

Creating “Our” NHS



What might be done?

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Abstract

This paper considers how a publicly accountable health system can continue to act coherently, learn, and improve when its problems are structurally wicked, politically charged, and repeatedly disrupted by short-term interventions.

Dedication

For all who make the NHS possible seen and unseen, named and unnamed.

This work is dedicated – with respect, gratitude and hope – to all those who serve within the National Health Service. To the clinicians, nurses, porters, paramedics, scientists, administrators, cleaners and carers – to everyone who gives their skill, energy and compassion so that others may heal.

You work within constraint, yet embody abundance; you carry systems that too often fail you, yet still uphold the spirit that sustains them.

May this work, in its own way, help to honour your endurance, clarify what burdens you should not have to carry, and re-imagine the system you keep alive each day.

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The Author

Julian Macnamara began his professional life working as a teacher. His early career was shaped by questions of learning, care, and the quiet architecture of human development. This instilled in him - a belief that systems - whether educational, technological, or social - should serve people first.

In time, this journey took him beyond education and into the world of commercial systems. He joined Gulf Oil in the 1970s, helping to modernise their planning and forecasting processes. Over the next two decades, he became a bridge between technology and strategy, taking on leadership roles in marketing intelligence, expert systems and organisational design – from Johnnie Walker to Rapidata, Tymshare, and Glandore Associates..

This culminated in nearly two decades at General Motors, where he worked on global transformation initiatives, eventually serving as CIO of Chevrolet Europe and Business Integration Leader for Opel Vauxhall. He became known not just for technical depth, but for moral clarity – ensuring that amidst scale and complexity, systems remained accountable to the people they affected.

When he retired in 2019, he started to explore how AI could be used to support the solution of complex problems. Glandore Associates is the outcome of that exploration: a living project that brings together lifelong passions – for education, ethics, systems and care. It is a place where architecture meets attention, and where the tools of the future are shaped in the image of moral presence.

His work now lives at the frontier: between machine intelligence and human wisdom, between past experience and future possibility.

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Acknowledgement

This work is based on a method for thinking with, rather than through, artificial intelligence called Tychevia®.

It makes extensive use of "Digital Associates" - *distinct epistemic identities*. These are analytical collaborators within the Knowledge Engine.

They interpret evidence, surface patterns and contribute to the evolution of the system itself.

Associates operate as reflective participants, able to reason across domains, trace feedback loops and refine artefacts through dialogue. Their role is interpretive rather than procedural – they extend human judgement rather than replace it.

It should be made clear that the main body of this report was crafted through the use of these Digital Associates and represents a synthesis produced by sophisticated algorithmic reasoning.

While final responsibility for the published work rests with the human author, authorship is not claimed in the traditional sense of sole creation. The contributions of the Digital Associates are integral and the text emerges through a process of co-creation rather than unilateral authorship.

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1 What the NHS really is

1.1. Introduction

Most people in the United Kingdom would say that the National Health Service belongs to all of us. We fund it through our taxes. We rely on it when we are ill or frightened. We defend it instinctively when we think it is under threat.

And yet, if we pause for a moment, the idea that the NHS is truly “ours” becomes less clear.

We do not set its priorities. We do not decide how it is organised. We do not choose how long it is allowed to learn from its own mistakes. Those decisions sit elsewhere, largely out of view.

This tension — between emotional ownership and practical control — lies at the heart of many of the NHS’s difficulties. It explains why people can feel both fiercely loyal to the Service and deeply frustrated by how it seems to function.

This document begins from a simple proposition: that “Our NHS” is not just a matter of funding or affection, but of stewardship. And stewardship, unlike ownership, is about how something is cared for over time.

1.2. What kind of thing the NHS actually is

The NHS is often spoken about as if it were a large organisation. In reality, it is closer to a national ecosystem.

It includes hospitals, GP practices, ambulance services, community care, regulators, professional bodies, suppliers, estates, digital systems, and local government interfaces. It employs more than a million people directly and supports many more indirectly. It operates continuously, at scale, under conditions of uncertainty and emotional strain.

Most importantly, the NHS is not primarily a technical system. It is a human one. Its effectiveness depends on relationships, trust, professional judgement, and memory. When those weaken, performance follows.

Understanding the NHS as a living system — rather than a machine to be fixed — is essential if we want to understand why sensible ideas so often fail to take root.

1.3. Why size changes everything

Large systems behave differently from small ones. They do not respond quickly. They do not turn easily. They do not recover from disruption without cost.

As systems grow, coordination becomes harder. The distance between decision and consequence increases. Unintended effects multiply.

In a small organisation, change can feel energising. In a system the size of the NHS, constant change becomes exhausting.

Every reorganisation breaks existing relationships. Every new structure requires people to relearn how to work together. Every shift in priorities diverts attention from care to adaptation.

Over time, the system becomes very good at coping — and very poor at improving. This is not because people are resistant to change. It is because the cost of change accumulates faster than its benefits.

1.4. The NHS as a workforce institution

When people talk about the NHS, they often focus on buildings, waiting lists, or technology. But the NHS is, above all, a workforce institution.

Care is delivered by people — clinicians, nurses, porters, paramedics, administrators, cleaners — whose skill, attention, and judgement are the system's true operating capacity.

Pay, pensions, training, morale, and professional identity are not secondary considerations. They are the system.

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When staff feel valued, supported, and able to do their jobs well, the NHS functions remarkably well even under pressure. When morale erodes, no amount of structural reform can compensate.

This is why so many problems that appear technical — access, flow, productivity — are in fact deeply human.

1.4.1. From system to fellowship: the NHS as a modern guild

The NHS has long been described as a system, an employer, a service, even an economy. Yet beneath these designations lies something older and more human: a fellowship of skill and care.

The guild metaphor retrieves this deeper dimension. In its medieval sense, a guild combined economic coordination with ethical order. It safeguarded the dignity of work, transmitted expertise through apprenticeship, and upheld a covenant between competence and conscience.

Seen through this lens, the NHS resembles a Guild of Care more than a corporation. Its legitimacy arises from trust rather than ownership, from vocation rather than control.

This perspective helps explain why many managerial approaches feel misaligned. They treat the NHS as something to be directed, when in practice it is sustained by belonging.

1.4.2. The craft of care

Modern healthcare already operates through guild-like dynamics.

Knowledge and practice are apprenticed — consultant to registrar, nurse to student. Entry is credentialed, but professional identity is earned through emotional and moral labour. Ethical codes substitute for market contracts; the patient is the shared master.

Where bureaucratic systems prioritise measurable outputs, guilds preserve meaning. They remind practitioners that competence without belonging becomes brittle, and belonging without competence becomes unsafe.

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Much of what now appears as workforce crisis can be understood as the erosion of this craft ecology.

1.4.3. What the guild protects

The guild model re-centres value in relationship rather than transaction. It helps explain why certain threats provoke such deep resistance within the NHS.

<i>Threat</i>	<i>Bureaucratic reflex</i>	<i>Guild response</i>
Productivity pressure	Proliferation of targets	Renewal of pride in craft and outcome integrity
Workforce burnout	Individual resilience schemes	Restoration of moral community and collective care
Fragmented learning	Mandatory training modules	Revival of apprenticeship chains and situated learning
Erosion of trust	Oversight and audit	Reaffirmation of professional covenant and peer accountability

These are not sentimental distinctions. They describe fundamentally different ways of sustaining quality under pressure.

1.4.4. Governance as stewardship

Traditional guilds governed through stewardship rather than command. Masters were accountable to peers. Standards were upheld through shared judgement rather than distant inspection.

In this model, learning is not imposed but crafted through dialogue. Institutional memory functions as a collective chronicle of experiments, successes, and failures – the living curriculum of stewardship.

This helps explain why repeated reorganisation is so damaging. Each reset disrupts not only structures, but the informal transmission of craft, memory, and trust on which the guild depends.

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1.4.5. Why the guild matters now

In an era of industrial fatigue and moral injury, the NHS risks losing its inner glue – the sense of belonging to something noble and mutually sustaining.

Re-imagining it as a Guild of Care reconnects technical excellence with moral purpose. It restores dignity to service. It rebuilds the social contract between professionals, patients, and the state.

Perhaps the NHS will not be sustained by another reorganisation, but by remembering itself as a guild – a living fellowship of craft, conscience, and care.

1.4.6. Closing reflection

The guild metaphor reframes the NHS not as a system to be managed, but as a culture to be stewarded. It invites every participant – clinician, manager, and patient – to act as a custodian of shared purpose.

In that sense, the NHS already possesses the materials of a modern guild: skill, solidarity, and story.

What remains is not to redesign its hierarchy, but to renew its hall.

1.5. Why funding alone does not resolve the problem

Once the NHS is understood as a working institution – a fellowship of craft, learning, and moral responsibility rather than a machine – the limits of funding-only solutions become much clearer.

This is not an argument against funding. Adequate and predictable resources are essential. But money cannot do the work that belonging, trust, and institutional memory are meant to do.

Funding can buy time. It can ease pressure. It can stabilise crises.

What it cannot do, on its own, is restore a damaged working culture or recreate a moral community.

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1.5.1. Why the funding debate keeps disappointing

Public debate often treats funding as the decisive lever. If outcomes are poor, the assumption is that spending must be too low. If spending rises and outcomes disappoint, frustration follows.

This pattern is understandable. Money is visible. It is countable. It is one of the few aspects of the NHS that can be adjusted quickly and publicly.

But this visibility is misleading.

When funding is increased in a system that lacks stability, memory, and trust, much of that resource is absorbed by adaptation rather than improvement. Organisations reorganise. Staff retrain. Systems change. Learning is interrupted.

The result is not waste, but dilution.

1.5.2. Money cannot substitute for craft

In a guild-like institution, quality depends on the preservation of craft.

Craft requires:

- ❖ stable teams,
- ❖ time to learn,
- ❖ mentorship and apprenticeship,
- ❖ pride in work well done.

None of these can be purchased directly. They emerge from conditions.

When those conditions are disrupted, additional funding often ends up compensating for loss rather than building capability. More staff are recruited to replace those who leave. Temporary solutions fill gaps left by exhausted teams. Short-term fixes become permanent.

Spending rises, but capacity does not deepen.

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1.5.3. Why morale absorbs money before patients see it

In a stressed system, new resources are first used to relieve pressure on people. This is not a failure; it is a necessity.

Pay settlements stabilise retention. Agency staffing prevents collapse. Overtime keeps services running.

But when funding is repeatedly asked to patch over structural instability, it never reaches the point where it can transform experience. It keeps the system upright, not learning.

Patients see little change. Staff feel little relief. The public wonders where the money went.

1.5.4. The quiet mismatch

At this stage, a careful reader may notice a quiet mismatch.

We treat funding as though it were a tool for redesign. But in reality, it is being used as a form of compensation — for instability, for disruption, for lost memory.

The problem is not that money is misused. It is that it is being asked to do work that belongs to stewardship.

Until the NHS is given the conditions to function as the kind of institution it actually is, funding will continue to disappoint — not because it is insufficient, but because it is misaligned.

1.6. Reform without memory

Over several decades, the NHS has been subject to almost continuous reform. Each reform has been introduced to address real problems. Few have been allowed to run long enough to learn from.

Structures change. Names change. Accountability lines move. But the same pressures return in new forms.

This creates a subtle but powerful effect: institutional forgetting.

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Lessons learned in one decade are lost in the next. Mistakes recur because the system has no protected way to remember them. Staff learn that today's initiative will be replaced by tomorrow's.

As a result, reform begins to feel performative rather than purposeful. People comply, but they do not commit.

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2 Why the NHS behaves the way it does

2.1. Understanding the NHS as a Complex Adaptive System

To understand why sensible ideas struggle to take hold, we need to understand how the NHS behaves as a system.

This is best understood by what is known as a complex adaptive system. This sounds technical, but the idea is simple.

In such systems:

- ❖ Problems are interconnected rather than isolated.
- ❖ Actions produce unintended consequences.
- ❖ Feedback loops amplify pressure.
- ❖ Outcomes emerge over time rather than appearing immediately.

In other words, cause and effect are rarely straightforward.

2.2. What makes NHS problems intractable

Many NHS challenges are not just difficult. They are what researchers call “wicked problems”.

A wicked problem has no single cause and no final solution. Every attempt to address it changes the situation itself. Different groups disagree, in good faith, about what should be done.

Workforce morale is a wicked problem. So is access to care. So is integration between services.

Treating such problems as if they could be solved once and for all leads to repeated disappointment. Each intervention helps in one place and worsens things in another.

This does not mean nothing can be done. It means improvement requires patience, learning, and adjustment – not resets.

2.3. Feedback loops and pressure

In the NHS, pressures rarely stand still. They circulate.

A shortage of staff increases workload. Increased workload leads to exhaustion. Exhaustion drives people to reduce hours or leave. Capacity falls further. Access worsens. Public frustration grows. Political pressure intensifies.

Each step makes sense in isolation. Together, they reinforce one another.

Breaking such loops requires coordinated action across time. Short-term fixes rarely suffice.

2.4. Moral injury as a system signal

Clinicians often describe knowing what good care looks like but being unable to provide it consistently. This gap creates moral injury.

Moral injury is not burnout. It is not a lack of resilience. It arises when people are prevented, by system constraints, from acting in line with their professional values.

When moral injury accumulates, staff withdraw emotionally. They stay, but they stop giving more than the minimum. Compassion becomes rationed.

This is not a failure of character. It is a signal that the system is asking the impossible.

2.5. Why morale cannot be fixed locally

Morale is often addressed through local initiatives: wellbeing programmes, listening events, resilience training. These can help. But they cannot compensate for structural incoherence.

If priorities change constantly, if systems do not work, if staffing is unsafe, morale will suffer regardless of local effort.

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Morale is a system output. It reflects the conditions people work within.

Ignoring this leads to misplaced blame and ineffective solutions.

2.6. The cost of short-term thinking

Complex systems require time to learn. The NHS rarely gets that time.

Political cycles reward visible action. They do not reward patience. Announcing reform signals control. Allowing a system to stabilise can look like inaction.

As a result, the NHS is repeatedly intervened in just as it begins to adapt. Learning is interrupted. Confidence is undermined. The cycle restarts.

This is not because people in the Department of Health are indifferent or unaware. It is because the system they operate within makes sustained sense-making extremely difficult.

2.7. Where this leaves “Our NHS”

By the end of this section, a careful reader may feel a quiet unease.

Many of the ideas discussed so far — stability, learning, stewardship, attention to morale — feel like common sense. They do not sound radical. They do not require new technology or vast new spending.

And yet they are rarely prioritised.

The question that begins to form is not accusatory, but unsettling: if this is so sensible, why does it seem so hard to do?

The next sections will turn to that question directly.

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3 Why sensible stewardship is so hard

By the time we reach this point, much of what has been said may feel quietly reasonable.

That the NHS is sustained by people more than structures. That learning takes time. That constant reorganisation damages memory. That morale and meaning are not optional extras but core system properties.

None of this sounds radical. Most of it reflects what people working in the NHS already know.

And yet, when we look at how the NHS is governed at national level, these ideas rarely appear to shape decisions in a sustained way.

To understand why, we need to look not at individual choices, but at the conditions under which those choices are made.

3.1. The Department of Health's role

The Department of Health and Social Care sits in a difficult position.

It is responsible for stewarding a vast, emotionally charged institution that touches almost every family in the country. It must do so on behalf of elected ministers, who in turn are accountable to Parliament and the public.

This chain of accountability is essential. Without it, the NHS would lose its democratic legitimacy.

But this same chain also places the Department under constant pressure to be seen to act.

In public life, action signals seriousness. Stability is harder to explain.

3.2. Why patience looks like drift

Many of the conditions that allow a complex institution to learn are slow and largely invisible.

Trust builds over years. Professional cultures mature gradually. Institutional memory accumulates quietly.

By contrast, political attention is episodic. It focuses on moments of crisis, media pressure, or public concern.

In this environment, patience can easily be mistaken for complacency. Allowing a system to stabilise can look like inaction. Resisting reform can look like resistance to improvement.

The safest response, politically, is often to intervene.

3.3. Visibility as a substitute for progress

Modern government places a premium on visibility.

New initiatives can be announced. New targets can be published. New organisations can be created and named.

These actions are legible to the public and to Parliament. They provide reassurance that something is being done.

Unfortunately, the most important drivers of improvement in the NHS – trust, morale, learning, continuity – do not lend themselves to this kind of visibility.

As a result, *visible* change often displaces *meaningful* change.

3.4. The problem of political time

The NHS operates on long time horizons. Training a consultant takes more than a decade. Building institutional memory takes longer still.

Political systems operate on much shorter cycles. Ministers change. Priorities shift. Crises intervene.

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This creates a structural mismatch.

Policies designed to show impact within a year or two struggle to support institutions that require continuity over a generation.

This is not a failure of will. It is a feature of how democratic politics works.

3.5. Why reform becomes the default

In this context, reform takes on a particular role.

Reorganisation promises renewal. It signals control. It creates a sense of forward motion.

But reform also resets relationships, disrupts learning, and dissolves memory. Each reset carries a cost, even when intentions are good.

Over time, the NHS becomes trapped in a cycle: reform intended to improve performance ends up weakening the conditions that performance depends on.

3.6. Performance management and fear

National oversight relies heavily on targets, inspection, and performance management. Given the scale of the NHS, this is understandable.

But these tools have side effects.

When failure carries reputational or financial consequences, people become cautious. Information is filtered. Problems are managed locally rather than surfaced openly.

In such environments, learning slows. The system becomes quieter, not wiser.

A guild learns through shared judgement and peer accountability. A fear-based system learns slowly, if at all.

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3.7. Why funding takes centre stage

Against this backdrop, funding becomes the most visible lever available to national leaders.

It is one of the few things that can be adjusted quickly. It can be announced publicly. It signals commitment.

But as Chapter 1 made clear, money cannot restore trust, rebuild memory, or recreate a damaged moral community on its own.

When funding is asked to compensate for instability and churn, it is quickly absorbed without producing the change people expect.

This is why debates about NHS funding are so often disappointing. They are being asked to do work that belongs to stewardship.

3.8. Understanding constraint, not blaming individuals

It is important to be clear about what this chapter is not saying.

It is not saying that people in the Department of Health do not understand the nature of the NHS. Many do. It is not saying that ministers are indifferent to staff morale or patient experience. Most are not.

What it is saying is that the system of incentives, scrutiny, and political expectation makes sustained, low-visibility stewardship extremely hard to practise.

Good intentions operate within constraint.

3.9. The reader's question

At this point, a thoughtful reader may find themselves asking a simple question:

If the NHS is best understood as a working institution — a guild of care rather than a machine — why do we persist in governing it as though it were the latter?

This is not a question of competence. It is a question of alignment.

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3.10. A pause before solutions

Before rushing to answers, it is worth sitting with that question.

Because if the diagnosis is correct, then the solution is not another reform, another reorganisation, or another set of targets.

It is something quieter and more demanding.

The final chapter turns to what that might look like — not as a plan to be imposed, but as a way of caring for something we already call “ours”.

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4 Creating “Our” NHS

This document began with a simple observation: that most people feel the NHS belongs to them, yet have little sense of how it is actually cared for.

Along the way, we have tried to understand what kind of institution the NHS really is, why it behaves as it does, and why sensible stewardship proves so difficult in practice.

Nothing here requires special expertise. Nothing depends on insider knowledge. Much of it reflects what those who work in the NHS — and those who rely on it — already sense.

The question is no longer whether these ideas are reasonable. It is what follows from taking them seriously.

4.1. What “Our” really means

Calling the NHS “ours” is not simply an expression of affection. It is a claim about responsibility.

Ownership, in this sense, does not mean control. It does not mean direct management or constant intervention. It means accepting that some institutions require care across time rather than direction from above.

To say the NHS is ours is to acknowledge that it cannot be run solely for immediate visibility, political reassurance, or short-term gain. It must be stewarded so that it can learn, remember, and renew itself.

4.2. From reform to stewardship

Throughout its history, the NHS has been repeatedly reformed. Many reforms were introduced with good intentions. Few were allowed to settle.

Stewardship asks for something different.

It asks for restraint as well as action. For continuity alongside accountability. For a willingness to protect institutions from disruption so that improvement becomes possible.

Stewardship is not passive. It is attentive. It requires judgement. It requires holding pressure without immediately dispersing it through change.

4.3. What sensible stewardship looks like

Sensible stewardship does not begin with grand designs. It begins with conditions.

It protects stable structures long enough for learning to take place. It treats workforce morale as a system signal, not a personal failing. It values institutional memory as a public asset. It recognises that trust, once lost, is difficult to rebuild.

These are not radical propositions. They are ordinary requirements for any complex, human institution to function well over time.

4.4. Why this is difficult, but not impossible

Nothing in this document suggests that democratic accountability should be weakened. Nor does it argue for removing the NHS from public scrutiny.

What it does suggest is that accountability can be exercised in ways that support learning rather than interrupt it.

Longer horizons. Fewer resets. More honest feedback. Greater tolerance for uncertainty.

These are choices. They are difficult choices. But they are choices nonetheless.

4.5. The quiet responsibility

If there is a responsibility that follows from this analysis, it is a shared one.

For those in government, it is the responsibility to resist the comfort of visible action when it undermines long-term sense-making.

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For those working in the NHS, it is the responsibility to sustain craft, mentorship, and moral community even under pressure.

For the public, it is the responsibility to recognise that some of what keeps the NHS healthy cannot be delivered quickly or announced easily.

4.6. An ending without a solution

This paper has not offered a blueprint. It has not proposed another reorganisation. It has not promised certainty.

That is deliberate.

The NHS is not short of plans. It is short of the conditions in which plans can mature.

Creating “Our” NHS is not about designing something new. It is about caring properly for something that already exists.

4.7. A final thought

If much of what has been said here feels like common sense, that may be because it is.

And if it raises an uncomfortable question — why more of this does not already shape how the NHS is governed — that question is not an accusation.

It is an invitation.

An invitation to think differently about responsibility, stewardship, and time. An invitation to care for the NHS not as a machine to be fixed, but as a shared institution that must be allowed to remember, learn, and endure.

In that sense, creating “Our” NHS is less a project than a commitment — renewed, patient, and collective.

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