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The general practice perspective on barriers to integration between primary and social care: a London, United Kingdom-based qualitative interview study

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ABSTRACT

Objective There is an ongoing challenge of effective integration between primary and social care in the United Kingdom; current systems have led to fragmentation of services preventing holistic patient-centred care for vulnerable populations. To improve clinical outcomes and achieve financial efficiencies, the barriers to integration need to be identified and addressed. This study aims to explore the unique perspectives of frontline staff (general practitioners and practice managers) towards these barriers to integration.

Design Qualitative study using semistructured interviews and thematic analysis to obtain results.

Setting General practices within London.

Participants 18 general practitioners (GPs) and 7 practice managers (PMs) based in London with experience of working with social care.

Results The study identified three overarching themes where frontline staff believed problems exist: accessing social services, interprofessional relationships and infrastructure. Issues with contacting staff from other sectors creates delays in referrals for patient care and perpetuates existing logistical challenges. Likewise, professionals noted a hostile working culture between sectors that has resulted in silo working mentalities. In addition to staff being overworked as well as often inefficient multidisciplinary team meetings, poor relationships across sectors cause a diffusion of responsibility, impacting the speed with which patient requests are responded to. Furthermore, participants identified that a lack of interoperability between information systems, lack of pooled budgets and misaligned incentives between managerial staff compound the infrastructural divide between both sectors.

Conclusion In this study, primary care staff identify intangible barriers to integration such as poor interprofessional relationships, in addition to more well-described structural issues such as insufficient funding and difficulty accessing social care. Participants believe that educating the next generation of medical professionals may lead to the development of collaborative, instead of siloed, working cultures and that change is needed at both an interpersonal and institutional level to successfully integrate care.

Strengths and limitations of this study

- This study reports the experiences of frontline primary care professionals with adult social care within the city of London.
- The study consisted of general practitioners and practice managers to obtain a clinical viewpoint on the relations between primary and social care.
- Qualitative opinions were ascertained to provide scope for expansion in the answers of the interview participants.
- This study was not designed to display the thoughts of all stakeholders involved in primary and social care.

INTRODUCTION

Primary healthcare in the UK is 'the first point of contact in the healthcare system within the community, acting as the 'front door' of the NHS' provided by primary care teams centred in general practices.[1] Adult social care refers to 'the care and support provided by local social service authorities pursuant to their responsibilities towards adults who need extra support'.[2] It is carried out by social carers and organised by social workers. While local governmental authorities most often provide social care, charities, voluntary and private institutions also provide this care, and are combined to form the social sector in the UK. While the social sector provides support for children, adolescents and those with mental illnesses as well as adults, this study focuses mainly on adult social care for physical needs.

Integrated care has many different definitions but can be understood broadly as 'an organising principle for care delivery that aims to improve patient care and experience through improved coordination'.[3 4] Integration between the primary and social sector in

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particular has the potential to reduce fragmentation of care for many in the elderly population suffering from multiple chronic conditions.[5] When successful, integrated care models lead to improved patient outcomes, preventative care and reduced emergency admissions resulting in significant cost savings.[6–9] Despite this being a long-standing aim for the National Health Service (NHS), recent efforts into nationwide integration such as the Better Care Fund have been unsuccessful, and the two sectors remain 'split' with separate funding, management and workforces, so much so that the demarcation has been referred to as the 'Berlin Wall'.[10–12]

One of the reasons stated in the literature for this is that current initiatives towards integration have focused solely on top-down approaches to integrate organisations, without engaging frontline staff to understand their views, leaving barriers directly faced by these professionals unresolved.[13] General practitioners (GPs) are the first and most frequent point of contact with the NHS for those living in the UK and act as the central coordinators of care, making them ideally placed to shift the balance of care from acute to community settings.[14] However, traditionally GP views have been neglected when developing new policy initiatives.[15]

This study aims to address this issue by establishing the key barriers to integrating services from the perspective of primary care staff, enabling further research and policy to take a bottom-up approach to integrated care. Designed as a cross-sectional phenomenological study, the research team sought to investigate perspectives of primary care staff on the barriers they face when working with social care, assessing whether these issues differ from those described in recent literature. Despite the potential challenges of collecting reliable and transferrable data through phenomenological research, this approach allows rich, contextual data to be collected aiding deeper understanding of complex phenomena, and therefore was chosen to add to the current literature which mainly comprises of narrative and case study approaches.[9 10]

METHODOLOGY

Sample and design

A constructivist paradigm (research which attempts to understand complex phenomena from the point of view of those who experience it) was adopted to generate theories and patterns in meaning, with an interpretive approach using semistructured interviews to collect data.[16] As the key focus of the study was establishing the views of primary care staff, primary healthcare professionals were sampled for interviews, including GPs and practice managers (PMs). These professionals were chosen as their views are currently not extensively documented, despite their unique insight into the operations of integration approaches, with a clear mandate and sense of what can be improved.

Ethical approval for this qualitative study was received. Following this, purposive sampling was employed to identify relevant professionals willing to participate. London-based GP surgeries were approached by phone and invited to participate, with interested teams being emailed the participant information sheet. For ease of data collection, GPs affiliated with Imperial College London either through research or teaching were contacted and included a range of practice sizes in multiple London boroughs. In total, 29 professionals were approached and invited to interview, out of which 25 accepted to participate (18 GPs and 7 PMs). Four professionals refused to take part in the study due to time constraints. There were no dropouts postinterview. See table 1 for participant characteristics.

Table 1 Participant characteristics

	GP (n=18)	PM (n=7)
Men (n)	8	2
Women (n)	10	5
Level of experience working in current role (n)		
>5 years	15	4
<5 years	3	2
London Borough (n)		
Hammersmith & Fulham	4	2
Hackney	3	1
Wandsworth	1	1
Ealing	2	–
Croydon	4	1
Haringey	2	1
Lewisham	2	1
Location of interview (n)		
GP surgery	10	3
Telephone	8	4
Interview length (mins)	26–52	31–45

GP, general practitioner; PM, practice manager.

Interviews lasted between 26 and 52 min and were conducted either face-to-face or on the phone, based on the participant's preference. Face-to-face interviews took place at the participants' GP Surgery in a quiet room to ensure minimal disruption and without any other staff present. Inclusion criteria of English-speaking and working within London were set with anyone under the age of 18 years and those with less than 1 year of experience in UK primary care being excluded. All participants were provided with an information sheet prior to interview (to remind them of study details after initial contact through email), and written consent was obtained for interview, recording and transcription. It was reiterated to all participants that they may withdraw from the study at any point, and that they would be updated on findings of the study should this be of interest to them.

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Box 1 Sample interview schedule with major questions and follow-up questions

1. What is your role in supporting patients in primary care?
   - What is the extent of your interaction with social care?
2. From your perspective, are primary care and social services integrated for patients?
   - What is the extent of integration? Do you feel the aims of integrated care are currently being achieved? Does this differ between patient demographics?
3. Can you describe your experiences of any approaches to integrate services in your borough?
   - Have these been successful? If not, why not?
4. What current barriers to integration have you noticed in your role?
   - How do they affect you/the patients? Have they always been present? Is anything being done to counteract these barriers?
5. Can you suggest methods to improve service coordination?

Patient and public involvement

Patients or the public were not involved in this research study.

Data collection

Questions in the interview schedule aimed to establish the interviewee's perspective on current primary and social care integration and what, if anything, can be improved. Open questions were used to elicit participant experiences of current approaches to integrated care and what barriers they had witnessed when using services. The interview schedule was tested with two pilot interview participants prior to the sample population to ensure fluidity of conversation and clear understanding of questions. The same questions were asked from all participants. Follow-up questions were used as prompts in order to stimulate discussion and facilitate dialogue, as shown in box 1.

DN and AM conducted all of the interviews with DN asking questions and AM taking field notes (online supplementary appendix 1). All interviews were audio-recorded using a voice recorder application and anonymised to maintain confidentiality and ensure unbiased discussion. Audio recordings were transcribed ad verbatim by the research team and then deleted, with transcripts being labelled with role and serial number to aid analysis (eg, GP1, GP2, PM1, etc). Anonymised data were stored on password protected computer systems and deleted after analysis in line with the data management policies. Data saturation was reported by the interviewers after 16 interviews with GPs and 6 interviews with PMs, and further participant recruitment was concluded with only previously booked interviews being carried out beyond this.

Analysis

Clarke and Braun's six-stage framework for analysis of qualitative interviews was used to thematically analyse transcripts.[17] Independent handwritten methods were used to generate initial codes for each line of transcription by ATah, ATar and MA. Following development of the initial codes, related codes were grouped together into subthemes and higher themes through an inductive process. FN and SV reassessed these themes to ensure internal homogeneity and external heterogeneity. Overarching findings were discussed with the whole research team to determine any further changes required, leading to an overall agreement of results. Findings were checked with participants through a presentation of the analysed results by the research team (attended by 12 of the participants), allowing opportunity to provide feedback; this aimed to improve validity, accuracy and credibility of the research study. The SRQR checklist for qualitative research was used to report study findings (online supplementary appendix 2).

RESULTS

Thematic analysis revealed three themes as barriers to integration, each with subthemes, as shown in table 2.

Accessing social services

Lack of awareness of roles and services

Many GPs and PMs mentioned that one of the biggest barriers to service integration is the uncertainty about which roles are carried out by which social service provider and how best to contact these individuals. Often numbers in practice diaries and on websites are out of date, so staff have to ask the patient directly what social care they receive and how to contact relevant departments, slowing down both communication and any attempts at collaborative working.

> CCGs [Clinical Commissioning Groups] have a website of contacts but they are often out of date, you don't know people's names, you don't know who to contact, you don't know how to get hold of them (GP3)

Many doctors admitted they were not aware of the roles carried out by each individual member within the social sector, as well as what local services are available and how long each service takes to arrange, which further added to delays in referrals.

> Sometimes what we find is that there's this amazing service and we knew nothing about it (GP1)

Overworked staff

When asked what prevents them from making greater efforts to collaborate with social care, participants described how local pressures have led to an increase in their workload and time constraints reduce the motivation to collaborate with other sectors to develop new methods of service provision.

> You just don't have the time to sit down and have these meetings (GP4)

Participants also emphasised staff working high workloads are unlikely to accept new responsibilities (such as

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Table 2 Thematic analysis of interviews showing emerging higher themes and subthemes

Accessing social services	Interprofessional relationships	Infrastructure
Lack of awareness of roles and services	Poor interprofessional culture	Fewer human resources
Overworked staff	Lack of regular contact	Insufficient funding
Logistical issues	Inefficient multidisciplinary team meetings	Minimal interoperability

those working for integration of care) when there is no immediate anticipated reward in return for their work.

> Everybody is already doing way more work than they can cope with so when there's no remuneration for it, nobody wants to do extra work (PM1)

Logistical issues

Communication between primary care and social care is logistically challenging, as doctors are busy with patients during the day and social care staff are working in the community, making joint conversations about patients nearly impossible. Participants explained how inefficiency with communication delays care interventions; there is often no standardised method for contacting the other sector and staff may wait weeks for replies to requests.

> If you want to speak to social workers urgently, there are barriers because you don't necessarily have a telephone contact or a hotline or an email address to contact someone from social care (GP10)

> Sometimes you fax over important things, but you have to wait weeks for a reply (PM4)

> It would be much more efficient if an allocated social worker comes along. It cuts out all the referrals and things like that. It saves time (GP8)

Interprofessional relationships

Poor interprofessional culture

All participants perceived the current interprofessional culture as a barrier to service integration, since many sensed a lack of mutual respect between social and primary care staff. There is often a siloed working mentality with different teams having different agendas for the patient and a lack of motivation for collaborative decision-making. This culture can lead to a diffusion of responsibility and a lack of clarity on who is performing which service for the patient, further delaying quality care provision.

> Sometimes medical people can be quite dismissive of social people, and I think social people can be quite hostile to medical people (GP3)

> The approach is 'this is a social problem and so that's for the social team' and 'we're the medical team so we deal with medical problems'. So there doesn't seem to be any integration in that way (GP6)

Lack of regular contact

Most GPs and PMs explained regular contact with social care teams is necessary for effective information transfer and a multidisciplinary approach to patient care. However, currently, contact is through forms and emails with minimal face-to-face contact, which professionals find inefficient and a barrier to continuity of care. Participants explained the need for a proactive approach to communication (especially for safeguarding issues), rather than the current crisis-led approach, with staff being overwhelmed with unnecessary paperwork. Some participants explained their boroughs had developed better systems for contact; however, the majority still described inefficient systems.

> Communication is often sporadic via email, emergency phone calls or when families raise concerns. There is not really a free-flowing system (PM4)

> In one borough we have really good referral pathways and really good contact with our social workers, in the other one I work in I often have to send generic emails or call the council to get in touch with social services, but you don't have that direct contact, so it is not as cohesive (GP6)

Inefficient multidisciplinary team meetings

Some practices have face-to-face meetings with social care teams, however participants described these as inefficient. PMs were concerned that social care staff attending these meetings had not looked up patients to be discussed beforehand, or that the relevant team member did not attend and so conversations regarding care were not informative and often did not conclude in action points. The main complaint from GPs was that there is often no protected time for these meetings, which often clash with patient clinics, so often the GPs cannot attend themselves. They also acknowledged geographical barriers; since these meetings are held in GP practices often community teams are unable to attend them between home visits.

> There is no blocked off time… they have these meetings in the middle of surgeries, 10 o'clock in the morning, I can't just leave the patients for one and a half hours and go somewhere (GP8)

Interestingly, participants who worked in more than one GP practice noted variation between boroughs and GP practices, with some having regular collaborative meetings, while others did not.

> In one practice I find it very integrated, there is a regular meeting once a month where the social workers, myself, palliative care and anyone else relevant all meets to discuss any relevant patient, any concern with social services and then we follow them up…

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the other practice which is in a different borough, you never know if the social worker will turn up and if they don't you have to wait a good few months to discuss a patient, so I end up calling but that doesn't work well either (GP17)

Infrastructure

Fewer human resources

Low staffing levels and inadequate training of staff were highlighted as barriers to service integration. Participants explained how collaborative working practices required staff time and resources; however, in both primary and social care, staff are barely able to keep up with their current workload due to short-staffing and post vacancies.

Human resources on both sides are an issue. Social workers are just under so much pressure: they have no resources, no time, they're looking after loads of vulnerable people. Same with us, we don't have enough resources to be able to do more other than run the clinics in the practice (GP18)

Doctors mentioned the social sector was not something they had enough exposure to or understanding of during medical school, so working with them became a novel task once they became GPs. Many suggested that earlier exposure to social teams would enable students to appreciate their roles in practice.

I know in hospitals, as a medical student, to be honest with you, I don't actually remember talking to a social worker at all (GP9)

The students I have taught recently have never even seen a social worker or carer, let alone spoken to one. And they have no idea what the social worker does. It is only when the come out into the community, which should happen much earlier…Obviously a lecture on social care would be really boring so being able to see them in their role may help, maybe like shadowing (GP5)

There isn't any structured teaching on social care in the GP training programme either, we definitely need something there to teach future GPs the intricacies of working with other teams (GP15)

Insufficient funding

A lack of funding underpins many of the other barriers mentioned, such as human resources and poor interprofessional culture, as described by some participants. Since staff are not remunerated for extra work, often, collaboration between sectors is not prioritised. Different funding bodies also reduce the incentive for collaboration, as they create a culture of competing interests between sectors.

Funding: that is probably what everything will be classed under… and requirements of social staff to meet general practice, which they don't have as a contractual requirement in most external services (PM3)

Interoperability between information systems

A major barrier preventing social care and primary care from integrating their services effectively is the lack of shared information systems. GP practices and social care teams use different software and there are no direct and user-friendly methods of transferring patient information. This lack of interoperability between systems means communication is limited to emails and phone calls, which often leads to patient confidentiality issues and delays in note sharing. GPs and PMs perceive information transfer between primary and social care as essential for preventative measures to reduce acute admissions and believe that the current obsolete information technology systems act as a barrier to this. In order to practise preventative medicine, integration of information systems is therefore critical.

We don't share the same computer systems. So social care would have their own system that we don't have access to and they don't have access to our clinical system… Social care needs to be integrated into the medical care more electronically, for them to be here within GP surgeries so they aren't picking up patients as an emergency - so they are ahead of the game so to speak (PM7)

DISCUSSION

Statement of the principal findings

Thematic analysis of participant interviews revealed the major barriers to primary care and social care integration as difficulties in accessing social services, poor interprofessional relationships and infrastructural issues. Interviewees emphasised that through improvements in these domains, there will be a greater movement towards preventative medicine and away from the current crisis-led approach, by improving the efficiency of service delivery and hence improving clinical outcomes.

Strengths and weaknesses in relation to other studies and important differences in results

Concurrent with recent literature, this study suggests changes are needed in the way NHS and local authority services are funded.[18–22] Currently, budgets for primary care and social care are separate, which not only perpetuates siloed working mentalities between sectors, but also results in misaligned incentives when allocating spending and resources.[23] While previous studies use literature review methods to analyse this issue, this study provides unique insight into the impact of separate budgets to routine patient care through staff interviews, a particular strength as it enables deeper contextual understanding of the consequences of poor integration.[24 25] Similarly, difficulty in accessing services and poor technological interoperability has been reported by other studies; however, this study adds knowledge about specific challenges faced by staff such as not having relevant phone numbers to contact social workers and lack of responses to referrals

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from social care teams.[26–29] Additionally, this study reveals variation in the extent to which these barriers exist, with certain boroughs and GP practices within London having fewer access issues than others. It is therefore suggested that clinical commissioning groups and local councils commissioning social care should audit service provision in their districts and publish results, enabling those with poorer access to learn from neighbouring successes.

Another substantial finding is the identification of intangible barriers, such as poor working culture and hostile environments between sectors. A 'tribal' culture within the NHS and social care has previously been commented on, describing negativity between staff leading to 'blame' behaviour when avoidable accidents occur.[30 31] Previous research into the effectiveness of integrated approaches highlights a lack of openness and professional staff boundaries as a key barrier, which was also found in this study, indicating that the nature of these issues is deep-seated and resistant to efforts made by management teams to remove them.[32 33] Participants described this cultural landscape as worsening the challenges of poor infrastructure and service access, and the fundamental inability of both sectors to work together being due to minimal communication between staff, hindering effective patient care.

A strength of this study is that it suggests solutions to such challenges as described by frontline staff (whereas previous studies offer perspectives of managerial staff).[34 35] GPs described a noticeable lack of exposure to social care in medical training, leading to a lack of motivation to understand the roles and procedures of social care when practising as doctors, so all referrals and interactions are made 'blind'. Participants suggest education (of both medical students and doctors in GP training) as a solution; ensuring all professionals understand each other's roles and meet face-to-face regularly to discuss patients, reducing the ideology of 'secret competing agendas' and creating a 'culture capital' to enhance collaborative working.[36] Interdisciplinary collaboration through education initiatives between both health and social care has already been identified as a major requirement for integration, with this study further emphasising this.[37]

The meaning of the study and possible explanations and implications for clinicians and policymakers

These findings have implications for policy makers and clinicians, especially medical educators. For policy makers who may not have considered frontline staff perspectives previously, this study highlights key barriers to target such as service access (creating streamlined referral pathways by providing teams with up-to-date information on who to contact for each type of service). However, it must be acknowledged that to improve accessibility and infrastructure in the short-term, effective change management needs to be implemented, which is difficult within a system like the NHS where many stakeholders are highly resistant to change.[30 38] Commonly, researchers describe integration as a 'Wicked problem' with many interlinked causes, where 'solutions' result in improvements in one aspect of the problem only but exacerbate other complexities of the issue, leading to minimal improvements overall.[39 40] Therefore, policy makers, in the face of repeated unsuccessful pilots, must adopt new approaches to facilitate change when implementing solutions to remove barriers. By making frontline workers aware of the challenges, creating desire to participate in and support change as well as providing them with the knowledge and ability to create and reinforce change (as mentioned in Hiatt's ADKAR model), management teams may see bottom-up approaches to integration being more successful than previous top-down approaches.[41] Furthermore, policies must be evaluated consistently to ensure a positive impact rather than detrimental effects on other outcomes of care while improving metrics in one domain.

For clinicians, the meaning of these findings is that widespread awareness of roles and activities in primary and social care may reduce cultural barriers as staff understand the limitations of their colleagues, tackling hostile blame behaviour. These results are also of interest to medical educators; exposure to social care and awareness of the benefits of integrated care systems should be incorporated to medical school curricula and GP training schemes to increase adoption of new care systems by medical staff and help shift care from being crisis-led to preventative. By integrating social care into interprofessional education and working from an early stage, other members of the team may become more educated on the roles of social care, thus further promoting interprofessional collaboration.[42]

Nevertheless, as is the nature of 'Wicked problems', a single solution is insufficient and systems-based thinking is required.[39] Although the major intangible barrier of cultural differences between sectors needs to be addressed, it is naïve to ignore other possible solutions mentioned such as increasing funding, training more health and social care professionals and achieving interoperability between IT systems. However, particularly in the current climate of austerity, primary care professionals appreciate the need for ground-level solutions that are not resource intensive and hence have emphasised interprofessional education as a step forward.

Weaknesses of the study and unanswered questions for future research

This study has some limitations that provide scope for further research. Due to resource constraints, the study was localised to London GP surgeries and so findings may not be transferable to other areas within the country (some areas, eg, where there has been pooling of budgets) or to other boroughs within London that were not sampled.[43 44] The participants were mostly professionals who had been in their current role for more than 5 years; it can be argued that this limits the information that they were able to provide to just their own practice without having much experience of other London practices. Additionally, as this study was from the perspective of frontline staff in

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primary care, views of staff in social care were not elicited, which would add important context to the findings; it may be the case that certain issues are more prevalent in the social care sector while others are less prevalent. It is suggested that further research assess the opinions of staff in both sectors working in the same geographical boundaries to develop a more nuanced understanding of these issues. Resource allocation and service provision vary greatly between urban and rural clinical commissioning groups and councils; it is suggested that further studies include participants from both settings to contextualise whether barriers to integrated services are affected by their geographies or the local demographics. In this study, contextual differences not only varied with geographical location, but also with various GP practices within boroughs, hence the need for further research incorporating these confounding factors. Finally, semi-structured interviews provide a 'snapshot' of data in a cross-sectional setting; a longitudinal approach may be required for future studies hoping to implement changes in relation to the barriers identified, to assess the long-term impact of these changes.[45]

CONCLUSION

This study, aiming to identify barriers to integrated services, found intangible barriers such as weak communication and poor interprofessional relationships to be major issues when it comes to integrating primary and social care, in addition to challenges with infrastructure and service provision. These findings indicate that effective communication, trusted relationships between staff and an educated workforce are required prior to making organisational changes, as structural changes have thus far been hindered from being successful by silo mentalities within staff. In order to achieve the aim of better clinical outcomes through more collaborative interprofessional working, future policy changes and approaches towards integrated care may find it helpful to adopt a bottom-up approach, incorporating interprofessional education and using the ability of frontline staff to influence and shape the provision of patient-centred care.

Contributors All authors partook in an aspect of designing the study, conducting the interviews, transcribing the qualitative interviews or thematically analysing the interview data; were involved in writing and then revising the manuscript drafts; accept the final version of the draft manuscript for publication; and agree to be accountable for all aspects of the work in ensuring any questions related to the accuracy or integrity of the work are appropriately investigated and resolved.

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