Written evidence submitted by Dr Virginia Pearson, Director of Public Health, Devon County Council (PHP0107)

Introduction

Virginia Pearson is Director of Public Health for Devon County Council, having previously worked in both service and academic public health in the South West.

She was a GP Principal in Northampton before completing her professional training in public health. She has held a number of senior professional and general management roles at Director/Chief Executive level, and has been a Consultant for over 20 years. From January 2007 to March 2013, immediately prior to the reforms, she was joint Director of Public Health for Devon Primary Care Trust and Devon County Council.

Public health in Devon

Devon is a largely rural county with pockets of urban and rural deprivation. The city of Exeter is the largest conurbation. There are eight lower-tier local authorities. Prior to 2007, public health was delivered by six separate small public health teams, each within a small primary care trust. The amalgamation of the six teams into one Devon team created a co-terminous arrangement between the NHS and the local authority. There were significant cost efficiencies in this new arrangement as well as enabling a county-wide focus on issues which were previously invisible due to the parochial nature of the organisations, such as the health inequalities that exist across the county. For the County, this made an immediate difference in terms of strategic relationships and alignment. The current public health team in Devon consists of 31 whole time equivalent staff.

Two Clinical Commissioning groups partially cover the County – Northern, Eastern and Western (NEW) Devon CCG and South Devon and Torbay CCG. NEW Devon CCG is currently part of the NHS Success Regime.

Health outcomes in Devon are generally good, and have improved significantly since 2007, and there is also measurable progress since 2013. Each year an annual report of the Director of Public Health is published which reviews progress and sets out a number of priorities for the population. These can be found on the Devon Health and Wellbeing website:
http://www.devonhealthandwellbeing.org.uk/aphr/

The delivery of public health functions

The most recent public health reforms (Healthy Lives, Healthy People, 2010) disaggregated what had been originally envisaged by Donald Acheson (Public Health in England, 1988), which was an integrated public health system where public health skills contributed to the activity of the NHS. The movement of public health from Primary Care Trusts to local authorities, to
Public Health England and to NHS England split the historic responsibilities which, for the statutory Director of Public Health, removed direct accountability for screening and immunisation programmes, health protection and some public health commissioning. One outstanding issue remains access to public health and health services data which is yet to be resolved and is a handicap in terms of discharging our statutory duty as Directors of Public Health.

The effectiveness of local authorities in delivering the envisaged improvements to public health

Our latest analysis of the progress made on public health outcomes since the move to the local authority has been one of improvement. The advantages of the move to the local authority have included benefiting from extensive procurement expertise, which has improved the quality of our commissioning, opening up a range of possibilities which would not have previously existed. The local authority's track record in public engagement and their commitment to equality has been a benefit to our approach. In general, although an onerous transition process establishing hundreds of new contracts, the quality of contract management and performance has improved.

The alignment with the council has been of benefit, strategically and practically, as the elected members are making an increasing personal contribution to the public health agenda. The impact of democracy on public health has been nothing but positive, and very different from working in the NHS.

The public health workforce

The disaggregation of the workforce has necessarily resulted in a weakening of cross-specialist influence and learning. We have mitigated this by establishing fora which bring the professional strands (and the responsibilities) together, for example a Devon, Cornwall and Isles of Scilly, Plymouth and Torbay Health Protection sub-committee of the five Health and Wellbeing Boards; several cross-organisational groups for strategy and commissioning, and seek to maintain relationships with other organisations which themselves have seen considerable organisational change, for example we have a Health and Wellbeing Justice Group.

Internally, we have reshaped the workforce profile of the team to create new opportunities for recruits to public health – new posts have included apprentices, advanced public health practitioners, with support for undertaking formal qualifications as part of their posts – and these have enabled us, with the structured training, to prepare suitably interested and qualified staff for specialist public health training.

Staff working for Public Health Devon are extremely positive about working in a local authority setting. Our experience is that public health seems to be more popular than ever as a career choice.
Public health spending

The public health grant for Devon for 2016-17 is £28.952 million, an allocation of £38 per head of population against a national average of £55 per head of population. We were only notified of the amount of this grant on 11th February 2016, one week prior to our full Council meeting at which the budgets were agreed by Members.

The reduction of £1.64 million in our grant in 2015 removed virtually all of the ring-fenced reserve that we had held back to manage the introduction of new public health programmes in 2016-17. As this recurring reduction in funding has then been compounded by a further reduction for 2016-17, resulting in a £2.5 million reduction for 2016-17. As we have protected the funding for 0-5 public health nursing this year, the entire reduction has had to be found from our original £22 million grant.

While protecting those areas in 2016-17 which are most responsible for reducing risk in the population, to manage a reduction of this magnitude without a reserve, we have already decommissioned services and will be commencing a programme of re-procurement of our major contracts as they constitute the majority of our budget.

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