

# Developing a Community-Oriented Health and Wellbeing Service for Cumbria, through Clinical Commissioning – Personal Reflections

**John Ashton**  
*Director of Public Health,  
NHS Cumbria*

## **ABSTRACT**

This paper includes my observations as Director of Public Health in Cumbria of success factors of clinical commissioning after a five year experiment

## **KEY WORDS**

Partnerships. Public health. Primary care

## **KEY MESSAGES**

- Initial talent-spotting of motivated and able clinicians to lead commissioning is important.
- It pays dividends to work alongside commissioners, and provide expertise and experience that they can apply in their own way and in their own time
- Capacity-building is a significant task that must continue into the future and extend to large numbers of future professionals
- When services are developed by those in closest contact with the public, and when leadership teams include those who span the relevant disciplines and organisations, including public health, and when they together share a vision for whole population health, there is powerful chemistry.

## **WHY THIS MATTERS TO ME**

I'm as passionate about general practice as I am about public health and have spent the last 35 years trying to find the common ground between them. Professor Jerry Morris, father of post-war public health in England once told me that he didn't pursue a career in general practice (although he spent some time as a GP) because it was too difficult. He went on to say it is much easier to be a good specialist than a good generalist'. T H Huxley advised that 'you should know something about everything and everything about something'. The other dichotomy that has to be bridged is between the perspective of the individual patient in the consulting room and the group from which they are drawn. If we could achieve that it would be holism indeed.

Correspondence address:

**John Owens**  
NHS Cumbria  
Ginny Hall  
Dent  
Cumbria  
LA10 5TD  
Email  
[johnrashton@blueyonder.co.uk](mailto:johnrashton@blueyonder.co.uk)

**T**he new Coalition policies for health and the NHS have brought into focus the issue of clinical engagement with population medicine and services for health and wellbeing. Apart from the earlier experiences of practice-based commissioning and the use of the Quality and Outcomes Framework, such a perspective has not been central to the British tradition of general practice. Rather, that tradition has been rooted in the concept of family medicine, with its emphasis on the individual within a family context. It has also been very much in keeping with the culture of private professional practice, such as is found in other areas of professional life, for example law, veterinary medicine and architecture, where the focus is

very much on the client who presents at the office rather than on a whole population that might include non-attenders as well as attenders.

This may seem curious, since each general practitioner (GP) has a list of registered patients, and hence the basic tool for a population approach.<sup>1</sup> The reluctance to think in population terms runs deep in general practice, and my own interpretation of it is that it reflects the tension inherent in the doctor being in a position where they would wish to do their best for the patient in front of them, and not be exercised by conflicting claims to scarce resources. My experience over many years of endeavour to interest general practitioners in public health has, until recently, been that many GPs regard public health practitioners as having betrayed the practice of medicine, are not themselves proper clinicians and are in some way preventing them from getting on and doing what they have been trained for. My recent, refreshing experience in Cumbria is that it doesn't have to be like that, and it is possible for general practitioners to be enthusiastic about a whole population approach while continuing to be excellent clinicians.

Finding ways of reconciling this conflict between individual and collective health is at the heart of the challenge of making clinical commissioning a success.<sup>2</sup> In turn, that involves recognising other tensions that will obstruct success unless made explicit and managed well through good governance. For example tensions between commissioning and providing, between advocate and enabler, and between choice and cost-containment.

## **LANGUAGE IS AN ISSUE**

If the concept of general practice implies a focus on individuals and families, rather than on populations, the commonly used term “primary medical care” or more briefly “primary care” is one that can also cause confusion in the search for a population orientation. Primary Care implies that a multidisciplinary team of workers will be found, and they will work together to treat illnesses of their registered patients and refer them to specialists when needed. However, that interpretation does not include addressing health needs beyond disease treatments and it does not

include whole population care beyond the practice list. A population orientation requires a further shift in the direction of the World Health Organisation’s concept of “Primary Health Care”, which situates two groups of the population (those experiencing ill health and those at risk of experiencing ill health) within whole populations however identified (for example, geographically or demographically – what town planners refer to as areas or groups).

The WHO concept of “Primary Health Care” can be seen as a philosophy, a level of care, or a set of activities ranging from health education and preventive measures through the treatment and care of common conditions within the community, and the provision of essential drugs. Although the WHO concept of “Primary Health Care” has been most widely promoted in developing countries, pioneers have tried to implement it in a range of settings. Perhaps the most comprehensive approach is that which was developed by Kark and his colleagues in Jerusalem under the rubric of “Community Orientated Primary Care”,<sup>3</sup> and in tune with the ideology of the Peckham Experiment.<sup>4</sup> This approach was piloted in this country some years ago in conjunction with the King’s Fund (see paper by Gillam in this edition of LJPC). Julian Tudor Hart’s work in South Wales is another celebrated example,<sup>5</sup> and components can be identified not least from examples of Primary Care-based epidemiology by Pickles in Wensleydale in the 1930s<sup>6</sup> and John Fry in Beckenham in the 1960s.<sup>7</sup> Other examples include the Health City 2000 movement of the 1990s and the New Public Health.<sup>8</sup> In this edition of LJPC, Meads describes similar models emerging in Latin America and Macedonia.

Until now, the political and philosophical climate has not been conducive to the championing and rolling out of what, to many observers, appears to be the most rational approach to providing cost-effective and efficient services closer to home, but which has struggled for acceptance in the face of the dominant ideology of hospital care. It would appear that one of the prerequisites for establishing a momentum for this more integrated approach to healthcare is for leadership to come from primary care professionals themselves, and in particular from general practitioners.

## MAKING IT HAPPEN – THE EXAMPLE OF CUMBRIA

Cumbria is one of the largest and most sparsely populated counties in the country: one hundred miles across, with a population of 500,000 (mostly living in small communities), the largest centre of population being Carlisle with just under 100,000 residents. Despite the popular image of Cumbria as being the Lake District, and although it is largely an area of outstanding natural beauty, it also features an industrial legacy of coastal towns such as Whitehaven and Workington which have health statistics every bit as challenging as those to be found in the big cities. One of its strengths is in its ability to attract some of the most resourceful general practitioners, whose standing with their patients is amongst the highest in the country.

Since 2006, when Cumbria Primary Care Trust was established, six of those General practitioners have increasingly led the management of investment decisions on the basis of six commissioning localities, which more-or-less map onto the six district council areas. Having been identified early on as a leadership group with the aptitude to take Cumbria from being an under-performing health care system, to one which could redefine itself through a strategy based on services “Closer to Home”, this group has been on a journey of personal development that has included international sorties to visit examples of best practice and personal study.

The role of the Primary Care Trust Directors on this journey, including that of the Director of Public Health, has been to position themselves alongside the group in a supportive and sometimes coaching *modus operandi*. In a sense, this style of operation has been akin to traditional community development: starting from the experiences and ideas of these six GPs and supporting them to have new experiences and explore new ideas that will help them to achieve their goals. En route they have had to deal with difficult issues, such as conflicts of interest which they resolved by creating a Clinical Senate (inspired by the American Senate as the policy forum). By accepting the responsibility of leadership, the group has become aware of its obligations to reconcile individual with group claims on

resources. Inevitably this led to ever increasing interest in a whole population approach and the imperative to work with a range of partners, including local government, to refocus ‘upstream’ towards prevention. The Director of Public Health has supported and reinforced this reorientation, for example by deploying visitors to run workshops.

Five years later, the six initial GPs have translated into several dozen out of about 400 in the county. It has begun to be possible to field GPs with a special interest at a range of multiple-agency groups, for example those relating to children. As we face the new arrangements for the NHS in England, with the withering away of the Strategic Health Authority and the Primary Care Trust, six GP-led locality commissioning boards stand ready to assume the mantle of responsibility, and to share it through the Board of Health and Wellbeing, with partners from Local Government, Public Health England and elsewhere.

## PERSONAL OBSERVATIONS

The past five years have been at once challenging and exciting, as together a wide-ranging group has worked with general practitioners to build the foundations of a Community-Orientated Health and Wellbeing Service for Cumbria. My engagement throughout that time leads me to offer four personal observations that are likely to be true in other places. Firstly, much of the achievement to date has rested on the initial talent-spotting of motivated and able clinicians. Secondly, getting alongside them with expertise and experience that they could apply in their own way and in their own time, has paid dividends. Thirdly, capacity-building is a significant task that must continue into the future and extend to large numbers of future professionals, and will require the reorientation of the Colleges responsible for their training (papers by Crisp and Spicer/Gnani in this edition of LJPC say more about this). My final observation is that when services are developed by those in closest contact with the public, and when leadership teams include those who span the relevant disciplines and organisations, including public health, and when they together share a vision for whole population health, there is powerful chemistry.

## REFERENCE

- (1) Ashton J. Public health and primary care: towards a common agenda. *Public Health* 1990; 104:387-398.
- (2) Ryle JA. *Changing Disciplines*. Oxford: Oxford Medical Publications; 1948.
- (3) Kark SL. *The Practice of Community Oriented Primary Health Care*. New York: Appleton-Century-Crofts; 1981.
- (4) Ashton J. The Peckham Pioneer Health Centre: a reappraisal. *Community Health* 1977; 8:133-137.
- (5) Tudor Hart Julian. *A new kind of doctor*. London: Merlin Press; 1988.
- (6) Pickles WN. *Epidemiology in Country Practice*. Torquay: Devonshire Press; 1939.
- (7) Fry J. *Common Diseases - Their Nature, Incidence and Care*. Lancaster: MTP (Medical and Technical Publishing Company) Ltd; 1974.
- (8) Ashton J, Seamore H. *The New Public Health*. Open University Press; 1988.

---

Submitted 7 October 2011, accepted for publication 10 October 2011.