# A Radical Return to the Beginning

Firstly, thank you for inviting me to give the Worcester lecture in such a lovely place. It's not often I get to speak from a lectern in a Cathedral and I'm deeply humbled by the invitation to speak to you today about a subject close to my heart: the NHS.

I'm the son of a nurse who worked in the NHS for over 45 years. It still makes me emotional to think of what my mum went through as a nurse in those years and perhaps I might touch on her experiences throughout this lecture.

There is something about the calling to work for the NHS that goes to the heart of what we admire in this country- an approach to care excellence and service delivery that gets to the best of this service, often called a national religion. A service that was celebrated during the Olympic opening ceremony with nurses literally bouncing on beds in theatrical hospitals and had us all banging pots and pans to express our thanks during the horrors of the pandemic.

However, I recall going to a service of thanksgiving for the NHS at St Paul's Cathedral and meeting up with two nurses who were specialists in critical care. They were wearing nurse's uniforms and had their badges on, and I introduced them as heroines to a colleague who was walking up the stairs of St Paul's with me. Their response reminded me of something important about the NHS, the way we think about it and those who work in it. The response to my respectful remark about these nurses being heroines was for one of the nurses to respond calmly and clearly "thank you but we aren't heroines or any kind of superheroes, we are doing our jobs as we are trained to do. We are just like everyone else and its worrying when we are othered as something different."

It highlights that we have a habit of creating a pedestal for our NHS and its workers, which puts them above the ordinary considerations of good leadership, credible and appropriate reward and recognition, and often the resources necessary to do their best as professionals. It isn't always about more money but actually about listening and greater trust in their judgement to do the right thing, at the right time, for the right people, for the right reason. People don't talk to heroes and heroines, they worship them, they lionise them, but there isn't a job description for heroes and heroines.

I begin with these remarks because I think that ultimately, the NHS is a human construct designed to engage, enhance and save human lives. Its only real assets are human ones and it's a fact that I always keep in mind whenever I am thinking of the NHS, and it was what was in my mind when putting this lecture together.

Now, let's look at the NHS as it is currently. I think I would describe it as sick (with parts in intensive care) but it will not die. Those people who talk about the collapse of the NHS misunderstand the sheer will of the people who work within it and their desire to provide services, sometimes at great cost to themselves and their families. No, the NHS will not collapse but it could become a service which is diminished and a long way from its original intentions when set up by Nye Bevan, whose NHS bill was passed in 1946 and was enacted in 1948. Nye Bevan said at the time:
"No society can legitimately call itself civilised if a sick person is denied medical aid because of a lack of means." (5th July 1948)

A sick NHS is in danger of failing in its mission, becoming a service so denuded of resource that it starts to provide a kind of last resort service for those who have no choice but to use it. While everyone else begs, borrows and steals the resources, to seek private healthcare in order to relieve their pain or alleviate the potential for their health to worsen while they wait. Or indeed, even those not in that category have an

experience which is devoid of the necessary humanity because they are confronted with exhausted, time poor, resource poor, under-led and under-managed staff and are suffering from the vicissitudes of moral harm.

The challenges facing the NHS as I speak are pretty daunting, but not insurmountable. We have a list of those waiting for elective care of over 7 million, a waiting list that has increased as a direct result of crippling strikes by essential workers, namely doctors, nurses, and consultants. Alongside other health professionals whose profiles aren't so high in the national psyche like (like physios, radiologists) all of whom make up the teams necessary to provide support and to treat and prevent ill health. Access to mental healthcare is equally challenging, there are 1.3 million people waiting for community services, 18% of people with mental health needs are waiting over 12 hours in A&E, we have seen an 100% increase in waits for young people with eating disorders and bed occupancy for acute inpatient units is 95% (safe levels should be 85%). Individuals with mental health challenges have a life expectancy up to 20 years less than people without such challenges. The workforce challenges that, in part, contribute to these woeful statistics have not abated- they may even be made worse by the feelings amongst NHS staff which are best summed up by a conversation I had while on a terrarium making course. One of my fellow terrarium crafters was a junior doctor who told me that his senior surgeon tutors were advising him not to enter the NHS in the first place because of the poor working conditions he should expect. This would be after having spent approximately £250K training this junior doctor to become a practicing clinician in the first place.

I often separate the challenges facing the NHS into stock and flow challenges. The stock challenges include the lack of investment in NHS estates where the maintenance backlog now stands at £11bn, and a lack of investment to support the roll out of digital technologies which can aid productivity.

Flow challenges are partly down to a lack of available social care packages, which impedes smooth running, as well as impacting the experience of NHS patients, and citizens at large. At some point we will all need an element of social care and yet it is currently underfunded. Since 2015/16, social care funding has risen in real terms, reaching £26.9 billion in 2021/22, although this includes around £3 billion of additional grants specifically to support the sector through the pandemic. It is also well below the £31.8 billion the Health Foundation estimated would be required by 2023/24 to restore service capacity to 2010/11 levels, including accounting for pay increases commensurate with the NHS over the same period of time[1].

While high vacancies have been a consistent challenge across the sector, post pandemic this has become significantly more acute. Between 2020/21 and 2021/22 the overall vacancy rate jumped 50 per cent from 110,000 to 165,000 vacancies[1]. As a result, there are 13,000 beds in the NHS that are currently filled with people who are ready to be discharged but cannot be because we have insufficient care packages in the community for them to go to.

Included in the flow challenges is public health which has received cuts of 26% since 2015/16[2] and yet is crucial as we found during the pandemic, both for preventing ill health and also educating the public. Poor health and wellbeing are strongly associated with living in socioeconomically deprived areas, as health is determined by a complex interaction of physical, social and economic determinants, such as employment, education and housing. Clinical care accounts for 20% of health outcomes, while the remaining 80% of health and care issues are impacted by wider factors (social and environmental) on our health and which drive increased demand on an already stretched NHS.

I would include key drivers as poverty and racism. Indeed, if you are a woman in Barking and Dagenham (one of London's poorest boroughs) your healthy life expectancy is likely to be 60, however if you live in

---

[1] https://www.nhsconfed.org/publications/adult-social-care-and-nhs - 22nd Sept 2023 Report

[2] https://www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greater-investment-is-needed

more affluent borough of Richmond on Thames, your healthy life expectancy is likely to be 69[3]. In Worcestershire, according to the 2022 joint specific needs assessment (JSNA), many health-related measures perform better than the national average, however the average masks health inequalities. For example, the difference in life expectancy between the most and least deprived areas in Worcestershire is 7.9 years for males and 5.6 years for females[4].
The biggest flow challenge relates to the inverse care law first devised by Dr Tudor Hart, a Welsh GP who noted that those the most in need of health and care tend to get it the least. This a major cause of the flow challenge and a law much of my career has been spent trying to reverse, in effect it means that poor people receive a poorer service than those less poor and this is particularly the case if they are from Black and Minority Ethnic groups. It's the reason why I set up the NHS Race and Health Observatory, to highlight and provide solutions for the staggering impact of the inverse care law as it applies to people's access, experience and outcomes of healthcare who are various shades of my skin colour.

Virtually every element of healthcare delivered by the NHS has the same gradient in relation to race; in cancer care black people are still most likely to receive news that their cancer has reached stage 4 while attending A&E, black women are most likely to die in childbirth, or their child is more likely to die or be injured being born. Mental health care (if one can call it that) is more likely to be harsh, criminalising and overly medication-focused if you are black. Furthermore, NHS careers are likely to be less rewarding, recognised or even paid as much if you are black, despite the fact the 26% of the NHS workforce are black.

I say these things because we need to face the problems as they are, with as little romance about the religion of the NHS as possible if we are to solve them. All of the above challenges and the ones I don't have time for, make up a heady brew of complex interacting challenges in a highly complex system. Influenced by political will and administrative diktat from NHSE, these challenges seem to fall like snow onto the heads of those trying to provide care and or administer the provision of care.

By the way, the NHS is under-managed not over-managed as often stated in the press. Management roles in the private sector run at around 20 percent of the workforce, in the NHS its 9 percent. I never give a talk like this one without thanking the many managers and administrators without whose dedication, commitment and sheer graft the NHS would be in a worse state than it is at the moment. I see you, and I thank you.

It would be easy to continue with a litany of despairing statistics about the current state of the NHS, but it is important to note that the NHS is still one of the most respected health systems in the world that manages to treat 1.5 million people a day, and it does so with a dignity and effectiveness that is the envy of the world. We need to remember that when we address the NHS's current challenges it's because we love it - and I mean love in its most romantic and soppy way - we have a national love affair with an institution, and it is a beautiful thing. But like most love affairs, it's hard to see the faults until they destroy the relationship. We must address these faults if our love affair can be maintained in a mutually useful and long-standing relationship.

Before I continue, I want to deal with one of the questions that usually gets asked whenever the subject of the NHS gets raised, and that question usually revolves around the cost of the NHS to the nation's purse. There are people who question whether the principle of a health service free at the point of need is a viable model for health service in the 21st century, where demand is outstripping supply as a result of an ageing population, who have the inconvenient habit of wanting to live and often do so with long-standing and debilitating illness before dying expensively.

I usually get asked this question by people around my age, who are in great health as a result of a life of middle-class choices, who pay the top rate of tax and have a subscription to a private healthcare provider. Like the learned Prof. of Economics I shared a platform with on Question Time, who was there because he

---

[3] https://fingertips.phe.org.uk/search/healthy%20life%20expectancy#page/1/gid/1/pat/6/ati/501/are/E09000027/iid/90362/age/1/sex/1/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

[4] https://www.worcestershire.gov.uk/sites/default/files/2023-02/JSNA%20accessible%20010223%20HW5.pdf

had written a book arguing that we can't afford the NHS and that we should resort to a German or French model of health provision or an American one (I sensed he was particularly keen on the US model). What such arguments fail to mention is that both Germany and France spend more per capita than the UK in the first place. They also fail to mention that in the US 55 per cent of bankruptcies are caused by healthcare costs. Those of you with private healthcare care arrangements will have noticed the pre-existing conditions clause which effectively voids your insurance if your condition is one that has developed from a pre-existing one, the definition of which can be pretty flexible depending on your provider.

But I think the best argument in favour of the NHS is that all other systems place the risk on you, the payer. In the UK, an individual health risk is shared across 57 million other people - the risk is spread, and the cost lowered. In short, the NHS is still great value for money and would still be so if we were to increase spending significantly through taxation. Indeed, recent work done by Carnall Farrar and the NHS Confederation shows that for every £1 spent on health by the government on our behalf, it generates £4 back to the economy through increased productivity[5] ; in short there is no wealth without health.

So, to the solutions- what can, or should, we be doing to cure our patients and the NHS - to bring it back to full health again so that this revered institution can most effectively contribute to the growth of our economy and our sense of health and wealth as a nation? Having thought about my approach to this question, I've had a look at other first world health systems in terms of the challenges they face, and to some degree or other, they all face the same ones which can be summarised as Equity, Access and Digital.

The UK has an advantage over other health systems in that our health system was borne by the people who use it and love it. That's why it's seared into our national psyche -the apocryphal story of how the NHS began in a village in Wales called Tradeger, where the people of that village created a health and care system free at the point of access. On his visit to the village where he was from, Nye Bevan said he was going to 'Tradegerise' health in England – and he actually did.

Often, we complicate the challenges the NHS faces by forgetting that the NHS is a complex and adaptive system which follows the basic rules of complex adaptive systems- that small things can have disproportionate impacts on whole system. It's not always possible to predict the outcomes of any one change or intervention but what I do know is that the most powerful and often disregarded intervention is the leadership- what they say, do, whom they say and do it with and when. So let me return to my proposition that most first world health systems have three challenges, namely Equity, Access and Digital.

Firstly, Equity as you know, is not the same as equality. Equity is about giving people what they need as opposed to what they want and certainly not what everyone else has. The provision of equitable care is one of the challenges, be that within primary, secondary or community care.

An example of what I mean might be best illustrated by what happened in the West Yorkshire and Harrogate ICS when they looked at waiting times, which like everywhere else, were heading in the wrong direction. When they disaggregated the list and looked carefully at who was waiting the longest, they discovered (unsurprisingly) that those waiting the longest for elective care were those who lived in the poorest areas, those who had learning difficulties and black people. Looking at why, the ICS realised that the reasons for this were that those people were less likely to have the conversations with primary and secondary care health professionals, often leading to delayed diagnosis or misunderstanding of the severity of their conditions. Everybody was equally on the waiting list from the point that they were diagnosed (that's equality for you), but those who actually needed the intervention the most, or were suffering the most, were waiting longest and were less likely to have the care needed while they waited.

This disaggregated list told a tale of inequity. When work was done to both identify those most in need and change the relationship with these individuals, not only did they wait less for their necessary intervention,

[5] https://www.nhsconfed.org/publications/safety-net-springboard#:~:text=The%20research%20from%20Carnall%20Farrar,net%20for%20our%20local%20communities.

but because these people were waiting disproportionately longer than everyone else on the list, then the average overall waiting time was reduced. This is an example of how equity works.

The NHS being free at the point of access according to need means an understanding of how we apply equity to our prioritisation of curative and preventative resource allocation, population health and clinical pathways. It is not at the fringes of our healthcare planning that we should consider the issues of equity a nice 'to do' or a charitable endeavour nodded to, but it should be at the core of how we test the efficacy of the NHS. When I was a board member of the NHS, I often raised the matter of poverty and inequality. The response was sometimes to see it either as a political issue or a personal one with 'rags to riches' stories, with accompanying expressions of sympathy and charitable concern. In fact, it is neither; it is the core business of the NHS and social care system and speaks to its roots as a service designed by and for the working poor, from which the middle class benefited.

The argument that a service for the poor results in a poor service isn't borne out in history or experience. Think of any public service worthy of the name and you will see it was either started by, or with the poor. Those whose critique starts with the notion that a service for the poor leads to a poor service do not make the link between what we learn from the poorest that benefit the middle, and aspiring classes, or the fact that concern for the poor is a zero-sum game. It is the key test of public service leadership; if a service fails to reverse the inverse care law, then it is a poor service.

Secondly, Access: Access is a tricky one but again is it best summarised in a story. I will tell you about a conversation I had with the last CEO of the NHS, Simon Stevens (now Lord Stevens) in which he recounted a trip to a London borough, where the providers of a diabetes service for young people bemoaned the fact that young people weren't turning up for their appointments, to which Simon asked, "so when is the clinic open?" The response was "between 9 and 3:30", to which Simon responded, "well I can see the problem". Their assembled leadership leaned in to hear the gospel-like insight from the blessed leader; Simon said school kids need to go to school at those times. The choice between school and a clinic, well, even school wins.

The point of this story is to illustrate three things; firstly, access is about design, and design is about commissioning, and commissioning is about understanding the needs of an individual and or a community such that a platform for procurement can be built. It's the only test of commissioning worth having; does the service add value in its design, or is it of negative value, even if it's cheaper than the last service? I don't have the numbers, but I can guarantee that there are billions wasted in services which actually generate demand because they fail to understand the needs of the individuals, and communities they serve or generate further demand on other services instead.

Whenever I consider the value of primary care as the doorway to the NHS, in which 95% of patients enter NHS services, I think of how much negative value transfer is generated by an underfunded, under-led and under-connected primary care service, and the examples of where a positive value transfer primary care service is making inroads into managing demand and improving healthcare across a population. A recent visit to Fleetwood gave me an instruction in how a scalable primary care model that is co-produced with the community and working in step with the local population is delivering better health outcomes for the poorest, reducing demand on acute services, and creating health and positive value for those at the sharp end of the inverse care law.

The challenge of access does not stop with service design because services are delivered by a workforce, and a demoralised and under-led workforce cannot be a contributor to better design and deliver in the way I've described. This lecture doesn't have time to go into too much detail about leadership and the effect on culture, so I'll summarise for you in three sentences: We need a single approach to leadership standards in the NHS, led from the top and supported by help in the healthcare system, as opposed to punitive inspection. We need accountability at the top for the culture created at the bottom. Culture isn't an accident; it is an act of deliberation or neglect of those at the top. And finally, we need to manage moral harm caused by the current challenges in the NHS by giving those closest to patient care the authority to

make judgements, as long as they are accountable for outcomes and learning across professional boundaries, geographies and cultures.

Finally digital- I leave digital till last deliberately because if digital doesn't help with the first two challenges, then why exactly are we using it? I should declare my interest as the co-founder of the company Visionable, a platform that allows video communication across clinical pathways and between patients, clinicians and administrators. So what?" I hear you ask. Well, there are only 7 companies in the world that own the intellectual property for video communications, including Microsoft and Zoom. My British tech company is one of them and in addition this tech can transmit any clinical data to a single screen so that clinician, administrator and / or patient can look at the whole relevant clinical picture when they are discussing a case or care pathway. In the East of England, it is an underpinning platform for their stroke service that has enabled thousands of lives to be prevented from unnecessary stroke injury and death, as well as advancing the management of strokes.

So why am I telling you this story other than to advertise one of my businesses to you? Well, it is an example of transformational health tech, not just transactional health tech. The difference between the two is that one simply speeds up a process which is just transactional such as ear wax removal / eye tests where these technologies don't require much of a transformation in the way care is delivered. They don't require a redesign of the care pathway in order to improve equity or access although they may contribute to both in passing. The kind of technology that needs to be prioritised is the kind of health tech that supports the redesign of care pathways, such that both equity and access are improved radically - in short, technology that brings the NHS to the patient and not the other way round but does so in a way that increases and improves that access for those at the sharp end of the inverse care law. Such tech shrinks the acute footprint and increases the community and preventative footprint. At Visionable, we are working with partners to do just that, but we aren't the only ones. Companies like Brainomix are also working to bring the patients and their communities to the centre of the NHS and social care system.

What these three strategic and operational priorities do is bring the NHS back to its roots in the communities - not just in the interests of the poorest and those that suffer from the sharp end of the inverse care law. I am not without hope in my thinking about the NHS. I consider that if you are lucky enough to be in this Cathedral then you are too lucky to be pessimistic about the future of the NHS.

You may wonder, as I close this lecture, why I haven't asked for more money for the NHS, public health and social care system. It's obvious that the cuts to all three of these essential services have proven poisonous alongside the shock of the pandemic but we all know that it's not just about more money - if the NHS is a sick patient, simply applying more of the same medicine will not get it back to health.

I note that this lecture was described as radical. However, I do not think that applying the principles I have set out in this talk tonight would seem radical to many. My proposition is a radical return to the first principles of the NHS as a service free at the point of need, created by the people for the people. This re-orientation to the principles of Nye Bevan requires the embedding and application of the strategic and operational priorities of equity, access and digital in our local and national healthcare system.