

A NATIONAL HEALTH EMERGENCY IN WALES

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Llanbedr DC

October 2024

Purpose

This paper has been written in the hope that it will stimulate urgent action and discussion about health and social care services in Wales. It is a personal account and is offered in good faith. It is in two parts: the first section is for immediate action, especially with the imminent arrival of another winter season, and the second section is to promote discussion about the longer term future of services.

In essence, there are three points: one, we have a national health emergency and need to act, now; two, we need a fundamental re-think about the nature and delivery of services; and three, no one is doing this - lots of analyses and aspirations, but a clear and comprehensive plan for how to address the immediate issues and develop fit for purpose services in the longer term, no.

The current situation is distressing, and I hope that we can, and will, do better.

A bit about me

I am a public health doctor and worked in senior medical management positions in the NHS in England, and moved to North Wales a few years ago, after retirement.

This paper has been written in my personal capacity, and for the record, I am a non-executive member on the Board of Llais (Citizen Voice Body) and am on the Mwy na Geiriau Advisory Board in Wales, and a non-executive director on the Board of Wirral University Teaching Hospitals NHS Foundation Trust in England.

I stayed in Trefil during my visit to Tredegar, the village where Nye Bevan used to walk and where his ashes were scattered, in the hope that his spirit will guide me.
<https://lingo.360.cymru/2024/cerdyn-post-drefil/>

I am a Welsh learner and see Wales as home now. My views and aspirations for Wales can be seen here - <https://ruthinindiaculturalexchange.com/wp-content/uploads/2023/12/my-wales-an-essay-by-rajan-madhok-2023.docx-5.pdf>

I do not belong to any political party, and do not believe that this is a single party issue – we need a cross-party approach. I support Assisted Dying, and hope that the politicians will change the law and vote in favour of the forthcoming bill.

Talking about reviewing the fundamental principles is seen as being against the NHS and undermining Nye Bevan's legacy. I disagree, after all I was a Jarrow Marcher-
<https://www.hsj.co.uk/comment/why-i-went-on-the-300-mile-march-to-save-the-nhs/5074587.article>

For my recent views on the NHS, please see some references below and for further details of my work, please see <https://ramareflections.com/>

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Some references

1. <https://ramareflections.com/pdfs/Personal%20reflections%20on%20the%20NHS%20-%20Vol%204%20by%20Rajan%20Madhok.pdf>
2. <https://www.bmj.com/content/384/bmj-2023-078903/rr-3>
3. <https://www.bmj.com/content/385/bmj.q1070/rr>
4. <https://www.bmj.com/content/386/bmj.q1464/rr-1>
5. <https://www.bmj.com/content/386/bmj.q1676/rr>
6. <https://www.bmj.com/content/381/bmj.p1000/rr-0>

Summary

It is time to recognise that our health and social care services have failed and that we need to act, now.

This paper is in two parts: Section 1 sets out the scene for urgent action whilst in Section 2 I share my learning from Tredegar and Nye Bevan.

When I read the stories inside (Section 1) I feel upset and professionally ashamed. Personally, my friends and I are scared, scared at the thought of getting ill and needing care. How did we get to this situation? Apart from the lack of certain services, waiting times and questionable clinical quality in some areas, does anyone think that it is OK to keep someone in hospital, despite their wishes, and 'slowly kill' them by modern medicine rather than letting them live out their days as they choose and at home, and letting them die with dignity? Or keep anyone in hospital when they could have been discharged a day earlier, with some careful follow up and use of basic IT? Does anyone think that it is OK for an ill person to sit on a straight back chair for 28 hours in a busy A & E department, and having to rely on friends to provide basic sustenance?

I cannot tell you how many times I have heard that we treat our animals better than fellow human beings, or where are the leaders, why is no one sorting out these simple problems. The soul seems to have been sucked out of the NHS, there is no accountability or anyone taking responsibility, people tell me when they know my background.

My intention is not to single out any of the services for criticism, as I believe that these cases could have happened, and are happening, anywhere in Wales. These experiences are not uncommon and are reflective of the current state of affairs in politics, society and services.

I have been given permission to share the stories on two conditions: one, each person here wants to acknowledge and thank the clinical staff, and two, they want these stories to be used constructively by promoting discussions on how to address any shortcomings. They do not want to criticise only, they are happy, and keen, to offer their expertise to the staff and help in any way they can. Some of these shortcomings are complex and systemic, and hence beyond the ability of any single body to address currently, but there are others which are entirely amenable to improvement by health boards. The abnormal has become the new normal.

Many reasons will be given for why things cannot change, but what these cases show is that there are more reasons why they must change, and soon. No one is safe now, it can happen to any of us, our families and friends, and we should work towards remedying the shortcomings. This is an emergency, not a call for yet another think-tank/inquiry/report, and for urgent action. Another winter is coming and we must get organised now.

I believe that immediate action is needed on four fronts as follows. It is not for me to make lists of tasks, it is for the Centre and each health board to work out for themselves, using proper analyses and their imagination to create comprehensive

plans, and which should be rigorously implemented and monitored. Ultimately we need to create a culture of continuous improvement, and I propose these four areas, not only because these are most urgent, but also because by addressing these, we can start creating the new culture and which will help us move from the current reactive, task-based, short term ways of working to proactive, systematic and longer term plans.

1. Reducing waste

We need to look at all areas from policymaking to organisation and delivery of services and identify which of the tasks are really essential, and how to make them efficient. At times, it seems that the business of the NHS is paperwork not clinical care; it needs to change, there is too much process, and not enough attention to outcomes. Take one example: the NHS board papers which are impenetrable and almost written in a foreign language, I am not sure if any board member reads them! The public certainly cannot make much sense of these since these do not tell them what they want to know: are they going to get the care they need in a timely manner, will they be treated with respect and dignity, will they get safe care etc. It is like we are living in two parallel worlds- one of the bureaucrats and the other of people. This bureaucratic machinery is paralysing, and creating the learned helplessness – ‘feeding the beast’ has become all consuming. In addition, the inefficiencies and duplications in the system need attention where ever these are, whether in processes or products, like medicines/equipment.

2. Accident and emergency departments

Of course it is a complex problem, involving various services: GPs, Out of Hours, hospitals, ambulances and will need some time, but how about doing some basic things. Why cannot we segregate disruptive patients esp the weekend drunks? Should patients keep sitting in the same crowded place- can they not be issued with a bleep and so that they can go and be comfortable elsewhere –open outpatient waiting rooms, after hours, for example or even let them sit in their cars, and bleep them when ready? Given the sparse facilities and inability of the NHS to provide basic pastoral care, may be every new patient at the A & E at the time of their registration should be given instructions on how to survive whilst waiting: how to get food/drink, how to remain warm, how to ensure you do not miss your appointment, how to make sure you do not acquire DVT/bed sores and bring a cushion etc. Even airlines advise you about leg exercises to avoid DVT, and patients spend more time on chairs in A & E than flights! The challenges for those on trolleys are greater.

3. Delayed discharges and care of the dying

Another thorny issue, and this time involving social services and voluntary sector, and will take time. But why cannot we look at each patient, on admission and work out an individual plan – many patients can be looked after in their own homes with minimal formal support. No one, already at the end of life, should die in an acute hospital, unless there are exceptional reasons. We under-estimate the community spirit that still exists, why not encourage communities to start their own care services – a bit like the Tredegar Medical Aid Society, with contributions from members

locally? Most of my friends are happy to pay more, but only if the system is efficient, effective and humane. We need to make it easy for the carers and communities to do so, cut the bureaucracy and give them some financial assistance.

4. Hospital waiting lists

Waiting lists are not a new phenomenon, but what is not acceptable is that each time we ignore the lessons from the past – basic issues like ‘cleaning’ up the lists, better scheduling, and adoption of best practices and innovative services have to be re-discovered every time. There is no systematic analysis, service by service, reviewing their effectiveness and efficiency- pockets of excellence, yes, but as a way of working, no.

Our patron Saint, Dewi Sant, said: *Gwnewch y pethau bychain*, so let us do small things now, while we work on the big things. I find it disappointing that there are hardly any scientists/operational researchers/mathematicians/sociologists who study health systems and work in the NHS or social care, there is plenty of academic work in these disciplines but not where it matters. There is also a reluctance to use imaginations and asset based planning method: using what you have rather than complaining about what is missing, and being creative.

In Section 2, I turn to the bigger problems. The above is only a start, and is about the most urgent issues to ‘buy’ time to work out the longer term plans. Of course, we need to look at everything from child health to mental health to cancers and so on, but none of these issues can be addressed properly at present. Our model of health and social care is not fit for purpose and requires a comprehensive and systematic approach for deciding how to plan and deliver future care. I went to Tredegar to see what I could learn from there, in the hope that the spirit of Nye Bevan would guide me. The ideal scenario would be to have another Beveridge Plan to create a better society but in its absence we can, and should, address health and social care services.

The visit to Tredegar reinforced to me why we should not be distracted, and try sticking plasters again, but to be ambitious and imagine a future in 20-30 years’ time, and then opportunistically and systematically develop plans in line with this vision. I believe this is the task in front of us.

Whilst it was not easy in 1948 when the NHS was formed, it is more difficult now since so much has changed. The nature of medicine and its advances would be unrecognisable to Nye. There is a plurality of workforce beyond just doctors and nurses. Expectations of both, professionals and the public, and the costs have changed. It will be challenging to reconcile all these within the current framework of the NHS with its existing fundamental principles or the current design and delivery with separate NHS and social care, not to speak of the growing health and income inequalities.

The recent episode when the First Minister of Wales, Baroness Morgan, ‘pressured’ the health bosses about long waiting lists, and the ‘push-back’ from the NHS Confederation underscores the problem. Of course, both sides have valid reasons – there are systemic problems such as structural separation of health and social care,

massive bureaucracy, poor infrastructure, and lack of workforce on the one hand, and the failure to innovate and adopt best practices to increase efficiency and improve the current patient experience on the other hand. Finding immediate solutions is necessary but to rely on an agreement between English and Welsh NHS to jointly tackle the waiting lists, given the situation over in England with the highest ever longest lists, as an example, seems puzzling. We can and should do better in Wales.

The most essential thing is a deep and detailed analysis of the situation – a root cause analysis in other words; not a dogmatic/bullish approach but an honest, open and respectful discussion with communities, not just about the symptoms – the waiting lists/access, but the underlying disease – how to promote health and how to organise and deliver services. I know that people are impatient for solutions, but unless the correct diagnosis is made, any treatment will not be helpful, and indeed can be harmful- that is what has led to the present sorry state of affairs. The discussions will be challenging, especially when it comes to questioning the ‘professed’ three fundamental principles of the NHS. If dentistry is no longer available on the NHS, as is happening, then how should it be organised? Who should pay for the education and training of dentists, for example? Should there be more privatisation overall: then how do we sustain comprehensive services, since many services like for children or the elderly or mental health are not that attractive to private companies compared to routine surgical services, and we end up losing the ‘profit’ generating services and retaining the ‘loss’ making ones? And any pension contributions that come when people work in the NHS, will instead go as dividends to shareholders, and be lost to the public purse. In any case, there is no private emergency care provision, so one may be rich but still not have access when needed. How many health boards and organisations does a small country like Wales need? Should we continue with current arrangements for NHS funding – with almost 40% of the government budget going into it, and which is depriving other essential services like social care, housing, education? And I could go on like this, but that will be futile and wasteful- rather we need a commitment to change and a clear process for systematic analysis first.

It is wrong to believe that the public can not deal with such complex issues, they are able and keen to do so. As Tredegar showed people are our best asset, and if we engage and empower the communities they will help find the solutions, fit for our times. It was done once, and can done again. It needs to be done. What the public is waiting for is leadership.

If not us, then who

If not now, then when

Section one: Why we must declare a national health emergency

In this section I describe the experiences of four people, known to me, and who received care in North Wales recently; I could have added many more examples, but our aim is not finding faults, but to ensure reflection and encourage action to address the problems. In case these examples come across as criticism, be assured that people do appreciate when things go right also, this is not a witch hunt.

My partner and I have previously shared our experiences

<https://ramareflections.com/wp-content/uploads/2024/02/Helens-cancer-diary-2022.pdf>

In describing these cases, we are being brief, and further details can be provided if and when needed.

CASE NO 1: Late Mr Gordon Stevenson

Gordon was my neighbour and became a good friend to me; he was 93 and I learnt about his life when I wrote my essay about Wales. He was a very active, independent man, living by himself with the support of his son – Michael who lived 25 miles away and a brother and both of whom visited him often. When his health started deteriorating, few months before his death, our conversations became ‘philosophical’ and we discussed the meaning of life and death. He had lived a full life and was very clear about his need to maintain his independence and dignity- the thought of not being able to self-care just terrified him. He did not want to live if he got to that stage, and used to ask me if I would help him (*sic*) - he was aware that I support the idea of Assisted Dying. Michael knew about his dad’s wishes and he and I spoke about how to look after Gordon and enable him to live at home. Gordon also asked Michael about getting him a pill, and when Michael told this to the health worker, they judged Gordon to have suicidal tendencies, which upset Michael who felt that the worker had failed to see the ‘person (Gordon)’ and the context. Neighbours rallied around, and there was almost a regular informal care system, except at night when Michael had to go back home, to support the rest of his family. Although Gordon had a spell in a local hospice for a few days, he was discharged, but no formal home support was arranged, despite Michael’s attempts with local health and social services. One night, Gordon fell down on his way to the toilet and another neighbour found him and rang the ambulance. This is what happened then.

The paramedics on the scene found no significant injuries and Michael did not want Gordon to go into hospital as that would have been against Gordon’s wishes, but even though Michael had Lasting Power of Attorney (LPOA), he was overruled, as Gordon said he wanted to go there. We can only speculate why Gordon did that, and the only explanation is that Gordon was really an ‘old style’ man and was brought up to always listen to ‘authority’, and the paramedics over-ruled Michael’s LPOA.

Gordon was taken to Glan Clwyd hospital where he stayed on a trolley for 36 hours and then via an assessment unit he went to a ward. Michael kept asking for support to take him home, especially after the physio felt that he should be home, and not be in an acute hospital bed. Six weeks passed and by this stage, Gordon had given up eating and basically started starving himself, and just lay in his bed. He was

catheterised, even though he could manage, but with support, and started getting pressure sores. After six weeks he was discharged to Ruthin Community Hospital, and the saga with the local social services continued – who even after the intervention of the GP, felt that he could not go home but should go into a nursing home. Michael ran from pillar to post to organise home support, and was shocked to get a phone call from a local nursing home to say that they were looking forward to seeing Gordon the next day- social services had arranged for him to go there. Michael was shattered, and made more noises. The nursing home was cancelled, arrangements then started to adopt Gordon's home- shower/commode etc for his return, but the bed was only going to come the day when Gordon was coming home.

Finally, Gordon came home on a Tuesday, by when he was in the last stages- Michael remembers him being carried in and the look in Gordon's eyes, knowing he was home, is one that he says he will never forget. Gordon survived 3 days and then passed away at home, with Michael by his side.

With hindsight, Michael feels that he should have talked to the GP much earlier, as the GP was very helpful, thought at a much later stage. Michael's explanation is that he thought the hospital was in charge as that is what had happened when he, himself, was having specialist treatment, when his GP (in another area) did not want to know.

Michael feels that Gordon was no one's responsibility, was seen as expendable, and he felt totally disempowered. A patient is a person and there is an attached family, and this seems to have been forgotten. He wonders whether the system currently is capable of looking after dying people, humanely.

Michael, like most people, felt himself unable to negotiate the complex health and care system, but did pick up that Gordon's care seems to be due to a wrangle between health and social care, and their budgets. By nature Michael is like his father and a very gentle person, who would not criticise anyone, but he is upset with the social care staff for thinking money and not Gordon. As a layman, he compares the huge cost of keeping Gordon in an acute hospital (apart from depriving more needy patients) with the small amount that would have kept him at home. My partner, Helen, who has had a lot to do with health and social services due to various elderly family members, tried to guide Michael as much as she could, but ultimately it had to be Michael- who between his stress and lack of detailed knowledge – and who struggled. It is almost a case of becoming a total nuisance, and a crisis before one can be taken seriously. The system has become a machine, devoid of humanity. He says that there was no plan for how to 'manage' Gordon after his admission, with roles and responsibilities of all parties clarified, since that would have helped a lot. There has to be a tailored plan- which should take account of wishes and circumstances; patients and families understand that not everything they want can be done, but not having a meaningful dialogue is a great missed opportunity to the detriment of the patients/families and wider society who has to pay for the waste.

NOTE: I wrote the above account after talking to Michael extensively, and afterwards this is what he wrote back:

“I hope my synopsis of events were not too contradictory or convoluted but in essence, although the hospital staff had evaluated my father’s medical condition accurately (in my humble opinion), Social Carers had a different agenda, and were intent on pursuing that agenda to the point of ignoring POA, and surreptitiously assessing Dad, ignoring both the Hospital’s analysis and without informing POA, in order to produce a bias report reflecting their agenda.

What has disturbed me most is that the medical staff in the Hospital, although advocating the best treatment for my Dad, evidently seemed totally aware that to contest the Social Carers bias assessment would be futile, (the hospital) staff resorted to informing me of the un-planned visits, hoping I could attend before The Social Carers left the hospital.

I (hopefully) am not a stupid man, but Social Carers attitude to me, when questioned about the validity of their reports, was very dismissive and condescending of my concerns, adopting their attitude of ‘we know better’(?)”.

CASE NO 2: Mr Paul Marfleet

It was indeed a crisis that led to Paul being taken to Glan Clwyd Hospital, most recently. Paul is someone I admire, a thoughtful, highly intelligent and caring person – he has been a councillor and non-executive director on NHS boards- who has given nearly 30 years of service to the community, after his early retirement. I will let him tell us his story.

On 4th September 2024 I attended the local A&E for the third time in the last twelve months, and I also had six outpatient appointments as well as CT scans and ultrasound scans.

In each case, I observed some of the best in clinical care and sadly, some of the worst. I will not use this note to describe my recent admission which had a very specialised medical condition associated with it (and there is other learning from it, which I have shared with the relevant authorities).

Instead, I will describe some observations from my overall experience of accessing NHS facilities over the last 12 months.

Firstly, I need to say what a fantastic GP practice I have access to. They are great in all matters and I can think of no areas requiring improvement. My Local Health Board is BCUHB and whilst they have experienced some significant problems in recent years and have some notable failings, I accept that most of the issues I have observed will likely apply to all other NHS Trusts.

I will describe my observations under six headings:

Admin and Patient Communication

I am always surprised at the hospital’s dependency on postal communications at a time when the majority of the population now communicate electronically. My GP practice confirms appointments by “message” and allows me to make and view

appointments online. There also seems to be a problem of delay between the clinician dictating a letter and it actually getting typed and posted. This sometimes runs into weeks rather than days.

In the same context, I am amazed at how many letters include a fax number. Facsimile communications are as out of date as VHS recorders.

Letters of appointment often give telephone numbers that when used have a recorded message saying "This number is no longer in use". Even when the number is connected the caller is often given options of up to a dozen departments. The complexity of these (urology, oncology, maxillofacial, cardiology, etc) will undoubtedly confuse many callers and may well contribute to missed appointments. Technology is widely available that department specific phone numbers could be issued from the outset, thus avoiding confusion.

Patient communications need to be considered in the context of the catchment area of the hospital which includes one the UK's worst areas of deprivation which will undoubtedly include low levels of literacy and numeracy.

A&E Experience

I won't include comments on the dire situation regarding ambulance access and queuing. That is a major issue in its own right.

On arrival at A&E by whatever means, the initial triage seems to work well and you are "in the system". From then on it is chaotic and confusing. The waiting area always appears packed. Some of these are multiple family members attending with the patient. As the doors to the outside open and close, there is always the waft of cigarette smoke from those "nipping out for a fag" despite it being against the rules. I was immediately surprised at how often patient's names are called but no-one answers. I now understand that this is because there is no patient tracking system. They may have been sent for a blood test, an ECG or a scan, but are still called by the duty doctor. When they don't respond, they then go to the back of the queue so when they return to the waiting area, they have no idea that they have missed their slot.

If it is eventually deemed necessary that they are admitted, they are often pushed into adjacent corridors either on a trolley or in a chair until a bed becomes free. This can be hours if not days. On one occasion I was in A&E for 25 hours despite having been diagnosed as requiring urgent vascular surgery.

The limited toilet facilities are often out of use and refreshments are spasmodic at best.

Variations in patient care

The vast majority of nursing care on the wards is good although it is immediately obvious as to how much time is spent on admin and "box ticking" rather than direct patient care. Sadly, there are some examples of poor nursing care and this is most obvious on the night shift where predominantly agency staff are on duty.

I observed an agency nurse going from bed to bed without washing her hands or changing her gloves. She came to change my IV drip and I asked her why she hadn't flushed the line first (The flushing line was in the kit) and she replied "Oh I forgot".

Infection Control

In recent years infections such as C Difficile and MRSA have been recognised as a major risk in hospital environments. The Covid epidemic raised this to a new level.

On two occasions as an inpatient in the last 12 months I have experienced a significant Hospital Acquired Infection, with a resulting sepsis and with CRP rates up to 200. Both these episodes necessitated a delay in my discharge and an intensive IV antibiotic treatment plan.

It looked to me as though Infection control was another case of "must be seen to be doing it" rather than actually doing it. Some ward cleaning is done by employees and some by contractors. The latter spent most of their time sticking labels on desks, tables and shelves stating the time and date when they cleaned it whilst at the same time missing obvious risk areas.

Follow up complaint procedures

In late 2023 I suffered a gram-negative bacilli of the type Acinetobacter baumannii-calcoaceticus. I was extremely ill.

At no time was the infection acknowledged as being hospital acquired, despite me having had sight of the blood culture report. It was my understanding that such a serious infection should have been reported on a DATIX report form, but this did not happen. I started to make enquiries and finished up being invited to a meeting with the Deputy CEO of the Trust. Nothing came of this and he referred me to their official complaint procedure. This was ineffective and I then made a Freedom of Information Request. I slowly sensed a "closing of the ranks" based on self-preservation of the trust management and I never got the answers I needed

Devolution in the NHS

Because the NHS in Wales is a devolved organisation, I have experienced "cross border" problems on several occasions. Following a re-rupture of an Achilles tendon it took a lot of time and effort to be referred for surgery to Gobowen in Shropshire.

Following a restenosis of my carotid artery, I asked for a referral to Wirral or Liverpool but it became a financial issue and got bogged down waiting for financial approval.

More recently, I have experienced lack of communication between my specialist endocrine support team in The Christie Hospital Manchester and local clinicians.

I personally think that devolution may yet prove to be a big problem for reform of the NHS. With governments of different parties in Westminster and Cardiff, it is politically inevitable that they will try to score points off each other whilst at the same time, it is crucial that pay settlements, recruitment and training programmes are uniform across the UK.

CASE NO 3: Mr Paul Taylor

Paul is a cycling enthusiast and recently had an accident when a car pulled out in front of him. He was rushed to Ysbyty Gwynedd in Bangor with suspected neck and back injuries. The local hospital liaised with the specialist unit in Stoke on Trent to assess and plan his care, and he was moved from the 'Resus' to 'Majors' and then to a general orthopaedic ward. Towards the end of day two after the accident, the specialists in Stoke had ruled out serious injury and requested an Xray before he could be discharged. However, this request was only noticed when the orthopaedic team came to do their round the next day at noon. When they read the notes; "the senior asked : has this been done, the junior said: I will order it now" says Paul, "but the junior had to wait till the end of the round, then access a terminal to order it".

Nothing then happened till 6pm, so when Paul asked if someone could check, the nurse rang the department but there was no answer. Half an hour later another nurse rang and got through and was told that the department had been ringing the ward since 1230! The Ward nurse however did not see any missed call, and believes that they were ringing for the wrong person. He was told that Paul will be sent for at 8pm, and but that did not happen. Next day, from 8am Paul started checking and by 1030 he was taken for the Xray, and which was read by the specialists in Stoke and who approved discharge. Fortunately his niece was there to pick him up, she works as a ward clerk elsewhere and knowing the system she liaised with the ward clerk on Paul's ward and noting that his medication was ready but not collected, she offered to go and pick it up. Paul says that "they forced the system" as medications frequently delay discharge, and also managed to get the discharge letter and escaped!

Paul works in IT and is a SAP/Logistic expert and was looking at what was going on, from a systems perspective and believes there is learning from his experience and scope for improvement.

His extra night because of delay in not acting quickly on the request from the specialist must have deprived someone else of a bed - esp for patients waiting on trolleys in A & E - and asks why did this happen? He does not think his case is an isolated example. The Xray ordering procedure itself caused further delay. Essentially, an Xray was ordered on the round, despite it being known the previous day, and then there was no mechanism to track the status of this request. There are simple IT solutions for these issues including possibly having a QR Code on the wrist band that every patient gets, and which can be scanned with every interaction?

He was on a busy ward and the IV drip alarms and call bells were going off all the time, and the staff were indifferent to these. He timed one alarm going off for 1 hour and 5 minutes, and saw many 'nurses' rushing around but who were they, and why were they not attending to these alarms? And if these alarms are unnecessary then why not turn them off? "Surely, in order to recover, you have to rest but nobody is getting any rest", he says. He found that the only way to get attention was to bang the side of his bed, and which seemed to annoy the staff. But, he had to do this, since he could not access his water beaker- basically, the nurses, whenever they

came for observations, would move the beaker out of his reach, and since he had to lie flat he could not access it.

He does not want to comment further, except to say that someone should see how things are being done currently- as would happen with his work. Someone needs to 'feel the pain' and take charge – solutions are there, but is there acknowledgement that something has to be done? Overall, he feels that admin should be taken off the clinicians' hands to enable them to concentrate on care, and that well designed systems using simple technology can do that. And he would be happy to help the staff by sharing his knowledge and experience.

CASE NO 4: Ms Julie Lloyd Owen

Julie is a retired NHS manager, and started feeling unwell with breathing and swallowing difficulties and rang for an ambulance on a Saturday morning around 630 am, as she lives alone. After some time, the ambulance triage decided that she was not a priority and sent her to the out of hours GP service. The triage nurse who rang Julie then told her to go to A & E, since the nurse could only offer oral antibiotics which Julie would not have been able to swallow.

A neighbour drove her to Glan Clwyd A & E Department by 10 am and where Julie could not be registered initially, as the receptionist could not locate Julie on her system even though Julie had moved from Shropshire and has been registered with a local GP practice since 2018. Anyway, between Julie and the receptionist, they found a way and got her registered and she sat in the waiting area for the initial assessment, which happened after about 2 hours. The triage nurse could not decide whether Julie was having a heart attack or needed an ENT assessment, and anyway Julie was sent back to wait. After about 3 hours, Julie was seen by an 'excellent SHO' who checked her for a possible heart attack, and decided to discuss with a senior doctor before doing anything, and sent Julie back to wait. Sometime later, Julie was called again, and discovered that she was being seen for an ENT issue- so somewhere the decision had been made not to go down the heart attach route- and again Julie was impressed with the care and attention given by the SHO. So, it came to 5/6 pm in the evening, when after these assessments, Julie was moved to a corridor where IV antibiotics and steroids were started, and where she remained till her discharge around 130/2pm next day, on Sunday.

She has praise for the junior doctors but not for the other staff, some of whom she describes as being unprofessional, not quite falling into disciplinary category but not far off either. As a former NHS manager, she says her hands were itching to get involved and address the poor practices she observed – from lack of communication about what was happening; being inappropriately questioned- about personal issues in an open space without the staff member introducing themselves; staff coming out and calling patients' names, unclearly since some staff were not familiar with Welsh names, and with no response after one shout, moving to the next; possibly only one senior nurse on in the evening shift; not being able to get the medicines on discharge (pharmacy closed at 1 pm on Sunday) and having to go to community pharmacy etc.

During her stay, the place slowly filled up with kids and then with adults with football injuries on Saturday, who were sharing the space with the drunks still sprawling on several chairs from the night before. The sandwiches trolley came around at 2ish but food was scarce after that- the only other time it came around was about 4/5am next morning when she had dozed off, and missed. When she asked for something later on, the staff were not able to provide anything. Apart from water, patients had to rely on dispensing machines and pay. She had to ask friend to bring breakfast in the morning.

She had to stay in an uncomfortable chair (about 28 hours altogether) and used her coat as cushion, and even then ended up with a sore bottom. She saw an old lady – about 80 years- who had been there since Thursday, and a young man, who just could not settle down in a chair but there was no trolley/bed. Julie uses words like scenes from Bosnia and shambles.

She says there is no point in complaining since she does not believe that the staff have insight anymore; she is adamant that this is not due to shortage of money- it is plain and simple mismanagement, and we need to get the basics right.

Her final words: There is something about wise older NHS people's experiences being useful and non-threatening as we could save them reinventing the wheel!!! The stuff I saw, we were successfully addressing in the 1990's to 2000's. It was Deja vu!!

Section 2: Back to the future: Tredegarising' the NHS



The future of the NHS is a complex and sensitive subject, and there are differing views about how to respond to what has been described as ‘Broken’, as evidenced by various reports over the years. While these reports provide appropriate analyses of the problems, I do not see a clear road map for the successful implementation of their recommendations. Overall, I feel that these reports do not tackle the underlying problems. My own assessment can be summarised as follows: the NHS is an amazing concept but it is broken and cannot be fixed. Rather, we should start again with reviewing the three fundamental principles: tax-funded, free at point of use, and comprehensive services. This will require a long term, meaningful, iterative dialogue with relevant stakeholders to establish some new principles, before we can redesign a new system spanning health and social care, and with due regard to public health and the wider determinants of health. Overall, there are no quick fixes, and we have no grand vision. (See some references, especially No 1, listed in the A bit about me section earlier)

Sometimes, it is important to go back to the past to plan the future, so I decided to revisit Tredegar to see if history can guide us. It was not an academic exercise about Nye Bevan or the history of the NHS, and I wanted to learn, at a deeper level, how it came into being, and if it is possible to ‘Tredegarise the NHS’ again.

In summary, this is what I found.

One, the Tredegar Medical Aid Society (TMAS) – the ‘blue-print’ for the NHS – was established in 1890, long before the start of the NHS. Walter Conway, its secretary, was the main architect.

Two, Walter was a major influence on Nye Bevan and together, with some others, they started the Query Club which was the platform for the launch of Nye’s political career.

Three, there were many societies like the TMAS in mining and industrial towns across the UK, and the fact that Tredegar became the lightning rod is the combination of an existing successful model and a leader with the ability to push through difficult political decisions.

Four, the NHS in 1948 was not perfect, and major compromises were made, but there was no mechanism for its periodical review and renewal; the NHS was a bold experiment, but no evaluation was built in. Soon after the start, it became apparent that some underlying planning assumptions were wrong, leading to charges being introduced in 1951. The Free and Comprehensive principles of the NHS were breached. Bevan resigned in protest and since then the NHS has become an ideological and party political battleground.

Five, each person I met during my visit is proud of Nye and Tredegar, but recognises that the NHS is not delivering what is needed, and accepts that changes are required. They pointed to the fact that TMAS existed until 1994 - so there were two systems co-existing: a state funded NHS and a local top-up service paid for by individuals to provide what the NHS would not. So, in Tredegar they knew that the NHS would not be comprehensive and that one may have to pay extra.

Six, people in Tredegar can see the evidence of what is wrong with the current system around them every day. Health inequality is growing, services are poor - especially for the most vulnerable including children, those with special needs, and those requiring end of life care. They see the waste – almost everyone had an example: from extra stays in hospitals due to absence of alternative, and cheaper, services; wasted equipment/medicines/appointments; duplication of services with limited joined up care etc. They do not need more surveys about what is wrong with the NHS. They do not see ‘emotional’ ownership of the area and of the problems by the managers and public leaders, some of whom even live far away and stay in post for only a short time. This might be appropriate if running a factory but not a human enterprise. This does not engender confidence and trust, and does not enable the necessary engagement with wise, committed community members who can help co-produce solutions.

Seven, there are examples of community members who are, in the meantime, getting on with what needs to be done and are making a difference - but not always with help from the authorities. Locals are also listening to and teaching the younger generations as hordes of school children visit Tredegar to learn about the NHS and Nye Bevan. This offers the opportunity for meaningful conversations with young people about society, the state of the world, the NHS, and Nye and Tredegar. These

locals recognise the need to take personal responsibility: about addressing unhealthy lifestyles including challenging the current drinking culture which is burdening stretched emergency services especially at weekends, and about challenging idleness – they believe in the value of work, for example.

So, what does this mean? Although a small personal study and specific to Tredegar, I believe peoples' experiences and aspirations would be the same in other places too. And, this means that major change is possible and the timing is right. But is there the necessary leadership?

Acknowledgements

Amongst others, I am grateful to Alfie Evans, Philip Prosser and Alyson Tippings in Tredegar for talking to me- they are however not responsible for the views expressed here.