CONFIDENTIAL DRAFT

A national health emergency in Wales: Part Two

It really is an emergency!

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Declaration

This essay is written in my personal capacity and is being shared in the hope that it stimulates discussions and action. If I have misrepresented or offended then please accept my apologies, and let me know so that I can correct any mistakes.

I am sometimes accused of being critical and forgetting the great work done daily by the NHS staff, and which is completely untrue. I write, not to criticise, but to ensure that its services remain available to all (and we have been beneficiaries). However, I am upset and impatient because things must change, and soon, or we will lose what we (still) have.

Most of my professional writings are available at www.ramareflections.com and to avoid repetition I will refer to the relevant articles in this essay. In particular I will draw on the Compendium of my writings: https://ramareflections.com/pdfs/Personal%20reflections%20on%20the%20NHS%20-%20Vol%201%20by%20Rajan%20Madhok.pdf

Background

Every country is renewed out of the unknown ranks and not out of the ranks of those already famous and powerful and in control. - Woodrow Wilson

"Did it have the intended effect, and what did you hope you would achieve by this", asked a colleague when we were discussing the paper I had written about the state of the NHS in Wales, and which had then been partly picked up by the media. Very good and understandable questions, but I have never found them easy to answer, as they require a deeper conversation. BuT the interaction made think, again. It was not the first time I had been asked the question of intended effect. The fact that at least we had started talking about the deeper problems of the NHS itself was an (intended) effect, and an achievement, but was there more? Should there have been more, and should not I have planned for it? Of course I would have been delighted if everyone applauded my paper and the powers that be started acting on it, but frankly, I had no major aspirations of the paper itself. I know that revolutions do not happen easily or quickly. I wrote because it is one of the ways to stimulate action and one that I can do – I cannot force the change but I have a choice about whether to contribute or not. For me it has always been about doing the right thing without worrying about the result or credit which I have no control over. I felt very strongly about the poor and inhumane treatment of sick patients and how things had to change radically for the NHS to survive, and did the only thing I could think of. The NHS requires transformational change, but it is not happening, and seems impossible in the current environment.

I know that I am often ignored, sometimes tolerated, especially by friends who teach me about the ways of the world, and occasionally rebuffed. But for me these are not reasons to stop; especially as I am clear that I offer my views with good intentions and for constructive dialogue, and if I am wrong then I am happy to be corrected.

The road to transformation is not linear or predictable, and where would we be if nobody aspired to it and waited till they were certain of the successful outcome is what I want to explore here in this essay. My central theme is that the reason why the NHS is in such a terrible state is that we are not doing the right things. We are shying away from confronting the reality, we do not imagine a different world or aspire to transformational improvements, and we are not taking personal responsibility – it is someone else's job. And there is no urgency.

Solving the NHS is not a technical exercise, there are no easy and immediate solutions; rather the battle is ideological and which requires passion, commitment and struggle. I was getting more and more exercised as I heard daily stories of problems. So, I looked at some recent personal experiences, and went to Tredegar, the birthplace of the NHS, to learn more about Nye Bevan and how the NHS came into being. I stayed in Trefil village where Nye used to walk, and tried to follow in his footsteps, in case some of the 'spirit' could guide me! The paper that prompted the afore-mentioned questions was the result.

I intended to use the paper constructively, and not to blame, and shared it with a few policymakers and talked to some senior NHS leaders. (As an aside I was concerned

that the media report had only picked up part of what I had written; I did not want sensationalism or headlines). Almost everyone had similar stories about family or friends, and one even told me that my paper described four cases whilst there are hundreds, if not thousands, of such experiences. What really concerned me was the lack of responsibility to do something tangible about the dire situation, I did not hear back from my local health board, and the Cabinet Secretary referred to the Expert Advisory Group he has established and will report in March 2025. There was no sense of urgency nor acceptance that there is no need to wait for another expert group, and that things can and should be changed now. Here is a simple test: why do we expect patients, many elderly, to sit in straight back chairs in crowded A & E departments for periods up to 30-40 hours without basic provisions, how did we sink to this level and what has this got to do with expert groups? If we cannot even sort out something so basic, then we are in very serious trouble.

To top it all, I was asked by an organisation to write a blog, based on the paper, and which I duly did, and followed their guidelines for presentation (Appendix 1), only to find myself being ignored. The Chief Executive, though shared examples of very poor personal experiences of family members in the NHS, stopped corresponding with me, and the Communication Manager is thinking about it. I do not know the reason, though I have my suspicion about why this has happened! And, they are also going to host (yet) another summit early next year.

The paper resonated with the clinical staff I spoke to, and who validated the patients' stories and shared their own experiences, with feelings of demotivation, not being valued and being exposed to moral injuries.

As I am writing this in early January 2025, the newspapers are full of shocking stories about the NHS, about the impact on patients and staff – and it is frightening. I had written my paper in October, to start preparing for the winter, and inject urgency. Sadly, it had little effect, and we, as a society, are currently going through a terrible time, as people continue to suffer. Here is a thing: I had family from overseas visiting me over the holidays and I kept praying nothing happens to them since the hospitals were completely full with long ambulance delays. Their expensive medical insurance, which they bought before coming over, would not be much use in an emergency here. And I keep getting messages from friends overseas with coverage of NHS in their national papers- even New York Times has covered it. What do I tell them- Donot come here if there is any chance you might need care, NHS, and UK, is closed. Shocking change from a few years ago when I used to travel overseas, with head held high, telling them about the wonderful NHS (sections on pages 287 and 303).

But, why? Why did we not take robust action in October, to avoid the misery in January, and more importantly, how do we prevent (another) repeat? If this is not an emergency, then how bad do things have to be, before we will act? None of my friends in the paper mentioned wanted to complain, rather they wanted to help, just like thousands of people who volunteered during the Covid pandemic to support the NHS. Such a waste of goodwill.

We are in a lose : lose situation currently. The NHS itself is a cause of health inequalities, since its funding is coming from depriving education, housing, social care, policing, etc and which create a healthy society. In its present form, it will absorb all the money that can be thrown at it, and yet fail to deliver good quality, effective and efficient care to the population.

Introduction

Testimonial injustice: "Wherein a speaker receives an unfair deficit of credibility from a hearer owing to prejudice on the hearer's part" - Miranda Fricker

The NHS is broken and is not fixable presently. The NHS as set up was of its time, but 75 years later it is a different world, and we have not kept up with the changes. However, there is a reluctance to engage in the necessary debate and imagine and create a better future. The NHS never had an in-built mechanism for systemic and systematic transformation – its establishment was a compromise and its founding principles ambitious. Its design faults became apparent soon after as charges were introduced, breaching the Free and comprehensive principles and Nye Bevan, the architect of the NHS, resigned. Since then we have been muddling through, and especially since Thatcher it has become an ideological battleground.

But can it be saved and how? Yes, but it won't be easy, because it requires us to start again, questioning the entire premise of the NHS. And there are no signs that this is happening. Over in England while I can understand that it will take 10 years to turn NHS around, but have they made the right start? I am not so confident. Not tackling Social Care or the basis of the NHS: tax funded, free at the point of use and comprehensive services means the current plans will go the way of Blair's 10 years Modernisation Plan or the Conservative Five Year Forward View. The first steps are critical in determining where one ends up; even a cursory review of the aim to emphasise primary and community services or more prevention will show that these are not possible to achieve, without a fundamental and whole systems review, and less we talk about reliance on AI, the better; we need more RI – Real Intelligence - first.

Here in Wales, can we do better? I do not know, and can only hope so. But there has to be a sense of urgency and a clear plan, and both of which are not evident to me. If it was being taken seriously then why are the basics not sorted, and why do not we have some humanity – for example, it is not patients' fault (with a few exceptions) that they end up in A & E departments, but once they are there why do not the hospitals take better care of them? How about giving them comfortable chairs, not straight back ones, when they may have to wait for 30-40 hours, or bring refreshments around regularly or keep the rowdy/drunks separate etc, not to mention those more acutely ill and being kept or trolleys in corridors. Or looking after the staff better, by creating efficient systems. Small, largely operational, things with big differences, and all doable, now. Why is there no concerted action to tackle: waste, whether in medicines or equipment; the mindless and bloated bureaucracy and the paperwork; and unsafe care with its associated direct costs and indirect costs due to litigation, insurance and inquiries. One would have thought that with a national emergency, these issues would have been prioritised and proper systems set up to tackle them urgently. None of these require expert groups; instead they require freeing up talent at the local levels, creating mechanisms to enable them to innovate, empowering and holding the system leaders accountable, and moving away from the learned helplessness.

We may need an Expert Group, however, for the Big Conversation about the NHS itself, but even that is not a short term thing, it will take a long time, given some hard questions and differing views. Essentially what is needed is a discussion about the purpose and scope of the NHS: is it only about health or also about social care and/or wider public health? What exactly is the state's vs individual's responsibility when it comes to these issues? Is a fully state funded NHS the right model now, how should the money be raised, can we have co-payments/insurance, and what is the right amount? And how should the NHS be organised, delivered, and governed etc. These are challenging questions, and need to be addressed with evidence, without indulging in rhetoric, ideology or party politics.

In my view, any stated policy aim must come with a road map to show how that aim will translate into practice: if A & E or cancer services are going to be sorted then show me how: what are the challenges and how will they be overcome and when? I can bet that detailed analysis will show that any significant improvements will require very tough decisions and will take time – there are no quick fixes, and certainly not money alone. There are too many aspirational reports already, we need (massive) doses of reality.

Although many senior people will agree with this analysis in private, most are not willing to say it openly or take action, and those who do are ignored or marginalised. It is like the 'Emperor is Naked' scenario.

But why should you listen to me? Why take note of what I am saying? After all I am not a 'well-known' expert. So, in the next section, I digress in order to share my experiences of transformation and to establish credibility.

Transformational change – Make a start

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

It was late Ron Wing, my chairman, in Hull, who first mentioned to me the words: Add Value; he had taken a risk when he appointed me as the director of public health (my second such post) in 1998, because he wanted someone different, and thought I was the one. I did not know the term until then but I was not in the NHS for a regular 9-5 job and doing just the basics; 'feeding the beast' never fulfilled me. I had to do more and make myself useful – add value. And that is what I have always tried to do; every job I took in the NHS, and otherwise, I was on the lookout for something more.

I could go on and describe many more examples but I will restrict myself to four; for further details please see my Compendium and other writings .

Example one: Streamlining emergency care – Facilitating Unit (1989)

I was a new public health trainee, and had moved from orthopaedic surgery (another story) and was based in Middlesbrough, in 1989. There were two separate general hospitals: Middlesbrough General and South Cleveland, with the former due to close; the option to create a new site: Middlehaven has not been successful, and so South

Cleveland was going to be the main centre. Whilst the proposal was being worked up, especially given the usual problems of resistance and 'politics' there was a logistic issue and which was about managing two separate accident and emergency services, and using the opportunity to create a new model. I was talking to my consultant, Ian Holtby, about this situation, and we shared our personal experiences. He had worked in Africa for a while and I had qualified as a doctor in Delhi, India, and both of us had seen and worked in a model whereby all the A & E work was centralised in one place out of hours, whilst the rest of hospital was left undisturbed. All patients needing urgent treatment and admission were admitted to this central unit and managed by the 24 hours on-call teams, by rotation. The shift started and finished at 9am, and at the end patients were transferred to the main hospital, for the start of the new team; all resident doctors used to stay for in the Unit which had sleeping bays. We wrote this model up and called it Facilitating Unit, and urged its adoption locally; and we were able to create a system for paediatric patients initially (and which required another indepth study).

Looking back on it, over thirty years later, Acute Admissions: Medical and Surgical, are the norm in NHS hospitals, though none have gone as far as the Facilitating Unit we described.

The Facilitating Unit was of its time, and clearly some of the features may be challenging; for example 24 hours shifts, though some specialties in the NHS do work on that basis.

The reality of the current NHS is that acutely ill patients continue to wait in corridors or ambulances, and waiting lists for elective procedures are getting longer, since it is challenging to plan for the latter due to the unpredictable demand of the former. Is not it time to recognise that there are two 'distinct' health systems: acute and elective, and we need to organise and manage them accordingly?

Example two: Better use of capacity - Common Waiting lists (1991)

I was very fortunate to get the Northern Regional Health Authority support to go and study at the Mayo Clinic in USA in 1991; I was a public health trainee in the region and wanted to go there to undertake research in orthopaedics, which was my major interest then.

After I arrived there, and started working on the research projects as part of Rochester Epidemiology Project which relied on their unique patient records, I looked up how these records came about and how they were used at the Clinic. It was a fantastic case of 'Systems Engineering' - not that I knew the term then! It was another example of the work done by Henry Plummer, the engineer, who along with Drs Will and Charles Mayo (sons of the Founder W W Mayo) and Harry Hawick, the administrator, the trio of an engineer, doctors and administrator, who made the Mayo Clinic the world's leading hospital.

Their work inspired me, and made me think of the problems of the NHS, and foremost of these was the long waiting lists. I began to think how we could address

this problem, I also drew on my previous experience when I worked in orthopaedic surgery. This led to describing the model for pooling waiting lists for common conditions (page 18) at unit or district level chronologically rather than by individual consultants. After I came back from USA, and became a consultant in public health in Middlesbrough, I undertook further research to look at the feasibility of this model and which by then was being termed Common Waiting Lists model.

Since then there has been growing adoption of this model, and which is almost the norm in the NHS, though increasing specialisation and sub-specialisation is creating its own bottle necks.

Example three: Team working (1992-93) - Nurse led clinic

I continued further work on waiting lists using orthopaedic surgery as the 'pilot' specialty since I was familiar with it, and also it was the one with longest waits. I had also developed an interest in Guidelines and Protocols by then and undertook work on referral guidelines for orthopaedic outpatients (page 140). It then led to focussed work on management of patients with back pain, and the establishment of a nurse led clinic. We had initially considered a physiotherapist to lead such a clinic, but due to shortages, and further analysis we went for a nurse to run the service. I used to 'dig deeply' into problem, trying to understand the root causes – later on I came across the 5 Whys, which is about progressively asking why at each stage of understanding a problem to get to its nub – and we realised that the distinction between a physiotherapist and a nurse was unnecessary, competence was more important.

I recounted the difficulties in spreading this model in a subsequent paper (page 147).

Example four: Working together – Specialty Management Approach (1996)

Encouraged by these successes I wanted to take the work to a higher level, and look at whole specialties and overall create systems for organising and delivering cost effective, quality care. I had moved to the director of public health position in Gateshead and South Tyneside and by then had joined the evidence based medicine movement including becoming an editor with Cochrane Bone Joint and Muscle Trauma Group. I was conscious that there was more to the NHS than just orthopaedic surgery (*sic*) and established a system for collating evidence to inform the organisation and delivery of clinical services – we called it the Clinical Effectiveness Resource Centre (page 24) and then used it to develop the Specialty Management Approach (page 40) using two pilot specialties this time: Orthopaedics and dermatology.

And your point is?

I specifically chose the four examples because they show that problems with emergency care or waiting lists are not new, and that we have neither systems for local innovations nor for faster adoption of proven practices.

I have another tale of the nurse led clinic story which I previously described here (page 25). “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 (as in previous section), 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”.

Or the work of Alex Anstey, a leading dermatologist. I have just been given the book: Under the skin by him where he described his Integrated Care Model. In 2017, and which not very dissimilar to the SMA above.

How many more such examples exist out there? Should we not have pulled them together as in the Specialty Management Approach mentioned, and not waited for 30 years to bring the benefits to patients? Does anyone know how many operational scientists or knowledge management people work at the health boards levels, to help undertake such necessary work?

I was very privileged to have worked with and learnt from people who could not only can think big but also steer the changes through. At the risk of singling some (with apologies to many others whose work has been equally important) I will mention a few people here who were game changers: Iain Chalmers who set up the Cochrane Collaboration (My involvement: I was a part of the Collaboration, and integrated its work in services –page 129); Mike Richards, the original cancer Czar (My involvement: I was on the original committee that helped prepare the cancer strategy after the Labour Government was elected in 1997, and which then led to the first National Service Framework); Muir Gray with amongst many things the force behind screening programme (My involvement: I followed this closely; our paper is not available online - Thornton-Jones, Helen & Hampshaw, Susan & Soltani, Hora & Madhok, Rajan. (2002). Reviewing local screening policies - A worthwhile exercise?. British Journal of Clinical Governance. 7. 165-176. 10.1108/14664100210438253) and Liam Donaldson, the architect of clinical governance and patient safety (My involvement: I was a supporter of clinical governance –page 188 and was the India envoy of National Patient Safety Agency in 2009-10). They had bold ambitions – two weeks wait for first appointment and one month from diagnosis to treatment targets for cancers were unimaginable at that time, for example. I learnt a lot from these

leaders, and which guided my practice in various jobs. But where are such people now? Why do not we harness their work and commitment?

We have run out of road, and in any case, the NHS has always been more a dream than reality; in practice it is very different to how it is portrayed in theory: a well-designed, effective and efficient 'organisation'. I used to tell the theoretical description of how the NHS worked with the GP as the guardian of one's health, and who referred to a consultant when needed, who then saw the GP's patient in the 'Sister's' Ward in the local hospital. This trio of GPs, hospital doctors and nurses working seamlessly in one's locality to ensure best care for the patient has been the espoused face of the NHS. This is how it has been sold, but sadly it has never been correct; there have been pockets of excellence but generally as a way of working no. It was, and now increasingly is, a polarised world, with the patients caught between various parties.

In addition to specific projects, as described in the previous section, I have tried to promote discussions on the fundamentals. I contributed to the discussions about the Lansley's reforms in 2012 (page 208 onwards), went on the 300 mile Jarrow March in 2014, and more recently tried, with my colleague, Stephanie Snow, to start a conversation about the NHS of the future as part of NHS 75 milestone, for example.

I tried with the BMJ Commission on the NHS most recently (here, here and here), but found no acknowledgment or support for my views. I wait to see what the final Darzi Report in England will say later in 2025, but given the starting point with limited attention to the fundamental problems, it seems to me to be more of the same- a triumph of hope over evidence. And of course, we will have the report of the Expert Advisory Group in Wales also.

Let me finish with three points relevant to the focus of this paper.

One, there are always ways to make a difference, to improve services for patients, and it is important to make a start. I always believed in seeking forgiveness than asking for permission, as ones on the front line are usually the best judges of what is the right thing to do- but we have constrained and demotivated them. If one starts, others follow and rally around – in each of these examples that I shared, whilst there was resistance from some quarters, there was also support and the latter prevailed. Success breeds success. There is so much that can be done, now, - the small things with big differences, and which will help build confidence and win trust as the public sees action being taken.

Two, it is hard to predict how things will evolve. Could I have foreseen how the examples described here will develop – were we the first one to advocate these anyway and is it right to say that the current Acute/Medical/Surgical Assessment units were informed by our Facilitating Unit model, for example? To make such a connection between an idea and the product is not easy, people do come up with similar ideas independently and make different uses of the idea – so while there is not a fully developed Facilitating Unit as we described it, parts of it exist, and slowly they spread and further develop, moving with the times. May be the Unit is history and we need a totally new model, as is being discussed in some places- like at

Withybush Hospital in Haverford West for example, led by Paul Underwood and Karen Brown. Let a thousand flowers bloom- encourage innovation at local levels.

Three, it is worth learning from the past, and others. On the one hand, it is disheartening to see how much time and energy is wasted by a lack of adoption of proven practices – like the nurse led back pain clinic above or the dermatology model, it is understandable on the other hand. Because, the NHS has no in-built system for innovation and adoption, we failed to create mechanisms to leverage some excellent national organisations like NICE and engineer the necessary cultural change. In the recent years this situation has become worse. I am not very familiar with all the great work being done across Wales, but why do not we pull it altogether?

Transformational Change – Mission Impossible: Is there a way?

Some men see things as they are
And ask why
I dream of things that never were
And ask why not

(Source unknown)

Going back to the questions at the start of this essay: “Did it have the intended effect, and what did you hope you would achieve by this”, or rather what is the point of this essay. Apart from, of course, showing off and stroking my ego! And my answer is as before: it is to Add Value, since the NHS is dying (or being killed off, depending on who you talk to) slowly but surely. It must reform fundamentally, and it is everyone’s job. But we are not doing it, we are not confronting the problems, we have not analysed them properly, we are not using imaginative solutions, and we are not taking responsibility. What I see from various reports and the media does not fill me with any confidence; take the emphasis on AI as the latest salvation, for example. How is it different from the way the NHS tried to introduce IT or patient records, where 20 years later we still do not have the basics in place? What have we learnt from that experience and which will ensure that we get it right this time: how will we design the system for successful adoption of AI? Leaving aside all the moral and ethical issues, or the fact that AI with its energy requirements and climate change may not be compatible goals.

At its heart is the need for conceptual clarity about the NHS and social care, and then it will be about design and robust, dynamic, implementation of the system. Such a system will also need constant review and renewal, because things do not last for ever. The Cochrane Collaboration is finished, the cancer strategy is in disarray, not to mention the problems with patient safety, for example. Of course things do stop working after a while – the inherent entropy – and maybe are not necessary any more but, there is something else. And which is that all these initiatives did not manage to engineer the systemic cultural change and make NHS continuously learning and self-improving; they made progress in their specific area, in silos, for some time, but not across the board or in sustained manner. In addition, these initiatives arrived with massive bureaucracy, stopped local innovations and created dependence.

More recently I have been very troubled about the handling of the Covid Pandemic- I am not talking about the national mismanagement and where the inquiry is ongoing, but at the local levels. I have failed to get the answer to my question of what did we learn locally- after all things were done differently in many areas and so how do we sustain the improvements? There is no national repository of best practices and plans to spread and sustain them – plenty of emphasis on fault finding and blaming, and we seem to have reverted back to old ways of working. The phenomenal amount of money – The Covid Cheque – could have been used to re-engineer the

system. No, I was not actively working then – and that is not due to lack of trying, another story as I repeatedly offered my help (free) to any of the stakeholders especially in my region. To me leadership is also about planning and using the crisis (page 152) to create a better future. Was anyone thinking about the post-covid world? All the sacrifices by health care workers, many of whom paid the ultimate price, seem to have been wasted. We should have done better.

I am not arrogant enough to say that I have the monopoly on ideas, in fact the opposite is true. The tragedy is that we are not sharing and learning fast enough. By sharing my experiences, this essay then is my contribution to the necessary discussion. We need to believe and have hope, and do what is right without worrying about credit or whether it will have 'the effect'. When I was doing the Jarrow March in 2014, all the 'practical' people used to say what is the point, and to some extent they were right. It made hardly any difference, just like with the original Jarrow marchers in 1936. On the other hand, could you have foreseen Beveridge Report and the creation of the NHS, that followed the Jarrow March and WW2? Or the fall of Berlin Wall or end of slavery and many other major transformations in society, and how did these happen? Because people thought about these, and then did their bit. So, giving up must never be an option. Do the right thing wherever you are, with whatever you have, and make a start. That is my intended effect.

If this essay leads to cross political party approach to looking at the NHS and social care, then it would be a bonus.

Who are you?

Late Aidan Halligan, when being introduced to someone would ask: Who are you? He was not as (much) interested in their position, as he was in knowing the person inside, what made them tick! It is not the positions *perse*, but what one does with them that is important was his point and that means knowing them at a deeper level. By now you will know who I am anyway – as someone who cares about the NHS and is a glass half empty person. You can see my professional details here www.ramareflections.com and the story of my time in the NHS is part of the NHS 70 archives at the British Library (currently available in person only, but in time, hopefully online by going to http://sami.bl.uk/and typing C1887/1172 in the simple search screen, I have been advised!).

I may be 'relatively new' to Wales, but it is home now and I have to do whatever I can to help.

Acknowledgement

I stood on the shoulders of giants, and am very grateful to them, and my colleagues and friends over the years.

APPENDIX 1

BLOG FOR THE THINK-TANK

The NHS is dead, long live the NHS: time for a fresh start

"*We are living today in tomorrow's world with yesterday's ideas*" said a former Yugoslavian Vice President, Milovan Djalas, and that about sums up the problem with the NHS. We are neither able to embrace the future nor let go of the past. The NHS in 1948 was not perfect, and major compromises were made, but there was no mechanism for its periodical review and renewal. 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. To some extent the fact that it has survived for seventy-five years is a miracle, and we should be thankful for it. But it is time now for its successor, a system which reflects the current reality.

Can we do it and how can we do it?

Yes, we can do it, but not easily and not quickly; revolutions only appear to happen suddenly, but are years (longer) in the making, and so was/will be the case with the NHS. Just as the old NHS was hard fought and won, the new NHS will need much effort too.

After decades of work-arounds/short term fixes, we have reached the stage that whichever area of services you look at, it is broken: GPs, dentistry, hospitals, ambulances, social care not to mention children, mental health, or elderly care; the education and training systems; organisation, governance, and regulation; staff morale; adoption of innovation; and the list goes on. I am not convinced that the NHS is the envy of the world or the most treasured institution; the real NHS I see is very different. I used to be proud of the NHS, and now I am upset and frankly ashamed. 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. Both, the patients, and the professionals are being let down. It is all very easy to critique but what is the answer then?

Of course, there are many reasons for this situation, and that is why solving this complexity will not be easy. But that is not the same as saying it can not be done.

So, what should/could we do? In my view, action is needed on two time-frames.

In the shorter term, we should declare a national health emergency and set up four projects to deal with choked accident and emergency departments, blocked hospital beds, growing waiting lists, and appalling waste. For each of these areas we need systematic analysis of the reasons, look at best practices from the past and from all around, use imagination to design solutions, and most importantly, act. We cannot talk our way out of the situation, we need to walk out of it - by acting. I will not go into

the details of what is wrong and what could/should be done, but share the following to illustrate how we must define the issues and solve them. I find it completely unacceptable that patients are having to sit for 36-48 hours in straight back chairs with limited access to any refreshments, and at weekends sharing the same space with drunks, in A & E departments. Why cannot we give them comfortable chairs, get a refreshment trolley around every 3-4 hours, keep drunks in a separate area? There is a lot we already know about what works- see this Bevan Commission report about Waste in health services (1), for example? My main point here is that abnormal has become normal, and we are not doing some small things to help improve services – the learned helplessness has paralysed the system. To overcome this tragic situation, we need to get angry (yes), stop accepting sub-standard services, get together lists of defined tasks – "Do or justify' why best practices from elsewhere cannot be adopted, and demand actions of those responsible for delivering the changes, including self - be the change you want to see. Every health board's meeting should start with an update on these issues – there should be a laser focus, just as in an emergency, starting now, and for the next six months. Frankly, without this the coming winter will be horrible.

I know that there will be competing priorities, and I can hear people asking what about mental health, cancers, children services and so on, but unless we sort out the immediate and most significant issues above, we will not be able to do the more important work on creating a new fit for purpose care system. In any case, if we do the above, for example tackle waste- we will free up considerable resources.

Simultaneously, we need to plan for the long term and start with asking, and answering, some fundamental questions:

1. What is the purpose, and the scope, of the NHS? Is it about health and social care and/or wider public health?

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, can we have co-payments/insurance, and what is the right amount for the NHS anyway?

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. What is the role of the private sector in providing services – love or loathe it, the sector is relevant. Given I live in Wales, a small country, how many organisations should be there, and who says that each of them needs a separate board, all developing their own policies on basics like risk registers, assurance frameworks, Equality and so on- the bureaucracy/waste is mind-boggling.

4. What about the 'wicked' issues which will continue to haunt us unless addressed: the political interference with micromanagement from the Parliament/Senedd; health: social care and primary: secondary care separation and massive fragmentation; 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?

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 money, but patient experience and quality!

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. I am aware that it is not easy to answer these questions, but we must avoid the trap of the urgent driving out the important. We may not get agreement on these matters, but the exercise is essential, and will help us see what choices we are making as a society. Sadly, none of the major Think Tanks or Government bodies have done that – these are too quick to jump to solutions without clarifying the problems and are sometimes pursuing a particular ideology. The fact that the NHS itself is a cause of health inequalities, since its funding is coming from depriving education, housing, social care, policing, and everything that creates a healthy and happy society, is not well understood, or publicly acknowledged. In its current form, it will absorb all the money that can be thrown at it, and yet fail to deliver good quality, effective and efficient care.

The battle 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.

John Gray, the political philosopher, wrote: *"politics is best understood, not as a path to salvation, but as the "art of devising temporary remedies for recurring evils,"* and that is what we need now. Another temporary remedy for the health and social care needs of the populations- NHS Mk 2; step forward Nye Bevan Mk 2.

Reference

1. https://bevancommission.org/what-a-waste/

About me

I am a retired public health doctor and have written this in my personal capacity. I was a Jarrow Marcher: https://www.hsj.co.uk/comment/why-i-went-on-the-300-mile-march-to-save-thenhs/5074587.article

For further details of my views on the NHS -see these articles below- and visit https://ramareflections.com/

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