981) pp.118-34

[27]Hall et al. p.55

value is the image of England or 'being English' which has two themes. First, the English are seen as tolerant, decent, moderate and prefer common sense solutions to problems. Second, it carries with it an 'imperialist myth' which believes that everything English is superior to anything originating from abroad.[28]

According to Hall's study, mugging provided a focus for the middle-classes to roll back the tide of liberalism and permissiveness in the 1960s and early 70s, and reassert the preeminence of the 'ideology of englishness'. For the working-classes, the mugger became what Cohen terms a 'folk devil' or a focus for anxieties which arise from the material experience of a way of life under threat from economic and social change during the 1960s and 1970s.[29] A moral panic erupted when these social anxieties and traditionalist views were connected and mobilised by the media. Dominant ideology and subordinate images were moulded together into moral indignation and outrage. The 'devils were summoned' by ideological work carried out by the media.

In summary, Hall's thesis is that in approaching the problem of why an issue becomes the subject of a moral panic, the analyst needs to uncover its ideological roots and locate the orchestration of public opinion in pre-existing systems of thought. There are 6 principal themes in the press coverage of mental hospitals which fuelled the moral panic; the antithesis of civilisation; the deserving poor; the image of the Victorian gothic madhouse; violence and theft; corrupted bureaucracy; and relatedly, the struggle of the individual against the system.

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[28]Ibid pp.140-49

[29]Examples include changes to the occupational structure with the disappearance of traditional industries and work roles, urban renewal and the demolition of traditional working-class communities. Hall's argument is that anxieties are the outward presentation of internalised frustrated urge to engage in overt class struggle against the changes. See Ibid. pp.161-2

At the very beginning of the AEGIS campaign a schism opened up between the case the group were presenting and the assumed image of the British mental health services as 'the envy of the world'; a view consistent with Hall's conception of 'Englishness'. Strabolgi and Barbara Robb were surprised by the coverage generated by his speech in the Lords in July 1965. However the speech directly challenged this assumption of the superiority of the British hospital service and not least affronted conceptions of British decency by comparing the English treatment of the elderly disfourably with that of primitive tribes. Once established the continued outrage against conditions reflected a consensual belief that services should be improved to harmonise the dissonance between the belief and reality.

An important second feature of the mentally ill and handicapped is their status as part of the 'deserving poor'. They are on the inside of 'the boundaries of citizenship' which excludes the social security claimants studied by Golding and Middleton.[30] The re-emergence of the deserving:non-deserving distinction in the 'scroungerphobia' episode, was an invocation, in the late 1960s and 1970s, of the Benthamite utilitarian concept of less-eligibility which produced the workhouse, corrupted the early nineteenth century asylum, and gave birth to the modern welfare state. The residents of mental hospitals were on the opposite side of public esteem from social security scroungers. It was thus as outrageous to have the deserving living in relative squallor as it was to have the 'work-shy' living in the 'lap of luxury'. The corruption of asylum and the close association of these institutions with the poor law[31], is an antecedent of the third theme in the manufacture of mental hospital scandal, that of the 'loony bin'. Whilst the reality of neglect and ill-treatment conflicted with assumptions about English superiority, it chimed with a popular image of the mental hospitals as the stuff of gothic horror. In the second half of the nineteenth century,

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[30]Golding and Middleton, op.cit.

[31]See Scull A.T. Museums of Madness, (London: Allen Lane, 1979)

largely working-class experiences of incarceration, often for 'morally reprehensible' actions, and entry via the workhouse, had turned the benign late-seventeenth century concept of asylum into an object of public fear, loathing and stigma. It was an attitude still widely abroad in the early 1960s. The case AEGIS made to the press, and individual incidents at Ely, Farleigh and particularly Whittingham, simply confirmed the image.

For Hall, violence represents the ultimate violation against the person and against property and thus "marks the distinction between those who are fundamentally of society and those who are outside it".[32] Theft and corruption are its less extreme bed-fellows. Sadly, once certain hospitals were subject to detailed public inquiry, they provided rich sources of copy under these headings. Relatedly Barbara Robb or the individual complainants at Ely, Farleigh, Whittingham and St.Augustine's emerge as 'little' people championing the power of the individual against a 'system' which pursued its vested and perverse interests, stifled legitimate dissent, and when found out resorted to 'cover up' and recrimination. Thus the triumph of Mrs Robb and her fellow complainants resonated with libertarian ideological constructs such as individualism, self-reliance and corrupt state bureaucracy. For Golding, journalists' self-image as self-made people makes them prone to this view and as they attribute their own values to the wider public and thus reinforce the process.[33]

It is also probable that the image presented in the press and was consistent with the experience of those members of the public who as patients or relatives were consumers of the mental health services.

To summarise so far, there is an inevitable process of selection of events for inclusion in the press. This selection process is structured from within a consensual framework whose ideological

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[32]Hall et al.op. cit. p.68

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elements are invoked to generate moral panics whose central issues serve as a focus for social anxieties (which in Hall and Golding's perspectives, originate in antagonistic, class-based, power relations). The next stage in the analysis is to examine the mechanics of issue definition, influencing public opinion and the impact of the press on politicians.

Golding identifies a three-stage process. First, "..precipitating events sensitise the media so that surveillance procedures and journalistic categories are sharpened to capture similar subsequent events and give them considerable prominence".[34] This was one of the most critical roles played by AEGIS in the process of change which produced the reforms. By generating its support in Fleet Street, priming strategically-placed journalists, publishing Sans Everything, and skilfully, out-manoeuvering the Ministry of Health over the subsequent White Paper, AEGIS cemented the preoccupation of the press with 'mental hospital scandal' and instigated the process which produced succeeding inquiries. Without AEGIS, it is difficult to conceive how Ely, Farleigh and Whittingham would have happened. The group was the major force in bring to light the hospital scandals.

Sources are instrumental to sensitisation and the expansion of coverage. Journalists depend on sources. Hall categorises these into 'primary and secondary definers'. Primary definers are people at the top of a 'hierarchy of credibility' or the likelihood that those in power or high status positions will be understood to have greater access to specialist information on particular topics than the majority of the population. Their definition of a problem therefore sets the terms for reference by establishing what is an issue for debate.

Golding and Middleton identify three major categories of primary definer for social policy issues: politicians, pressure groups and

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[33]Golding et al. op. cit. p.39

[34]Ibid. pp.59-60

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professionals. That politicians and civil servants are key, 'authorative' sources for the press. has three consequences of concern here. First, politicians are crucial to the process of agenda-setting. This was the role which Crossman sought to play in publishing the Ely Report, and stealing some of the initiative from the Ministry's external critics. He was a politician highly sensitive to his media image and the importance of media management. Some politicians are more technically skillful at this than others; similarly some personalities are more colourful and flamboyant and therefore make better copy than others.[35] Coverage was therefore skewed towards inter-personal conflicts and individual styles; Barbara Robb's own flamboyance made her good copy as a political adversary. Secondly, (and ironically) in the early days of its campaign, AEGIS ability through Strabolgi and Mrs Robb, to involve the Minister directly attracted press coverage.

Journalists classify pressure groups as reliable and unreliable. They also make a separate distinction between those representing the cause of others, and 'axe-grinders' representing their own or their members interests. Since the relationship between a pressure group and the media is a central aspect of this study, Golding's summary of the role of groups is particularly pertinent.

> "By and large the more successful, articulate and aggressively publicity-oriented groups have been those for whom Fleet Street and Westminster are primary targets and whose objectives seem acceptably reformist in content however radically expressed and promulgated. For the journalists, pressure groups are used less and less often as source of primary material than as a source of expert comment on policy initiatives from government. They serve a twin function. On the one hand they act as research

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agencies, able to point out the inconsistencies or evasions in official version of policy. On the other hand they provide hand-wringing reactions to the iniquities of government policy that can be used to 'balance' a story. The success of some pressure groups lies in their ability to exploit these functions and shrewdly to produce what journalists need."[36]

There can have few if any pressure groups who have performed these roles more successfully than AEGIS. The role played by Barbara Robb in quickly establishing herself as a reliable source and feeding good copy direct to her contacts was critical.

The third group are professional organisations, and particularly their specialist journals. There is often a 'three step flow' as the quality press take stories from the journals and the populars then pick up stories from the qualities. They players in this game are the specialist correspondents in all three outlets who read each other and keep each other informed. Indeed the very fact that one senior journalist covers a story is often enough to confirm its news value in the eyes of others, so that coverage is amplified. Two contrasting features of the campaign are relevant here. Firstly AEGIS quickly and successfully recruited influential nursing journalists who in turn acted as a second, primary definer to AEGIS itself. Secondly, by paying little or no attention to AEGIS and the press campaign until the publication of the Sans Everything White Paper, organised medicine failed in this role by default. By the time it started it get its views into the press, opposing change in complaints machinery, it was denying an already established and legitimised case.

The media themselves are the secondary definers, or 'switchmen' diverting attention to a limited range of metaphors and explanations, orchestrating and reinforcing among the volume and range of attitudes more widely abroad. It is in this context that

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[35]Barbara Castle is often cites as being a good copy politician.
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their formulation of newsworthiness is important to the selection and presentation of material. Major news values are entertainment value, and extraordinariness.[37] Entertainment value skews selection towards the exceptional or sensational. This effect of repeatedly presenting unusual cases is to make them appear typical or commonplace. As a result the scale of the relatively rare event can become exaggerated in the eyes of the readership and without any attempt by the press to measure the extent of problems, isolated incidents of 'mugging', 'scroungerphobia' 'staff cruelty' are soon widely believed to be merely the 'tip of iceberg'. It is for this reason that the more extreme forms of neglect and ill-treatment dominated the coverage of the mental hospital inquiries. These themes also correspond to a second key news value, 'negative consequences' which embraces crime, corruption and disaster.

How does this impact on public opinion and relatedly, but separately, politicians? After definition and at the second stage, ".... the ensuing period evokes a steady stream of previously latent mythologies about the 'social problem' thus dramatically 'uncovered'".[38] Thirdly, "....the legislative, administrative and possibly judicial responses to this cultural thrust reinforce its potency and provide a real shift in the structure of state responses to the definitions provided in the moral panic. The responses in turn provide material and confirmation of the arrival of a new matter of concern on the political agenda."[39] Again, AEGIS extracted responses from the Minister which in the eye of journalists simply reinforced its case.

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[36]Golding, P, and Middleton, S., op.cit. p.9

[37]Seymour-Ure, C., op.cit p.90

[38]Golding P., and Middleton S., Op.cit pp.59-60

The media can also act as primary definers by adopting an active, campaigning stance, which assumes public opinion and plays it back to elites with a demand for action. In turn elite groups often interpret this as 'impartial evidence' of what the public wants, although of course, the public has been completely bypassed. This is most likely to happen where journalists are following a story in areas which primary definers such as politicians and civil servants try not to recognise. Again this was exactly the role of journalists as primary definers which the Ministry under Kenneth Robinson inadvertently encouraged.

More frequently, Hall contends, the media plays a mediating role in the formulation and orchestration of public opinion. At its inception, opinion begins as the interplay of factual knowledge, rumour, and folklore dispersed and fragmented amongst the wider public. Events and issues become public when the professional and lay worlds of the press and the public overlap, such as when correspondents are researching stories on the ground. In the case of AEGIS, correspondents undertook direct research by visiting hospitals, or by getting jobs as nurses. As opinion on an issue thus passes into the public domain the press structure and interpret it using the same ideological framework which governs selection of news items. The dominant consensus thus shapes public opinion by underpinning and supporting viewpoints already in circulation thus helping "to close the consensual circle, providing the linchpin of legitimation." [40]

The media's search for novelty leads them to present information on events which are outside the direct experience of most people; Hall calls this 'structured ignorance'. The media is thereby cast in the dual-role of interpreter and communicator of public opinion.[41] In the case of mental hospital scandals, there is no evidence of direct participation by the public at large in

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[39]Ibid

[40]Hall et al. op.cit. pp.137-8

defining the issues. This was purely undertaken by AEGIS, other members of the 'policy community'[42] in mental health or staff in the service.

How is this communicated back to politicians? The channels are the letters columns, the editorials, the volume of coverage and more personally through the 'lobby system'. The letters columns often act as the point of entry of issues into the political arena. The quality press attract and carry letters from members of elite groups to influence issues 'from within'. The populars seek to represent the opinions of their readers to those in power and their letter columns contain correspondence from the 'ordinary public'. Again there is little evidence of the 'general public writing' to the press in this case study. It was members of the policy community, individual professionals and (rarely) patients' relatives, who filled the letters columns of popular and quality papers alike. There is anecdotal evidence of nursing staff in mental hospitals, at the height of the adverse publicity, being taunted by neighbours accusing them of ill-treating their patients as 'all mental hospitals do'[43], but we can never know what the public really thought.

Editorials have a relatively small audience but it comprises the influential and the powerful. Volume of coverage simply reinforces the likelihood that an issue will be seen as a legitimate subject for government action.[44] From January 1967 until the mid-1970s, the volume of coverage was of course huge.

The Lobby system serves as the direct, personal interface between journalists and politicians. Although, throughout the 1960s the Lobby was staffed increasingly by specialist correspondents in areas like economics or social policy. The Lobby is particularly

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[41]Ibid. p.64

[42]This concept is discussed in more detail in the next chapter

[43]Direct discussions with senior psychiatric hospital staff.

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involved when legislation is going through and certainly was active in some detail during the passage of the Health Service Commissioner clauses of the 1973 NHS Reorganisation Bill, widely covered in the press.

The last stage in the analysis is to understand how politicians react to the press. Seymour-Ure singles out two means of influence on politicians; vertical and horizontal communication. Vertical communication links public opinion to three different sections of the 'political public'; Ministers and civil servants, Government backbenchers and party officials, and thirdly the Opposition. Seymour-Ure's main argument is that whatever the empirical reality, the significant factor is the belief by politicians that newspapers influence public opinion. They are one of the key transmitters of perceived public opinion. Secondly the media are primary information sources to party activists, Backbenchers and the Opposition who in turn bring pressure to bear on the Executive. In the course of the campaign there were myriad such examples of press coverage (often inspired by AEGIS) being fed back to Ministers by backbenchers during Parliamentary debates as reflections of public feeling.

Horizontal communication takes place when newspapers act as sources of information for the political public about its members.[45] This can either take the form of partial coverage which threatens further revelations, or innuendo and oblique references for 'those in the know'. There was ample evidence of horizontal communication in the AEGIS campaign. Partial revelation in the press, and replication of the minutiae of current arguments with the Ministry in the letters columns, was used extensively by AEGIS during the campaign for an independent inquiry into Sans Everything to keep the threat of further revelations firmly in the mind of the Executive. Once AEGIS became an insider group, Barbara Robb submitted pieces to the

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[44]Golding P., and Middleton S, op.cit. p.65

[45]See Role of the Press in this guise in the Profumo Affair in
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Daily Telegraph, or persuaded her Fleet Street allies to publish feature articles at strategic points in the campaign, less to inform the public, than to remind politicians and officials that she retained the option of whipping up the media if appropriate policy outputs were not forthcoming.

As Seymour-Ure argues, it is problematic to measure the extent of media influence over politicians. Nevertheless three main sources can be summarised. Firstly they transmit perceived public opinion to which politicians respond. Secondly they wield power by virtue of belief on the part of the political public that they influence public opinion. Thirdly they can exercise a key sanction over politicians by publishing (or threatening to) on issues which the latter would prefer kept secret.

Parliament

What then of the role of the people's representative body, Parliament? To begin with, mental health was not a party political issue and therefore party competition is not a major parameter. This would tend to discount a pluralist, representative democracy model of its role. Lack of party antagonism in turn reflects the fact that mental health is an issue which does not influence voter support to a marked degree: although Crossman was ever concerned at the ability of hospital scandals to damage the Government's caring image. Public choice theory would tend to predict from this that Parliamentarians would show no interest in the subject. However the study has shown that although Parliament has not been highly prominent as a source of policy change, it has played three important roles.

Firstly MPs and Peers have provided pressure groups with a platform from which to develop national recognition of an issue. Given the focus of press interest on Parliament, this is not an insignificant role. Perhaps unsurprisingly, for an issue which does not win or lose elections, the Lords has been prominent here.

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Strabolgi's speech originally launched AEGIS, and Peers from the medical profession represented the BMA line during the passage of the Health Service Commissioner clauses of the 1973 NHS Bill.

The Commons was more active in the second major function, that of acting as a source of pressure on Ministers. Even if the public is largely uninterested, Ministers still have a Parliamentary constituency and reputation which are important to their career path. A Minister who is consistently apologising to Parliament for problems in his policy sphere widely reverberating in the press, or worse has to admit one month what was denied three earlier, is unlikely to inspire confidence either in backbenchers or members of his own Frontbench. In this regard, it may be significant that the ministerial career of the first holder of a high profile portfolio in the 1964 and 1966 Labour Government, and who scored such a great success in re-negotiating a new contract for General Practitioners and appeared to be on the crest of a cabinet post, was in 1968 given a second junior post before moving out of Government.

The third function was to amend the legislation on the Health Service Commissioner to ensure that the office could take complaints direct from hospital staff raising concerns about standards of care. Although AEGIS claimed this as a great triumph, it was a marginal concession by the Government which in practice has proved to be relatively insignificant due to the limitations on the Office otherwise carried through Parliament. There was certainly a very strong campaign by the Opposition parties to make it a more powerful office. But as the Secretary of State explained to the Committee Stage of the Bill, the formula he presented had been agreed by the BMA and he was not prepared to move on it.[46] Parliament was therefore approving a formula which had already been subject to a degree of effective veto by the medical profession.

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Seymour-Ure op.cit. pp.266-276

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It is also significant that although the Opposition health team in the Commons which pressed for the inclusion of clinical complaints within the Commissioner's remit was led by the Secretary of State for Social Services from 1974 to 1976, she brought forward no amending legislation even though she also published the South Ockendon Report. To be fair to her, Barbara Castle did more than any politician to try and implement the major components of the Davies Report but in two years, a senior Cabinet Minister, did not succeed. This is a clear indication that in mental health and health complaints policy, even the Executive can be subservient to other interests. This is the concern of the next chapter.

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[46] See Chapter 9

CHAPTER THIRTEEN

POLICY-CHANGE IN MENTAL HEALTH - THE STATE'S RESPONSE

> "Policy analysis involves the use of social science tools that produce inherently uncertain and incomplete findings, and these doubtful findings are then brought forward in an attempt to understand goals which are ambiguous and conflicting."[1]

To complete the evaluation of the five models of state activity, this chapter focuses on the response of the state to the demands placed upon it by the major spheres of input politics analysed in the previous chapter. The aim is to examine what the AEGIS campaign, the hospital scandals and the policy reforms they precipitated can elucidate about the structure of power in society. Two major spheres of analysis are employed. Initially, the nature of the process of decision-making within the Executive is considered. Secondly, its structure, its internal dynamics and its responses to demands are analysed against the competing theories of the State. A final section draws together the findings of both evaluative chapters into a concluding commentary on the appropriateness of these models. As in Chapter 12, Dunleavy and O'Leary's typology is the major source for the characterisation of each model.[2]

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[1]Rein, M. Social Science and Public Policy, (London: Penguin, 1976) p.76

[2]Dunleavy, P. and O'Leary, B., Theories of the State, (London: Macmillan, 1987)

Nature of the decision-making process

Elite and neo-pluralist theorists describe the process of decision-making as 'rational'. Elite prescribes that decision-making should be rational, comprehensive and search for the optimum policy strategy. Policy-makers review current outputs, formulate precise objectives, identify all policy options which could meet the objectives, subject the options to systematic evaluation and implement the best-performing option. In the face of criticism from pluralists, this was modified by neo-pluralists into the 'bounded rationality' model, or, as Etzioni has termed it, 'mixed scanning'[3], which has five components: the factorisation of problems into separate issues dealt with by sub-organisations; the more limited aim of 'satisfising' or meeting a narrower spectrum of needs and demands: the range of alternatives considered is limited; uncertainty in the environment is absorbed as much as possible; there are standard operating procedures that categorise problems and formulate category-specific approaches.[4]

Bounded rationality is said to have resulted in a gathering trend towards the specialisation and 'technocratisation' of policy development and resource planning. Techniques such as cost benefit analysis[5], and PPBS[6], have superseded political

[3]Etzioni, A., Mixed scanning: a third approach to decision-making, Public Administration Review, Vol. 27, No. 5, December 1967, pp.385-392

[4]See Dror, Y., Policy-making Re-examined, (New York: Elsevier, 1973) Chapter 12, and Dror,Y., Muddling Through - Science or Inertia, Public Administration Review Vol.24, No.3, pp.153-57 and Etzioni, A., Mixed Scanning - A third approach to decision-making, in Ed. Faludi, A., A Reader in Planning Theory, (Oxford: Pergamon, 1973) pp.219-229

[5]Williams, A., The Cost-Benefit Approach, British Medical Bulletin, vol.30 No 4. (1974) pp.252-256

[6]See Etzioni, A., 'Mixed Scanning - A third approach to
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considerations as criteria for decision-making. This disadvantages non-specialists and the wider community in the process and increases the relative autonomy of professionals and experts.

In contrast, pluralist conceptions are both descriptively and normatively incremental. Normative because comprehensive-rationality is dismissed as impossible. Descriptive, because empirical research indicates that the base outputs of policy and budget are rarely examined and changes take place only at the margins.[7] Policy-making is also pragmatic. Since decision-making is the product of group bargaining and because policy-makers cannot know all the facts pertinent to complex problems, the process is often 'disjointed'. It is based on accommodation between organised interests or 'partisan mutual adjustment': a phrase associated with Lindblom. Policy-makers practise the art of 'muddling through'.[8]

The process of decision-making in this study suggests that the polarity between incremental and rational models is an over-simplification. Prior to Crossman's administration, the Executive made marginal changes to existing policy but only in the context of a general denial of the case for more radical change. After Ely, and with a new administration in the Department of Health, the case was accepted. Of central importance was Crossman's

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decision-making, in Ed. A. Faludi, A Reader in Planning Theory, (etc) pp.219-229

[7]Heclo, M., and Wildavsky, A., The Private Government of Public Money, (London: Macmillan, 1974)

[8]See the seminal statement of this position by Lindblom, C.E., The Science of Muddling Through', Public Administration Review, Vol. 19, 1959, pp.79-88, also Edwards, G., and Sharansky I., The Policy Predicament (San Francisco: W.H.Freeman, 1978) pp.6-12, and Wildavsky, A., Rescuing Policy Analysis from PPBS, Public Administration Review, Vol.28. (1969) pp.189-200

decision to use outsiders to construct the programme and whose work was coordinated by a professor in empirical social administration, pre-disposed to bounded rational approaches. He brought into the exercise two further academics, Pauline Morriss and Peter Townsend both of whom were on the record with criticism of policy for failing to examine the base. The work of the post-Ely working party constructed a 'rational' policy. Better Services for the Mentally Handicapped reviewed existing outputs, re-formulated objectives, identified need both qualitatively and quantitatively and constructed a policy programme which tailored objectives to need; research and monitoring mechanisms then provided the feedback loop. Once the post-Ely policy had established this approach, a second academic and technically-oriented Secretary of State developed it and applied it when the Whittingham report established the case for re-examining policy objectives in mental illness. A year after he left office, Better Services for the Mentally Ill was the result. In each cases crisis was the catalyst.

The financial strategy conflicted with incrementalism since a re-appraisal of the NHS revenue budget led eventually to programme targets which restructured programme shares, effectively redistributing the base. As Chapter 10 notes, although the relative shift in real resources across programmes over time has been substantial, movements towards target were incremental since it was not possible to move large volumes of resources across functional boundaries over a short period. There is a natural lead-in time for development, and even if feasible, any attempt to implement the policy in one year would have generated huge political opposition from the Regions and the BMA. Similarly, both policy reviews were conducted within a commitment established after the 1957 Royal Commission Report to de-institutionalise psychiatric and mental handicap services.[9] From this perspective they could be seen as incremental reforms. However, this extant policy emerged from a major review in the mid-1950s.

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[9]See Chapter 2

In summary then, bounded-rationality was used to formulate objectives to be achieved by incremental changes. Similarly, resources were redistributed incrementally. However in each case there was a framework of bounded rationality which accordingly emerges as the predominant feature of the process of decision.

Public choice and Marxist theories are less concerned with process than outputs. According to the former, there are two major tendencies in government activity; institutional atrophy and ever-expanding budgets. Institutional atrophy is a process of degeneration from collective goals into the individual interests of those holding official positions. Since the state is so large, diversified, complex and not least, secretive, citizens can rarely mount any effective scrutiny and hence rarely waste time and money trying. Second, unlike commercial managers whose earnings are profit-related, the welfare of bureaucrats is linked to the size of their empires and budgets from which power, status and often, increased remuneration levels are derived, and therefore aim to maximise them. In this the interests of officials and political heads converge. So long as the effect of official action does not reduce the welfare of society, the tendency will be towards an over-supply of the output of government agencies.[10]

There is insufficient evidence in the study to evaluate whether institutional atrophy can be said to characterise the process. An entirely cynical view that all the participants were in it for themselves seems unsupportable. Also, successive governments have sustained the priorities policy and elaborated the strategies for moving services from large hospitals to the community as experience and research uncover unmet needs and demands at a more detailed level of policy disaggregation. It is conceivable that more recently, predominant interests at local level, which in health services generally favour the acute sector, may be reversing the trend of redistribution of resources and in so doing, have the tacit approval of the centre. There was probably

[10]Dunleavy P., and O'Leary, B. p.115-7

a degree of empire building amongst some of the participants, and budgets in mental health have increased steadily in real terms where health authorities hold the line on Priorities whilst the number of hospital residents has and continues to decline. Over-supply can certainly happen in the NHS, as for example in the continued over-provision and even rebuilding of acute hospital beds in parts of inner-London. Whether the British mental health services are heading for a position of over-supply is difficult to evaluate; although, an informed impression suggests that twenty years after the Ely Report was published, they may still have some way to go.

Since Marxists are primarily concerned with identifying the structural determinants on the policy-process and less with the process itself, their characterisations are considered in the next section.

The activity of the state

The nature of decision-making and the inputs politics can now be used to supplement an analysis of state activity to evaluate the appropriateness of the macro theories of the state to the case study. Each is examined in turn.

Pluralism

Thus far the claims of pluralists are not substantiated in the case study. Once the case was accepted, decision-making was not incremental. The media was not an open, freely-accessible mirror on society. The pressure group community, although polyarchic, is not infinitely dynamic and open to all interests.

What of the nature of the state? Pluralist accounts contend that the character of policy outputs demonstrates the state's neutrality in dealing with competing interests and present the

state as dynamic and reflecting the balance of pressure group forces at any one time. The 'neutral state' model sees the ideal state as one which balances, re-weights and referees pressure group contests to protect unorganized or weakly organised groups in the public interest, actively enforcing the rules of fairness and championing the underdog. The model asserts the ideal of a constitutional bureaucracy to safeguard the public interest, recruited meritocratically and motivated by a public service ethic.

The nature of the policy outputs in the AEGIS campaign and their bias towards professional demands indicates that the state has not acted neutrally. Within bias towards selected demands, which, one could argue, Parliament simply reflected in the passage of the Health Service Commissioner, the Executive actively managed what Dunleavy and O'Leary term a 'deformed polyarchy'.[11] The administrations of Crossman and Joseph resisted medical demands, which favoured the status quo, in areas where this had been demonstrated to be no longer legitimate. They were not passive, 'weathervanes'. This could be interpreted as supportive of the 'neutral state' model of a bureaucracy championing the public interest. However, Crossman had to bring in outsiders to assert the policy over his permanent officials and in any case, British Parliamentarians, senior civil servants, and Ministers were not meritocratically recruited in the mid-1960s.[12]

According to the 'broker state' model, state activity equates to the aggregation of internal pressure group activity and policy outcomes are the outcome of bureaucratic politics reflecting self-interest of officials as much as outside pressure. Therefore if external contending groups are equally balanced, state officials can tip the policy decision in favour of their own preferences. This model identifies 'policy communities' or internal coalitions

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[11]Dunleavy and O'Leary, op.cit.

[12]Guttsman, W.L., The British Political Elite, (London: Macgibbon and Kee, 1963)

within the civil service, however, cohesion and coordination only happens when group interests accidentally coincide with the general interest.[13]

If Crossman is correct in identifying the resistance and denial of Barbara Robb's case during the first three years of AEGIS as typical of the preferences of the dominant coalition of the Ministry of Health, then the broker state model is not appropriate. Crossman's Post-Ely working arrangements represented a means effectively to counter any policy community amongst his officials.

There is some evidence of the kind of shifts in position under pressure which pluralist systems approaches would predict. When AEGIS appeared as a threat, the first reaction of the Ministry was to ignore and deny. Once it became clear that this strategy was failing, minimal but cumulative policy responses, characteristic of 'dynamic conservatism' were produced. The threat grew and the next response was to try and co-opt AEGIS to divert its energy to the Department's overall objectives. With the crisis generated by Sans Everything and Ely, the 'system' changed, but in terms the impact of the resultant policies, the compliance with demands was minimal, in Schon's terms 'token' rather than 'significant'.[14] The problem with this approach is that a system is self-contained. Whereas in the case study, the state and the inputs acting on it were not always distinct from one another. Professionals in the environment had representatives inside the 'system', and individual AEGIS advisers played diverse roles and 'wore more than one hat' at once.

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[13]Dunleavy and O'Leary op.cit. pp.45-47

[14]Schon D., Beyond the Stable State, (London:Pelican, 1973) Chapter 2 'Dynamic Conservatism'

Public Choice theory

Public choice theory encompasses two major models. The demand-side model is based on the median-voter theorem which is said to govern the output of the Executive. Political markets are aggregated to assert the self-interest of the majority and direct budgets accordingly. This model is singularly inappropriate to this study. Although mental illness afflicts a substantial proportion of the population, there is not the overt recognition of this amongst the general public which translates itself into commensurate demands for spending (as in acute services). Within the NHS budget, the assertion of the needs of the mentally disordered must overcome the predominant political pressure to spend money in other sectors. One could argue that between central government programmes, shifting money into priority sectors is achieved only by expanding the budget which in turn is a result of median-voter pressure. However, this redistribution continued even in the mid 1970s when due to the oil crisis, the trend of expanding budgets in acute services shifted into reverse, (albeit temporarily).

According to the 'supply-side' model, policy outputs are the result of log-rolling and pork-barrel politics within the government machine. The earlier discussion on pressure groups argued that neither of these conceptions are appropriate to the case study.[15] AEGIS does not conform to the characterisation of interest groups in public choice theory. However, all actions of other members of the policy community could be seen as promoting their vested interests, if one had the inclination so to interpret human motivation. Medicine was protecting its empire from nursing. Parliamentarians and academics were enhancing their reputations. A group like the NAMH was a coalition of all these vested interests. QCs were creating business for themselves. Ministers were making political capital to promote their careers. Without in-depth examination of the personal motives of all the

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[15]See Chapter 12

participants this study cannot be conclusive here although two observations are pertinent. If Barbara Robb was not motivated by material gain, as she was not, then why should she have been the only person involved acting with altruism? Moreover, a public choice interpretation requires a degree of cynicism unsupported even in the Crossman Diaries!

Elite Theorists

A major theme in elite models of state activity is the focus on the executive bureaucracy.[16] More radical elite theorists argue that policy-level functionaries are either directly controlled by a business-elite or, through the use of limited selection criteria, including specific educational background and the 'old boy network', are implicitly biased by social background with a shared culture, and interests of the business elite. Secondly, politicians are seen as dominated by their officials who have greater experience and technical knowledge and sustain continuity as Ministers come and go. A more 'revisionist' approach lies in the concept of 'technocracy' used to describe administrative elites who operate primarily in their own interests or according to their own professional norms, whilst being unbeholden to outside elites.

There are several strands to the technocratic mentality. Firstly, it asserts the superiority of the technical over the political in decision-making. Secondly, technocrats are organisational imperialists, ever-ready to expand their spheres of interest and budgets and restructure the organisation in their favour. Thirdly, they play a critical role as coordinators by writing policy programmes, and implementing the processes without which the tasks of government would be impossible. Fourthly, their technical expertise makes them difficult to replace easily,

[16] Dunleavy and O'Leary, op.cit. pp.169-73

therefore they can only be removed as part of a medium-term strategy. Lastly, their focus on specialist policy areas tends towards 'tunnel vision' to the exclusion of a multi-dimensional perspective on issues.

During the 1960s, senior British Civil servants were recruited from a narrow social stratum. They were largely educated at Oxbridge in subjects not directly relevant to most of the specialist areas they came to work in, particularly social services. Indeed the recruitment policy in the Civil Service favoured the generalist to the functional expert. The Department of Health had professional divisions but the personnel who fulfilled the coordinating role were generalists. This was one of Crossman's principal complaints about the Permanent Staff. His response was to import specialists to construct a technical policy programme. The Post-Ely Working Party can thus be seen as an alternative technocracy to a generalist permanent staff. The approach to policy-making developed by this group was continued by Joseph who like Crossman was a technical politician. Although there was some circumstantial evidence that the permanent staff may have won back a little ground during the former's period of office. The drafting of the 1971 Better Services White Paper was 'flattened out' with all references to Ely removed so that the new policy appeared as a consistent development from the old.[17] The HAS no longer reported direct to the Minister but was mediated by his officials. Despite wide calls for a legal appointment to the office of Health Commissioner, the first postholder was a former Deputy Permanent Secretary at the DHSS.

Bringing in outsiders is also a sub-theme, within elite theory, of the assertion of political leadership which is ascribed four roles. Firstly, it has a symbolic, non-rational role as a charismatic authority which is 'running the show', and creates an atmosphere which appears to fulfil electoral promises and obligations to interest groups whilst in reality, the

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[17]Crossman's term for diluting the drafting, see Chapter 6

configuration of policy-making and outputs may be scarcely affected. Secondly, it concentrates power in a core Executive which is selectively recruited. Thirdly, it determines policy direction by ensuring ideological conformity in key areas of influence within the government machine. The leadership's tentacles are extended through parties and political appointees to the bureaucracy. Fourthly leaders take crisis decisions "....when the normally routinized operations of the bureaucracy are insufficient or cannot be relied on, when decisions have to be pushed through the chain of command..."[18]

All three Secretaries of State in the case study were high-profile, charismatic figures with distinct ideological identities and potent personal styles. There are particularly strong resonances between the three other roles of leadership and Crossman's administration where more detailed evidence is available. To begin with, he engineered a crisis by publishing the full text of the Ely Report, to push through a programme and assert his authority over resistant officials. He then created a core executive, selectively recruited, including senior academics associated with his own political party and thus extended the tentacles of his leadership into the permanent staff. The concept of an 'imported technocracy' serving the interests of a charismatic politician with whom it shared policy objectives seems accurately to characterise the most significant role of academics in this case study. They were certainly idea definers as Banting suggests[19], but their ideas were not absorbed by the Executive until the political climate was right. Townsend had been writing on the conditions of the elderly in longstay care for seven years before he was brought in by Crossman. Academics were directly involved in the lobbying which helped create the climate, but

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[18]Dunleavy and O'Leary, op.cit., p.168 Note: Crossman and Ely to force his hand and legitimate his direct involvement in detail policy areas.

[19]See Banting K., Poverty, Politics, and Policy (London, Macmillan, 1979) and discussion in Chapter One

their impact was most potent when they were on the inside of government.[20]

The third theme is the central-periphery dynamic. Democratic elite theorists argue that the role of peripheral agencies and local governments as implementors of central policy has grown and offset any trend in the centralisation of policy-making. However the radical theorists argue that this is merely window dressing because it represents the diversification of central elite domination through networks of patronage and the control of expenditure.[21] Central political authority is simply extended into lower-tier sub-organisations. The decision-making process appears open and ostensibly legitimate, however the membership of quasi-government agencies to whom authority is devolved can be controlled by the centre but cannot be overturned electorally. This process also serves to spread the blame when things go wrong thus immunising the central elites.

The fourth theme focusses on the link between business and the state and is not relevant here.[22]

The development of systematic monitoring in the NHS is consistent with the critique of the use of quasi-government agencies at local level whose membership is controlled by the centre. The post-Ely shockwaves were used to re-assert the centre's authority over the health authorities responsible for implementing Ministerial policy

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[20]Klein's position here is closest to the findings of this case study. He argues that academics working with Labour ministers "....used policy analysis as a springboard to influence public policy... and have conducted overtly political campaigns", Klein, R., The rise and decline of policy analysis: the strange case of health policy-making in Britain, Policy Analysis, Vol. 2, No.3, (1976) p. 474

[21]Dunleavy P. and O'Leary B., op cit p.179

[22]Dunleavy and O'Leary also discuss a fifth theme of the role of the law and judiciary which is not relevant to the concerns here.

which Ely had found deficient in ways which rebounded on the centre through pressure brought by AEGIS and the press. Crossman used this to reverse previous policy of genuine devolution to extend his networks of leadership through the regional board chairmen into the periphery. He employed systematic, 'technocratic', information gathering and feedback on performance against centrally-determined targets designed largely by the outsiders in the post-Ely working party. These early attempts at monitoring and review were continued by Keith Joseph and subsequently more fully developed into the systems now in use.[23] The amount of discretion available to health authorities has thereby been systematically and inexorably reduced. It remains to be seen whether the implementation of proposals to create National Health Service Trusts will produce more genuine independence at local level.[24] As the NHS now spends over £25 billion of public money, the Treasury is bound to require close scrutiny and control of this expenditure both within central economic policy and not least since its Ministers and officials are answerable to the Public Accounts Committee for any cases of apparent ineffective resource use which may come to light. It also seems difficult to conceive how political accountability can be circumvented to the extent that health ministers no longer have to answer to Parliament for standards of service delivered on the ground in an area as party political as the NHS has become. Certainly the proposals to reduce the size of health authorities and create executive members at unit, district and regional level[25] seems to be a logical development of the trend to centralisation established in the late-1960s.

Two models of the state in elite theories seem pertinent. According to the 'autonomous model', the state is run by elected

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[23]See Chapter 10.

[24]See NHS, Working for Patients, Working Paper 1, Self-governing Hospitals, (London: HMSO, 1989)

[25]NHS, Working for Patients, (London :HMSO,1989) pp.64-66

governing elites or bureaucracy, but each group is separated from control by socially-privileged groups. To begin with politicians are able to resist outside pressure. They have other personal options if they lose office, many others have safe constituencies and besides any outside influence on public opinion is only important at election times. Secondly officers devise strategies to enhance their autonomy and countervail pluralist pressures. They can alter opinion and attitudes and weaken or instil uncertainty amongst their enemies. Officials choose which interest groups are consulted.

There was certainly an element of choice in the selection of pressure-groups for consultation. However, the way AEGIS moved from an outsider to an insider group demonstrates that the central bureaucracy can have its choice circumscribed by the power of outside pressure. Moreover, the failure of Crossman to get agreement for his more radical health service complaints policy in the face of medical opposition, replicated during the Castle administration, is counter-indicative of autonomy of action. Besides, most politicians who reach Cabinet status have invested a great deal of personal commitment, energy and many years to a political career. It is not something they readily put at risk, even if a directorship of a major company is on offer, since moving out of politics is often construed as having failed.

The 'liberal corporatist model' identifies "....a pattern of interest group representation where a liberal democratic state does not outlaw rival interest groups but rather accords certain corporate groups a monopoly over representing given social interests".[26] Interests are thus integrated and non-competitive but their influence is dependent upon the observation of certain controls on the selection of their leaders and articulation of demands and supports. Elected governments and functionaries facilitate bargains struck by corporatist elites. Officials set

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[26]Dunleavy, P. and O'Leary, op.cit. p.193

the agenda, decide participants and exercise considerable influence if the area is technical.

The policy communities described later in the chapter are evidence of a liberal corporatist model of policy-change. The spheres of political action were limited in number and most were coopted at various stages. There were rules of the game and the Executive struck bargains. For example, AEGIS agreed not to use its muscle to fight the Sans Everything white paper in the press so long as the Executive was embarked upon a programme of acceptable policy outputs. However to characterise state activity in the case study by this model would be to deny the tensions and conflicting interests between the communities. There was a significant degree of polyarchy in the input politics, albeit bounded and deformed. Moreover the range of possible operational details of the same broad policy innovation and the various means of implementation create a wide variety of policy outcomes. Thus AEGIS' prescription for the remit of Health Commissioner was very different from that agreed between the government and the BMA.

Marxism

Original Marxist theory conceptualised the state are as a markedly repressive apparatus serving the interests of capital. This appeared inconsistent with the 'welfare consensus' of the 60s and 70s and therefore was modified in three forms. Of these functionalist approaches are the most frequently used in Marxist explanations of the development[27] and purpose of welfare services.[28] These interpret the state's primary aim as maintaining capitalist development. There are four sub-functions. The state preserves order through 'social expenses' (eg. the

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[27]See Scull A.T., Museums of Madness, (London:Prentice Hall, 1979)

[28]Gough, I., The Political Economy of the Welfare State, (London: Macmillan, 1979)

police). It promotes capital accumulation through social investment (eg. infrastructure), and manufactures legitimation through social consumption (welfare state). It has a reproductory function by maintaining a healthy, educated workforce. Decision-making is deliberately pluralist "mopping up political energies, providing a reassuring appearance of controversy and popular influence and sustaining a needs-oriented ideology which seems to indicate the social neutrality of state policy".[29]

Structuralist Marxism is a variant of functionalism. It seeks to derive an understanding of political phenomena from the fundamental economic relations involved in the capitalist mode of production, interpreting policies as determined by impersonal changes in economic and political and ideological systems. The state apparatus acts with a measure of autonomy from the owners of capital and again the direction of policy is towards the preservation of the overall social order within which the processes of capital accumulation can proceed. The state also has a legitimation role, within which the welfare state is crucial since it portrays the state as equitable.

How can a case study in mental health, presented at such a marked level of disaggregation and whose net effects were reforms to existing programmes, serve to evaluate such abstract arguments? To begin with it has already been contended that of all the perspectives on the role of the media in politics, Marxist 'sub-cultural' theorists who emphasise ideology as a power parameter have developed the most sophisticated analysis of how mass media coverage of given issues arises and a national scandal or 'moral panic' is created. They also have the most highly developed conception of the dynamic between the media and state activity. Applied to the AEGIS campaign this approach offers a workable explanation of the centrality of the press to the policy process in the study.

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[29]Dunleavy and O;Leary op.cit. p.252

Scull has tried to apply a functional Marxist approach more widely in mental health in his book on the development of community-based psychiatric programmes on both sides of the Atlantic.[30] The relative poverty which has characterised implementation in parts of the US, together with some unlikely political alliances are presented to validate Scull's argument that 'decarceration' should be seen as part of a growing concern in powerful circles with the massive increases in state spending since the war and its relationship to profitability and capital accumulation in the private sector of advanced capitalist countries. Community care is therefore seen as the cheap alternative to institutional care in both welfare and penal policy. The financial evidence for this thesis is largely American and in the author's own words "highly fragmentary and incomplete".[31] His perspective seems less appropriate to the British experience of expanding real budgets on hospital services in priority groups relative to other groups in health care, and alongside substantial growth in local authority expenditure on these sectors. Whether without AEGIS and the scandals the progress to community care would have proceeded more cheaply is a hypothetical question, although AEGIS certainly discouraged any initiatives in that direction. As noted in Chapter 10, concern has been expressed recently about the possible additional social security cost of de-institutionalising large numbers of people. But this seems to arise as much from a concern to ensure that the entirety of existing hospital budgets in priorities are redirected into community programmes in other agencies so that the Exchequer avoids 'paying twice '[32], than a

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[30]Scull, A.T., <u>Decarceration</u>, (New Jersey: Prentice Hall, 1977)

[31]Ibid p.144

[32]There is some suspicion that health authorities managing large hospitals are trying to retain at least some of the revenue accruing from the rundown of large hospitals for redistribution to other service sectors, whilst social security benefits pay the large part of the cost of de-institutionalising .ong stay hospital residents.

desire to retrench the programmes overall. To date, however, Ministerial commitments at least to maintain the current spend in the priorities seem to have been held. As the number of inpatients in institutional care continues to dwindle and provided the level of spend remains constant, community care will not be a cheap alternative in the UK.

This is not to say Marxists have nothing to contribute to the debate. A critical dimension to the politics in this case study was the influence of organised medicine. The BMA became seriously involved in events driven by Barbara Robb when AEGIS proposed radical changes to the complaints machinery, and revived earlier concerns about the role of the Parliamentary Commissioner and the profession's determination to keep this Office away from clinical complaints. But there is also an undercurrent of medical influence which derives from the wide acceptance amongst politicians, and most of the participants, including AEGIS, that psychiatry is a branch of somatic medicine and is therefore the legitimate professional territory of doctors.

This consensus masks a controversy elsewhere surrounding the claims of conventional, positivist medical science uniquely to understand the aetiology and treatment of mental illness. There are the critics from within the profession who have argued that the concept of mental illness is entirely metaphorical and that the conditions said to symptomatic of it are best understood and treated from the knowledge base of the behavioural and social sciences. One of the least controversial, Russell Davis, has thus characterized the approach of somatic psychiatry as the 'diabetes-model' of psychiatry which approaches the disturbed individual as a biological malfunction - rather than a social being in a social context to which the psychiatrist is inevitably integral.[33] Like diabetes, the 'illness' is not curable but can be managed by drug

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[33]Russell Davis, D., Depression as Adaptation to Crisis, British Journal of Medical Psychology, Vol.43 (1970), pp.109-16

therapy subject to occasional 'breakdowns' which may require hospitalisation to restore the 'equilibrium'.

There are also external antagonists such as Ingleby and others who have won few friends in the psychiatric profession by disputing its claims to be a medical science and asserting those of other professions who are still largely subordinate to psychiatry in the treatment of madness in the UK.[34] After well over a century of searching, it is far from clear that an organic base for major mental illnesses (the equivalent of the disease-entity in diabetes) is demonstrable in physically healthy adults. Moreover, such indicative evidence as exists may convince doctors predisposed to understand problems somatically, but it has not resolved the dilemma of extraneous variables and cause and effect. If the brain of a person in an acute psychotic phase shows biochemical and electro-physical activity different from that of a person in full self-control perhaps we should not be surprised. It does not prove that the physical change is causing the emotional and behavioural abnormality: the reverse is equally logical. Moreover physical treatments and drug therapies are also known only to be palliative (and should not be undervalued for that considering how debilitating some severe disorders can be). Neither does their history inspire confidence. Insulin Coma Therapy (ICT), once the great wonder of the pre-war psychiatric age, was later abandoned as ineffective. The source and extent of the effectiveness of ICT's post-war successor and the most durable physical therapy, ECT, is so contentious today that some psychiatrists decline to use it. Wilding's observation is relevant here:

> "The important point is that any attributes listed by occupational group members must be regarded as assertions until they are proved substantial."[35]

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[34]Ingleby, D., 'Understanding Mental Illness', in Ed. Ingleby, D., <u>Critical Psychiatry</u>, (London:Pelican, 1981) pp.23-71

[35]Wilding P., <u>Professional Power and Social Welfare</u>
Continued on following page

Friedson interprets the existence of a wide range of schools in professional practise and the variability of treatment outcomes as evidence of a substantial subjective element in the diagnosis and choice of intervention, which calls into question the the "stability and and objectivity of the corpus of professional knowledge"[36]. Taking this one stage further, the widescale acceptance by policy-makers of medicine's legitimacy as the pre-eminent profession in mental health becomes essentially ideological. It is therefore the dominant ideology in an antagonistic power relationship with subordinate ones. Thus far there is some consistency with a structuralist approach.

The difficulty arises in attempting to follow Marxist method and locate a material basis for this ideology. Its acceptance certainly has much to do with making the stigma of madness manageable to people. 'Being mad' becomes an illness thereby bestowing normality and removing culpability[37] and thus the patient become complicit with professional bias. Doctors accordingly restore respectability to 'the lunatic' and his or her family. Thus for Wooton writing in the 1950s when medical models sealed their dominance:

> "Without question.... in the contemporary attitude towards anti-social behaviour, psychiatry and humanitarianism have marched hand in hand. Just because it is so much in keeping with the mental atmosphere of a scientifically-minded age, the medical treatment of social deviants has been a most

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(London:Routledge and Kegan Paul, 1982) p.5

[36]Friedson E., The Profession of Medicine (New York:Dodd Mead, 1975) p.262

[37]Bott, E. Hospital and Society, British Journal of Medical Psychology, Vol.49 (1976) pp.97-140

powerful, perhaps the most powerful, reinforcement of humanitarian impulses..."[38]

Also, psychiatrists shoulder the responsibility for the sufferer's condition (particularly where there are contextual but hidden inter-personal difficulties) absolve him or her from certain social obligations such as work or family responsibilities[39], and provide a 'technological fix' which 'resolves' the problem without challenging established power relations in the person's social circumstances. 'Psychiatrists as doctors' also dominate the hierarchy of status and material rewards amongst competing mental health professionals.[40]

If an explanation of the development of institutionalised psychiatry can be convincingly located in the rise of capitalism and the utilitarian poor law as Scull has demonstrated[41], we may be able to develop some argument about medical models of de-institutionalisation being functional to late twentieth century capitalism[42]. This requires an analysis of how schizophrenia and depression are threatening to capitalist accumulation and reproduction or perhaps symptoms of it, and why a somatic approach is reactionary. So far attempts to develop the links needed to support any such contentions seem tenuous, and speculative. Moreover as the medical model comes under increasing pressure from professions with alternative approaches, so capitalism seems to

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[38]Wooton B., Social Science and Social Pathology, (London: George Allen and Unwin, 1959) p.206

[39]See Talcott Parson's definition of the sick role in Friedson, E. The Profession of Medicine (New York: Dodd Mead and Company, 1975) pp.228-231

[40]See Freidson, op.cit. pp.48-70

[41]see Scull, A.T., (1979) lp.cit.

[42]Scull A.T., From Madness to Mental Illness, European Journal of Sociology, Vol. 16, No.2

grow more secure than it has been since before the First World War. Marxists would reply that this simply supports their general contentions that all social welfare professions are functional to capital[43]. But the argument starts to sound circular. If the state is functional to capital, professions work for the state, so that professions are functional to capital, because the state is functional to capital.

However, for the time being, we can suggest that the claims of somatic psychiatry in conflict with other models amounts to an ideological determinant on policy. This may or may not be a material structural determinant as Marxists such as Baruch and Treacher would imply.[44] For the time being, it can only be seen with confidence as a Weberian 'ideal type' which requires further research.[45]

Neo-pluralism

The emphasis on the central role of professional ideology is used in neo-pluralist analysis to address the fundamental problem of how professions who are recognised as legitimate to inspire policy gain, sustain and exercise their influence. Neo-pluralist interpretations of state activity stress the professionalisation of decision-making, and the high level of fragmentation of state organisational structures.

The 'professionalised state' model contends that although Western democracies remain basically pluralist in their mode of operation, state activity is characterised by the professionalisation of government. The process remains fundamentally pluralistic due to three developments: the development of internalised controls

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[43]Wilding, Op.cit. pp.12-18

[44]Baruch G. and Treacher, A., Psychiatry Observed, (London:Routledge and Kegan Paul, 1978) pp.8-21

[45]See Chapter One

amongst state professionals, the creation of a fragmented network of interactive policy-systems and the growth of issue-specific forms of public participation.

Firstly, many of the operational functions of the state are undertaken by professional experts governed by a code of ethics. Secondly, the professional code, comprising the doctrines of self-regulation and the public interest ethic, has persuaded governments to grant substantial discretion to professionals over policy-development and delivery. The public interest ethic manifests itself either as a commitment to scientific integrity and impartiality in technical spheres, or in the case of social policy areas, a commitment to the interests of the client.[46]

Third, the professionalisation of policy-making transfers power, particularly over policy-implementation. Expert judgement is preferred to interest group representation or direct political control. Professional influence over policy has two strands. The profession is a key forum for developing and testing knowledge, setting standards and policing both policy-making and implementation. New techniques of service delivery and new models of policy so developed, create demands on the government bureaucracy through the privileged position of professionals as insider groups in input politics and are thus translated into national policy. Policy-making can also become 'implementation skewed'; as innovations in technical practice give rise to retrospective, overt policy change or a change by default manifested in a radical alteration to policy through service delivery.

In addition, neo-pluralists argue that there remain few areas of government which are managed directly by central departments (defence, foreign policy, taxation, transfer payments). The remainder have been devolved to local government or the

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[46]Dunleavy, P., Quasi-governmental sector professionalism, in Barker, A., Quangos in Britain, (London: Macmillan, 1981)

proliferating quasi-government agencies. There is no single policy elite therefore. Rather there are many separate elites with lines of communication between them. Complex systems of inter-agency relations have evolved creating 'policy communities' - networks of personal contacts or more importantly, professional or occupational groups. There are two types of policy community. Firstly a hierarchical system of mutual dependency, wherein usually the centre controls strategy and resource allocation and the periphery controls detailed policy and implementation. Second, responsibility for different aspects of decision in complex policy areas can be split across a number of agencies.[47] Thirdly, rationalised participation is required to prevent professionalised organisations becoming too insular and losing sight of the public interest.

Controls can be exercised, as in the AEGIS campaign, by set-piece investigations into particularly areas which are at their most powerful when precipitated by scandal.[48]

They can also be hierarchical, thus centrally-formulated performance targets used to determine differential resource allocations to competing peripheral agencies. Other scrutineers include independent policy agencies such as the health policy units in universities who are also part of the insider lobby network or are able to attract media interest.

The National Health Service is a prime policy area for testing out neo-pluralist contentions. It is a multi-tiered organisation with professional representation at each tier. There are two major professions - nursing and medicine upon whom policy-makers and managers are dependent to implement policy. Because of the widespread acceptance of the concept of clinical judgement, the medical profession has enjoyed particular autonomy in the deployment and use of resources.

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[47]Dunleavy and O'Leary op. cit. pp.307-8

[48]Dunleavy and O'Leary op.cit. pp.311-2

A network of spheres of influence or community[49] in this case study has been referred to earlier. The number of individuals inhabiting these spheres was small. AEGIS had links to the NAMH, through Barton and Rolph, to the Bar through Fitzwalter Butler, to the nursing profession through Kirkpatrick and Barbara Robb, to the political head at the DHSS through Abel-Smith and through Barbara Robb's informal contacts with Baroness Serota and Rolph's with Crossman. The NAMH had links through membership of the Ely (Russell Davies), Farleigh and Davies inquiries (Mary Applebey) and through Kenneth Robinson. Barbara Robb had her small caucus of keen supporters in Fleet Street, and Barry Askew, the lead journalist at Whittingham and Anne Shearer of the Guardian were also members of the Davies Committee. There were close networks between the QCs since medical litigation was a relatively small area in the late 1960s and therefore a small specialist community. The Chairmen of some of the inquiries shared Chambers. Howe, of course, was a member of the PEP working party and Russell Davies had been his colleague at Ely. Abel-Smith was a founder of AEGIS, Crossman's special adviser. He was also acquainted with Howe, and a close academic colleague of Townsend who supervised Pauline Morriss's PhD; both were on Crossman's PEP. Both nursing and medicine were represented in the professional divisions of the Department of Health, in the NAMH and through representation on all the inquiries and working parties, including PEP. Even Russell Barton of AEGIS was in the BMA. In addition, John Revans of PEP and Kathleen Bell, a member of the Council on Tribunals were both members of the Davies Committee.

The documentary evidence is replete with the formal, public consultation inputs and reports of delegations to the Minister. However, Barbara Robb's files also contain substantial inter-community correspondence which would have been characteristic of each sphere, but which is generally unavailable to researchers.

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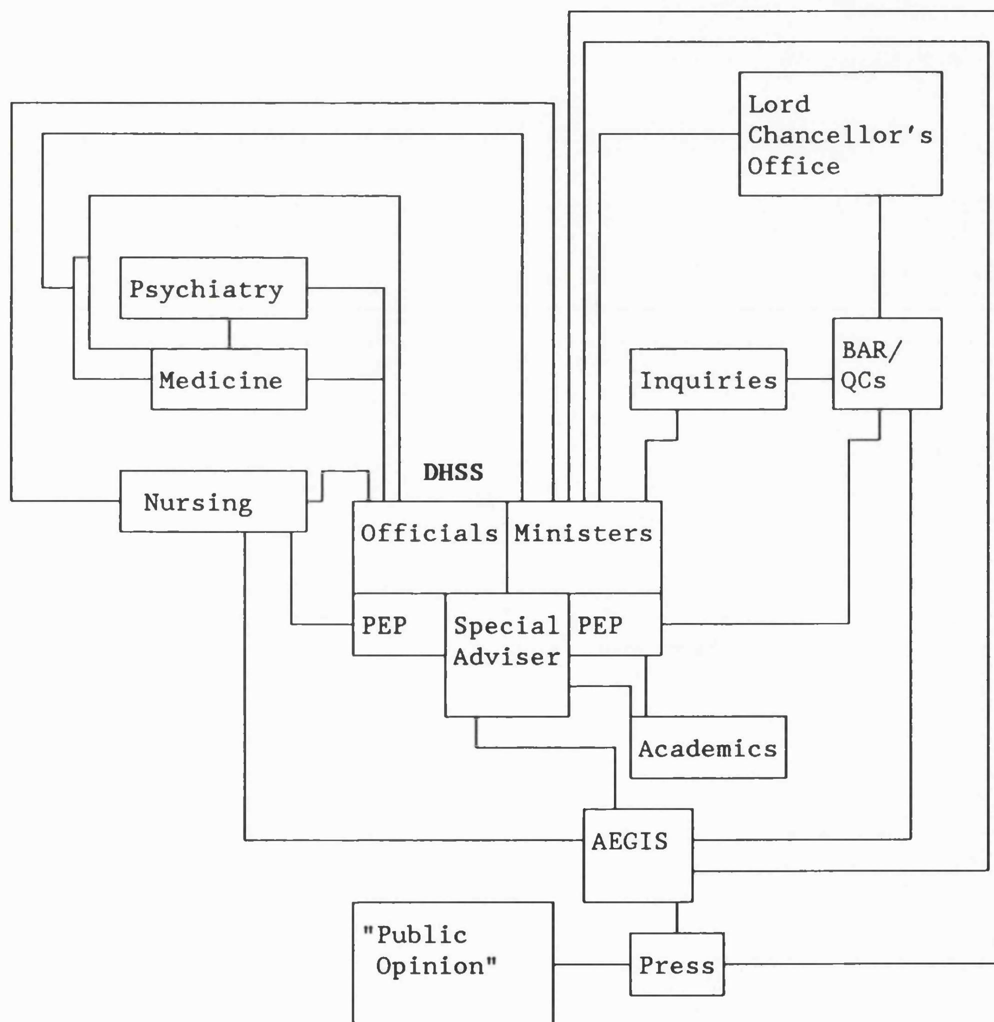
[49] I find Laffin's attempt to draw a distinction to these terms unconvincing, Professionalism and Policy, (London: Gower, 1986)

Just as important, she left a record of all informal discussions with individuals over dinner or over the telephone, which at times were critical to outcomes. It can be safely assumed that numerically, these were the tip of the iceberg of all the informal cross-talk that went on between the various spheres as policy was developed. This community can be represented diagrammatically, as follows:

AEGIS Campaign - Policy Communities



These communities were largely outside the formal structure of the Service. The nature of more formal centre-peripheral relations in the study also supports neo-pluralist contentions. As argued

earlier, the post-Ely policy set into reverse an established dynamic in the relations between the Ministry of Health and Health Authorities which had formally accorded considerable discretion to the latter. As noted earlier, since the early 1970s there has been a trend towards increasing centralisation over the periphery on policy and use of resources. Moreover the evidence of any sanctions by the wider public over professional action is scant indeed.

There is also ample evidence in the AEGIS campaign that professional interests have played a significant part in determining the detail of policy. The medical profession secured medical leadership of the Hospital Advisory Service nominated from a list prepared by the Chief Medical Officer. It fought the Crossman's Health Service Commissioner proposal and although it seemed to concede the major argument after the Farleigh Report, it soon became clear that the BMA had secured concessions which substantially diluted the impact of the Office. The Association has since been able to stave off a number of attempts to bring clinical decisions under independent scrutiny, except through the courts. Analysis of this professional influence is complicated since it involves three major professions, nursing, medicine and the law, with differing perspectives on the problem and accordingly differing loyalties and objectives. Moreover there is also evidence of a heterogeneity of view within the medical profession. An investigation of these complexities and an understanding of why the medical profession wields such influence in health policy requires further elaboration on the role of professionals in policy-making beyond the confines of neo-pluralism which adequately incorporates the significance of professional ideologies.

Professions and Policy

Following Dunleavy,[50] the starting point is marked by critiques of descriptive approaches which used to characterise the sociology of the professions. So-called 'trait analysis' identifies characteristics said to define professions and differentiate occupations into 'semi-' and 'full' professions. Following Friedson[51], Larson[52], and Johnson[53], the concern here is more with the impact of professional organisation on patterns of social and institutional power, and particularly the role of professional ideology in the formulation and implementation of policies.[54]

At the outset, an important distinction is drawn between professionalisation and professionalism. For Larson, professionalisation is a process through which an occupational group seeks to establish its monopolies over the supply of a service commodity, and the supply and training of its own members, in order to secure a price over and above the value they would command if the labour market was free and competitive. Professionalism is a mode of exercising power distinguished where such monopolies are under-pinned by state protection and license, in turn based in the acceptance of a professional ideology which comprises the assertion of a unique, relevant, highly specialised and technical knowledge-base, and a professional ethic said to qualify the profession uniquely to deliver the service over which it seeks to establish a monopoly. The professional ethic claims to value the interests of the client before the material concerns of the professional. An occupational group has thus achieved what Friedson calls legitimised autonomy which grants social status,

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[50]Dunleavy P., Quasi-governmental sector professionalism, in Barker A., op.cit. pp.182-3

[51]Friedson, op.cit.

[52]Larson, M.S., The Rise of Professionalism, (London: University of California Press, 1977)

[53]Johnson, T.J. Professions and Power, (London:Macmillan, 1979)

[54]Dunleavy op.cit.

material privileges and power over the sphere of work not afforded to other occupational groups.[55] For Dunleavy, the relationship to the state is of primary concern. The ideology of professionalism places a particular emphasis on the organisation of an 'occupational community' emphasising, work autonomy both individual and collective, occupational self-regulation, and state licensing through formal recognition of professional monopoly of certain skills or titles.[56] Professions can also compete for a particular sphere of activity both in terms of material reward and autonomy. At any time a given profession will be dominant if its ideology is perceived as most legitimate.

The major concern here is in British health care where professionals are almost exclusively employed and practise within the public sector. In this context, two aspects of the internal organisation of the state are relevant: these are patterns of influence between central and peripheral agencies, and levels of policy-making autonomy.

Dunleavy argues that conventional policy analysis which focuses either on the formal relationships between agencies or on those informal relations which are essentially interest group activity, the role which Eckstein accords the BMA[57], overlooks the ability of professional groups to nationalise the process of policy change through two distinct mechanisms. Firstly, the profession creates a national-level forum for proselytising new innovations and professional practises in one peripheral agency through which they can be generalised to others. National level developments in the profession can also define the techniques available to professionals in peripheral agencies and effect consistent changes in professional practice within government. Secondly, where both central and peripheral agencies employ the same professions, the

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[55]Friedson op.cit. pp.47-48

[56]Dunleavy, P. Op.cit.

[57]Eckstein, H., Pressure Group Politics, pp.83-91

profession comes to subvert horizontal distinctions between tiers. The profession's national body influences the central agency thereby strengthening the position of peripheral agencies, where its members work, viz-a-viz the centre.[58] Thus both nursing and medicine have representatives on advisory machinery, and as permanent officials at all levels in the NHS and in the various policy divisions in the Department of Health.

The national professional ideology also determines the parameters and even the character of policy changes by professionals at the periphery, so that they are at once both defining and being constrained by national policy changes.[59] These are the mechanisms through which somatic psychiatry has been able to dominate policy at all levels in the NHS. The pattern of post-war mental health policy, particularly in mental illness services, has been founded on a consensual view of the legitimacy of doctors to treat mental illness and thus the validity of somatic psychiatry. As Keith Joseph told the House of Commons in 1971:

> "Psychiatry is to join the rest of medicine..... the treatment of psychosis, neurosis and schizophrenia have been entirely changed by the drug revolution. People go into hospital with mental disorders and they are cured and that is why we want to bring this branch of medicine into the scope of the 230 District General Hospitals that are planned for England and Wales."[60]

Indeed as Ramon notes, since all politicians shared this view lack of resources was inevitably blamed for failures in service, such as those revealed by AEGIS, and very few people asked whether a

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[58]Dunleavy op.cit.

[59]Ibid

[60]House of Commons Official Report, Vol. 879, col. 280-281, Written Answers 7.12.71.

hospital-based, institutional philosophy of care might have been a major contributory factor.[61]

The dominance of somatic psychiatry is reinforced by two further consequences of professionalisation and professionalism in the policy process: the relationship between policy formulation and implementation; and patterns of policy change.[62] Dunleavy argues that professionalism produces an implementation-skewed process of policy-definition, which increases the potential for the implementation of policy to be constitutive of policy-making. There is a high level of generality in legislation and executive regulations, specifically to avoid professional direction in the substantive content of policies. Definitions of what is good detailed policy are often omitted. Instead, legislation establishes organisations and lays down general goals. Policy-makers thereby become highly dependent upon professionals to implement policy according to the spirit of the law, as well as to exercise the responsibilities conferred upon politicians by the health service legislation. Both sides are mutually-dependent and cooperation is bought at the cost of a privileged role for professional representatives at all stages in the preparation of policy proposals and detailed guidance.[63] Thus government sets an administrative framework within which somatic psychiatry is widely practised and thus reinforces the legitimacy of the framework.

Professionalism also increases the scope and intensity of policy conflicts particularly where issues of professional competence are at stake. This issue was and remains central to the argument about involving the Health Service Commissioner in clinical judgement. The case for the office was established by failures in

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[61]Ramon, S., Pscyhiatry in Britain, (London: Croom Helm, 1985) p.268

[62]Ibid pp.201-4

[63]See Eckstein op.cit. pp. 78-91

the psychiatric and mental handicap sectors. The interests within medicine were divided over some of the reforms which resulted. For example, the policy of redistributing resources from acute to priority sectors disadvantages professionals working in the former sphere who, along with the regional boards made known their opposition to Ministers and initially, at least, limited the extent of the policy. However, leaving aside dissidents such as Barton and Whitehead, the BMA has spoken with one voice over the Commissioner proposal.

More fundamentally, the case for the Health Service Commissioner and Davies' proposals for the scrutiny of clinical judgement call into question the competence of doctors to exercise that judgement autonomously, to undertake professional self-regulation to prevent abuse and failure, and to promote the interests of the client. As noted earlier, the case grew out of the deficiencies in the psychiatric services, but since psychiatry was an established medical specialty there could be no question of the BMA allowing it to be singled out for special treatment on clinical judgement since this would have risked an enormous rift within the profession as a whole. Not least, any case against psychiatry could not, on the evidence, be generalised to all branches of medicine. The mental hospital scandals established no general case to bring clinical decisions by surgeons and general physicians within the remit of the Office. Indeed the curative clinicians within organised medicine may have viewed the scandals as something discrete to a relative low status specialty such as psychiatry.[64]

Therefore, an acceptance by the medical profession of the general case that its judgements should be subject to legal or administrative scrutiny on a fairly routine basis, would have been to concede the cornerstones of its legitimised autonomy over its market and sphere of work, thus its unique knowledge base and

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[64]Watkins, S., Medicine and Labour, (London: Lawrence and Wishart, 1987) pp. 108-9

public interest ethic. Since this legitimacy is based on the wide acceptance of doctors as uniquely competent to exercise clinical judgement, the questioning of it by those, such as lay people in AEGIS, and lawyers, seen as not so endowed, was unlikely to be favourably received by the agency accepting the expertise and conveying the legitimacy; thus the state. To do so could have undermined the whole basis of the government's relationship with medicine upon which, as we have seen, the state is dependent to undertake its responsibilities and implement policy.

What of the dynamics between professions? The balance of opinion on the issue amongst the legal profession supported the case for scrutiny of medical decisions by non-medical professionals, namely lawyers. However, this is a relatively marginal concern for them. In contrast it is crucial to medicine maintaining its autonomy and 'market share' viz-a-viz competing professions such as nursing, and in mental health, psychology and social work. The balance of power between medicine and the law, generally seen as the most powerful professions, is difficult if not impossible, to measure on an issue which is disproportionately significant to each. It is interesting to note, that the inquiry reports criticised the competence of some nurses and administrators, but merely drew public attention to the excessive use of drug treatment and seclusion by consultant psychiatrists - remaining content to accept these practices in the name of clinical judgement. Even in the minds of barristers who practised in medical litigation, this was the legitimate territory of medicine. Unlike numerous nurses involved, no doctors were ever so seriously censured that they faced dismissal.

Certainly one could cynically argue that nursing staff had much to gain in their relative status and autonomy, by backing a campaign which was critical of a system where doctors were the dominant and major competing professional group. Politically, the support which AEGIS enjoyed amongst nurses was critical in countervailing the medical opposition. Again, however, the forces are difficult to quantify. And in the final analysis, a number of nurses faced

the Courts and dismissal. The period of the campaign was one in which the reputation of the nursing profession was enhanced by virtue of its willingness to confront the inadequacies within it.

The policy process in mental health

The discussion over the last two chapters has largely eliminated conventional pluralist and public choice theories as adequate explanations of the input politics in the policy process in mental health and health service complaints during the period under detailed review. In terms of the case study material on pressure group activity, elite theory contentions of government partiality, the coopting of groups into compliant positions, and a limited number of key policy participants, if not corporatist in the classic sense, were all to some degree supported by the evidence. In terms of the nature of state partiality, the neo-pluralist model of the privileged position of professional views in policy outputs was similarly sustained. It was also shown that not only did Marxist cultural theorists offer the most sophisticated analysis of the role of the media in public policy, there were loud resonances with the AEGIS campaign, including, the concept of 'moral panic', the importance of professional ideology amongst journalists, and the extent to which this can reflect a wider, dominant ideology in society.

In terms of prescriptive models of decision, 'bounded rationality' aptly describes the framework used by central government to review and decide on policy change. In terms of the actual process of decision-making, pluralist models and public choice theories of state activity are largely contra-indicated by the case study evidence. What of the remaining three? There was strong evidence to support elite theory. Technocratic decision-making combined with charismatic leadership to extend central policy into the periphery through tighter monitoring and financial controls. There was a limited and relatively impermeable policy community, recruited from a narrow stratum of society, which was

neo-corporatist in its nature and operations. However, to characterise the process as elite would overlook the real degree of plurality between the competing spheres of interest. There was not one but the several policy communities identified in neo-pluralism. Moreover the process of change and the nature and impact of policy outputs firmly supports the professionalised state model.

Yet to confirm a diagnosis of neo-pluralism also remains problematic since there is one further issue which only Marxist theory seems to resolve satisfactorily and that is why, in a field of competing professions, do medical interests predominate. As noted earlier this is a particularly relevant question in regard to mental health where somatic psychiatry remains controversial and open to challenge.

There would seem to be strong evidence to support the concept of professional ideology, in conflict with other competing belief systems, as an ideological determinant on the direction of policy. The major problem from a Marxist point of view is that drawing links between the medicalisation of mental health policy and material relations under capitalism is highly problematic and most attempts to date have been crudely and speculatively functional. Historically, it is difficult to accept the contention that 'non-alienating' socialist relations of production would eliminate the medicalisation of madness.

The conclusion must therefore be that the policy process in this case study is best explained by elements of elite, Marxist and neo-pluralist theory. Neo-pluralism emerges as the dominant of the three in describing the process and predicting outcomes. Marxists offer a means of understanding why outcomes and processes take a certain consistent form which is not understandable on face value. The approach remains unsatisfactory nonetheless since the full extent of the theory cannot be applied.

For those who advocate self-contained theories of the state, this is a rather unhelpful conclusion. However at the outset, this study cited the question posed by Johnson et al. of the value of synthesising the best elements of competing methodological approaches in order to progress the development of method.[65] The outcome of this study is a good example of the value of this approach. On the evidence reviewed, the policy process in mental health is therefore an example of the professionalised state thesis in neo-pluralism, set within an ideological framework which establishes medicine as the dominant profession.

A final word on AEGIS

The content of the case study is much neater in its findings. Through her network of influential friends and advisers, Barbara Robb was able to change the course of DHSS policy. In the space of five years her campaign and its wider ramifications hauled mental illness and mental handicap to the top of the political agenda. AEGIS made a major contribution to rescuing these services from the twilight world of decrepid Victorian asylums where they had been festering throughout the post-ward period. She also changed the self-perception of pressure groups in these fields from polite, self-apology to pro-active assertiveness. The style of high proflile, media-based campaigning, now typical of MIND, the National Schizophrenia Society and RESCARE, was largely invented by Barbara Robb - although whether they use the approach as effectively as she did is an issue to too broad to explore here.

Lastly, there are lessons for politicians in the mental hospital scandals of the 1960s and 1970s. If a policy arena is so seriously negelected for so long and if the reality of that neglect is consistently denied, the pressure inexorable mounts.

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[65]Johnson, T., Dandeker, C. and Ashworth, C., The Structure of Social Theory, (London: Macmillan, 1984), See discussion in Chapter One.

As we move to a more diversified pattern of care for the mentally disordered and the elderly, effective monitoring, inspection and accreditation will be required to ensure continuing improvement in quality and penetration of services.

Yet history offers little comfort to those who expect this to happen as a matter of course. The regularity over the last two centuries with which public outrage and scandal have forced politicians to review policy and resource allocation in mental health (or other areas without natural political clout) is sufficient to convert the most radical anarchist to cyclical theories of history. Isolated cases of individuals left uncared for at home or drifting into vagrancy are already creeping into the press. If we are going round this wheel again, before the century is out some ambitious and talented politician may be destined to have his or her career reversed by being unfortunate enough to be in office when the opening of the next sustained period of media cries of scandal, neglect and cruelty explodes in front of an unsuspecting public.

Appendix 1

List of people interviewed for research

Brian Abel-Smith

Mary Applebey

Sir George Godber

Audrey Harvey

Sir Geoffrey Howe

W.A. Kirkpatrick

Sir Kenneth Robinson

David Roxan

C.H.Rolph

Lady Serota

Lord Strabolgi

Dr J. Anthony Whitehead

Hugo Young

Sir Arnold France was approached but declined to be interviewed. The content of the research has also been discussed with a number of current and former Departmental officials and senior health authority officers who have asked not to be named.

A Postscript

Barbara Robb and Richard Crossman were met twice whilst he was Secretary of State. The second meeting was not of major significance in terms of political outcome, although both principal participants left detailed records of it. The event and the background to it provide a rare insight into the means through which Barbara Robb synthesised her public campaigning and her use of informal contacts. it also demonstrates the respect that AEGIS commanded as a pressure group. Additionally, it gave clear testimony of her fearlessness, formidable talent for penetrating argument and not least her pointed sardonic wit.

It has been previously noted that Mrs.Robb agreed to maintain a dignified silence about her dissatisfactions with the Sans Everything White Paper, in exchange for an assurance that the conduct of the inquiries would be investigated. According to Mrs.Robb she had agreed with Abel-Smith that the health ombudsman would, upon taking office, conduct an inquiry into the Reports.[1]

This was a matter of some importance to her given that her personal reputation had been questioned both by the attack on her in the Friern Report and also by her failure to give evidence to the Committee Inquiry at that hospital which suggested to those who were already disinclined towards her that she did not have a case to present. She also had a certain score to settle with the previous Minister who had opposed her campaign and consistently denied her cause for three years. Now as 1969 gave way to 1970 there was still no sign of any inquiry from Crossman's administration. Indeed, the Secretary of State had not gone on the record with so much as a good word for her and her "organisation". Mrs. Robb therefore began to get a little

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[1]See Correspondence between B.Robb and Eric Moonman MP in Robb Files Sans E. Vol.11

suspicious. She also had in the back of her mind, the advice of Doctors Barton and Whitehead to maintain the momentum of public revelations to sustain pressure on the government.

Crossman was aware that she posed a threat as a potential source of bad publicity, particularly as the Government appeared to be out of favour with public opinion. He therefore committed an uncharacteristic public relations error when in February 1970, in the course of a debate on the mental health services, he made a critical remark about the chapter on Cowley Road Hospital in Sans Everything. In his diaries he elaborated on his feelings.

> "This hospital has had a very bad time because it had been attacked by Mrs. Robb's book....and defended in a rather half-hearted White Paper. Clearly what had happened had been that this driving little doctor.... had intimidated the nurses to keep these old people active, to shove and push and let only the acute cases be in the wards.... And of course, if you take bad staff and second rate nurses, say push them and shove them, they will push and shove the old things and there will be lots of cruelty as well and obviously that's what had happened at Cowley Road"[2].

Clearly then he had given the House the impression that the attack in Sans Everything was unwarranted, whereas privately he was perfectly ready to believe that there had been cruelty and second rate nursing care. Whether by accident or design, he appeared to be discrediting AEGIS. It was a very unwise move.

To begin with the two contributors to the book wrote to Crossman expressing their alarm at his remarks. They pointed out that their complaints had been in essence that the excellent work of the doctor in charge was not being implemented on the wards[3]. Mrs. Robb discussed the matter with Rolph who agreed to approach

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[2]UWMRC Crossman Diaries JH/68/69

[3]Letter from E.Porter and S.Skrine to R.H.S.Crossman 19.2.70 in Robb Files Sans E. Vol.11

the Secretary of State as a personal friend[4]. He explained Mrs.Robb's growing impatience that the reports had not yet been reviewed and hope that Crossman would find a way of doing this without her having to return to public print. In his reply, Crossman explained that the words which had given offence were in response to an intervention not reported in Hansard. However, he avoided the issue of reviewing the White Paper and tried instead to reassure AEGIS that the HAS teams would be visiting the <u>Sans Everything</u> hospitals carrying with them a copy of the book.[5] In his reply to the two nurses he explained:

> "For someone like myself who is seeking to prod public opinion by exposing the scandalous overcrowding without demoralising the staff of our long-stay hospitals, the Ely Report was in a sense providential because it gave me a chance to clear the air by showing that I was not going to cover up or whitewash, but use the exposure of malpractice in order to create the climate of public opinion required to come to the rescue of these hospitals."[6]

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[4]It is also clear that they were to become colleagues after the election as Crossman had decided to leave politics and become editor of the <u>New Statesman</u>. Letter C.H.Rolph to Crossman 9.3.70 in <u>Robb Files</u> Op.Cit.

[5]Letter Crossman to Rolph 19.3.70 Copy in <u>Robb Files</u> Op.Cit.

[6]In his reply to the two nurses he explained:

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This strategy was strengthened by a letter to Mrs. Robb herself adopting the same line, and inviting her to meet him to discuss her concerns after Easter.[7] As he recorded:

> "I had said in an ad lib ...that I was cross with Barbara Robb for attacking Cowley Road, and this was a great danger. Were we going to reopen the sores, and have her attacking us all over again?.... In the case of Ely I wanted an annihilating report which did show up a scandal because that helped me, but an annihilating report which showed up an incidence of cruelty in a hospital of tremendous reputation.... this is something more complicated for me and I want them to understand it".[8]

Mrs Robb was not appeased and decided that in order to set the record straight, and also promote constructive progress on the health commissioner front, AEGIS would have to go back to public campaigning, this time for a statutory inquiry into the White Paper. Again the tactics were exemplary. She enlisted Eric Moonman to write to Crossman urging him to instigate the inquiry[9], and ensured that this letter, together with her own reply[10], arrived on the Secretary of State's desk on same day she had arranged to brief journalists at St.Bride's church Fleet Street. She told the press of her agreement to keep quiet, however, especially now that Crossman seemed to be bowing to pressure against the health commissioner proposals, the time had come for a statutory inquiry to reveal the "inaccuracies, inconsistences and .... the denial of natural justice" contained in the White Paper.[11] She also provided a detailed brief for

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[7]Crossman to B.Robb 26.3.70 in Robb Files Op cit

[8]Diaries 70/sw/116

[9]Letter E.Moonman to Crossman 30.3.85 in Robb Files Op.Cit.

[10]B.Robb to Crossman 30.3.70 in Robb Files Op Cit

[11]AEGIS Press Statement 1.4.70 in Robb Files: Sans E.Vol.11 Forwarded in advance to her contacts on The Times, The Guardian, The Daily Mail, The New Statesman, The Nursing Mirror, The Nursing
Continued on following page

Hugo Young on the Sunday Times, who obliged her with a 2000-word feature article on the reports headed by photographs of Crossman one side and on the other, a smiling Mrs Robb sporting one of her most striking, broad-brimmed hats.[12] This article rehearsed the background to the reports and for the first time, published extracts from the dossier on the Friern Inquiry which Mrs Robb had presented to the Council on Tribunals.[13]

Hence, backed by this highly orchestrated and highly successful publicity campaign, Mrs. Robb met Crossman in his office at the Commons on April 30th. Fortunately, both protagonists left detailed accounts of the event, Mrs Robb's "written immediately afterwards"[14] and Crossman's dictated a few days later.

When she was shown in, Crossman was sitting in his shirt-sleeves with his foot on a leg rest. His Private Secretary and Brian Abel-Smith were also in the room. She remarked that she had not expected to see the Professor whom she believed was kept locked up at the Elephant[15]; Crossman explained that he was let out occasionally "to do a little grazing". Mrs. Robb was wearing a green maxi-coat, newly in fashion at the time, which she refused to take off when invited since she had purchased it specially for the occasion; it was part of her image. Crossman found her:

> "a curious little thing, terribly neat, precise, cold and venomous, with a certain serpentine charm".[16]

Continued from previous page
<u>Times</u>, <u>The Lancet</u>, <u>The Medical Tribune</u>, <u>The Brtiish Hospital Journal</u>, <u>The Hospital Times</u>, <u>New Society</u>, <u>Peace News</u> and to a certain Nigel Lawson on <u>The Spectator</u>.

[12] <u>The Sunday Times</u> 5.4.85

[13] See previous Chapter.

[14] In <u>Robb Files</u> Sans E Vol.10B "Some Events"

[15] DHSS Headquarters at Elephant and Castle.

[16] UWMRC <u>Crossman Diaries</u> JH/70-26

As she sat down, Crossman noticed her large red ring-file and asked if it was the AEGIS dispatch box. Mrs. Robb made an amiable reply and "trotted out" a pre-prepared agenda in her usual efficient style and its was agreed that this would structure the meeting. Firstly she wondered if Crossman had ever repeated the remarks he made about AEGIS in the Commons; Crossman had no recollection of having done so and assured her he would never say them again. He explained that a speech only comes alive when the speaker leaves his script and speaks from the heart. He added that all he knew of her satisfied him that she was passionate but had a cold heart and would be unable to understand how a sentimental person such as himself could get slightly carried away. Mrs. Robb remarked given they had hardly ever met he could have no knowledge of her personality and if he genuinely wanted accurate information on the state of her heart he should consult one of her friends. Crossman replied that he and Lady Serota cheered themselves up by discussing her. Mrs.Robb was gratified to know that she provided them with relaxation but advised him in future to stick to his scripts.

> "I asked him "Are you telling me that you really said those things without knowing you were saying them?" He insisted that this was so. I said, "There's a fine thing! The Secretary of State for Health and Social Services stands up in the Commons in an important debate and speaks and doesn't know what he's saying. Marvellous!""[17]

They then disputed the merits of publicising cruelty at a hospital such as Cowley Road; Crossman conceded that she had a certain "nuisance value" but complained that she never stopped to think of the problems she created for a Minister trying to keep up morale. She denied this, suggested his Private Secretary should read her evidence on Cowley Road and handed over her file; Crossman assured her that he would read it himself. She then posed her "million dollar question" which was a request for a categorical assurance that Kenneth Robinson had not required any

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[17] Robb Files Op.Cit

of the QCs heading the inquiries to alter their reports. Crossman had no information on this. Mrs. Robb explained that she had good reason for asking, a point which Crossman did not follow up suggesting to her that he knew more than he was letting on.

This took her onto her demand for a statutory inquiry which would indicate that the Government was honourably motivated rather than concerned to save the faces of members of the whitewashing establishment. AEGIS also hoped that opposition to an effective ombudsman would be resisted. Crossman refused her demand and remarked that to begin asking for a statutory inquiry nearly two years after the White Paper was published was a little late in the day. Mrs Robb retorted that he knew very well why she had said nothing since he came to office and who had so persuaded her. Crossman then argued that even if he thought the White Paper was a fraud, Cabinet responsibility would prevent him for saying so.

> "She sparred with me for an hour...trying to persuade me to agree that I should investigate the whitewashing operation. And I said of course I won't investigate a White Paper made by my predecessor. I am perfectly prepared to investigate conditions in all the five hospitals you are complaining about and indeed the new HAS will be onto these geriatric hospitals within at least 18 months. You can be sure of impartial investigation."[18]

This was what Crossman would allow her to tell the press. He then suggested that her continued interest in the White Paper was part of a personal dispute with the Robinsons.

> "..that was her pound of flesh to destroy Kenneth Robinson, and I said it's a pity to have a personal squabble (that was

[18] UWMRC Crossman Diaries JH/70-27

the only time she got really angry) because of course it's true she and Elizabeth Robinson were bosom friends.."[19]

In her defence, Mrs.Robb suggested that no one could have been more moderate in the face of the attacks she had suffered from Kenneth Robinson. Was she to understand that the Secretary of State wished her to tell the press that he regarded the White Paper as part of a family quarrel? Crossman was firm that she should not. The discussion then became a little more conciliatory. Mrs. Robb complimented him on his record thus far. He was doing magnificently in investigating the hospitals and she was sure he do his utmost to get a satisfactory commissioner.

> ""But I am very disappointed that the Socialist Government which is supposed to stand for peoples' rights and for this and that and the other and so forth, is prepared to let this dreadful, dishonest, libelous White Paper stay on its records." I accused him of behaving, in this health service matter "....like a politician: I'm very disappointed.""[20]

Crossman replied that she could not have expected any other response from a Minister. As she got up to go she again expressed her disappointment. Crossman, however, had to confess that he had not been disappointed in her. He promised that Abel-Smith would arrange for her to see some of Dr.Baker's reports to help put her mind at ease.

> "Well, I talked to her at great length, and I have now written a letter to Eric Moonman which is to some extent an appeasement of her because of course, AEGIS her organisation, like the CPAG[21], these small splinter groups, can be extremely powerful if they provide the press with

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[19]Ibid

[20]Robb Files Op.Cit.

[21]Child Poverty Action Group

hot, poisonous news. They really damage our image a great deal, and I want really to avoid that being done this summer, and also I happen to rather like her..."[22]

[22]UWMRC Crossman Diaries op.cit.

Appendix 3

Selected Mental Hospital Scandals in addition to the Sans Everything, Ely, Farleigh, Whittingham and South Ockdendon Hospitals, 1968-1973

Garlands Hospital

One of the cases forwarded by David Roxan to the Department of Health in August 1967 along with the Ely allegations, was the alleged ill-treatment of the patients at Garlands hospital. This listed hosing down, punching, and excessive sedation.[1] The Ministry of Health originally turned down the HMC's request for a full inquiry only to reverse its decision in January.[2] The report upheld the allegations of violent assault on patients by staff; usually in circumstances of staff shortages, long working hours and when patients themselves were acting up.[3]

St Margaret's Hospital, Birmingham

In January 1968, 2 nurses were dismissed and 4 others reprimanded following an attack on patient.[4] In August 1971, an RHB inquiry reported gross overcrowding, the exploitation of working patients and discovered further allegations of violence against

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[1]The News of the World, 10.12.67

[2]The Yorkshire Post, 11.12.68

[3]Newcastle Regional Hospital Board, Report of the Committee of Inquiry at Garlands Hospital, March 1968

[4]The Daily Telegraph and The Daily Mail of 27.1.69.

patients.[5] A second inquiry upheld them and a student nurse was sacked and convicted, for sticking a needle into patients for fun[6]. The hospital was repeatedly in the press over the next 18-months. The most serious case was that of a sectioned patient who escaped and raped and assaulted two girls. This led to a yet a third inquiry.[7]

Randolph Wemyss Hospital, Buckhaven, Fife

In February 1968, the press report ill-treatment of elderly patients, including the use of sticking plaster to seal patients mouths to keep them quiet, and an assault on an elderly man leading to a dislocated shoulder.[8]

Shelton Hospital

In February 1968, 24 women patients died in a fire when locked in a secure ward. The incident led to a spate of recriminations, including a former HMC Chairman who told the press that he had been sacked from his position for trying to get something done about conditions at the hospital.[9] Having assured the Commons that his Department were unaware of this, the Minister of Health instigated a Section 70 Inquiry into the disaster, which reported in December that year. It made banner headlines in all the

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[5]The Daily Telegraph, The Times, The Guardian, The Daily Mail of 26.8.71

[6]The Yorkshire Post of 5.1.72

[7]The Daily Telegraph of 16/6/73 and The Times of 23/8/73

[8]The Daily Telegraph, The Times, The Daily Express (Front Page lead), The Scottish Daily Express, Editions of 8/2/68

[9]The Daily Telegraph 25, 26, and 27.2.68

dailies.[10] This was followed by a spate of mental hospital expose articles including one in the Lancet headed 'Psychiatric Dinosaurs' which observed:

> "The student of Lunacy reform, when he reflects upon the iniquities of the past which are self-evident to the present generation, must himself ask what aspects of today's services will be judged barbaric by our grandsons, as we think of chains or whirling stools. Surely they will condemn us for allowing these antique monstrosities, these mausolea for the living to survive into 1968."[11]

High Royds Hospital

In March 1968, the local coroner passed an open verdict on the death of a 54-year old patient who had suffered abdominal injuries on New Year's Eve 1967.[12] Two years later two doctors died under strange circumstances at the hospital, apparently poisoned with drugs.[13]

Harperbury Hospital

Also in March 1968, Ann Shearer reported that 40 children were being kept in unclean, locked accommodation at this mental handicap hospital. The HMC complained to the Press Council who upheld the complaint. This produced a rather gloating letter from the Chairman of the North-West Metropolitan RHB, followed by a spate of correspondence attacking him from nurses and parents.[14]

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[10]See editions of 17.1.68

[11]Lancet 2.3.68

[12]The Daily Telegraph, 1.3.68

[13]The Yorkshire Post, 21.1.70

[14]The Guardian, 28.3.68, 11.12.68, 14.12.68, 20.12.68

Broadmoor Hospital

Again in March 1968, a report from the House of Commons Estimates Committee on Special Hospitals, found appalling overcrowding.[15] This was picked up in the press, and the Government decided to build what became Moss Side Hospital.[16]

Springfield Hospital, Tooting Bec, London

In August 1968, the press reported that a 12 year-old boy was secluded on an adult secure ward.[17] The Daily Mail estimated that there were 1000 similar cases across the country. This led to a series of articles reporting similar cases, over the next 6 months.

Friern Barnet Hospital

Also in August, Friern Barnet was back in the news after a patient was found dead in the hospital grounds after six weeks of absence from his ward. He was found on the 1st of July or 8 days before the Sans Everything White Paper reported.[18] Then in October 1971, one of Barbara Robb's allies on the Daily Mail got a job at Friern through a local labour exchange and wrote a series of

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[15] House of Commons: The Special Hospitals and the State Hospital, Report from the Estimates Committee, (London, HMSO:1968)

[16] The Times 22.3.68 and The Guardian and Daily Telegraph of 29.3.68

[17] The Daily Mail 1/8/68, The Daily Telegraph, 2/8/68, , and The Daily Mail, The Times and The Guardian, 3/6/68

[18] The Hornsey Journal, 23.8.68

expose articles.[19] The HMC held an inquiry which attacked the journalist in its report.[20] The HMC in turn was accused of complacency by one of its own consultants and numerous other correspondents in the press, including Tony Whitehead of AEGIS.[21] The Nursing Times carried a leading article supporting the Daily Mail, headed "The Monstrous Inhumanity of Authorities".[22]

Carlton Hayes Hospital, near Leicester

In March 1969, six patients died in a fire and there was a Committee of Inquiry.[23]

Coldharbour Hospital

In July 1972, the front-pages of the press were filled with reports of the deaths of 30 residents of a longstay ward at Coldharbour Mental Handicap Hospital. The papers carried graphic photographs of an evidently shocked Secretary of State amongst the charred and twisted remains of the steel-framed bunks in which the sleeping residents were incinerated. The fire was started by a patient when the nursing staff had left the ward unattended for 20 minutes. Sir Keith Joseph established an Inquiry under Section 70 of the NHS Act, two days after the fire which the press covered in full.[24] Its report was published in December, once the Director

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[19]The Daily Mail, 18.10.71 and 19.10.71

[20]The Daily Mail, 19.10.71

[21]The Daily Mail, 28.10.71

[22]The Nursing Times, Vol 6743, October 28.1971, p.1327

[23]The Daily Telegraph 12.3.69 and The Nursing Mirror 25.10.69

[24]The Evening Standard, 5.7.72, described it as "A nightmare to inflame the conscience of the nation", see also The Times, Daily Telegraph, and The Guardian and Daily Mail, of 6.7.72, and The Nursing Times Vol.68 No.28 (13.7.72), Editions of 17.7.72, Continued on following page

of Public Prosecutions had decided that there were no grounds for criminal proceedings against the staff on duty at the time of the incident. The inquiry criticised night staff for leaving wards unattended for long periods, and also raised questions about the hospital's policy on locking wards, otherwise, there was no criticism of management and no national policy implications. The inquiry was formal, with legal representation of the major interested parties, and conducted in public.

Napsbury Hospital

A rather different procedure was adopted for the inquiry into professional practices at Napsbury psychiatric hospital, whose report was published in February 1973. This investigation followed complaints about conditions on two wards "...alleging dirty unhygienic conditions, broken windows, neglect of patient care, abrupt withdrawal of drug therapy leading to deterioration and harsh attitudes by medical and nursing staff...".[25] The complaints arose from the consultant's clinical policy which aimed to hand responsibilities to the patient by the planned withdrawal of nursing care. Instead of appointing a formal, legally-chaired inquiry, the Department chose a committee of senior professionals given that the object was to review clinical practice on the wards concerned. The Committee found that although the theoretical basis may have been unexceptionable, the practical application led to to situations and conditions which should not have existed in an NHS hospital.

Continued from previous page
covering the hearing, and Editions of 14.12.72 covering the Report.

[25]ibid para 36.

Appendix 4

Detailed cost and activity data

Table 1:Hospital services in England and Wales 1959-1986 - net spend by type (£000s)

Year (31.12)	All	Acute	MI	MH	Other
1959	323,169	156,620	49,242	17,365	99,942
1963	429,596	211,974	63,647	23,749	130,226
1964	458,643	229,790	67,122	25,190	136,541
1965	493,103	248,207	72,152	27,200	145,544
1966	546,319	277,660	78,142	30,068	160,449
1967	587,626	303,253	82,438	32,045	169,890
1968	626,852	328,312	84,892	34,072	179,576
1969	684,140	358,905	92,452	37,730	195,053
1970	745,128	395,763	99,018	41,940	208,407
1971	880,405	471,797	113,188	51,810	243,610
1972	1,036,850	563,879	132,526	63,401	277,044
1973	1,187,385	656,391	150,980	74,521	305,493
1974	1,376,166	765,694	175,738	87,447	347,287
1975	1,989,410	1,128,322	247,310	124,683	489,096
1976	2,602,654	1,490,950	318,881	161,919	630,904
1977	3,015,439	1,761,433	360,724	179,368	713,914
1978	3,383,107	1,925,487	397,147	203,653	856,820
1979	3,827,219	2,190,824	437,619	231,971	966,805
1980	4,606,611	2,648,098	502,350	276,035	1,180,128
1981	5,945,339	3,437,330	667,676	357,276	1,483,057
1982	6,670,416	3,910,657	746,165	394,392	1,619,202
1983	7,055,230	4,257,915	788,666	422,709	1,585,940
1984	7,435,915	4,534,773	822,204	441,725	1,637,213
1985	7,881,487	4,822,341	866,936	465,924	1,726,286

Sources: Health and Personal Social Services for England and Wales 1970-73:
Health and Personal Social Services for England 1974-86
Health and Personal Social Services Statistics for Wales 1974-86.

Table 2: Hospital services in England and Wales - % distribution of spend by sector

Year	All	Acute	MI	MH	Other
1964	100	50.1	14.6	5.5	29.8
1965	100	50.3	14.6	5.5	29.5
1966	100	50.8	14.3	5.5	29.4
1967	100	51.6	14.0	5.5	28.9
1968	100	52.4	13.5	5.4	28.6
1969	100	52.5	13.5	5.5	28.5
1970	100	53.1	13.3	5.6	28.0
1971	100	53.6	12.9	5.9	27.7
1972	100	54.4	12.8	6.1	26.7
1973	100	55.3	12.7	6.3	25.7
1974	100	55.6	12.8	6.4	25.2
1975	100	56.7	12.4	6.3	24.6
1976	100	57.3	12.3	6.2	24.2
1977	100	58.4	12.0	5.9	23.7
1978	100	56.9	11.7	6.0	25.3
1979	100	57.2	11.4	6.1	25.3
1980	100	57.5	10.9	6.0	25.6
1981	100	57.8	11.2	6.0	24.9
1982	100	58.6	11.2	5.9	24.3
1983	100	60.4	11.2	6.0	22.5
1984	100	61.0	11.1	5.9	22.0
1985	100	61.2	11.0	5.9	21.9

Source: as table 1

Table 3: Hospital services in England and Wales - net spend by sector standardised at 1964 spend

Year	All	Acute	MI	MH	Other
1964	100	100	100	100	100
1965	103	104	103	104	102
1966	109	110	106	109	107
1967	113	116	108	112	110
1968	117	123	109	116	113
1969	122	128	113	123	117
1970	127	134	115	130	119
1971	139	149	122	149	129
1972	151	164	132	168	136
1973	159	176	138	182	138
1974	170	189	149	197	144
1975	194	220	165	222	160
1976	208	237	174	235	169
1977	215	250	175	232	171
1978	223	253	179	244	190
1979	232	265	181	256	197
1980	239	274	178	260	205
1981	253	292	194	276	212
1982	263	308	201	284	215
1983	263	316	201	286	198
1984	264	322	200	286	195
1985	265	324	199	286	195

Sources: as in table 1

Table 4

Cost per Inpatient Week by hospital type (£)						
Year end 31/3	Acute*	L/S	MI	MH	MI as % of acute	MH as % of acute
1958	23.2	9.3	6.5	6.1	28	26
1959	24.7	10.1	7.0	6.4	28	26
1960	26.7	11.1	7.6	7.0	29	26
1961	28.5	12.7	8.4	7.5	29	26
1962	30.6	13.8	9.1	8.1	30	26
1963	32.4	14.7	9.8	8.6	30	27
1964	34.0	15.6	10.5	9.1	31	27
1965	37.2	16.9	11.3	9.9	30	27
1966	41.2	18.9	12.6	10.9	31	26
1967	46.7	20.5	13.6	11.6	29	25
1968	49.5	21.3	14.4	12.3	29	25
1969	53.8	23.5	16.1	13.5	30	25
1970	59.7	25.7	17.6	15.0	30	25
1971	71.4	29.7	21.4	18.9	30	26
1972	84.2	34.9	25.5	23.4	30	28
1973	98.0	40.3	30.3	28.0	31	29
1974	115.9	46.7	36.6	33.7	32	29
1975	166.9	67.8	53.7	48.2	32	29
1976	218.0	88.8	70.8	62.7	32	29
1977	249.1	100.2	81.8	71.3	33	29
1978	284.9	116.6	95.2	81.2	33	29
1979	319.6	131.7	108.9	94.1	34	29
1980	383.8	159.0	133.1	114.8	35	30
1981	506.2	209.6	176.5	152.8	35	30
1982	555.4	232.9	197.8	173.6	36	31
1983	603.1	247.8	217.0	191.7	36	32
1984	626.2	258.4	232.3	205.6	37	33
1985	665.6	277.6	256.8	228.4	39	34
1986	697.4	295.8	275.6	248.1	40	36

* over 300 beds and teaching hospitals
up to 1969 England and Wales
1970 onwards England Only (between 95 and 100% of both E and W)
No figures for 1974/5 issued as immediately post reorganisation
To 1974/5 gen acute figures adjusted for teaching hospitals
1975/6 onwards RHA teaching hospitals in with general acute
Source: Health Service Costing Returns 1958-1986
Cost per Inpatient Week by hospital type at 1985 prices

Table 5

Year	GDP/NHS Multiplier *	% increase over previous year (inflation rate)
1964	6.47	N/A
1965	6.21	4.27
1966	5.91	4.99
1967	5.70	3.73
1968	5.56	2.62
1969	5.30	4.85
1970	5.05	4.86
1971	4.70	7.57
1972	4.33	8.51
1973	3.98	7.32
1974	3.67	6.67
1975	2.90	16.18
1976	2.37	20.42
1977	2.11	11.65
1978	1.96	12.20
1979	1.80	9.67
1980	1.54	14.44
1981	1.26	15.65
1982	1.17	8.94
1983	1.11	6.75
1984	1.06	4.46
1985	1.00	4.27
1986	0.95	5.63
1987	0.89	3.06

GDP inflation to 1971-2 then NHS price index

Table 6: Hospital services in England and Wales - Cost per I/P week at 1984/5 prices

Year	Acute*	L/S	MI	MH	MI as % of acute	MH as % of acute
1964	220.5	101.0	67.8	58.8	31	27
1965	230.9	104.6	70.2	61.4	30	27
1966	243.8	111.8	74.6	64.4	31	26
1967	266.1	116.7	77.3	66.0	29	25
1968	275.1	118.3	79.8	68.2	29	25
1969	285.3	124.3	85.2	71.4	30	25
1970	301.5	129.9	89.1	75.6	30	25
1971	335.6	139.4	100.5	88.6	30	26
1972	364.4	150.9	110.2	101.3	30	28
1973	390.4	160.4	120.9	111.6	31	29
1974	425.7	171.7	134.4	123.7	32	29
1975	483.8	196.4	155.6	139.7	32	29
1976	516.6	210.5	167.7	148.6	32	29
1977	526.3	211.8	172.7	150.7	33	29
1978	557.2	227.9	186.2	158.8	33	29
1979	575.2	237.1	195.9	169.3	34	29
1980	590.5	244.7	204.7	176.6	35	30
1981	638.9	264.5	222.8	192.9	35	30
1982	651.5	273.2	232.0	203.6	36	31
1983	666.6	273.9	239.9	211.9	36	32
1984	660.7	272.7	245.1	216.9	37	33
1985	665.6	277.6	256.8	228.4	39	34
1986	663.1	281.3	262.0	235.9	40	36

Source: Health Service Costing Returns 1958-1986
* over 300 beds and teaching hospitals
1970 onwards England only (within 100-95% of both E and W)
No figures for 1974/5 issued as immediately post reorganisation and therefore mid-point 1973/4 and 75/6 used. To 1974/5 general acute figures teaching hospitals shown separately and therefore apportioned. 1975/6 onwards returns include RHA teaching hospitals in with general acute.

Table 7: Hospital services in England and Wales - annual percentage Increases in cost per I/P week by sector

Year	Acute*	L/S	MI	MH
1964	N/A	N/A	N/A	N/A
1965	4.7	3.6	3.5	4.4
1966	5.6	6.8	6.3	4.9
1967	9.1	4.4	3.6	2.5
1968	3.4	1.3	3.3	3.3
1969	3.7	5.0	6.7	4.8
1970	5.7	4.5	4.6	5.8
1971	11.3	7.4	12.8	17.2
1972	8.6	8.2	9.6	14.3
1973	7.2	6.2	9.7	10.2
1974	9.0	7.1	11.2	10.8
1975	13.6	14.4	15.7	12.9
1976	6.8	7.2	7.8	6.4
1977	1.9	0.6	3.0	1.4
1978	5.9	7.6	7.8	5.4
1979	3.2	4.0	5.2	6.6
1980	2.7	3.2	4.5	4.3
1981	8.2	8.1	8.8	9.2
1982	2.0	3.3	4.1	5.6
1983	2.3	0.3	3.4	4.1
1984	-0.9	-0.4	2.2	2.4
1985	0.7	1.8	4.8	5.3
1986	-0.4	1.3	2.1	3.3

Source as table 3

Table 8: Hospital services in England and Wales - cost per I/P week standardised at 1964 spend

Year	Acute	L/S	MI	MH
1964	100.0	100.0	100.0	100.0
1965	104.5	103.4	103.3	104.2
1966	110.1	110.2	109.5	109.0
1967	120.0	114.9	113.3	111.6
1968	124.0	116.4	117.0	115.2
1969	128.3	121.9	124.5	120.4
1970	135.2	127.2	130.0	127.2
1971	152.9	138.6	148.8	151.3
1972	205.7	186.0	202.3	214.4
1973	218.8	196.1	220.2	234.5
1974	236.7	208.4	243.2	258.0
1975	244.1	221.4	261.3	270.5
1976	253.5	225.5	267.7	273.5
1977	254.5	223.5	271.6	273.2
1978	267.7	239.0	290.9	286.1
1979	274.3	246.7	303.8	302.7
1980	273.5	247.3	308.3	306.7
1981	281.7	254.5	319.4	318.8
1982	285.6	261.4	330.7	334.7
1983	291.1	261.1	340.6	347.0
1984	287.9	259.3	347.2	354.4
1985	289.1	263.2	362.7	372.0
1986	288.0	266.7	370.1	384.2

Table 9: Hospital services in England and Wales - Available beds by specialty

Number 000s						% distribution				
Year	Non-Psych	chron /ger	MI	MH	total	Non-Psych	chron /ger	MI	MH	total
1964	202	59	145	61	467	43.3	12.6	31.0	13.1	100
1965	201	58	143	62	464	43.3	12.5	30.8	13.4	100
1966	202	59	141	62	464	43.5	12.7	30.4	13.4	100
1967	201	60	139	62	462	43.5	13.0	30.1	13.4	100
1968	201	60	136	62	469	42.9	12.8	31.1	13.2	100
1969	199	60	134	62	455	43.7	13.2	29.5	13.6	100
1970	197	60	130	62	449	43.8	13.4	29.0	13.7	100
1971	198	61	127	62	448	44.3	13.5	28.4	13.8	100
1972	196	62	121	60	439	44.7	14.1	27.5	13.6	100
1973	193	61	116	59	429	45.0	14.2	27.1	13.7	100
1974	192	61	110	58	421	45.7	14.4	26.2	13.7	100
1975	189	61	105	57	412	46.0	14.8	25.5	13.8	100
1976	188	61	103	56	408	46.2	15.0	25.2	13.7	100
1977	185	61	99	55	390	46.4	15.3	24.7	13.7	100
1978	181	62	96	54	393	46.0	15.8	24.5	13.6	100
1979	178	61	94	53	386	46.1	15.8	24.5	13.6	100
1980	175	61	92	52	377	46.0	16.1	24.3	13.6	100
1981	173	61	90	50	374	46.2	16.3	24.0	13.4	100
1982	171	61	89	49	370	46.2	16.5	24.0	13.3	100
1983	169	61	87	48	365	46.3	16.7	23.8	13.2	100
1984	165	61	84	46	357	46.3	17.2	23.5	13.0	100

Sources: Health and Personal Social Services for England and Wales 1970-73: Health and Personal Social Services for England 1974-86: Health and Personal Social Services Statistics for Wales 1974-86.

Table 10: Hospital services in England and Wales - Discharges and deaths

Net 000s (Workload)						Per available bed(throughput)				
Year	Non-Psych	chronic /ger	MI	MH	total	Non-Psych	chronic /ger	MI	MH	Avg
1964	4389	157	168	11	4580	21.7	2.7	1.2	0.2	9.8
1965	4477	158	171	12	4730	22.3	2.7	1.2	0.2	10.2
1966	4544	157	174	12	4820	22.5	2.7	1.2	0.2	10.4
1967	4656	159	179	12	4894	23.2	2.7	1.3	0.2	10.6
1968	4774	165	185	12	5018	23.8	2.8	1.3	0.2	10.7
1969	4902	167	189	12	5270	24.6	2.8	1.4	0.2	11.6
1970	4941	184	189	14	5328	25.1	3.1	1.5	0.2	11.9
1971	5104	187	189	16	5496	25.8	3.1	1.5	0.3	12.3
1972	5140	200	193	18	5550	26.2	3.2	1.6	0.3	12.7
1973	5043	202	191	17	5453	26.1	3.3	1.6	0.3	12.7
1974	5092	205	187	17	5501	26.5	3.4	1.7	0.3	13.1
1975	4872	216	189	18	5295	25.8	3.5	1.8	0.3	12.9
1976	5142	241	192	18	5593	27.4	4.0	1.9	0.3	13.7
1977	5231	248	189	21	5689	28.3	4.1	1.9	0.4	14.3
1978	5252	261	185	22	5720	29.0	4.2	1.9	0.4	14.6
1979	5280	263	183	24	5750	29.7	4.3	1.9	0.4	14.9
1980	5524	290	196	27	6036	31.6	4.7	2.1	0.5	15.9
1981	5596	309	200	30	6135	32.3	5.0	2.2	0.6	16.4
1982	5533	327	198	32	6090	32.3	5.4	2.2	0.6	16.4
1983	5812	359	205	38	6414	34.3	5.9	2.4	0.8	17.5
1984	5949	387	210	43	6589	36.0	6.3	2.5	0.9	18.5

Sources: Health and Personal Social Services for England and Wales 1970-73: Health and Personal Social Services for England 1974-86: Health and Personal Social Services Statistics for Wales 1974-86.

Table 11: Discharges and Deaths by type of hospital, 1963-84as % distribution

Year	acute	chronic /ger	MI	MH	total
1963	92.7	3.5	3.6	0.2	100
1964	95.8	3.4	3.7	0.2	100
1965	94.7	3.3	3.6	0.3	103
1966	94.3	3.3	3.6	0.2	102
1967	95.1	3.2	3.7	0.2	101
1968	95.1	3.3	3.7	0.2	102
1969	93.0	3.2	3.6	0.2	100
1970	92.7	3.5	3.6	0.3	100
1971	92.9	3.4	3.4	0.3	100
1972	92.6	3.6	3.5	0.3	100
1973	92.5	3.7	3.5	0.3	100
1974	92.6	3.7	3.4	0.3	100
1975	92.0	4.1	3.6	0.3	100
1976	91.9	4.3	3.4	0.3	100
1977	91.9	4.4	3.3	0.4	100
1978	91.8	4.6	3.2	0.4	100
1979	91.8	4.6	3.2	0.4	100
1980	91.5	4.8	3.2	0.4	100
1981	91.2	5.0	3.3	0.5	100
1982	90.9	5.4	3.3	0.5	100
1983	90.6	5.6	3.2	0.6	100
1984	90.3	5.9	3.2	0.7	100

Source as table 6

Table 12: Trends in staffing levels in mental illness hospitals figures show per 100 patients resident

Year	Cons	All Nurses	Qual Nurses	Unqual Nurses	% u/t* Nurses	Domes-tics	Psychol-ogists	Thera-pists
1964	0.36	24.5	9.5	15.0*	N/A	4.1	0.08	0.62
1967	0.44	27.0	11.6	15.4*	N/A	4.9	0.15	0.77
1969	0.63	31.9	19.2	12.7	39.8	5.4	0.20	0.92
1970	0.66	33.9	19.9	14.0	41.3	6,0	0.27	1.05
1971	0.72	36.9	21.2	15.7	42.5	6.8	0.26	1.59
1972	0.81	42.2	23.6	18.6	44.1	8.2	0.35	1.88
1973	0.92	45.3	25.0	20.3	44.8	9.1	0.45	2.28
1974	1.04	48.1	26.6	21.5	44.7	10.1	0.53	2.76
1975	1.15	54.8	28.5	26.3	48.0	11.0	0.59	3.19
1976	1.28	57.7	30.9	26.8	46.4	11.9	0.67	3.50
1977	1.36	59.1	33.1	27.6	46.6	11.3	0.73	3.38
1978	1.47	62.7	34.2	28.5	45.5	11.7	0.81	3.58
1979	1.53	65.1	35.2	29.9	45.9	12.1	0.89	3.68
1980	1.58	70.8	37.3	33.5	47.3	12.4	1.01	4.40
1981	1.67	75.7	39.3	36.4	48.1	12.8	1.08	4.79
1982	1.77	80.2	42.3	37.9	47.2	13.1	1.17	5.15
1983	1.88	83.2	45.1	38.1	45.8	13.1	1.19	5.33
1984	2.04	87.1	48.2	39.0	44.7	12.8	1.31	5.11
1985	2.22	90.9	50.6	40.2	44.3	11.3	1.45	6.00

Source: Ministry of Health, DHSS: The facilities and services in mental illness hospitals 1964-1985
1974 onwards England staffing figures only
*includes SENs (later figures excluded them)

Table 13: Trends in staffing levels in mental handicap hospitals
Figures show per 100 patients resident

Year	Cons	All Nurses	Qual Nurses	Unqual Nurses	% u/t* Nurses	Domes-tics	Psychol-ogists	Thera pists
1964	0.22	23.2	7.6	15.6	3.5	0.07	0.44	67.2
1967	0.22	24.6	8.1	16.5	3.5	0.07	0.44	67.1
1969	0.23	25.8	14.9	10.9	4.5	0.10	0.63	42.2
1970	0.22	28.6	16.2	12.4	5.3	0.12	0.78	43.4
1971	0.24	32.2	16.7	15.5	7.1	0.15	1.85	48.1
1972	0.27	36.7	17.4	19.3	8.3	0.15	2.16	52.6
1973	0.28	38.8	18.0	20.8	9.7	0.16	2.44	53.6
1974	0.31	41.3	18.6	22.7	9.8	0.19	2.77	55.0
1975	0.33	46.6	19.9	26.7	11.1	0.23	3.05	57.3
1976	0.34	48.6	21.5	27.1	11.5	0.25	3.03	55.8
1977	0.36	51.4	22.4	28.9	12.3	0.29	3.29	56.3
1978	0.38	54.2	23.6	30.6	12.7	0.33	3.62	56.4
1979	0.38	56.7	24.3	32.4	13.0	0.37	3.88	57.2
1980	0.39	61.7	25.8	35.8	13.9	0.43	3.97	58.1
1981	0.42	67.9	27.4	40.5	14.7	0.48	4.35	59.6
1982	0.45	73.9	29.3	44.5	15.4	0.51	4.69	60.3
1983	0.45	72.5	30.2	42.2	15.3	0.56	0.00	58.3
1984	0.43	73.8	30.9	42.9	15.0	0.55	0.00	58.1
1985	0.46	78.5	32.1	46.4	13.7	0.63	0.00	59.1

Source: Ministry of Health, DHSS: The facilities and services in mental illness hospitals 1964-1985
1974 onwards England staffing figures only
*includes SENs (later figures excluded them)

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