

INTEGRATING NHS CARE: LESSONS FROM THE FRONT LINE

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INTRODUCTION

This briefing paper reports on a series of seminars held at the Nuffield Trust in February and March 2008, to explore experience in the NHS in integrating care. The paper identifies the lessons to emerge from the examples presented at the seminars, and the implications for the NHS in the context of the Darzi review. The aim of this briefing is to suggest the practical steps that need to be taken to achieve closer integration of care on the ground.

Summary

- There is increasing interest in the development of clinically integrated systems in the NHS in England
- the Bolton managed diabetes network, the Epsom Downs Integrated Care Service, and the Birmingham and Solihull Kaiser pilot are all examples of local initiatives designed to bring about closer clinical integration
- these examples illustrate three different ways of making progress: through community-based specialists, primary care reaching into hospitals, and partnership between primary and secondary care
- all three examples arose out of the initiative and commitment of local medical leaders working in partnership with senior managers; a key characteristic of those involved in leading change was resilience and persistence in the face of barriers and setbacks
- the evidence from these three examples indicates that it takes time to make change happen, and integration often involves a complex path of development
- national policies have acted as both barriers and facilitators of clinical integration
 - practice-based commissioning has failed to offer a significant stimulus to integration to date
 - payment by results is often perceived as a barrier, though this can be overcome where relationships are sufficiently mature
- in the future, there need to be stronger incentives to support clinical integration, for example through a radical expansion of practice-based commissioning of the kind proposed in Epsom
- a key challenge is how to reconcile clinical integration with patient choice; one way forward would be to encourage patient choice between competing integrated systems
- Government policy following the Darzi review needs to recognise that there are different routes to integration, and contain a commitment to evaluating the performance of integrated systems.

BACKGROUND

In a series of seminars held in the summer and autumn of 2007, the Nuffield Trust explored the evolution of the health reform programme in England. The seminars focused particularly on the use of competition and collaboration to bring about service improvements. A briefing paper based on the series, *Clinically Integrated Systems: the next step in English health reform?* was published in December 2007; this argued that more attention needed to be given to collaboration and clinical integration, alongside the use of choice and competition in relation to planned care. In the longer term, the briefing paper suggested that Ministers should explore how the health reform programme might support patient and citizen choice between competing clinically integrated systems.

To take these ideas forward, the Nuffield Trust organised a further series of seminars in February and March 2008 to examine the facilitators of and barriers to clinical integration. The seminars were led by clinicians and managers who have been involved in clinically integrated systems, and were designed to address the following questions:

- What elements in the health reform programme facilitate clinical integration, and what elements serve as barriers?
- What contractual and other mechanisms are being used to achieve clinical integration – for example Specialist PMS (SPMS) contracts?
- What is the impact of payment by results and practice-based commissioning?
- How are primary and secondary care clinicians working together to achieve closer integration of care?
- What lessons have been learned about the scale needed to achieve clinical integration (for example, the size of the population served)?
- What needs to be done to build on progress to date, including in the final report of the Darzi review?

The seminars were led by:

- John Dean, Medical Director and Consultant Diabetologist, Bolton PCT
- Andrew Donald, Director of Redesign and Commissioning, Birmingham East and North PCT
- Hugh Rayner, Medical Director, Heart of England NHS Foundation Trust
- Tim Richardson, GP in the Integrated Care Partnership, Epsom, and Medical Director, Epsomedical Ltd

This briefing paper is a synthesis of the seminars and the issues to emerge from the discussions.

INTEGRATION THROUGH COMMUNITY-BASED SPECIALISTS: DIABETES CARE IN BOLTON

There has been a long history of strengthening care for people with diabetes in Bolton, stretching back to a regional review in 1989. Since the mid-1990s the main emphasis has been on increasing skill levels within primary care teams, to provide a wider range of care. An external review in 2000/01 highlighted a wide range of strengths in the provision of diabetes care but recommended more work to reduce quality variation in primary care, and to improve specialist interaction with primary care. There is now a local managed diabetes network that provides integrated care. The specialist team has been part of the PCT since 2004.

Case study: Diabetes care in Bolton

Bolton has a population of 268,000, 60,000 of whom live in some of the top ten per cent of most deprived areas in England. Life expectancy is two years less than the English average, although there are wide inequalities (ranging from 82 to 67 years). There are 57 practices and 158 GPs. Bolton is served by one general hospital, one local authority and a PCT that is a significant provider of services itself. 12,600 people (4.6 per cent of the population) are registered with diabetes. 9.3 per cent of the population are of South Asian origin. 90 per cent of the 57 practices provide structured diabetes care. The Bolton Diabetes Centre was set up in 1995. It is the base for a community specialist team that sees 15 to 20 per cent of the population with diabetes. These patients are mainly those with complex needs or in transition. The team also reaches in to the local hospital for inpatient care, and into general practices for support and shared consulting. The ethos of the team is to facilitate and provide high-quality patient centred diabetes care throughout Bolton, through education and expert practice.

The vision is that care should be patient- and not organisation-centred. Care should be delivered in the appropriate place at the appropriate time by the appropriately trained professional. The objective is that Bolton should have a fully integrated service without gaps or duplication, and with smooth and quick referral from primary care to specialist advice.

The enablers of integration have been:

- a shared vision
- clear, accountable leadership
- defined roles for staff and organisations
- a common patient record and information.

The lessons from Bolton's experience are:

- it takes time to develop an integrated service (the journey started in 1989)
- there is a need for a shared vision and purpose
- education of staff is critically important
- management and decision-making need to be devolved.

The provision of appropriate specialist care also depends on a skilled primary care workforce.

Specialists' roles

In current thinking, specialists have a role in care for people with chronic conditions at four levels:

Level 1: Specialist helps to define best practice (guidelines/protocols).

Level 2: Patient does not easily fit the guideline, brief discussion with specialist required by phone, email, informal consultation.

Level 3: More detailed review of the case is required with the specialist as multiple decisions are needed or the case is more complex. This will be by case note review or joint consultation.

Level 4: The patient requires detailed face-to-face assessment by the specialist team members, and may require a period of continuing specialist care. This will be by referral.

Other areas of care

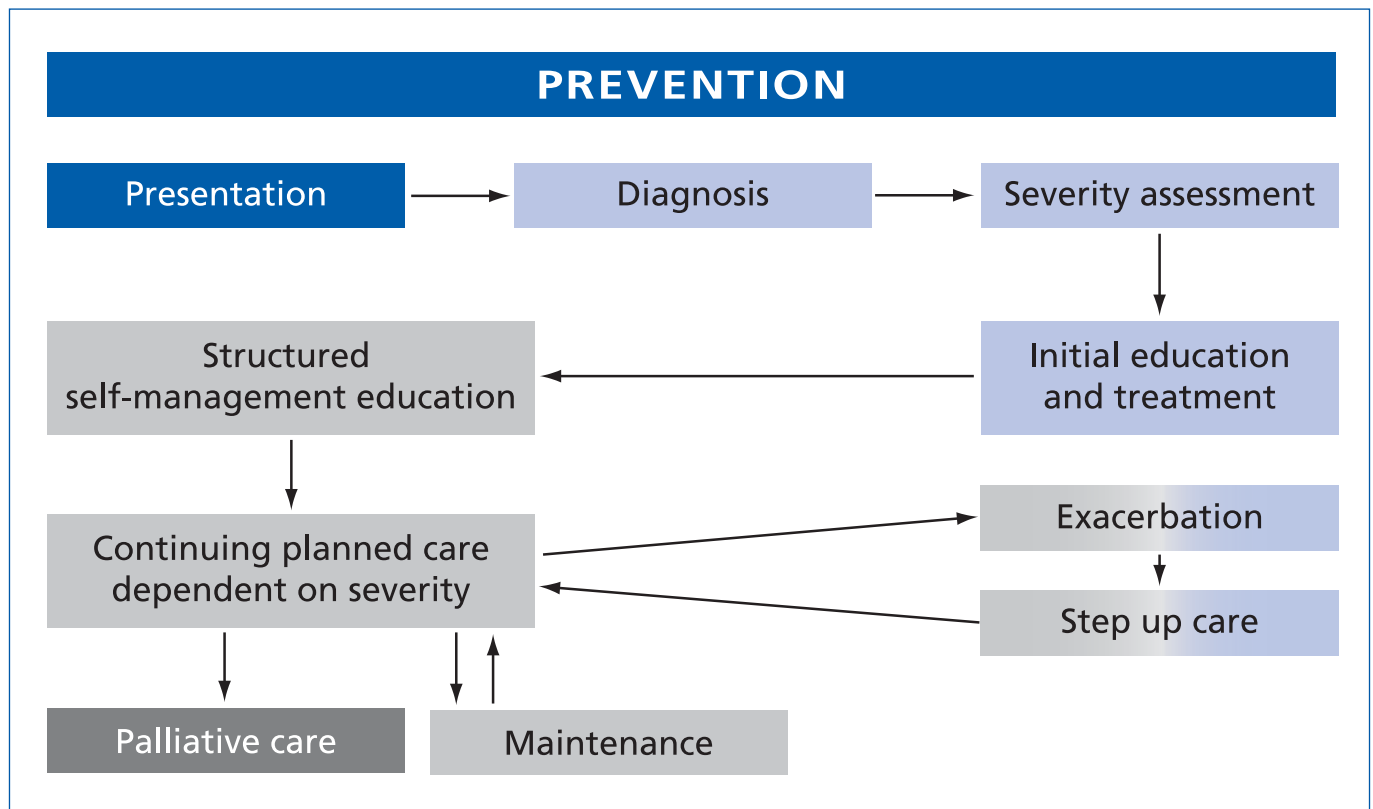
Building on the work done so far, Bolton is extending its approach to other chronic conditions, recognising the following:

- local models of care must be described, and need to be acknowledged by all stakeholders
- measurement systems must be defined
- networks have a strong role in advising, integrating, educating and monitoring – linking with practice-based commissioning (PBC)

- commissioners have corporate roles in setting standards, IT, training, interface issues, measurement and feedback, and acting as change agents.

The following diagram illustrates the different components of care. Bolton is developing its approach around heart failure, chronic obstructive pulmonary disease (COPD), neurological conditions, skin care and kidney disease. Work is also underway to create an integrated urgent care service and to use similar principles to strengthen care for older people.

Figure 1. Components of care at Bolton PCT



Source: Bolton PCT. Reproduced with permission.

INTEGRATION THROUGH REACHING IN TO HOSPITALS: THE EPSOM EXPERIENCE

The story of integrated care in Epsom started with fundholding in 1991. Tim Richardson's practice bought the Old Cottage Hospital and developed the ground floor into space for the practice. Fundholding enabled the practice to provide a much wider range of services in-house, such as physiotherapy. It also provided incentives to look after patients in the practice rather than to refer them to hospital.

An example was the care of patients with diabetes. Before fundholding, one of the GPs with a special interest in diabetes had treated his patients in the practice, while other GPs had referred their patients to the specialist clinic in the hospital. With the advent of fundholding, the GP with a special interest received referrals from fellow GPs, and the practice was in this way able to use funds to strengthen services in the practice instead of paying the hospital to provide these services.

In 1992 the Audit Commission produced a report on day surgery showing the scope to increase the number of operations done in this way. Kingston Hospital had been a pioneer in day surgery, and fundholding provided the incentive and opportunity to develop a local service using space at the Old Cottage Hospital. The upper floor of the building was converted for this purpose by a private sector healthcare company and Epsom Day Surgery became the UK's first freestanding and independent day surgery unit with a private sector partner.

Total purchasing and personal medical services (PMS)

The next chapter in the story came with total purchasing in 1996. The practice was keen to take part and it took on a budget for a much wider range of services than had been possible under fundholding. The total purchasing pilot operated as a sub-committee of the health authority. Arrangements were made to 'block back' some higher-risk services that the practice did not want to take on. A medical registrar working in the local acute trust was employed by the practice to manage patients who

were admitted, and to move patients who were past their acute phase to more cost-effective rehabilitation care in the community hospital under GP management.

Around this time there was contact with the Conservative Health Minister, Gerry Malone, who was undertaking a national listening exercise on the future of primary care. The practice was keen to become a recognised provider organisation and supported the idea of PMS contracts. It became a first-wave PMS-plus provider in 1998. By this stage, with the change of Government in 1997, it was clear that fundholding and total purchasing were coming to an end, and PMS was the natural way of taking primary care-based services forward.

The partnering private day surgery company got cold feet due to the political changes and pulled out, because it could see fundholding was about to disappear. The practice took over the ownership and management of the day surgery facility in 1998. The taking on of the PMS-plus contract enabled the practice to preserve the services it had developed as a provider under total purchasing, including day surgery. The contract also enabled the practice to manage GP beds in the community hospital.

Under PMS-plus, the practice provided a range of services. These included:

- specialist clinics that involved GPs working with specialists
- diagnostics including X-ray, ultrasound and vascular Doppler
- therapy services such as physiotherapy, chiropody, audiology and dietetics
- open-access endoscopy and a full range of specialist day surgery.

The practice was able to achieve savings of around £500,000 each year for the practice population of 25,000 (comparing its costs with those of local hospitals/community providers).

Practice-based commissioning and SPMS

The next important development came with practice-based commissioning (PBC). An example of what could be achieved relates to treatment of patients with deep vein thrombosis (DVT). This is much more expensive when provided in the local NHS trust and the service is also more complex and disjointed from the patient perspective. The practice is able to purchase the service from a local private hospital very quickly for around £250, whereas the NHS trust charges are up to £3,000 under tariff for a service that is less accessible. The problem is that PCTs in general have been slow in developing PBC, and the practice still has not received a real budget. They also receive poor and slow data from the PCT.

Much more positive has been the negotiation of an SPMS contract under Epsom Downs Integrated Care Service. EDICS involves a network of 16 practices working together to serve a population of 121,000. The practices are able to provide outpatient services at 65 per cent of the cost at the local NHS trusts and day surgery at 87 per cent of the cost. (These figures are based on local costs, inclusive of market forces factor.) It was estimated that the cost of providing outpatient care under SPMS was around £6.8 million, compared with an expected acute care cost (based on the NHS' healthcare resource group (HRG) costs) of £8 million. Almost all the practices' referrals go to EDICS and over half of these of those go to local rather than acute hospital services. The aim now is to extend beyond outpatient services to whole care pathways. These are natural extensions to primary care provider services and begin the process of integrating care out of hospital.

The future

Looking to the future, the aim is to take on a full, capitated provider contract rather than a notional ('soft') practice commissioning budget. This would be 'PBC-plus' and the budget would need to include funds currently held back in the market forces factor. The result would be a Kaiser-like integrated care service; there are currently discussions taking place with the Department of Health about this. Expensive, low-volume services such as HIV services and transplants would be managed outside the contract. The same integrated result could be achieved by hospitals reaching out into the community, but this might be used to preserve hospital-based care rather than to drive care closer to home, as hospitals seek to secure their future role.

The group of Epsom practices offering to take on a managed-care provider contract are partnering with Integrated Health Partners in developing these ideas. Under PBC-plus, the aim would be to develop an urgent care and medical assessment service to ensure that patients receive the right care in the right place. This would help to take pressure off hospitals and would also save money. The managed/integrated care organisation would work closely with the community health services organisation in Surrey that has recently been set up as a social enterprise. The joint aim would be to deliver more chronic disease management as well as step up and step down care in the community, and to reverse previous disinvestment in community services.

INTEGRATION THROUGH PARTNERSHIP: THE BIRMINGHAM AND SOLIHULL KAISER PILOT

Integration in Birmingham and Solihull started in February 2003, when six senior clinical staff from the NHS trust and two PCTs participated in a study visit to Kaiser Permanente in northern California. The NHS trust had a new chief executive who had been a medical director; there was also a new chief executive at one of the PCTs. The chief executives sent a team to Kaiser from the three organisations involved.

The visit to Kaiser showed the possibilities of running services in an integrated way, for example in the quality of care provided to people with chronic diseases. Kaiser also showed the importance of having inspirational clinicians leading the development of services. Over the last five years the link with Kaiser has been sustained. There have been further visits to northern California. In the opposite direction, Kaiser's clinical leaders have visited the UK to provide ongoing support to Birmingham and Solihull and the other two Kaiser beacon sites (Northumbria and Torbay).

The experience and principles of Working Together for Health were presented by the six staff who had visited

Kaiser, to meetings of clinicians from Eastern Birmingham and Solihull and to the boards of each of the partner organisations. Commitment was gained to these shared principles as the basis of the service strategies of each organisation. Notably, there was strong support from the chairs and non-executive directors, who in many ways represented the voice of the public.

Clinical leadership and project management

Progress over the last five years has been marked by events where large numbers of clinicians have come together to develop their understanding of, and ideas for, an integrated health and social care community. Staff from Kaiser Permanente have provided mentoring to the NHS clinicians through the Kaiser Beacon Site programme. Relationships between individuals across organisations have developed and deepened during time spent travelling, learning and socialising together. A project management approach has been used to design new kinds of integrated services, notably as a pilot site

Case study: Working Together for Health in Birmingham and Solihull

In Birmingham and Solihull clinical and service integration have been taken forward as part of a programme known as Working Together for Health. The programme is based on the following principles:

- an emphasis on integration of care
- priority given to keeping people out of hospital
- active management of people to prevent illness and improve quality of life
- promotion of self-care and partnership in care between clinicians and patients
- clinical leadership to drive change
- use of information technology to support integrated patient care and change management.

A logo was designed to give the programme an identity. At a later workshop facilitated by leaders from Kaiser Permanente, the principles were condensed even further into three slogans:

- patients as partners
- promoting self-care
- care in the right place.

The logo and slogans were used on slides and paperwork connected with the programme to continually reinforce the message.



Working Together For Health

in the NHS Institute's Care Outside Hospital programme. The track record of change projects in healthcare is poor: a 70 per cent failure rate is often quoted. This figure is reduced where there is skilled project management to provide a framework, discipline and support to the clinicians involved, who have usually taken on the change project in addition to their normal duties.

There have been many examples of service innovation. These include the Partners in Health Centre, the award-winning orthopaedic triage service, an integrated COPD service, and an integrated diabetic kidney service. Working Together for Health is now moving to the next stage of development and will be adopting a more formal board structure to take the work forward. Even after five years, Birmingham and Solihull would still not claim to have created an integrated system. While there are an increasing number of successful examples, the integrated way of working is not universal. The challenge is to move from 'cottage industries' to industrial-scale integration; from the enthusiastic innovators to the early and late adopters, from the special award winners to 'the way we do business'.

Budgets and incentives

One common device to encourage integrated thinking is to 'pool' the budget for a service and thereby share control of resources. If the pool is protected so that savings made in one area can be reinvested to support a shared aspiration, this may liberate change.

A good example of how a pooled budget has been applied is in the management of delayed discharges between health and social care. If a patient's discharge from hospital is delayed beyond an agreed limit solely due to social care issues, a fine may be levied against social services to cover the cost of hospital care until the patient is discharged.

The Birmingham and Solihull health and social care community felt this negative approach would do little to accelerate patients' discharge or foster partnership working. Instead, it agreed to invest the money that it anticipated would otherwise be required to cover fines, to provide services that would expedite discharges and avoid delays. Regular multi-agency meetings are held to review issues and monitor the performance of the discharge process. Since these

arrangements have been in place, the number of delayed discharges has reduced markedly and working relationships between the health and social care agencies have improved greatly.

Relationships

Willingness to use flexibilities within NHS contracts requires a level of trust and understanding between the parties. Just as in the private sector, successful business partnerships between public sector organisations require long-term trusting relationships. This approach to the arrangements between the foundation trust and Birmingham East and North PCT was enshrined in a set of agreed principles for the operation of the contracts. (see box right).

The relationship between the PCTs and the NHS foundation trust is not always cosy. For example, one of the PCTs put out a tender for dermatology services, and the foundation trust lost part of the service. This challenge strengthened the resolve within the dermatology team in the FT to work with the PCT to create an integrated service: this is now being developed.

Integration is not about organisational mergers and budgets. Primarily it is about relationships between people. These relationships are not informal friendships. If clinical integration is to be meaningful, they have to be worked on and built professionally, and sustained through good and bad times. This challenge is being tackled by applying a fundamental principle: change will only happen and be sustained through the commitment of the clinicians and managers involved in delivering the care. If their ability to make change happen can be developed, then they will make the vision of an integrated system a reality.

It is the responsibility of leadership to provide first the necessary training and development and then the project management support and framework required for collaborative working. Training and development are particularly needed in methodologies for clinical system redesign that employ 'lean' thinking. A collaborative approach to removing unnecessary processes (waste) and measuring system performance in terms of quality, timeliness and cost over time is proving an effective way of getting clinicians and managers to see issues from the patient rather than the organisational perspective.

Commissioning principles between Birmingham East and North (BEN) PCT and Heart of England NHS Foundation Trust (2007/08)

In arriving at a 2006/07 agreement and in order to implement the model contract and BEN's local commissioning proposals in a manner agreeable by both parties, a set of commissioning principles, or a local operating framework, has been agreed as follows.

Principle 1

Separate 06/07 full and final settlement from 07/08 LDP; 07/08 to include resolution of issues of principle. Both to be concluded by 28 February and sign off dependent on satisfactory outcome for both by that date. Discussions to include HEFT and Good Hope Hospital simultaneously.

Principle 2

HEFT will support reductions in consultant-to-consultant referrals, outpatient follow-up visits and issues of prior approval where an agreed speciality-based protocol is in place.

Principle 3

HEFT accepts circumstances where BEN wishes to commission lower activity levels and will work with BEN to achieve these. If patients bypass these arrangements and present to HEFT they will be treated; BEN will pay for this activity, we will work together to understand why and set up better processes to prevent this in future.

Principle 4

HEFT and BEN agree to create a local category for N12 activity with a zero length of stay. This is chargeable at a local tariff of £299 for 2007/08 only, pending the introduction of V4 HRGs. This is subject to any national guidelines.

Principle 5

Where tariff guidance is unequivocal, HEFT and BEN will abide by it.

Principle 6

BEN only pays for activity which has taken place, not activity resulting from the grouper assigning to highest diagnostic category e.g. cellulitis.

Principle 7

HEFT suggests rigorous data audits by BEN would be helpful and prevent excessive queries. HEFT agrees to undertake two data quality audits per quarter in areas defined by BEN, without advance warning.

Principle 8

HEFT agrees that diagnostics form part of the first outpatient appointment price and propose to accept this for the 2007/08 contract. This will remain the case unless tariff guidance is released that clearly reverses this.

Source: Birmingham East and North PCT/Heart of England NHS Foundation Trust. Reproduced with permission.

IMPLICATIONS FOR POLICY AND PRACTICE

The examples described in this summary report illustrate that there are different ways of achieving closer clinical integration. The three main routes are through:

- community-based specialists
- primary care reaching in to hospitals to provide more care in the community
- partnership between primary and secondary care.

All three routes are likely to be used in the future, as further progress is made in developing clinically integrated services. One of the implications is that policy-makers need to resist the temptation to prescribe a single approach and to focus instead on encouraging the development of integrated care using the means that appear most appropriate in different contexts.

A common feature of these three examples is that they arose out of the initiative and commitment of local leaders, who overcame professional and organisational barriers to service improvement. Of particular importance was the part played by medical leaders, who developed a compelling vision of how care could be strengthened and worked with clinical and managerial colleagues to turn the vision into reality. These medical leaders often received support from senior managers in the organisations concerned, and the resulting partnerships between medical leaders and senior managers contributed significantly to the progress made.

A key characteristic of those involved in leading change was resilience and persistence in the face of the barriers and setbacks that were encountered along the way. This is most starkly illustrated by the example of Epsom, where periods of progress were followed by times when developments stalled or in some cases went into reverse. The ability to keep faith with the work that had been started was explained in part by the exceptional commitment of the individuals involved and also, as the Birmingham and Solihull example shows, by the strength of the relationships established at the outset. The continuity of involvement of local medical leaders while all around them was changing (NHS structures, managerial

leaders, governments and national policies) is especially worthy of note.

A linked observation is the time it takes to make change happen. This is well illustrated by the development of the local managed diabetes network in Bolton which evolved progressively from a regional review undertaken in 1989. The integrated care service in Epsom emerged over a similar timescale and came to resemble a roller-coaster ride, as changes in government and national policies interacted with the vision of local leaders to shape a complex path of development. The Birmingham and Solihull approach is of more recent origins; but even here, progress has focused on selected priority areas, with the outstanding challenge being how to move from cottage industries to ‘industrial-scale’ integration.

The stories reported here illustrate that national policies have an important bearing on the emergence of clinically integrated care. This is most evident in the case of Epsom where fundholding, total purchasing, PMS and SPMS contracts all helped at different stages to facilitate the provision of a wider range of care outside hospital. As yet, practice-based commissioning has failed to offer an equivalent stimulus. Payment by results and the policy of local authorities reimbursing the NHS for delayed transfers of care were other national policies identified as influencing progress towards more integrated approaches, though these were more often seen as barriers than as facilitators of change.

The approach taken in Birmingham and Solihull, of seeking to find agreement on the appropriate pathways of care and then fitting payment by results around these pathways, illustrates that the barriers can be overcome where relationships are sufficiently mature. This included unbundling the tariff to support new care pathways and developing and codifying shared commissioning principles to avoid the Government’s transactional reforms impeding progress in the desired direction. In other areas, the introduction of payment by results was reported to have set back attempts to integrate care, as hospitals focused on maximising the benefits to them from this system of payment rather than continuing efforts to achieve closer collaboration. In Bolton, for example, the integrated diabetes service

was initiated well before the current health reform programme was introduced, and there are challenges there in extending this approach to other long-term conditions now that the programme is gathering pace.

The role that incentives play in supporting clinically integrated care emerged as a particularly powerful theme in Epsom, where integration has been led from primary care. The view in Epsom is that further progress depends critically on a radical expansion of practice-based commissioning in which a group of practices is given responsibility for a 'hard' budget covering most services used by the registered population served. As this happens, there is a need to ensure that practices who take on risk for deficits as well as surpluses work with like-minded practices, and not just those with whom they are geographically contiguous. It is also important that practices have excellent back-office support; in Epsom this is being sourced through a partnership with a private-sector organisation.

A key challenge in the future is how to reconcile clinical integration on the one hand with patient choice on the other. Under one scenario, the NHS may end up being served by a small number of relatively large integrated organisations that are monopoly or near-monopoly providers and commissioners of care in their area. If this were to happen, then it would be important to enable patients to exercise choice outside the organisation, for example in the case of specialist treatment, rather than be restricted to care within the network. More importantly, if the approach being explored in Epsom, of collaboration between like-minded practices to both provide and commission care, comes to predominate, then it should be possible

to combine this with patients being able to choose between competing integrated organisations. Whatever arrangements eventually emerge, PCTs would need to retain a role in overseeing the performance of integrated organisations to ensure they offered value for money and did not exclude innovative providers entering the market.

Finally, the importance of assessing the performance of integrated systems and measuring their effectiveness needs to be acknowledged. While at a macro level the performance of integrated systems like Kaiser Permanente and the Veterans Health Administration has been described and acknowledged (Jha, Perlin, Kizer and Dudley, 2003; Lohr, 2004), the evidence base on integrated systems in the NHS is only now being built. Not only this, but also reviews of the effectiveness and cost-effectiveness of providing specialist services in the community are equivocal in their findings, indicating that the business case for clinically integrated care remains a matter of debate and dispute. In view of these uncertainties, future policy in this area needs to encourage a degree of experimentation, recognising that there are different routes to integration, and a commitment to evaluation to gather data about the performance of integrated systems in relation to costs, outcomes or other parameters.

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