Wirral and West Cheshire Community National Health Service Trust (Establishment) Order 1997: National Health Service, England and Wales, Great Britain, Great Britain. Department of Health, Stationery Office, 1997, 0110642295, 9780110642291, . Enabling power:National Health Service and Community Care Act 1990, s. 5 (1), sch. 2, paras. 1, 3, 6 (2) (d).. Issued:24.03.97.. Made:13.03.97.. Coming into force:01.04.97.. Effect:None.. Territorial extent & classification:E/W. General...

"When the NHS celebrated its 50th anniversary with much pomp, commemorative stamps, and a service in Westminster Abbey, a new Labour government was busy reversing many of the policies of its Conservative predecessor. The internal market was abolished, as was general practitioner fundholding. The NHS would indeed be modernised, but it would be on the basis of cooperation not competition.

Who then - in the euphoria of the celebrations when Frank Dobson, the secretary of state for health, could claim that "the NHS remains the envy of the world" - would have anticipated that within a couple of years policy would go into reverse gear? Who then would have predicted the emergence of a new model for the NHS based on choice, competition, payment by results, and a plurality of providers, let alone the emergence of institutions like foundation trusts?" Rudolf Klein Editorial, British Medical Journal, 5 July 2008 BMJ 2008;337:a549

The decade opened and closed with Labour in power and the NHS in financial crisis in spite of the greatest increase in expenditure the NHS had ever seen. The economy was sound for most of the decade. The UK, like many other countries, experienced terrorism, often fuelled by radical Islamic influences. The devastation in New York 9/11, atrocities in Spain and the London Underground, and the Iraq war cast long shadows. Following the Kyoto Protocol in 1997, climate change and carbon emissions became an international issue. Globalization, the pressures of the European Community and the digital revolution were driving changes. The introduction of the Euro in 1999 led to debate on our place in Europe and a European constitution. To bring Britain in line with the Community ambulances changed colour from white to an eye catching yellow.

Population movement increased. First London and then the whole country experienced an influx from the European Union. Tens of thousands of young French came. Even before the EC expanded many from Eastern Europe and especially Poland arrived, filling jobs that the indigenous population did not want. Over a decade around a million people came. Local authorities complained of the pressure on their services. Retired English travelled to France and Spain for the quality of life. Emigration from the UK increased steadily to nearly 200,000 in 2006. Public reaction to economic migration and asylum seekers changed the political landscape throughout Europe. Some migrants came from areas with a high prevalence of AIDS, tuberculosis and hepatitis B. While Bevan

explicitly believed that the NHS should be available to everyone, resident or visitor, government now said that it should not be free of charge to those who did not live in the UK. Front line staff had little time or inclination to ask patients too many questions.

["How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats both must be classified. What began as an attempt to keep the Health Service for ourselves would end by being a nuisance to everybody. Happily, this is one of those occasions when generosity and convenience march " (In Place of Fear, Bevan, 1952)]

The World Health Organization's twenty-year plan to bring â€˜health care to allâ€™ failed. More than 2 billion people had no basic sanitation. The European Regionâ€™s Health for All, equally ambitious, was in tatters. (Moore W. The impossible dream. Health Service Journal 2000: 6 January: 8-9.) The campaign for the reduction of third world debt made only limited progress, and poverty, famine, wars and the AIDS crisis seemed worse day by day.

The north/south divide was increasing. The need to commit 24/7 to one's employer stressed some. Crises hit agriculture (BSE, foot and mouth disease). Our multi-ethnic society was increasingly apparent. Racially motivated riots (Oldham), protests against a global economy and violence in the streets, sometimes black on black and against NHS staff, soured the atmosphere. The fashion for body-piercing and cropped tops changed the townscape while pressure led to the establishment of smoke free public places. To the profit of pharmacies, a gullible public spent increasingly on ineffective "alternative" medicines, while a split in the anti-vivisection movement led to terror tactics. For the young, adventure holidays and gap years proliferated, with a rising use of recreational drugs and clubbing. Institutional and financial malpractice, threats to the pension schemes and banks (Northern Rock) led to financial crisis.

In 1998 Labour devolved power to an elected Parliament in Scotland and an elected assembly in Wales and Northern Ireland. Four different health services emerged. In England there was an accent on the purchaser/provider split, improving performance and setting targets; in Scotland a professionally led integrated system based on clinical networks and in Wales, partnership between the NHS and local authorities. Both in Scotland and Wales benefits were available in the care for the elderly, drug availability and in prescription charges that were not in England. The differences in funding under the Barnett formula were apparent.

In 1999 Frank Dobson told the NHS to adopt a single logo to imply focus and consistency of service. Health advisors in No 10, economists and operational research staff played a role in shaping policies. Virginia Bottomley's concept of a service tax funded and largely free at the point of use but where provision was not necessarily in the public sector facilities was increasingly accepted. A raft of policies emerged; not always compatible, private sector involvement, quality, peer review, central direction, performance reporting, accountability, competition, trusts, patient choice, and payment by results.. Dixon J. Editorial, BMJ 2008,336; 844-5. There was bipartisan support for many policies such as NICE, a purchaser/provider split, foundation trusts, concentration on long term illnesses, patient choice, involving primary care in commissioning, a tariff system to pay providers and a more personal service. Both Parties looked at what could be learned from managed care organisations such as Kaiser Permanente whose characteristics included integration of funding with provision of service, integration of inpatient care with outpatient care and prevention, focus on minimizing hospital stays by emphasizing prevention, early and swift interventions based on agreed protocols, and highly coordinated services outside the hospital, teaching patients how to care for themselves, emphasis on skilled nursing, and the patients' ability to leave for another system if care is unsatisfactory. Kaiser did NOT have a purchaser/provider split.

In each decade there are concepts affecting the organisational pattern of the NHS. In the seventies it was consensus management. In the eighties the general management function. Now, spurred by scandals in the financial sector and industry, good governance became a guiding principle. In 1992 the Cadbury Report had identified principles of good governance in organisations - integrity, openness and accountability. This was taken further in the Nolan Report (1997) and absorbed into

NHS management.

To improve capacity nursing and medical school output rose. Staffing grew as the growth rate of the NHS was increased.. There were 1.3 million NHS staff in 2007, just over 50% being doctors (128,200) or qualified nurses (399,600) The idea of "modernisation" stimulated the development of new roles. After years of negotiation, a new pattern of pay system, the Agenda for Change was introduced for all directly employed NHS staff except very senior managers and those covered by the Doctorsâ€™ and Dentistsâ€™ Pay Review Body to harmonize the conditions of service staff, provide a clearer system of rewards for staff working flexibly and assist in the development of new types of job. For example rapid increase in the demand on ambulance services encouraged the education of paramedics and Emergency Care Practitioners. The development of nurse practitioners in primary care led care led Birmingham and Wolverhampton Universities to train physician assistants.

Moving from a services provider to a commissioning organisation there was an increasing role for the private sector, though this was opposed by Frank Dobson, substantial parts of the Labour Party, unions, NHS management and sometimes the medical profession. Previously the NHS used the private sector largely as a pressure release valve, often at high cost to handle an immediate problem. Now it was becoming integral to all segments of the NHS. In primary care, commercial organisations tendered and supplied family practitioner services. Hospital trusts increasingly contracted out services and patients might have a choice of a private hospital. The private finance initiative was funded hospital building and privately managed independent treatment centres handled NHS patients. DHL took over the supply and transport of hospital supplies.

The UK spends less than almost any other Western country on private health care. The number of those in the UK with private medical insurance had remained static for several years but increased again in 2000 to 5 million, about 12.6% of the population. More were insured in the south than the north and the growth in the numbers was even larger among those paying for private treatment out of their own pocket, sometimes on fixed cost 'pay-as you go' packages. Cataract removal for Â£2000, knee replacement for Â£7,000 or a heart bypass for Â£10,000 might be a practical proposition.

Ethical problems abounded, particularly in genetic medicine and in vitro fertilisation. In 2008 Parliament considered issues such as the creation of 'rescue babies' whose stem cells could help a sibling. The GMC issued advice in 2008 on consent and ethical problems stating that doctors must set aside their religious and other personal beliefs if these compromised the care of patients, instancing face veils worn by a doctor if that was an obstacle to communication and trust,.

It was the decade of Google, Yahoo, Facebook (2004), YouTube, Wikipedia, Blogs and Amazon. Apple gained market share; Microsoft stumbled. In 1998, 6 million in the UK had access to the web at home or at work and within the decade the majority had broadband access. People might make direct contact with doctors via health web sites (c.f. www.drgreene.com). The clinical knowledge on the web was so vast that doctors might find useful suggestions by using Google.

The US Government, the Mayo Clinic and Kaiser Permanente were early as in the field. The UK was initially cautious but by 2000 the NHS, the Department of Health and the British Medical Association had effective sites and increasingly used them to publish their documents and reports. The NHS website was re-launched as NHS Choices in June 2007 to provide patients, carers and the public with accurate and up-to-date health information.

Education benefited. The National Electronic Health Library, a resource primarily for professionals, was followed by the National Library for Health. In 1998 the BMJ became an open access journal, making the full text freely available. In 2003 the BMJ Publishing Group provided access to the evidence-based summaries available in Clinical Evidence and NHS Direct linked to this material. Journals increasingly offered on-line editions, sometimes free, and Stanford University's Hire-Wire Press hosted several hundred electronic versions of scientific journals and provided a search system. U.S. National Library of Medicine's free digital archive of biomedical and life

sciences journal literature (PubMed Central (PMC)) aimed to digitise a complete archive of medical journals, including the BMJ, some going back more than 125 years.

An effective NHS information system centred on clinical need was at last under development. Appropriate technology was becoming available. In 2002 the Audit Commission stressed the importance of accuracy in Data Remember: Improving the quality of patient-based information in the NHS. The assessment of the quality of care, and contracts that required information about who had done what for whom, increased the importance of IT. Finally, new services such as pharmacist prescribing and walk-in centres made a coherent IT system essential. An NHS Information Authority was established to manage the development of systems and oversaw the introduction of the NHS number, new numbers for babies, payments for GPs and national screening programmes. It was later phased out to be replaced by the NHS Connecting for Health and the Health and Social Care Information Centre (2005).

The strategy for NHS IT dated back to 1992 but recurrent problems reduced support for the programme. In 1998 a white paper, Information for Health, created new momentum and shifted the emphasis to the clinical from the administrative. It committed the NHS to provide life-long electronic health records for everyone with round-the-clock, on-line access to patient records and information about best clinical practice for all NHS clinicians. Every GPs would be connected by 2000 - targets missed.

Further impetus followed a seminar in Downing Street in February 2002 and the Wanless Report in April 2002 which criticised NHS IT as piecemeal and poorly integrated. In July 2002 Delivering 21st century IT support for the NHS was published. An unprecedented investment began, some Â£18 billion over ten years. It was the world's largest and most ambitious health programme, aiming to create comprehensive electronic health records to be made available to all providers.

Richard Granger was appointed National Director in 2002, . Contracts stressed speed, competition and payment to contractors only if they delivered. In 2004, the Department created a new body to deliver the programme renamed NHS Connecting for Health in April 2005 The programme was handled in a top down fashion and was organized in two parts, a national spine and five local providers covering five regional clusters. There was a habit of placing very large contracts, often outsourced. In retrospect this hindered innovation and flexibility as issues changed, including the patterns of NHS organisation. In 2004 BT was awarded the contract to provide the national infrastructure (National Application Service Providers [NASPs]) and to be one of four Local Service Providers (LSPs). Three other firms won contracts to provide services in other areas. (see map). LSPs were responsible for IT systems such as GP and trust systems and would make sure local applications could share information with the national systems.

National contracts were also awarded to BT for the NHS Care Records Service, Atos Origin (formerly SchlumbergerSema) for Choose and Book, BT for the New National Network. BT would act as a system integrator, and BT Syntegra for information and payments under the Quality and Outcomes Framework. The system involved

The programme fell behind schedule. Many hospitals had to upgrade ageing systems as the long term solution was not in sight. GPs could continue to choose one of a wide range of existing systems, rather than being forced onto a national standard that was not available. Contracted suppliers faced major losses and gave up contracts. Public anxiety about the security of personal information was increased by a series of alleged security breaches. Richard Granger left the programme in 2007. By then the NHS spine was in place, covering basic data, name, address and NHS number but the summary medical record and its transmission between providers remained far off. Electronic appointment booking and electronic prescriptions were slow to come on stream. A Department review found failures at the top; no one seemed to "own" the big picture on information, there was no system to translate policy into business requirements, and a shifting of responsibility for IT around the Department.

By 1996, 96% of general practices were computerised and about 15% ran "paperless" consultations.

In hospitals computing was treated as a management overhead and doctors had few incentives to become involved. The reasons why it was easier to computerize general practices related to scalability. For twenty or more years GPs had used PCs; hospitals needed larger machines. The sheer size of the hospital sector and the way technological advance rapidly outpaced information technology in the NHS, led to substantial difficulties. The differing structure of patient records from specialty to specialty, computer standards and security all made for problems. (Benson T, BMJ 2002: 325,1066-9 &1090-93)

In 1995/6 a new NHS number was issued to all patients on GPs' lists. These numbers formed the basis or electronic patient medical records. The data base was soon used for a National Strategic Tracing Service (NSTS) to provide the NHS with accurate patient administrative data. Based on the names of all people born, or who had been registered with a GP in England and Wales, by 2001 it provided on-line access to over 60 million records It included:

Until the 1990s the NHS tended to the paternalistic, with limited choice for patients. Public spending had been controlled firmly, NHS waiting lists had risen, and Kenneth Clarke and Alain Enthoven aimed for an internal market to improve allocation of resources. Purchasing and provision were separated and the aim was to give patients more choice of provider and the information to make that choice. Initially purchasers continued to enter into large bulk contracts, the accent being on activity rather than outcome. With temporary hesitations, these principles were adopted by Labour that added a fourth element in 2003, a better payment mechanism, and also increased the contribution of private providers.

The organisation of the NHS is unlike that of most other western health systems, as the ultimate responsibility lies with government and the responsible minister (the Secretary of State for Health). From 1948 until 1974 the organisational structure was unchanged. Since then there has been a series of modifications every few years under both Labour and Conservative governments. Management systems have been hierarchical with the Department of Health at the apex, and been based upon the idea of one district hospital for each area. Hospital medicine has usually been separate from the organisation of primary care, and remains so. During the successive reorganizations senior managers have often retired - or been culled - those remaining or promoted feeling insecure, and of low morale.

The decade saw an unparalleled level of change, organisational, clinical and financial. The "New Labour" model of the internal market saw PCTs selectively contracting with providers. There was a succession of "reviews of the NHS". The history of "reforms", "modernisation" and "reorganisation" hardly bears repeating.

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