Reflections on the state of the NHS:
In the last chance saloon

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I have written this book fundamentally as a study in harmonization of the Babel of views on man and on the human condition, in the belief that the time is ripe for a synthesis that covers the best thought in many fields, from the human sciences to religion. I have tried to avoid moving against and negating any point of view, no matter how personally antipathetic to me, if it seems to have in it a core of truthfulness. I have had the growing realization over the past few years that the problem of man's knowledge is not to oppose and to demolish opposing views, but to include them in a larger theoretical structure. One of the ironies of creative process is that it partly cripples itself in order to function. I mean that, usually, in order to turn out a piece of work the author has to exaggerate the emphasis of it, to oppose it in a forceful competitive way to other versions of truth; and he gets carried away by his own exaggeration, as his own distinctive image is built on it. But each honest thinker who is basically an empiricist has to have some truth in his position, no matter how extremely he has formulated it. The problem is to find the truth underneath the exaggeration, to cut away the excess elaboration or distortion and include that truth where it fits.

From The Denial of Death by Ernest Becker

Dedication

This paper is dedicated to all those working to provide health and social care in very challenging circumstances in the NHS; they have my thanks. It is also dedicated to all those who supported me during my time in the NHS; the paper is a thank you to them, and a way of repaying them by sharing my learning.

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Foreword

This passionate appeal to rescue the UK National Health Service (NHS) from its demise deserves to be read. The value of the NHS is probably only really understood by those who have experienced other health systems. Rajan came to the UK from India and has seen the alternatives there as well as through his exposure to systems elsewhere including in the USA. Rajan's passion reminds me of that of my father who came to the UK as a refugee from Austria in 1938. He had been establishing his medical practice there before events overtook him, and he was at the start of the NHS where he worked as a consultant chest physician. He used to say how wonderful it was to be able to offer diagnosis and treatment regardless of the cost to the patient, but dependent on the medical needs.

Of course, time has moved on, medical advances and the ageing of the population with the extra demands on the health system require us to place the needs of the individual patient in the context of the needs of the population. Rajan's clinical and public health perspectives allow him to reflect on that. His experience as a manager and proponent of evidence-based medicine allows him to make a clear identification of the problem, an exploration of the reasons for the problem, and offer an approach towards a solution.

I came to know Rajan as we each moved to Manchester, for me to take the Chair of Public Health and for Rajan to a senior NHS role. We worked together on a number of projects, and I saw how he identified ways in which service and academic roles could combine to serve the interests of the NHS. He was a tireless advocate for the NHS, and later completed the Jarrow March in 2014, and always looked for ways to improve things. He was awarded the prestigious Milroy Lectureship by the Royal College of Physicians, and prepared extensively for it. His message, however, was misinterpreted by the College who did not appreciate the importance of what he was trying to tell them. Rajan and I have continued to work together in global public health capacity building, where his passion for improving the health of populations has had a global as well as local reach.

He has achieved senior medical management positions, has been a member of the General Medical Council and held many other positions relevant to developing an understanding of the NHS. His interests have extended beyond a service role to include teaching and research – leading to honorary professorial appointments in a number of UK universities. Rajan has himself been the subject of discrimination and he describes his own career setbacks and disappointments, as well as many of the innovations which he fostered. He has used these experiences to develop a way of personal reflection that we could each emulate. Rajan's approach has sometimes ruffled feathers, especially when he would challenge assembled groups to go back to basic principles when they were in a rush to reach a conclusion. Those of us who have worked closely with Rajan appreciate his commitment and have been perturbed that his desire to improve and innovate can be seen as an unnecessary challenge to the status quo – which does not always win you friends.

All of Rajan's experience and expertise leads to this essay - a reflective, evidence based, passionate narrative. It is a call to action. I hope that it will play a part in leading to change that will allow the NHS to revive and achieve the goals for which its founders hoped.

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Summary

Providing good quality affordable health care is becoming more challenging and yet more necessary globally. We have (had) been relatively fortunate in the UK with the NHS but the last few decades have damaged it, and it is imperative that we take stock and explore what should be done to preserve what was once the envy of the world; at present it is a lose: lose situation all round.

There are no easy fixes for the NHS – it is broken and needs not more of the same but a new approach for organising and delivering fit for purpose 21st century health and care services. But it will not happen with more reports and inquiries, the society is divided and there is no grand vision or leadership, unlike the situation that brought the NHS into being. Currently there are no solutions, and neither are they possible since there is no agreement on, or a critical mass for, the fundamental principles that should govern the NHS that we need. So, we must first decide what we want in terms of health and social care and then help to create the organisation. It is not entirely in their control, but doctors are, and are seen as, important and trusted people by society, and hence they must get involved. They need to start the conversation, seek and encourage diverse views, and actively participate in developing a compelling vision for the NHS.

Note: The core of the paper was written in late 2022 and early 2023, and whilst I am aware of the recent developments and policy announcements, I do not believe they change the fundamental points in this paper. For example, the Workforce Strategy with promise of massive expansion in numbers fails to demonstrate how the proposal fits in with the scheme of things, and will solve the NHS problems, either now as it will take years to produce these clinicians or in the future. And Lib Dems have promised free care to all today as I finalised the paper for the first session of the NHS75 Conversations (23 Sep 2023). Leading up to the next election, there will be more of such headline catching announcements, and the sad fact is that none of these in isolation can fix the problems, and indeed will deepen them.

Introduction

This paper, although written from a doctor's perspective, is for everyone who is passionate about the NHS but knows that it is seriously ill. It is for those who do not know what the treatment is, yet, because there is no clarity or agreement on what is ailing it. It is for those who are open-minded enough and prepared to explore all possibilities and ensure not just its survival but an invigorated revival. And most importantly, it is for those who believe that it is their job to sort it out. It is definitely NOT for those who already know the answers – do not bother reading it if your mind is already made up.

I have very mixed emotions as I write this. I am angry with what is happening to the NHS – I used to be proud and now I am mainly sad and ashamed. I feel grateful to the people who are continuing to provide services despite all the challenges. I also feel cautiously hopeful that maybe the time has come for a change, after all things are pretty much rock bottom. But not to tempt fate and knowing that we cannot assume this as change won't just happen and we will have to push for it, I wanted to write this paper.

I know that the paper will fall short of some people's expectation since it is not detailed or comprehensive, neither is it academic in the sense of distillation of current literature. I have resisted the suggestion of publishing a 'proper' book simply because I would not even know where to begin on such a project. The subject is huge, each part – funding, organisation, regulation, services etc - merits a book of its own, and anyway what would be its purpose especially as there are already a number of these commenting on the NHS? My purpose is not to do a detailed analysis but is to provide some ideas to help achieve conceptual clarity and agreement on the way forward. It is a personal account based on lived experiences, largely professional as a medical manager and latterly personal from the other side as a patient and carer.

You cannot make decisions on parts of the jigsaw of the NHS – which is where it is going wrong as some parts work well but the whole fails. We need to first build the picture and then make the parts and ensure they fit together. It means going back to the fundamentals, reviewing and where necessary revising the basic premises, and which will provide the foundations on which to build the NHS for the 21st century. In my view this lack of conceptual clarity is why things are the way they are. It could, and would, be argued that there is implicit conceptual clarity by the disingenuous politicians supported by free market ideologues and their plan is to break the NHS up, and that then begs the question of whether that is acceptable to us or should/can we do something about it. Once past that stage will be the time for a definitive book, but we are not there yet, and it will be a collective effort. So, my main, and only, point is that currently we have no agreement on what we want from the NHS and hence on how to organise and deliver health and social care. We know, roughly, what we do not want but not enough about what we do want, in the current circumstances; in

doing so we should remember the quote attributed to Aristotle *"In framing an ideal we may assume what we wish, but should avoid impossibilities".*

The NHS needs a fresh start, and this paper is an attempt to explore the possibility of engineering the necessary discussion as a first step to fixing it. Currently, the discussion is polarised with strongly held views and we need to open our minds first.

The last part comes across as rather judgemental and arrogant and begs the question of why anyone should take any notice of what I am writing? Writing is my way of making sense, thinking aloud on paper, and what I am describing is how I see the NHS. But I am not the only one, there are others who have also thought deeply and written about the state of the NHS, so what will I say that is different and what are my credentials? Re former read on, and re latter I am not a 'pundit' or have any visible markers of distinction after all– so why should you bother with me? I do not think one should always ask for credentials, especially as many disasters have come from the so-called experts, and often solutions come from the unknowns, and by lateral thinking. Or in the words of Woodrow Wilson… "Every country is renewed out of the ranks of the unknown, not out of the ranks of the already famous and powerful in control". But for those still wanting it, you can read about me, and my work here – RaMa Reflections .

In any case, I request you to keep two things in mind as you read this paper:

1. These are one person's views, you may or may not agree with them, and we can both be right or wrong, and there is no need to fall out.
2. If anything I have written comes across as negative (in the sense of saying something hurtful for the sake of it) then please know that it is not intended. I acknowledge that a lot of good work goes on under increasingly difficult working conditions in the NHS.

Disagree with me, but then let me know why, so that I can learn and improve too: we tend to ignore this important principle of being a professional, we are responsible for each other's development and well-being and must learn together. We have stopped talking and listening to each other, and not just with the patients who are interrupted within 11-18 seconds of a consultation, we must do better. Disagreement is OK, but not talking (respectfully) is not OK; a lot is at stake and together we need to save the NHS.

The paper has been written from an English NHS perspective as that is the one I am most familiar with, but the issues may be relevant to other health systems. It is in four sections. Section One is a description of the way forward for the NHS. Section Two has some observations on the current state of the NHS to confirm that it is broken, even though the evidence is all around us. Section Three touches on two major essentials for a successful NHS. Finally, in Section Four I appeal to those who want a change with particular reference to doctors, not that they have the monopoly or that the NHS can be fixed by any one party. I am proud to be a doctor and believe that most of us want to do a good job but we have a problem. We have not

organised ourselves well enough to challenge and overcome those who are running it down; we can and must do better.

Section One: What do we need: *Fit for purpose 21st century NHS*

What is now proved was once only imagined - William Blake

I am not convinced that the NHS is the envy of the world or jewel in the crown and most treasured institution; the real NHS I see is very different. It is a challenge to get into the NHS as a patient with waiting times for every aspect and bit of a lottery whether one will get safe care, and staff are voting with their feet or becoming disillusioned with being ignored and disrespected. So, both the patients and the professionals are being let down. It is all very easy to critique but what is the answer then?

The answer to me is not money or more staff at present, though needed as short-term fixes, relying on them to make a broken system work is only compounding the problem. I have always been fascinated by the obsession with finances in the NHS, and the supreme power of finance directors - I used to 'annoy' them (actually apart from an occasional one, most of them were very good colleagues, but they had a public job to do as well) by pointing out that the 'currency' in the NHS is not money but clinical interactions, and we need to learn to better manage these; money management then is secondary.

The way forward to me is a fundamentally different approach to the NHS. There are no immediate answers. This exchange between Declan Walsh, writing in The Nine Lives of Pakistan, and a local (in Pakistan) perhaps sums up the problem we have: *….he (the local) threw up his hands in exasperation: 'That's the difference between us,' he said. 'you are always looking for answers. I have trouble with the questions.*' And that is the challenge before us - there are no answers, because we do not know the questions. So, that is where we need to start, and here are some of the important ones to my mind:

1. What is the purpose, and the scope, of the NHS? Is it about health and social care and/or wider public health? Currently the purpose is at best fudged, the H (Health) seems missing from the NHS and I (Illness) dominates; we keep paying lip service to prevention and public health but health care especially acute care trumps everything every single time. Let us get some clarity on this balance first; much as it hurts me to say, as a public health doctor, let the NHS focus on health and social care for now, especially as the wider public health agenda is a major socio-political issue and needs a fundamental rethink of society, and I am not touching on this issue in the paper. But the NHS can have a role in public health and especially on the prevention side and we should define this.
2. What is the 'nature' of the NHS? What exactly is the state's responsibility when it comes to health and social care? Is a fully state funded NHS the right model now, how should the money be raised, and what is the right amount for the NHS anyway. Our track record of managing resources is not good. In the

current period of austerity, it is easy to forget the feast we enjoyed (and squandered) for many years especially during the Blair era, and the amount of money (mis) spent during the pandemic is mind-boggling!

3. How should the NHS be organised, delivered and governed? There is no one NHS, it is a set of organisations behaving as separate kingdoms. Frank Dobson managed to get the Blue NHS logo to unite them and even that has now lost its currency as the NHS logo is being freely (mis) used. I am not talking about the next level of challenges across UK with devolved nations. My own view is that to think of the NHS in organisational terms alone is limited. At its core the NHS is about values and behaviours – the best of the British values brought it to life in 1948. It's all about people- by the people for the people; bricks and mortar and machines are secondary. But it does need a structure, and the question is what is the ideal configuration?
4. What about the 'wicked' issues, the elephants in the room and which will continue to haunt us unless addressed; here are some of the ones I struggled with during my time. One, the political interference with micromanagement from the Parliament – the dropped bed pan in the ward clanging in Whitehall means a constantly reactive policy-making leaving everyone bewildered and demotivated. Two, the health: social care and primary: secondary care separation and massive fragmentation now means that patients are truly stuffed as they get passed from one to another, seamless care is an unattainable goal. Three, the absence of clear limits to what the NHS offers: we remain unwilling to confront the inevitable issue of 'rationing' even though it is all pervasive and growing as post-pandemic the rush for private care has started because of long waiting lists. Can we define what care is essential – and must be available to all citizens, and what is extra? Four, the constant restructurings of the NHS to create the illusion of progress - I calculated that between 2001-10 when I was a board level medical director I wasted half my time on dealing with job changes and re-organisations, having to wind one organisation up and set another, transitioning staff and indeed ensuring own survival; my seventh major change was what led to my redundancy years ago, and it is not just loss of experience but also of values as each reorganisation is reinforcing the ideological grip whereby only those who can fit in survive. Five, the limited professional leadership - we cannot blame everyone else and must accept that doctors (and all professionals) also need to do more and put patients first – we need to bring back the vocational spirit.
5. Once established, what should be the operating principles for a successful NHS – the touchstones for every major decision in the NHS at all levels? Not sure what you will come up with but over the years two fundamental principles that have struck me as the most relevant (and so poorly followed) and need to be 'hard-wired' into the fabric of the NHS have been by Darzi and Nicholson, who said that Quality (patient safety, patient experience and cost-effectiveness) should be the organising principle and by Lansley who came up

with the phrase: No decision about me, without me (to empower patients). Are there any others? Can (and how can) we put the patients at the centre of planning and delivery of quality services?

The above is not a comprehensive list, and I have shared these to illustrate the challenges we need to overcome. The important thing is to create a scheme and then follow a systematic process for thinking about the NHS by posing and deciding on the fundamental issues. Only then will we get any clarity on how to organise, manage and deliver services. I am aware that it is not easy to answer these questions, and we will fall in the trap of the urgent driving out the important, but unless we have a consensus (or at least explicit clarity) on what sort of services we want, I personally do not see how the NHS can be saved. Critical to this is the need to get the NHS out of the election cycle (not that the fixed term parliament rule means anything). In a fit of despair, after too much political interference, I had once written about the need for the Secretary of State to "Not just do something but stand there"; the repeated re-organisations were taking a huge toll. A Hands-on approach by politicians from the Centre, who are obsessed with managing the news cycle, is a disaster. Trusting people and giving them time to sort out the system is essential - but sadly careers are made from crises. So, we are in a vicious downward spiral.

The battle currently is for hearts and minds since fixing the NHS is not a technical issue, and we need to draw on the experiences of movements that led to major societal changes. We are not there yet, we have outcries/grand standings and reports but neither a fresh, conciliatory approach by parties with entrenched views nor sustained effort. Indeed, it seems to me that on certain levels maintaining continuing strife is preferrable - both sides: the establishment and the activists 'enjoy' the struggle whilst both: grass roots workers and patients suffer. Jaw: jaw not war: war as Churchill said is the way- we need to stop fighting and start talking, respectfully.

So, we need to challenge the current ideology shaping the NHS. The undeniable fact is that the NHS is systematically being under-mined and destroyed, whilst giving the impression of saving it with sticking plasters and workarounds; in a Machiavellian way it is a very clever approach by the ideologues in cahoots with a tiny minority of profiteers. But it does not serve the profession and the public well.

I am concerned about some of recent reports (here, here and here) on the future of the NHS. These are partly ideological and partly more of the same but neither stance is appropriate in my view, and the absence of a comprehensive review addressing the issues I have pointed out above will continue to hamper any progress leaving both professionals and patients dis-satisfied. There is talk of integration again, making GPs salaried, or introducing patient charges etc, but none of these things in isolation will solve the problems of the NHS - it is all interconnected, changing one part affects others and the only way is to look at the whole picture. We need to start with reviewing our fundamental premises- are they still relevant? We can learn from the past, but must take note of present circumstances and plan for the uncertain

future – which means a completely new start. Nobody can predict the future fully, but we can be alert to as yet unknown developments and deal with them through an ongoing review process. In any case we must know what is Enough – how much healthcare, and hence funding, is right. After a certain amount, health and funding are inversely related.

"*The fool reasons incorrectly on correct premises, while a madman reasons correctly on absurd premises"* said John Locke, seemingly. I will let you decide which category I fit in. But my point is that there are underlying fundamental issues and unless we resolve them, we will keep struggling with the NHS. We have to discuss, compromise, and imagine. I have been a believer in the paradigm of And not Or (page 157); as human beings we want cost and (not or) quality, good and (not or) quick for example and so with the NHS we should have doctors and nurses, doctors and managers, prevention and care etc.

I am sure there are ways to improve on what I have outlined but any detail does not take away the central point that we need a framework to do the thinking about the NHS for the future. The system will deliver what it is designed (implicitly or explicitly) for – and we will have to live with the consequences. Currently, what it is delivering is failing everyone, and I use some examples in the next section to show how broken the NHS is.

Section Two: Why do we need to do this: *The broken NHS*

"Fuck the future, let it look after itself, it's not my responsibility. Fuck the management, and fuck the government and fuck the pathetic politicians and their fiddled expenses and fuck the fucking civil servants in the fucking Department of Health. Fuck everybody" writes Henry Marsh in his Do No Harm bestseller book.

How did we reduce one of the most respected clinicians to this state (Declaration: I am on the Clinical Advisory Group of My Death My Decision Campaign, of which he is a Patron). His comments and frustration may have been a situational reaction – given his concern that time about training, but they are also emblematic of the state of the NHS, and representative of the views of many doctors. I certainly echo his sentiments, and have really struggled throughout the pandemic with the political leadership.

In this section, I want to share some personal observations about how badly broken the NHS is. Some would question whether it is necessary at all since the evidence is all around us: horrendous waiting lists, long waits for life saving ambulances, choked A & E department, wards full of patients who cannot go home since there is no community support available, burnt-out staff with strikes everywhere and patient safety a lottery, and so on. My point is not to deny these but to explore why they are only part of the story. To pre-empt my critics, I will not be providing detailed and systematic data for the examples, and neither will I cover all aspects of the NHS, because I am not qualified to write about some of these and because each will require many PhD type theses of its own. More importantly my submission is that it is not lack of evidence and data which is impeding progress.

'So you think our medicine's pretty primitive?'

'That's the wrong word. It isn't primitive. It is fifty percent terrific and fifty percent non-existent. Marvellous antibiotics- but absolutely no methods for increasing resistance, so that antibiotics won't be necessary. Fantastic operations – but when it comes to teaching people the way of going through life without having to be chopped up, absolutely nothing. And it's the same all along the line. Alpha Plus for patching up when you have started to fall apart; but Delta Minus for keeping you healthy. Apart from sewage systems and synthetic vitamins, you don't seem to do anything at all about prevention. And yet you have a proverb: prevention is better than cure.'

And the dialogue goes on.

The above extract is from the book: Island by Aldous Huxley published in 1962. I have always been an eclectic reader and more so lately as I try and find meaning, and resilience, and thought it apt since it reflects the current situation where medicine is fifty percent terrific and fifty percent non-existent. That is not, however, what the architects of the NHS set out to do, they dreamt of an NHS which was there from cradle to grave and would provide free best quality care to all based on need, and by keeping people healthy there would not be much demand for its services. Sadly, the cradle in the light of many maternity scandals and grave with the poor

care for the elderly (and certainly during the pandemic, when the NHS sent many of them to their graves with the government policy of discharging the elderly to nursing homes) ambitions seem misplaced, the principle of ‘free care’ had to be abandoned almost immediately after its establishment: the legislation needed for the introduction of health charges was passed in 1949 for prescriptions and 1951 for dental and ophthalmic services, and the trend has continued with restrictions and increasing use of private sector; and despite continuing talk of prevention and public health there has never been any serious effort to tackle the fundamental structural problems causing health inequalities, and the demand for care keeps growing.

A dream gone sour, and since then it has been a case of muddling through with a plethora of initiatives, sticky plasters, and constant structural changes. More recently, new organisational arrangements have been put in place in England with the establishment of Integrated Care Boards to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money and
- help the NHS support broader social and economic development.

I do not want to be too cynical and may be the ICBs will do what has defeated the NHS so far, but they will need to move quickly and sort out our immediate problems to get the trust and confidence of people first. At present, there are limited signs of the necessary cultural change and every time some problem is highlighted in media, the Department of Health ‘Spokesperson’ pipes up with banal statements and exaggerated claims: delayed discharges or mental health issues we have put money, shortage of nurses we have recruited and so on, and lately even this patina has been dropped and the policymakers have turned to ‘attacks’ on healthcare workers by blaming them for the shortcomings.

Take any major element of the NHS and you can see how bad things are. I will touch on three key aspects briefly which apply to all health and social care: patient safety since that is at the core of what NHS should be about; worker safety without which there cannot be former, and racial discrimination as an example of equality and fairness, which should be at the heart of the NHS. I won’t refer to public health, important though that is, as the evidence of failure with wide inequalities is everywhere now. Prevention and anticipatory care are beyond the ability of the NHS currently, all it is providing is episodic care, on demand, of questionable quality, apart from very few organised services like cancer care.

Example One: Patient safety

Here is what Bill Kirkup wrote in his latest inquiry on maternity and neonatal services in East Kent:

The primary reason for this Report is to set out the truth of what happened, for their sake, and so that maternity services in East Kent can begin to meet the standards expected nationally, for the sake of those to come. But this alone is not enough.

It is too late to pretend that this is just another one-off, isolated failure, a freak event that "will never happen again". Since the report of the Morecambe Bay Investigation in 2015, maternity services have been the subject of more significant policy initiatives than any other service. Yet, since then, there have been major service failures in Shrewsbury and Telford, in East Kent, and (it seems) in Nottingham. If we do not begin to tackle this differently, there will be more.

For that reason, this Report is somewhat different to the usual when it comes to recommendations. I have not sought to identify detailed changes of policy directed at specific areas of either practice or management. I do not think that making policy on the basis of extreme examples is necessarily the best approach; nor are those who carry out investigations necessarily the best to do it. More significantly, this approach has been tried by almost every investigation in the five decades since the Inquiry into Ely Hospital, Cardiff, in 1967–69, and it does not work. At least, it does not work in preventing the recurrence of remarkably similar sets of problems in other places.

There has been a familiar pattern following a major failure of a service in the NHS, usually after attempts to keep it quiet for some time even when the problems were well known locally, and then much hand wringing, grovelling and firings, setting up of a high-powered inquiry, with promises of learning for the wider NHS and cries of never again. Only for the scenario to repeat elsewhere, and soon after. A bit like that seaside parlour's game of whack a mole. So, well done to Bill Kirkup.

Of course, we can point to some good examples and fall back on the usual reasons that the NHS is a big organisation/ship that will take time to turn around, there is not enough money, lessons have been learnt and new teams appointed etc. But can, and should, we wait until the ship turns around or more money becomes available – are any of these reasons valid and acceptable? By the way medical errors became the third leading cause of death in USA in 2016- from being 8th in 1999, whilst health care costs spiralled. How many more patients need to die, unnecessarily? We are failing children, the elderly, women (and men), people with mental health and learning difficulties, and so on. The current approach is a triumph of hope over evidence.

Have all the initiatives and resources in this 'huge' industry of quality and safety made much (any) difference, and could/should these be directed in a different way? I will focus only on one aspect of this overall puzzle, and that is that we do not own patient safety personally – we have not internalised it enough, it is somebody else's problem to fix things, and hence we end up relying on regulation which is a failure.

The regulatory system in the NHS is not fit for purpose and never will be without significant changes; there are too many regulators, and no one is in overall charge. At the national level the separation of system- e.g. Care Quality Commission (CQC) vs professional - regulators, e.g. General Medical Council (GMC), and locally

between NHS and social care makes it impossible to look at the whole patient journey. My job as a medical director in a commissioning body was impossible as all national regulators bypassed (paid lip-service to) me. One of the provider medical director told me (not quite like Marsh, but close) in 2006 of 62 (I think that is the number he told me, but anyway, there are many) different regulatory demands on his trust, and I as the commissioner of services and the body ultimately responsible, in theory, for the services paid for by it, was not important enough! In my last official position, I tried to find a way to address his challenge and set out to show how commissioners could work with providers to promote patient safety. My co-author and I shared our paper with Robert Francis who was writing his report following Mid-Staffs at the time; to be fair he commended it but was not convinced that it could/would be adopted, he had little faith in commissioners. Similarly, frustrated with Safeguarding for children and adults, with split responsibility between local authorities and the NHS, we tried to promote inter-organisational governance to create a system to oversee the whole patient journey; I had even put myself forward as the overall area/system lead for patient safety, closely working with medical directors, directors of social services and coroners for example, in one last ditch attempt.

I have been out of active practice for some time, but I do not get the sense that things have changed much, and certainly not for the better. If this situation is not a reason for rethinking our approach to regulation, then what will it take to convince us? In my view national direction and local execution with the right amount of self- and external - regulation, with professional and system regulators working together must be the way. The mindset is all wrong in the NHS; there is no trust, rather mistrust is rife, the system is adversarial and not a learning one, and too much is wasted on checking and re-checking. I do not condone certain actions - some things are so bad that we must do everything to prevent them and sanction those who do them, but it is wasteful to have the same approach for everyone and anything gone wrong. Zero tolerance must be balanced with proportionality.

Could we make a start with a few things as follows? Does anyone know how many people are employed as inspectors – forming delegations to visit hospitals etc as part of external regulation? How about if we stopped inspections for some time and the inspectors all stayed in their own organisations and focussed on applying the learning there, and on clinical work - as many are clinicians - to address waiting times? Not to mention the direct and indirect costs of this huge bureaucracy? Should we reconsider investigations of critical incidents? I used to peer-review all major clinical untoward incidents with a fellow trust medical director (not the same as the above one!), and after two years had to plead that we stop these - I saw increasingly sophisticated reports but the same lessons in each; the usual mistakes of not being respectful to patients/carers, not communicating, ignoring early warning signs, poor hand-writing, inadequate hand-overs, fraught team relationships, inadequate supervision etc, and asked for a moratorium on investigations till all these lessons had been fully implemented across the trust. I was laughed out when I raised the

issue of temporarily stopping all investigations at a national meeting of the then National Patient Safety Agency, and suggested that we use the resources spent on investigations to implement the lessons learnt; you will have to try very hard to convince me that the NHS is a learning organisation. A more senior non-executive director (declaration: not at the trust where I am a non-executive director) told me of her despair at the Patient stories which open every board meeting – these had become mechanistic and repetitive. Having promoted the concept of Never Events – I had worked with the then National Patient Safety Agency to launch them in Manchester, I had later talked about Ever Events – things that should be done everywhere, every time. I think there is enough knowledge from last few years of experience to mandate these – why do we tolerate post code lottery of best practice, we need to universalise these. How about every patient story that comes to the Board has a narrative on why it could not have been prevented, especially if the underlying causes were well known ones, and indeed how the positive elements can be rolled out more widely. To use that much used American import; let us double down on making sure that we do what we already know and should be done.

Example Two: Worker safety

When it comes to patient safety, we need to look after the workers; these are two sides of the same coin, safer patients need safer staff and vice-versa. In another (I am prone to these) fit of frustration at ignoring the obvious and coming up with more and complex solutions I had written to the then incoming Chief Executive of the NHS, Simon Stevens, on this topic; I reminded him of the Paul O'Neil story from USA and how his relentless focus on worker safety turned Aluminium Corporation of America around.

As I worked with the General Medical Council (as a Council/Board member), with the British Association of Physicians of Indian Origin (BAPIO - as Chairman and ran their Medical Defence Shield organisation set up to support doctors in difficulty), and with my day job as a medical director I saw first - hand how we dealt with doctors in difficulty. These widely differing perspectives gave me a rounded view of the situation and made me realise that there was a long way to go before we can guarantee safe working environments for doctors (and having spoken to other professionals, all clinicians), and that our disciplinary systems were broken, not to talk of wholly inadequate support systems. None of the clinicians work in isolation, they are part of the team which work in units (hospitals/practices etc) which work in regions and report to national bodies; how the whole system works determines how the individual performs, and hence the obsession and relentless focus on the individual with little regard to what happens elsewhere does not make sense. All professional regulators work independently when the whole health care model is team based now a days and the professional and system regulators do not talk to each other! Most importantly, based on adversarial principle there was no hope of having a fair/transparent disciplinary process and engender confidence; the heart-

breaking stories of whistle-blowers while the perpetrators went unpunished are enough to radicalise anyone. Having thought a lot about these challenges and recognising that the necessary change will take a lot of effort and it was important to do something specific to help start the process, I decided to focus on suicides by clinicians undergoing disciplinary proceedings as the nub of the issue. As an aside I also went and trained to become a mediator.

Like most of us involved in patient safety I had been taught about the related science and principles and especially from the aviation sector, which was seen as an exemplar, and yet we had not adopted the most basic of its strategy to ensure safety. Detailed investigations of air accidents were what helped to make it the safest mode of transport over the years. So, why not do the same in health care- a detailed and independent investigation of each suicide – and being mindful that NHS workers can take their own lives for various reasons, these could be limited to those cases where the clinician was under investigation, given widely held views that disciplinary processes are unfair and stressful. We also did detailed work on what should be done and explored a potential alliance of all professional regulators, since the issue was not limited to doctors. And that is all I will say on this matter, since like with many other of my ideas it never took off, and we had another report from the GMC in 2022.

My views on GMC have been shared before (page 277) and this is what Esmail and Everington had to say recently:

The General Medical Council has made dealing with criticism into a performative masterclass. It has honed several strategies: deny that there is a problem, cite the lack of evidence, commission research that often produces predictable answers to banal questions, and produce an endless series of reports so that it can wring its hands in false contrition and promise that change will come.

There is something fundamentally wrong with an organisation which treats those who matter the most as poorly as the NHS does. Should we not be addressing this as a matter of urgency? Of course, NHS workers are no different to most workers who are all struggling given the state of the world with rising costs of living, and it seems the whole society is broken. I was pleased to be a part of the Clinical Leaders Network (CLN) work on enhancing mental health resilience during the pandemic, to ensure that health care workers were supported given the enormous stress they were under. But I do not see much sign of change now that the pandemic is over (as far as the policymakers are concerned).

Whilst waiting for the Big Bang change, we can start with some things; I do not know what you will come up with but top of my list would be cutting down drastically the bureaucratic burden on staff, stopping some of the so-called mandatory training, reviewing Revalidation (Declaration: I was on the GMC UK Revalidation Board when it was being introduced, and other professionals have started this too), checking the growing CPD industry including by the professional bodies with increasing hoops and fees for accreditation, ensuring decent occupational health services, and

expediting disciplinary inquiries and having a more fit for purpose approach with support for whistle-blowers; rather than the first port of call, the national regulator should be the last resort, local first should be the principle…… and let us be kind to and look after each other.

Example Three: Racial discrimination

If there is one issue which exemplifies the failure of the approach to sorting out the big issues in our society, then look at equality and diversity, and in particular racial discrimination.

Let me start with a few declarations: one, as an overseas doctor in the NHS I have experienced it; two, I have tried to address it in various ways; three, I believe it is a sad indictment of the society and a tragedy for the NHS; four, the current solutions are not working and something different is needed; and finally, my comments are limited to discrimination against staff, not patients in the NHS or general societal concerns about race.

I am not qualified to speak from an expert/academic perspective and my experience and views are limited to the NHS, but I submit that what I have to say is relevant generally; my views, from a few years ago, can be seen here and more recent examples here, and here for example.

I tried both, stick and carrot- with BAPIO we went to the court to fight discrimination in the Royal College of General Practitioners examination system, and I worked with a range of partners including the GMC where I was a Council member for some time and the Clinical Leaders Network where we tried to create the Race Equality Action Leadership (REAL) project for all health care professionals, not just doctors. Since then I have seen further deteriorations in race relationships generally and in the NHS and have become disillusioned with the current approaches to tackling it. I had resigned from the Workforce Race Equality Standard (WRES) Steering group in England as I could not see how that would help.

Whilst not denying the problem - frankly racial discrimination is a shameful blot on our society - I am less and less convinced with the current approaches to tackling it.

Here are the kind of things that concern me.

One, the terminology and groupings and labelling of specific ethnic communities – it was White vs Non-white and then BME which became BAME and more recently South Asian, for example, and all these promote Otherness just as continuing discussion about Institutional Racism ignores that the NHS (and many other institutions) is just not person centric (one could substitute race with any other protected characteristic like gender or sexual orientation and find that the NHS ‘fails’ on these as well). The reality is that the NHS is not an organisation, it is a group of separate organisations, some good others not so. To me the NHS is a set of values, and which attracts a certain type of people but sadly some of these values have

been lost now. The more recent use of People of Colour term just flummoxes me - so some of us are now colourless? Values, which are lacking, are not the monopoly of any particular colour.

Two, the repetition of the old struggles/stories which is keeping the wounds raw – we have seen how the divide is in danger of getting wider when the English footballers were rebuked for gesture politics by senior politicians or the saga with the Late Queen's Lady in Waiting, Lady Susan Hussey and Ngozi Fulani, not to mention Prince Harry and Meghan case, as the SoMe fuels and hardens prejudices (as an aside, it is the most unsocial media, and I do not use it!). And this hardened attitude is getting passed on from generation to generation, with lowering of tolerance. When I hear stories of mistreatment such as the use of a nickname or the childish torment by calling Anwar John – told by second/third generation BAME professionals recounting stories about their parents/grandparents, I feel depressed. I am not condoning anything, simply pointing out the process of growing up with bullies/tormentors who are everywhere and at all ages; we all called others (and in turn got called) names in schools (I did, and I was four-eyed). If only that was the worst thing that happened. I remember collecting the different way people used (and still do) to spell my surname in my early years in the UK including Madhog, Maddog, Haddock, and even now as soon as I am introduced, I am greeted with "nice to meet you Raj (an) (*sic*)". Yes, Esmail and Everington did a very useful and timely piece of research to show bias in selection in medicine based on 'foreign' names but that is hardly the case now; there are a large number of BAME doctors in top positions.

Three, our current approaches especially seeing the issue as a problem of proportional representation is itself the problem - a 'BAME' person in the leadership position is not enough and sadly sometimes when they are there it is due to their race, or they come up against resistance and many 'turn natives'. I object to being seen as the BAME representative; I am not even able to represent 'Indians' - my geographical roots, as there are many Indias with South and North Indians being different, or 'Punjabis'- my cultural roots since Punjab got partitioned and India and Pakistan are 'enemies', so am I for Pakistani or Indian Punjabis; not to mention the rest of the BAME world. If only representation was the solution, we would not have the problems in UK; just look at the ruling political party. Hands up anyone who believes that with Sunak as PM good times are coming - the final ceiling has been broken - and race equality will be a thing of the past. Indeed, one could look at a number of professional bodies where there have been 'BAME' leaders at the top and yet the challenges remain. It is not the person, but the system and it is not institutional racism, it is immoral institutions - with the powerful oppressing the powerless. The Black on Black or Black on White discrimination is a taboo subject.

Fourth, as with safety, reliance on mechanisms like inspection and regulation through bodies like CQC or the GMC is misplaced; they have not risen to the task and are not fit for purpose of addressing racial discrimination.

And I could go on, but my only point is that 'It' is not working and continuing as we are is a triumph of hope over evidence. We need to do something different.

However, meaningful discourse in the current environment with the SoMe cacophony is becoming challenging and the situation is being manipulated. Yet, unless we, as society, find some common ground it is hard to see how to move forward. It is difficult to keep track of reports on racial discrimination, I struggle with them and most recently with Critical Race Theory, as none of them on their own can solve the problem. The reports point out the problems and the government does not give a damn, and the society keeps getting more confused and polarised and the majority stop engaging. I can see good parts to many of the reports including the Sewell report which was roundly criticised.

So where do we go? My view is that we need to create a new narrative starting with clarity on what it is that we want; I am not sure anyone can define what is the right outcome - can anyone describe a society without racial discrimination, leave aside how to engineer it? Frankly, the answer is not in vertical programmes - race/gender etc but in systemic improvements to promote humanistic values and creating person-centric processes which respect each one as an individual. We should not get bogged down in academic debates about virtue ethics or the deeper philosophical aspects and let us start afresh including with a new language and terminology and building on what we agree with. What is happening, however, is that there is no comprehensive overview - just specific initiatives, often driven by vested interests who use race (all protected characteristics) as 'Vote Banks', whilst the issue can only be understood, and solved, as a whole, not in bits. There seems to be an impatience as well as the prevailing mood that 'Something' must be done - people are (rightly?) angry and hence not able to step back. I, on the other hand, feel that maybe Doing Nothing or Less for a while is necessary. We are being 'used', so stop stoking the fire and spreading hatred - I feel like those placard carrying guys on the high street: spread the love.

In summary, I have used three example to highlight the broken NHS, and whatever else happens, these three priorities will remain; we have to make patients and staff safe, and we need to be fair to everyone. Do any of the proposed solutions currently address these fundamental problems, and in any case is there any report that does so? If we are not doing these things then what is the point of the NHS?

Section Three: What will help: *The underlying essentials*

There are many reasons why the NHS is the way it is, and to most experts the answers are plain - of course it is the lack of money, not enough infrastructure including hospital and social care beds or shortage of staff etc. I agree with them, up to a point. Because even if we had all these, we would still fail to do the best for the patients, because money and staff will never be enough to make a broken system work, and whilst the need for health care may be limited, the demands are limitless especially with ever changing scientific and socio-political-economic context. I have worked during both, austerity and abundant, regimens in the NHS - the situation when John Major took over in early 1990s was dire, we had very little money in the health service and frankly some of my best work was done then. Tony Blair came and changed the rules, and money was no problem; although he started well and made some real difference the waste started soon after since the underlying problems (page 215) were left untouched. His 'worst' legacy was the creation of a cadre of managers who saw money as the solution to all the problems, and over the years we lost the prudent mindset, and which has challenged us in the last decade of austerity. I sympathise with those asking for more money, and which is sorely needed, but there is no way to ensure it is well used and not diverted into ill thought-out initiatives, mindless privatisation, and endless bureaucracy at present. The waste that happened during the pandemic is tragic - and that is why I feel for the striking workers who are being denied basic pay whilst billions have been siphoned off the state funds. I also struggle to make sense of the workforce shortages overall, I have seen hospital departments that had 3 consultants and a handful of support staff burgeon to over twenty consultants and plethora of other grades, for example, in last twenty years, yet the patient experience and staff satisfaction is lower.

Where and why have we gone wrong? Re the first, as Craig Barrett pointed out in his excellent article about the Museum of NHS failures (also see my note under Readers' comments) the failures are too numerous and recurring, sadly. At its heart the main reason is political expediency and interference of course, but I suggest that we need to look further, and I share two things crucial to proper functioning of the NHS, which in my experience have contributed significantly. These two essentials will complement, nay are crucial to, both now and in any future redesign of the NHS; eventually we need an 'agile' NHS that moves with the times and is well led.

Essential One: Innovation

The first reason why the NHS is broken is because it is slow to change is the constant refrain. Since Tony Blair modernisation has become the mantra; the answer to the NHS problems is innovation, and there have been numerous reviews and initiatives from the Centre. Afterall, the NHS has a long and proud track record of

innovation stretching back across its 63-year history as the report said in 2012, but then it went on to add:

However, whilst the NHS is recognised as a world leader at invention the spread of those inventions within the NHS has often been too slow, and sometimes even the best of them fail to achieve widespread use.

Unless innovations spread beyond pockets of excellence and into everyday practice, the NHS will struggle to produce the improvements in quality and productivity it requires. Therefore the focus of the review, and this report, is on adoption and diffusion rather than invention.

This was followed a few years later by another report, this time from The Nuffield Trust:

The idea that we have a small number of nationally accredited innovations (i.e. the Innovation and Technology Tariff) that we add to, feeds into the (supply-side) narrative and the simplistic change model. It pretends there is a change model that requires a national body to pull a lever to facilitate innovation, which is wrong. The transactional model is broken in this complex innovation space.

It was, I think, 2011 or thereabouts, and I was chairing the Northwest Conference of the three HIEC's (Health Innovation and Education Clusters – another great idea, long dead, nothing is forever in the NHS in one sense, and in another these things keep coming back under new labels) when the prize for innovation went to a nurse from down south for establishing a nurse-led back pain clinic. I had mixed feeling about this award. I had worked with colleagues to set up such a clinic in Middlesbrough in 1993 and replicated it later in Tyneside a few years later (You can read more -page 148), and felt aggrieved that we were still talking about it in 2011. But on the other hand, I knew what it would have taken for them to set it up – introducing 'disruptive' models is very hard in the NHS, so the nurse and her colleagues must have struggled, and I was happy to note that they had stood up to the pressures and created the model.

I was a supporter of the NICE when it was set up and worked hard in my early jobs to ensure that we aligned our policies and processes with its guidance. It did not need much to convince me, since before it was set up, I had become a part of the Cochrane Collaboration (where I was involved with its Musculo-skeletal Injuries Group including as the Coordinating Editor for some time), and also developed the Specialty Management Approach (page 41) to ensure that all disparate initiatives were harnessed in a systematic manner locally (page 21) . This was an attempt to look at the whole pathway, using all available sources of evidence of effectiveness and methods of efficiencies including business process engineering systematically to organise and deliver the service. The proof of concept worked but it was not easy (impossible) to replicate it, so the help from NICE was very welcome. However, soon after its establishment it became apparent (to me) that NICE was in danger of doing too much too fast – the NHS was not ready to absorb so much change, and I made a

plea to complement NICE with LICE (Local Institutes of Clinical Excellence) (page 125), the danger of trying to control things centrally was evident but not mitigated.

More recently I had to keep quiet when discussions were going on about elective surgical centres or HVLC (High Volume Low Complexity) procedures, in other words Day Surgery. The excited looks on the faces of clinicians and managers who were presenting their successful developments stopped me from being the party pooper. What if they are thirty years late (page 19 for example for day surgery) – still, better late than never. Sad none the less; it is like Ground Hog Day as each generation learns the lessons again, and again. It does not have to be that way; just imagine the amount of health gain lost to patients who could have benefitted, or the money wasted by not being efficient.

There is a tendency to think of innovation only in terms of technological developments, apart from drugs and diagnostic breakthroughs, the most visible example when the NHS thinks of innovation is IT (and now AI). As if the 'tool' itself will solve it all; I have been around the IT revolution since the National Programme for IT (NPfIT) in early 2000s and indeed worked with the private sector for a while (which got me into Private Eye, another story) to explore how to accelerate the development of electronic patient record, and over twenty years later, this still eludes us.

We don't develop either the Thought Innovation or Process Innovation, and I am intrigued by the latest 'fad' of setting up 'innovation labs'. We ignore the whole system approach to change management and forget the saying that IT is 10%, and humans are 90% of the solution. I made the points about innovation and workforce development when I gave evidence to the select committee. Rather than talk about innovation we should be fixing the system to enable creativity and innovation to flow first. I am sad that we are not able to sustain some of the innovative practices that were adopted during the pandemic; my attempts to find out more in terms of how people coped and provided care in extremely challenging situation to ensure that lessons are learnt, and these changes embedded in routine practice to sustain them have had limited impact. We do not need any national inquiry for this - if we were really innovative and learning organisations and people; we would be doing this as a matter of course. Even simple things like observing basic hand hygiene are going by the wayside (confession: I do not shake hands or touch people anymore especially in public not just because of corona, as there are other germs also, so why spread them, and there are other ways to show respect). Important though vaccines maybe they are not enough against the wily corona, and that is only one germ, for example.

We need innovation to tackle the underlying fundamental problems, not just in science but in how we, professionals, public and policymakers work and interact. We failed to continually review and renew the NHS with the changing context over the years and hence the current dire situation. We are also not good at delivering innovation where it matters most, at the clinical interface to provide the best patient experience. Overall, the NHS is incapable of adopting, sustaining, and spreading innovation, there is no in-built continuous quality improvement system.

Essential Two: Leadership

The reason why we do not change is because we do not have good leaders, so enter the leadership industry, with the current situation being where I cannot turn around without bumping into a leader of some sort. I will only focus on medical leadership, again noting that there are professional managers and other professional groups too.

My journey with leadership (not that the word itself existed in the NHS lexicon then) started after I became a consultant in public health in 1991 in the then South Tees Health Authority. Before I took up the post, I went on a sabbatical to the Mayo Clinic in USA and used to visit it regularly subsequently. In early 2000s I had an interesting exchange with the then Chief Executive Officer (Dr Michael Wood) who told me of the various UK delegations who were making visits to the Clinic to learn the reasons for its success with a view to emulating it in the NHS. He commented that he wished he knew the 'secret sauce' as he could then 'bottle' it and make millions from its sale! The Clinic 'happened' when the original founder Dr William Worrall Mayo (by the way he was born in Eccles, Salford where I used to live) who happened to be in Rochester at the time of the tornado in 1883, got asked to help by the local nuns, and then due to the long and hard work of his sons, William and Charles, with two close associates – Plummer and Hawick over the next few decades. Their leadership and usual ingredients of right time, right person, teamwork, and sustained effort over prolonged period were the reasons behind the success of the Clinic.

Over the years whenever I reflected on the NHS, I used to visit this exchange and more recently tried to distil Mayo Clinic's secret sauce, and for what it is worth this is how I saw their journey to the world's best heath care system. At heart it was 'common sense' and 'desire to do good', unencumbered by jargon/management theories, and by keeping things simple. I do not think there was any mission statement or a detailed description of values or plan to create the 'Culture' – these emerged through delivering what was needed by both: patients and staff. The Mayo brothers had three aims at the start of their journey:

a. Continuing pursuit of the ideal of service and not profit
b. Continuing primary and sincere concern for the care and welfare of each individual patient
c. Continuing interest by every member of the staff in the professional progress of every other member

They also recognised that patient centric care requires integration of clinical services, teaching, and research and which is enshrined in the three shields in the Mayo logo. So far so good, but what really made it possible was team working by the Mayo brothers, and Dr Henry Plummer, the world pioneer in systems design and Harry Harwick, the first administrator (not a manager or executive!).

Together they helped to create their Operating model which has stood the test of time, at its core there are three Operating Principles:

1. The establishment of robust systems and processes for the governance and management of all activities with oversight by doctors –design
2. The attention to detail with clear project plans, performance reviews and management – execution
3. The appointment of the 'right' staff who accept and can flourish with the above – people

Of course, the Mayo Clinic has grown from the original set up in Rochester, Minnesota and is now a network in the USA and has also spread internationally including with a centre in London, and I am not up to date on how it works now though the Clinic enjoys continuing high ranking.

Over the years I travelled to a lot of centres of excellence in USA, and one of my 'favourite' examples was (since I do not know how things are now) the way Veterans Health Administration (VHA) system was transformed to Veterans Integrated Service Network (VISN) – this was the closest to the NHS in terms of scale and the 'political' challenges, But someone rose to the challenge – I was privileged to meet the architect of the reforms, Ken Kizer, and learnt a lot from his experience of steering the changes through; I recommend reading the article. I also learnt a lot from the health systems in India, especially the voluntary systems, and facilitated visits by UK delegation to some of these. My mention of these two countries: USA and India does not mean that I do not respect other health systems; I am aware of the good work in many places globally, through my other associations. I particularly recommend a reading of Che Guevara's speech on revolutionary Medicine which provided the foundations of a very strong health system in Cuba. The important point is to travel within, into yourself, to learn rather than travel without – outside - since the lessons do not differ, and it is not the theory but practice; the basics are clear, what is missing is action which comes from within.

Almost everyone in a senior managerial position has been to a 'jaunt' overseas to discover the secret sauce, and often to the USA, but did they learn the basics, and more importantly is anyone practising these in their true spirit, and can they? What I took away from my learning was that it is not about spreadsheets, ROIs, performance management – rather it is about clarity of goals and principles that will guide the journey, creating the team to cope with ups and downs, and sheer hard work and persistence. Do today's job well, keep at it and grow organically. An impossibility in the NHS where suspicion/blame is rife, and senior executives hardly stick around. You can read more about my views on leadership and management and the NHS here (page 259)

There is plenty of literature on the durability of organisations- here is just one example How Winning Organizations Last 100 Years (hbr.org), How does the NHS compare?

And now we have a leadership industry, with everyone being urged to become a leader with a plethora of courses. Then there cannot be just medical leaders, so there must be similar ones for each professional group in the NHS, and for each

subject area and at every level. For example, there is a national Czar for each topic now, we have learnt nothing from research about vertical programmes and are using the model uncritically.

Has anybody stood back and worked out the costs of this so-called leadership especially in terms of lost clinical time, and more importantly defined what is at the heart of leadership. Not sure about you but to me leadership is about these essential qualities:

1. knowing yourself – everything will always come down to knowing your values, strengths, weaknesses and most importantly having insight; do not ever fool yourself;
2. following your passion – be very clear what you believe in, my life mantra has been Do good, Have fun and Make (decent) money; and be flexible in terms of methods to use to stay true to your passion;
3. doing your best at whatever stage of life you are at – student, practitioner, child, parent, friend, whichever role you are in at that time do it well, live in the moment, and if it does not feel good then ask why and change;
4. stepping up if there is a problem and doing the best you can – do not wait for permission when things are going wrong, get involved, and take the lead if necessary or defer to someone who is leading 'better', nothing like being a good follower;
5. checking if you are being kind to others – do not complain and always respect others, apart from a few truly evil people, most are trying their best;
6. constantly learning – read widely, remain curious, meet different people, travel, and all with an open mind, not to reinforce existing views - the biggest problem these days especially with SoMe, cut down time on it;
7. finally looking after yourself – most important, if you do not self-care you are doomed, both physically and mentally; do not take things too seriously and laugh daily and often.

There is nothing else (*sic)* in books or courses; in different ways they will come down to these basics. But do let me know if I have missed anything!

When I look back on my introduction to NHS management, it was years before leadership and management became fashionable, it was not that there were no leaders or good managers – except that they did not know that that is what they were. They were just doing their job: the general manager (administrators) listened to the doctors and vice versa, the hospital doctors listened to GPs, doctors listened to nurses and so forth, local authorities worked with health through joint planning and there was a strong community spirit and ownership. Everyone respected each other and all were equal. No doubt I will be pulled up and reminded of stories from managers of poor general practice in old houses with single handed GPs, consultants on golf courses and Sir Lancelot behaviour, horrendous waiting times, shabby hospitals, poor meals and so on. But has the emphasis on management and

leadership solved these; in fact, the situation has reversed as what I hear now a days are the complaints about managerialism, and generally does more leadership equate to faster spread and uptake of innovation? Do not rush to answer – it is a rhetorical question. For the record, my best work was done in teams with managers and clinicians, across the divides working together.

In summary, I am disappointed with how we have approached both, innovation, and leadership development; we have not got either of them right, for two reasons.

Despite what we say we do not have the interest of the patient at the forefront of whatever we do, and our approach is based on emphasising deficits – we keep doing Needs Assessment and not Asset Management.

If we put the patients first (My Mum principle- how would I like her to be treated, which guided me) we would not have the current situation. People are struggling to book a GP appointment even for blood tests or routine appointments, not in emergency but for planned reasons in advance as doctors do not release dates until two days before, and so patients have to keep ringing the surgery (listening to long messages and muzak); it is hard to see the same GP twice even when one is prepared to wait; one cannot have a prescription for more than one month even though they have been getting, and will continue to, the same medicine for a long time for example. Patients wait for hours after discharge from the wards to pick up their medications before they can go home, and many of them have come out without understanding their discharge plan even when started on therapy like anticoagulants that require monitoring. I could go on – as I am more often on the other side now a days as a patient or carer – but that would be repetition; these are all straight forward things, I am reluctant to say simple since if they were really that simple they would have been done, that we want for ourselves. I am not talking about not getting ambulances or long waiting lists which are wider system issues, but about small things, which in leadership parlance is culture, and which is in our hands to solve.

The lack of imagination and ability to use the available assets creatively, and drive systematic improvements is the other major factor. There is a lot of intellectual capital in the NHS; in my professional life I tried with every major initiative - I have already referred to the Specialty Management Approach, the work with NICE and NPSA, I had also harnessed the work of Cochrane Collaboration (page 129) and the Screening Committee (*Thornton-Jones H, Hampshaw S, Soltani S, Madhok R. Review of antenatal and childhood screening programmes. Br J Clin Gov 2002: **7**; 165-76; not available on internet but can provide a copy*), for example, and there are other examples in the Compendium of my reflective writings (page 13 onwards). I was very frustrated in my job as the medical director in Manchester, which had some of the best internationally renowned experts in mental health and primary care yet some of the worst services in these subjects. I tried hard to bridge the academia : service divide, as world class research but little impact locally seemed tragic to me.

As an aside, I remember talking to the doctor leading health care quality improvement at Mayo Clinic on one of my regular visits in early 2000s, and he said why was I asking for his advice, since the Guru was in Manchester - he was referring to James Reason who provided a lot of the scientific knowledge for patient safety efforts in the NHS! And we had people like the Late John Yates, with pioneering work on waiting lists in Birmingham and Peter Homa with his business process re-engineering in in Leicester in late 1980s and mid-1990s, and there was a buzz in early 1990s thanks to work of Iain Chalmers with Cochrane Collaboration, Muir Gray with his Bandoliers and Trevor Sheldon with the Health Care Bulletins. Yet, the NHS had to go to IHI, Boston and Virginia Mason Hospital in Seattle, USA to learn (Declaration: I have visited both these centres, and found them to be doing excellent work; I particularly respect Don Berwick). We do not value what we have. I was proud of what we were doing in the NHS; (an example) and disappointed that we did not build on the advantages.

Ignoring the obvious and chasing the chimera and looking for quick fixes is wasteful - not just in terms of money and effort but also health gain forgone. Leadership is not positional but is about making a difference wherever one is with whatever there is and stepping up. I am conscious of some irony here with my rant about too much leadership as I went on several leadership development courses during my time, and I was the first member of the Faculty of Medical Leadership and Management. My point is not that this is not needed but that we should be clear about its purpose and have the right type of leadership development, suitable for the system and the times.

To me there are four necessary aptitudes: Scholarship, Leadership, Entrepreneurship and Servitude, and what I see of leadership in the NHS is largely managerialism and compliance, if not self-promotion, and not a way of harnessing the four aptitudes. I make a distinction between positional and visible leaders which is the usual way to think of leaders, and the others who are quietly beavering away and remain invisible – it is these latter that we need to look out for, support and celebrate, they are the Unsung Heroes. Sometimes I wonder whether we should start a School on Followership: Servitude, and reward those who focus on spreading and sustaining the best the NHS has to offer. We need better administrators, far fewer leaders/managers, and properly organised systems so clinicians can be clinicians.

Section Four: Who will do it: *Role of doctors*

There are those that look at things the way they are, and ask why? I dream of things that never were, and ask why not? - George Bernard Shaw

I am aware that this paper may seem dated and since the bulk was written in late 2022 and early 2023 there have been other developments and announcements from policymakers, but none of these change the central message in my paper. I can be accused of not discussing mental health and community services or ignoring public health, but in my defence, I have not talked about any specific services at all; rather my emphasis has been on the principles governing the organisation and delivery of a comprehensive health system which should provide for all the 'relevant needs' for 'everyone'. Clearly, I am 'biased' since I am only looking at things from a medical perspective. I do not even have any practical answer to the question of how to fix the broken NHS, just some philosophical, and some impractical (*sic)*, suggestions. So, where do we go, who can help?

In my experience the politicians have consistently failed over the last few decades. If any more proof was needed then we only have to see what happened with the pandemic; I am not prepared to let them off the hook because we got the vaccines, thankful yes but not at the price paid in 'collateral' damage, and which will continue for years sadly; not just fiscally - with billions down the drain with Test and Trace (even a fraction of that money used through our well established but starved public health system would have made such a difference, not to mention wasteful PPE) but morally (with blatant rule-breaking and lying) as they have seriously damaged basic values in society. I found the whole experience during the pandemic very stressful, as I, and my friends and colleagues, watched politicians compounding their mistakes of the past with underfunding and running down of the NHS with arrogant handling of the crisis – our rants (pages 48 onwards especially, and here) were of no avail, and their continuing undermining of experts and failure to take responsibility is very disappointing. The Covid inquiry will take too long, and any way the early sessions (in early July 2022) are painful to watch with arrogance and hand wringing from key witnesses. At the very least, I fail to understand why the politicians and senior establishment leaders do not take immediate steps to ensure proper systems have been put in place to prevent future disasters – the Inquiry is not going to tell us much new, the lessons are already there from history. We owe it to those who paid the price – let their sacrifices not be in vain.

I am grateful to, the community volunteers and essential workers, and especially the NHS staff who bore the brunt; claps for clapped out workers who were then slapped with derisory pay awards, shocking. The only surprise is that we keep being surprised by the behaviour of politicians and am reminded of Rousseau's On the Social Contract: "*The English people think they are free. They are badly mistaken.*

They are free when they elect members of parliament; as soon as those are elected, the electorate is enslaved; it is nothing. "

Overall, the politicians have used the NHS in opposition and misused it in power, and in my time in the NHS the underlying ideology has remained consistent, regardless of the colour of politicians. Currently, the only salvation is with the professionals and the public, unless there is a sea-change politically and we have the Royal Commission on health as suggested by Sajid Javid and Simon Jenkins. And even then, the politicians will need help. I have just finished reading Michael Foot's biography of Aneurin Bevan, the architect of the NHS, and would recommend it to understand the challenges Nye Bevan faced (of course Foot's account is only one perspective but to me it captures the key issues); sadly the world is more divided now making it more difficult to sort it out. Frankly, as the saying goes every system gives what it is designed for, and the NHS is well designed to fail currently.

To 'misquote' Jerry Garcia from Grateful Dead: *Someone has to do something. It's just incredibly pathetic it has to be us*. He was speaking in another context, but it is relevant here, but we, as doctors, are not pathetic; apathetic may be but we have the power if we choose to exercise it. However, we have to earn the power first. I was very perturbed with the contract changes in early 2000s; when GPs opted out of providing out of hours services they lost the moral high ground of looking after the patients holistically by being there 24/7, and when consultants got the new contract they became time keeping service providers. I fully understand the need for work: life balance and appropriate remuneration for doctors, just like anyone else, but we should note that it was then that medicine stopped being a vocation and became a job. We have some making up to do with the public to be able to (re) claim the moral high ground.

This is all the more necessary as the politicians do not take the situation seriously (not that they take anything seriously except looking after Number One); they have seen the current strikes and threats of leaving the NHS before – "No future for us in Britain", "Doctors turn to Empire" and "50,000 doctors say the (NHS) plan won't work" were the headlines in 1946 during the discussions to set up the NHS, and they know how many youngsters want to get into medicine, the medical schools are over-subscribed. For them, nothing has changed, and they keep pushing their ideological, evidence free (or indeed full of evidence to the contrary) policies.

What is in our favour is the fact that regardless of what the critics/media say the society will always need doctors, as Lantos explains:

"*Medicine today is facing many problems, many changes. Doctors fifty years from now will do things that we cannot imagine, just as we do things that our forebears would have found miraculous. There may not even be doctors as we know them today. And yet, doctors today do some of the same things that doctors have always done and will always do. That permanence, it seems to me, has nothing to do with science, nothing to do with technology, nothing to do with whether we work in fee for-service solo practices, HMOs, the British NHS, or the Veterans Administration. It*

doesn't have much to do with tort reform, managed care, or 'safe havens' from conflict-of-interest legislation. And, oddly enough, it doesn't even have much to do with whether what we do works or doesn't work. Instead, it has to do with whether, like William Carlos Williams, we nurture the capacity to respond to "the haunted news" we get from "some obscure patient's eyes." No matter how good our science gets or how our health system is organized, someone will always have to do that."

I do not think good doctors have anything to worry about, they can only win. But what can they do?

I have limited experience of formal working with national professional bodies, apart from the GMC I had joined committees of the BMA and Faculty of Public Health for short periods, though I did engage with a large number of national organisations during my time, and generally struggled. My attempt at engendering national debate when I gave my Milroy Lecture at the RCP, UK in 2003 (page 230) completely backfired, with the College even refusing its publication (which was the norm) and unbeknown to me even splitting the award that year (something never happened before or since). My friends have been bemused, and mischievous amongst them pointed that I am the only BAME (as far as names can tell) on the list. In my assessment the primary purpose of these organisations is to look after the interests of their members and funders; being by nature curious I used to find myself in a minority when I raised issues which did not fit in with the prevailing 'mood'. Introspection and questioning whether things could be done differently was not very welcome generally; 'careers' were (are) made by defending their position and blaming others for any of the wrongs. I must, however, acknowledge that my comments do not mean that people within were not aware or considerate, and indeed privately wanted change, but to shift the organisations, not transactionally but transformationally, is hard and 'career-limiting'. I am sure there are others who are more skilled than me and who have managed better, but overall we do need to find a way to ensure that we have the right institutions. The current situation is interesting (*sic):* under 50% of doctors on the GMC register are British Medical Association (BMA) members, and the leadership of the BMA was elected by just 7% of their members in 2022. So, who are they representing? I do not want to fall out with another organisation this time, having fallen out with the RCP, but only want to point out that there is work to be done.

"*One of the criteria for national leadership should therefore be a talent for understanding, encouraging, and making constructive use of vigorous criticism"* said Carl Sagan. For sure, we must challenge the establishment and especially the politicians, but we must also come together and win the public support. This means starting with ourselves, we need to become active and participate in changing things, we need to do what is in our control and to model the behaviours that we want to see elsewhere in our professional bodies and the policy makers. The overall societal context shapes the health and care system; the NHS did not come into being in isolation, it was a part of the overall package of changes post war, and happened because the people wanted it, they were ready for it, they were prepared to work for

it, and there was good leadership. Although concerned about the financial situation of the NHS I worry that such funds are depriving other essential services for a civic society and for the future – if not careful, then the NHS can become the cause of widening inequalities (hard words, I am aware). So, we need to create a critical mass of people without whom the necessary transformational change will remain elusive, and the doctors need to be actively engaged in this process.

To finish off this section here is something I came across, from Octavia Butler "

"I didn't make up the problems," I pointed out. 'All I did was look around at the problems we're neglecting now and give them about 30 years to grow into full-fledged disasters.'

"Okay," the young man challenged. "So what's the answer?"

"There isn't one," I told him.

"No answer? You mean we're just doomed?" He smiled as though he thought this might be a joke.

"No," I said. "I mean there's no single answer that will solve all of our future problems. There's no magic bullet. Instead there are thousands of answers–at least. You can be one of them if you choose to be."

She was talking about climate change (and by the way the above article is worth reading as it touches on medicine directly too), but it equally applies to the NHS – we ignored the problems decades ago and are now paying the price. But it is still not too late. We must come together and show the way: *Be the change you want to see*, as Gandhi said.

Conclusion: Are we being good ancestors

I came to the UK in September 1980 soon after qualifying as a doctor in New Delhi, India and then mainly worked in the NHS, apart from some time overseas in between till I was made redundant in 2012. I had to change my career plans due to limited opportunities in the 1980s and at the peak of my career as the medical director for NHS Manchester I had to sign a confidentiality agreement and leave. You can take a man out of the NHS but not the NHS out of the man and so I have continued to support and promote it (and here is another example), have defended it including by taking part in the Jarrow March in 2014 to protest against what was happening, and am still trying to add value through my work .

I do not say the above to brag or invite sympathy- whilst it has not always been easy in the NHS and UK generally, it was my choice to stay here (like many of my contemporaries who left UK due to limited opportunities for career progression in the NHS I had also passed my USA ECFMG exam but when I studied their system I decided not to go, but later spent time at the Mayo Clinic). I did not expect equal treatment - I grew up in India with its vast inequalities - and the setbacks I had here were the price to pay for wanting to live and work in the UK. It does not have to be that way, but we must recognise the reality, it is what it is. Do not think I am suggesting that we should be passive and accept inequalities - I did not and challenged where necessary.

But just because I am OK, the idea that I should sit back and enjoy my retirement, with as my younger colleague mentioned gold plated NHS pension which will be paid for by his sweat, does not work for me. I have to keep trying for a better NHS for him and the future generations. I do not believe in feeling helpless - one must do what one can with what one has got has been my philosophy, and at each stage of my life I have tried to find ways of adding value, and I am not alone. I know of many who share and practise these things. That is what gives me hope.

James Rebanks in his book, English Pastoral, asks whether we are being good ancestors? What will our successors say about us - did we build on our legacy or squander it? What sort of NHS are we leaving for them?

The problems of the NHS are beyond doctors, but there is still a lot that the doctors can do, even within the existing constraints. We can make services more efficient, we can adopt innovation, we can practise proper leadership, we can integrate services, we can help with patient safety, we can look after each other, we can do more to keep people healthy, and so on. We can actively participate in shaping our professional bodies and helping to restore the sense of vocation, and working with managers and the public we need to support and challenge the policymakers in helping to create a better NHS. The specifics are for each of us to decide, and we need to start by acknowledging that there is a problem and that we have a responsibility to fix it, each of us must do whatever is within our control to help patients and colleagues. We must set an example and do what we can, the patients

and the public cannot be pawns in the fight between the profession and the politicians.

In summary, I believe that the politicians, aided by compliant managers - political-managerial axis - have a lot to answer for the poor state of the NHS. They have sabotaged the NHS with their ideological and self-serving control of policymaking and organisations. But I also believe that doctors should do more; we have not done as much as we could/should have. Do not shoot me as I am not blaming all politicians , all managers and all doctors - far from it; I have certainly worked with and learnt from some of the best managers and doctors. We can wait for everyone else to change or we can start and be the role models. There is a lot an individual can still do, to make a difference.

When the NHS was created in 1948, we, as the medical profession, had some misgivings and which led to various compromises – 75 years later we, and the public, are paying the price of our failure to engage constructively and design a fit for purpose NHS. Will, and can, our generation do better – that is the question for us.

Another one of my favourite management books is Zen and the art of motorcycle maintenance by Robert M Persig, and I cannot resist quoting it here:

I think if we are going to reform the world, and make it a better place to live in, the way to do it is not with talk about relationships of a political nature, . ….. Programs of a political nature are important end products of social quality that can be effective only if the underlying structure of social values is right. The social values are right only if the individual values are right. The place to improve the world is first in one's own heart and head and hands, and then work outward from there. Other people can talk about how to expand the destiny of mankind. I just want to talk about how to fix a motorcycle.

One other thing

I feel that I had to write the paper at this stage of my life; I do not feel comfortable with the state of the NHS especially as I feel that some of the damage happened on my watch. It is to show solidarity with and respect to many like-minded, hard-working people in the NHS. It is also to encourage others since by staying quiet we are helping those who are destroying the NHS – apathy is what they are relying on. Karl Popper talked about the Paradox of Tolerance*: If everyone is tolerant of every idea, then intolerant ideas will emerge. Tolerant people will tolerate the intolerance, and the intolerant people will not tolerate the tolerant people. Eventually, the intolerant people will take over and create a society of intolerance. Therefore, to maintain a society of tolerance, the tolerant must be intolerant of intolerance.*

I have struggled with the paper. I am aware of many problems with it; the paper is not comprehensive - it covers only a small number of (pet?) topics. There is no detailed examination of any of the issues, it is all personal stuff and self-advertisement. But this is because partly these issues are the most important ones (to me) and partly these are illustrative, and if we address them then we are on way to fixing the NHS. I am also guilty of broad brushstrokes and generalisations, and only highlighting what is wrong and not what is good even though we have been recent beneficiaries: my partner has just had intensive treatment for breast cancer (it was not complication free, if not entirely preventable, there are lessons from her treatment, sadly). But that is all the more reason as to why we have to inject some energy into the system since we have a long way to go to ensure everyone gets the care they need, and we need to speed up. I am also guilty of not mentioning the excellent work of many others who are working to address the shortcomings; and again this is not to deny their contributions but merely due to the fact that I cannot do justice to all of them and do not feel comfortable with selective quoting. Finally, I face the double whammy since I have only talked from a doctor's perspective and will be told off by them for being critical and blaming them for the problems, and by other groups for ignoring the important roles they play in the NHS.

Now, you have a choice (if you got this far) - you can choose to pick a comment that offends you and blow this up or look at the whole paper and find things you agree with, or indeed put out your version, and we can use it to promote discussion and resolution. Together we can do what Ernest Becker (the quote at the start) wanted – *the time is ripe for a synthesis that covers the best thought in many fields*. I will be sad and will have failed if either I or my experience becomes the story rather than my message.

As a doctor I believe in the First, Do No Harm principle and hope that I have not caused any harm/hurt and if I have then please note it was not intended and accept my apologies, and as regards the Do-Good principle I will let you be the judge of whether this paper does any good.

“Some say that my teaching is nonsense.
Other call it lofty but impractical.
But to those who have looked inside themselves,
this nonsense makes perfect sense.
And to those who put it into practice,
this loftiness has roots that go deep.”

Lao Tzu

Acknowledgements and Declarations

Thanks to my dear friend and teacher, Professor Dick Heller, who has provided invaluable support over the years. Similarly, Professor Stephanie Snow has indulged and helped me with my interest in learning from history to inform service delivery and policy making, applied history so to speak. I am afraid, being lazy, I have not been as academically rigorous! I am also grateful to Trevor Sheldon and Carole Langrick for reviewing an earlier draft; they are, however, not responsible for any remaining shortcomings; these are my responsibility.

The views here are personal and not to do with any of my past or present associations. For the record, I am currently a non-executive director, Wirral University Teaching Hospitals NHS Trust Board; non-executive member, Llais Cymru (Citizen Voice Body) Board; and Governor, Coleg Cambria Council. For further information about my background and work, please see www.ramareflections.com and particularly the papers under the About Me section.

As I approach my 70th year I have become aware of how little I know, and neither have I any answers to the challenges facing the NHS and am sorry for disappointing you if that is what you are after. But I do know and believe that things can change – in my moments of despair I often return to the books by Rebecca Solnit (Hope in the dark) and Rutger Bregman (Humankind: A hopeful history), and I know that there are enough people who share my aspirations. I wrote this paper to stimulate discussion on the way forward; I apologise if I have inadvertently offended in any way.

If I was asked for one thing I wish, then it would be that there should be a Royal Commission to determine the future of the NHS; health is too important to be left to the politicians now.

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Somebody said that it couldn't be done,
But he with a chuckle replied
That "maybe it couldn't," but he would be one
Who wouldn't say so till he'd tried.
So he buckled right in with the trace of a grin
On his face. If he worried he hid it.
He started to sing as he tackled the thing
That couldn't be done, and he did it.

Somebody scoffed: "Oh, you'll never do that;
At least no one ever has done it";
But he took off his coat and he took off his hat,
And the first thing we knew he'd begun it.
With a lift of his chin and a bit of a grin,
Without any doubting or quiddit,
He started to sing as he tackled the thing
That couldn't be done, and he did it.

There are thousands to tell you it cannot be done,
There are thousands to prophesy failure;
There are thousands to point out to you one by one,
The dangers that wait to assail you.
But just buckle in with a bit of a grin,
Just take off your coat and go to it;
Just start in to sing as you tackle the thing
That "cannot be done," and you'll do it.

Edgar Guest