

Implementing health and social care integration in Scotland: Renegotiating new partnerships in changing cultures of care

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Abstract

Health and social care integration has been a long-term goal for successive governments in Scotland, culminating in the implementation of the recent Public Bodies (Joint Working) Scotland Act 2014. This laid down the foundations for the delegation of health and social care functions and resources to newly formed Integrated Joint Boards. It put in place demands for new ways of working and partnership planning. In this article, we explore the early implementation of this Act and how health and social care professionals and the third sector have begun to renegotiate their roles. The paper draws on new empirical data collated through focus groups and interviews with over 70 professionals from across Scotland. The data are explored through the following key themes: changing cultures, structural imbalance, governance and partnership and the role of individuals or “boundary spanners” in implementing change. We also draw on evidence from other international systems of care, which have implemented integration policies, documenting what works and what does not. We argue that under the current framework much of the potential for integration is not being fulfilled and that the evidence suggests that at this early stage of roll-out, the structural and cultural policy changes that are required to enable this policy shift have not yet emerged. Rather, integration has been left to individual innovators or “boundary spanners” and these are acting as key drivers of change. Where change is occurring, this is happening despite the system. As it is currently structured, we argue that too much power is in the hands of health and despite the rhetoric of partnership working, there are real structural imbalances that need to be reconciled.

KEYWORDS

boundary spanner, health and social care, integrated care, partnership working, Scotland

1 | INTRODUCTION

Scotland, like most other countries in the Global North, is struggling to reconfigure its public services as it seeks to meet challenges imposed by the many “wicked problems” it faces (Rittel & Webber, 1973). These include managing demographic change, widespread income, employment, health and learning inequalities, all of which are greater in Scotland than in many other European states (Mair, Zdeb, & Markie, 2011). As a step to meet these challenges the Scottish Government (SG) launched the Christie Commission on Public Service Reform (Scottish Government, 2011). Christie highlighted two key issues which

underpinned the need for public service reform. First, economic and fiscal challenges, with spending not expected to return to 2010 levels until 2026 (Scottish Government, 2011) and second, demographic and social pressures culminating in huge demands for public services.

These have become a central part of the emerging “Scottish approach” to Public Service Reform, Scotland’s legislative move towards its own distinctive approach to policy making (Cairney, Russell, & St Deny, 2016). In this article we explore how the focus on partnership working set out in the Public Bodies (Joint Working) Scotland Act 2014, has impacted on the initial roll-out health and social care

integration (HASCI). We draw on data from interviews and focus groups with practitioners and professionals from health, social care and third-sector organisations carried out during the implementation of integration. Interviewing began in June 2015, with focus groups run early in 2016, during the shadow year when all the new structures and partnerships were in place and prior to the full roll-out of integration in April 2016. This was a major period of transition for health and social care and related sectors and was a timely opportunity to ask those involved in the process to comment on their experiences. It followed a highly critical report by Audit Scotland which had identified “significant risks which needed to be addressed if integration was to ‘change the delivery of health and care services’” (2015, p. 5). The Report centred on evidence suggesting that the structures that had been developed would not be able to make a major impact in 2016/2017. It expressed concerns about the ability of the new system to set out comprehensive strategic plans. Our findings concur with those of Audit Scotland and we argue that while the discourse that surrounds policy development in Scotland articulates a new way of working, in practice we found little evidence for this claim.

The drive to integration in Scotland is in line with global aspirations which suggest that—if achievable—joint approaches between health and social care partners can promote more positive and cost efficient outcomes (Suter, Oelke, Adair, & Armitage, 2009). International research over the past 20 years has consistently shown how economic and demographic pressures have combined to force the need for radical new pathways in service provision (Williams, 2012a). We start with an overview of the policy development around HASCI in Scotland and then examine international evidence as to what works in this policy domain. We then move on to describe the methods we adopted and reflect on the data collection process. This is followed by our analysis in which we identify four key themes: structural and cultural gridlock, barriers to integrated working, governance and finally the role of individuals or “boundary spanners.”

1.1 | Health and social care integration in Scotland: Mapping the policy

The overarching aim of the Act is to bring together the various health-care systems (primary and secondary) with other human service systems provided by both the local authorities and the third sector. This includes long-term care, education, community rehabilitation and vocational services to improve outcomes. While the Act does not draw on any specific definition of integration, it is similar to that provided by Leutz (1999) with emphasis on connecting healthcare systems with other human services. HASCI is a significant departure in service implementation and planning; however, principles of integration and partnership in Scotland have appeared in different guises over recent years. Notably from 2005 to 2015, *Community Health Partnerships* (CHPs) were established as a means to link up primary and secondary healthcare with key local authority services. Implementation of the 2014 Act saw the delegation of health and social care functions and resources to newly formed Integrated Joint Boards (IJBs) under which the roles of the Health Board and local authority controlled

What is known about this topic

- Faced with unprecedented economic and demographic pressures, governments across OECD countries are increasingly developing new policies to integrated health and social care services.
- Most successful examples of health and social care integration are small scale and highly localised.
- Successful integration requires structures that permit shared assessment and joint governance.

What this paper adds

- New evidence from Scotland shows that the structural and cultural policy changes required to enable integration are not currently in place to secure transformative change.
- Health is emerging as the dominant partner in the newly established integrated boards. It is better financed, has a stronger evidence base and has greater political capital.
- Under the current model, the roles of individuals, or “boundary spanners” are central, but on their own they do not have the capacity to facilitate the necessary transformative change.

social care and other related human services were subsumed. As a result, the Act set out two models for Integrated Authorities (IAs). The first—and used by all IAs with one exception—followed an “IJB” model. This created the IJB to plan and commission integrated services. IJBs are not independent of NHS Boards or local councils, do not employ staff and are different from the full structural integrated approach of the second model: the “Lead Agency.” There are 31 IJBs, broadly coterminous with the 32 Scottish local authorities (two authorities have opted to amalgamate). The 31 IJBs work across 14 Health Boards, each of whom partner with a varying number. Greater Glasgow Health Board, for example has six IJBs, while Fife is coterminous with the local authority. Hendry, Taylor, Mercer, and Knight (2016) provided a comprehensive explanation of the system adopted in Scotland.

A key focus of HASCI is to reduce hospital admissions, move towards prevention, promote more personalised health plans and to enable individuals to live more independently. Co-production and partnership working are prominent and HASCI has incorporated a shift from voluntary to mandatory arrangements (Cook, Mulherin, & Seditas, 2015). It is in part driven by economics—the SG aim to make annual savings of £138–157 million (Audit Scotland, 2015).

Having explored the background to the policy in Scotland, we set out how these policy domains have been addressed in other welfare regimes through a review of the literature. In carrying out this review we adopted a “snowball” method, using the term “health and social care integration” in search engines and selected relevant examples. In selecting our literature, we focused mainly on countries where integration has been formalised through legislation. These are described below.

1.2 | What works? International lessons in integrating care

Scotland is attempting full structural integration of health and social care, which is rare (Weatherly, Mason, Goddard, & Wright, 2010). In their review of HASCI, Cameron, Lart, Bostock, and Coomber (2013) reported a general lack of understanding about the aims and objectives of integration and marginalisation of social care interests in favour of acute services. They also maintained that successful integration has tended to be decentralised and small scale and evidence of the effectiveness of joint and integrated working remains limited to evaluations and local initiatives. Much of the previous research on integration has focused on process with little attention paid to outcomes (Dowling, Powell, & Glendinning, 2004). Glasby (2017), in a *British Medical Journal* editorial, highlighted three key lessons from previous attempts at integration. First, he warns against over-reliance on structural “solutions” arguing that partnership working and mergers rarely, if ever produce the predicted savings and outcomes. Second, systems that were not designed to work together pull apart over time and it is difficult to retrofit integration. Finally while integration may not save money, it can improve patient experience, especially for those with most complex needs. There is also evidence to suggest that integration can reduce hospital admission rates and length of stay for some (Damery, Flanagan, & Combes, 2016).

Definitions of integration vary and may be different to that adopted in Scotland; for example some models are limited to the continuing care of chronic medical conditions (e.g. Wagner et al., 2001). With this in mind, in the following sections we set out the main themes identified from international literature on HASCI to assess what works in systems which have sought to legislate for integration. These centre around control, partnership working and challenges to dominant models of care.

New Zealand presents a particularly relevant comparator because of its similarities to Scotland (Ham, Heenan, Longley, & Steel, 2013). Over the past 20 years, New Zealand's health policy has shifted, from one based on markets and competition to a more co-operative approach. Initial attempts at macro-level reforms failed to deliver more integrated care partly due to distrust between the partners (Cumming, 2011). Reforms in Canterbury were, however, more successful. Here emphasis was placed on locality planning and the re-aggregation of the semi-autonomous hospitals to health boards. Control moved from a top-down model to one which placed significant investment to facilitate change at grassroots level. For example, the *Canterbury Clinical Network* was set up to establish collaborative relationships for integration. This included engagement across a number of professions: urban and rural GPs, practice and community nurses, pharmacists and allied health professionals. This enabled better care for patients and reduced demands on hospital services (Timmins & Ham, 2013).

A similar process of decentralisation can also be identified in Sweden. Responsibility of support for older people, disabled people and persons with long-term psychiatric conditions was transferred

from the 21 county councils to the 290 municipalities (Burgess, 2012). The aim of this move was to improve integration between county council health services and local social services to facilitate greater collaboration. Integration has included localised restructuring whereby health services provided by county councils are community oriented and supported by flexible hospital services and pooled budgets (Ahgren & Axelsson, 2011). Rather than establishing a unitary model, Sweden has focused on local needs. Services are highly localised and there is no single approach to integration.

Finland's tradition of municipal autonomy has enabled local areas to determine service provision. Yet, these powers have brought with them ongoing problems as to how best to offer access to HASCI (Kokko, 2009). Experiences of the *Eksote* model in South Karelia demonstrated how separate health and social care services can be successfully integrated. Since 2010, *Eksote* has co-ordinated primary and secondary healthcare with care for users across eight municipalities (Korpella, Elfvengren, Kaarna, Tepponen, & Tuominen, 2012). This has required major reconfiguration, for example prevention has formed the basis of child protection to reduce use of children's homes, and systems have been put in place to reduce hospital stays for older people. In the last 5 years, integration has made some modest savings; care costs for older people are down by €2 million a year and the overall integrated budget in the region has stabilised (Crouch, 2015).

Northern Ireland led the way on full integration in the UK, implementing its own plans in 1973 and with more recent legislation in 2009 stating that all commissioning, delivery and regulatory functions should be integrated, covering all health and social care (Kaehne, Birrell, Miller, & Petch, 2017). The original adoption of plans differs from those described above in that the main impetus was created by local government failure (Heenan & Birrell, 2006). HASCI highlighted the importance of a common patient record system to support integrated community services (Roots, 2016). There remains limited research on the relative success of structural integration in Northern Ireland, but Kaehne et al. (2017) argued that the model used is firmly embedded and has operated well in terms of planning, management and delivery. However, broader questions remain in relation to issues of equity between partners, delayed discharge, expanding community-based services or producing financial savings.

The dominance of health and the medical model across the system in Northern Ireland remains a concern (Ham et al., 2013; Heenan & Birrell, 2009). Even after 40 years of integration the clash of values and culture between health and social care remains a barrier to joint working (Bamford, 2015). Problems remain in understandings of need where the tendency of the medical model to pathologise predominates. Resource allocation is also problematic, particularly post austerity where health budgets have been protected, often at the expense of social care. There is a widely held perception that in order to cut costs, it is easier to reduce community services rather than hospital provision.

Having outlined the policy and reviewed the relevant literature we now move on to set out the methods used in this study as we sought to document how HASCI is being implemented in Scotland.

2 | METHOD

We adopted a qualitative approach to allow us to look in depth at how practitioners and managers were experiencing HASCI in the shadow year.

We used a purposive sampling technique to select individuals and interested parties with specific knowledge and experience of this process (Patton, 2002). Our data are drawn from two main sources. First, a series of semi-structured telephone interviews conducted with personnel involved in planning and frontline delivery of HASCI: health, local authority and third sectors. These were drawn from across Scotland to ensure geographical spread. We asked organisations to identify the lead person in this area and then made direct contact with them. This included 11 staff located in local authorities, 3 in health and 6 in organisations for or of disabled people. IAs used different titles, in some we spoke to the integration manager, in others we spoke to the lead in social care and/or service managers. We developed a topic guide based on key themes drawn from the literature and we piloted this with two interviewees and adjusted it accordingly. The interviews lasted between 20 and 40 min, took place between June and October 2015. All informants completed written consent forms and these were returned by email. Telephone interviews are a cost-effective and user-friendly means for data collection (Ward et al., 2015). These sensitised us to the field and participants were invited to comment on a range of themes, including their involvement in policy roll-out and the impact of implementation. After 20 interviews, we reflected on the key findings and felt that we had reached "thematic data saturation," with no more new patterns or themes emerging (O'Reilly & Parker, 2013).

Second, in February 2016, we ran four focus groups with 65 participants from across Scotland. No participant took part in both interviews and focus groups. This method was chosen because it would allow us to efficiently collect data on a complex and emerging topic about which little is known from a range of different views and to compare and contrast experiences (Krueger, 2014; Powell & Single, 1996). We worked with NHS Education in Scotland (NES) to identify key professionals and managers and they sent out invitations. These were sent to all IJBs and to a range of third-sector organisations. No organisations refused to participate. We ran four focus groups, each of nine senior management staff from health, social care and third-sector organisations. We also ran two focus groups, one of 14 and one of 15, with frontline practitioners. Participants were drawn from community and acute nursing, community and hospital pharmacy, hospital and health board managers, social work, local authority managers and third-sector organisations. In total, 42 participants were from health boards, 11 from local authorities, 4 from the third sector and 8 from other statutory organisations. We worked with NES to ensure that we recruited participants from across Scotland and included as many interested parties as possible. Both models of integration were included. Participants were invited to discuss a series of questions around shared governance, reciprocity, partnership and collaboration. Each focus group lasted 90 min and the topic guide was developed drawing both on the themes that emerged from the interviews and in collaboration with officers from NES.

Prior to the focus groups, all participants were sent an information sheet and on the day of the focus groups were asked to provide written consent. Ethics approval for the study was received from the Authors' institution's ethics committee.

All interviews and focus groups were recorded and transcribed for analysis. We adopted a standard qualitative thematic approach to data analysis (Bryman, 2015). Both authors independently read the transcripts and coded them manually, looking for emerging themes. Together they produced a joint coding framework as a basis for analysis, developing more detailed coding as themes and sub-themes emerged.

We now move on to present the findings. This begins with a discussion on how HASCI has affected structures and cultures and how it has impacted on different working practices across the sectors. We then examine power and how this has affected integration, followed by an exploration of the patterns of governance that have emerged in the shadow year. We finish with an analysis of the role of those who are making integration work and employ the concept of "boundary spanners" to explore how this has happened.

Throughout the interviews and focus groups our participants used generic terms such as "health settings," "local authority services," "charities" or "social care" to describe the range of settings that they worked in. We recognise that there is a great deal of diversity within these terms, however for heuristic reasons we have, where appropriate employed terms such as "health" or "social care" as shorthand.

2.1 | Changing cultures and structural gridlock

Integration was welcomed and supported by almost all. People felt that services needed to work together, not just for efficiencies but also to improve outcomes. Many wanted to work in ways that "stopped the duplication," allowing them to "see what they can do to work together" (both FG: frontline practitioners). At this time, the framing of the policy and its practical application was still in development:

I think everybody's still trying to find out what everybody else is doing. Everybody's still on a journey with that, because there is so much knowledge out there within the kind of different organisations.

(Focus group (FG): senior managers)

There was a great deal of flux within public services in Scotland and implementing change had become normal across both sectors. HASCI was one of a series of recent attempts to introduce "transformative" change. Previous attempts at integration or joint working had left a number of unresolved problems, particularly around differences in organisational cultures, planning, performance and financial management (Audit Scotland, 2011). In some areas, this left a difficult legacy for implementation of integration. Participants talked not just about integration but also Self Directed Support, the implications of the recently enacted Scottish Parliament (2015) and forthcoming changes in care pathways for both children and people with mental health problems. Integration was seen by many as something different and unlike other initiatives, "every part of what we do has to change" (FG: frontline practitioners).

It would appear that there has been little attempt to bring front-line staff on board or involve them in the re-design of services. They have for example not been involved in decisions either about policy implementation or what structures were needed. With “decisions being made at the senior level” (FG: senior managers), the whole process was seen as an inflexible top-down initiative. Across the study, participants told us that they had not been given the time to properly develop the changes needed. There had not been the investment to give people time to carry out work around implementation and this meant that they were “too busy doing the day job” (FG: senior practitioner) to implement change. This is a central theme found across the data and frames much of the analysis and discussion that follows.

In rolling out integration there was little evidence of any work which aimed to create a shared culture across partners or explain how their roles would change. Staff commented on how integration had challenged their understanding of different working cultures and limited effort was made to explore how their practices could be adapted to work with those from other professions. For example, misunderstandings were described in relation to language used around assessment procedures:

In one of the meetings, we had a ... conversation about assessment and we all thought we were talking about the same thing, except assessment in a health setting means something completely different to what assessment means in social services ... It took us 3 quarters of an hour to work out that two sides of the table were actually talking about two very different processes.

(FG: senior managers)

Similar problems were described by frontline practitioners:

We're actually developing a new single shared assessment which is quite interesting, because we've got different areas of the health board and the hospital system and everybody wants to keep their own part in it. So we're now sitting with a 10-page document which is totally ... ludicrous because nobody wants to give up their bit.

(FG: frontline practitioners)

As the partner groups came together to try and negotiate new ways of working, it became apparent that there were structural issues that were undermining successful partnership working; it is to a discussion of these that we now turn.

2.2 | Structural imbalances and barriers to integrated working

Many felt that key structural changes had not been put in place to facilitate integrated practice. Across a range of levels, health was described as being more centralised:

Local government is very decentralised, so we would be going to colleagues in health and they're saying, we want to do x ... and we're going, well, we can't do that because we need to go and consult with the stakeholders and that's going to take time ... we've got to take the employers with us, because we just can't tell them that's how it's going to be.

(FG: senior managers)

Budgets were also identified as a major challenge for joint working:

When you think about the fact that health boards set their budgets in June and local authorities usually set theirs in February or March? ... You've got two parent organisations setting their budgets at entirely different time, which means that risk-wise ... one of them takes on more [risk] than the other.

(FG: senior managers)

The impact of austerity and cuts in public expenditure also added to problems:

...the local authorities have had very significant cuts, probably about 25% over the last few years, so there is a tension between a kind of open ended values driven process and the requirement to deliver the financial savings at the same time to a difficult timetable.

(FG: senior managers)

Differences in workloads, expectations and salaries, with some claiming that there was a £5,000 pa pay differential between senior managers across the sectors for the same posts were highlighted. This, it was argued, could “start to divide the workforce” (FG: senior management).

Participants were frustrated by the absence of integrated IT systems. This had major implications for sharing information and effective joint working. In one IJB, for example, the three local authorities each used separate IT systems, which were also different from the health team. Without this joint infrastructure, as lessons from Northern Ireland demonstrate, effective integration will be hard to achieve.

The development of new structures to enable the incorporation of agencies and sectors other than health and social care was also absent. It is important to remember that legislation is about more than health and social care, but to promote integration across all sectors (Scottish Government, 2011). Our findings indicated that to date, integration has not successfully included the third sector, a key provider of social care. Health in particular was felt to be at an early stage in developing its relationship with the third sector—many thought that it had little understanding of commissioning or how processes worked. This meant that there had been little co-operation between the two agencies with regard to incorporating the views of service users:

I don't think you would find very much of harnessing of joint values around outcomes for service users.

(Interview with organisation of disabled people)

Without better structural integration, it is hard to see how shared governance can emerge. These impediments will not just disappear over time, but need strategic change to prevent them negatively impacting on policy.

2.3 | Equal partners and shared governance?

Northern Ireland's experience has suggested that there is a danger that health can become the dominant partner. In seeking to set out equal relationships and try and prevent this in statute, HASCI legislation created new partnerships—IJBs—with joint and equal responsibility across the partners. The IJBs were established with jointly appointed senior officers reporting to both the NHS and local authority. Some felt that there were sufficient safe guards in these arrangements to ensure that one sector could not dominate another. Others, however, were less sure:

Maybe you need some time for governance arrangement[s] to evolve, because ... another thing that's caused issues in the past on joint projects has been the fact that the two sectors have different approaches to organising.

(FG: senior practitioners)

Health professionals were less centred on the health and social care divide, arguing that the divide between acute and primary care sectors was more real:

Depending on the area you work in, your training's very ... different. You know, a community pharmacist and a hospital pharmacist, very different training backgrounds and very different expertise....

(FG: frontline practitioners)

Social care and third sector participants identified a power imbalance:

My [health] colleagues are very knowledgeable in their own areas and they're very strong in saying this is the right way to do things in their areas ... But ... I'm never asked for my view ... and I'm not sure we've actually got past that bit where everybody's view is equal.

(FG: frontline practitioners)

The sheer size of health boards—both geographically and financially—and lack of coterminous boundaries meant that they had often become the dominant partner. Local authorities do not have the resources to match their analytical power and their evidence base is seen as being stronger. The need to work across several IJBs also affected the relationship:

Greater Glasgow will be covering six different partnerships ... It will be very difficult for them to do that differently in all six ... so to an extent you can understand why perhaps there might be some efficiency in them saying, right, this is how we'll do this part of it across all six.

(FG: senior practitioners)

The variety of different approaches to social care across the local authorities was highlighted as a problem:

We've got 3 Ayrshire's in the one health board ... that must be a nightmare for health, to try and negotiate your way round. And we're all called different names, we all do different jobs.

(FG: senior practitioners)

Issues surrounding the dominance of health were expressed consistently. We were told for example about a case in one Health Board where the local social work department had set up a programme that aimed to provide support to help older people stay in the community, only for this to be taken over by health and become a hospital discharge programme. Some felt that any progress that has been made towards promoting a social model of disability could be undermined by HASCI.

2.4 | What works—The role of the boundary spanner

It would be wrong to say that HASCI is not working at all or that there had not been any positive effects. One interviewee for example told us that as a direct result of integration she is coming “into work every day with a great big smile,” although she was very much in the minority. There were some areas where services have become, or were starting to become, integrated and joint working was emerging. However, one of the key constraints has been the renegotiation of roles and concerns over a power imbalance between health and social care sectors. Where partnership was emerging this is the result of individuals coming together to achieve change, rather than structures creating integration.

As we analysed the data, it became clear that where integration was working it was through individuals and their relationships with others. This led us to draw on the idea of “boundary spanning” developed by Williams (2002, 2012a). Boundary spanning emerges through complex and interdependent problems that link across different types of boundary, some of which are structural and others which are socially constructed through agency. While the role can be formally ascribed in multi-organisational or multi-sectional settings, the boundary spanning activities we identified emerged as part of an organic process. It was in this informal format that, despite structural impediments, some of the most important work in progressing joint working was emerging:

I think we're lucky within our structure ... I think the fact that our senior manager is a social worker ... and she does listen to what health have to say ... I've got a lot of respect for [her].

(FG: frontline practitioners)

Although these roles were largely welcomed in taking HASCI forward, caution was expressed in the focus groups on the reliance this placed on key individuals:

You're relying so heavily on individual members of staff being motivated ... to have the time ... it's just a bit concerning, for members of the public that actually more and more pressures on individual practitioners [are emerging] to do more with less.

(FG: Third sector representative)

3 | DISCUSSION AND CONCLUSIONS

The data we draw on here reflect the early experiences of the implementation of integration in Scotland. The aim of the research was to garner a snapshot of how the roll-out was progressing and we sought to draw on the experiences of a wide and varied constituency. In total we consulted with over 70 HASCI professionals and while in dealing with a problem as vast as this one, it has allowed us to make some early observations on the process of integration in Scotland. It has enabled us to document how the structures and cultures of the partners were changing in the light of the legislation. Our findings have been triangulated by Audit Scotland (2015) and we feel that the data were robust and that we reached data saturation. By adopting such a broad recruitment strategy, we have been able to provide an overview of the experience and what is needed now is a more in-depth and focused approach to the topic, looking at the experience of the various sectors.

Legislation for HASCI in Scotland represents a major challenge and it is of course too early to comment on its impact on user outcomes. Scotland's embrace of partnership in public services over the past decade has provided the framework for this policy change and in this discussion we focus on HASCI's ability to achieve this.

We found neither the flexibility nor structures in place that would enable the emergence of good partnership working (Cook et al., 2015). While there were examples of individual innovation around the policy changes, this was not enough on its own to secure widespread structural change and facilitate integrated practice. This has left areas like assessment, budgets and information sharing subject to ongoing negotiations. Developing new organisational dynamics are further complicated with the absence of shared IT systems.

We also found that not enough effort has been made to bring staff from all sectors on board with change. Framing the 2014 Act around "Public bodies" rather than simply "health" or "social care," acknowledged the ethos of the Christie (2011) Report, including those representing user interests. Yet the policy is neither "co-produced" nor "owned" by those charged with implementing it. The absence of collaboration at all levels to facilitate new working practices has been compounded by poor structures and, in some areas, historical animosity between health and social care sectors. Glasby (2017) has warned against placing too much emphasis on structures; however, if integration and changes in cultures are to be implemented, systems that allow

collaborative working practices have to be in place. Cultural change goes hand in hand with structural change.

This illustrates the need for a more formal role for boundary spanners, so that connections between different interests can be made. Kousgaard, Joensen, and Thorsen (2015) showed how the boundary spanner role has been developed in Denmark through *Municipal Practice Consultants* (MPC). The MPC is a local GP employed part time by the municipality with the task of improving collaboration between general practice and social agencies. The role of an "information gatekeeper" was seen as especially helpful. However even with a high status post, problems remain with defining specific tasks and securing consensus among colleagues. Structural boundaries in place through legislation inevitably make problem-solving between different groups difficult to secure. This meant that an ongoing process of formal and informal negotiations was required to achieve any level of agreement.

The role of HASCI in Scotland in the broader legislative shift from representative to participative working also has its challenges. Cook et al. (2015) argued that partnership cultures inevitably lead to "hierarchical mechanisms" emerging. This results in one partner being privileged over the other. Our study highlighted the emerging dominance of health in the new partnerships, alongside a clear disjuncture between the third sector and statutory bodies over their role. This has important implications for the entire direction of policy, whereby barriers rest on professional boundaries and cultural differences (Erens et al., 2016). Health has significantly greater financial and analytical powers at its disposal. The announcement that £250 million of additional funds for social care funding in the 2016 budget would be allocated through health boards (Scottish Government, 2016), rather than local authorities has helped to reinforce this perception. This has caused great concern particularly for disability organisations (Inclusion Scotland, 2016). The attempt to carve out a new role for third-sector organisations is an innovative feature of the legislation. However, without a clearer focus in the new structures, ensuring that all voices are heard, this may be a lost opportunity.

As it is currently formatted, HASCI in Scotland is leaning towards Northern Ireland's model of health-led integration, albeit without the same level of IT infrastructure in place. At its heart, HASCI is premised on the notion of partnership working, yet there are real structural imbalances that need to be reconciled and until they are, it is hard to see how true partnership can emerge.

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