The London Health Partnership is an alliance of charitable foundations, business interests and government, formed to generate a distinctive programme of work which will help to develop urban primary care. It is chaired by Liam Strong, chief executive of Sears plc, and managed by the King's Fund, one of the contributing foundations.

Primary Health Care in Cities: A Whole Systems Approach

London Health Partnership

The aim of the London Health Partnership (LHP) is to improve the well-being of older people by addressing the long-standing, intractable problems of providing care and promoting health in cities. The methodology is based on a 'whole system' approach and brings together large numbers of people from many agencies, who want to find different ways of working. Older people are an integral part of the process.

The approach recognises that the 'local system' has the necessary wisdom to know what needs to change. The role of the development programme is to offer a mechanism that allows this change to happen. Whole System Events are a part of this mechanism. They are one very visible aspect of a process which enables the local system to come up with its own actions to tackle its own concerns, which will be site-specific and unpredictable. As part of the development programme, a grant is available to cover the costs which no single agency is likely to be able to bear, in the initial stages.

What do we mean by primary care and *The problem of the city*

We take a wider view of primary care than one which equates it simply with general practice (or even more simply with general practitioners). Our definition encompasses the network of community-based health services which work with and through general practice to deliver services and to access secondary care and, in turn, is connected with an even wider social care network. Primary care is complex, organic, small, local. It is multi-agency, multi-professional, multi-shaped and multi-sized. And diversity (as long as services reach an agreed standard) is entirely legitimate and to be welcomed in local organisations striving to meet local needs.

Primary care in cities is one of the well-rehearsed problems of the health service. Although in recent years there have been substantial improvements, these have not kept pace with improvements in other parts of the country. The gap may even be widening. In an attempt to understand this, we often try to explain it in terms of some deficiency in one or other part of the system – something wrong with city GPs/with the quality of management/with city populations. We tried thinking about it another way – perhaps it is not that the parts are somehow 'wrong' but that health services in cities work in different ways. In other words, if the city itself is seen as a complex system, it cannot be understood simply by understanding the individual parts.

This summary is based on work for the LHP by Martin Fischer, John Harries, Pat Gordon, Chris Shearin and Diane Plamping of the King's Fund. It was presented to the 1996 British Urban Regeneration Association Conference.

Intractable problems, Boundaries, and *Avoiding projectitis*

We consulted widely in setting up the LHP programme and one clear message was that what was needed was help with the long-standing, intractable problems of providing health care in cities. If problems had proved to be intractable then, by definition, old ways of working had proved to be inadequate. New approaches were required. This development programme offered an opportunity to explore ways of working which agencies might otherwise be unable or unwilling to adopt. One of the criteria for engagement is that key local people are dissatisfied with traditional ways of doing things.

The focus of the work became the well-being of older people. This group was chosen for three main reasons: they tend to have multiple health needs and a high degree of chronic ill health; like many city dwellers, a high proportion of older people live alone and are relatively poor; and they tend to make use of a wide range of agencies.

We referred to the intractable problems as 'elephant problems'. We took this idea from the tale of the blind men examining the elephant, each describing what he knew from his perspective and each coming to a different conclusion about the nature of the beast. Our hypothesis was that the problems in which we were interested would be interpreted differently by different stakeholders and the difficulties in reconciling these perspectives would in turn contribute to the intractability. This meant, inevitably, that we were dealing with another well-recognised problem – boundaries between services, professional groups and between organisations. Rather than searching for the illusive 'seamlessness', we were interested in recognising boundaries, making them explicit and tailoring them to the needs of users.

Another clear message from our consultation was about the drawbacks of projects, time-limited 'soft' money and the competitive bidding process. Only rarely were projects thought to make real change to the mainstream. Often they were seen as a distraction. This chimed with some of the King's Fund experience of inner city primary care development. Much has been learned from demonstration projects but there are reservations about their relevance to other settings and therefore the generalisability of 'solutions'. We were keen to find an alternative development approach which did not rely on the project/bidding model.

Systems thinking and *Complexity*

Against this background the approach we adopted was based on the following:

- with long-standing problems it is unrealistic to expect any one person to have the whole picture or any one agency to come up with a satisfactory solution;
- intractable problems are the ones which 'ordinary' ways of working do not address;
- key concerns for elderly people include lack of information, inadequate transport, ageism, discharge from hospital;
- quick fixes often fail because they address the symptom and not the cause;
- there are inappropriate beliefs about cause and effect – any intervention is likely to have unintended and unexpected consequences. These are often distant in space and time and frequently shift the burden to someone else's organisation;

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- the concept of *system* embodies the notion of a set of elements connected together to form a whole. At certain levels of complexity, properties emerge which are not explicable in terms of component parts. For example, the taste and wetness of water belong to the whole substance of water and are not explicable in terms of hydrogen and oxygen;
- the system of care for older people involves many agencies and individuals, extending way beyond the statutory health and social services;
- solutions to long-standing problems would have to involve many agencies and professional workers, and crucially, elderly people themselves.

Whole System Interventions: large events and small meetings

The 'whole system' approach seems to offer a means of addressing these issues without trying to tidy them up or deny that life is indeed complex and unpredictable.

Whole system events (WSE) are a means of bringing together large numbers of people who represent the whole community of interest around specific service users. Participants range from top to bottom of organisations, and great care is taken to ensure they are 'not all the usual suspects'. The events take place over 2–3 days. They are not about consultation or problem solving. There are no expert presentations. Through lots of small group work people are enabled to access new information and form new relationships, which, in turn, allows them to find common ground they are prepared to work for.

We have now worked with six WSE sites at city level, borough, general practice population, and neighbourhood. Participants numbered between 80 and 200 people from housing associations, post offices, police, gas board, churches, libraries, supermarkets as well as voluntary organisations, hospitals, general practices, health and local authorities, and included significant numbers of elderly people themselves.

WSEs require a burning local issue and a desire to find new ways of working. They are about creating disturbance. They rely on the belief that the 'local system' knows what needs to happen if things are to be done differently.

The key to *whole system interventions,* whether large events or small meetings, is the same:

- unusual mixes of people, to ensure multiple perspectives;
- spending enough time together, to move beyond first impressions and start to generate possibilities;
- sharing and using information in different ways;
- real time work together in the same room;
- significant numbers of service users.

Short-term outcomes and *long-term unpredictability*

Whole system events are one very visible aspect of a process from which a great many actions and interactions may be expected to flow. They are highly structured events with unpredictable long-term outcomes. However, from experience we can now 'predict' some short-term outcomes:

- lots of energy and enthusiasm are generated;
- enjoyable and renewing experience which builds or rebuilds solidarity;
- 'ordinary' people do indeed have the information and the interest to contribute to the exploration of difficult issues;
- new working relationships are possible, through putting faces to names;
- new skills in running meetings in ways which encourage participation;
- conference report which includes new extended contacts list;
- many elders are willing to be involved in follow-up activities;
- common ground themes which may reinforce old priorities but give legitimacy for new work;
- necessary conditions for how we might address the common ground issues. This is crucial if things are to be done differently;
- membership of possibility/action groups and how to get in touch.

We hoped and expected that the information shared and the new relationships formed at the WSEs would lead to new collaborative ways of working. We did not expect that developments arising from the event alone would be enough radically to improve the well-being of elderly people. We are now learning about the kind of support that possibility/action groups need in order to help them work in new ways.

Many things, large and small, happen in the follow-up and include a group of 19 elders now working with 13 social services managers to monitor the quality of community-based services; physiotherapists and leisure centre managers now embarked on ageism training; Chinese elders succeeding in relocating a bus stop; major European Union telematics initiative refocused towards services for elders; housing association using WSE methods to reorganise regional strategy meetings, resulting in more engaged participants willing to take more responsibility; elders recruited to help train bus drivers; passenger transport executive approaching voluntary organisations to find out about mini-bus usage; an area bidding for Single Regeneration Budget monies planning to use WSE to establish common ground issues; work already in the pipeline being influenced and accelerated (e.g. one stop information shop); Somali elders now connected to healthy cities project and working for a community centre.

The development programme is continuing with several new sites and follow-up activity of many sorts. Evaluation is being undertaken by the Public Health Research & Resource Centre, University of Salford, part of the National Primary Care Research & Development Centre.

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