Developing Community-Oriented Integrated Practice

Authors:

1. Paul Thomas, Mb ChB, DCH, FRCGP, MD, DSc (Hon). General Practitioner. Carer. Honorary Senior Lecturer in the Department of Primary Care and Public Health, within the Faculty of Medicine, Imperial College. Visiting Professor, College of Nursing, Midwifery and Healthcare, University of West London. COIN Co-Chair (Community-Oriented Integration Network). Email: Paul.thomas7@nhs.net. Address for correspondence: 52 Okehampton Rd, London, NW10 3EP. Tel: +44(0)777 594 3960.

2. Raj Chandok. FRCGP, FRCP, FRSA, MSc. GP Principal, Dr G Singh & Partners. Vice-Chair & Diabetes Strategy Lead NHS Ealing CCG 2012 -2020. Email: rajchandok@nhs.net

3. David Colin-Thomé OBE, MBBS, FRCGP, FRCP, FFPH, FFGDP (Honorary), FQNI. Independent healthcare consultant and formerly a GP in Castlefields, Runcorn for 36 years, the National Clinical Director of Primary Care, Dept of Health England 2001-10, and visiting Professor Manchester and Durham Universities. E-mail: david@dctconsultingltd.co.uk

4. Laura Calamos, PhD, MSN, APRN-BC. Family Nurse Practitioner. COIN Co-Chair (Community-Oriented Integration Network). Email: lauracalamos@outlook.com

Roles in the Ealing work on integrated care described in this paper:

1. Paul Thomas served as Ealing Primary Care Trust (PCT) Clinical Director (2007-11); Clinical Commissioning Group (CCG) Clinical Lead (2011-13).
2. Raj Chandok served as Vice-Chair & Diabetes Strategy Lead NHS Ealing CCG (2012-2020).
3. David Colin-Thomé provided informal advice and critique for the Ealing Project between 2007 and 2013.
4. Laura Calamos (formerly Laura Nasir) served as an embedded researcher in the Ealing Project (2010-2014)

Acknowledgements. Thanks for help with presenting the ideas in this paper to: John Ashton, Vicki Doyle, Steve Iliffe, Peter Kinch, James Kingsland, Linda Lang, Lynne Madden, Maggi Morris, David Nabarro, John Spicer, Kurt Stange, Victoria Tzortziou-Brown, Alison While. Thanks to Norman Jackson from Chalk Mountain Education and Media Services for making the video of the Southall Initiative for Integrated Care. Thanks to Julian Burton from Delta7 Change for drawing Figure Two.

Abstract

Context. Community-Oriented Integrated Practice (COIP) provides a vision for society where people of different backgrounds collaborate at local levels for the health of whole populations. It enables whole system integration for Health and Care where efforts come together within village-sized geographic areas. COIP includes, but goes well beyond, healthcare to potentially involve all citizens and all organizations.

Integration of effort is needed for effective health promotion and care for medical conditions. It is also needed to effectively address many 'big picture' or complex issues – pandemic response, environmental degradation, racism, violence….. As well as improving *specific outcomes,* integrated efforts need to improve *action competence* and *social cohesion,* so people are ready, willing and able to improve the health of whole populations, beyond their personal interests.

Integration in COIP is less 'hard-wired', linear connection and more alignment of ways of operating, with methods that help people from different parts of different systems to step out of their 'silos' to co-create locally-relevant innovation.

Cycles of collective learning and coordinated change within and between geographic areas help to maintain such comprehensive integration by developing shared vision and binding people together as teams, communities and systems.

Methods. Between 2007 and 2013 the London borough of Ealing piloted and implemented policy for COIP, using organisational learning, generalists as sense-makers and multi-method evaluation. Outcomes were good, as evaluated by routinely gathered data.

Findings. This paper proposes inter-connected policy and a curriculum to develop COIP, including five policies based on the science of constructivism which: 1) Build structures to support whole system learning and change. 2) Facilitate local engagement in local developments. 3) Develop case studies. 4) Empower the learning of theory and practice of integration. 5) Support multidisciplinary leadership teams.

Conclusions. The approach can be used, at scale, in different contexts and at different speeds.

Key Words: Whole system integration. Community-Oriented Integrated Practice. Primary Care Networks. Integrated Care. Comprehensive Primary Health Care.

Policy Points

1. Community-Oriented Integrated Practice (COIP) is important because it energizes people to work for the good of whole populations. To contribute to COIP, primary care and population health practitioners need to embrace a science of constructivism to counterbalance reductionist thinking that prevents integration.
2. COIP helps people to think about whole systems, complexity and co-evolution, different from the common mindsets of compartmentalisation and linear control.
3. COIP uses an inter-connected set of methods, including cycles of collective learning and coordinated change within and between geographic areas, fuelled by modest multidisciplinary projects that improve action competence and social cohesion.

HEADINGS IN THE PAPER

The Nature of Community-Oriented Integrated Practice
The Ealing Experiment [Fig One]
Community-Oriented Integrated Practice – Health is a Citizen Issue
Fourth Generation Evaluation – Local Reflection on Quantitative and Qualitative Data
Policy for Community-Oriented Integrated Practice Binds Different Tribes together

Community-Oriented Integrated Practice Originated in Healthcare
Lessons from Ealing
Why was Comprehensive Primary Health Care not implemented at scale?
The Medical Model as Obstacle to Integration

A Curriculum for Community-Oriented Integrated Practice

1. Primary Care as a lead for community-oriented integrated practice [Box1]
2. Reality as an organic, living system – a complex adaptive system [Box2]
3. Health as positive narrative unity - overcoming difficulties with a smile [Box3]
4. Leaders as Sense-Makers – facilitating co-evolution of forests and trees [Box 4]

Policies for Community-Oriented Integrated Practice

1) Build structures to support whole system learning and change
2) Facilitate local engagement in local developments
3) Develop case studies of community-oriented integrated practice
4) Learn about community-oriented integrated practice
5) Support multidisciplinary leadership teams to facilitate co-evolution

Primary Care Networks could develop community-oriented integrated practice [Fig 2]

Epilogue. Boxes 1 - 4. References.

Developing Community-Oriented Integrated Practice

This paper describes Community-Oriented Integrated Practice (COIP).[1] It is a form of local participatory democracy. COIP enables whole system integration through networks of village-size geographic localities. There are five sections: 1) Nature of COIP, 2) Origins of COIP, 3) Curriculum for COIP, 4) Policy for COIP, 5) Epilogue. Each section weaves together insights from history, theory and an experiment in Ealing primary care, UK.

COIP requires us to work with the dynamic nature of the world, including co-evolving aspects as well as individual facts and inter-connected factors. We include four boxes with further reading about these in respect of: 1) Primary Care, 2) Reality, 3) Health, 4) Leadership.

The Nature of Community-Oriented Integrated Practice

The Ealing Experiment

In 2007 the Primary Care Trust (PCT) in Ealing - the authority charged with commissioning primary, community and specialist health services in the UK National Health Service (NHS) - set about improving service delivery by integrating various contributions to health and care, including primary & community care, hospital & specialist care, public health, social & voluntary care, and self-care. Ealing is one of 32 London boroughs in the UK. It has a population of over 400,000. General practitioners (GPs) work in 75 general practices (similar to family practices in the USA) in multidisciplinary primary care teams.

In 2008, Ealing PCT developed four multidisciplinary 'Development & Research (General) Practices' (a play on words to emphasise the 'D' of 'R&D practices' that were traditionally more concerned with 'R' than 'D'), supported by an Applied Research Unit. In collaboration with various PCT managers they coordinated locally-led innovations.

In 2009 the Ealing PCT set up a four-year pilot of *community-oriented integrated care*, called the *Southall Initiative for Integrated Care* (SIIC). It used annual cycles of collective reflection and coordinated action to enable 26 general practices to collaborate with other organizations that served the same geographic area of about 70,000 population. The

group learning processes helped participants to identify four areas in particular need of development, and devise a modest project in each area – 1) Anxiety & Depression in Black & Minority Ethnic Populations, 2) Child & Family Services, 3) Dementia, and 4) Diabetes.

The SIIC motivated people from different backgrounds to collaborate for the health of everyone in the locality. The potential of the approach to have impact beyond heathcare prompted a later change in language to talk about *community-oriented integrated* ***practice*** (a broader version of community-oriented health ***care)***.

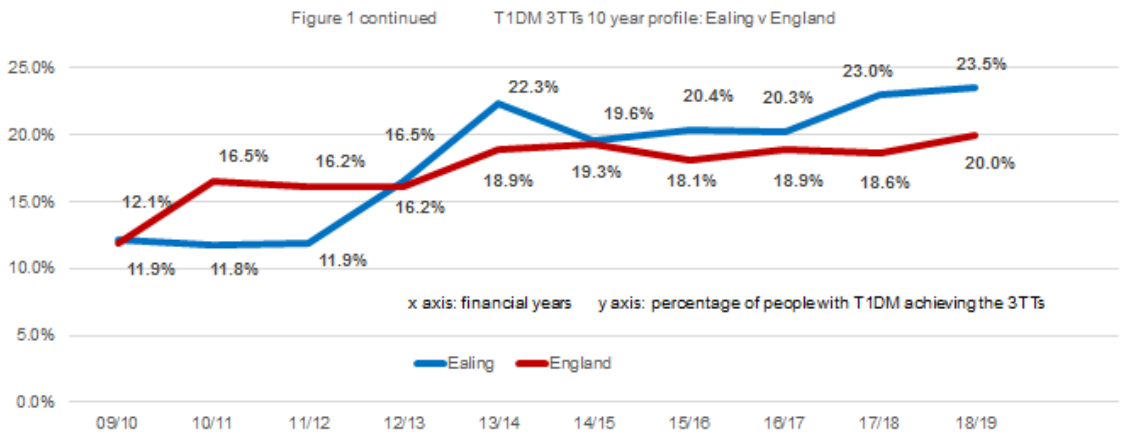
Between 2011 & 2013, PCTs handed over commissioning to *Clinical Commissioning Groups* (CCGs) with strong GP leadership. The success of the SIIC led Ealing PCT/CCG to end it early and use the learnings to inform 2011 policy for the whole of Ealing.

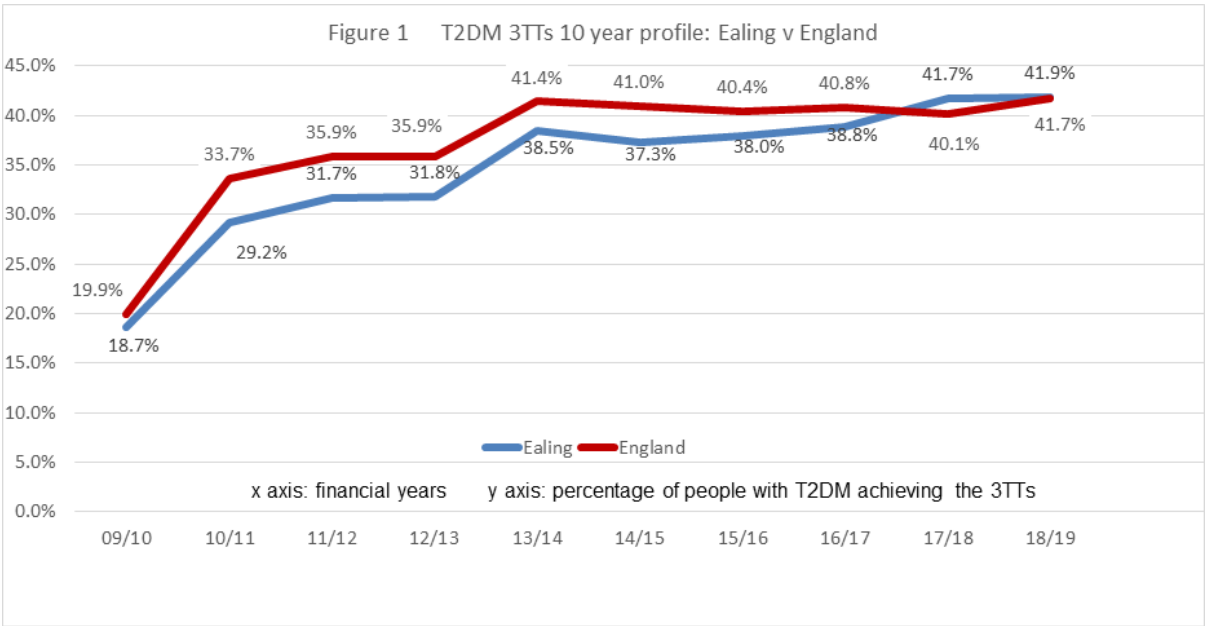
A 2019 paper[2] described improvements in diabetes care in Ealing between 2011 and 2018, the strategy for which originated in this 2011 policy. Data from the UK National Diabetes Audit (NDA), Quality and Outcomes Framework (QoF), Secondary Uses Service data (SUS) and Hospital Episode Statistics data (HES) demonstrated that Ealing:

1) Moved from below to above the national average for diabetes care metrics for both Type 1 and Type 2 diabetes (NDA data)
2) Achieved a significant reduction in the cost of diabetes-related hospital admissions (HES & SUS data)
3) Achieved a significant reduction in the number of people with undiagnosed Type 2 diabetes (QoF data)

Figure 1 shows the first of these, with an additional year of data. In 2013/14 Ealing's achievement for the 'three treatment targets' (HbA1c < 58 mmol/mol, BP < 140/80 mmHg and total cholesterol < 5.0 mmol/L) for Type 1, and in 2017/18 rates for Type 2 Diabetes Mellitus, improved to above those for England and this improvement was sustained in subsequent years. Achieving the three treatment targets reduces the risk of diabetes-related microvascular and macrovascular complications.

Figure One: 'Three Treatment Targets' (HbA1c < 58 mmol/mol, BP < 140/80 mmHg and total cholesterol < 5.0 mmol/L) in Ealing 2009-2019.





Community-Oriented Integrated Practice – Health is a Citizen Issue

What the 2019 paper about the improvements in diabetes health outcomes in Ealing did not explain is that policies that led to those improvements had their origins in a vision for community-oriented integrated practice (COIP). In this paper we describe this vision, and a curriculum to move towards it, drawing on insights from the Ealing Experiment,[3;4] the Liverpool Primary Care Facilitation Project (1989-1995)[5] the West London Research Network (1997-2001) and in a ten-year conversation with case studies published in the London Journal of Primary Care (2008-2018).

COIP is not a specific model to be blindly implemented. It is a way of thinking and a set of processes that encourage people in the melting pot of life to work together to care for others, beyond individual self-interest. It improves patient outcomes for specific illnesses, but even more important, it strengthens social cohesion and action competence, increasing the abilities and preparedness of local people to collaborate for the common good.

Community-Oriented Integrated **Care** marries the concepts of Community-Oriented Primary Care and Comprehensive Primary Health Care to integrate multiple efforts for healthcare in a local area.[1 [p.11-13]] Community-Oriented Integrated **Practice** is the same concept expanded beyond healthcare to include all aspects of society. It means whole system integration for Health (broadly defined) where everything comes together in a network of 'village'-sized geographic localities. It is a form of local participatory democracy.

Origins of COIP include the 1948 NHS that intended to treat Diseases in the **whole** population and the 1978 Alma Ata vision for Comprehensive Primary Health Care (supported by 134 member states of WHO and UNICEF, and 67 international organisations). The Alma Ata vision included disease treatments AND whole population Health - much more than medical care. Practical ways to integrate the work of those who treat diseases of individuals (e.g. GPs) and those who promote health throughout whole populations (e.g. Public Health Practitioners) include Kark's Community-Oriented Primary Care,[6] Ashton & Seymour's New Public Health,[7] Tudor-Hart's 'A New Kind of Doctor',[8] Healthy Cities Projects[9] and UK 'Vanguard' and 'Integrated Pioneer' sites.[10]

Meads' 31 country study describes six 'ideal types' of primary care organisation, of which the 'community development agency' is the kind of local hub COIP needs. He wrote:

"*Throughout such countries as Colombia, Bolivia, Peru, Brazil, Argentina and even parts of Canada (e.g. Quebec, Ontario), the community health centre or clinic is emerging as an engine driving forward participatory democracy"*[11[p.17]] *where participants maintain that: "health is a citizen, not a profession issue".*[11[p.100]]

Policy for COIP sets up *connected learning spaces* that enable people from different parts of different systems to engage in cycles of collective learning and coordinated change. Crucially, these cycles also happen in 'village-size' localities that are small enough to feel a sense of belonging and large enough to make a difference. In each cycle, perhaps annually, localities achieve modest, coordinated changes. The iterative, and self-referential nature of this process is what allows COIP to develop in any context – local people think through what matters to them and their locality, and what changes are realistic in their context. Different places permit different activities, led by different people, but there will always be something to work with. Incrementally, the process transforms cultures and systems as those involved learn to appreciate what others bring and integrate their ways of working.

COIP requires an organic, community development approach to change. This is different from, and can be (not always) complementary to the more common approaches to change that are: a) Individual (entrepreneurial innovation) or b) Mechanistic (fixing what is broken). The strength of a community development approaches is its gentle, locally-owned and persistent nature. This is also its weakness because the effects of such activities may be invisible to those who are not involved, do not have the eyes to see them, or think that change has to be forced. In the same way that it is easy to trivialize the work done by those who maintain the infrastructure of society (e.g. carers, parents, voluntary groups, public services), it is easy to ignore this effective yet undramatic process that builds and maintains connections and communities for health and care. This paper proposes ways to integrate individual, mechanistic and organic approaches - by purposefully using all three in the same geographic localities.

There are many examples of COIP being successfully developed in specific projects, like the Ealing experiment described here. However, attempts to develop it at scale seem to fail. One reason that COIP is difficult to achieve at scale is that it requires us to talk about the dynamic nature of the world, including how 'I' becomes 'We' and how overlapping 'We's' become a community. Everyday experience teaches us that life is like this, but when it comes to talking about it, our language is usually 'reductionist' – we speak as though 'effects' happen directly from 'causes' and complex things are reduced to simple parts.

Reductionist ideas lead to linear, compartmentalized ways of thinking that are associated with an approach to evaluation called 'positivism'. The positivist mindset (mindset = way of thinking = a 'paradigm' = way of looking) imagines the world to comprise solely of individual items that I can observe and touch and possibly alter. The complex ways that 'I' and 'We' emerge, inter-relate and change are invisible to the positivist mindset. Two other paradigms can overcome this weakness – *critical theory* and *constructivism.* They reveal connections and co-evolution rather than individual parts. For COIP we need to combine all three paradigms in what Guba and Lincoln call *Fourth Generation Evaluation.*[12]

Fourth Generation Evaluation – Local Reflection on Quantitative and Qualitative Data

COIP needs an approach to evaluation that integrates multiple perspectives. As Heisenberg famously pointed out - what we see is not nature itself, but nature exposed to our method of questioning. If I look for hope I will see it; if I look for despair I will see that too. And the things I see are in any case only snapshots of more complex, co-evolving stories. Furthermore, the assumptions I make about the nature of the world affect what I look for, and find. If I believe that the world consists of separate individual facts, I will look for the most important facts. If I believe that the world operates like a machine I will look for linear connections. If I believe that the world operates like a complex adaptive system I will look for dynamic interaction between multiple players. To make sense of a complex, dynamic world we need to be able to use all three of these paradigms.

Guba's analysis of three paradigms - positivism, critical theory and constructivism[13] – helps to make sense of a complex, dynamic world. Each paradigm makes different assumptions about the nature of the world (ontology) and the relationship of the researcher to it (epistemology). (*Post-)*positivism analyses individual facts. Critical theory maps inter-connected fact(or)s. Constructivism allows us to feel emerging wholes by personally engaging in the process. We can think of these paradigms as different lights that illuminate[14] different aspects of a dynamic situation. For example, in a garden positivism examines individual phenomena like branches of a tree or petals of a flower. Critical theory describes how the diverse contents of the whole garden hang together - like trees and flowers and crops, birds and weather and soil. Constructivism feels moments of emergence – how the garden changes as a whole as everything reacts to everything else, like blooms responding to rainfall. All are useful. Each is different. None reveal the entire picture. Together, these paradigms reveal individual, mechanistic and organic aspects of the world.

Positivist science helps to understand *simple, linear* things – we do want to know if COVID vaccination works. *Critical theory* helps to understand *complicated connections* - we do want vaccination clinics designed to fit the local context. *Constructivis*m helps to understand *complexity and emergence* – we do want to know how to galvanize people to feel part of a collaborative effort to respond in helpful ways to a pandemic.

Guba & Lincoln described 'fourth generation evaluation' to integrate these three paradigms.[12] It uses the learning organisation method, originally attributed to Kurt Lewin[15] of 'unfreeze-change-refreeze'. At moments of 'unfreeze', stakeholders review data in the light of their experiences. At moments of 'freeze' they get their heads down to make changes. This results in cycles of collective reflection and coordinated change.

Localities, like Primary Care Networks in the UK, can use fourth generation evaluation to develop COIP. It requires cycles of collective learning and coordinated change, punctuated by large group events[16] like Open Space or Real-Time Strategic Change, at which participants review different kinds of quantitative and qualitative date. By coordinating activity between localities they could also improve 'big picture', complex issues.

Contemporary issues, like environmental degradation, highlight the importance of local collaboration to address 'big picture' issues. The COVID-19 pandemic has made us aware of a need to combine 'bottom up' insights with 'top down' policy. 'Black Lives Matter' and Brexit in the UK remind us that a healthy society requires trust between people from different backgrounds, at local and central levels. These needs for local collaboration might make community-oriented integrated practice more acceptable now than in the past.

Policy for community-oriented integrated practice binds different tribes together

Policy for community-oriented integrated practice is concerned with more than mechanically implementing evidence-based solutions. It develops multidisciplinary leadership teams to facilitate creative interaction between people from different backgrounds in ways that help them to see how their individual and collective actions can affect 'bigger pictures', and collaborate to improve things in synchrony.

Policy means '*a set of ideas or a plan of what to do in particular situations that has been agreed to officially by a group of people*'[17] It is often interpreted in a hierarchical way - the rules made by 'important people' in 'top down', 'high' or 'central' places to control people's behaviour. It closes down options. To achieve community-oriented integrated practice, policy needs to open out options by helping people to better see their individual relevance within 'bigger pictures' and build networks and communities to improve those bigger pictures and their own situations. This empowering interpretation of policy improves the *action competence* of individuals and *social cohesion* of communities - so they become ready, willing and able to collaborate to improve things for themselves and for others.

McKnight's work on Asset Based Community Development[18] reminds us that communities are built by working with the assets of ALL involved, especially appreciating those whose contributions are often trivialized. Shared action for the common good (ranging from helping at school fetes to recycling to reduce pollution) binds people together. Feeling bound together is important – it helps people to <u>want</u> to collaborate for the health of each other and of the whole population. It can make a whole locality feel welcoming and safe.

Durkheim has been credited with identifying that traditional societies were bound together (he used the term 'solidarity' = sense of shared identity = social cohesion) by belonging to a tribe or family that often defines itself as opposed to other tribes.[19] He argued that the main shared value in modern societies, based on capitalism and individualism, is *inter-dependence*. This causes *bridging* more than *bonding*, since people collaborate more from obligation than desire. Bridging is important to get things done (it causes connections), but it is Bonding that builds social cohesion (it causes community). Bonding comes from co-creative action – for example participants in a project, or fighting a shared enemy (like coronavirus). The question is - should policy facilitate bonding between different 'tribes', as well as bridging? We say it should. It is the route to social cohesion from which comes a preparedness to collaborate to improve 'big picture' issues. Putnam agrees, arguing that Bonding between people 'who are alike' and Bridging between people 'who are different' are both needed.[20] Creative activity between people who are 'different' can bond as well as bridge, broadening a sense of 'we'. When efforts to bond cease, communities can fragment, forming new tribes with new reasons to distance themselves from each other. It's the same with all relationships - when people stop making a constructive effort, they drift apart.

Community-Oriented Integrated Practice Originated in Healthcare

In this section we describe how the need for COIP has been especially described in healthcare, but the medical model can obstruct progress.

Lessons from Ealing

The Southall Initiative for Integrated Care demonstrated that cycles of learning and change within geographic areas can bond AND bridge – they stimulate people to <u>want</u> to collaborate for the sake of the local community and also be ready to give and take in reciprocal ways. It showed that not everyone needs to take part to stimulate a sense of solidarity. Participants from different disciplines can bond, then carry that sense of shared identity and appreciation back to other members of their discipline or organization.

The Southall Initiative stimulated four whole system integration projects. Routinely-gathered data helped to monitor progress. Three times a year, broad groups of stakeholder critiqued progress and offered new ideas at large group events. A video of one of these meetings - https://www.youtube.com/watch?v=-u40x7-76iU&feature=player_detailpage [21] - shows the power of the approach. It shows participation as equals of lay people, health, social and mental health care practitioners, policy makers, public health practitioners.

This comment by a voluntary sector participant reveals the value of COIP:

"*It's not revolutionary; Yet it is revolutionary… If it is institutionalized, that would be incredible for our healthcare services"*

The ability of the approach to energize people and help them to interact creatively across disciplinary boundaries is revealed in this comment by the dementia project lead:

"I've never had so much access and opportunity to talk across primary care and secondary care about mental health services…. and I find that the most exciting thing I have experienced in my professional life"

The ability of participants to carry a sense of shared identity back to other members of their discipline or organisations is revealed in this comment by a public health consultant:

"*We certainly talk about it in the office. Whoever comes feeds back to everyone else. I think that's what the initiative does – it generates communication; it shares knowledge"*

The effectiveness of the approach to cause change across a whole area is revealed in this comment by the Head of Service Improvement and Transformation:

"I have seen a massive change that was initiated by this initiative. It started small and it grew to pretty much the rest of Southall"

In 2011, Ealing PCT/CCG applied learning from the Southall Initiative in policy for the whole of Ealing. This laid the foundation for later work that led to the improvements in diabetes care described above. Particularly relevant to the development of COIP were:

- Seven localities of 50-70,000 population where generalist and specialist clinicians, public health and social care practitioners, and others met monthly to develop care plans for frail patients, learn about new developments, and co-create innovations

- Routinely-gathered data amalgamated to locality boundaries to provide comparative data of progress that participants reviewed at their locality meetings
- Trained leadership teams to facilitate collaboration and share learning in localities
- A committee co-chaired by a CCG Director and Adult Social Care Director to oversee development in all localities; meetings attended by locality leadership teams
- An innovation fund (e.g. one project worked with intense users of emergency services to address underlying issues, not necessarily biomedical)
- Hospital-led diabetes clinics aligned to the localities (thereby developing relationships between hospital teams and practices that served the same locality)
- Targeted resources to reverse inequalities
- A multidisciplinary team to co-design a system for diabetes care for Ealing
- Education courses for primary care staff to facilitate diabetes clinics in their practices
- A GP advice line to access specialist expertise for medical issues, including diabetes
- Structured education for patients to contribute to their own diabetes self-care
- Other initiatives (e.g. mental health service redesign) contributed to the improvement in diabetes care by also stimulating awareness of whole systems of care

By 2013 the diabetes care system was transformed[3] and localities were established.[4]

Why was Comprehensive Primary Health Care not implemented at scale?

Community-oriented integrated practice translates the 1978 Alma-Ata Declaration[22] vision for *Comprehensive Primary Health Care* (PHC) into a contemporary context. Since 1978, this vision has been pursued by most countries throughout the world in one way or another. However, the vision has never been successfully implemented at scale. Within one year of the Alma-Ata Declaration, Comprehensive PHC (whole society contribution to whole society health) gave way to Selective PHC – targeted initiatives like improving immunisation rates and promoting breast feeding.[23[p.76]]

Selective PHC has profoundly improved specific aspects of healthcare. The international, coordinated response to the COVID-19 pandemic would not be possible without the advances in understanding systems that stem from Selective PHC. However, the broader vision of whole society contribution to whole society health has remained elusive. In 2008, Margaret Chan, WHO Director-General argued the need to rediscover the broader vision of Comprehensive Primary Health Care to solve serious problems in contemporary societies, including inequalities, complex problems and system fragmentation.[24]

Chan challenged the adequacy of a mechanistic image of healthcare – one in which different disciplines live in different 'silos' and connect with each other in simple transactional ways. The image of a living system is also needed, where different 'cells' have lives of their own yet also co-evolve with other 'cells' in the 'body' of Primary Health Care. A healthy community requires constructive interaction between these various 'cells', just as for a healthy physical body. Chan argued that integration of contributions to health and care from throughout the whole system need to come together in community-based 'hubs of coordination' – hence what we have termed *community-oriented integrated practice*.

Internationally, policy for healthcare integration is shifting to promote models that enable co-evolution. For example, researchers of the 2015 Luohu Model in China identified a need for "*multiple stakeholder engagement, organizational integration, alignment with payment reforms and normative integration to promote collaboration*".[25]

Researchers of integration in the Singapore Regional Health System wrote:

"*Given the typical depth and breadth of needs driving any one intervention, the intricacy of many intervention components and the involvement of numerous actors with different perspectives and agendas within the integrated care setting, the implementation experience of such interventions can rarely be comprehensively or even meaningfully captured by a linear narrative of cause-and-effect. For this reason, a complex adaptive system perspective has been increasingly advocated for categorizing and analyzing information*…"[26]

These models from Singapore and China emphasise hospital leadership (with primary care collaboration), and a focus on diseases. Community-oriented integrated practice emphasises local leadership (with hospital collaboration and strategic partnerships), and a focus on whole society health (as well as diseases). Quebec has been working more than most to achieve this vision at scale. Its public health and social care agencies have been structurally integrated under a single governance authority since 1971.[27] Its Health Services and Social Centres have been developing *local health networks* to support local collaborations since 2004.[28]

Yet even Quebec has difficulty in reconciling different views and engaging clinicians. In 2019 integrated care for older adults remained problematic owing to '*divergent perspectives of actors'*, and particularly the difficulty in engaging clinicians.[28]

> *"Despite advances in structural integration, all groups of stakeholders expressed concerns on the implementation (of) the clinical dimension of integration. This dimension is at the heart of integration efforts given that it is at the front scene or the interphase where patients and their families receive care from the health system."*

Why is it difficult to engage clinicians? How can it be that a discipline that includes some of the most intellectually able people of any generation, some of the most altruistic, some of the most highly trained, and some of the most experienced people, can be a main obstacle to integration? In the next sections we explore this question and propose a way forward.

The Medical Model as Obstacle to Integration

In 1979, Macdonald explained why the medical profession can be a main obstacle to integration. He wrote:

> "*Throughout the world the public is now conditioned to see health and ill health as being the medical profession's business: we submit ourselves into their hands rather as we hand over a machine to be repaired by a mechanic*".[23[p.37]]
>
> "T*he selective version of PHC can be understood as medicalisation of the PHC message".*[23[p.72]]

Medicine is an obstacle to Comprehensive PHC when doctors think of health solely as the absence of diseases, and diseases as broken parts of a machine – mindsets of positivism and critical theory, described above. Both positivism and critical theory examine things that have already come into being, so they give a sense of certainty – diseases 'really' exist as objective, measurable, discrete entities that can be combatted with tried and tested treatments. They don't see the complex ways that different things interact and co-adapt and overlap and change, moving forwards - this requires a constructivist mindset.

Physicians are taught that constructivist thinking is separate from the main function of Medicine – 'The Art' rather than the 'The Science' of Medicine. So, 'integration' in the medical world mainly means direct, linear, structural linkage - what Checkland calls a *hard system* rather than a *soft system* that would '*allow completely unexpected answers to emerge at later stages'.*[29[p 91]] So, despite being immersed in the biological world, doctors are not trained to think about what Schumaker calls a *biological system*[30[p.41]] or use tools to work with complex interactivity, like *learning organization principles,*[31-32] *Participatory Action Research*[33] and *Mind Maps.*[34] Can this change?

The COVID pandemic is teaching the world the value of the dynamic, constructivist mindset as well as individual (positivist) and mechanistic (critical theory) ways of thinking – we do want to organically develop local communities for the health of whole populations AND combat specific diseases AND mechanically manage mass vaccination. In the next section we explore implications of the constructivist mindset on some key issues - Primary Care, Reality, Health and Leadership - to frame a curriculum for community-oriented integrated practice. These dynamic aspects have always been known, but history has forced hierarchical, compartmentalized, structural interpretations – the centrality of which now need to be challenged.

A Curriculum for Community-Oriented Integrated Practice

Community-oriented integrated practice requires us to work with the dynamic nature of the world, including co-evolving aspects as well as individual facts and inter-connected factors. In this section we explore how this might affect how we think about four concepts that are essential in all healthcare systems: 1) Primary Care, 2) Reality, 3) Health and 4) Leadership. For each of these we provide a Box with further reading. These can help to delineate a curriculum for community-oriented integrated practice.

Those who are unused to ideas of complex co-adaptation will take some persuading that whole system transformation can come from cycles of collective reflection and coordinated action, fuelled by a series of modest, locally-led projects. They are likely to prefer high profile directives that force people to comply. When people understand the rationale of working with the dynamic nature of co-evolution, and witness the powerful effect of thoughtfully coordinated small efforts, they are more likely to trust the process.

1. Primary Care as a lead for community-oriented integrated practice

Public health practitioners are likely to have a lead role in community-oriented integrated practice because COIP is a version of the *New Public Health* described by Ashton and Seymour.[7] Others with a holistic, social and health, whole population concern may also have lead roles – faith communities, schools, social services, police, voluntary groups…

Primary and community care practitioners – GPs/family physicians, advance practice nurses/nurse practitioners/district nurses and others - are also likely to have lead roles despite the medical model being an obstacle to integration because, as Starfield et al. point out in their classic paper, primary care '*focuses on the person rather than on the management of particular diseases'*.[35[p.480]] Focusing on a person rather than diseases encourages a clinician to think in a constructivist way because he/she has to consider the effects of many interacting things, more than treating diseases. To develop COIP at scale they will have to learn the theory of constructivism. Instinct is not enough.

In **Box One** we describe the history of general practice/family medicine, especially in the UK to argue that constructivist thinking has always been there, but often overshadowed by a priority to treat diseases. Many primary care thinkers have argued a need for constructivist thinking, using the language of 'narrative-based primary care' as a way to integrate paradoxical aspects of people's lives within the consulting room.[36-41] The idea that GPs could become sense-makers of complexity outside as well as inside the GP practice room was voiced by Tudor Hart who advocated a 'New Kind of Doctor'[8] who fuses epidemiology with primary care (page 99) and develops the idea of primary care centres as '*growing points for participative democracy'* (page 338).

In the UK the 2019 NHS Long-Term Plan[42] now positions GPs as the go-to discipline to understand a constructivist science - as leaders within Primary Care Networks (PCNs). To continue a vocation as generalists at the centre of communities, who care for whole families on a continuing basis and are also gateways *'for all diseases and problems that the public consider require skilled help and advice'*, GPs and other primary care practitioners will have no option but to learn this constructivist science - through PCNs outside the consulting room and through narrative-based primary care within it.

See Box One for further reading.[43-54]

2. **Reality as an organic, living system – a complex adaptive system**

Capra writes elegantly about complexity. In the *Turning Point* he wrote: *"Biomedical science has concentrated too much on the machine-like properties of living matter and has neglected to study its organismic, or systemic nature".*[55 [p.266]] In Healthcare this is changing, as the Health Foundation shows when describing the value of *complex adaptive system thinking* in its 2010 'evidence scan': "*Complex adaptive systems thinking is an approach that challenges simple cause and effect assumptions, and instead sees healthcare and other systems as a dynamic process. One where the interactions and relationships of different components simultaneously affect and are shaped by the system*".[56]

There is now broad recognition that, outside of a laboratory, the 'real world' behaves less like a machine with predictable effects and more like an organic 'living system' where change happens from co-evolution, as everything adapts to changes in everything else. The concept of a complex adaptive system is much more in tune with this reality than a machine.

See Box Two for further reading[57-58]

3. **Health as positive narrative unity - overcoming difficulties with a smile**

In Box Three we provide a definition of health as a '*positive narrative unity'*. It combines Antonovski's definition of health as overcoming adversity[59-60] and MacIntyre's idea of narrative unity.[61] *Positive narrative unity* helps to link the concept of health with life stories and identities. We can imagine that we are each the lead actor in the 'feature film' that is 'my life story', and a support actor in the 'films' of others. Health means being able to make these stories coherent and positive. Diseases get in the way of making positive stories, so treating them is important – but not an end in itself.

This idea of health explains the importance of *action competence* that improves our ability to seek positive things, like happiness, rather than negative things like fear and conflict. It helps us to see discrete events in life in the context of longer-term stories and take actions that make a whole life story unfold in coherent and triumphant ways.

See Box Three for further reading.[62-65]

4. **Leaders as Sense-makers – facilitating co-evolution of forests and trees.**

The machine image of reality leads to a static image of the world where change happens in 'linear' ways. This leads to a belief that leaders take 'followers' to the correct place. This 'heroic' idea of leadership does not work well with the image of the world as a complex adaptive system and health as a positive narrative unity, because the 'correct place' depends on what the people who are travelling want, and what they can realistically achieve. In such situations, leaders are 'sense-makers'[66] who help people to listen to each other and collaborate to take small steps in good-enough directions.

In Box Four we explore this idea of leadership. In the 'real world' everything is continually adapting to changes in everything else. Leaders help stakeholders to engage thoughtfully in this co-adaptation. Cycles of collective learning and coordinated action help to do this.[15;31;32] Large group models[16] enable large numbers of people from widely different backgrounds to creatively interact. Typically, participants find the first event to be exciting and fun. When the second and third large group events are equal fun and objective improvements become obvious, participants change from thinking of the events as simply being fun to being an effective approach to whole system transformation.

See Box Four for further reading.[37;67-71]

Policies for Community-Oriented Integrated Practice

In this section we describe five policies, each with four actions that will help to develop community-oriented integrated practice – 20 actions in total. The policies are:

1. Build structures to support whole system learning and change
2. Facilitate local engagement in local developments
3. Develop case studies of community-oriented integrated practice
4. Learn about community-oriented integrated practice
5. Support multidisciplinary leadership teams to facilitate co-evolution

They are described more fully in the book 'Collaborating for Health'.[1] None instrumentally force integration to happen, but they make it easier to achieve. They help people to reflect, constructively interact and collaborate to improve 'bigger pictures' as well as their own lives.

They also help to think about evaluation. A selection of the 20 actions can be measured and compared between localities and in the same locality over time. Measures for action competence, social cohesion, wellbeing, citizenship, capacity and economics can also be used.[72] Targets depend on what local people consider to be important – some national priorities, like diabetes; and some local priorities that will be different in different places.

Community-oriented integrated practice uses a dynamic image of the world, where everything is continually adapting to other things. If things appear still, we are observing slow movement. Insights provide snap-shots of more complex stories-in-evolution. Policy for integration aims less to achieve an ideal state and more to help people to engage thoughtfully and constructively with complexity. One example – a 'healthy death' would be less concerned with prolonging the date of death and more with supporting a community of people to help someone's life story come to a positive end, and in a way that helps the life stories of all involved to transition to positive new stages.

By bearing in mind the range of things to accomplish, we can do them when times allow. We can keep existing initiatives going with a light touch and resist efforts to destroy good past progress. We can all keep a sense of humour about the strange things that happen - community-oriented integrated practice is too serious to be too serious about it!

Policy One: Build structures to support whole system learning and change

Policy for COIP maintains 'connected learning spaces' where people from different backgrounds can choose to take part in coordinated improvements. Actions include:

- **Networks of geographic localities.** Localities for collaborative activity can naturally define themselves because of boundaries like roads and shopping centres. They need to be 'village-size' - small enough to feel you belong and large enough to have political clout. In UK cities, population of 30-70,000 seem about right.[1[p.30-31]] When initiatives within and between localities span different 'tribes' they can stimulate positive trusted relationships and build a sense of community.
- **Systems for shared care for long-term conditions.** Local community centres can be hubs to support lay action,[73-74] in collaboration with medical and social care for long-term conditions (e.g. diabetes). In the UK, many COVID vaccination centres are already linked to Primary Care Networks. They could develop into this broader role.

- **Seasons of learning and change, for health and care.** 'Seasons' reflect natural events like end of year reports, flu campaigns in the winter and weekly, monthly or quarterly data gathering. They shape a calendar of events to align efforts, identify new priorities, provide training, devise new projects and coordinate actions.
- **Applied Research Units**. Such units can help localities to develop strategies, gain strategic partners, support research teams to find new ways to evaluate local actions, facilitate stakeholder workshops, gather and present data, devise and lead innovations, share learning within and between localities, and use new technologies.

Policy Two: Facilitate local engagement in local developments

Policy enables a range of people to engage in locally-relevant ways. Actions include:

- **Annual cycles of collective reflection and coordinated change.** Multidisciplinary leadership teams can support improvement projects that emerge from each cycle, incrementally building a sense of community. Different organizations can sponsor – healthcare, schools, social care, voluntary groups, businesses, public health….
- **Live manuals.** A live manual can be continually updated and practically used every day. It is where multidisciplinary leadership teams can put information, including educational updates, contact information for various stakeholders, data-gathering methods like surveys, and information about improvement projects.
- **Facilitate rather than chair meetings.** Techniques like small-group-large-group oscillations help participants at meetings to value different perspectives and make sense of them in the light of bigger stories and objective facts.
- ***Action Learning Sets* for leadership teams.** These help multidisciplinary leadership teams to bond, lead projects, build communities & systems, and learn that everyone can contribute to learning and leading. Techniques like role play help participants to become skilled at iterating between focused detail and bigger pictures, and know when to lead from the front and when from the back.

Policy Three: Develop case studies of community-oriented integrated practice

Developing localities as case studies of integrated practice will help the local story to be developed by local people. Routinely gathered quantitative data (e.g. hospital admissions) and qualitative data (e.g. patient stories), aligned to locality boundaries, can help to evaluate the combined impact of multiple activities on diseases, wellbeing, capacity, citizenship and economics. Links with community colleges and universities provide opportunities for student-led projects. Learning between case studies can embolden more ambitious projects. The following actions will help them to develop as case studies:

- **Locally-led initiatives.** Projects can emerge from cycles of learning and change. Other projects led by other local groups can inter-link with them for added effect.
- **Externally-led initiatives.** Educational establishments and others can lead projects, aligned to a calendar of activity, to provide useful local insights. For example student-led documentary films can gain insights into aspects of health and care in a locality.
- **Large group methods.** Methods like Future Search, Real-Time Strategic Change and Open Space[16] help large numbers of people to explore different agendas and perspectives and work with others to make better sense of complex issues. They can be embedded within annual calendars of events.
- **Maintain inner peace.** To keep sight of who we are within complexity, we need inner peace. Each of us needs a buffer of sanity around ourselves that reminds us to see the complexities in our own lives, engage purposefully with others and deal with grace with the misunderstandings of others. Mindfulness methods can help.

Policy Four: Learn about community-oriented integrated practice

People often don't know how to work with co-adaptive ideas. Often, we talk about the world as though it is a machine, unfamiliar with thinking of it as a complex adaptive system as described in Box Two. Modules can be added to courses for children and adults, under- and post-graduates, professionals and citizens, to learn about the following:

- **The nature of community-oriented integrated practice.** COIP needs multidisciplinary team-working within geographic areas, working with a holistic vision for health. Local people need a 'stake' in developments and be able to contribute – to strategy, to shared care, to self-care, to healthy living, to healthy dying.
- **Generalists as sense-makers.** In complex situations leaders are sense-makers.[66] Generalist primary and community care practitioners, more than many, see different aspects of health, and value different contributions to care (see Box One). People often have multiple problems and the most important often lurk below the surface of what is initially presented.
- **Health as a positive narrative unity.** People can learn to see positive things in any experience, even when very difficult and negative things are happening. This helps to make stories as positive and meaningful as possible, and integrate mental, social and spiritual aspects of wellbeing, as well as physical wellbeing.
- **Three paradigms of inquiry to illuminate co-evolving stories.** COIP requires local reflection on quantitative and qualitative data to mark the development of the local story. 'Fourth generation evaluation' shows how to do this.

Policy Five: Support multidisciplinary leadership teams to facilitate co-evolution

Multidisciplinary leadership teams within localities may want to facilitate integration in ways that develop action competence and social cohesion, but not be confident to do it. In particular they may need support for the following actions:

- **Build systems for health and care.** Network theory shows how to design systems that people can easily navigate and have creative adventures within. For example, a railway network allows travellers to go to different places and align travel plans with: a) Nodes (junctions) where routes connect – e.g. pharmacies, b) Timetables and Maps – e.g. services and self-help courses, c) Learning spaces – e.g. community events where people interact, dream up new ideas and plan future shared journeys.

- **Develop team players and systems thinkers.** Team players see broadly across systems. They interact positively with others as equals whilst valuing different roles. Transactional analysis shows how **equality** is often less about being the **same** as others and more about being able to **creatively interact with 'other' as equals**. It highlights how we move between three 'ego states' – 'parent', 'adult' and 'child' – to play 'games'.[68] Good games result in a sense of 'I'm OK; You're OK'.[69] They cause laughter and mutual appreciation, making participants feel equal and bound together,
- **Build learning organizations and learning communities.** Learning organizations embed cycles of learning and change that go on and on and on, helping communities and systems as well as individuals to continually learn, adapt and co-evolve.
- **Build public health/primary care partnerships.** All citizens need to contribute to a healthy world. Shared planning between practitioners from public health (that emphasises population health) and primary care (that emphasises individual health) can engage a full range of disciplines and organisations - families, schools, voluntary groups, universities, faith communities, local authorities, political parties…..

Primary Care Networks could develop community-oriented integrated practice

Individuals are not as individual as we may think. We form our identities from creative activity with others, as well as allegiance to tribes and our personal beliefs. A modest investment in shared leadership for COIP in village-size geographic areas could stimulate collaborative projects that strengthen both local and personal identities, with hugely positive benefits. In the UK, Primary Care Networks have the resources and authority to do this.[75]

The COVID pandemic has highlighted the importance of whole system integration that comes together in local areas. This could provide momentum to an already growing call for reform of primary care to what Ferlie calls a '*New Localism'*.[76] This paper contains theory

and policies that show how to practically do this at scale, combining ('vertical') hierarchical oversight AND ('horizontal') collective learning, team-working and coordinated change.

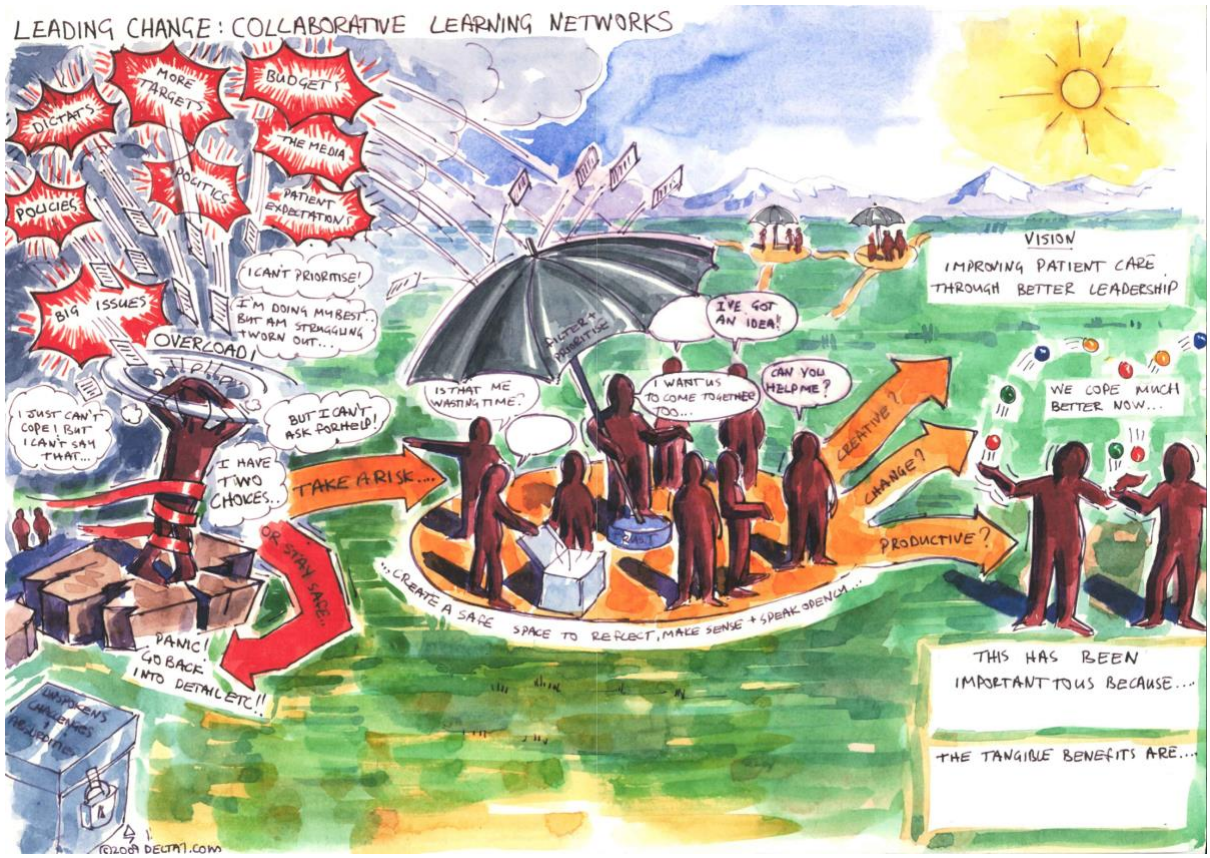
Effective policy actions are *fractal* – they can be applied in different contexts in different ways. It is less important who leads creative interaction as long as it happens, and it continues to build social cohesion and action competence, even when energy flags. The Ealing Experiment shows that they can also improve quality of care AND save hospital costs. Anticipating this leads us to set up systems to evaluate locally-agreed actions, social cohesion, action competence, cost and quality of care. Preferably, comparisons between localities can be made in real-time to evaluate short- and long-term effects of policy and so motivate further progress and the development of better metrics.

When people witness the power of inter-linked, locality initiatives to improve health and care, others may want to join in, using their own resources to develop quality through things like: Care for Long-Term Conditions,[77] Public Health initiatives,[78] Community-embedded schools,[79-81] University-linked localities,[82] Socially-embedded photography,[83] Parenting,[84] Early hospital discharge,[85] Buddy groups for the bereaved,[86] Healthy behaviours like breast feeding,[87] Music for wellbeing in older people[88] and much more. Each locality/Primary Care Network could list what happens each year to encourage learning and collaboration between places, and increasingly ambitious initiatives.

Figure 2 provides an image of community-oriented integrated practice. On the left is someone who is overwhelmed, stressed, confused. He or she has too much to do, too much conflict, a sense of being trapped. And the most curious thing is that the way out of this entrapment - getting under an umbrella - feels like a Risk. Staying trapped feels safe! Yet those who are prepared to take the risk can work with others to not only achieve their aims, but also to become more action competent (the jugglers on the right) and develop more and more trusted relationships. In the bottom left hand corner is a box full of things that are too difficult to look at - you will see that under the umbrella that box is open. In the distance you will see large numbers of other umbrellas where others are also taking risks to explore

complex things. One challenge is to facilitate ongoing learning and collaboration between umbrellas for increasingly ambitious goals. We can do that too with this approach.

Figure Two: Community-Oriented Integrated Practice



Epilogue

To prepare for future pandemics, societies throughout the world will need to develop infrastructure to support local collaboration and innovation. Collaboration is helped by village-sized geographically-defined areas because this allows different people to lead different initiatives, building, over time, a sense of community. By approaching this need in a way that could support the broader agenda of community-oriented integrated practice, hidden potentials may become apparent. For example, there might be an army of retired people who would enjoy taking part in health-improving, community-building activities. There might be experienced carers prepared to support novice carers. Some localities may be able

to explore issues that are usually on the 'too difficult to deal with' stack – dying at home, climate change, abuse and trauma of various kinds…. It could lead to an expectation that citizens in a healthy society work together to tackle difficult situations.

It is easy to see the need for community-oriented integrated practice when we are in a difficult real-life situation that requires multiple inputs. It is for the same reason that Starfield, Shi and Macinko identified '*focus(ing) on the person rather than on the management of particular diseases'* as a key rationale for the strong association between 'low-cost-high-health' and Primary Health Care orientation.[35[p.480]] In these situations, making good things happen involves integrating a unique set of factors to improve a complex set of problems. Merely working with those factors separately or blindly following protocols will not be as effective. Success starts with recognizing this potential.

Take the example of someone dying at home. The best plan considers medical matters AND empathy, responsiveness AND tenderness; it focuses on needs of the patient AND the carers, families and community involved; it controls symptoms like pain AND maintains alertness; it pays attention to mobility AND feeding AND dignity AND pressure sores AND a sense of control. This will be obvious to a good generalist within such a situation. He/she will know that the best plan adapts bits from different specialist guidelines.

The need to manage complexity may not be obvious to those who have a narrow interpretation of quality, or who are panicking or frightened, or who simply don't know that it is possible and desirable to weave a plan that addresses multiple needs. Many people are unaware that 'truth' has as much to do with the way of looking as with what there is to see; and we all *project* – we imagine traits in others that are really our own.

In this paper we explain that medicine has been an obstacle to community-oriented integrated practice (COIP) because it is aligned to a science that examines issues one at a time as though with a microscope. It therefore has difficulty in seeing the need for integration to manage complexity and co-evolution as well as linear connections. This problem is much broader than medicine. When any of us sees only single issues and single ways to improve

them, we will not see the need for COIP. When we see many inter-connected issues and recognize that improving them requires co-ordinated and co-adapted inputs, we will.

Achieving community-oriented integrated practice at scale requires us to understand that what we expect to see (and want to see) greatly affects what we actually do see. We need to learn from the past, but co-creating the future requires more than applying the past, however successful it was. Why are we still struggling with this dilemma? Why, in the 21st century, are we still frustrated by Keirkegaard's complaint from the 19th: "*It is perfectly true, as philosophers say that life must be understood backwards. But they forget the other proposition, that it must be lived forwards*".[57]

In theory, resolving this dilemma is easy - we acknowledge that the things we see ('evidence'; 'facts', 'perspectives') are snap-shots of more complex stories-in-evolution. We oscillate between focusing on snap-shots and bigger pictures to take good-enough next steps in these journeys. In practice, this can be unrealistic because it requires us to work with complexity and uncertainty and this can make us feel anxious, vulnerable or overwhelmed. For our own sanity we naturally seek certainty.

Certainty, wherever it comes from, despite being an illusion, is comforting. It can also stimulate harmful linear, compartmentalized thinking and conflict - if I am certain I am right, it is easy to imagine that others are wrong. Many 'certainties', born out of an overly simplistic understanding of life - sexist, racist, classist, castist prejudices - are now exposed to be wrong. A danger is that we now replace them with new 'certainties' - also wrong. That is why societies need to help people to engage with uncertainty and complexity with confidence.

We have to see beyond opposing wrong. When a police officer kneels on someone's neck, or soldiers shoot protesters, or an adult rapes a child, or a politician destroys an ecosystem – the impulse is to say 'No' and fight against wrongdoers. Yet, getting to 'Yes' requires us to appreciate the wrong-doers, or at least understand the contexts that make them ready to do such terrible things. And sustaining an openness to 'Yes' requires policies that inspire policemen/soldiers/adults/politicians to behave in more caring ways and help

them to see difference as an opportunity to learn and grow. This requires us to recognize that integration requires 'I' to become 'We', and we can all become better at doing this.

'I's' and 'We's' change all the time, but compartmentalized thinking, that comes from failure to appreciate the dynamic nature of the world, imagines they don't. 'I's' and 'We's' interact and overlap and mutually reinforce each other to build networks and communities and new 'tribes'. To do this in a way that produces healthy societies, infrastructure needs to develop social cohesion and action competence. We all need to be skilled at living in the present, mindful of the past but not stuck in it.

We can be liberated from focusing too much on the past OR the future by recognizing that life is much more messy, contextual and paradoxical than theories can ever appreciate. We are all 'actors on a stage' (or stages) where we contribute to the development of 'life's rich tapestry' (or tapestries). From the perspective of any one actor, our individual contributions will be apparent as a linear thread in various tapestries. But a beautiful tapestry contains many different coloured threads – equal but different – woven together to produce patterns that are not attributable to any one thread.

We can all be weavers.

BOXES 1 – 4

Box One: Primary Care as lead for community-oriented integrated practice

In his argument for a 'New Kind of Doctor'[8] Tudor Hart presents data that showed dramatic reduction between 1939 and 1960 in maternal mortality, male death from pneumonia, child death from diphtheria, and all cause deaths.[8[p.13-16]] No longer did primary care practitioners need to focus exclusively on treating life-threatening diseases that were so common in the early 20th century. Specialists can focus on them. Generalists can pay more attention to broader concerns that patients have always brought – bio-psycho-social distress, multiple morbidities, long-term conditions, life transitions, end of life care….

Since the 19th century, UK GPs have been 'gate-keepers' for hospital specialists.[43] This led to a perception in hospitals that GPs were doing the same job as specialists, but not as well. The perception in the general population, however, was that they were doing a different kind of job, and rather well, as John Hunt (1905-1987) pointed out:

> "*Why were so many of them (GPs in the late 19th century) so highly regarded at the time? It was largely because of their strength of character, kindliness, clinical acumen, and wisdom in applying their often empirical knowledge. The deep insight into family life and character remains paramount to this day, so that his role as friend and adviser may still far outweigh, in importance to some families, his purely medical responsibilities*" [44[p.258]]

The idea that a GP could be at the heart of communities, understanding all aspects of health, and also gateway to all things medical has been an expectation, or hope, ever since the 19th century. However, infrastructure and theory to achieve this are recent. In the UK, the 1966 Family Doctor Charter led to funding for practice staff, soon followed by GP vocational training and post-graduate centres. The College of General Practitioners, founded in 1952 was given a Royal charter in 1972, to become the RCGP (Royal College of General Practitioners) - lead for the discipline of generalist medical practice, including training GPs in

the UK. Stimulated by the late, great John Horder, the Leeuwenhorst Working Party in 1974 developed a definition of a GP agreed by eleven European countries:

> *"The general practitioner is a licensed medical graduate who gives, personal, primary and continuing care to individuals, families and a practice population, irrespective of age, sex and illness…… will include and* ***integrate physical, psychological and social factors in his considerations about health and illness****…".*[45]

So, by 1972 it was expected that a primary care practitioner should develop a constructivist mind and routinely weave together a range of different factors to improve health as well as treat diseases. In 1977, other RCGP leaders re-iterated this, writing that a GP is 'a *generalist family physician (who) usually cares for the whole family on a continuing basis…*'[46[p.44]] 'for **all *the diseases and problems that the public consider require skilled help and advice'.***[46[p.36]] They also described help that primary care would provide that has more to do with helping people to <u>flourish</u> than merely <u>treating their illnesses</u> – including support for life transitions like Child Care, Elder Care, Obstetrics, Fertility, Abortion. Also in 1977, the bio-psycho-social model was described to point out that diseases are often caused by a combination of factors rather than single causes assumed by the biomedical model. It was quickly adopted by GPs.

Caring for: '*All the problems that require skilled help'* goes beyond physical diseases and beyond what individual GPs can do. It requires multi-disciplinary primary care teams and systems of care. In the UK a '*primary care led NHS'* was developed in the 1980s - the Griffiths Report (1983), Promoting Better Health (1987), Working for Patients (1989) and the New GP contract (1990). These introduced into the NHS, general management, market principles, and increasing emphasis upon health promotion and disease prevention. Barbara Starfield accelerated interest in a *primary care-led NHS*. She developed a score to measure a country for the strength of its orientation to Primary Health Care as envisaged in the 1996 Ljubljana Charter, demonstrated a strong association between 'low-cost-high-health' and policy that scored high for Primary Health Care orientation.[47]

In the UK, the 1997 Labour government continued the aim for a primary care-led NHS, but *"..the internal market will be replaced by a system we have called 'integrated care', based on partnership and driven by performance."*[48 [secn.1.3]] The 2000 NHS Plan continued the integration theme, aiming to: '*develop partnerships and co-operation at all levels of care – between patients, their carers and families and NHS staff; between the health and social care sector; between different Government departments; between the public sector, voluntary organisations and private providers in the provision of NHS services'.*[49[Secn.8]] 'New Care Models'[50] provided insights into how to achieve this. The role of the GP and the primary care team got even broader. As Hellman put it in 2002:

> *"...the modern GP has multiple, often contradictory roles - not only as medical scientist, but also as educator, priest, beautician, government representative, researcher, marriage guidance counsellor, psychotherapist, pharmacist, friend, relative, financial adviser, as well as anthropologist - intimately familiar with the local community, its needs, traditions, dialects, and ethnic composition."*[51]

Achieving these requires biomedical AND bio-psycho-social models to "*understand how suffering, disease, and illness are affected by multiple levels of organization, from the societal to the molecular*".[52] However, it also requires something else - to help people to make sense of their lives. As Toon puts it… "*(If) the main purpose of health care is to help patients to construct a flourishing narrative, biomedical treatment and biomedical prevention are secondary to the interpretive function*".[53[p.45]]

Toon is arguing that GPs should use the same three ways of thinking (paradigms) described by Guba: Biomedical = positivist = isolated facts. Bio-psycho-social = critical theory = interlinked fact(or)s. Interpretive = constructivist = coherence emerging from complexity. Everyone uses these three ways of thinking/acting/seeing to navigate everyday life. You can test this idea by pausing whatever you are doing and asking: Do I see: 1) Specific individual objects? e.g. specific ingredients with which to make supper. 2) Sets of objects that are connected together? e.g. the

ingredients for my chosen recipe. 3) The process of integrating all the ingredients when preparing the meal? e.g. the recipe, oven, experience, skill, preferences of those I am feeding. These three aspects of life are always there when things are complex.

Complex is not the same as *Complicated*. It means that things are interacting and co-adapting – learning and changing. People of all ages can easily distinguish between Simple, Complicated and Complex phenomena, and use them usefully, when they are working with real-life people in real-life situations with practical tasks. Abstract theory is much more difficult.

Launer makes a similar point about weaving together different 'ingredients' to co-construct a story in his concept of 'narrative-based primary care'. He writes: *"Postmodern thinkers reject the idea that exploring reality is like peeling away the layers of an onion, looking at the inner meaning concealed at the centre. Instead, they see it more like a tapestry of language that is continually being woven*."[41[p.3]]

Outside the GP's consulting room the linear language of *evidence-based medicine* remains dominant. Inside the consulting room the limitation of this approach to address human concerns has long been known. A broader understanding of 'evidence' is now developing. Working with 'patients as partners' – 'meetings between experts'[54] - many GPs use *narrative-based primary care* to make sense of multiple complaints and complex life stories.[40;41] The language remains linear/simple - 'patient-centred medicine' - but the reality in many consulting rooms is complex/emergent - dialogue between equals to make sense of multiple problems informed by, but not driven by, scientific evidence.

To continue a vocation as a generalist health worker at the centre of a community, who cares for the whole family on a continuing basis and is also a gateway *'for all diseases and problems that the public consider require skilled help and advice'*, primary care practitioners of all kinds, including doctors, need to be equally comfortable with treating diseases and facilitating improvements in health, broadly defined. Because of their contact with everyday complexity it makes sense for them to guide the development of community-oriented

integrated practice - through localities outside the consulting room and through narrative-based primary care within it. It makes sense for all citizens to learn this, in order to build a more integrated and healthy world. Children should learn this in primary schools.

Box Two: Reality as an organic, living system – a complex adaptive system

The theory of a linear relationship between research and development - 'R' and 'D' - has been attributed to thinkers from the 'Enlightenment' like Rene Descartes, Charles Darwin and Adam Smith. Their writings suggest that they did not themselves believe in simple relationships between cause and effect. Descartes, to whom the theory of body-mind split has been attributed, believed in an all-powerful God who managed things to do with complexity, mystery and surprise. Darwin, in his theory of natural selection, did not mean by 'survival of the fittest' survival of the most ruthless, but of the most adaptable (whether accidental or designed). Smith, to whom the theory of market forces has been attributed, lived in times when the market-place was a dynamic, creative, haggling place where collaboration and competition were inter-twined. His 'invisible hand' describes the ways forward that open out from multiple-way co-adaptations in a complex adaptive system.
In one way or another, Descartes, Darwin and Smith said that 'soft', organic co-adaptation and uncertainty is a natural aspect of the world; and so is 'hard', linear, control and certainty. The 'real world' involves a dynamic entwinement of both. We can see either or both of these, depending on how we choose to look. And we need to look differently when living life forwards than when researching the past.

Kierkegaard (1813-1855), as Weick reminds us, put it well: "*It is perfectly true, as philosophers say that life must be understood backwards. But they forget the other proposition, that it must be lived forwards*".[57] Too often people imagine that the certainty they see with hindsight is the same as the emergent order that frames living forward. Too often people fail to see that they are caught up in the complexity of life, and make misleading assumptions about what is 'causing' what. Complexity thinking in research, and systems thinking in development, reveal this mistake. They have given rise to a concept that has the power to see dynamic interactions and complex co-adaptation in real-life situations – the 'complex adaptive system'. The term has been particularly associated with Fritjof Capra, Ralph Stacey and Paul Plesk.

Capra writes: *"A living organism is a self-organizing system*[55[p.269]]*…." (that has to) "maintain a continuous exchange of energy and matter with their environment to stay alive."* [55[p.270]] *… "Self-renewal is an essential aspect of self-organizing systems"* [55[p.271]]

The complex adaptive system could become a unifying concept for practitioners and academics because it shows how the natural state of the world is movement, but discrete insights also have value. Discrete insights – 'facts' - are snapshots of more complex stories-in-evolution. Some fact(ors) are linked with others in these stories. This highlights the importance of listening to (more of) the whole story, keeping an open mind about new interpretations, and adapting actions to the specific context, rather than blindly implementing protocols and assuming we know what others mean. The complex adaptive system idea gives us permission to feel uncertain; to expect uncertainty. It reminds us to engage thoughtfully and patiently with difference, expecting the unexpected. It reminds us to trust processes of complex co-adaptation, distrust too much predictability and recognize the truth of the phrase – 'the more you know the more you know you don't know'.

Traditional science helps us to 'see' micro-effects within complex co-adaptation, but that does not make them predictable. For example, Candace Pert has shown that the brain floods the body with polypeptides in response to emotional stimuli, with healing or harmful effects.[58] This might demonstrate that smiling at someone across the street can help to heal their illnesses - but it won't explain why I chose to smile.

Box Three: Health as positive narrative unity - overcoming difficulties with a smile

Often when people use the word 'health' they mean disease – part of the body has become faulty, making someone feel ill at ease – 'dis-eased'. But **Health** is something positive. A healthy person is alert to possibilities, creatively interacts with others, has adventures, smiles and laughs. Being healthy means being alive in the moment, able to make a difference. Health goes beyond words. We often only recognise it with hindsight - after having achieved something we did not think we were capable of. We need a definition of Health that is adequate for its complex and personally-defined nature. And also practical. The Alma Ata definition: '..*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*'[22] signals the important and broad nature of health, but it isn't very practical.

Seedhouse concluded that health is: '*Foundations for Achievement*'[62 [p.61]] This helps to focus attention away from a static measurable 'state' of health towards the dynamic things we do with it. An athlete needs different combinations of physical, mental, spiritual and social health when preparing for a race than when the race is over. In one way or another, health is what we need to meet the challenges encountered in life. Antonovsky agrees. He argued that health is being able to rise above adversity, after observing that some holocaust survivors achieve positive emotional outcomes despite having had experiences that we might expect to break them completely.[59-60] So Health produces a positive and meaningful sense of self.

Taylor and Habermas argue that "*the self is constituted through exchange in language*"[63 [p.509]] and Shotter argues that the "*flow of activity*" in these exchanges causes "*identities of feeling*" and "*common sense*".[64[p.54]] MacIntyre argues that these exchanges have a purpose – to construct unifying stories. He calls it '*narrative unity*'…. *"man is, in his actions and practice, as well as in his fictions, essentially a story-telling animal*"[6 [p.216]] …. *"The self inhabits a character whose unity is given as the unity of a character"*[[p.217]] …"*I am part of their story as they are part of mine*"[[p.218]].

Defining Health as '*positive narrative unity'* brings together the insights of Seedhouse, Antonovsky, Taylor, Habermas, MacIntyre and Shotter. We can imagine that each of us is the lead actor in the 'feature film' that is 'my life story', and a support actor in the 'films' of others. Health means being able to act and interact to shape positive, coherent stories. Stories to be proud of. Health is more about how I engage, than what I have.

Thinking of Health as personal property is a particularly Western idea that emerged in the 18th century Enlightenment. It is often called the 'bio-medical model' because medical doctors emphasize discrete entities – diseases. It is a main obstacle to integrating the work of medical doctors and others (e.g. public health) because they mean different things when they use the word 'health'. Integration requires a more holistic definition of health.

Non-western cultures often use a more holistic definition of health. For example, the 1979 National Aboriginal Health Strategy in Australia used the following definition of health:

"Aboriginal health does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole-life-view. Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and must bring about the total wellbeing of their communities."[65][p.56]

Thinking of health as a *positive narrative unity* has the advantage of being meaningful throughout the twists and turns of life, including difficult or 'unhealthy' times (e.g. we can talk about a 'healthy death'). It also provides a definition that could unite everyone and be practically useful – everyone can contribute to positive developments, whether mental, physical, social or spiritual. However, the term can sound clumsy and academic. It might be better to use more familiar language for practical purposes. We can use language to describe **how we feel** - like happiness, love and fun; **things we can do** - like empower, help and give; **things we can imagine** - like vision, belief and hope. But in really difficult situations we may need to revert to the deeper meaning of positive narrative unity - for example, at end of life we may choose not to treat pneumonia when someone's life story is complete, or treat if something is unfinished (e.g. not having said goodbye to a friend).

Box Four: Leaders as Sensemakers – facilitating co-evolution of forests and trees

The machine image of the world leads to a belief that change happens in mechanical, 'linear' ways – direct and predictable effects of purposeful action. Consequently, a leader is imagined to be a hero who walks ahead of 'followers' to lead them to the correct place. This idea of leadership does not work well with the image of the world as a complex adaptive system and health as a positive narrative unity, where complexity, uncertainty and co-adaptation means that there is no 'correct place'. In this context, leaders are sense-makers[66] – they facilitate processes that help people to stand back and make sense of their lived experiences in the light of 'bigger pictures', then take collaborative actions to move forwards in good-enough directions; then later get them to again stand back and review the distance travelled, long-term vision and next steps that are in good-enough directions.

Learning Organization theory shows how to help people from all parts of a system make sense of complexity and move forwards in good-enough directions. Senge describes five disciplines (Team Learning, Building Shared Vision, Mental Models, Personal Mastery and Systems Thinking).[31] Argyris & Schon describe a) Single-loop, b) Double-loop and c) Deutero-learning.[32] Their three types of learning resonate strongly with Guba's three paradigms of evaluation. Single-loop learning, like Positivism, is concerned with separate, objective facts. Double-loop learning, like Critical Theory, is concerned with inter-connected fact(or)s in a unique context. Deutero-learning, like Constructivism, is concerned with learning from experience - '(it) *sometimes refers to a process of collaborative inquiry and reflection and sometimes to the structures, policies, and techniques facilitating that process*…. (and/or) *Argyris & Schon's theory of action framework*….. (and/or) *aspects of adaptive behavior, context, and relationship.*[67] These three paradigms also chime with the complexity theory distinction between 'simple', 'complicated' and 'complex' phenomena.

From these different bodies of knowledge comes the same idea – three different lenses see different and equally valuable aspects of the melting pot of life. Even the three Christian faces of God (Father, Son and Spirit) and Donabedian's three categories of Change (Structure, Process and Outcome) – echo these paradigms. All three paradigms are

needed to co-create positive stories within community-oriented integrated practice. If we are to stimulate **positive** social change we need all three. Cycles of collective learning and coordinated change can use them, as in 4th generation evaluation,[12] with embedded large group events, to enable large numbers of people to learn from and with each other at the same time, and so collectively move forwards multiple, interconnected stories.

Why these three paradigms exist is an interesting question, beyond this paper. Are they properties of the world or is this how our minds construct ideas? One possibility is they come with a sense of self – 'I' stimulates a sense of connection with 'Other' to make 'We'.

Transactional Analysis (TA) shows us that a healthy relationship beween 'I', 'Other' and 'We' develops from positive, respectful 'play'. TA defines three 'ego states' – 'parent', 'adult' and 'child' (another example of those three paradigms) - that we move between to play 'games'.[68] One person speaks from one ego state and indicates the ego state he/she expects the other to respond with; the other responds from that expected ego state and switches the conversation to indicate the ego state he/she expects the other to respond with. This continues until a 'punch-line' appears that indicates the end of the game. 'Good' conversations result in a sense of 'I'm OK; You're OK'[69] that gives a feeling of positive energy, equality and solidarity (and laughter). Conversations that get stuck in 'linear' transactions (to and from the same ego state) and crossed transactions (responding in a different ego state than indicated), feel manipulative and boring (NOT equal).

Repeated, creative, positive interactions, that treat 'other' as equal, change 'I' into 'We'. They bind people together. This approach to social interaction is to be found in Buber's distinction between 'I-Thou' and 'I-It'[70] and Freire's 'problem-posing education' where learning happens less from transfer of information and more from a shared struggle to build a just world – where teacher and student "*become jointly responsible for a process in which all grow*".[71[p.80]] Maybe, community-oriented integrated practice can help us to rediscover, in modern terms, ancient wisdom about spirituality and love where people combine self-interest with respect for 'other'; where people thirst for equality; where people appreciate mystery,

uncertainty and positive change; where people are good custodians of this beautiful planet. Leadership should stimulate all of this.

References

1. Thomas P. *Collaborating for Health.* Abingdon: Routledge; 2018.
2. Chandok R, Baynes K, Willis T, Birnbaum M, Unadkat N. Collaborating for improving diabetes care in Ealing, London: a time for cautious optimism, years 2011 to 2018. *Practical Diabetes.* 2019;36(5):1-7.
3. Unadkat N, Evans L, Nasir L, Thomas P, Chandok R. Taking diabetes services out of hospital into the community. *London Journal of Primary Care*. 2013;5(2):87-91. https://doi.org/10.1080/17571472.2013.11493386 .
4. Chandok R, Unadkat N, Nasir L, Evans L, Thomas, P. How Ealing Health Networks can contribute to efficient and quality healthcare. *London Journal of Primary Care*. 2013;5(2): 84-86. https://doi.org/10.1080/17571472.2013.11493385
5. Thomas P. *Integrating primary health care, leading, managing, facilitating*. Oxford: Radcliffe Publishing; 2006.
6. Kark SL. *The Practice of Community-Oriented Primary Health Care*. New York: Appleton-Century-Crofts; 1981.
7. Ashton J, Seymour H. *The New Public Health*. Milton Keynes: Open University Press; 1988.
8. Tudor Hart, J. *A new kind of doctor*. London: Merlin Press; 1988.
9. Wikipedia. *Healthy Cities*. https://en.wikipedia.org/wiki/Healthy_city. Accessed 14 Oct, 2020.
10. National Health Service. *New Care Models*. www.england.nhs.uk/ourwork/new-care-models/. Accessed October 14, 2020.
11. Meads G. *Primary Care in the Twenty-First Century: an international perspective*. Abingdon: Radcliffe; 2006.
12. Guba E, Lincoln Y. *Fourth generation evaluation*. Newbury Park, California: Sage; 1989.
13. Guba E. *The Paradigm Dialog.* Newbury Park: Sage; 1990.
14. Parlett M and Hamilton D. *Evaluation as illumination: a new approach to the study of innovatory programmes.* Occasional Paper No 9. Edinburgh: Centre for research in the educational sciences; 1972.
15. Cummings S, Bridgman T, Brown KG. Unfreezing change as three steps: Rethinking Kurt Lewin's legacy for change management. *Human Relations*. 2016;69(1):33-60. https://doi.org/10.1177/0018726715577707
16. Passmore W, Bunker BB. et al. Large Group Interventions. *Journal of Applied Behavioral Science.* 1992;28(4).
17. Cambridge Dictionary. Meaning of Policy. Cambridge University Press. 2020. https://dictionary.cambridge.org/us/dictionary/english/policy. Accessed 14 Oct 2020.
18. Kretzmann J, McKnight J. *Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. 3rd ed. Chicago, IL: ACTA; 1993.
19. Durkheim E. *The Division of Labor in Society.* Translated by Halls WD. Intro by Coser LA. New York: Free Press; 1997.
20. Putnum RD. Bowling Alone: America's Declining Social Capital. *Journal of Democracy.* 1995;6(1):65-78. doi:10.1353/jod.1995.0002.
21. Video: Southall Initiative for Integrated Care. https://www.youtube.com/watch?v=-u40x7-76iU&feature=player_detailpage
22. World Health Organization. *Declaration of Alma-Alta.* 1978. https://www.who.int/social_determinants/tools/multimedia/alma_ata/en/. Accessed 14 October, 2020.
23. Macdonald JJ. *Primary Health Care – Medicine In Its Place*. London: Earthscan Publications Ltd; 1992.
24. Chan M. Director General's Message. The World Health Report 2008. *Primary Health Care - Now More Than Ever.* World Health Organization. 2008. https://www.who.int/whr/2008/en/. Accessed October 14, 2020.

25. Wang X, Sun X, Gong F, Huang Y, Chen L, Zhang Y, et al. The Luohu Model: A Template for Integrated Urban Healthcare Systems in China. *International Journal of Integrated Care*. 2018;18(4),3:1–10. DOI: https://doi.org/10.5334/ijic.3955
26. Nurjono M, et al. Implementation of Integrated Care in Singapore: A Complex Adaptive System Perspective. International Journal of Integrated Care, 2018;18(4):4,1–7. DOI: https://doi.org/10.5334/ijic.4174
27. Breton M, Maillet L, Haggerty J & Vedel I (2014) Mandated Local Health Networks across the province of Québec: a better collaboration with primary care working in the communities? *London Journal of Primary Care*. 2014;6(4):71-78. https://doi.org/10.1080/17571472.2014.11493420.
28. Breton M, et al. Multiple Perspectives Analysis of the Implementation of an Integrated Care Model for Older Adults in Quebec. *International Journal of Integrated Care.* 2019; 19(4):6,1–13. DOI: https://doi.org/10.5334/ijic.4634
29. Checkland P. *Systems Thinking, Systems Practice*. Chichester: John Wiley & Sons Ltd; 1993.
30. Schumaker EF. *Small is Beautiful*. London: Abacus; 1974.
31. Senge PM. The fifth discipline: the art and practice of the learning organization. New York:Doubleday/Currency;1990.
32. Argyris C, Schon DA. *Organizational learning 2 - Theory, method and practice*. USA: Addison Wesley; 1996.
33. Foote Whyte W (ed). *Participatory Action Research*. Newbury Park: Sage Publications; 1991.
34. Buzan T. *The Power of Creative Intelligence*. London: Thorsons; 2001.
35. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Quarterly. 2005;83(3):457-502. doi: 10.1111/j.1468-0009.2005.00409.x. PMID: 16202000; PMCID: PMC2690145.
36. Heath I. *The Mystery of General Practice.* London: Nuffield Provincial Hospitals Trust; 1995.
37. Griffiths F,.Byrne D. General practice and the new science emerging from the theories of "chaos" and complexity. *Br J Gen Pract.* 1999;48:1697-9.
38. Kernick D*. Complexity and Healthcare Organisation - a view from the street*. Abingdon: Radcliffe Medical Press; 2004.
39. Thomas P. Primary care professionals need to be aware of the theories on which our work depends. *Annals of Family Medicine*. *Annals of Family Medicine.* 2006;4:250-454.
40. Greenhalgh T. Narrative based medicine in an evidence based world. *BMJ. 1999;*318(7179);323–325. https://doi.org/10.1136/bmj.318.7179.323
41. Launer J. *Narrative-based Primary Care. A practical guide*. Oxford: Radcliffe Medical Press; 2002.
42. National Health Service. *NHS Long Term Plan 7January 201*9. https://www.longtermplan.nhs.uk/. Accessed 15 October, 2020.
43. Hannay D. Undergraduate Medical Education and General Practice. Chapter 7 page 167. In Loudon I, Horder J, Webster W eds. *General practice under the National Health Service 1948-1997*. London: Clarenden Press; 1998.
44. Horder J (ed). *The Writings of John Hunt.* Exeter: RCGP; 1992.
45. Horder J. Developments in Other Countries Chapter 11 page 258. In Loudon I, Horder J, Webster W eds. *General practice under the National Health Service 1948-1997*. London: Clarenden Press; 1998.
46. Loudon I, Fry J, Howie J, Pollak M, Thompson K, Lloyd G *et al*. *Trends in General Practice.* London: RCGP; 1977.
47. Starfield B. *Primary care - balancing health needs, services and technology.* Oxford: Oxford University Press; 1998.
48. Department of Health. The new NHS: Modern. Dependable. The (UK) Stationery Office; 1997. Accessed May 13, 2021.
49. Secretary of State for Health. *The NHS Plan: a plan for investment; a plan for reform.* 2000. London, HMSO.

https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960. Accessed May 13, 2021.
50. NHS. New Care Models. https://www.england.nhs.uk/new-care-models/. Accessed May 13, 2021.
51. Helman C. The culture of general practice. *Br J Gen Pract.* 2002;**52**:619-20.
52. Borrell-Carrió F, Suchman AL, Epstein RM. The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry. *Ann Fam Med*. 2004;2(6):576–582. doi: 10.1370/afm.245.
53. Toon P. *A Flourishing Practice?* London: Royal College of General Practitioners; 2014.
54. Tuckett D, Boulton M, Olson C, Williams A. *Meetings between experts.* London and New York: Tavistock Publications; 1985.
55. Capra F. *The Turning Point; science, society and the rising culture.* New York: Bantam Books; 1983.
56. The Health Foundation. *Complex Adaptive Systems.* August 2010. Available from: https://www.health.org.uk/publications/complex-adaptive-systems. Accessed October 14, 2020.
57. Weick KE. That's moving: Theories that matter. *Journal of Management Inquiry*. 1999;8(2):134-142.
58. Pert C. *Molecules of Emotion*. London: Simon & Schuster (Pocket Books);1999.
59. Antonovsky A. *Health, Stress and Coping.* San Francisco: Jossey-Bass; 1979.
60. Antonovsky A. *Unravelling The Mystery of Health - How People Manage Stress and Stay Well*. San Francisco: Jossey-Bass; 1987.
61. MacIntyre A. *After Virtue: a study in moral theory.* 2nd edition. London: Duckworth; 1985.
62. Seedhouse D. *Health: The Foundations for Achievement.* Chichester: Wiley; 1986.
63. Taylor C. *Sources of the Self – the Making of the Modern Identity.* Cambridge: Arcata Graphics; 1989.
64. Shotter J. *Conversational Realities - Constructing Life through Language*. London: Sage; 2000.
65. Telethon Institute for Child Health Research/Kulunga Research Network, in collaboration with the University of Western Australia. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. National Aboriginal and Islander Health Organisation Editors: Pat Dudgeon, Helen Milroy and Roz Walker. 2014 2nd edition.
66. Weick KE. *Sensemaking in Organizations*. Thousand Oaks: Sage; 1995
67. Visser M. Deutero-learning in organizations: a review and a reformulation. *Academy of Management Review*. 2007;32(2): 659–667.
68. Berne E. *Games People Play: The Basic Handbook of Transactional Analysis.* New York: Ballantine Books: 1964.
69. Harris TA. *I'm OK – You're OK*. New York: Harper Collins; 2004.
70. Buber M [1878-1965] (translated by Smith RG). *I and Thou.* London: Bloomsbury Academic; 2013 (Kindle location 188-190) [original 1923].
71. Freire P. *Pedagogy of the Oppressed*. London & New York: The Continuum International Publishing Group Inc; 2003.
72. Thomas P et al (29 authors). Evaluating case studies of community-oriented integrated care. *London Journal of Primary Care*. 2018;10(4):73-81. https://doi.org/10.1080/17571472.2018.1477455.
73. Levin LS, Idler EL. *The Hidden Health Care System.* Golden Apple Publications; 2010.
74. Levin LS, Katz AH, Holstein E. *Self-Care*. London: Crook Helm; 1977.
75. National Health Service. *Primary Care Networks: Frequently Asked Questions.* 5 July 2019. https://www.england.nhs.uk/publication/primary-care-networks-frequently-asked-questions/ Accessed October 14 2020.
76. Ferlie E. Public management 'reform' narratives and the changing organisation of primary care. *London Journal of Primary Care.* 2010;3(2):76-80. https://doi.org/10.1080/17571472.2010.11493306 .

77. Tzortziou-Brown V et al. New ways of working; delivering better care for people with long-term conditions, London Journal of Primary Care. 2017;9(5):60-68. https://doi.org/10.1080/17571472.2017.1361619
78. Whitehouse P. The music of trees: the intergenerative tie between primary care and public health, London Journal of Primary Care. 2016;8(2):26-29. https://doi.org/10.1080/17571472.2016.1152100
79. Gallimore C, Davies S, Maskell K, Allinson D, Bailey R, Bates F, Reed J. The Adventurous School, London Journal of Primary Care. 2013;5(2):114-118. https://doi.org/10.1080/17571472.2013.11493393
80. Clarke S. The Lime Tree School endeavour: healthy body, brain and heart. *London Journal of Primary Care*. 2013;5(2):111-113. https://doi.org/10.1080/17571472.2013.11493392
81. Whitehouse PJ. InterWell: an integrated school-based primary care model. *London Journal of Primary Care*. 2013;5(2):106-110. https://doi.org/10.1080/17571472.2013.11493391
82. Thomas P, Gnani S, Banarsee R. (2013) Achieving University Linked Localities through Health Networks. *London Journal of Primary Care*. 2013;5(1):12-13. https://doi.org/10.1080/17571472.2013.11493363
83. Gary Bratchford G, Giotaki G, Wewiora L. Socially engaged photography and wellbeing: reflections on a case study in the northwest of England. *London Journal of Primary Care*. 2018;10(4):82-88. https://doi.org/10.1080/17571472.2018.1477439
84. Robert Winston & Rebecca Chicot (2016) The importance of early bonding on the long-term mental health and resilience of children. *London Journal of Primary Care*. 2016;8(1):12-14. https://doi.org/10.1080/17571472.2015.1133012
85. Meehan L, Banarsee R, Dunn-Toroosian V, Tejani S, Yazdi A. (2018) Improving outcomes for patients discharged early using a home assessment scheme. *London Journal of Primary Care*. 2018;10(3):62-67. https://doi.org/10.1080/17571472.2018.1489467
86. Riley SG, Pettus KI, Abel J. The buddy group – peer support for the bereaved. *London Journal of Primary Care*. 2018;10(3):68-70. https://doi.org/10.1080/17571472.2018.1455021
87. Michie C, Ng KYB, Doucet S. Breastfeeding will reduce many NHS budgets. *London Journal of Primary Care*. 2015;7(4):61-65. https://doi.org/10.1080/17571472.2015.11493436
88. Hallam S, Creech A. Can active music making promote health and well-being in older citizens? Findings of the music for life project. *London Journal of Primary Care.* 2016;8(2)21-25. https://doi.org/10.1080/17571472.2016.1152099