

Introduction

There remain a number of problems to be faced in pursuing the objective of implementing integration seen both in limited initiatives and projects and in more comprehensive strategies and processes. Their continuing significance is demonstrated in the use of the strong language of barriers and obstacles in discussions of the issue. There is more of a consensus on the nature of the main barriers than on the more diffuse identification of enablers of integration. In some instances it can be noted that the conditions and actions that promote integration are the reverse of factors that are identified as barriers (Wilkes, 2014). In other issues examined, the barrier may be of a more complex nature. Some of the clearer examples of barriers have been integrated partnerships which had to be ended because of a breakdown in delivering the intended objectives. Other barriers have been identified and addressed but with varying degrees of success.

Professional differences

Differences in professional values and attitudes, different priorities and even different languages, supported by different structures, have combined to create a professional barrier, originally seen as so intractable as to be called the 'Berlin Wall'. Baggott (2004, p. 287) argued that it was the cultural barriers between professional groups and organisations that have caused major problems. Different approaches to service eligibility, assessment, delivery, and priorities in respect to community care are emphasised by Cestari et al. (2006). Attention has also been drawn to the lack of empathy, understanding and trust between professions, with health staff unfamiliar with social care perspectives and social care marginalised within a health paradigm (Huxley et al., 2008). Frequent references have been made to the barrier between medical and social models of care. Lack of trust between professional groups would correlate with lack of trust between the organisations involved. Given the limited nature of integrated structures and projects, health and social care professionals have a history of normally operating separately within very different administrative and management systems. Not all innovations have helped remove barriers and some, such as the widespread introduction of direct payments in adult social care, may present another 'difference' challenge. The impact of traditional professional differences

is demonstrated in aspects of integrated practice. The Care Quality Commission (2016, p. 12) reported difficulties in organisations creating a culture to work together and a lack of understanding.

Even when integrated working projects are set up or integrated teams established, professional stereotyping and a rigidity of views may continue. With different views and philosophies and a lack of appreciation of professional contributions even within multi-professional teams (Cameron et al., 2015, p. 13), some groups may see their professional values and integrity as under threat. This also may affect attitudes to information sharing. Attention can be drawn particularly to the perception that social workers' status is under threat in a health dominated environment. Differences in attitudes towards risk management have also been identified as a continuing problem (Cameron et al., 2015, p. 12). Communication across professional boundaries may remain difficult within partnership and team working although there is evidence from Northern Ireland's experience that removing structural barriers can be important (Birrell and Heenan, 2012). The absence of team building and a lack of time to develop relationships can enforce barriers (Lotinga, 2015, p. 176) indicating a need for focused training. The two most common barriers were cited by Glasby and Dickinson (2014) as different language and different models of care. Priest (2012, p. 13) found that staff still considered existing different perceptions that professionals held were a barrier to implementing integration. Cameron (2016) describes different professional ideologies, working practices, definitions of care, and continuing rivalries between medical professionals, social workers, district nurses and home care staff. Staff can become socialised into a profession's way of thinking and values, and develop a loyalty to protect their particular 'turf', skills and values from others (Miller et al., 2016, p. 158). These professional tensions arise over skills and identity; status and power; communication and understanding; and incentives and performance. A consequence of the continuing prevalence of professional differences is a difficulty in accepting change required to promote integration, or resistance to new ways of working. The British Association of Social Workers (2015) emphasised the different value base of social care, covering the empowerment of users, person-centred focus, self-determination, and social justice. Ham (2009, p. 4) suggests that adaptation to new ways of working may be more of an obstacle for managers than for frontline staff. It has also been noted that social care has made greater progress in relation to personalisation, co-production and user voice than is the case with the NHS (County Councils Network, 2016, p. 30). With integrated working, cultural differences can lead to tensions between professional groups working in integrated teams and those who are not working in this manner (Hutchison, 2015, p. 133).

Equity issues

Equity in the balance of power and respect in relationships has been an issue, particularly relating to full integration and equal status between health and social care. The problem or barrier has been the likelihood of the health side and the

health professions dominating, meaning that social workers are a minority voice on partnership boards compared to health professionals. Social care might be in danger of being marginalised (Weekes, 2006, p. 18) or there is a perceived status difference between professions, with a higher status given to health professions. Traditionally, even as professions working separately there was a lack of equity in power relationships (Cameron et al., 2014), mainly driven by the dominant position of the acute sector. The continuing acceleration of the integration of social care with health care has drawn attention to the issue through the introduction of legislation and developments such as the formation of multidisciplinary integrated care teams. Even structural integration may not resolve this problem, as in the integrated structure in Northern Ireland social workers still experienced a vulnerability and a lack of equal partnership (Heenan and Birrell, 2006). The composition of management boards and special bodies related to integrated working may also reflect an inequity in representation between people with backgrounds in health and social care. Other consequences may be: the medical model may dominate operational and service configurations; performance targets and outcomes may have a health bias; and there may be inequalities in allocations of budgets (Cameron et al., 2015, p. 11). The most extreme expression of this barrier is the view that attempts to integrate health and social care under a principle of equity is a mistaken endeavour (Huxley et al., 2008) and social care should adjust to being either a junior partner or one of a multiplicity of professions. The alternative view is of two equally large structures having to come together in a more egalitarian relationship.

Funding difficulties

The funding systems for health and social care have traditionally been separate and different in Great Britain. The funding mechanism for the NHS has been through the government Department out of general taxation but for social care it is through local authorities. The funding relationship with the user has also differed with health services free at the point of delivery and universally available on the basis of need whereas social care services are substantially means tested and this can be seen as an obstacle to integration (National Audit Office, 2014, p. 45) although there are differences in the constituent parts of the UK. The barriers that finance can impose have been expressed thus: 'if adult social care is not put on a sustainable foundation, integration becomes more difficult' (Local Government Association, 2015, p. 6). The main vehicle for funding integration has been through pooled budgets but this process has been subject to difficulties. There has been an underuse of joint budgets. Less than 5 per cent of combined budgets is spent through joint arrangements and pooling budgets has been seen as difficult, complex, and sometimes an impossible task (Priest, 2012, p. 20). Pooled budgets carry with them the potential for disagreement and conflict between those involved over such issues as cost shunting between health and social care contributions. Differences over spending criteria can also contribute to the undermining of the aims of joint working (Cameron et al.,

2015, p. 11). Funding pressures have been increasingly identified as a barrier to integration. This can arise over uncertainties about the financing of joint initiatives, or over a lack of financial investment in integration or insufficient funding on social care. As spending on health and social care has been under pressure and falling as a proportion of GDP, Barker (2014, p. 16) suggests there is a need to move towards a new financial settlement to strengthen integration. Combining health and social care budgets also faces a potential difficulty as social care provision has become increasingly the responsibility of the private and voluntary sectors. External providers may not be incentivised to pursue integration.

It has been argued that the Care Act (2014) created substantial new financial burdens for local authorities which are currently unfunded (Maker and Lucas, 2015, p. 47). Funding for innovations is often pump-priming and aimed at short-term pilot studies (Goodwin et al., 2012, p. 7). Integration developments have financial requirements including: setting up costs; matching spending to contracts; targeting government grants; organising pooled budgets; having to undertake disaggregation for dispersed accounting purposes and limitations on discretion and flexibility (Weatherly et al., 2010, p. 18). An initiative in England has been the introduction of the Better Care Fund, as a form of a single pooled budget for health and social care services, for local areas based on a plan agreed between the local authorities and the NHS. The Better Care Fund (BCF) will bring together existing resources, so is not new money. Thus most CCGs will have to redeploy monies from existing NHS funds which could cause financial pressures and the Better Care Fund may not ameliorate the financial pressures faced by local authorities and CCGs (Bennett and Humphries, 2014). Pioneer pilot projects have found themselves caught up in rows over the BCF pots of money as they put pressure on hospital finances without guaranteeing cost savings. The BCF has been criticised as being too heavily centralised and bureaucratic, as undermining relationships between local authorities and Clinical Commissioner Groups and an actual barrier to promoting locally led integrated care (Maker and Lucas, 2015, p. 39). While there is some pessimism regarding long-term funding for integrated care, the BCF has raised more in budget contributions than anticipated, but has still been criticised as only compensating for reductions in local government expenditure (PAC, 2017). Funding remains a core constraint in realising the full ambitions of integration.

Lack of clarity

A lack of clarity and understanding concerning policies, the roles and responsibilities and procedures has led to concerns, confusion and inappropriate referrals which can affect both managers and frontline staff (Cameron, 2016, p. 10). Frontline staff may not always understand the reasons for the introduction of integration or their roles. It has been suggested that there is a need for a commonly accepted definition of continuity of care, coordination of care, team

working and partnership in response to ambiguity and confusion (El Ansari, 2011). The absence of a shared vision has also been referred to along with a lack of interest in formulating rationales. There is a need for strategic agendas to be turned into operational reality with similar aims and objectives. The need for clarity can also apply to integration supplying a much simpler pathway through the maze of health and social care delivery systems (Barker, 2014, p. 6). There continue to be issues concerning the major direction of integration, for example, the sustainability of adult social care initiatives and the implications of integration reducing the need for acute care. In a study by the County Councils Network (2016, p. 32) 85 per cent of respondents identified conflicting targets and incentives as the number one barrier to health and social care integration. If professionals can be confused over the aims of integrated processes then users and the general public are more likely to have a limited understanding of the meaning of integrated care.

Problems with information sharing

This can be presented as one of the main barriers to successful integration where there remain major difficulties in the sharing of data between different organisations. This results in incompatible IT systems, resulting in a lack of access to data. Glasby et al. (2012, p. 14) refer to IT systems as the most common barrier and one study found IT systems were most cited as a hindrance (ADASS/NHS Conference, 2013). Oldham (2014, p. 46) argues that organisations could do more to examine how information systems can be linked, while it has also been suggested that some bodies are 25 years behind in making use of modern technology, and creaky infrastructure and lack of IT investment remain clear barriers (County Councils Network, 2016). There are also some difficulties related to legal constraints on the release of an individual's information. Goodwin et al. (2012) state that the absence of a robust shared electronic patient record is a major drawback to supporting integrated responses. Beech et al. (2013) found communication between professionals, particularly across organisational boundaries, remained problematic and noted the absence of vertical integration in governance. The National Audit Office (2014, p. 45) has commented on the lack of investment in IT to improve data sharing and end separate information systems. The absence of common access to electronic care records stands as a key factor making integration more difficult. The evaluation of the North West London Integrated Programme revealed how the lack of information sharing was a barrier to progress (Wistow et al., 2015). The report on Pioneer pilots found in most cases IT has proved a barrier to progress (Erens et al., 2015). The Care Quality Commission (2016, p. 13) found it striking that health and social care professionals reported that information from assessments was not routinely shared. In general a lack of effective communication between staff in different organisations and unawareness, or lack of use, of data sharing tools create barriers. It does not appear that information governance now precludes the transfer of information for direct care but data from different systems needs to be compatible (Oldham, 2014, p. 48).

Structural divisions and complexity

The NHS and social care have continued in Great Britain to be administered by different structures with different models of governance and accountability, distinct legal frameworks and accountability systems. This underlying structural divide has continued even within operating partnership arrangements. It has been suggested that in many ways the biggest barrier to local integration is the massive disparity between a highly centralised NHS and a localised social care model (County Councils Network, 2016, p. 52) with different approaches to national and local control. In England different central government bodies have responsibility for policy and funding, the Department of Health, the Department for Communities and Local Government and NHS England. Conflicting organisational priorities can be regarded as one of the biggest barriers to achieving more integrated care in that each of the two sectors has its own internal processes and different ways of working (Priest, 2012, p. 4). Coordination becomes more difficult between multiple organisational structures which may have different geographical boundaries, while fragmentation within bodies may lead to even bigger problems (Oldham, 2014, p. 22). Integrated practice has often been promoted by ad hoc arrangements which may only add to the complex mosaic of arrangements. A significant number of respondents in surveys and research have highlighted organisational complexity as a key barrier (Glasby and Dickinson, 2014). Work remains to be done on reducing the importance of the traditional structural barrier in Great Britain between the NHS and local government. A series of contemporary reforms in structures across the whole area of health and social care for adults and children carries the risk of adding to the complexity in organising integrated services.

Adaptation to change may present barriers for those involved. This may arise in the context of developing integrated initiatives or pilot studies, where tensions may arise with boundary disputes, unrealistic expectations, reactions to the blurring of roles and orchestrating the implementation of change (Fillingham and Weir, 2014, p. 32). A different form of barrier has also arisen because of major changes in the overall structure of health service delivery and planning. The NHS in England, in particular, has undergone major changes including the abolition of Primary Care Trusts and the introduction of Clinical Commissioning Groups. Priest (2012, p. 12) described the constant changes in health structures as preventing stability and a barrier to integrated structures. Glasby and Dickinson also argue that system stability is essential to enable integration to become established. Continual reform of the NHS structures in England can cause confusion and complexity in governance and accountability and may create barriers to effective integration. Some case studies have demonstrated that any changes in governance should be driven by the functional requirements of the care delivery model (Local Government Association, 2016e, p. 48). Robust and clear governance arrangements are cited in these case study sites as an essential enabler. The increasing role of the private and voluntary sectors in social care provision can also bring challenges for determining integrated governance arrangements across health and social care.

Staffing differences and problems

Differences between professionals can still constitute barriers to the development of integration. Medical staff and social care staff can still be identified as having differences in mindsets, values and worldviews (Brand, 2012). The health workforce is highly professionalised whereas the social care workforce is only partly professionalised, and is largely low paid, has low status and has a rapid turnover of staff. The relationship between GPs and social workers has been seen as a major barrier to integration or fundamental to the success of integration. A study by Mangan et al. (2014) highlighted the poor quality of the relationship and GPs' poor knowledge of social care services but also found that GPs wanted better relationships. A further study of focus groups (Mangan et al., 2015) showed that the negative aspects of GP–social worker working outweighed the positive, based on different values, lack of knowledge of each other's roles, poor communication and a hierarchy with GPs at the top. GPs' reluctance to take on the role of care coordinator, which can be seen as necessary to promote whole person care, is a further difficulty (Hudson, 2015). Structural changes have, at least in part, been intended to increase GP engagement. The introduction of CCGs with a major role for local GPs has provided opportunities to improve collaboration with local authority social workers. The continuing limited development of senior managers and practitioners in the social care workforce produces obstacles for a balanced professional relationship. Also identified as a barrier has been rigidity in traditional roles and skills or what has been called the 'not invented here' syndrome (SCIE, 2015). An example is skilling-up staff to take on roles that community nurses would traditionally have done.

Lack of training

A lack of inter-professional training on integration remains a barrier to developing integrated approaches and practice. Undergraduate and initial training for the main groups in medical training, professions allied to medicine, sub-specialisms and social work are largely uni-disciplinary and separate with little teaching or study in common and on integrated themes. Post-qualifying training is little different but may introduce some more integrated material. Social work training also does not escape criticism in terms of excluding material relevant to integration, such as housing (Oldham, 2014, p. 26). The fault rests mainly with the various professional bodies in protecting professional status and with higher education institutions in following traditional academic boundaries which are no longer aligned with the pace and complexity of change in policies on integrated practice (Preston-Shoot, 2010, p. 32). The development of training tends to come late and is directed at those staff working directly in integrated teams but resources for continuous professional development may be stretched. For integration to work, an integrated workforce can be seen as necessary, and integrated professional training seen as necessary to remove silos.

Poor communication between health and social care agencies in general has also received much attention and criticism, and was particularly highlighted in

the case of Baby P. The inquiry into the death of Baby P identified inadequacies in communication and sharing of information across agencies and poor planning and frontline practice (McKimm and Phillips, 2010, p. 143). There was a clear need to reduce the barriers inherent in university structures and use appropriate placements for inter-professional and integrated learning. An associated dimension is the large growth in size of the social care workforce and the need for appropriate levels of training related to delivering quality care. An independent inquiry argued that care was the key to the new spectrum of integrated health and care and significant improvements were needed to increase the capacity of the social care workforce across a continuum of pay, training and conditions, to tackle poor standards (Kingsmills, 2013). A government review proposed new common training standards across health and social care and noted the growing issue around the blurring of roles, not just between health and social care but between registered and non-registered staff. The Cavendish Review (2013) suggested that the support workforce in both sectors is increasingly going to need to draw on similar core knowledge and approaches and to be flexible across health and social care.

Other barriers

A series of other barriers have been suggested which are essentially the opposite side of an argument or factor identified as contributing to the promotion of integration. These have also attracted less attention than the barriers discussed above and a brief summary of the nature of these barriers is presented below.

Lack of evidence – Limited research and evidence on successful ways to bring about integration has been seen as a major barrier (National Audit Office, 2014, p. 9). There are particular gaps in data across adult care provision and in people moving between health and social care. Cameron (2016) sees the variety of different approaches making conclusive evaluations difficult. The lack of hard evidence has prevented the emergence of guidance for use. More research is needed to provide empirical evidence of processes which integrated teams use. Writing in 2015, Glasby and Miller (2015) still described the limited nature of the evidence base and the need for new research to shape policy and practice. Although much evidence is now emerging from Pioneer and Vanguard projects and case studies in England it has been argued previously that integrated care takes five years or more to deliver its objectives (Bevan Commission, 2013, p. 4). One research study has highlighted a lesson that caution must be exercised in focusing solely on the evidence of specific outcomes as this may miss the value of how professionals work together to deliver care (Institute of Public Care, 2017).

Leadership – The complexity of leadership and management within multi-agency teams has been thought to impede integrated working. Leadership in these teams is seen as challenging, with a tendency to rely on senior managers and neglect more middle management. It has been suggested that there has been a lack of insight into the dimensions needed to approach integration (Hafford-Letchfield, 2009).

Specialist models of leadership and management tools have been slow to emerge for complex structures. Much of integrated practice has been project based and these have often one or several key individuals who become central to running the initiative and consequently the loss of leadership may be crucial and produce difficulties (Miller et al., 2016, p. 200). Lessons from the North-West London project highlighted management issues in implementation and balancing tensions between collective leadership and local autonomy (Wistow et al., 2015, p. 16).

Fragmented commissioning – The lack of integrated commissioning presents a barrier to integrated services. Even with joint budgets there can be difficulties in the nature of integrated commissioning. Hospital based provision is based largely on episodic treatments (Oldham, 2014, p. 22) while social care extends from short periods of care to lengthy periods. Generally health and social care are still commissioned separately (Barker, 2014, p. 3), including key services of reablement and intermediate care. Some aspects of primary care are not commissioned at a locality level while short-term commissioning makes expenditure on prevention difficult (Ernst and Young, 2015, p. 19).

Views of service users – It has been suggested that there is still a lack of knowledge of the aims and value of integrated care (Cameron et al., 2015). There has not been a strong focus on explaining the benefits of integrated structures, practice and programmes. This has contributed a knowledge barrier to user and public support for integration and the lack of demand for the more extensive development of integrated provision.

Lack of vision – The absence of a strong vision at political, central, local government and professional levels has the potential to present a barrier to integration. There have been improvements in policy narratives, including elements of a vision, but it has been suggested that turning strategic agendas into operational reality is a problem (Cameron, 2016, p. 10). Spreading a shared vision concerning aims and objectives among frontline staff could help make practice less difficult. While producing compelling vision statements on integration is relatively straightforward, obtaining wholesale buy-in has proved much more challenging.

Legal constraints – A number of legal obligations can impose constraints on the establishment of integrated services, for example, on the nature and terms of integrated partnerships and the legal basis for sharing social care data.

Central government role – Too much central government control over the development of integration has been put forward as another possible barrier. The argument is that too much central guidance, too many rules, monitoring mechanisms, centrally imposed pilot studies have prevented more rapid progress and been a barrier to locally appropriate solutions. On the other hand it has been argued that central government's governance and oversight across new integration initiatives has been poor and uncoordinated (National Audit Office, 2017, p. 9), with the departments not systematically addressing the barriers to integration they had identified.

Limitations of Health and Wellbeing Boards – While HWBs are a new framework to promote integration, an opposing view regards the initiative as likely to prove ineffective as the boards do not hold budgets, have no delegated powers and do not commission services.

Barriers in different services – There is a view that some areas of integrated provision experience more barriers than others. Monitor (2012, p. 36) noted difficulties within mental health, children’s services and chronic conditions arising from sharing information between organisations, unclear accountability, financial problems, cultural differences, and relationships with voluntary bodies. Areas with the involvement of a large number of agencies, whether within health and social care or including other services, are more prone to encounter barriers.

Conclusions

Wilkes (2014, p. 18), in a research study, found barriers in England related to five principal areas: cultural differences, financial structures, fear of loss of autonomy, insufficient upfront investigation, and lack of trust. Another study implied four main barriers to joint working as culture, underfunding, fragmented commissioning, and national regulations (Ernst and Young, 2015). The National Audit Office (2017, p. 10) identified the three main barriers as misaligned financial incentives, workforce challenges, and reticence over information sharing. Four major barriers identified by Maker and Lucas (2015, p. 31) are conflicting target incentives, short-term financing, cultural differences, and problems with data sharing.

The factors presenting barriers to the development of integration which have been identified can perhaps best be classified into three groupings: factors which can be regarded as primary and core and often complex; second-level factors, which can be identified as enabling or advancing integration but which amount to barriers when they are missing in some circumstances; and thirdly, specific barriers that in practice are not so important. The primary barriers identified were:

Box 9.1	Primary Barriers
– professional and cultural differences between staff and a lack of knowledge or understanding of what different professional roles bring – insufficient financial resources and lack of investment, funding difficulties with pooled budgets and cuts, and underfunding of adult social care – loss of equal status and autonomy between health and social care sectors – confusing and complex organisation, structures and accountability mechanisms – problems with information, data sharing and integrated record systems.	

The second level of barriers are those enabler factors which may be lacking or poorly developed:

Box
9.2

Second-level Barriers to Integration

- a lack of leadership and senior leaders failing to recognise problems and difficulties and agree priorities
- limited research and evaluation and limited dissemination of good practice
- continuing issues of trust between health and social care professionals
- limited general training and staff development in multidisciplinary working, shared roles and improving staff capacities
- fragmented commissioning and underdeveloped joint commissioning
- a lack of user, carer and public support
- difficulties in moving from design to delivery
- reliance on evidence from small local projects which may not be effective.

The third category of barriers identified includes less significant but specialist factors:

Box
9.3

Third-level Barriers to Integration

- local barriers that exist for political reasons, or staff differences arising in different service areas
- local constraints within community organisations and the operation of partnerships
- the role of central government, whether in Whitehall or the devolved administrations, which may be too restrictive or may lack clear direction
- major structural reorganisations in health and local government, which may impact on integration.

The second category of barriers does have the implication that action can be taken and lessons adopted to remove the barriers and replace them with more enabling and promotional structures and processes, thus turning things around. The third category requires locally based solutions and again potentially the barriers can be removed. The first category may present more severe obstacles and in particular the active participation and help of staff, leaders and decision-makers may need to be sought to reduce the significance of the barriers.

While listing these remaining barriers and evaluating the differences in their significance it may be argued that more action has been taken to reduce barriers to health and social care integration, compared to other public services. Generally, in England there is successful reporting of removing at least some of the barriers that existed.