NHS at 70:

A personal remembrance since 1988

Rajan Madhok

2018

To be read in conjunction with

1. ***Compendium of reflective writings (2013) – Vol 1***
2. ***Notes from the Jarrow March (2014) – Vol 2***

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INTRODUCTION

He was quite excited and could not wait to leave the class and get back to the Headquarters of the Northern Regional Health Authority; Richard was my fellow trainee on the Public Health Training Scheme and was attached to Liam Donaldson, the Regional Medical Officer, and that day the Secretary of State (SoS), Kenneth Clarke was launching the new White Paper: Working for Patients. It was 1989 and in an another first there was a live video link up with London (so I was told) for everyone to hear directly from the SoS. Although Richard took pains to explain the content and importance, I found it all incomprehensible – I was few months into my training, after working for many years in orthopaedic surgery and was struggling to transition; terms like White Paper, SoS, not to mention internal markets, purchase/provider went over my head. Richard was, however, a rising star and on a fast-track and indeed became a consultant about 18 months into training (this is all pre 'Calman' and structured training, though it does make you wonder which was better – Richard Thomson has just retired as (an eminent) Professor of Public Health at University of Newcastle upon Tyne. Go Figure). Little did I know then that I was witnessing history making, the start of the new phase of the NHS as part of the wider Thatcherite reforms of the state and introduction of neo-liberalism, and how it would affect my life for the next few decades.

As you would have gathered already my sense making is largely post-hoc, partly due to the survival instinct and need to get on with the job and partly being a slow learner; my story is largely the lived experience and suffers from memory (it's a long period), geographical (since I have only worked in Northern England albeit across its length and breadth) and commissioning (since although I had some knowledge of provider sector, I mainly worked on the health authority/commissioning side) biases and of course like all personal accounts is tainted by my preferences; I have had to be selective given the vastness of the subject, and also superficial as each theme is a PhD in itself.

I am writing this as part of the NHS at 70 project after discussion with my friend and colleague, Stephanie Snow who is directing it, and this piece is meant to complement my already published compendium of reflective writings and reflections from the Jarrow March in 2014; it picks on either issues not detailed there or which I believe are the most relevant for the NHS now. Nonetheless I did wonder about what more can I say that I have not done already or cannot be said more eruditely and authoritatively by the policy pundits, and how to avoid the ego trap of self-congratulation and the need to be impartial – to not sit on judgement but tell to learn. In any case does anybody read or care and what blind bit of difference does it all make – but these are questions beyond my pay-grade and for what it is worth I am happy to share my life in the NHS. And for the purposes of NHS at 70 it all started in autumn 1988 when I joined the Public Health Training Scheme in Newcastle, though I had started working in the NHS in 1980.

To begin with and to orient readers the table below is a brief timeline of my career with the NHS with some highlights.

DATES	ORGANISATIONS	POSITION	ADDITIONAL ROLES
1988-91	Northern Regional Health Authority	Trainee	
1991	Mayo Clinic, USA	Researcher	
1991-94	South Tees Health Authority/Tees Health Joint Administration	Consultant	(Hon) Lecturer, Newcastle University
1994-98	South of Tyne Health Commission/Gateshead and South Tyneside Health Authority	Director of Public Health (DPH)	Visiting Professor, Teesside University
1998-2002	East Riding Health Authority/East Riding and Hull Health Authority	DPH	(Hon) Professor of Public Health, Hull University
2002-2005	North and North-East Yorkshire and Northern Lincolnshire Strategic Health Authority	Medical Director/DPH	(Hon) Professor of Public Health, Hull University
2005-6	South Manchester PCT/Withington Community Hospital	Consultant in Public Health/MD	(Hon) Professor of Public Health, Manchester University
2007-2010	Manchester PCT	Medical Director	Also, P/T Medical Director, Computer Science Corporation – for NPfIT (Hon) Professor of Public Health, Manchester Metropolitan University Chair, Greater Manchester, Comprehensive Local Research Network Trustee then Chair, Local CAB Chair, Peoples-uni (an education charity) India Envoy, National Patient Safety Agency Member, General Medical Council Chairman, British Association of Physicians of Indian Origin
2010-2012	Manchester PCT	Special Projects Director	Chair, Greater Manchester Health

			Education and Innovation Cluster Trustee then Chair, Local CAB Chair, Peoples-uni (an education charity)
2012-	Various	Consulting assignments including in India	Director, Clinical Leaders Network Director, Global Health Exchange

KEY THEMES

In the following sections, I comment on some of the key themes.

Overall assessment

When I was doing the Jarrow March in 2014, I was asked why and my response was that it was a penance – I was actively involved in the 'destruction' of the NHS and not just a bystander, and was walking to atone. Afterall the seeds were sown by Margaret Thatcher and despite changes in the Government since then the direction has remained constant, and as a medical bureaucrat during this period I played my active part in implementing all the changes – with their intended and unintended consequences. I can claim the 'Nuremberg' defence – of doing my duty- but it does not sit well with my conscience. This probably tells you where I am coming from.

Sadly, during my time 1988- present I have seen the NHS go downhill overall with some brief periods of respite and pockets of brilliance, but generally decline none the less. Approaching the three scores and ten she is elderly, frail, and terminal, sadly hastened to this stage in the last few years through neglect and wanton destruction. Since I wrote my reflections of management and leadership in 2012 I have become less generous with my assessment of the NHS with the benefit of further experiences; in the last few years not only did I learn a lot about the (poor) state of the NHS throughout England during the Jarrow March I can genuinely say that I know of no one with complementary things to say about the NHS leadership overall. The latter includes diehard fans and those who are usually optimists and the opportunists – even the latter have given up as unable to navigate the system, big bucks are being made but by big boys, the days of small entrepreneurs are over.

What to me is the conundrum is that despite above the NHS continues to top the international health system league table; this either says more about other systems and how things are getting worse globally or we do not appreciate the NHS and remain critical. Although not an expert in international health I have and continue to travel professionally and am aware of the global health challenges and growing inequalities, and so yes other systems are not as fortunate as the NHS. I am also aware of the comments from more experienced observers and especially who predate me and can point out the dire state of the country and the NHS pre-Thatcherite changes (I struggle to label them reform since that term means better). But that sort of defence is wrong in my view – my comparison is not in terms of a before and after and nor with the other systems, my view is that things did not have to be this way and we should have done much better with the NHS, and have squandered opportunities. Overall, the NHS is structurally sound given its founding principles and in fact could be not just top of the league table but be in stratosphere if we stopped messing it up.

Also, I should make another distinction, at a personal level I know of friends and colleagues who have received excellent care and support, and something which still

makes the NHS the envy of the world, and again this gets exploited politically and used to continue current policies whereas the fact is good things happen not because of but despite the system in which people are working. A few swallows do not make a summer.

I find the current media coverage challenging with NHS being the usual political football and despite evidence of service cuts, missed targets, long waiting lists, compromised patient safety, staff shortages and the list goes on, the incumbent policymakers are spouting the usual more investment, claiming successes, and blaming the predecessors and naysayers. Future historians will have great difficulty making sense of this period with its ‘spin’ and cacophony, and for that reason alone I want to leave my record in the hope someone will pick it up.

Now I am aware that I will be discounted and painted into a corner as part of the medical establishment which has never agreed with anything going back to the examples of BMA opposing the creation of the NHS to Ken Clarke having to stuff their mouths with gold and did not the establishment back off from opposing Lansley’s reforms. Again, I should point out to my record which clearly shows that I have been a great critic of the medical establishment, to the point of banishment from the Royal College of Physicians for my Milroy Lecture. Speaking truth to the power has landed me in trouble a few times.

Overall, frankly any meaningful conversation on NHS currently is not possible – it has nothing to do with evidence or science and all to do with shouting, emotions, and ideologies.

You would not be able to convince me that the NHS is better now.

My best time

I am aware of the “The past is a foreign country, they do things differently there” trap and clearly there will be competing views especially as there are so many facets to the NHS and what is best for me may not the best for you. None the less, with the benefit of distance and comparing various stages of my career, I believe the period 1994-1998 when I took up my first director job in the NHS at the South of Tyne Health Commission was the best for many reasons.

Surprisingly, the top of the list of reasons for this is the lack of money; it really focussed our minds and made us innovative. During my time there I remember hardly ever going to London, in contrast to later years when NHS was perhaps the largest contributor to the rail operators’ profits, and we hardly ever had meetings in hotels and in fact I had to take permission to be able to stay overnight in a hotel once a month after late finish of the LMC to avoid very long commuting. It did not stop us railing against the injustice as other areas in the then Northern Region got preferential treatment (and such differential treatments are inevitable, in a system where patronage matters) or condoning the shortages; but it made us tougher and creative. Though glad of the bounty after Tony Blair got into government, I was also sad since we lost the mindset and took to throwing money at every problem. I was quite clear in my letter to Tony Blair that whilst more money was needed, it had to be tied with two other objectives: focus on health not illness and local delegation, and this was a package of three. Sadly, we never followed the latter two and became like spoilt rich kids for a few years. I particularly feel sorry for the later generations of managers who have gone from prosperity to austerity – a much difficult journey than the other way, they know only one way (gross generalisation I accept, and done to emphasise a point).

In addition, we were still in the early days of the purchaser: provider separation and the relationships were not adversarial, as frankly we were ‘mock fighting’ in the absence of any real markets, and where we shifted contracts (see the example of Dermatology services in .....) it was with much cooperation and not competition. I personally benefitted from a rather benevolent, none the less tough, chief executive –Bill Worth- and was surrounded by talented staff – something which goes unappreciated in the NHS. Sadly, the goodwill has eroded over the years, with each reorganisation we have lost talent and core NHS values. We were also some time away from the draconian target culture – this is not to deny we lacked discipline or were not ambitious, in fact to the contrary we were tougher on ourselves than any externally imposed targets. I remember our major programmes on tobacco control, maternal and child health, dental services, pharmaceuticals and not to mention hospital services where we punched hard. Of course, later on targets helped improve services but by piece meal approach and lack of attention to the whole system these became more divisive – managers started chasing targets.

In summary, my best time was due to the overall “Less is More” rule – less money, less interference, and less competition.

My worst time

It may be the Parkinson Law: You ultimately reach your level of incompetence and which led to my downfall as the Medical Director for North and North East Yorkshire and North Lincolnshire Strategic Health Authority (the one with the longest name) or it may be that these SHAs were fundamentally flawed in their design as proven by their abolishment few years later or it was the times. The SHA was a huge and diverse – geographical and economically – area, what had Harrogate and Hull in common after all? And it was also the start of the real push from an emboldened Labour Government – Blair's Modernisation agenda with plans to promote reform with investment made great strides, and although I must confess that not all was bad, the problem was that it was non-stop and too much without any time to implement properly or consolidate. I ran ragged trying to cover the geography and policy imperatives, and discovered my strengths of creating change at grassroots from the last 10 years had no relevance in this environment. My attempts to use my by then considerable experience especially with more junior gung-ho managers – and Labour government had unleashed the take no hostages and a very demanding brigade – were seen as soft. And where I tried to manage for the long term I went against the prevailing spreadsheet, tick boxes and shouting mentality as the way to deliver targets, and indeed had to ultimately call it a day and move out of the situation.

Frankly, there was little understanding of change management for the complex system that is the NHS is – do not get me wrong, there were enough experts and enough investment went into education and training of managers and clinicians except that the theory and practice gap widened. In fact, I ended by 'complaining' after a very expensive leadership development programme that the teachings had no bearing on reality – the theory imagined a world very different to the one I inhabited, had strong leaders, clear vision, stability, and all of which was a far cry from the real NHS. We became expert commentators and not effective practitioners – good at diagnosing but not treating.

In my view this period which started in 2001 set the scene for the downfall of the NHS – in a demonstration of the party-political agnostic nature of the health (and general public services policy) sector, Simon Stevens who was Tony Blair's advisor then came back to pick up the reign under the Coalition government of Cameron: Clegg later, and overall, the culture of the NHS management changed radically. There was almost a 'Two legs bad, four legs good' culture and anything from the past was derided, hard edge and commercial approaches became the new *Lingua Franca*. History was really bunk and tradition was being sacrificed at the altar of progress; for example, one of my regrets was Liam Donaldson's decision to change the format of his annual report; the previous reports were almost a historical record of the year and very useful references. It may be that he realised the futility of trying to record the increasingly high numbers of policy directives or their ephemeral nature but it was a loss; historical research.is harder as a result. Small thing but symbolic of direction of travel.

Despite my personal worst time, I should note some excellent progress with National Service Framework or the focus on clinical governance and patient safety for example, and I did build on these in my later job in Manchester when perhaps I was more in my comfort zone in a smaller role.

In summary, just as “Less is More” is useful, “More is Less” is equally true, you can have too much of a good thing and it is important to pace yourself. In a pique, and to paraphrase that old saying, I once wrote about Alan Milburn, another SoS: “Do not just do something, stand there” and sent it to a magazine. Etiquette or fear, but they did not publish it.

Commissioning

I start with a confession: I have worked in the private sector and generally am not averse to it, but I am getting ahead slightly.

Again, unknown to me at the time, I was at the start of the revolution, underpinning the purchaser: provider separation was the need to understand costs, and rightly to the consternation of policymakers there was hardly any information on the costs in the NHS. Newcastle at that time was leading the Resource Management Initiative (RMI) and indeed I worked with one of the early health economists – Martin Backhouse, though many of the lessons did not sink in for a while, and in later years I had some very interesting discussions with Trevor Sheldon and Alan Maynard and the staff at the York Health Economics Consortium.

But it was a big jump from RMI to a purchaser: provider separation and then to competition and privatisation; from 'internal' markets to 'free' markets was uncharted territory but the bandwagon had started rolling. The South Tess Health Authority, where I was when this was happening, which until then was working well (in my view) with a district wide board was thrown into turmoil with directly managed units being set up (even though operationally the hospitals were directly managed but now this was taken to the next level- sowing the seeds for the creation of trusts). In another example of the excellent administration capabilities of the time, Bill Murray went onto head (one) acute hospital and Moira Britton took over mental health services- both were proteges of Ian Donaldson, the District Administrator – but positions make people and the relationships changed soon after.

Cooperation soon turned to competition – despite pleas for "Coopertition", commissioning became the new currency. We all became businesses, and the irony was that in most health organisations, the Chief Executives would have had little business experience- with the quote being that the biggest deal they would have done would have been buying a house and later fancy cars but they were now managing millions and in some cases billions. And of course, needed to be appropriately compensated, but that is an aside.

Fast forward few years and we had the start of the World Class Commissioning- a real oxymoron since nowhere in the world is there a successful example of a comprehensive health system founded on commissioning. And of course, NHS still had the public sector mentality and resisted change- any common sense was seen as resistance – and so the private sector had to be brought in, and rather than patient care, money became the focus of NHS management. From PFI to big private providers for the range of NHS services not just clinical but housekeeping and IT has brought us to this stage where profit is outsourced and risk is in house.

I found it fascinating that the NHS was so (wrongly) influenced by American health expert -Alain Einthoven who was Thatcher's Health Guru and credited with the Internal Market concept and yet there were other voices such as the Jackson Hole Group and later Don Berwick and Ken Kizer who were marginalised; confirming the

selective use of information and supremacy of ‘Policy Based Evidence’ over ‘Evidence Based Policy.’

Frankly, the NHS has always been provider led- in fact acute services led (with primary, community and mental health taking backseats), and commissioners were never able to exercise their muscle – partly due to the inherent power imbalance and partly due to commissioning organisations suffering from ‘weaker’ management; now I am conscious that is a loaded comment and not all provider organisations were also well led but in general the comment stands. Smart managers stayed on the provider side, as also evidenced by the large number of Knights and Dames on provider or regulatory side with hardly any on the commissioning even though in theory commissioners had the upper hand.

Good intention gone wrong or deliberate pursuit of ideology, and now workarounds such as Accountable Care Organisations (and some would argue, the Trojan Horse), but the NHS currently is doomed because of this fundamental design fault in how it is organised. Yes, competition is good and yes, private sector can have a role – but as part of an overall design with area-based planning, service organisation and delivery as the main mechanism; I did write on alternative ways of commissioning (ref letter to BMJ) and we also showed how commissioners can improve quality and patient safety (ref).

Staff

It is the people, stupid; after all the NHS is a service industry and its staff are its backbone. The NHS has been touted as the Third largest employer, after US Defence and Chinese Army, and in an irony its staff suffer the same fate as soldiers – they serve as cannon fodder and at the mercy of the generals. It may be the societal trend or blame it on Thatcher: There is no society but the NHS as a workplace has become very challenging. My deep concern led me to writing to Simon Stevens about Workers Safety (ref) in 2014. How did we get here?

Not just my clinical years where as junior doctors we all stayed together in hospital messes with their social clubs and where everyone socialised together and thereby creating *espirit de corps* but also in my early management career there was a feeling of we are in this together. I was depressed by Cameron's big idea of Big Society in later years – not because of its need but because we had it and broke it all up. When I first started training the health authorities' boards were made of lay local people, unpaid and boy did they work hard; the whole district moved in concert – albeit competing with others in the region. And slowly it unravelled post Thatcher– paid positions and increasingly higher pay (some chairs and board members' salaries are objectionable and I did vote against rises when I was on the GMC Council) and too many chiefs; Greed is good. The local NHS was a community asset, cherished and nurtured by them, and then it became a business – I find it shocking that now a days non-execs including chairs do not even have to live in the area and can hold more than one such post. I may be accused of focusing on small things at the expense of big picture – but I am from the Rudy Guiliani School – you let the 'squeegee man' operate at traffic lights and before you know New York had a serious crime problem; I am not heartless to deny the need to understand why people became squeegee merchants. You ignore small infringements at your peril.

And before long there was a strong political: managerial nexus – indeed complete blurring of legislative, executive, and judicial elements - and the NHS split along managers (and even there along senior and middle) and workers; and with each reorganisation this has been reinforced and unions broken or weakened leaving workers at the mercy of politicians, management, and profiteers.

However, they were helped by the workers also, especially the clinical workforce with its increasing tribalism. I used to joke that as a public health doctor I was a nobody – the doctors did not trust me as I did not see patients; managers do not like doctors so I was tolerated; nurses and doctors are at loggerheads anyway and to top it all for me I was not even accepted by my professional body which had split along medical and non-medical public health workforce. Joking apart, the increasing specialisation though inevitable as part of the progress (*sic)* has been used explicitly and inadvertently to divide and rule.

I still believe that NHS staff are different, they are driven by values and in a properly organised and managed system can perform miracles, but currently there is a mismatch – the system and people are not aligned, indeed the staff are maligned. I truly worry not least as two of my children work in the NHS. The NHS policymakers

know the price of things but not their value- time to redress this. As I started writing this (Feb 2018) the health news was about the protests in London – NHS in crisis, fix it now- organised by Peoples Assembly and Health Campaigns Together, and the response from Government – “we are aware of the pressure and that is why we have supported the NHS with extra funding”. A classic parallel universe; never the twain shall meet.

Again, in terms of disclosures I should point out that I was a Whistle Blower, signed a confidentiality agreement and took redundancy – at least I was old enough to be able to bail out, unlike many others.

Organisational form

Forming, Storming, Norming and Performing goes the old saying about achieving success but what do you do when you never move past the first stage – and get stuck in the forming and (re) forming loop. There is an obsession with the organisational form – in Manchester they keep going around- from one health authority to 3, 3 PCTs to 1, 1 PCT to 3 CCGs and then 1 again, and very now and then for a change, they go bigger like Manchester SHA and now Devo Manc. Once in conversation about the NHS changes with the Late John Pickstone we realised that a collage of my business cards with different organisations would have made an excellent cover for his book, a picture is worth a thousand words- except sadly I had not made or kept such cards! The troops meanwhile carry on blissfully unaware about such changes which really exercise the boards, executives, and managers. Now why is this, and here you must really go back to 'Dilbert' – the ultimate Management Guru - since many a times these changes are deals between the senior partners who use it to advance – either lucrative retirements or bigger jobs, there has never been any documented evidence of sustainable benefits of these changes either monetary or better services. Indeed, I calculated that between 2001-2010 (when I finally had enough) we lost 5 years dealing with restructuring only – a colossal waste. Indeed, it made me wonder if the system can do with paralysis 50% of the time, then why not abolish it altogether.

And this is not just at local levels; it is throughout- Northen became Northern and Yorkshire and then split into 8-10 SHAs for example, and my favourite (*sic)* was the plan to create four Directorates of Health and Social Care for England and whilst the preparations were being made with a date for 'inauguration', just a few months prior to this they were abolished. Or the 'Sunset' reviews of national organisations by Ian Carruthers and the abolition of Workforce Development Corporation and their reincarnation few years later with Health Education England.

"No more Top-Down Reorganisation," you believe that you will believe anything, utter tosh.

To be fair the provider side used to less affected by organisational changes but is catching up fast in the last few years; super trusts, franchises, integrated providers are all being explored.

Frankly, it is all a case of what one can get away with as there are hardly any checks on the system and the cliches like what works is what matters are used by opportunists. Overall, we have broken two rules: Form should follow function and as a national health system we have never been clear about the function beyond the NHS Founding principles, and more importantly stability. I cannot emphasise the latter enough as also confirmed by the examples of successful organisations due to the longevity of the CEO and the Board.

Definitely a need for "Do not just do something, stand there."

Patient empowerment

The whole idea of asking people about the services with the popularisation of health needs assessment and scientific approaches to planning to reconcile needs with resources and community aspirations was almost new in the wake of the Working for Patients. I remember intense discussions, when I was a trainee, with talks about designing forms and standing at street corners asking the public who were equally amused/puzzled, and rushing to learn about public engagement. And like many other ideas, this one also acquired a life of its own with Patients Charters soon following and typically overlooking two fundamental concerns in any new policy: first, what exists already and how to improve them, and second, can it cause harm? And before long engagement became communications and managing the message became the business!

We already had Community Health Councils, again citizen 'owned' largely but surely, they could not be accepted- careers are never made with status quo, you have to do something new and so the baby went out with the bathwater. We could have avoided yeas of agony and costs by boosting these than create and recreate an increasing plethora of organisations. Another example of More is Less.

And soon the promise: delivery gap emerged, policymakers with eyes on votes forgot that there are give and takes and promising everyone everything, all the time is nonsense and rational planning became impossible. I personally paid the price when I frequently used to get pilloried in the press as the bad guy who denied treatments including to Mr Manchester – Tony Wilson, and shutting services created storms.

I believe that the problem is due to the policymakers' belief that the public is stupid and cannot be trusted (We know best), and their reluctance to accept variations – local decision making will inevitably create inconsistencies and 'Post Code Lottery' - an anathema yet inevitable. Instead, they have abrogated responsibility by passing the buck locally and created the Blame culture – no wonder the NHS litigation costs have soared to £1.7 billion.

The answer to me is to manage expectations and have a two-tiered NHS- with core available to all, and additional based on ability, but then I cannot see who will ever promote this, despite evidence that this is how it works now.

As opposed to policymaking, personalised care at individual level remains a lottery – complaints continue to soar and professionals have become better at deflecting these, and one has to be really hardy to pursue any serious breaches as a number of high-profile individuals' cases show – James Titcombe at Morecambe Bay or Julie Bayley at Mid Staffs. 'No decision about me without me' was and remains a nice and empty slogan.

We keep doing things to patients and the public, and not with or for them.

Regulation

Perhaps it is not a good time to write about regulation as the medical world is seriously up in arms with the case of Dr Garba Bawa – a junior doctor struck off after the GMC challenged her previous conviction. But why was it a surprise and why now, there are numerous examples of doctors who have suffered, and a few of them managed to successfully challenge their conviction but generally they have been at the receiving end of systems failures for some time. Although I supported Revalidation and was on the UK Revalidation Board, I had seen revalidation as a byproduct of good management locally and not another industry and a paper exercise, and had cautioned against holding the individual responsible.

Overall, I was privileged to have lived through the era of quality – from its start with medical audit in 1990s to clinical governance and then increasing focus on patient safety and have been a strong supporter of these developments, and indeed proud of what the NHS did. There truly was a very comprehensive approach with major investments into the many elements: Evidence based medicine with Cochrane Centre, learning through confidential enquiries, Research and Development, appraisals and CPD and the setting up of organisations like CHI (precursor of CQC) and NICE are just some examples. I tried to build on these and integrated them into my work (ref CERC paper with SMA).

However, somewhere along the line we lost patience – Bristol is seen as the watershed (really) and more importantly started confusing means with the end. Regulation – and the debate goes on about internal versus external, light versus heavy – is the means to promote quality and safety and not the end in itself. Power corrupts and absolute power corrupts absolutely and regulators got carried away – each created their own empire; system regulators carved up finance (Monitor) and quality and safety (CQC) for example and professional regulators of course cannot speak to each other- ‘how dare doctors tell nurses’ problem. There was no joined up approach to regulation, and the most important, nay the only, player, who should/could have managed the agenda – the commissioners - was the weakest link and most marginalised.

Our regulatory system is broken and we have failed to reconcile two dimensions:

- the level of regulation at individual/team/provider and national and
- joined up systems and professional regulators

and at present, there is too much ‘regulation’ and too little protection for both: patients and staff.

I remember going to meet the ‘Two Sues’ – National Patient Safety Agency then had a job-sharing CEO post and both were called Sue – and pleading about creating a concordat between various regulators and helping me, I was then at the NEYNL SHA as medical director, to help them. Each of the regulators was doing their own thing, often bypassing me, yet holding me accountable. There was too much leakage around the SHA, and we had no power and all the responsibility.

I also tried to enforce the role of the commissioner when I was at Manchester PCT, with mixed results – the large trust almost told me off and pointed out that they already had 54 (approx.) regulatory demands and who was I! I remember ringing the medical director of Wythenshawe Hospital in my early days first thing in the morning after seeing the late-night news which mentioned a serious patient incident, and effectively then agreeing that I should not discover these things via media, and in fact should be the first person to be notified. To give him his due, Brendan Ryan accepted and rose to the challenge and some of the work we did in Manchester was due to his support (ref). I was not always so fortunate; this attitude led me to finally whistle blow and leave the NHS when my local mental health services were failing and as a PCT we were not doing our job to hold the Trust accountable.

I ultimately fell due to my two working rules, and frankly nobody (*sic)* wanted to know the reality and the messenger was shot:

1. Not knowing is not an excuse – as the medical director it was my job to find out how services were working, and the very least show what attempts I had made to find out – and not just at face value but critically judging information
2. Not doing something is not an option- I had to act once I became aware; you cannot unknow once you know, and in any case, you will be caught out in time.

The saying in management was that one needed to be the regulator (and if not then to be the performance managers!) and not the regulated – and hence the droves who went to join the inspection teams of CQCs, if only they had stayed at home and practised what they were preaching! A very senior colleague (not to be named) ‘pitied’ me for wanting to take on all risk management including corporate governance as part of my job as the medical director at Manchester PCT to develop proper integrated governance; his advice was: Always have power but never the responsibility. Wise man for these times (he is a Knight), and perhaps I should have listened.

MY WISH

So having moaned and criticised, and hopefully not insulted, what are my learnings and suggestions.

I am not party political and frankly have seen that parties use the NHS in opposition and abuse it in power. Whilst I have sympathy for Jeremy Corbyn, I am not sure when and if he will get into No 10 and in any case what will he do with the NHS? I had extensively interacted with some of the Labour health advisors especially in my active Jarrow March phase, and did not 'get' their solutions for the NHS since I found that their thinking was just variations on the old themes and basically workarounds. Although I liked Allyson Pollock's NHS Reinstatement Bill, I felt that it would not work. More recently, Sarah Woolaston's call for a cross party approach to the NHS makes sense but will it ever happen and what would it do?

To my mind there is a need for a compelling vision for the NHS. Chanting the founding principles of the NHS shows the ignorance about reading but not learning from history – these principles were of a time and indeed as we know failed within a few years when demand exceeded supply. What is needed are the new principles for designing the 21st century NHS. In my 2011 article on lessons from the NHS, I had written: "If I was to name (my) main disappointments, then the biggest stumbling block has been the primary-secondary care (and some would argue health and social care) divide, and rather than find ways of bridging it, the consistent policy direction with emphasis on purchasing/commissioning has reinforced it. The second is the denial by politicians that the NHS is not affordable and has to set some limits; it cannot provide world class state of the art health care to everyone. Rationing has become a taboo word despite evidence, and lately increasing evidence, that some sort of rationing is already happening. Thirdly, I have been really pleased with some of the major developments such as the work of the NICE, NPSA, National Institute for Innovation and Improvement and National Service Frameworks, which have generated unprecedented, and unparalleled elsewhere, intellectual capital, but disappointed to see that we have failed to fully capitalise on this. Amongst other reasons, the failure of execution is partly to do with constant restructuring and resultant instability and partly to do with overall leadership. Finally, and the subject of this paper later, is the limited leadership by the doctors, for various reasons including the lack of career progression in medical management and the associated stresses of the roles with limited incentives."

We need to acknowledge such challenges and then design the new NHS – Form should follow Function – and create something relevant and sustainable for the next few decades; only so much can be achieved by workarounds which is what is happening with the new initiatives on Devo Manc/STPs/ACO etc (and I have frankly lost the plot). Jeremy Hunt's elevation to SoS for health and social care is just window dressing without subsequent system alignment from top to bottom. Taxing rich to pay for 'As is NHS' is a recipe for disaster; providing free for all to everyone from cradle to grave 21st century healthcare with its advances in science and technology is impossible in the face of a changing world with Artificial Intelligence,

Machine Learning, Robotics, and an unimaginable and frankly horrifying job situation.

Though never implemented and remained as empty slogans, the two ‘thoughts’ that impressed me were: first, the Darzi and Nicholson review which started with quality (in holistic sense) being the organising principle for the NHS and second, Lansley’s “No Decision about me without me.” If only we had followed these up! I think these two thoughts should be on top of every board agenda and on every chief executive’s desk, the only reasons for the NHS.

CONCLUSIONS

Despite the ups and downs the one constant has been my deep interest in and commitment to the NHS, I have always reminded people that I chose to work in it (unlike most of my White contemporaries who were born and brought up here and naturally moved into it) and despite struggles with career progression I did not follow my peers from India and move to the USA – a market system that I abhorred – the option exercised by many of them. I persisted, though in the twilight of my life now I do sometimes wonder why.

A child whose birth brought so much joy 70 years ago is now old and frail and we must accept the responsibility for its current state and for its successor. The NHS needs a reincarnation as a 21st century fit for purpose institution. We owe it to ourselves and future generations to reverse the decline, learn from the past and move forward. But where is the new Nye Bevan?

I will be variously accused of being too negative, ungrateful and shroud waver and I accept that there are some elements of truth in these. I am also aware that I have been away from day-to-day NHS for the last few years and have limited specific knowledge, but what is clear from my various interactions is that nothing has changed – the search for holy grail goes on, quick fix artists are thriving, staff are demoralised, patients are suffering, and there is total denial of the problems or the political will to solve things and create a better society.

I have tried to give credit where credit is due and have continued to defend and promote the NHS at home and internationally, but at this time I have a negative overall assessment and am genuinely struggling to find a more balanced view.

I was very privileged to work in the NHS- even though due to serious discrimination I ended up changing careers – and did have a comfortable living. I remember a conversation with a CEO in India many years ago who noting the ‘usual’ state of unhappiness with the NHS (it is true that the NHS is unique in that most people whilst working in it are also its severest critics) asked me why and probed me on my earnings (almost in the top 1% of the earners), 32 days annual leave and 8 bank holidays plus study leave, and I could literally see his eyebrows going up! I benefitted from all these and was able to have a very comprehensive and rounded professional life. I am also the lucky one to have retired under old pension rules, and so have much to be thankful for.

I am shroud waving mainly because the last nails are being knocked in the coffin; you name it and that component of the NHS is broken – clinical services, education, regulation etc and mega private sector contracts are being awarded and not just for provision but also for commissioning – ACOs are going to get whole loads of public money, and the list goes on. Hospitals are expanding their private wings and we are staring at the pre-NHS Victorian era scenarios, and yet it is the ‘Emperors Clothes’ syndrome. My shroud waving is to inject some challenge and support the residue of activists and the few conviction politicians in the hope that we can pull back from the

brink. It is my way to pay back to the NHS – which gave me a good professional life – and to the British society.

Back to the drawing board, I am afraid but also excited at the potential given the high regard for the NHS, and considerable experience and knowledge – the NHS is truly a world leader, and I am proud to have been a part of it.

ACKNOWLEDGEMENTS

I reiterate my thanks to all those people who helped me on the journey – I have stood on the shoulders of giants – they are mentioned in my various writings already. I am prepared to be challenged on any aspect of my writing and if I have taken a particular slant then it is deliberate and to provoke debate; without discussion we cannot progress and I want to challenge the ‘Group Think.’ Of course, I do apologise if anything I have written causes offence, not meant to be personal.