"Everyone needs to encourage clinical leadership, professionalism and the involvement of clinicians in the organisation and management of services…"

Sir Cyril Chantler

In 1942 I had my tonsils removed on a kitchen table in Edinburgh. An unnecessary operation and one that would be unusual today in a place that would be unthinkable. In contrast like most men of my age I would not be alive without the medical advances that have taken place since I qualified over 50 years ago.

The paradox is that we have never lived longer or had better treatments but the NHS is still short of money and a recent report suggested that errors in hospitals are the third commonest cause of death with perhaps as many as 8000 per year occurring in England.

The NHS is rightly loved by the British people but it is not perfect. Amenable mortality, defined as premature death from causes that should not occur in the presence of timely and effective health care, is higher in the UK than in a number of developed countries such as France or Australia.

The European Health Consumer Index places the UK 14th of 28 countries criticising in particular poor accessibility to health care and an autocratic top-down management culture.

Each year its author suggests that social insurance funded health systems are more effective in meeting patients' needs than central government tax based systems though not necessarily as efficient.

An exception to this appears to be the Scandinavian systems where an element of locally raised taxation is combined with local accountability.

Aneurin Bevan said:

"…the NHS is a novel experiment. It is an attempt on the part of British society to reconcile two normally conflicting interests, centralised financial responsibility and de-centralised administration at the periphery".

Since 1989 British and later English governments have sought to decentralise the management of the NHS. Most recently we have had the Health and Social Care Act of 2012 that so far has had mixed results.

It has involved Primary Care and General Practice more in the management of the NHS but has left overall strategic uncertainty.

NHS England has made a good start and is stimulating new models of care and the 5 year forward view sought to coordinate these ambitions.

The government made the intention to improve hospital services at weekends a key manifesto commitment and has sought to fulfil this by changing the junior doctor's contract.

This has led to a dispute that is damaging patients, the profession and the government. The answer to the weekend problem and indeed issues of quality in care does not lie with junior doctors' contracts alone but requires strategic change.

We spend a great deal of money on the NHS. According to the World Bank in 2014 this amounted to 9.1% of GDP compared, for example, with France at 11.5%, Australia at 9.4%, Spain at 9.0% and notably Singapore at 4.9%.

Doctors' contracts need to be replaced by compacts

Much of this, maybe about 75% goes on the management of chronic diseases many of which are related to health behaviours and lifestyle and particularly afflict our poor and marginalised fellow citizens.

In spite of this most of the attention in the NHS has focussed on hospitals without recognising that as many as 29% of beds are occupied by those with chronic illnesses who would be better and safer out of hospital.

Our hospitals are dangerously over occupied. In 2006 the Netherlands faced with the same challenges determined to organise the care of people with chronic illness as a separate "compartment" of their health service.

The responsibility for the provision of social care rests with local authorities that are democratically accountable to their local populations.

The Health and Social Care Act 2012 established the health and wellbeing board as a forum for the health and care system to work together to improve the health and wellbeing of their local population and reduce health inequalities.

Increasingly joint budget arrangements between NHS and social services at the local council level are being agreed. Such "accountable care" arrangements can bring together all aspects of health and social care such as primary care, general practice, community nursing and pharmacy, allied health services, social services etc.

They should provide emergency access for medical problems reducing the reliance on hospitals. They can and must embrace work to reduce health inequalities and improve health behaviours in local communities.

A key point is that they will have a measure of strategic responsibility and democratic accountability removing this from central government responsibility as in Scandinavian countries.

The task is to keep more people well in their own homes where possible and to reduce admissions to hospitals. Reducing occupancy levels to around 90% will make hospitals safer and easier to manage.

However, fundamental changes are required in hospitals too. People admitted to hospitals nowadays are sicker and have more complicated illnesses than before at least in terms

of more complicated options for treatment. All such patients need to be seen on admission by trained specialists working alongside those doctors who are training to be specialists.

This would be in line with a comprehensive report on the Shape of Training published in 2013.

Specialists in training need to be better supported and have time for a proper work and life balance as well as time out to support a family. The period of training could also be shortened in line with other European countries if they spent more time learning whilst being supervised and less providing the service.

Maybe, if this report had been implemented we would not now be facing the industrial action.

Maybe also, patients would be safer in hospital all days of the week not just at the weekends.

One of the safest hospitals in the world is the Virginia Mason Hospital in Seattle. As well as introducing new patient safety systems some years ago they replaced their doctors contracts with compacts; arrangements that recognised the importance of professionalism with doctors taking responsibility for organising as well as providing care with appropriate authority and accountability. The top down managerialism of the NHS, developed over the last 15 years, has been widely criticised by friends from abroad as well as here, and the doctors' contracts that resulted need to be replaced by compacts.

The NHS needs strategic assessment and incremental change. It does not need further massive reorganisation. Central politicians have to let go and they now have the democratic legitimacy to do so to a reasonable extent especially in relation to operational matters.

We need urgently to develop services for people with chronic illnesses on a local basis.

The medical royal colleges, the BMA and the profession need to facilitate change and accept more responsibility whilst the government should, in return, act to reduce the climate of top down management and overwhelming regulation that has contributed to the present problems.

Everyone needs to encourage clinical leadership, professionalism and the involvement of clinicians in the organisation and management of services. Jaw-jaw, said Churchill, not war-war!

chantler@doctors.org.uk