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PROFESSOR FIONA SIM OBE

Career summary:

Fiona trained in medicine at University College and Hospital, London before training and working for a short period as a principal in general practice. She then joined community medicine as a trainee in North West Thames. Her first consultant and District Medical Officer posts were in North East London before she was appointed Director of Public Health at Barnet Health Authority. She later worked as Medical Director of a hospital and community services Trust and then returned to public health in north London before becoming Training Programme Director and Associate Postgraduate Dean in London. Her next move was to the Department of Health as Head of Public Health Development at the time of the introduction of multidisciplinary specialists in public health. Fiona was instrumental in establishing and supporting many of the underpinning structures. She also set up the national public health leadership programme. Since leaving DH, Fiona retrained in general practice and now works as a part-time GP. She has also been chair of the Royal Society for Public Health since 2012 and is a visiting professor at the University of Bedfordshire whilst retaining close links with the London School of Hygiene and Tropical Medicine.

Interview 16/04/15

EDUCATION, FAMILY BACKGROUND AND MEDICAL TRAINING

Tell me about your early life and why you went into medicine?

I went to a convent grammar school. It was an all girls' school. I did well in my 'O' levels which made me think I may as well apply to do something that is quite challenging and I decided to apply for medicine. My father was a GP and I guess that was probably some sort of influence but it was more that it was the only career I knew anything about that needed decent school grades to get into. It was quite competitive to get into and I wanted that challenge. My choice in the sixth form, because I was looking for a challenge – I am foolish like that! – was either to apply for medicine or to apply to Oxford or Cambridge to do a science subject as I was doing science 'A' levels. My school wouldn't allow anybody to take the Cambridge or Oxford entrance exam without staying on for a third year in the sixth form so I made my decision not to apply for Oxford or Cambridge and that made me think, well I will stick with medicine and apply for medicine. It was a crazy reason but it was the only career that I knew much about at all and even then quite limited knowledge. I did a summer job, got some exposure, work experience in a trivial way and decided that was what I wanted to do.

What did your parents think?

My mother was fairly supportive. My father was very antagonistic. He did not want me to do medicine partly because he was a bit miserable as a GP, quite unfulfilled, and partly because he thought it was too long a course for a woman and also partly because he had encouraged my sister to apply and she hadn't got in and I think that part of his concern was not to be

disappointed again for himself or to have another disappointed child. But we never really articulated any of that. All of his negativity just made me more obstinate; I decided I was going to apply. I did have good 'O' levels so I knew I had a reasonable chance. My school also thought I was fairly crazy because nobody had gone to medical school for about ten years and it wasn't the sort of school that encouraged that. Most pupils either did secretarial training or teaching. Most of my class went to teacher training college or left to get jobs. So it was quite exciting when I did apply and got a place.

Did you more or less apply on your own?

Yes. I did not use any family contacts because I couldn't see the point and I just wanted to do it under my own steam.

Where did you apply?

I applied to Nottingham, Newcastle, UCL and the Royal Free and Birmingham, probably, I can't quite remember. I got interviews at the Royal Free then UCL. UCL was my first choice and the Royal Free was my second. I got an offer without an interview from Newcastle which I will always treasure. I thought that was very special because it was totally stress free, that somebody had the confidence in you to make an offer remotely. My lowest offer as it happens was from UCL – a three 'E' offer which in those days was not uncommon if they decided they wanted someone. So I was delighted with that. I went to UCL medical school then UCH.

Where had you been brought up?

On the east coast, Southend-on-Sea. A country bumpkin – a seaside person!

Once I got in my father was very delighted and changed his view. He described me then as his "blue stocking" until the end of his life. I was going to be a career person and he just decided that was how it was.

He was proud of you?

With reservation because he assumed I would not get married, have a family or do any of the normal things that women might do in his view. He had quite a Victorian view of life. I did not mention that he had met my mother when she was a medical student and she left medical school to get married. Then when she tried to go back after she had one child she was told to go back and look after her family. The track record of women in medicine in my family was fairly limited! Their best friends were a married husband and wife GP team so the wife of that couple was very much a role model for me, someone who could have it all in that sense. She was working hard, had husband and children, was always extremely stressed but the fact she could do it I looked up to and admired.

What year did you start at UCL and what was it like?

1972. I enjoyed being a student. I loved UCL. I didn't particularly enjoy pre-clinical medicine. I found it quite tedious, very much rote learning of facts which I didn't enjoy. I did science 'A' levels because I had to for medicine. I am not really a pure scientist in terms of the things I love and am good at but it was OK. I passed everything. The idea of retaking exams appalled me. I worked really hard so I wouldn't have to retake anything! I stayed on and did an intercalating BSc because by that time it was something that was offered to 20-

25% of students. We had 20% of women in the year when I was a student and it was 25% of students who did the BSc. Either that or the other way round! So I took a year extra which my father thought was a very bad idea. I loved that year. I learnt to play squash and other extracurricular stuff I hadn't allowed myself to do in the pre-clinical years. I had a great time. Then I went onto University College Hospital (UCH) to do clinicals. I enjoyed that a lot more than the pre-clinicals because it was what I understood medicine to be about. You were actually working in a health care environment and seeing patients and interacting and learning to do the real job. The scientific background with hindsight was important but at the time I just wanted to get on. But I was really worried that I wouldn't enjoy it and that was partly what drove me to do the BSc. Part of it was just to see if I could get into the BSc stream and part of it was if I had a degree under my belt and I hated clinical medicine I still had something else I could do. In the event I enjoyed the clinical work.

What was it like for a woman in medical school then?

We were just part of the group and I don't think I particularly thought about women. The only thing different from now - but at the time I did not really think about it at all- was that we were required to wear skirts or dresses on the ward. We were not allowed to wear trousers as female medical students. At the time I accepted that as part of the dress code and it didn't occur to me that there was anything unusual about it because there wasn't at the time. Now, clearly, you would not contemplate it being a requirement. As far as being a student was concerned, we were part of the large year - just over a 100. Compared with today's medical students it was comparatively small. There wasn't a particular thing about whether you were male or female. One anatomy demonstrator in pre-clinicals did demonstrate a particular part of my anatomy to the rest of the group which at the time I thought was quite funny but looking back I suppose wasn't. I was fully dressed at the time! It is the sort of thing, I guess, he wouldn't have done to a male. Apart from that, we were treated very much as part of the year group, not particularly as males or females. That is how it felt.

EARLY HOSPITAL JOBS THEN MOVE INTO PUBLIC HEALTH

Where did you do your house jobs?

I went back to Southend to do one and the other I did in Barnet in north London. You had to live in hospital the whole time. I saw my parents more when I was doing the job in Southend. I chose to go there because I thought it would be quite fun to go back to a hospital I knew. I didn't get the opportunity to stay at on UCH. At the time that was quite a major frustration because the job I wanted to do, the person who got it failed his finals but you weren't allowed to give up another job to take a job. That would have been completely unethical. I was very envious of the person who stepped in who hadn't managed to organise their house jobs. Otherwise, I was quite glad to get out into DGH territory and do ordinary house jobs. I enjoyed those - very stretching, lots of responsibility very suddenly. The camaraderie was amazing, probably hasn't changed that much. Very hard work and very long hours. No shift work. Great fun.

What did you decide to do next? Had you got ideas of what you wanted to specialise in?

I had very little idea of what I wanted to do. The specialty I most enjoyed at medical school was obstetrics and gynaecology. I was thinking possibly of that. I probably would have enjoyed that. I met my husband when I was doing my house jobs and by the time I had finished them we were engaged so that influenced my career choices because when I stayed away in hospital, when I was living in hospital, he would very frequently say how unbearable it was that I was away for most of the week doing on-call. When we decided to get married it became very obvious to me that wasn't going to be compatible with 8-10 years' training and a very intense on-call acute specialty in hospital. I definitely parked obs and gynae! Then I did not know what to do so I did GP training really as something next to do rather than knowing what I wanted to do with my life. I became a GP for a short while as a principal for less than a year then I made my big decision to do public health. It was based on two things that happened more or less at the same time. I was very much the junior partner in a practice and my partners were a husband and wife team. That was OK but what became a problem was that I was really quite enthusiastic about health promotion and disease prevention although we didn't call it that then. I was busily telling people it was a good idea to stop smoking and things like that and they were both smoking in their consulting rooms which you were allowed to do in those days. There was no issue as far as they were concerned but for me it was a massive issue and I decided it was not very compatible with what I wanted to do in terms of making any difference to the health of the people I was seeing every day. About the same time I saw an advert for public health training. The advert I saw was for the North West Thames training programme. A big feature of the advert for me was that some trainees would be allowed to do an MSc in community medicine at the London School of Hygiene and Tropical Medicine. I was totally seduced by this prospect so I applied not knowing very much at all about community medicine. I did a fair amount of rapid homework, phoned up the then Faculty Adviser whose name was on the advert - William Kearns - and asked him every possible question I could think of about community medicine. By the end of a short conversation with him I knew a lot more than I had done before and somehow got short-listed and managed to get appointed. My dream was to do the MSc at the London School and I was offered one of those places which I was incredibly delighted with – icing on the cake! I took up my place. I was sent out to Bedfordshire. That was my first placement as a registrar and a few months later I went to the London School of Hygiene and Tropical Medicine.

Had you had any exposure to community medicine at medical school?

It was on the curriculum. We were taught it in the pre-clinical course as I remember. We had a few lectures. My recall is that at the time I thought it was rather poorly taught and delivered. It wasn't interesting and I did not find it inspiring in any way. It wasn't given any relevance to what we were going to be doing as doctors. That is something I have taken very seriously subsequently in terms of delivering undergraduate teaching. It didn't influence my decision.

How did you find community medicine training?

I loved it. During my first few months in Bedford I did not know what I was doing. There was a very nice consultant I was working with and I was asked to do some small projects which I really enjoyed. I discovered I really enjoyed doing analyses, working with data and

producing reports when people asked for them. It was nice to get a bit of feedback from people saying yes, this was what they wanted but I really didn't know any more than that. Before you have done the MSc you are really very limited in terms of what you really understand about what you are doing. I only met the Area Medical Officer once or twice and I didn't understand what was going on but I heard subsequently he had a health problem so he was pretty much an absent landlord. It didn't affect my training; it didn't affect me in any way because my trainer was fine. When I went to do the MSc 1981-2 I loved nearly every moment of it.

Where did you go after the London School to complete your training?

I did a really nice project at the London School for my MSc dissertation. I did it on workforce. It was about the effectiveness and efficiency of the workforce in obstetrics and gynaecology. I don't think I chose it completely alone. It was suggested to me but it was really nice because I knew I had that interest and it would be fun to look into that particular area. That was a really nice piece of work. I enjoyed it. It enabled me to present a paper at a conference for the first time, those sorts of things. I think we coined the phrase "performance indicators." In those days when you had done your Part I examination (for membership of the Faculty of Community Medicine) as it was then you had then to do a big dissertation for your Part II. My supervisor at the London School, John Ashley, said this would make an ideal Part II so I really ought to carry on with it. When I went back to talk to the training programme in North West Thames about it they said no, I had to do a project for my Part II that they chose for me. It had to be something in North West Thames and my project didn't meet their requirements. I said that was a great pity as I had been told it was a really good piece of work and it would be good to develop it further. But the view was no, I couldn't do it. So I looked around and went to talk to people in North East Thames and asked whether they had any space for a transfer mainly because I was doing this project which by pure chance was largely based in North East Thames. Would they be interested in me as a registrar and in that particular project for my Part II? They said yes on both counts. So I shifted to North East Thames which did not make me very popular with North West Thames but I was allowed to do that. I carried on with that work, did a lot more detailed research and submitted it for my Part II. I have had a career-long interest in workforce. Although it was about the clinical workforce it was still interesting and it was very much multidisciplinary as I looked at midwives as well as medical and other staff. So at the end of the MSc which I passed with a credit or merit - they didn't give a distinction - I went to North East Thames. Most of my time there was with June Crown, District Medical Officer in Bloomsbury, as my trainer. I spent a few months as well in Newham with Jane Jackson and that was great fun too. They were very different. I learnt a lot from both of them.

What was the gender balance in London when you were training?

I don't remember. On the MSc course there was a preponderance of men. In an international group most of the non-UK students were male. Overall a significant majority of the group was male. Of the community medicine trainees, we were probably near half and half. There was no feeling you were in a minority in community medicine at that time. I never had that thought at the time.

CONSULTANT AND DIRECTOR OF PUBLIC HEALTH POSTS

When did you finish?

My training was really quite short - of its time that was not unusual. I was a trainee for three to three and a half years. I got my Part II and Faculty membership, jobs were coming up and the general view was you were ready to be a consultant so off you go. So I applied for a consultant job before I had served my time but it was considered I was competent enough to do it. So I finished my training when I was appointed to a consultant post. That was June 1984. I went to Waltham Forest as a specialist in community medicine. I don't think I had brackets after my title which some SCMs did in those days.[1] I was pretty much a generalist. It was a small department with a DMO towards the end of his career so he was slowing down quite a lot. I had loads of opportunities to get every bit of experience possible. There was the DMO and myself. We worked closely with Redbridge. They had been part of the same area health authority and we still worked closely between the two departments with their DMO and consultant which was nice, for mutual support. There were also non-medical people in the team such as health promotion.

Were you full time?

Yes. I did have maternity leave whilst I was there and came back full time on that occasion. The only time I have had a very negative opinion of me to my face was one of the senior clinicians who said to me I should not have applied for the job knowing I was going to have a child in the near future. Of course I didn't know I was going to have a child in the near future but he had reached this opinion that this was foul play on my part. I didn't even respond I think. One of those things that left me speechless. Apart from that we got on fine!

How long were you in Waltham Forest?

About two years. I got head hunted by a nearby health authority which was slightly closer to home. I got a call out of the blue about whether I was interested in the job of DMO. I was interested. With hindsight I probably shouldn't have been because it was a very tiny department, very poorly supported. But I was ambitious and quite naïve. I applied and got the job so I moved to Enfield. I was treated quite badly in Enfield for a couple of reasons, one was that though they called me the District Medical Officer they only wanted to pay me as a consultant. That was unfortunate but I tolerated it on the basis nobody seemed to think I could argue it. I don't recall the BMA being particularly energetic because I had accepted the job and the terms and conditions. Money has never been my driving thing but it left a bit of a sour taste. The other issue I had there was that the person who had been the acting DMO was someone who had been working in community health for many years, was towards the end of her career but had missed out on becoming a member of the Faculty because of the way the Faculty had been set up and so she was not eligible to be appointed DMO. I don't think on a personal level there was any problem at all but clearly it was difficult for this person my being appointed on her patch. She hadn't been treated very well at all in terms of her expectations which were clearly not being met. Otherwise it was OK. I got on well with the chief exec who was one of the people who came from industry in that influx when the NHS was trying to encourage people from other backgrounds. He knew very little about the NHS.

[1]To denote specific areas of expertise such as child health, social services

He knew about oil and petrol and he did know things about management from a completely different perspective. He didn't stay all that long but it was interesting watching the way he worked and understanding working with a different culture. He appreciated any community medicine advice he could get.

How long did you stay there?

Almost three years. That job was a joint job with the borough. It was a time when, well before the recent changes, I was appointed the Medical Officer for Environmental Health to the borough council as well as being the DMO to the health authority. We worked very closely with our colleagues in environmental health and in social services and education. That was an interesting way of working which I hadn't had in my training but learnt a lot. It was really good multidisciplinary/multiagency working.

Then somebody called me up who I didn't know so I suppose that is being head hunted in a different way. He was a community paediatrician who I had never met who worked in Barnet. I can't remember if there was a reason he had somehow heard of me but he told me he had heard of me and his health authority - he was a consultant paediatrician heading up the community child health service which in those days was still part of the health authority- had one of the "new breed" - this was 1988 - of Director of Public Health posts coming up and they thought I should go to Barnet. That was exciting. I thought, should I be stupid and say I was going again? So I did a bit more homework than I had done for Enfield and met with the District General Manager in Barnet and spoke to other people in public health in the region. The general view was this was a job I should be applying for so I applied at the end of 1988 and got that.

Was there much competition?

I can't remember now. I am pretty sure they did interview other people but I don't remember exactly what that looked like.

Was it a much bigger department?

Not much. There was a consultant but I think I had grown up enough to know I should make certain expectations known. The District General Manager knew that I had expectations of the team and was very enthusiastic to achieve that with me. That was good. When I arrived there was one consultant. We then appointed another. Then with the reforms at that time the Communicable Disease Control role was invented so we appointed a Consultant (CCDC). I became a trainer so we became a training department. That was good. It was small compared with somewhere like Bloomsbury which was the gold standard but it was a good size.

Did you notice any difference from the role as DMO?

Around health protection there was a big difference because we were expected to have a dedicated person to lead that function. I am not sure day-to-day there was a massive difference. Perhaps the role became spelt out more clearly so the organisation as a whole would understand what the DPH was going to be doing and the expectations of that role rather than the DMO role being more nebulous, still growing out of being responsible for community health. The DPH has never had that clinical responsibility. I felt that the skills I had brought with me was the right skill set so I don't think it was a massive change.

Were you working full-time?

I worked full-time until my children were at school. I did it that way round so I could be at the school gates without having a guilty conscience rather than when they were smaller. The guilt still lives with me - I don't know which was the right way round! That was the way I did it. I was appointed full-time. I can't remember exactly when I changed. I didn't make it a secret that I wanted to work part-time.

You were a DPH at the time of the purchaser/provider split?

Yes. It was fascinating. I had the added complication or the added interest if you like that Margaret Thatcher was our local constituency MP in Finchley. We knew we were always under scrutiny by Margaret Thatcher and that was for real. My general manager at the time was very accomplished at managing upwards and managing politicians so I learnt a lot from him, Nigel Weaver, very much a career NHS manager. He would occasionally advise me and say Fiona, this isn't the thing to be seen to be doing or you might think of doing things differently, but in a way that was very constructive. The only thing he said to me once which I took umbrage at was when I was quoted in the *Health Service Journal* for speaking out at a BMA conference on something fairly contentious at the time and he said he wasn't sure that was the sort of thing that was a good idea in Barnet and I said that was how I was and that was part of my responsibility as a BMA representative at the time on the Public Health Committee so, sorry, I wouldn't do anything really stupid, he wouldn't be embarrassed by me.

We had to implement the purchaser/provider split. I was involved with the BMA and we had lots of discussions and debate, conferences about the likely impact on the profession and on the public's health and with, by and large, negative views coming out from the profession I think at the time. But we all went with it because we had to implement it. As a DPH I found it very interesting to be in that role because up until the purchaser/provider split I had professional responsibility for consultants working in my patch who were employed directly by the Regional Health Authority in those days, but if there was anything that needed fixing, if there were any performance issues or anything that needed looking at from an HR point of view I was always involved with that. The purchaser/provider split removed that responsibility which was interesting. It brought a whole load of other responsibilities about what we were commissioning and how we were going to organise services. My two local DGHs on the patch were required to merge to become a single NHS Trust and that was probably the most interesting thing managerially I worked on because it was my job to bring together the clinical body and from my point of view you couldn't have imagined two culturally more different hospitals that were being forced together in a very unwanted marriage. We were busy introducing people to their peers who worked only seven miles down the road but who had never met. They did not even know each other existed and they didn't want to have anything to do with each other by and large. One hospital was very 'English' and quite snooty by reputation, the other more cosmopolitan and in a poorer part of the borough with a much greater diversity amongst the consultant staff. The 'English' lot at one hospital did not want to mix with all this riff raff at the other place. It was really very fascinating bringing them together, encouraging them to treat each other as equals, matching and forming new teams together, even working together. From a public health point of view I am not sure where it sits. As a DPH a lot of the role - as it had been as a DMO - was

management and system leadership. That probably took over. This was at a time when a lot of my colleagues were bemoaning the fact that they couldn't do public health any more, they were forced to becoming managers. I actually enjoyed the managerial and leadership role and thrived on it. I still felt I was working in public health.

Did you ever think of becoming a chief executive?

It passed through my mind but I didn't seriously consider it. Some of my colleagues made that decision and went that way but it wasn't what I wanted to do.

Did you enjoy the commissioning side of the role?

I did. We had a good relationship in our executive team so I worked very closely with the general manager who became the chief exec, commissioning director, nursing director. We worked well as a commissioning team. I was aware in other places that public health was separated or isolated from commissioning or had got swept in completely. Neither of those seemed to be satisfactory but I think we had quite a decent relationship that worked quite well.

NHS TRUST

How long were you there for?

I was working incredibly hard as a DPH. I was working 80 to 100 hours every week regularly. By this time I had two children and I wanted to cut down my hours. The only way I could think of doing it was by saying I wanted to work part time which with hindsight was probably quite ridiculous as I probably should have worked out somehow with my boss how to manage my time more sensibly. At the time it wasn't something I could contemplate so I thought the only way I could do it was to say I wanted to work part time. I ended up saying it wasn't working, I had to step back, I couldn't function in that role working less than 80 hours a week to do it justice with the size of team I had and the amount of responsibility and the job that needed doing. I had always felt I wanted to do a job properly if I was going to do it at all. I am quite conscientious and I wasn't going to be able to do it in significantly less time so I said I was going to step back. I was creative with my chief exec and colleagues and said I believed we needed public health in providers. At that time I didn't realise I was being innovative. I explained to him why I thought public health needed to be in NHS trusts as well as in commissioning organisations. I put it to my chief exec and also to the chief execs of the two trusts that had formed out of our providers. One was the acute trust made out of the two DGHs. The other was the community and mental health trust which was massive, particularly on the mental health side. It had a very big institution and extensive community services which covered more than the one borough. I wrote a paper setting out the role of public health in provider organisations and they all said yes, thank you Fiona, we want you which was wonderful on the one hand but was not actually solving my problem at all. I agreed that I was stepping down from my DPH role and that I would work between the two providers which I did for a while, which was quite interesting, I carved out a role as a public health physician with significant management experience working in providers. The significant management experience was relevant because I am not sure I could have just walked in having finished my public health training. After a year one of the Trust medical directors stood down, he decided he wanted to go back to full time clinical work. He was a psychiatrist in the community and mental health trust so the immediate suggestion was that I should

become the medical director of that trust. Like a fool I said that sounds wonderful, I think I will do that if you wish to appoint me. I went through some sort of appointment process – I can't remember if it was advertised or not. I suppose it was. I was appointed to that role at which point I withdrew from the acute trust. So I became a Trust medical director from a public health background, which was pretty unusual in its day. I had been supporting the medical director in his role anyway so it was pretty obvious that this might happen although I wasn't expecting him to resign. I was part time, probably 50 hours a week! But it did allow me to pick my kids up from school, to take time off for concerts and other things I wanted to go to school for without any conscience whatsoever and for me that was the value of being allowed to work "part time." If you look at it from a hard-nosed point of view I am sure I was fulfilling the requirements of a full time job but it suited me fine. The Trust got a good deal!

How long did you do that job for?

Three or four years. We have got to the late 1990s. At that point I was enjoying things in my trust. We had had a lot of churn. The chief exec had had to leave. A really nice person but wasn't quite chief exec material. A new person came in and was fine. The top team tried to be supportive of one another. But I was beginning increasingly to worry that I had fallen out of the public health community and I was quite isolated professionally. I am not sure I was but that is how I felt. For that reason at the time I thought I needed to go back to a mainstream public health job for a while. With hindsight that was one decision that was a definite error career wise because I applied for and was appointed to a job in another London health authority which covered two boroughs. I knew it was an error almost as soon as I arrived but it was too late. What I had done was apply for a consultant in public health job and I found it was a job I could have done ten years before. I didn't find it in the least bit stimulating or stretching. I found it worrying from that point of view. I made a decision at that point that I wouldn't again go back to a job that I had done before, because of that experience. That is probably a bit too rigid but at the time that was my view. Within a few months of getting there I knew it was an error, but soon after my arrival - and I don't know if this was planned or not, I never asked - the DPH retired and there was an expectation because I was senior and experienced that I would want the DPH job, but I said no, I wasn't going to apply for a job I had done before. They advertised the job and very few people applied, nobody with any chance of being appointed. The feedback was that they all thought I had that job wrapped up, nobody was going to show an interest because they all viewed it as my job. So I then had to go public to say I was not applying, I was not going to be in the way of the person who got it. I was acting DPH for quite a long time because they couldn't appoint and then when they did make an appointment fortuitously I moved, because another opportunity came up for me which really suited me and I was very delighted to do and that was to become Programme Director for Public Health so I moved to North Thames (which subsequently became London) Deanery. It had been a slightly embarrassing interlude career-wise!

Had you been involved with the Faculty during this period? Were you well known in public health circles?

Yes, I was Faculty Adviser for many years in North East Thames and then in North West Thames. I was a Faculty Board member for many years as well. Then I became a national Director of Training for the Faculty whilst I was at the Deanery. I was quite well known, I guess. I had always been in London apart from my first few months of training so we were a

close knit group. We did a lot between us. For a lot of time I was in London Sheila Adam was our Regional DPH (North Thames)and she was very good and keen to keep a cohesive group of DsPH. We met regularly. Five of us set up, probably with her blessing and encouragement, a group to look at needs assessment as a group of north London DsPH. That was very exciting because no one had done very much around needs assessment before. The term had emerged but no one really knew what to do with it. It was important. We brought in a trainee to support that work. I was the youngest of that group of public health directors and most of the others had had long careers before they came into community medicine then public health. The registrar took me to one side when he first joined the group and said he was not sure he felt very comfortable working with this "blue rinse" brigade! I said I would counsel him that this work was going to be really important and he might not think much of their looks but there were some really good brains around this table and we are going to do some really important stuff. Which we did. And that registrar flourished and launched his career as an eminent academic, subsequently publishing widely on needs assessment! You may guess who!

Sometime or other we had become North Thames from the merger of North East and North West Thames so it was quite a big group of DsPH. Most of the women were in inner London and most of the men were in the outer authorities - and we still had Essex, Hertfordshire and Bedfordshire at the time.

A couple of other things I did in Barnet. It was nice to be able to be creative within a small department. I created a couple of new posts. I went there when HIV was beginning to be a really important issue for London so I created a new post of AIDS co-ordinator then once I appointed him he wanted one or two other people to work with him. They did some really great stuff working with gay communities particularly and also working with the local authority. At my first meeting with the local authority social services chair she looked at me and said so how many people were there with AIDS in Barnet. I said it was less than ten, but I was not allowed to tell her the exact number. But she said "there can't be any, we don't have people like that in Barnet." So I thought, OK that was where we were starting from. The other post I was really pleased about creating - and at the time we didn't think about them being public health posts, you just needed resource to do the job but clearly they were -was someone to lead on equality and diversity and particularly with regard to race and colour. That was a really great thing to be able to do as well. Those teams achieved a lot. That is one of the nice things about doing a public health job when things are possibly informal enough to be innovative and creative. Hopefully it has never been lost. One didn't then have to worry too much about a role fitting the right band or grading!

MOVE INTO PUBLIC HEALTH WORKFORCE ROLES

You moved into training and workforce?

I was Programme Director and allowed to be based at the RHA headquarters which was nice. My boss was at the Deanery but I was allowed to work really closely with regional public health people and other people at region, encourage them to have trainees. That was when I first met Sally Davies when she was heading up R&D at North Thames and I introduced her to the fact she could have a public health trainee.[2] That was very exciting so she took on

[2]Later Chief Medical Officer at the Department of Health

public health at that time. The job was part time intentionally on my part. When I had been doing that job for a year or two three things happened. We merged North Thames and South Thames training programmes so I headed up both and integrated them. I was able, with the agreement of my Dean Director, Liz Paice, who was very forward-looking, to make my training programme multidisciplinary and we did it properly so we had our multidisciplinary trainees doing exactly the same as our medical trainees which was brilliant. I had to go with my begging bowl to the health authorities to get funding because at that point we couldn't fund it through the Deanery. Once the education levies were merged we then managed to get funding sorted and it has been mainstream for some years now. Ours was the first fully integrated full length programme. We even had to invent a certificate for completion of training which they wouldn't have had otherwise. The other thing that happened was that I became an Associate Dean which was really nice in terms of personal development because it allowed me to have what was called at the Deanery a "basket" of specialties, so I had public health but also several clinical specialties. A nice spread of work. We developed a lot of training locations in that period. I did quite a lot of work involving unusual placements which became known as "national treasures." Places like the King's Fund, the Department of Health, the Department for International Development (DFID), various academic departments which had been semi engaged, all became formally approved training locations.

What took you to your next job?

I can't remember how exactly I heard the job was being advertised for Head of Public Health Development at the Department of Health. I was already so wedded to the stuff about workforce and having been a Faculty Adviser and trainer for so long I thought I had to give it a shot, because it sounded exactly the sort of thing I would love to do. I applied and got it. It was reporting to Don Nutbeam as Head of Public Health. It was a lovely little team. I had a lot of people reporting to me, but the senior team was Don and what I described laughingly one day as the "three witches," the three women (including me) reporting to Don as his senior people, each with their own teams. Incredible learning curve. I knew nothing about working in the civil service. The thing I went in saying I would deliver 100% which was essential, because I was already passionate about the idea, was regulation for multidisciplinary public health and full equity for the multidisciplinary public health workforce at specialist level, but also to develop practitioner and wider workforce. That was my brief. It was a fantastic time to be able to do that because it was not long after the CMO's report came out on public health so we had that to work with and on. The Register was set up.[3] I did a lot of work to support the Observatories as well.[4] They were part of my portfolio as was everything that was viewed as a public health resource, open for development. A nice, broad remit. I also had public health R&D and I developed much closer links with the R&D Directorate in the Department than had existed. A decade later this has reaped dividends as public health research is much better resourced than it was when I started out. We also all had efficiency savings to make and we were forever looking at reorganising and reforming, so that was going on as well, but that wouldn't have come out in the public domain so much. In policy terms, it was a very positive time. I worked with four Ministers of Public Health whilst I was there, all very different but all very interesting, mostly very or quite enthusiastic. Some of them really picked up their brief and were passionate about it and for others it was today's job and they

[3] now known as UKPHR

[4]Public Health Observatories providing health intelligence information at regional level

would be doing something else in a year or two. Learning to work closely with ministers was interesting anyway as I had not done it before.

BACK INTO GENERAL PRACTICE AND KEY ROLE FOR THE ROYAL SOCIETY FOR PUBLIC HEALTH

When did you leave this job?

In 2004. I wasn't there very long. Everybody assumed I had been there longer because so much happened. I also had responsibility for the inequalities team when Don Nutbeam left so that was interesting too. I brought in Deirdre Cunningham to support that work.[5] She was great. I also brought in Mala Rao to support me on workforce. That was good, too.

I went to the Department full-time. It was really nice because I had decided by then that my kids were in their teens so it was a good time to go back full time and give it my best shot. I actually thought I would be there until retirement if I could hack it and if I enjoyed the environment. But as it turned out that didn't happen. One of my sons got very ill and I was carrying on working but finding it quite difficult to get my priorities right – to be in the right place at the right time. I was delegating and feeling uncomfortable, feeling distracted by a very sick teenager in hospital. I sought the possibility of taking some time out. That wasn't granted so I said no, I would put my family first. That was my career as a civil servant – interesting while it lasted.

It was horrible year. I came out of the Department thinking what would I do now? I wasn't going to dwell on the fact I had a sick son. I had to look forward. I was not not going to work forever more, so I contradicted myself and did something I had done before but which was still going to be novel because it had changed such a lot since the last time I did it. I did a returner scheme for general practice. I went to speak to my old colleagues at the London Deanery and said did they think I would be crazy to do this? The answer was I would be mad but they had to encourage me to do it because the NHS desperately needed good GPs. So I said, OK I would give it a go. But please find a training practice that could cope with me and treat me like any other trainee or returner and they did. It was brilliant and I really enjoyed it when I went back. So I did a six months returner scheme in general practice in 2004.

Have you worked part-time in general practice ever since?

Yes. I stayed in general practice but also retained my interest and have always done something in public health whether voluntary or paid. I had completed my returner scheme and was doing some part time work in public health as a locum as well as working as a GP when the Department of Health initiative from Mala came out developing teaching public health networks. I was probably encouraged to apply - can't remember. I led the TPHN for London based at the London School of Hygiene because of Martin McKee's involvement - he was instrumental in making that happen.[6] A good move. I enjoyed being there - a very stimulating environment. Our priorities were working with the third sector, developing teaching and training and initiatives for undergraduates from areas that wouldn't normally be reached by good public health teaching and training. The skills passport we worked on then is

[5]Director of Public Health in London

[6]Professor of European Public Health, London School of Hygiene and Tropical Medicine

just being reborn! The TPHN initiative was nice while it lasted. Funding was limited, support from the centre was limited and once it dwindled we knew out days were numbered!

I had also previously set up the public health network for London when I was Programme Director so we had already had a culture of meetings for the wider network, the whole idea of meeting with people who came from local councils, commissioning and public health people, for continuing professional development (CPD). We held conferences a few times a year. So we had set that up several years before. Then through LTPHN we recreated the networking side of the network as well as the work it was going to produce. It was a nice opportunity to get that going again. I believe the network is still running for public health people in London.

I had also been responsible for setting up the public health leadership programme. I was very fortunate. I had always been interested in professional development and was writing stuff about the need for better leadership and was very fortunate that my RDPH at the time [late 1990s] was Maureen Dalziel. I asked her if she could sponsor me to do the American public health leadership programme which she did - it was mostly a distance learning programme. Then I came back and set up the public health leadership programme in London and then joined up with Rod Griffiths, Regional Director of Public Health in West Midlands, and we established the national multidisciplinary public health leadership programme. Trying to ensure everyone who was in a management role had an opportunity to develop their leadership skills. I recall making the case to DH and saying I would withdraw completely if they restricted participation to doctors and they accepted my proposal!

When did you get involved with the RSPH?

I had been a member of council for the RSPH for several years; I came from the old Royal Institute of Public Health (RIPH) when it merged. I have been chair for two and a half years. An honorary role and a great privilege. I appointed a new chief exec, saw through transition which was beautifully smooth. The outgoing chief exec left with head held high and happy with his decision and the incoming chief exec, Shirley Cramer, is doing a really good job.

REFLECTIONS ON PUBLIC HEALTH

What are your views about public health's place in management tiers in the health service?

My passion was that public health should be absolutely central to decision-making in the NHS, so to be in a position where you are sitting as an executive director on a board wearing the public health hat was core to the workings of the health service, so that you could try to influence decisions so that they would be made in the interests of the health of the population and describe and explain in a clear way to your colleagues, who from a public health point of view, were lay colleagues on the board, what the implications of decisions were, depending on which decision they made. So for a decision that was going to be antagonistic to the health of the population we were there to be able to describe what the impact was going to mean. If it was going to have a positive impact to be able to say why this was such a great idea. Without public health there people might speculate around some of that. They possibly don't in my experience, so it was incredibly important. Some chief execs have got it and they will go and seek it out if they realise and others will assume the other person will fill that gap and view it as important. It did vary from place to place how vocal the public health input

was and in some places maybe it was stifled and in other places it was less competent and didn't find its voice. You only know directly about where you were yourself. You hear stories about elsewhere where public health was viewed as very weak.

My personal view is that public health has to get involved in management. There were certainly people in management roles in public health because they felt it appropriate or because it was the most senior position who didn't want to get their hands dirty with management. I think that has been a problem for public health. It is very difficult to have a senior role and not be deeply immersed in management and get your hands dirty and deal with the politics. We have had a history of people being promoted to roles not that they were capable of doing, but which didn't suit their whole being. I think possibly a similar situation still applies with Director of Public Health roles, but it is probably different in a sense, because you have Public Health England so some of the people who don't want mainstream management roles in local government or the NHS will find roles that are more professionally oriented in Public Health England. They are still needed but you can't do a purely technical role in a managerial capacity and be competent in my view. You have got to use your management role and have the management or leadership capacity to do that.

What has been the impact of periodic reorganisations on public health sitting in management tiers of the health service?

I suddenly decided that at the time of the most recent reforms that came in in April 2013 I was describing myself as a 'change junkie'. I was getting a kick out of all this change and I was going with it and finding it quite exciting to be part of change, going through change, creating change. That's in no way suggesting the changes were correct - I did have real concerns about what was proposed and still do now that they are with us. But change process itself I really enjoy at a personal level. I am happy to change jobs - I have changed jobs many times in my career because I enjoy change. The fact is I have never wanted to do a job for 30 years. When I trained as a GP I knew that I wouldn't be able to do it for the rest of my career. I knew that was just not me, something innate in me that I need to do a variety of things. Part of the reason I enjoy being involved in change is I absolutely hate seeing people harmed by change - so I have worked really hard through change to minimise the harm to individuals. I have not been a victim of change myself which is a privileged position which allows me to be supportive of other people without feeling I have to look after myself as well. I think over the period of my public health career we have certainly lost expertise and skills at every reorganisation. We know that and I think it has been a great pity, but you can see why people look after themselves and decide if they lose their jobs and are damaged why they make the decision to go and if the alternative is sometimes people say no, this is one reorganisation too many. I have heard many people say that and just make the decision to go. I see it with clinical colleagues now too, particularly in primary care. People are making decisions to go rather than stay for yet another year or two of things getting more challenging or less likeable. At a personal level I am someone who has moved house several times, I have not changed families- some consistency and stability there! - but personality-wise I do like to do different things, see change.

When you become a public health consultant you have an expectation that you are not going to do the same job until you retire, whereas when you become a clinical consultant - though it is beginning to change in some specialties –you choose your consultant post for the rest of

your career, you stay in general practice for close to thirty years. Certainly as a young consultant people were amazed at me, saying oh you are moving, doctors don't behave in this way, you are behaving like a general manager - they don't stay very long either. So there was always that bit of a taint to it as well as a bit of curiosity as to why you were not behaving like a "proper" doctor or an "average" or "normal" doctor.

What are your reflections on being a woman in public health and public health as a career for women doctors?

For me initially I thought it was going to be a bit of a compromise because I thought I don't know anything about medicine apart from clinical medicine and I enjoy that but having discovered public health quite unexpectedly really for me as a woman I was initially pleasantly surprised at how exciting and stimulating it is. As a woman with a family it is a great career. As a specialty that offers diversity and amazingly wide opportunities for men and women it is great. When I was a programme director I was always very keen to recruit people who viewed themselves as being able to take on lots of different roles rather than just "I am training just because I want to be a DPH" or "I am training because I want to be a CCDC." Those kind of people bothered me, because when you do have change you have to be able to cope with it. It is a really wonderful career - and this is not a gender thing – for people who like variety and never want to be bored. If you want to do something that is very stable and doesn't change year in year out there may be some jobs in public health that are like that but in the main it is not like that. Whether it is particularly good for women? In terms of you can do all the stuff that takes you away from home and makes you work long hours and all the things that are not family friendly if you want, but you can also find jobs that are much more flexible or you can create your own flexibility more so than in many other areas of life. Medicine has become much more flexible in that regard. Now the story is very different and someone like me: possibly I would have ended up in public health, but probably not as early as I did. I think the opportunities are very different for young doctors coming through the system. That passion was there but I did not know it was there until I was prompted to apply for public health early on in my career. If I hadn't had that prompt I probably would have stayed in clinical medicine longer, although I suspect I probably would eventually have got to public health. It is a great career for women; it is a great career for men. In terms of individual jobs, the history of public health is such that it is a great pity to make a lifetime decision, career decision based on how things are right now, which we all tend to do. I talk to young doctors a lot, medical students and foundation programme doctors. Some of them are saying they are not sure they want to work for a local authority. I can understand that. I say to them, we don't know what is going to happen to public health in the next decade, by the time you have finished your training. There are other public health jobs with opportunities. The management training in public health is really important so that people who have trained as doctors, go into public health then back into clinical medicine take with them a whole lot of added value.

Why do you think no one has looked at public health women doctors?

I don't know! Possibly because women have always been a significant feature in public health it has not been particularly newsworthy. Women in medicine - there were none and then there were some. There is a story to be told. The birth of public health, a story. But women in public health? We have always been there and people have thought it was steady

state. I am not sure it is. Maybe we need to understand why it is more attractive to women than men if that is the case. Why is it unattractive to men? There has been speculation about that over the years. Whether there has been research I don't know. The speculation over the years has been that private practice in public health is negligible so that for doctors who are looking at maximising their incomes, public health is not a particularly attractive option. So from a medical career point of view, why do public health unless you are absolutely passionate about public health or unless you are going to be a very successful academic whose work is recognised through clinical excellence. But for non-medical people in public health a different set of arguments may or may not apply. I don't think that is the whole reason. I think a lot of women generally are possibly less driven by income than men, but I may be making a broad and dated generalisation about married women rather than all women. Certainly when I joined public health it was already a very mixed group. When I joined it as a public health trainee - a doctor in public health training - there were already more women in public health than in any other area of my experience including my 20% at medical school. So we were already there. Is it men saying "no" or women saying "yes" - which is the stronger element or is it both?

Is there anything we haven't covered?

In terms of the earlier days of public health when we had a reputation in community medicine for not being a very effective specialty. I wasn't aware of that being attributed in any way to having a large proportion of women. I have never been aware of that. In terms of people being able to carry weight, have their presence be heard, I don't think it's been a case of well the men get heard and the women don't. I am not aware of that. There has been continuously concern that the public health voice has not been as effective as it should be. Hopefully it is improving - but I have been saying that for a long time! But I don't think that is a gender thing as far as I know. There have been some very effective women; there have been some very effective men. There have been, unfortunately, some ineffective people in both genders. As far as I know it is not particularly a gender thing. One could possibly argue that women might be more intimidated in some circumstances than some men but I don't know if there is any truth in that or not!

We haven't covered multidisciplinary public health. As a doctor in public health my biggest passion really has been to make us multidisciplinary and I have no idea whether that has anything to do with my gender. I think it probably hasn't. Coming from a minority -in my training as a doctor I was in a minority, in most specialties women are a minority. There is something about giving a level playing field for people we think ought to have a level playing field. It is something I have felt really strongly about for a long time. There has been an immense change this century. Public health is great!

Thank you very much for your time