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DR. SUE ATKINSON, CBE

Career summary:

Sue originated from nearby Liverpool. Initially she studied zoology at university and started research at University of Cambridge before switching to medicine, undertaking her clinical training at the Middlesex Hospital in London. She went into paediatrics in Bristol before switching to public health (then called community medicine). During her training she spent a year in academic epidemiology in Australia then, back in Bristol, time training in primary care before completing her public health training. Her first consultant post was in Bristol. She then moved to London as consultant/ senior lecturer before being appointed Director of Public Health and later Chief Executive in South London and then Regional Director of Public Health for Wessex Region, South West Region and then South Thames. She became the first Regional Director of Public Health for London and developed the role as Health Advisor to the Mayor and Greater London Authority (GLA). Upon retirement she, together with other public health colleagues, set up and became chair of PHAST (Public Health Action Support Team), a not-for-profit Community Interest Company) and Non Executive Board member of UCLH (University College London Hospitals NHS Foundation Trust) and Board Member of the Food Standards Agency. She is Visiting Professor in the Department of Epidemiology and Public Health at UCL, continues to Chair PHAST and is Co-Chair of the Climate and Health Council.

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EDUCATION, FAMILY BACKGROUND AND MEDICAL TRAINING

Tell me about your early life

School was relatively uneventful. At about 14 or 15 I vaguely thought that I might study medicine but at that time at my school you had to choose between sciences or languages and I was doing languages. 'A' levels came along and I decided that, as I was quite good at maths and biology, my 'A' levels would be chemistry, maths, physics and both 'A' and 'S' level biology but then in parallel with that I did 'O' level chemistry and physics at the same time, as I hadn't previously studied these. It was a complete nightmare. I was running from class to class. I was doing stuff in chemistry 'A' level that I had no idea about as I hadn't done the 'O' level bit yet. Challenging but I managed to do it!

What made you do this?

I decided I would quite like the option to do medicine. Then at the end I thought, I don't want to do medicine, so I decided to do zoology - my first degree is in zoology. I went to the University College in North Wales at Bangor because that was very good for zoology. When I finished, I went to Cambridge to do research on animal behaviour in monkeys, but I only did that for a year. Sitting in a hide in the freezing cold I wasn't sure I wanted to spend the rest of my life watching monkeys. My supervisor, a famous animal behaviourist, was really nice. His son had just started to do medicine. He said don't worry about research. Stay if you want to but if you think at some point you want to do medicine just go and do it. He was very supportive. I went to Cambridge to do medicine at the grand old age of 22 - I felt much older

than all the other undergraduates! There were four of us in our year who had done other degrees before. For me going into medicine was definitely the right decision.

Were there any medics in the family?

My grandfather was a pharmacist and there had been medics in the family on both sides in earlier generations. But no, not in my immediate family. My father was an engineer and my mother was an arts person.

How about school?

I was at a girls' school, Merchant Taylor's School in Crosby. They were quite encouraging but they really didn't tap into everyone's potential. In every year of 30 there were about five who went to Oxbridge. I never thought about applying for Oxford or Cambridge at that stage as I thought, for a long time, you could only get in if you got a scholarship or an exhibition because everybody who was put forward from our school got one. They could have had another whole tranche going if they had tried ordinary entrance. At my school you were either going to get a scholarship or an exhibition or you applied somewhere else. I didn't learn about that till years afterwards.

I don't know what sparked it off but once I started doing medicine I loved it. Because I was a mature student, I only had to do two years at Cambridge, covering medical sciences there, and I also got out of doing some of the biochemistry because I had done it before with my zoology degree. The thought of doing it again was dire! It was in the days when you then went to one of the London hospitals for the clinical training and I came to the Middlesex Hospital.

Were there many women doing medicine at Cambridge?

There were quite a few in medical sciences, which also mixed with natural sciences for some courses anyway. It was a quite a big group - a quarter probably women. I didn't really think about it in those days.

Tell me about your time at the Middlesex?

It was good. We had reasonably small "firms" of eight of us and you had two firms doing general surgery, two firms doing general medicine etc. I remember there was one other woman in my group, two of us out of eight. Of course, once we came into the Middlesex we mixed with the people who had also done their pre-clinical work at the Middlesex so there were some people from Cambridge and some people who had done their whole training at the Middlesex.

In those days the Middlesex was linked to the Central Middlesex Hospital so we went there to do surgery and saw more general work. At that time there was not much of a population living in central London nor round the Middlesex. I remember one night someone came in with appendicitis and we literally all called each other up and went in to see the management of the patient because it was so rare.

I had no idea at the time that public health existed. I think with hindsight we got one week when we did Ear, Nose and Throat (ENT), eyes, dermatology and what was called occupational medicine. The good bit about occupational medicine was they took us to see one of the coal mines in Kent and we went down a coal mine. The coal miners were amused.

There must have been a very small number of women because they made remarks such as "what are you girls doing down a coal mine?" I learnt to take snuff down there because that was what they did. The coal dust was so horrible they took snuff to clear their nostrils - it probably only pushed the coal dust further down into their lungs! There was a lot of amusement from the miners because I (a woman!) was perfectly willing to try taking it whereas others did not want to try. That was the sum total of my introduction to public health!

EARLY CLINICAL CAREER

I was all set on a clinical career, I wanted to do paediatrics. Essentially that is what I followed for five years. I did house jobs then various paediatric and neonatal jobs in Cambridge then I moved to Bristol, to the Bristol Children's Hospital where I had the professorial job as a Senior House Officer (SHO) initially, later a registrar. I started to question whether I really wanted to stay in hospital medicine. It was just about the time when the Court Report had come out and it was intended that more paediatrics would be community-based.[1] I thought that would be good. I saw all these children in Bristol Children's Hospital who I thought did not need to be there. I also did an oncology job that was fascinating - I loved it - but grim and obviously all those children needed to be in hospital but there were an awful lot who did not. But the Court Report did not seem to come to much in terms of action. So I shifted to do a part clinical job and part research job with Professor Neville Butler who was a "big brain."[2] Lovely to work with but quite eccentric.

The research I was doing was on the survey that was called "Child Health and Education in the 70's" and it was the first big national survey of children up to the age of about ten: a huge cohort study across the UK. I was working on several areas - epilepsy, vision, febrile convulsions. I did various parts of the analyses. Because I had done zoology and research I was very able to switch to do medical research because I knew quite a lot of the research methodology and statistics. It came in useful. But I also discovered this thing called "epidemiology." That got me into thinking, this is fascinating and this is about populations. I met a very good woman connected with public health, which was called community medicine at the time. She was a Specialist in Community Medicine (Child Health). There was myself and another guy who were doing this research and she asked had we thought about doing community medicine? We said, we had never heard of it but, basically, she recruited us as registrars! I continued some of the research in epidemiology on the child health data base but moved across to do community medicine.

ENTRY INTO COMMUNITY MEDICINE

Did you formally apply?

We did but it was a bit vague. I think at that stage it wasn't a very formal system. We did have to apply and be interviewed, so went through a proper process. We became registrars in community medicine in what was then Avon Area Health Authority (AHA). I was part of the training programme that covered the south west, Oxford, Southampton, Wessex, Wales etc -

[1] Report of the Committee on Child Health Services (Fit for the Future), 1977
[2] Professor of Child Health, Bristol.

the South West Consortium. I worked as a registrar with the AHA and every month to six weeks as trainees, we would spend a week or a fortnight away in one of the bases of the Consortium - eg Bristol for epidemiology, Southampton for stats. etc - as part of the training package. I was based in Bristol.

Did you do this full time?

I always worked full-time. Then I took Part I, the theoretical exam (of the Faculty of Community Medicine). This was the "theoretical" part of the exam equivalent to the current Part A.

My partner at the time was also a zoologist and he had done his PhD in Australia and wanted to move back there. We decided to move to Australia although I wasn't totally enthusiastic about it. I said I would give it a go. I took a year of unpaid leave from my PH training and was appointed to a job in Perth in the NHS Medical Research Council (MRC) Unit of Epidemiology run by Fiona Stanley, a very well respected important person in paediatric epidemiology in Australia. I spent a year and a bit doing research there on cerebral palsy and other disabilities related to low birth-weight neonates. It was a wonderful place to do that sort of research because Western Australia is a huge geography with about a million population - but it is a long way from the rest of Australia. You don't have the problem of cross boundary flows! There was one centre which saw all the children with developmental problems. You had a captive epidemiological population. So that was great. I wrote various papers. I decided I didn't want to stay in Australia so we moved back and I started back in Bristol again as a registrar and then senior registrar in public health. Then it was coming up to the time when the training programme for general practice was about to change, the early 80s. I decided I wanted to keep my options open and also, more importantly, if I was going to do public health, which I was now thinking I would definitely do, then it would probably be good to know how all parts of the NHS runs including primary care. Then, if you had done four different relevant house jobs followed by the one year GP training programme, that covered the qualification for general practice. I had done enough of the hospital posts to add up and I went off to do the one year general practice training. I took a year out again from public health.

The one thing I have left out of this is something that really influenced me about coming into public health and it was when I was still at the Bristol Children's Hospital in 1978. The King's Fund used to take four doctors, four nurses and four administrators to the United States for a month. I applied when I was doing paediatrics and I was accepted. We were taken to the States for a month with twelve others and we spent two weeks in Duke and Chapel Hill, learning about the health system, health delivery and two weeks in Washington , connected in more to the "politics." I found it fascinating and it really influenced my decision to go into public health, where planning and delivery of health services is part of the role. While we were in the States we went to talks and seminars but a lot of it was learning about how different health systems worked, the different costing systems. At that time Health Maintenance Organisations (HMOs) were new. It was a really exciting time. It was really influential in me deciding to shift from paediatrics to public health, because of an interest in health service delivery systems and I have been fascinated by them ever since. The research I have been doing recently on diabetes internationally has taken me back to the same, interesting aspects of how health services are delivered in different places. That aspect of

public health was always important to me, to improve the calibre of health services is what I wanted to do.

I finished the year in general practice but did not go into general practice. I was pregnant with my daughter, Zoe, and my partner and I split up whilst I was pregnant (he moved back to Australia). I had to work up to the end of my pregnancy to complete the GP Training year. I took a couple of months' maternity leave after it. Zoe was born on my last day at the practice. I rang in - I didn't know I was in early labour - to say I felt ill and I couldn't do the clinic that morning. Later that evening I gave birth.

Doing general practice did convince me that I really wanted to move back into public health so I moved back as a senior registrar in Avon Area Health Authority in 1982 just as it was changing back to a District Health Authority - I remember going with Zoe one evening, when my nanny was ill, to an Area Health Authority farewell do.

I had done my Part II - I set up a vision screening programme in Bristol.[3] I naively thought I could write it up while I was having two months' maternity leave. If you have had children you will know that is very naïve! So that didn't work. I went back as a Senior Registrar, wrote up my Part II whilst I was doing that job and then I got my first post in Bristol as a consultant in public health with Bristol District.

CONSULTANT POSTS

Was there much competition?

There had been a vacant post for a time and I was an SR there. I went through all the proper application and an interview processes. I think there was one other person interviewed. I did two years there as a consultant, picking up different aspects, which was good experience. We had a gap in community disease control so I covered that, it wasn't what I desired to do but it was very good experience and of course we were all on call for health protection. We had to cover port health, not that it was a huge, thriving port, but we did get called every so often and had to go out and see what was happening, people arriving who had been ill on a ship for example. I remember being rung one night about rats and I thought it's a good job I know something about this from my zoology, at least to ask what sort of rat, brown or black, to know what was important or not. It was a fairly mixed sort of post. But I wanted to move back up to London.

So I moved back to London. I applied for a combined senior lecturer/consultant post at Guys and Lewisham and North Southward and was appointed. Graham Winyard was the DPH there.[4] The academic part was between Guys and St Thomas' - Jock Anderson and Walter Holland.[5] I was very excited. I needed two to three months to finish in Bristol and by the time I moved back to London Graham told me he had just been appointed to a post at the Department of Health. I was surprised to be asked to be acting DPH. There was one other consultant, part time and she was focused on health promotion and there was another vacant

[3] Second part of the Faculty of Community Medicine membership examinations consisting of dissertation and oral exam

[4] Later Deputy CMO and Medical Director of the NHS, England

[5] Professor John Anderson, Head of Department of Community Medicine, Guy's Hospital Medical School; Walter Holland, Professor of Public Health Medicine, Guy's and StThomas' and former president of the Faculty of Community Medicine

post - there should have been three consultants and a DPH. I had my arm twisted really. I was pretty unhappy about it at the time - I had come to do this nice job which I thought would be perfect, half academic and half service. This was around 1987, 1988. I ended up as acting DPH and was then appointed as DPH and never had time to focus much on the academic role. We knew the academic department quite well and went to seminars and talks at Guys and Thomas'. There was a bus which ran between the two and we would pile onto it and go to the seminars.

DIRECTOR OF PUBLIC HEALTH ROLES, LONDON

It was a good time and we did some good work.

Were you able to build up a team?

Yes and I also built up the role - I had planning, information, a separate health promotion department and a public health department - quite a big span. I enjoyed it. I stayed there a while - we went through loads of changes - they brought in the purchaser/provider split whilst I was there. We did some really good work as South East London Commissioning Authority (SELCA) before we became South East London Health Authority (SELHA). We developed a lot of the systems that were initially put into place with commissioning. There were a number of projects. I remember "Project 26," which was the front runner for developing commissioning health services. Because we had planning and information and public health together we could connect it all. By then I had a really good team. Originally we were Lewisham and North Southwark then we put together Lewisham, Southwark and Camberwell Health Authorities as South East London and because there had been three departments of public health so I ended with a big department. We must have had six or seven consultants, and a great team. There was one nasty moment when I had to get everyone into a room and say there were ten people in the department who all thought they were "doing" haemophilia and we needed to sort that out! It was not a good use of our resources in terms of capacity. There were some "frisson" moments! We wrote, on the evidence that was available at the time, really good specifications for services. We were genuinely front runners (along with some other HAs) on commissioning and took it forward quite a long way, building in evidence and quality and not just cost driven.

I don't remember doing very much with other DsPH. We weren't London, we were part of South Thames when London was divided into four - north, south, east and west. We had South East Thames meetings usually held in Tunbridge Wells. That was the next step because the RDPH post came up in South East Thames and I applied for it. Most people thought I would get it, including me, and I didn't. It was a great blow. I did a terrible interview. I wouldn't have appointed me either! I was naïve, and thought I could swing through it. I didn't do my homework and waffled on in the interview. So that was that. I had huge support though from my team. The next organisational changes in the NHS were about merging Family Health Service Authorities which managed primary care, and Health Authorities together. Ron Kerr was our chief executive and he moved off and I ended up as acting chief executive for South East London HA for about six months. Hugely relevant experience. Really enjoyed doing it. I was very pleased to be given it because it was obviously in recognition that I was doing a good job. I then had a difficult dilemma as to whether I moved

across and applied to be the substantive chief executive and go into management or whether I wanted to stay in public health and look at other possibilities there. Wessex Region was just appointing a Regional Director of Public Health. Ken Jarrold was the chief exec there and he was keen that I apply. It was one of the most difficult decisions of my life - which way to go? Weighing up all the pros and cons I thought I really wanted to stay in public health because that was my passion, I was fascinated by inequalities. I was appointed the Regional Director of Public Health in Wessex Region. That must have been 1993/4. I had just been appointed to Wessex and I had Zoe (my daughter) as an eleven year old - just landed in a good secondary school. My heart sank at the thought of moving her and the disruption, so I decided initially to commute. The RDPH job was based in Winchester. I discovered outside London there are fewer evening meetings. In London you work 14 hour days. In Wessex, most of the work happened in the daytime. Occasionally I had evening meetings and I would stay over. Most of the time I could commute and there was a good train from Waterloo which took an hour and I could work on the train there and back. That worked fine. Within six months of me going there, however, there were all the regional reorganisational changes. We had to do the reduction to only 200 people in each region and then there was the merger of the regions. South East and South West Thames came together. Wessex and South Western came together. I initially became RDPH for the whole South West Region, based in Bristol and it became more tricky to manage. We all had to reapply for our jobs. You could apply for all eight RDPH posts if you wanted, but as everybody said, you would look a bit "needy" if you did! Between us - we were all incumbent RDPHs - we negotiated which ones we would apply for. I applied for the South West one having been there for a while but I also applied for the South Thames RDPH post. It was again a difficult decision because I got offered both and I had to choose. I chose South Thames for London, the convenience, not having to move. It is difficult when you are a single parent, as you have to provide some stability. My support mechanisms, family etc were based in London. I started the South Thames job in 1994, and then we stopped being Regional Health Authorities and became Regional Offices in 1996. We had the two Regional Offices, North Thames and South Thames. Maureen Dalziel was RDPH in North Thames and we tried to do some things together, where we needed to cover London. We were both involved in an interesting programme called "Megapoles" which was about health in capital cities in Europe.[6] When the mayor was to be elected in 2000, following the Greater London Authority (GLA) Act in 1999, that was the first time the NHS decided to have a single London Region. London had previously always been divided for health management into four and then two. Nigel Crisp became the Regional Director for London and he had to appoint his team from the North and South Thames teams.[7] It was a closed ring initially. I was pleased to be appointed as RDPH, the first RDPH for London. That was in 1999 so that we would be functioning as one London Health Region when the GLA came into being, in 2000.

That must have been one of the biggest public health jobs in the country?

Yes it was. It was very interesting. It was noticeable in the Megapoles project. You would meet with our equivalents from capital cities like Copenhagen or Stockholm; 15 of them as it was prior to the accession countries joining Europe. They would say, my population is (say) 250,000 and I would say mine is seven million and they would comment that "that is twice

[6] Megapoles was a EU funded project examining comparative health aspects of the capital cities across Europe.
[7] Nigel Crisp later became Chief Executive at Department of Health and NHS and is now Lord Crisp

the size of our country!" or some such. Very exciting. I persuaded Nigel that we should do a Health Strategy for London - I mean a health strategy, not a health services strategy. We set to in 1999 to do this in the most collaborative way we could. I had a steering group of something like 35 people - even I know that is not a good size for a steering group - but this was about ownership, engagement, working collaboratively with people who we hadn't necessarily worked with before. Sally Davies was appointed as London Director of R&D and she and I worked closely together.[8] She was immensely supportive. She supported us with some research funding - we applied for it through all the proper processes - for action research on the process of developing the Health Strategy. We had observers who followed us through and fed back as we went along. We had to modify what we were doing. It was very exciting in terms of methodology and product. It was a huge process and we finished with a massive conference - about 1,000 invited people - to identify what would be the priorities. We came out with four - inequalities, black and minority ethnic groups, regeneration and health and transport. It was the first time that health had come out with those sort of priorities. Transport was influenced, at this stage, by the mayoral elections – all the candidates had said transport in London was a really big issue, so we wanted to include the health aspects. The strategy was evidence based. Sally had supported us with the evidence colllation. We got good feedback. Remarks such as "this was the first time that the NHS had ever involved us in anything like this." Out of the process and people involved, we created something that was initially called the Coalition for Health, they later became the Mayor's London Health Commission. They were there to keep watch over the priorities and what became of them and to ensure the health aspects were progressed.

In the run up to the mayor being elected, a functioning office had to be set up - so the mayor could start the moment he was elected. This was set up as a forerunner to the Greater London Authority (GLA) at officer level and I seconded one of my senior team to be part of that. The basis for this was that within the GLA Act there is a clause which says that the Mayor will take the health of Londoners into account. We had managed to get that into the Act via a lot of manoeuvring on various people's part not least people in the King's Fund. The Mayor did not have responsibility for health services but there was this health aspect included in the Act. That has been a really important clause in the GLA Act that we used over and again. The GLA is a strategic body and had responsibility for eight strategies at that stage-– transport, culture, spatial development, noise, waste etc. Seconding a public health person there was significant because it made the point that we expected health to be a key element in the strategies and not just an add-on.

The next big step was that Ken (Livingstone) was elected. We were all set to meet him - Nigel Crisp, myself and Ian Mills, who was the chair of the London NHS Regional Office. The meeting wasn't at the current City Hall because that was still being built but in a building that had been a hotel in 1940's - all corridors with rooms off them. We were told he couldn't see us. We were disappointed and hung around a bit when I suddenly saw this figure walking towards us down the long corridor. So I said here he is. He was indeed coming to talk to us and he said I am very sorry I can't see you today because I haven't been briefed on what this is about. I said, let's tell you what it is about, have a quick chat, it's not a big deal. We were delighted when he said OK then. So he took us into this massive room with a huge table, with all new odd office chairs around it, and he said to me someone tells me you are my

[8] Later national Director of R &D and first female Chief Medical Officer, Department of Health

health advisor. I said, yes that's exactly right, I am the Director of Public Health for London. He said yes and we are going to have a London Health Commission. I said we had done a lot of work already on a London Health Strategy, and outlined some of it briefly for him. He suggested as his health adviser I should tell him which of the new office chairs would be best for people's posture and backs. The look on Nigel Crisp and Ian Mills' faces! I thought, oh well…thinking back to my GP days and what I could remember from orthopaedics, I outlined some of the issues re lumbar support etc. It was one of those wonderful moments where I thought I just had to take the opportunity. That was our first encounter and at least we had had our first meeting - it went OK, a bit different from what we thought it was going to be! You suddenly realise, and I always say this to people, you have to get your toe in the door, you have to start with *their* agenda. You don't start where you are - no point as they aren't there!

We developed the approach with the Mayor, working between the NHS Regional Office and the GLA, and linking into the Government Office of London (GOL), who still had some of the responsibilities for London. We in public healath, were later transferred over to Government Office of London when NHS Regional Offices changed again. We developed health impact assessments. The first thing I did jointly with the Mayor was to produce a leaflet on "demystifying" health impact assessments (HIA). At that time HIA had been used mainly in PhDs and very substantial studies and not much else and they took a substantial length of time. We produced a process, a methodology that enabled us to do HIA on each of the Mayor's strategies in the time during which it was still in draft but in the public domain, while the London Assembly was looking at it - basically we had to do it in two to three months. What we negotiated was that we could help the people drafting the strategies with the evidence base on each of the strategies and we used some of our funding to commission experts to pull together an evidence base from secondary research on the health issues in relation to each strategy. They were very useful. After the first two or three the Mayor's office funded them. Taking that HIA approach was powerful. Because I had people based in the GLA - still there - they were able to work with the people developing the strategies from the beginning. We took the threat out of the HIAs because they had already built a lot of the health evidence into the strategy early on, so by the time we came to do the HIA many of the health issues had already been taken into account. The first one we did was transport. This caused a major headline because we showed that air pollution killed more people than accidents in London - that was a massive Evening Standard headline. Using the HIA process we managed to get much more active transport, cycling and walking into the transport strategy and that has been externally evaluated and published. We think the HIA process had a real impact in practice on the health aspects of the strategies.

We did loads of stuff with the GLA. We were always boxing and coxing between the GLA and GOL. The Government was very wary of the GLA and Ken was not in the Labour Party at that stage - he was independent. It was tricky times with the politics and I used to wear different hats at different times. Sometimes I was a civil servant, sometimes a health advisor, sometimes the Regional Director of Public Health. Not in a malevolent way. We used the Coalition of Health - which became the London Health Commission (LHC) - which was the standing body for Ken to focus on health.. Ken had said in his manifesto he would have a LHC. Health wasn't the highest thing on his agenda to be honest, transport was a major first issue in London, but we ran the Health Impact Assessments (HIAs) through the LHC. We

also had some sub groups. One particular one was Smoke-Free London. There were also others on different topics and they were run through the London Health Commission and were "independent" of me (as RDPH) although my team often supported the work. That was useful because, for example, in the run up to whether no smoking in public places should be made law or not, the LHC Smoke-Free London group ran an on-line questionnaire about it. It got a huge response - over 100,000 - and over 70% of the public supported no smoking in public places and about 65% of smokers said the same. Now these are regarded as standard figures but at that stage they were new. I wouldn't have been able to do that through my RDPH role because that was part of government, but the Mayor's group - Smoke Free London could, as it was independent. Then several of the other RDsPH borrowed the questionnaire and ran it in their regions. It was quite powerful as it demonstrated that the public were supportive of stopping smoking in public places. My experience is that you have to be practical, have alternative ways of doing things. When the proposals for congestion charges came in there was quite a lot of opposition from the Department of Transport. I said it was a good idea because if you looked at the health impact it would reduce air pollution and that was good for health. I said that outright as RDPH for London and with the responsibility for the health of Londoners but I got my knuckles rapped because I was a civil servant!

The Observatories were very useful, a fantastic resource to us to be able to monitor what was going on.[9] We identified ten indices for the health strategy, broad criteria such as employment rates in black and ethnic minority groups. We did include some mainstream health indicators eg infant mortality rates, but overall they weren't just health indicators, they covered broader health issues, which sent out important messages to people. We used those indicators to monitor London's health over a number of years. Just before I left London Region - in 2006 - the Government did a review of the GLA and concluded that actually it was OK and doing good stuff. I made the case for reviewing the health aspects as well. As part of that, we established in the revised GLA Act (2007) that the Mayor now has a strategic responsibility for inequalities in health and, in collaboration with others, has to write a strategy for inequalities, enhancing the health aspects. The Regional Director of Public Health is also now the statutory Health Advisor to the Mayor; so I was able, on demonstration of what had been achieved, to sort out what would be a sensible way to have influence.

Why did you leave?

When the reorganisation happened in 2006 I had to take stock. I would have liked to have stayed on but only for a couple of more years, not five or six. Realistically I would have had to stay on for that length of time and I had the option to go. I decided I had probably left a reasonable legacy and I felt it might be time to do other things and for someone else to focus on London. So I took retirement.

[9] Public Health Observatories providing health intelligence information, one per health region, formerly established in 2002

ACTIVITIES SINCE RETIREMENT

What I have done since then? I chaired, for the Mayor, the Greater London Alcohol and Drug Alliance (GLADA) and I applied and was appointed as a non-executive Director at UCL Hospitals NHS Foundation Trust. That was interesting, using your executive experience in non-executive ways, particularly because, having been an executive director, you know what you want non-executives to do and what not to do, asking enough questions but not interfering in the day to day management. I was also on the Board of The Food Standards Agency. For both of those I came to the end of my two terms last year. They were both interesting; I could use my skills in a different way. Then at the time when the reorganisation was happening in 2006 we set up the Public Health Action Support Team (PHAST).[10] Catherine Brogan was, and is, the main driver as chief executive. PHAST came out of a discussion of what would happen to public health staff when they disbanded Strategic Health Authorities (SHAs). London was the only place where the Primary Care Trusts were not being reorganised as well as SHAs. I made this point to people over and over again, that there was nowhere for people in the Strategic Health Authorities to go, whereas in the rest of the county they could apply for posts in the new and bigger PCTs. Nobody took much notice. I think nobody could think of a solution so there were a lot of people displaced from the SHAs. PHAST came out of that. There were initial conversations, prior to the reorganisation, about a more collective approach between PCTs on public health, but that never came about. The five Strategic Health Authorities and myself had always worked closely together. In other regions I know some of the RDPHs were at loggerheads with the SHA DsPH. But we had always worked collaboratively in London, because there was always so much to do; I had wrapped everyone up in the London Public Health Network. That is my style of working; I can't work in an adversarial way. We put together a proposal of whether, across the 31 London PCTs, we could have a small team acting collectively to help with the local issues in the PCTs but the PCTs all wanted to do their own thing so they wouldn't fund it. PHAST was really a development of that. It was a different way of approaching things. The name arose initially as a joke (a pun) because everyone said public health was slow. I think PHAST has been very successful. We had a good Department of Health contract initially on 'Informing Healthier Choices' that some London people were already working on and that was helpful because it gave us initial funding which helped to get the organisation off the ground. None of us had done that sort of thing before; we had no idea about social enterprises or what a community interest company was. I think it has worked, it has 100 or so associates we can pull into teams as appropriate. I continue to chair it. I regularly say shall I stand down and they say no!

The next important thing was my opportunity to go to the United States. We had done some comparative work on city health with Michael Marmot and his WHO commission, between London, New York and Glasgow.[11] Through this I met New York colleagues. They informed me about the Tisch Distinguished Fellowship for Public Health at Hunter College in New York and enquired whether I might be interested in applying? I talked to my husband about being in New York for three months and he said he was in the middle of his PhD so he couldn't go but he was happy if I wanted to. He was very supportive. So I applied for the

[10] A Community Interest Company undertaking commissioned public health work

[11] Sir Michael Marmot, Professor of Epidemiology and Public Health, University College, London who produced in 2008 a WHO Commission on Social Inequalities 'Closing the Gap in a Generation' and in 2010 a major report on health inequalities in England 'Fair Society-Healthy Lives'.

Joan H. Tisch Distinguished Fellow in Public Health at Hunter College, New York City University and was appointed. That was an interesting time. I had to teach on their Public Health Masters course and run a seminar series. We have just finished writing up a series of papers from the seminar series which will be published shortly. The third thing I had to do whilst there was to run a major public health event and I focused that on city food issues. I learnt a lot from New York. The Mayor has different powers and could do things differently.

REFLECTIONS ON PUBLIC HEALTH

Reflections on your career

Public health has to be strategic and that is the thing registrars who come into PH, especially from a clinical background, find difficult. When treating a patient, they get better and in something like paediatrics children can get better very fast. Consultants in Communicable Disease Control (CCDCs) are the closest to clinical medicine but with anything else in public health it can take ages to achieve anything and you might be waiting around for things to happen.

With public health moving across to local authorities (LAs) it is very interesting. I did an interim DPH job for Tri-borough - Westminster, Royal Borough of Kensington and Chelsea and the Borough of Hammersmith and Fulham in London, as much as anything out of curiosity because I wanted to see what it was really like. The move across to local government reinforces the need to bridge the short with the long term. You have to be able to function strategically, know where you are going, know the evidence but the important part is convincing councillors of what you are trying to do. Then once they have "got it" they expect immediate action - what is happening about this? We need, in public health, to understand that dynamic and we can't just say it's going to take another three months. So we need to think what are the things we can do quickly to demonstrate action is taking place? We need to give public health people in local government much more support on how to work differently in those environments. People say to me well, you did it (in London in the GLA), but it was a huge learning curve both for me and also for all my team as we had not done it before. We were just learning as we were going along. There are now elements we can start to recognise; bearing in mind every local government, every politician is different. There are some common currencies. I am not sure as a specialty we are giving enough support to those people in shaping the "what" and "how" they need to work. It can be very lonely. There are a lot of threats - local authorities are obviously in dire financial straits and here is the public health pot that has come across, often more generous than they initially thought; there is a huge pressure to use it to bail out other services. People are trying to do public health in the best way they can, do it collaboratively, but it is hard. They are the new kids on the block in LAs. There is also the question of whether public health remains a department on its own in local government or is spread around, into other departments, with the risks of spreading it too thinly; have they got the capacity? You do have to take the long strategic view. We need in our training of new people coming through to make sure they understand how they influence strategies. The role is a lot about influencing. You still have to start where other people are and it may not be where you want to be. You will only seem credible if you can help them with their problems.

Being a woman in public health

For a lot of people of my generation I am sure it was seen as an easier job if you were going to have a family and children. It was very hard staying in some of the clinical specialties. I know one female in my cohort of medical students who became a surgeon but she was very unusual, it was unheard of, and she really had to battle and prove herself better than her male colleagues and you had to be more willing to demonstrate you could be there as much as the men. You couldn't say "my child….." My daughter always says to me to this day there were three people in her class who's mothers were doctors and the three of them (the daughters) were not allowed days off school as much as the other children. "It's just a sore throat, you will be fine dear…." and off she went to school. These are tough jobs. I can certainly remember when I was in Lewisham and North Southwark and later in South East London Commissioning Authority we used to work all hours, writing business cases or whatever till midnight four nights a week. It was crazy. I felt quite guilty. I would go home and there would be this sad little note saying "I didn't see you before I went to bed." She had forgotten about it the next morning but I felt such a cruel mother! So if it is like that in public health goodness knows what it is like in some of the clinical specialties. I moved to public health from paediatrics, finding epidemiology and public health the specialty I wanted to do. Thinking public health was an easy option is very naïve, however, and we need to debunk any notion that moving into public health is a soft option. That is something I have heard said and it is not the case, not if you are going to do it properly and there is no point in doing it if you are not going to do it properly. Particularly now in local authorities, even in straight hours it is not a soft option with many evening commitments and committees you have to attend, probably worse in London than elsewhere but still very pressured everywhere. You have to have a passion, because it is tough stuff, it doesn't get easier and we have a long way to go.

Why has no one looked at public health women doctors?

I was interested in doing this, I had just made a list and was interested in talking to a number of people in public health who have made a huge impact and then your letter arrived – someone is doing it, which is great! It had gone through my head as well. We need to capture their stories, all that has been achieved despite re-organisation after re-organisation. I'm sure much of the disruption to public health through the many reorganisations would not have been allowed to happen to clinical specialties such as orthopaedic surgeons! That is the dilemma and it is quite a dilemma in local authorities. I have heard people say public health will become a non-medical specialty because of pressures in local authorities. I have heard of several DsPH having their salaries cut and not being recognised as doctors. I don't know whether that matters or not, but I think a balance of people in public health is important and it might affect whether people go into the specialty or not. That is a huge change. In my experience of talking to F1 doctors, even if only doing a little bit of public health they have had their eyes opened.[12] Clinicians of the future will have to know about resources in the NHS, how you best use them, using the evidence base, so even doing a bit of public health is helpful. To be clinicians of the future in the NHS they are going to have to be able to bring those concepts into whatever they do. We can't go on saying I will do everything for this

[12] Foundation Year One. Upon completing medical training, doctors undertake two foundation years in clinical practice before applying for specialty registrar posts

patient in front of me. My personal view is we are not doing it right at the moment. There is a real risk of over-treating, particularly older people. For clinicians, just having some concept about resource allocation and asking am I really delivering a quality service, is important. I also worry that in giving over public health to local authorities will public health in the future have sufficient experience in healthcare public health to contribute to CCGs, to what is happening on the quality of health care side of things. It is very easy for that aspect to get dropped when you have pressures on what is happening with health improvement in LAs. As public health we need to keep the three areas - health improvement, healthcare public health and health protection - running in parallel. They are three sides of the same triangle.

My experience of women is that they are better at collaborative working on the whole, not always. When I think back to the latter parts of my career when I worked in London, working strategically and collaboratively with the five Strategic Health Authorities, all six of us were women and we were able to work collaboratively together. It helped, no doubt, we had all known each other for a long time but it does seem to me that women are better at working collaboratively and in public health you have to collaborate with loads of people. People have succeeded because they are flexible, able to adapt, make sure things work.

Thank you very much for your time

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