

integrating primary health care

LEADING, MANAGING, FACILITATING



Paul Thomas

FOREWORDS BY
MAYUR LAKHANI,
KURT C STANGE AND
DAVID COLIN-THOMÉ

Integrating Primary Health Care

Leading, Managing, Facilitating

Paul Thomas

*Professor of Primary Care Research, Education and Development
Centre for the Study of Policy & Practice in Health and Social Care
Thames Valley University*

Forewords by

Mayur Lakhani

Kurt C Stange

and

David Colin-Thomé

Radcliffe Publishing

Oxford • Seattle

Radcliffe Publishing Ltd
18 Marcham Road
Abingdon
Oxon OX14 1AA
United Kingdom

www.radcliffe-oxford.com

Electronic catalogue and worldwide online ordering facility.

© 2006 Paul Thomas

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the prior permission of the copyright owner.

Paul Thomas has asserted his right under the Copyright, Designs and Patents Act, 1998, to be identified as Author of this Work.

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library.

ISBN-10 1 85775 662 2

ISBN-13 978 1 85775 662 3

I dedicate this work to the memory of Mario Kawayawaya. A one-time expert elephant poacher in Southern Zambia, he became a facilitator to preserve the African elephant. We debated facilitation methods in a series of conversations in 1994. I learnt that what he had to do to help local people, police and poachers to see each other's points of view and work together was very similar to what I had to do to develop primary care in England. In May 2004 he was paddling his canoe along the Kafue river when his spleen ruptured from malaria.

He died. Zambia lost a fine facilitator.



Taylor & Francis

Taylor & Francis Group

<http://taylorandfrancis.com>

Contents

Forewords	x
Preface	xiv
About the author	xvi
Acknowledgements	xvii
How to use the book	xviii
What I mean by . . .	xx
Part I: Why integrated primary health care is important	1
1 Mapping the territory	3
Summary	3
Is this book for you?	4
What is leadership for integrated primary health care?	7
What leadership theorists say	9
The author's story	12
The need for better theory	13
References	18
2 New ways of thinking about leadership	21
Summary	21
Leaders help stories to unfold	22
Leaders build an infrastructure of facilitation and communication	24
Leaders facilitate synchrony between different forces for change	26
An image: interactive jugglers	27
A model: entering and exiting a system	29
References	33
3 The extraordinary potential of primary care organisations	35
Summary	35
A worldwide need for integrated primary health care	36
Obstacles to achieving integrated primary health care	37
What is whole-system learning and change?	38
Where should we look for leadership for whole-system learning and change?	43
Interdependence of individuals and communities	46
References	47
Part II: Developing your leadership skills	49
4 Moving the story forward	53
Summary	53
Choose your case study: facilitating a shared understanding of the story	55

An image of leadership: Mary Poppins	56
A model of leadership within complex situations	58
Examples of change as play	58
Things you can do to help the story evolve	61
<i>Anticipate your future support needs</i>	
<i>Appraise situations quickly</i>	
<i>Initiate whole-system conversations</i>	
<i>Develop networks of high-performing teams</i>	
Exercises	66
Revisit your case study	67
References	67
5 Helping people to enquire and learn together	69
Summary	69
Choose your case study: developing shared plans for action	71
An image of teacher: Paulo Friere	72
A model that connects individual and team learning with action for change	74
Examples of learning spaces in primary care	76
Things you can do to help people to enquire and learn together	78
<i>Facilitate whole-system events</i>	
<i>Institutionalise cycles of enquiry</i>	
<i>Surface mental models</i>	
<i>See things through other eyes</i>	
Exercises	83
Revisit your case study	84
References	84
6 Infrastructures that facilitate ongoing learning and change	87
Summary	87
Choose your case study: building infrastructures for ongoing learning and change	89
An image of inter-organisation innovation: a carnival	91
A model of connected learning spaces	93
Examples of infrastructures that facilitate ongoing learning and change	94
Things you can do to build infrastructures for ongoing learning and change	95
<i>Create coalitions for ongoing political support</i>	
<i>Build system maps and timetables</i>	
<i>Connect 'nodes' in a system</i>	
<i>Use backwards mapping to develop strategy</i>	
Exercises	100
Revisit your case study	101
References	101
7 Having the right information at the right time	103
Summary	103
Choose your case study: anticipating what knowledge you will need, and when	104
An image of multiple complementary insights: the case study	107

A model that frames a breadth of understanding	108
Examples of complementary insights that help to make sense of an evolving story	108
Things you can do to have the right information at the right time	111
<i>Devise a personal knowledge retrieval system</i>	
<i>Design multi-purpose databases</i>	
<i>Coordinate the timelines of multiple related projects</i>	
<i>Nurture the stewards of organisational memory</i>	
Exercises	117
Revisit your case study	118
References	118
8 Looking after yourself	119
Summary	119
Your case study revisited: attaining personal balance	121
Images that hold creative tensions	121
A model of self-development: a flotilla of boats	122
Examples of things that facilitate balance	123
Things you can do to remain buoyant in the moment	123
<i>Use images and phrases that keep you alive in the present</i>	
<i>Deal with projection</i>	
<i>Convert bad into good</i>	
<i>Run off the ball</i>	
Exercises	128
Revisit your case study	129
References	130
Part III: Theories of integration	131
9 What can we learn from ‘comprehensive primary health care’?	137
Summary	137
What is comprehensive primary health care?	137
A pull towards linear thinking	140
A pull towards whole-system thinking	141
A need for combined linear and whole-system thinking	143
Implications for primary care organisations	145
References	146
10 Where is general practice heading?	147
Summary	147
Origins of general practice: 1858–1948	147
From diseases to whole people in families and communities: 1948–1978	148
From practitioners to practices, institutions, networks and systems: 1978–2006	150
Choices for future general practice?	152
Implications for primary care organisations	154
References	154
11 Towards an integrating theory of knowledge	157

Summary	157
A brief clinical encounter	158
Positivism, critical theory and constructivism reveal different kinds of insight	159
What you see depends on how you look	161
An epistemology of common sense	162
Implications for primary care practice, management and enquiry	163
References	164
12 Towards an integrating theory of health	165
Summary	165
Health is the foundation for achievement	166
The meaning of meaning	166
Identity construction	168
Each person is the lead actor in the feature film that is his or her life story	169
Finding win-win	170
Implications for society	171
References	171
13 Reconciling linear and systems thinking	173
Summary	173
Facilitating for surprise	174
Three dimensions of learning in learning organisations	175
From whole-system transformation to multiple incremental revolutions	179
From incremental revolutions to ongoing whole-system transformation	181
Primary care organisations as learning communities	183
Conclusions	183
References	187
Part IV: Techniques that integrate linear and systems thinking	189
14 Mapping the system of concern	191
Summary	191
Brainstorming and rainboding	191
<i>Listing things in a fast 'storm of the brain', then drawing connections between them</i>	
Nominal grouping with sticky squares or magnetic hexagons	193
<i>Clustering things together, and devising pathways between the clusters</i>	
Force-field analysis	194
<i>Analysis of power and influence in one particular focus</i>	
Drawing a complex power diagram	195
<i>Producing a map of how different factors, including people and organisations, affect each other</i>	
Drawing your life-line	196
<i>A description of what happened when and why</i>	

15 Whole-system events	199
Summary	199
Future search conference	200
<i>Helps a diverse group of people to explore their past, present and desired futures, as a back-drop to agreeing a shared way forward</i>	
Open space technology	201
<i>Forms self-organising groups that deal with complex overlapping issues and develop sets of coordinated action plans</i>	
References	202
16 Facilitating learning in groups	203
Summary	203
Switching between chairing and facilitating a meeting	204
Checklist for a meeting	204
<i>A list of easy-to-forget things</i>	
Centring the learning space: the story, energisers, ground rules, evaluation	206
Small-group–large-group iterations	207
<i>Connecting the intimacy of small-group reflections with whole-group consensus</i>	
17 Seeing things through different eyes	209
Summary	209
Personal visualisation	209
<i>Rehearsing in your mind what you will do in real life</i>	
Vision workshop	211
<i>Groups of people go on an imaginary journey into the future and later describe the insights they gain</i>	
Role-play, scenarios and simulations	212
<i>A facilitator sets a scene in which people adopt unfamiliar roles. They rehearse the scene, or a sequence of scenes, then de-role and discuss what insights they gained</i>	
Fish bowl	213
<i>A small number of people in a circle discuss something of importance, surrounded by observers. Rules govern entering and exiting the bowl</i>	
References	214
18 Interviewing for team players	215
Summary	215
Assessing shared leadership skills	215
In-tray tests	217
A final word	219
Index	221

Foreword

This is a sophisticated book that addresses the important issue of integration in health care. It is particularly timely coming as it does in the context of the new health and social care White Paper for England, *Our Health, Our Care, Our Say*, which signals a decisive shift away from hospitals to primary care. But this begs a question: how can primary care be developed to respond to all that is being asked of it? This is a critical question for the health community. One thing is for sure – it will not happen by chance! The improvements that patients need require the extraordinary potential of primary care to be realised. This will require a major cultural change and support for the primary care community to deliver. The ingredients necessary for this exciting transformation are described in this book.

Paul Thomas's book contains information about leadership, transformation, facilitation, support, systems development, learning organisation and much more. I am in no doubt that effective integrated primary health care is the answer to many of the problems facing health care worldwide. But a lot of lip service is paid to integration in health care. What is integration? What does it look like? How do you know you have got it? It is a word like 'teams' that is bandied around with superficial discussion. This book changes this: it offers a comprehensive analysis of the theory and practice of integration in health care. The author argues powerfully for the need for approaches that include both vertical and horizontal integration.

This is one of the most powerful books I have read. It offers well reasoned and researched ideas for improving primary care. Above all what comes through is the author's sense of passion about the subject and issues, and a sense of credibility from having being in the front line and undertaken practical work in the area.

This is a serious book tackling a serious subject. In my view it is required reading for anyone interested in or involved in primary care development.

As a practising GP, I know the problems that my patients face. As Chairman of the RCGP, and with experience of being a leader in primary care organisations, I am well aware of the problems facing general practice. Through extensive practice visits I have come to the conclusion that general practice needs to become more strategic. If we are to fulfil our 'extraordinary potential' that Paul Thomas writes about, then general practice-based primary care has to move 'up a gear'. Key to this is to develop strategic learning organisations in primary care.

The Royal College of GPs was established in 1952 and is charged with promoting the highest possible standards of general medical practice. I am particularly pleased to welcome this book as the author is also the chairman of one of the college's faculties.

The college is in the business of driving up standards, and core to this is the development of optimal team working and skill mix. GPs are the backbone of the NHS. Most GPs I meet wish they had longer consultation times, responsive access

systems and could promote greater patient enablement. To achieve this we have to think creatively about the organisation of primary health and social care and Paul's book helps us do just that.

Dr Mayur Lakhani FRCGP
Chairman
Royal College of General Practitioners
January 2006

Foreword

This is an important book. It is important because of the *ideas* it contains, the *time* in which it appears, and the *grounding* of the ideas in rich practical lived experience and in theory. Readers of this book will be well-armed to make sense of challenging paradoxes and to work to improve health care and health. Although focused on primary care, health care systems and community, this work is relevant to anyone trying to bring together individuals and groups to become learning organizations moving toward a larger end.

The *ideas* in this book show very practical and realistic ways to bring together individuals and groups to become whole systems – learning organizations moving toward an emerging shared goal. Uniquely, the book is about how multiple systems can interact and evolve together toward a better whole. The first and third parts of the book help us to understand the potential of integrated primary health care and to think differently about how it really works. The second and fourth sections show us how to act on that understanding to effect change. Throughout, the author stimulates us to deepen our learning and actions by applying the ideas to our own experience.

The *time* is right for these ideas. We are experiencing a crisis of fragmentation in health care. Although we vaguely recognize the complexity of health care, as individuals and as organizations we act as if working harder on the parts is somehow going to improve the whole. It has not and will not. The phenomena of health and health care are too complex to be understood and improved solely by linear thinking. In this book, Professor Thomas shows us how we are all leaders of change, and how by working on our parts, while appreciating and developing their essential interconnectedness, we can improve the whole.

This book is *grounded* in the author's deep experience as a facilitator of whole systems change. He presents an explanatory theory that is breathtakingly integrative yet immensely practical. It is all the more powerful because it is deeply grounded in personal experience. Practice without theory is unable to move beyond isolated experiences to draw the overarching lessons. Theory without practice blinds us to the ways of knowing that don't fit our paradigm. Professor Thomas's work to discover theories that fit his radical experience of systems change gives us new ways of thinking and acting that bring together both practical experience and overarching lessons.

Join me in using this book as a springboard to 'travel hopefully' together toward integrated, equitable and effective health care.

Kurt C Stange MD, PhD

Editor, *Annals of Family Medicine*

Gertrude Donnelly Hess, MD Professor of Oncology Research

Professor of Family Medicine, Epidemiology & Biostatistics, Sociology and Oncology

Case Western Reserve University

Cleveland, Ohio, USA

January 2006

Foreword

This is a 'must-read' book if you are in any way involved in the development of primary care. It has something for everyone – both practical and theoretical – with an appropriate focus on an underpinning philosophy. I particularly enjoyed reading Part III, but would recommend that, first, read the whole and then focus on relevant parts for future use. The book is very well cross-referenced.

Integrating Primary Health Care is extremely relevant to the present as well as the future, given the centrality of primary care and health care in many countries. All primary care organisations (including general practice) have populations for which they are responsible. They should all be viewed as resources for their communities: delivering high-quality bioclinical care while addressing broader community needs.

The English White Paper links primary health care, public health and social care. This book references and explores the Alma Ata declaration and I believe that we in primary care, in particular now in England, have a unique opportunity to deliver on this declaration by linking treatment, care, the enablement of individuals and addressing the social determinants of health.

I particularly like the author's view that if we are to deliver on such an agenda we need to embrace managerial approaches that traditionally are perceived as inimical. For instance, Paul Thomas cites the need for both linear management and system reform. I suggest that other related areas which are seen as in conflict similarly need to be embraced: transactional and transformational leadership and, at a practical level, that urgent and planned care are inextricably linked. In a similar vein, I do not see localities as the only way forward for practice-based commissioning. We need a more 'organic' approach, in which activity can be based at either practice or locality level depending on what is best for patients. As is much quoted: form should follow function.

I write in a personal capacity as a general practitioner, a Department of Health worker (for England), and as a colleague and a friend of the author. I have been fortunate to be a small part of Paul's journey of discovery. This excellent book, which I thoroughly recommend, is a fitting product of that journey. Knowing the author there will be more.

David Colin-Thomé
National Clinical Director for Primary Care, Department of Health (England)
General Practitioner, Castlefields, Runcorn, Cheshire
January 2006

Preface

My childhood in South Wales taught me that communities and individuals grow together. Economic hardship and high levels of disease can also be associated with strong community identity, friendship and song. The social role of the general practitioner (GP) was also obvious to me. My father, a GP who worked alone, would watch from our house the crowds leaving the football ground, observing his patients and anticipating who would knock on his door later in the week. Once when there was a smallpox scare but no vaccine he ordered his own supply from Cardiff and travelled there to buy it, rather than wait for the local Executive Council to provide it. He and my mother immunised queues of people in the street for no charge. I was eight when he died, and, two years later, my mother took me to England with my older brother and four younger sisters. The seeds that led to this book were planted at an early age.

At school I became enthralled by relativity theory and puzzled how it was that things can, at the same time, have tangible, objective form and also be made up of dynamic energy. An interest in what lies beyond the immediately visible has been with me ever since. As a GP myself I often ask patients what they make of their symptoms and what is the best thing to do. I often receive wise and thoughtful answers that make me realise the power of 'common sense' – a sophisticated process of pattern recognition. I also witness the extraordinary ability of the human mind to overcome all kinds of adversity, and the need we all have for trusted relationships to define ourselves.

But I was trained to think in straight lines about compartmentalised problems: discrete diseases are caused by malicious agents that laboratory science can defeat. This training offered me little insight into the interplay of forces that improve health in most situations. My training also expects me to listen and reflect, solely to get to a correct diagnosis or to ensure patient compliance. I also recognise that listening and reflection can reveal hidden worlds of meaning that are barred from me if I assume in advance what I am going to find.

It was as primary care facilitator in Liverpool that I recognised that hidden worlds of meaning powerfully affect what happens in all human situations. When working across boundaries it became clear to me that different people use words to mean different things, and what they really mean is often hidden even from themselves. I often found it easier to make progress by putting aside words and theories, and getting people to play together and create shared 'win-win' projects. I slowly found resonance with the ideas about change I was developing – in complexity and systems theories, organisational learning and narrative. Slowly I began to see coherent patterns within dynamic interactivity, like a beautiful form of music whose beat and harmonies are new, but also very familiar and human.

I came to see that quality comes from reflecting one thing against another in search of coherence – reflecting internal against external realities, subjective against objective interpretations and theory against practice. This helps to avoid assumptions. It promotes active listening and ongoing learning. It helps to

recognise that the more you know the more you know you don't know. It reminds us that the path ahead is uncertain and we have to work hard to make it meaningful.

Finding a meaningful path through uncertainty is what leaders do in complex situations. Will Miller gave me an image to illuminate this. It is the walk of the Lenape Native American Indian. Balanced and relaxed on one foot, alert and listening with all the senses, progress is achieved by cautiously testing the safety of the ground ahead with the toes of the other foot. When it seems safe, a step is softly taken, slowly transferring weight onto the front foot. The front foot is now the one balanced in safety. Again listening with all the senses, and communicating with groups of colleagues about the overall direction, each prepares their next step in their own individual but connected way.

I wish you an enjoyable walk.

Paul Thomas
January 2006

About the author

Dr Paul Thomas graduated at Bristol University in 1979. In 1986 he became a general practitioner (GP) at Princes Park Health Centre, Toxteth, Liverpool, which is famous for its community involvement and patient participation. In 1989 he became a primary care facilitator for Liverpool Family Health Services Authority and translated the holistic ideals of his practice – of multidisciplinary learning – into multiple models throughout the city, working closely with the Liverpool Healthy City 2000 project.

In 1996 Paul was appointed as senior lecturer at Imperial College in London, from where he set up the West London (Primary Care) Research Network and chaired the Advisory Group for the National Primary Care Facilitation Project. In 2003 he was awarded a MD for his thesis: whole-system learning and change – the role of primary care research networks. In 2004 Paul was awarded Fellowship of the Royal College of General Practitioners (RCGP). In his role as Chair of the North and West London Faculty of the RCGP and as a professor at Thames Valley University he continues to develop leadership programmes for integrated primary care.

Acknowledgements

I learnt how to do most of this in Liverpool. I owe thanks to the thousands of people in the hundreds of teams with whom I worked in those 10 years. In particular, I remember with affection the contributions to my learning of members of the Primary Care Facilitation Project, Medical Audit Advisory Group and the practice teams with whom we worked. I remember teams from Princes Park Health Centre, Liverpool Health Authority and the Family Health Services Authority, the Liverpool Occupational Health Project, local multidisciplinary facilitation teams, the Teambuilding Workshop Local Organising Group, the Healthy City 2000 Project, the Heart Disease Strategy Group, the Liverpool City of Learning, Age Concern, the community health council, Open Eye Film and Video Gallery, the John Moores Centre for Health Studies, and Liverpool University departments of General Practice, Public Health and Nursing. I enjoyed finding like-minded people through the Association of General Practice in Urban Deprived Areas, the Health Education Authority, the Oxford Primary Care Facilitation Project, the King's Fund and the Royal College of General Practitioners (RCGP) Health Inequalities Standing Group.

I especially remember the fun I had trying to work it all out with Janet Hayes, Cathy Hogan, Annette James, Conan Leavey, Helena Lunt, Len Ratoff, Gill Ridpath, Rose Sands, Janet Snodden, Claire Vile, and Sheila and her friends.

I learnt how to express the ideas mainly in London. In addition to the above, I have been fortunate to have had my thinking challenged and stretched by Louise Acheson, Jen Anderson, Franklin Apfel, Richard Ashcroft, Ricky Banarsee, Fritjof Capra, Peter Cawley, Siobhan Clarke, David Colin-Thomé, Ben Crabtree, Vicky Doyle, Chris Dowrick, Charles Easmon, Ewan Ferlie, Rosemary Field, Madeleine Gantley, Steve Gillam, Pat Gordon, Jonathan Graffy, Susanna Graham-Jones, Frances Griffiths, Iona Heath, John Horder, Ray Ison, Joe Kai, Maurice Keane, John Launer, Lou Lukas, John MacDonald, Lynne Madden, Janette McCulloch, Will Miller, Sue Morrison, David Nabarro, Aislinn O'Dwyer, Mike Parker, Diane Plamping, Julian Pratt, Paul Quin, Peter Sainsbury, Patricia Shaw, Ralph Stacey, Susan Weil, Alison While and my many new friends at Thames Valley University (London, UK). Many also helped with the presentation of ideas.

I owe special thanks to Peter Kinch, Gillian Nineham and Kurt Stange, who were with me at every stage of writing this book. I am not sure I would have got there without you.

I want to thank my mother, Wendy, for having such courage and being such an inspiration to me, and thanks to my brother Michael and sisters Manda, Gaynor, Anne and Nonita.

I want to thank my father Ronald – I know you would have been proud of all of us.

I also want to thank my beautiful wife Eunice, and our children David and Peter.

How to use this book

There are many possible paths through this book, and simply reading it from beginning to end may not be the most helpful one. The book is a map of the practical and theoretical things that I have found important to understand how to integrate different efforts for health. Key to grounding this knowledge in (your) everyday practice is moving between theory and experience. The book is intended to facilitate this movement.

In addition to the Contents, the following are intended to help you to find your best path.

- A summary at the beginning of each chapter – you may like to read these first to get a feel of the whole book.
- Images and models – in Chapter 2 and in chapters 4–8 I propose images and models that may help you to catch the ideas better than the text. You may wish to view these first.
- Examples, practical things to do and exercises – these are included throughout Part II and may help you to find a focus for your reading.
- Connecting theory and practice – Parts I and III of the book are concerned largely with theory; parts II and IV are concerned with practice. I cross-refer so that you can move between them.
- Pause – these prompt you to pause and reflect on how you make sense of something. Doing this gives you a chance to disagree with my interpretation, and also to skip whole sections that are not presently a priority for you to explore.

The four parts of the book have different purposes:

- Part I explains why integrated primary health care is important.
- Part II helps you to develop leadership skills.
- Part III explores theories of integration.
- Part IV describes useful techniques.

Read Part I if you want to know why this is important. It maps the territory, discusses the meaning of leadership and explores the potential of contemporary health care. In Chapter 1, I begin a discussion of power, identity and culture, which is continued in Part III.

Read Part II if you want to develop your leadership skills. In each chapter I pose three evolving scenarios: the development of a general practice; the development of a community hospital; and locality development. You are invited to choose the closest to your real-life experience. The scenarios reflect three different kinds of organisation:

- A small enterprise that comprises a multidisciplinary team with shared vision and plans.
- A large institution that houses multiple semi-independent programmes of work.
- A network where members dip in and out of many activities depending on their interest at the time (the idea of a network as an organisation may be unfamiliar, but bear with me).

At the start of each chapter I pose a new twist to the stories and invite you to describe how you would deal with this. At the end of the chapter I ask whether the chapter has helped you to think differently about your plan, and what you have learnt.

Read Part III if you want theory about integration. People are complex, semi-independent but also inter-dependent. Facilitating integration, like ‘herding cats’, is not straightforward. I first relate integrated primary health care to the idea of ‘comprehensive primary health care’ as envisaged by the World Health Organization (WHO), and also to generalist practice (medical and otherwise). I then highlight changes needed in our understanding of science, health and change, to better understand how to think about integrated health care. I argue in each situation how linear thinking and systems thinking offer different insights into the whole.

Read Part IV if you want to learn techniques that help to see parts and wholes at the same time. They can be used in different situations to help people to ‘see’ how their work is relevant to bigger, evolving stories.

What I mean by . . .

This list includes abbreviations and the meaning I have attached to certain terms.

General practice/practitioners (GP) – this term, from the UK, is equivalent to ‘family physicians’ in the USA. These are medically trained practitioners who mainly operate outside of hospitals, are often the first port of call for people with health problems, usually work in multidisciplinary teams, and are responsible for orchestrating a diversity of support for health needs.

Integrated primary health care – this term comes from contemporary health care. It remains to be seen if this will be more like comprehensive or selective primary health care.

Leader – an individual who helps people (perhaps a named constituency) to move forwards.

Leaders, managers and facilitators – these roles have traditionally been distinguished in a linear way: a *leader* shows the way; a *manager* makes things happen; a *facilitator* eases the process. But in complex situations these distinctions are blurred. Leaders cannot avoid considering how ideas can be applied practically, managers cannot avoid inspiring and wisely directing people, and facilitators need vision and political sensitivity to know how far to allow people to deviate from a pre-ordained path.

Leadership for integrated primary health care – also includes the leadership teams, networks and an array of resources and agreements needed to move forwards a whole story.

Organisation – in its broadest sense this means any way of organising people that produces a collective identity. In particular, I use the terms *institution*, *small/medium-sized enterprise (SME)* and *network* to show how different organisational types have different strengths and weaknesses.

Primary care – this means more than general practice and less than primary health care.

Primary care organisation (PCO) – this includes any organisation that considers itself to be part of primary care, for example general practices, dentists, pharmacists. PCOs are statutory network organisations in the UK, termed **primary care trusts (PCTs)** in England. They have a role to integrate a diversity of services.

Primary health care (PHC) – this is the term used by the World Health Organization (WHO) at the 1978 conference of Alma Ata. It means that all aspects of society and all citizens have a responsibility for health. Medical practitioners contribute an important part, but it is only a part. *Comprehensive PHC* includes horizontal and vertical integration of effort. *Selective PHC* means vertical integration of effort only.

Theories in use: mental models, mindsets, personal constructs, hidden motivations – these terms have different origins, but all describe the subconscious ideas that guide the ways in which people think and act. These are often more powerful than what people actually say.



Taylor & Francis

Taylor & Francis Group

<http://taylorandfrancis.com>

Part I

Why integrated primary health care is important

Part I explains why integrated primary health care is important, and offers some challenges to achieving it.

Chapter 1 provides an overview of the ideas being put forward. Leadership is described as making sense within complexity. A discussion of power, identity and culture is also begun, and is continued in Part III.

Chapter 2 puts some flesh on the bones of this image of leadership, pointing towards Part II, in which leadership skills are developed, and Part IV, in which useful techniques are described.

Chapter 3 signposts ways to achieve long-term integration of primary health care, in particular by applying the principles of a learning organisation to health care localities.



Taylor & Francis

Taylor & Francis Group

<http://taylorandfrancis.com>