Doctors’ perspectives on integration in the NHS

BMA interim report

December 2011
Executive summary

This interim report contains the findings of two surveys of BMA members conducted in 2011 to uncover their views and experiences of integration. This work forms part of a wider project on integration.

Key survey results

Joined-up care pathways

- Conflicting organisational priorities is the most important barrier to achieving joined-up care pathways (47.8 per cent of respondents).
- Separation of purchasing and provision (in England) (20 per cent) and lack of coherent IT systems (19.2 per cent) are the second and third most important barriers.
- A collaborative culture is the most important enabler to achieving joined-up care pathways (29.9 per cent). Good professional relationships (28.2 per cent) and effective clinical leadership (26.8 per cent) are the second and third most important enablers.
- 26 per cent of respondents work as part of a joined-up care pathway in their main clinical practice much or all of the time. 44.2 per cent of respondents work as part of a joined-up care pathway a bit of the time.
- The most frequently cited reason as to why pathways are not more effective was poor communication between organisations and professionals within them. Buy-in and engagement were also identified as problems. This suggests that pathways alone are not sufficient; it is the relationships within them that make them work.

Mergers

- Respondents are not strongly opposed to merging with organisations in different parts of the health and social care sector.
- When thinking about their employing organisation merging with another provider, the biggest concern for respondents is whether the merger would achieve its objectives (46 per cent), followed by competing priorities between merging organisations (34 per cent) and the cost of the merger (24 per cent).
- The majority of respondents (79 per cent) have not been involved in a merger of organisations for the purpose of integrating services.
- The important role of clinical leadership in ensuring successful mergers was emphasised by some respondents, alongside the need to consult staff and reflect the clinical perspective.
- Some respondents feel efforts should be focussed on establishing more joined-up ways of working and promoting a common ethos of shared values to include cooperation and pragmatic problem solving, rather than on mergers.

Objectives and criteria for success

- The two most important criteria for the NHS when measuring the success of efforts to integrate services are improved clinical outcomes (81.8 per cent) and better patient experience (64.1 per cent). These are also the most important criteria for success for individual doctors.
Competition and integration

- 60 per cent of respondents think government policies on competition will have a greater impact on the NHS over the next 10 years than policies on integration.
- Primary care doctors are almost evenly split in their view of which policy will have the greater impact whereas secondary/tertiary care doctors feel more strongly that competition will have the greater impact (competition 66 per cent, integration 35 per cent).
- Respondents feel that governments are more committed to competition than integration and that competition is uppermost in political thinking. There is also a feeling that while integration may be a worthy goal, it will be difficult to achieve, and will therefore have less impact in the long term.
Overview of integration and integrated care

Although not new, the concept of integration and integrated care has been rapidly gaining profile during the second half of 2011 as part of the debate on how the NHS (particularly in England) can better meet the needs of patients and the public in the future. The main challenge in meeting those needs is well-rehearsed: rising prevalence of long-term conditions and co-morbidities, within an ageing population.

What is it?
There are many academic and policy definitions of integration and integrated care, but the one with the greatest circulation at present comes from The Nuffield Trust:

‘Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination. Integration is the combined set of methods, processes and models that seek to bring this about.’

Many other understandings of what integration means exist however, particularly if you consider different viewpoints i.e. commissioners, providers, patients. It is not safe to assume therefore that everyone is talking about the same thing. This lack of consensus is the first challenge in the debate around integration, something echoed in the results of our survey.

What does it look like?
There are a relatively small number of well-documented examples of different types and levels of integration taking place in the UK. Some have involved merging organisations into a single body in order to break down traditional boundaries and deliver a more holistic package of services. Others have taken seemingly less radical routes, such as implementing integrated teams, joint care pathways and shared information systems. There are likely to be many more examples that have either not been defined by those taking part in them as integration, or thus far have remained below the national-policy radar.

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3 Torbay Care Trust is a well known integrated care organisation. More information is available from King's Fund. Integrating health and social care in Torbay, March 2011
4 See the work of The King’s Fund and The Nuffield Trust in particular who have documented a number of these case studies in their publications on integration.
Integration terminology

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>Horizontal</td>
<td>Bringing together organisations providing services of care at the same level e.g. merger of two acute hospitals</td>
</tr>
<tr>
<td>Vertical</td>
<td>Bringing together organisations providing services at different levels e.g. merger of primary and secondary care organisations</td>
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<tr>
<td>Virtual</td>
<td>Partnerships and networks between organisations</td>
</tr>
<tr>
<td>Real</td>
<td>Structural merger of organisations</td>
</tr>
<tr>
<td>Organisational</td>
<td>Organisations working together or joining e.g. mergers or networks</td>
</tr>
<tr>
<td>Clinical</td>
<td>Integrating care through coherent processes e.g. shared guidelines and protocols</td>
</tr>
<tr>
<td>Service</td>
<td>Integration of different services provided within one organisation e.g. multidisciplinary teams</td>
</tr>
<tr>
<td>Commissioner</td>
<td>Groups of commissioners coming together</td>
</tr>
<tr>
<td>Macro-level</td>
<td>Delivering integrated care to populations</td>
</tr>
<tr>
<td>Meso-level</td>
<td>Delivering integrated care to a particular population sub-group e.g. for a certain condition</td>
</tr>
<tr>
<td>Micro-level</td>
<td>Delivering integrated care to individuals</td>
</tr>
<tr>
<td>Pooled budget</td>
<td>Combining budgets e.g. across health and social care these could be allocated to a lead commissioner</td>
</tr>
</tbody>
</table>

Existing literature and experience show that there is no single approach to achieving successful integration and that it will take many different forms across health and social care. This brings us onto the second challenge for the debate around integration. As attempts towards integrated care look different in different settings, a good example in one setting will not necessarily translate to another. Although some lessons can be learnt from looking at the case studies, this lack of transferability limits the scope of efforts at a national level to encourage greater integration in the NHS.

**What problem is it trying to solve?**

Generally speaking, the NHS as a health system is fragmented. Silo working, poor communication and a lack of coordination between organisations prevent patients from being able to move around and through the system easily. The interface between primary and secondary care, and/or health and social care can be particularly unsatisfactory in terms of the patient experience. Primarily therefore the problem that integration and integrated care is trying to address is fragmentation in the NHS. However integration and integrated care is also hoped to achieve more, far-reaching health system goals in relation to quality and efficiency. The third challenge then is precisely how to measure its impact and/or success.

**An England-only or UK-wide issue?**

Although the debate around integration is often framed in the context of the market reforms in England, the issue is just as relevant elsewhere in the UK. For example if we accept the definition of integrated care given above and the centrality of the patient perspective, in Scotland and Wales where the health system is formally integrated – Boards both commission and provide health care – this does not necessarily mean that patients experience integrated care within that system. In Northern Ireland,
as in England, while commissioning and provision is not integrated, Trusts provide both health and social care services. But again, this does not necessarily mean that patients experience integrated care for example between secondary and primary care services, or even between health and social care.

**What is the evidence?**

The evidence regarding the impact of integrated care is currently limited and much of it comes from Europe and the United States. This includes the following findings:

- Integrated systems in the US that offer a full range of services to defined populations have been found to have a beneficial impact in terms of fewer bed days and improved quality of care.
- Integrated care designed specifically for older people has been found to be beneficial in the US, Canada, Italy and the UK (Torbay). In the case of the UK example, benefits were measured in terms of the number of bed days, delayed transfers from hospital to community and emergency admissions and re-admissions.
- The evidence from the US, Germany and the UK for using integrated care or ‘case management’ for long-term conditions is mixed.
- ‘Chains of care’ or established care pathways in Sweden have had a limited impact and managed clinical networks in Scotland have had a varying impact.

Specific and significant gaps in the existing evidence base have been highlighted including in relation to costs, patient experience and clinical outcomes.

**What is happening at a national policy level?**

**England**

As part of its White Paper proposals, in July 2010, the Coalition Government made a commitment to pursue greater integration of health and social care services and to ‘break down barriers between health and social care funding to encourage preventative action’. This was quickly overshadowed however by the parallel proposals to increase competition in the NHS.

In July 2011, the NHS Future Forum made several recommendations to promote integration in the NHS as the culmination of the Coalition Government’s ‘listening exercise’ on its plans for reform. Many of these recommendations were then reflected in amendments to the Health and Social Care Bill and in Department of Health policy. These include:

- A duty on clinical commissioning groups (CCGs) and the NHS Commissioning Board to promote integrated services for patients, both between the NHS and social care (and other local services), and within the NHS;

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9 Department of Health (2010). Equity and excellence: Liberating the NHS
- The NHS Commissioning Board will also be required to promote innovative ways of demonstrating how care can be better integrated, for example by exploring moves towards single budgets for health and social care; and
- New health and wellbeing boards will promote integration across the NHS and social care.

The second round of the NHS Future Forum’s work began in October 2011 focusing on integration as one of the four strands of inquiry. Their recommendations and the Government’s response were expected in December 2011. The Government has also tasked The King’s Fund and The Nuffield Trust to develop recommendations for a national strategy for the promotion of integrated care at scale. This report was also expected in December 2011.

In 2008, following Lord Darzi’s review of the NHS, the previous Labour Government launched a national integrated care pilot programme. The final evaluation report of the 16 pilots – being carried out by Ernst & Young, RAND Europe and The Nuffield Trust – is expected by the end of 2011.

Most recently, the Secretary of State has “advocated the model of accountable care organisations... "in so far as they bring hospital and community services together, in order to create an organisational form that is more integrated””. The aim of accountable care organisations is to pay providers in a way that encourages joint working and high quality care, while allowing flexibility in the organisational form. Other ways in which the Department of Health might support integrated care in the future include “‘tariffs based on care pathways and bundles’”.

Scotland
As mentioned above, the NHS in Scotland is formally integrated in that NHS Boards both commission and provide health care. This does not apply to social care however, and projected future demand for elderly care services have added to the desire to achieve greater integration between health and social care. Community Health Partnerships (CHPs), were introduced in 2004 as the means to improve delivery of health and social care in the community and foster greater integration of primary and secondary care. However, they have so far not proved hugely successful, and an announcement is expected shortly from the Scottish Government, on how it plans to address this. At the same time, a pilot is being planned for NHS Highland to start in 2012 based on a lead agency model. The NHS board and local authority will both be accountable for deciding the resources to be committed and the outcomes to be achieved for specific services, but the lead agency will be responsible for all aspects of delivery.

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13 West, D (2011). Exclusive: Lansley on the CQC, integration, the reform risk register and commissioning. HSJ available online at [http://www.hsj.co.uk/5037949.article?referrer=e94](http://www.hsj.co.uk/5037949.article?referrer=e94) (accessed on 30 November 2011)
14 Ibid.
Wales
As in Scotland, the NHS in Wales is formally integrated in that NHS Boards both commission and provide health care, but social care is organised separately. In Wales local authorities and local health boards are jointly responsible for formulating local health, social care and well-being strategies. Although the Welsh Government has committed to reshaping social care services in the light of the challenges of rising demand increasing expectations of quality and a poor financial outlook. NHS Wales and local government bodies will be expected to work together to form coherent, whole-system plans to deliver integrated services in their localities, and deal with the budgetary pressures they face. A key aspect of this exercise will be reducing the number of social services authorities to seven, to match the number of local health boards. The Welsh Government recently stated that ‘sustainability depends on picking up the pace of [service] integration’; and that ‘In order to add momentum we will prioritise three areas of work where we will expect much greater integration of delivery:

- Families with complex needs
- Transition to adulthood for disabled children
- Frail older people

One of three priorities in the Welsh Government's flag-ship ‘Rural Health Plan – Improving Integrated Service Delivery Across Wales’ identified the need and opportunities for closer service integration – it said ‘integrated service models, workforce planning and systems are necessary to improve service provision and ensure effective use of resources and skills within communities’. In addition research by the Social Services Improvement Agency (SSIA) and the National Leadership and Innovation Agency for Healthcare (NLIH) is due out in the next few months, which we are told will report that there has been real progress in Wales in implementing new models of integrated health and social service, but that there is still more to do.

Northern Ireland
Health and social care are currently integrated in Northern Ireland, where Health and Social Care Trusts provide services, which are commissioned by the Health and Social Care Board. A major review of public administration took place from 2002-2009 resulting in a reduction of the number of Trusts and amalgamated four health and social care boards into one.

A new Review of Health and Social Care Services was announced in June 2011. The review is examining the future provision of services including acute hospital configuration, the development of primary health care services and social care, and the interfaces between the sectors.

Integrated working and the BMA

The BMA has long advocated greater integration in the NHS, most vociferously in response to the pursuit of market-based policies in the health service by successive governments since the early 1990s. One of our main concerns about increasing competition in the NHS in England is that this will fragment the health service further, a belief held by nine in 10 of our members. It is difficult to reconcile therefore how integration and competition can co-exist, particularly as the underpinning values appear fundamentally mismatched.

Recent commentary suggests that the two are not mutually exclusive. Competition could be encouraged between integrated organisations, involving not only the integration of providers, but also of providers and commissioners, thus removing the purchaser-provider split that was introduced in the early 1990s. Putting aside the desirability and feasibility of such a large-scale shift in current NHS organisational structures, this implies that commissioners would no longer be regional monopolies, with assigned patient populations. Instead, patients would be able to choose which commissioner-provider package of care they wished to have access to.

A similar model exists in the US private health insurance system in the form of Health Maintenance Organisations (HMOs). However, perhaps more relevant to the NHS context is the model of insurer or purchaser competition in the Netherlands, as it is a part state, part private health insurance system. Since 2006, individuals have been able to switch insurers on an annual basis, and insurers have been free to either selectively contract with or integrate with providers. In practice however (and for various reasons) very few people do switch insurers – only 4 per cent of the population in 2009 – no insurers have integrated with providers, little selective contracting takes place and competition still focuses mainly on price rather than quality. Of course take away the competitive aspect of the suggestion and you are left with a model along the lines of the District Health Authorities that existed in England until the early 1990s, or NHS Boards as they currently stand in Scotland and Wales.

The BMA has not been specific about how integration and integrated care should look, nor how far it should go. This is in keeping with our desire not to make proposals that might rely on significant organisational change or upheaval, nor to pre-empt decisions that are more appropriately made at the local health economy level as part of a system-wide approach. We hope that a professionally-inclusive
form of commissioning, a more mature commissioner-provider relationship and stronger clinical leadership\textsuperscript{22} will play a key part in this in the future.

Much of what we have promoted in relation to integration focuses on ways of working and the professional relationships that would underpin integrative processes. The importance and appetite for what we refer to as integrated working came out clearly in our survey of BMA members. Experience shows that changing the behavioural and relational aspects of the way different parts of the health service work together is very challenging\textsuperscript{23}. That said it is potentially far more effective than organisational integration, which by itself is unlikely to have a sufficient impact upon patient outcomes\textsuperscript{24}. Alongside the softer aspects of integration however, a fundamental reappraisal of national-level policy is also required. This would include a realignment of incentives across the service, as echoed by the fact that our members identified ‘conflicting organisational priorities’ as the most important barrier to achieving more joined-up care.

By encouraging and supporting integrated working, we believe that the NHS will move closer to being an integrated service: one which will be able to deliver improved health outcomes to the population as well as more co-ordinated services that better meet the needs of patients.

\textsuperscript{22} The BMA has conducted separate research into clinical leadership, the results of which will be publicly available in early 2012.


About the project

As part of the growing body of literature on integrated care in the UK, much attention has been paid to learning from the experiences of doctors, nurses and other clinicians who are heavily involved in integrative processes. In order to offer an additional perspective, we were interested to seek the views of doctors in the generality. As such, this interim report contains the findings of two surveys of BMA members conducted in August and October 2011.

This work forms part of a wider project, which focuses on three distinct forms of integration.

- Real integration, including vertical and horizontal integration, focussing on structural change.
- Virtual integration, including service and clinical integration, focusing on relational or behavioural change.
- Integration of health and social care.

A final report will be published in the first half of 2012.
Survey results – interim findings

Overview
The results of our two surveys indicate that the doctors who responded are largely unsure of the meaning of integration, what it involves and with few respondents having much direct experience of integrative processes. There was little appetite for integration shown by the high proportion of doctors who said they did not know whether it had the potential to produce desirable outcomes. This is likely to reflect the aforementioned confusion over the terminology.

Nevertheless, survey respondents displayed openness to change in the organisations and systems they work with. There was no strong opposition to the prospect of moves to integrate services such as by merging organisations.

The emphasis respondents placed on improved clinical outcomes and better patient experience as the most important measures of success for integration indicates that for doctors, any structural change should have a strong clinical case. This should be coupled with recognition of the concerns expressed around the costs involved in structural change, in particular the risk of diverting resources and staff efforts away from patient care during the process.

So for doctors to actually support such an agenda, a clear evidence base that demonstrates the longer-term clinical benefits alongside the commitment to properly resource and staff the process would be necessary.

A clear message of willingness to work together and recognition of the need for good professional relationships, clinical leadership and multidisciplinary approaches came across strongly in the survey. The main obstacle to such activity was seen to be conflicting organisational priorities. This suggests that one of the major attributes of integration should be alignment of organisational incentives in a way that allows professional relationships and linkages to develop across disciplines, teams and organisations.

This message is supported by the views of primary care doctors involved in commissioning who were more likely to identify the national tariff as a barrier to achieving joined-up care pathways than secondary/tertiary care doctors.

Overall, our findings are consistent with the existing literature on integration which does not find rearranging organisational structures through mergers to be absolutely necessary or even sufficient to produce genuine joint working and more coordinated care. Instead, the emphasis is often placed on good information sharing and effective, professional relationships across disciplines and organisations.
Is integration a good thing?

KEY FINDINGS:
- When asked whether integration had the potential to produce desirable outcomes, respondents answered as follows:
  - Nearly half said ‘yes’ (47 per cent);
  - Nearly half said ‘don’t know’ (45 per cent); and
  - The remainder said ‘no’ (8 per cent).

As part of a regular broader survey of BMA members’ perceptions, respondents were asked whether they thought integration had the potential to produce desirable outcomes. We did not give doctors a specific definition of ‘integration’ intentionally so as not to pre-empt their own understanding of the term.

The findings suggest a number of things. First, as was set out earlier in this report, the lack of consensus on or even understanding around integration, its aims and benefits, would explain why so many respondents did not know whether it has the potential to produce desirable outcomes. This is significant given the central role that doctors will need to play in efforts to integrate services. Also, while nearly half answered ‘yes’, it was highly likely that the specific understanding of the meaning of integration varied within that group.

Respondents were then given the opportunity to indicate the reason behind their answer: their responses are summarised below. Many of the themes that came up were then explored in more detail in our second survey.

If ‘yes’, why?
Respondents who felt that integration does have the potential to produce desirable outcomes described a number of reasons. Most respondents cited improved quality of patient care as the key aim for integration. It was commonly suggested that improved quality would manifest in better patient experiences such as smoother referral between specialities and time saved throughout the care pathway. It was thought this would be particularly important in managing chronic disease.

A significant proportion of respondents proposed that greater effectiveness and efficiency could result from integration, with less duplication of efforts it could generate potential cost savings, for example reducing the number of repeated diagnostic tests. Some respondents referred to the alignment of incentives within the overall system in order to reduce costs by greater efficiency of delivery across boundaries, and breaking down silos.

Better joint working between primary and secondary care was frequently cited. Many respondents highlighted multidisciplinary team working as an essential component to improving clinical outcomes. The primary – secondary care divide was described as a major obstacle to improving care, for example, reducing hospital admission rates and managing conditions in the community.
Many respondents thought it would be impossible to have integrated care with competing organisations and outlined that this is at odds with proposals to increase market forces in the healthcare sector. Concern was expressed with regard to the purchaser-provider split and the involvement of private healthcare providers.

Understandably some respondents pointed to the differing meanings of the term integration in the context of healthcare as a concern. One respondent highlighted that integration of organisations does not necessarily result in integration of care for patients and that effective sharing of information and joint working are essential.

**If ‘no’, why?**

Those that felt integration would not improve outcomes raised concerns that further reorganisation in healthcare without clear goals and objectives could result in loss of resources. In particular, lack of clarity of a definition of integration may result in complex proposals, suggesting it is “too big a task” to be achieved. Furthermore, there would be risks of producing large organisations and potentially increasing rather than decreasing the cost of administration.

**Main survey**

Following this initial piece of research, we then conducted a dedicated, online survey of a sample of members of the BMA Intouch Research Panel. The BMA Intouch research panel contains BMA members from across fields of medical practice and is broadly representative of the BMA membership and the UK medical workforce.

The sample size was 2,500 and 369 doctors responded; a 15 per cent response rate. The breakdown of respondents by the type of provider they carry out most of their clinical time working for was as follows: It was not possible to analyse responses by UK country due to relatively low numbers of responses from the devolved nations.

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>%</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary/tertiary care</td>
<td>53</td>
<td>(196)</td>
</tr>
<tr>
<td>Primary care</td>
<td>37</td>
<td>(137)</td>
</tr>
<tr>
<td>Community care</td>
<td>4</td>
<td>(13)</td>
</tr>
<tr>
<td>Commissioning organisations</td>
<td>3</td>
<td>(10)</td>
</tr>
<tr>
<td>Integrated organisations</td>
<td>3</td>
<td>(12)</td>
</tr>
<tr>
<td>Social care</td>
<td>0.3</td>
<td>(1)</td>
</tr>
</tbody>
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**Joined-up care pathways: barriers, enablers and doctors’ experience**

The shorter survey referred to above found ‘joined-up care pathways’ to be the most important factor in the integration of healthcare services. As the term ‘integration’ is subject to interpretation, we chose to focus on joined-up care pathways as one of the key areas of the main survey, with a view to identifying a set of barriers and enablers.

**Barriers to achieving joined-up care pathways**

**KEY FINDINGS:**
- ‘Conflicting organisational priorities’ is by far the most salient concern for doctors in terms of the barriers to achieving joined-up care pathways.
- Primary care doctors involved in commissioning are seven times more concerned than secondary/tertiary care doctors with responsibility for managing a department or clinical services about ‘Payment by Results/national tariff’.
- Secondary/tertiary care doctors are twice as concerned as their primary care counterparts about the ‘lack of coherent information technology systems’.

Respondents were asked which of the following they considered to be barriers to achieving joined-up care pathways.

**Table 1 – Barriers to achieving joined-up care pathways**

<table>
<thead>
<tr>
<th>Barriers to achieving joined-up care pathways</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Conflicting organisational priorities</td>
<td>82%</td>
</tr>
<tr>
<td>Lack of coherent information technology systems</td>
<td>63%</td>
</tr>
<tr>
<td>Lack of leadership (managerial)</td>
<td>54%</td>
</tr>
<tr>
<td>Competition between providers</td>
<td>49%</td>
</tr>
<tr>
<td>Ineffective commission</td>
<td>48%</td>
</tr>
<tr>
<td>Separation of purchasing and provision (England only)</td>
<td>47%</td>
</tr>
<tr>
<td>Concern over destabilising existing services/facilities</td>
<td>46%</td>
</tr>
<tr>
<td>Lack of leadership (clinical)</td>
<td>44%</td>
</tr>
<tr>
<td>Poor professional relationships</td>
<td>43%</td>
</tr>
<tr>
<td>Payment by results/national tariff</td>
<td>43%</td>
</tr>
<tr>
<td>Lack of capacity in primary care</td>
<td>35%</td>
</tr>
<tr>
<td>Resistance from secondary care</td>
<td>28%</td>
</tr>
<tr>
<td>Patient choice</td>
<td>26%</td>
</tr>
<tr>
<td>Other (unspecified)</td>
<td>5%</td>
</tr>
</tbody>
</table>

*Multiple response

25 The description given of a ‘joined-up care pathway’ was ‘a patient pathway that spans different parts of the health service, and which may or may not also include social care’.

26 The list was derived from existing literature, some of which were also included in the list of options for ‘enablers’.
We then asked respondents to choose the two most important barriers from those they had identified in the previous question. ‘Conflicting organisational priorities’ was the only listed barrier to come out strongly in this question (48 per cent). The next most important barrier identified was ‘Separation of purchasing and provision’, but this only had the support of one in five respondents (20 per cent). The results from this second, qualifying question therefore confirms that ‘conflicting organisational priorities’ is considered the biggest barrier, and was more than twice as likely to be identified than the next highest response.

**Barriers: do all doctors have the same opinion?**

Given the relevance in the integration debate about how to break down the barriers between primary and secondary care, we were interested to see how opinions varied between these two groups of doctors. We were also keen to learn whether those doctors reporting a higher level of involvement in planning and running health services had different views to those delivering health services. We analysed the responses of these different groups in relation to the second question in this section (i.e. the two most important barriers.)

When comparing the views of primary and secondary/tertiary care doctors the results showed no notable differences except in one area. Secondary/tertiary care doctors (25 per cent) were twice as likely than primary care doctors (13 per cent) to have considered a ‘Lack of coherent information technology systems’ to be one of the two most important barriers.

When comparing the views of primary care doctors involved in commissioning and secondary/tertiary care doctors with responsibility for managing a department or clinical services, two of the three most important barriers identified correlated with the cohort as a whole (‘conflicting organisational priorities’ and ‘separation of purchasing and provision’). However primary care commissioners (28 per cent) were seven times as likely to have chosen ‘Payment by results/national tariff’ than the secondary/tertiary care management group (4 per cent). Although unsurprising, this suggests that primary care commissioners may face some degree of challenge if trying to negotiate tariff flexibilities with their secondary/tertiary care counterparts.

**Enablers for achieving joined-up care pathways**

**KEY FINDINGS:**

- The top three enablers identified were:
  - Good professional relationships;
  - Effective clinical leadership; and
  - Collaborative culture e.g. ethos of shared values

- Secondary/tertiary care doctors with a management responsibility considered ‘Collaborative culture e.g. ethos of shared values’ more important than both the cohort of respondents as a whole and any other separate subgroup analysed

- Secondary/tertiary care doctors were twice as likely to identify ‘Shared information technology systems’ as one of the two most important enablers than primary care doctors
The same format was followed for two questions on enablers to achieving joined-up care pathways as was followed for the questions about barriers.

Table 2 – Enablers to achieving joined-up care pathways

<table>
<thead>
<tr>
<th>Enabler</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Good professional relationships</td>
<td>84%</td>
</tr>
<tr>
<td>Effective clinical leadership</td>
<td>74%</td>
</tr>
<tr>
<td>Collaborative culture e.g. ethos of shared values</td>
<td>68%</td>
</tr>
<tr>
<td>Shared information technology systems</td>
<td>65%</td>
</tr>
<tr>
<td>Shared guidelines/protocols across organisations</td>
<td>64%</td>
</tr>
<tr>
<td>Effective managerial leadership</td>
<td>63%</td>
</tr>
<tr>
<td>Aligned organisational priorities</td>
<td>50%</td>
</tr>
<tr>
<td>Well-defined outcome measures</td>
<td>44%</td>
</tr>
<tr>
<td>Strong commissioning</td>
<td>44%</td>
</tr>
<tr>
<td>Contractual agreements across organisations</td>
<td>42%</td>
</tr>
<tr>
<td>Pooled budgets</td>
<td>35%</td>
</tr>
<tr>
<td>More flexible use of tariffs/payment mechanisms</td>
<td>34%</td>
</tr>
<tr>
<td>Patient choice</td>
<td>14%</td>
</tr>
<tr>
<td>Competition between providers</td>
<td>4%</td>
</tr>
<tr>
<td>Other (not specified)</td>
<td>2%</td>
</tr>
</tbody>
</table>

*Multiple response

The same top three enablers emerged when we asked respondents to choose which two were the most important enablers from those they had identified in the previous question. However there was little difference between them (‘collaborative culture’ – 30 per cent, ‘good professional relationships’ – 28 per cent, ‘effective clinical leadership’ – 27 per cent). While this confirms that these are the most important enablers from the perspective of the respondents, in contrast to the barriers, there is greater ambiguity between the three as regards which is most important.

**Enablers: do all doctors have the same opinion?**

The top three enablers identified above applied to all the subgroups analysed (primary care doctors, secondary/tertiary care doctors, primary care doctors involved in commissioning and secondary/tertiary care doctors with a management responsibility). Secondary/tertiary care doctors with a management responsibility considered ‘Collaborative culture e.g. ethos of shared values’ more important (41 per cent) than both the cohort of respondents as a whole and the four subgroups.

As was the case with barriers, secondary/tertiary care doctors (23 per cent) were twice as likely to identify ‘Shared information technology systems’ as one of the two most important enablers than primary care doctors (11 per cent).
Doctors’ experience of joined-up care pathways

KEY FINDINGS:

- One in five respondents work as part of a joined-up care pathway in their main clinical practice much or all of the time
- Joined-up care pathways made no better than a moderate benefit to care coordination for patients

We also asked respondents whether their main clinical practice involved working as part of a joined-up care pathway. The results can be found in table 3.

Table 3 – Main clinical practice involves working as part of a joined-up care pathway

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>5%</td>
</tr>
<tr>
<td>Much of the time</td>
<td>21%</td>
</tr>
<tr>
<td>A bit of the time</td>
<td>44%</td>
</tr>
<tr>
<td>None of the time</td>
<td>17%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>12%</td>
</tr>
</tbody>
</table>

*Multiple response

For those respondents who did work as part of a joined-up care pathway, we asked if it had been effective in coordinating care across different provider organisations. The average score was 5.07 showing that in respondents’ experience, the joined-up care pathway had made no better than a moderate benefit to care coordination for patients.

Respondents were then given the opportunity to provide any further comments in relation to joined-up care pathways.

The most frequently cited issue in terms of why pathways were not more effective was poor communication between organisations and professionals within them. Buy-in and engagement were also a problem. For example, some professionals or organisations within the pathways do not follow the guidelines, or managers fail to see the benefit in them. The fact that 12 per cent of respondents said they did not know whether they worked as part of a joined-up care pathway correlates with such comments.

One doctor said ‘Much depends on the individuals involved’ and another ‘I am very concerned that when certain individuals retire the effectiveness of the joined up care pathways will be adversely affected.’ Another respondent commented that pathways had been written by one part of the health service and passed on to another to follow, rather than a more joined-up approach.

Together these contributions suggest, as is consistent with the literature, that pathways alone are not sufficient and that it is the relationships within them that make them work.
Another challenge highlighted was where providers were working to the different requests of multiple commissioners, alluding to the need for a more strategic, region-wide approach. Others cited the additional bureaucracy and time commitment involved to get pathways in place. Finally, there was a comment that while shared pathways across primary and secondary care were operating, there had been no investment in determining whether this was efficacious or cost-effective. Issues around the desired outcomes of integrating care were explored in more detail later on in the survey.

**Mergers of organisations**

**KEY FINDINGS:**
- There was no indication of strong opposition to merging with organisations in different parts of the health and social care sector from any of the groups asked (primary, community, secondary/tertiary and social care).
- For primary care doctors, this finding should be read with some caution as whether or not such mergers would result in loss of GP practices’ independent contractor status was not explicit.
- Those working in secondary/tertiary care were, overall, the most welcoming of the prospect of merging with organisations working in the other sectors.
- The three most important concerns of respondents, were such a merger to take place, were:
  - Whether the merger would achieve objectives 46 per cent
  - Competing priorities between merging organisations 34 per cent
  - The cost of the merger 24 per cent

The shorter survey carried out earlier in the year indicated that doctors did not consider merger of organisations particularly important to the integration of health care. However, if more concerted efforts were made in the NHS to achieve integrated care at scale in the future, this would inevitably involve some organisational mergers. As such, we included a section in the main survey to establish how doctors would feel about organisational mergers specifically in order to be able to deliver more integrated services.

Respondents were asked what their reaction would be if the organisation they work for merged with an organisation working in a different part of the health and social care sector namely:
- primary care;
- secondary/tertiary care;
- social care; and
- community care.

Those working in secondary/tertiary care were, overall, the most welcoming of the prospect of merging with organisations working in the other sectors with six out of 10 respondents (63 per cent) happy to merge with primary care, and around half of respondents happy to merge with social care or community care.
Respondents working in community care were particularly keen to merge with primary care (70 per cent) and around half would be happy to merge with social care, however, this group were more or less indifferent to merging with secondary/tertiary care.

Overall, those working in primary care were neither particularly welcoming nor unwelcoming of the idea of merging with the other sectors, with the exception of a preference of nearly half the respondents (48 per cent) for merger with community care. The results of the primary care group need to be read with some caution as the survey was not explicit about whether or not such mergers would result in loss of GP practices’ independent contractor status. For example, it is worth noting that 90 per cent of respondents to the BMA’s National Survey of GP Opinion 2011 supported maintaining independent contractor status for GPs with relatively modest differences according to status of GP.27

There was no indication of strong opposition of merger between any of the groups.

**Concerns with mergers**

When asked what would be the two most important concerns if this type of merger happened in their organisation, respondents indicated the following:

<table>
<thead>
<tr>
<th>Concerns with mergers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competing priorities between the merging organisations</td>
<td>34%</td>
</tr>
<tr>
<td>Whether the merger would achieve objectives</td>
<td>25%</td>
</tr>
<tr>
<td>The cost of the merger</td>
<td>24%</td>
</tr>
<tr>
<td>Disruption to patient care caused by the merger</td>
<td>20%</td>
</tr>
<tr>
<td>Threat to professional autonomy</td>
<td>18%</td>
</tr>
<tr>
<td>Status of the merged organisation (e.g. whether NHS body or not)</td>
<td>15%</td>
</tr>
<tr>
<td>Changes to pay and terms and conditions</td>
<td>13%</td>
</tr>
<tr>
<td>Whether the merger was necessary</td>
<td>8%</td>
</tr>
<tr>
<td>Reason for the merger is not clear</td>
<td>7%</td>
</tr>
<tr>
<td>Disruption to your way of working</td>
<td>6%</td>
</tr>
</tbody>
</table>

*Multiple response

There was no clear difference of views between the different groups of respondents (e.g. primary and secondary/tertiary care doctors). The majority of respondents (79 per cent) had not been involved in a merger of organisations for the purpose of integrating services.

Further detail about these concerns was given in written responses, which indicated the following main points. Respondents emphasised the important role of clinical leadership in ensuring successful mergers. The need to consult staff, and reflect the clinical perspective in decision making and to improve the ethos for the resulting organisation was highlighted.

27 To see the full survey report visit [http://bma.org.uk/working-for-change/negotiating-for-the-profession/general-practitioners-committee](http://bma.org.uk/working-for-change/negotiating-for-the-profession/general-practitioners-committee)
Many respondents questioned whether there is a genuine need for organisational mergers given that the desired outcome of joined-up care for patients can be achieved without the costly and difficult merger of organisations. Instead, efforts should be focussed on establishing more joined-up ways of working, and promoting a common ethos of shared values to include cooperation and pragmatic problem solving. Concerns were raised by some respondents at the prospect of merger with non-NHS organisations.

The cost of mergers was queried as an unnecessary expense, especially if resulting in additional layers of management structure. A number of respondents cited poor previous experiences of merging organisations, resulting in poorer patient care due to the distraction of efforts and time required by the merger. Detracting time and resources from patient care with potential decline in standards was a commonly cited concern.

However, some respondents felt that if a merger occurred for the right reasons with efficient planning and insight some benefits could ensue. This was particularly noted in light of pooling budgets for health and social care. Furthermore, some respondents reported good experiences of mergers.

**Objectives and criteria for success**

**KEY FINDINGS:**
- Respondents considered the two most important criteria for measuring the success of efforts to integrate services, from both the perspective of the NHS and individual doctors, to be the same. They were:
  1. Improved clinical outcomes
  2. Better patient experience
- Just over one in 10 doctors consider ‘cost savings’ to be important in measuring success from an individual perspective, rising to almost four in 10 from the perspective of the NHS.

As part of the survey, we were keen to find out how doctors view success when thinking about integration from two different perspectives; that of the NHS as a whole and for them as individual doctors. Respondents identified the same two most important criteria for measuring success from both perspectives, as set out in table six.
Table 6 – Three most important criteria for the NHS and individual doctors when measuring the success of efforts to integrate services

<table>
<thead>
<tr>
<th></th>
<th>NHS</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved clinical outcomes</td>
<td>82%</td>
<td>84%</td>
</tr>
<tr>
<td>Better patient experience</td>
<td>64%</td>
<td>66%</td>
</tr>
<tr>
<td>Cost savings</td>
<td>38%</td>
<td>13%</td>
</tr>
<tr>
<td>Quicker services/faster access</td>
<td>38%</td>
<td>37%</td>
</tr>
<tr>
<td>Less duplication</td>
<td>33%</td>
<td>20%</td>
</tr>
<tr>
<td>Working more closely together across professions</td>
<td>22%</td>
<td>32%</td>
</tr>
<tr>
<td>More care delivered closer to home</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Greater professional satisfaction</td>
<td>7%</td>
<td>32%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

It is worth noting that doctors were three times less likely to chose ‘cost savings’ to be one of the three most important criteria from their individual perspective. This suggests one or a combination of things. First, that while making cost savings is not necessarily a key motivation for individual doctors, respondents acknowledge the need for the NHS to work as efficiently and cost-effectively as possible. Second this could reflect doctors’ perception that efforts already underway to integrate services have been motivated by the need to make savings.

Respondents were almost five times as likely to choose ‘greater professional satisfaction’ from their individual perspective (32 per cent) than that of the NHS as a whole (7 per cent).

These results give us an important insight into doctors’ motivations when it comes to the potential integration of services. The evidence on the impact of integrating services on quality and clinical outcomes is weak at present and it has been recommended that more evidence be gathered in this area. For the purposes of engaging doctors in the debate around integration, our findings reinforce this important message.

Impact of policies on integration and competition

Alongside the Government’s growing interest in integration is a continued focus on promoting the use of competition in the health system. We asked respondents which of these two policy approaches they believed would have the greatest impact on the NHS in the coming years: 60 per cent chose competition and 40 per cent integration.

Doctors working in different settings had differing views. For example, primary care doctors were almost evenly split in their view of which policy would have the greater impact whereas secondary/tertiary care doctors felt more strongly that competition would have the greater impact (competition 66 per cent, integration 35 per cent). This could reflect a greater involvement of primary care doctors in existing local integration initiatives which have proved successful, and/or perhaps more experience of competition among secondary/tertiary care doctors through current patient choice policies which focus on elective services.
Among doctors who felt that the reason why competition would have the greatest impact there was the feeling that the Government was more committed to competition than integration, that competition is uppermost in political thinking. There was also a feeling that while integration may be a worthy goal, it would be difficult to achieve, thus having less impact in the long run.