Directors of Public Health

175 Years

1847 - 2022

Directors of Public Health
175th Anniversary Essays

Foreword

Professor Jim McManus, President ADPH

We are 175 years on from the appointment of the first Director of Public Health in the UK, then called a Medical Officer of Health.

One of the ways we are marking this is through a series of essays by serving directors of public health from across the UK. Though in each individual nation and administration public health may differ in its institutional setting, together these essays provide us with clear signs that public health endures, innovates and reinvents itself for changing circumstances.

We find ourselves once again, at the time of publishing, in what feels like dark and portentous times. There is economic and social strain, inequality and injustice persists to the harm of many, and "culture wars" sowing division and discord rage, seemingly without respite.

Coming out of the worst phases of a global pandemic with the virus still very much around, and its multiple, syndemic, impacts hurting those who can least bear that burden, adds to the sense we are in tough times.

At such times it is right we ask ourselves what our role is, so we can respond.

These essays attest to the tried and tested return to the sources from which our practice and our values spur, what in French is termed *ressourcement* -–- so that in reflection on these foundations of our practice we may be refreshed and renewed by them.

They speak to the fact that directors of public health form part of the infrastructure of keeping our country functioning, for the long term, not just for Covid.

I believe there are several lessons for us in this:

Science and values go hand in hand

Good science is informed by values and purpose. In public health the enduring values include the dignity and worth of the human person, the nature of health as social, that our health has value; and that this value is not just for the individual but for society and, by definition, for the state. It therefore follows that the value of justice is central to public health and that concern shines through these essays. This is Public Health at its best.

Innovate and refresh

Each of these pieces speaks of enduring and refreshed values of public health made new for a new time. The shift back into local government in England and the significant policy lessons to be learned from Wales about national wellbeing are just two examples which come from these essays.

Sustained presence

Short termism fails the public and wastes money. Central Government, it could be argued, has never quite understood the value of public health. It focuses too much on the short term. The enduring changes in the wellbeing of our nation have been due to public health approaches which have happened over timescales

longer than our current, short-term horizons. These remain more important than ever. How we communicate that and get people on board with us is one of the many challenges these essays cause us to reflect on.

Absorbing new disciplines and learning

The ability of public health to absorb, include and be enriched by new disciplines has been shown by the significant move to multidisciplinary public health practice in many – but sadly not yet all – parts of our profession. These essays speak of taking the best of our traditions and clothing them anew for a changed world. The much needed inroads of social and behavioural sciences to add to what we learn from biomedical science is just one example of the living nature of public health.

There is much more of course. The opportunity to reflect on leadership in reading these pieces is significant. The need for a workforce strategy for public health in the UK is also vital and the need to understand how the diverse agencies in the public health family work together for good also needs continual revisiting.

All of this means that the need to debate how our core purpose, ideas, values and knowledge is fit for the challenge remains. These pieces should inspire us to reflect and repurpose us as we set about navigating the next 175 years.

John Henry Newman, writing in 1878, said that "here below to live is to change, and to be perfect is to have changed often." This could have been written about directors of public health at their best. The ability to be agile, while being consistent with our evidence and values, is something we must prize.

I wish you, as you read these, the refreshment, renewal and recommitment to the health of our public and our planet that they have given me.

Councillor David Fothergill, Chairman of the Local Government Association's Community Wellbeing Board

We are proud to celebrate 175 Years of Directors of Public Health during 2022.

We wanted to mark this important milestone with ADPH by recognising the rich heritage and community of which directors are an important part and acknowledge the important role they continue to play in contributing to the future of protecting and improving the public's health.

The history of public health is built on a long tradition of innovation, compassion, curiosity and the relentless push for progress.

Improving health in Victorian times concentrated on developments in sanitation, living and working conditions, and tackling infectious diseases. Today's directors of public health are working to address the impacts of climate change, poor mental health, preparing for future epidemics and working out how new technologies are revolutionising our ability to prevent, diagnose and treat many illnesses.

In 1846, Liverpool became the first city in the world to appoint a Medical Officer of Health (now known as a DPH) when it appointed Dr William Henry Duncan. You can even visit a pub in honour of its namesake.

Duncan challenged the commonly held conception that it was the fault of the poor themselves that they became ill; he viewed social poverty as the cause, not individuals, and looked into things like improving sanitation and housing to help the situation.

Many of the public health challenges have remained as major public health concerns for centuries. The absolute and relative magnitude of these issues in various communities may have changed, but they still remain serious public health concerns especially among the poorest and most disadvantaged in society.

Directors of Public Health came back to local government in 2013 with an ethos of using influence and evidence to encourage all parts of their council to actively promote health and wellbeing – creating a public health council – a council-wide public health team – a public health family. This ethos continues to be widely embraced today.

In spite of the many changes the world has seen over the past 175 years, we want everyone to join us as we mark the rich history of directors of public health and celebrate how that spirit endures today.

The role of the director of public health over time

Professor Matt Ashton, Director of Public Health, Liverpool City Council

'We Have Been the Health Problem-Solvers for 175 Years'

Liverpool was the birthplace of the director of public health. Back in 1847, Dr William Henry Duncan was appointed as Medical Officer of Health as the role was called. Since then, there has just been 13 incumbents – and for the current one, Professor Matt Ashton, the similarities in the job are striking even 175 years on.

When Dr Duncan was appointed following his work as a hospital doctor and GP in the city, he found himself having to contend with inequality and infectious diseases after the growth of the port in Liverpool and boom in trade saw a rapid expansion in Liverpool's population.

"Dr Duncan was seeing people with poor health, but he did not think it was their fault," said Professor Ashton. "It was clear to him social poverty was the cause with the poor housing and lack of sanitation the biggest problems. He was identifying what we now call the social determinants of health. That has always been a fundamental principle of what the role of director of public health is. It is not about blaming the individual but thinking about what to do to stop that individual being in that situation."

How directors have come full circle with collaboration

Dr Duncan was initially appointed to the role part time and with no staff of his own he had to rely on a "team of teams". He worked closely with two other new posts that Liverpool pioneered – the borough engineer and the inspector of nuisances, which is what we would call an environmental health officer. Together they looked at providing solutions to the housing and sewage problems."

The need to collaborate is something today's directors of public health will recognise.

"Over the years budgets and teams grew. In 1974, when public health moved from local government into the NHS, the medical officers of health were renamed community physicians. Later, in the 1980s, they became known as directors of public health and oversaw big teams, incorporating areas like environmental health and planning.

But since we returned to local government budgets have been tight and the emphasis has certainly been on building relationships and working with others – not just with other council departments but also with the voluntary and community sectors."

As the decades passed, other areas followed Liverpool's lead appointing their own public health professionals, until eventually all were required to do so by central government after 1875. These individuals were confronted with a myriad of challenges over the years from the ongoing impact of the 1840s Irish potato famine to the 1918 flu pandemic and then the impact of the Second World War.

"The war saw a huge loss of men followed by a baby boom, which then required schools, health services and housing planning – all part of the new welfare state.

"In the 1960s, for example, the medical officer of health for Buckinghamshire was closely involved in the planning of the new town of Milton Keynes, which saw thousands of people being relocated from the old, dirty and overcrowded slums found in industrial towns and cities of the day."

The 1960s also saw public health professionals increasingly getting involved in the drive to get people to quit smoking after the link with lung cancer was proven. It, of course, is something that continues today.

"We have made tremendous progress," said Professor Ashton. "But 14 per cent of people still smoke – more in areas of multiple deprivation. The problem is it gets more difficult the more progress you make. It is not simply about telling people now but supporting them to quit. That provides different challenges. But I think what has remained true throughout is the need for directors of public health to be trusted figures. That's what Dr Duncan became, and I think what we have all tried to be."

'Epidemiology - from Cholera to Covid'

But being trusted does not mean directors of public health have escaped criticism.

"We've been accused of being agents of the nanny state. That has been thrown at us at various points, but sometimes you have to be prepared to take the criticism. When the evidence is clear you have to make the case even if it is unpopular. We saw that when seatbelts became mandatory, and we have seen it more recently with calorie labelling and units on alcohol. Not everyone will like everything we do, but what is important is what works on a population level, not just what works for the individual."

Professor Ashton said the importance of being a trusted figure was something that came to the fore during the Covid-19 pandemic.

"Directors of public health played a crucial role in helping explain what was going on and putting the case for testing and then vaccination. We were out there in our communities, talking to the media and trying to influence the public and protect them from infection."

The pandemic also illustrated the need for good data and the importance of epidemiology in public health.

"That's not surprising," said Professor Ashton. "It has always been the case. When you look back at John Snow tracing the source of Cholera - that's what he was doing. He was putting crosses onto a map to see how cases cluster geographically.

"There was one outlier who helped make his case for a radical re-thinking about how cholera was transmitted. A widow who lived in Hampstead, then some distance from where most cholera deaths were happening, was the only person to contract the disease there. But she got her drinking water delivered in buckets by her sons, who collected it from a pump in Soho because she preferred its taste.

"That was on-the-ground epidemiology. Snow was out talking to people. We did much the same with test and trace for Covid-19. Alongside all the new technologies, we also had people out and about trying to establish the contacts people had. Sometimes that is what you have to do. It is remarkable in a way how that hasn't changed. But that's directors of public health for you – we are problem-solvers. We always have been."

Those skills are going to be needed more than ever, Professor Ashton believes.

"I think we are going to have to get much more involved in some of those really sticky difficult issues – climate change and mental health for example. Both affect physical health.

"Employment is another one. Working is so important for your health and wellbeing, but it has to be the right job. Low skilled insecure employment is not good for your health. If we are to be a gig economy, we have to be very careful. There will be very difficult things for directors of public health to navigate, but I am sure we will rise to the challenge – as we have for the past 175 years."

The role of local authorities in public health

Amanda Healy, Director of Public Health, Durham County Council

‘Moving out of NHS a decade ago was a pivotal moment’

Ten years ago, public health in England moved from the NHS into local government. It paved the way for a new way of working for directors of public health. Like many of her peers at the time, Amanda Healy had spent a significant part of her career working in the NHS when the transfer happened. At the time she had just been appointed acting director of public health in South Tyneside.

“It was a complete change,” she said. “There were contracts and budgets to sort out as people moved to different parts of the system. I remember one member of my team did not want to go – he stayed in the NHS. We also moved buildings. I think there was probably a year of planning that went into it, but even then, there was an awful lot to adjust to.”

The challenge of handling the politics

Ms Healy said the political element was undoubtedly one of the biggest changes. “In the NHS you are protected from that to a large extent. But all of a sudden, we had politicians asking questions and we had a lot more meetings and scrutiny in public. In many respects it is a good thing, but it took a bit of getting used to.

“I remember carrying out a health impact assessment about the closure of a local health service. I basically came to the conclusion it would not widen inequalities and could happen, but of course that was not popular with the politicians. Closing local services is politically sensitive and I remember that was a steep learning curve in terms of managing relationships.

“But the politicians also supported me. The cabinet member for public health at the time was a big supporter of public health coming to local government. That helped a lot in terms of easing the transition and educating people. There were new services that we brought over too, drug and alcohol treatment and sexual health services for example, that had not been in local government before.

“However, not everyone really understood what wider public health was about and we spent time developing and agreeing public health priorities. Having the director of public health attending cabinet and having key politicians chairing and being part of the Health and Wellbeing Board was also key and helped us to develop a joint health and wellbeing strategy.

“I also remember relying heavily on the Making Every Contact Count Programme to start with. Local government staff have a huge reach into the community through the services they provide and also the fact that many live locally. The training and subsequent conversations helped them understand what public health was about and how, in their everyday lives, they could make a difference. Lots of frontline staff completed it from librarians to refuse workers. I was proud that this work achieved a national award.

“And I remember when I started in Durham public health was not practical, it was still seen as a little academic. We started to talk about ‘Our Taylor Family’. It was a fictional family that was meant to be typical of the families in our area. It helped people to understand how an issue like obesity is linked to work in schools and the local plan, or how mental health, housing, smoking and education affect members of the family differently.”

‘Local government is steeped in public health now’

As public health began to bed into local government, Ms Healy found there was plenty of potential for new ways of working. “Local government is steeped in public health now – we have come a long way. And it feels completely the right place. It is allowing us to work with our communities in a very different way than before by addressing the social determinants of health.

“When we were in the NHS we talked about prevention, but we did not have the same levers we have now. Whether it is working with regeneration colleagues, schools, with planning or with welfare and benefits, we are able to do things that we were not before. The extent of the reach of local government is phenomenal.

“Take the work that is done with planning across the county. We have policies in place that take into account the public’s health, from the impact assessments that are done, the emphasis on outdoor spaces that encourage physical activity and the policies on takeaways – all of which are having a real benefit on people’s lives at a population level, not just an individual level.

“That is because public health considerations take a front seat in new developments. Indeed, the County Durham Plan 2020 was itself subject to a health impact assessment, which strengthened local planning policies, providing a strategic direction for decision-making so that interventions, such as encouraging more walking, cycling and access to green space, can help to shape behaviour. These are significant and sustainable long-term contributions to reducing the impact of an increasingly obesogenic environment.”

Ms Healy also cites the Reading for Wellbeing scheme that has been run across several North East council areas with the author Ann Cleeves. It has seen community reading workers based in local libraries supporting local residents to improve their wellbeing through the love of reading. “It’s the sort of collaboration that has been easy to set up being in local government and can make a difference to people’s lives in a non-medical way.”

Ms Healy said the work done during the pandemic also illustrates the benefits of being in local government, whether it is supporting schools, care homes or getting grants out to vulnerable people.

“We set up a community hub – it helped with medicine distribution, food packages and then social isolation. Leisure centre and library staff all got involved as did the whole community. We were able to mobilise a huge operation very quickly.

“And because of the nature of councils we were able to widen the support we provided far, far beyond just the clinically extremely vulnerable of whom there were 27,000. We reached out to many thousands more – people who had been victims of domestic abuse and blue badge holders, for example. We knew who they were and worked with our local community partners to reach out to those residents.”

Coping with the funding cuts

One of the undoubted difficulties of being in local government, however, has been dealing with the squeeze on funding. “Money has certainly been a challenge,” said Ms Healy. “We’ve had to cope with the public health budget being cut - the NHS is much more protected in comparison.

“But what I would say is the cuts we have seen have just forced us to work more collaboratively. Public health has been embedded in everything we do in local government. I really enjoy working with the NHS and in an integrated way. But I believe it is local government where you can make the biggest difference to the wider health and wellbeing of local residents.”

The role of business in public health

Ruth Tennant, Director of Public Health, Solihull Council

Health and wealth 'two sides of the same coin'

Public health is traditionally associated with issues such as tackling obesity, reducing smoking and controlling infectious diseases. But Solihull Director of Public Health Ruth Tennant is in no doubt – public health is intrinsically intertwined with economic health.

"It is really clear. The economy and health are two sides of the same coin," said Ms Tennant. "On an individual level, having a fulfilling job that provides financial security is hugely important for both physical and mental health.

"But the flipside of that is that if you don't have a healthy population able to work you cannot have a healthy economy. It really is that simple so as directors of public health we have to see economic health as an essential part of our work. Locally, we are clear that health and economic outcomes drive each other – we talk about health inequalities in our economic strategy."

Our work to help those furthest from labour market

Ms Tennant said the relationship between the economy and public health will be different from area to area. In her case, it has been about tapping into one of the fastest-growing local economies in England and helping those at risk of being left behind. Solihull has significant automotive, aerospace and energy industries, complemented by being in close proximity to five major universities.

"We're a real growth engine in the regional economy so a big focus of mine is to make sure our local people are able to benefit from that. The most obvious starting point is making sure children have the best start in life and get a good education so they have the skills they need.

"But we have also focussed on helping those who are furthest from the labour market. As part of my team, we have a skills and employment team. They work with people who are furthest from the labour market including people with learning disabilities and autism. They also do lots with young people who aren't in education or employment (NEETs). They looked at our local numbers and that NEETs have much higher rates of mental health problems than their peers – and they are problems they are not getting support for, so we are looking to address that and tackle one of the key barriers they face.

"As part of our work to reduce health inequalities, we opened up a recruitment and training centre in a big shopping centre and we have skills advisers in there, working with Department for Work and Pensions. It is about targeting the support where it is needed most.

"It will be different in different parts of the country. Local economies vary greatly. But no matter what the local circumstances, all directors of public health will take a close interest in the economy and health. There is now loads of evidence that health and economic outcomes drive each other and this is increasingly reflected in the work of public health at local level."

Making the most of the public sector pound

Part of that work involves making the most of the spending power of not just the council, but also other public sector bodies – the so-called anchor institution concept.

“Local government is a significant spender in a local area so as part of the contract tendering process, we have we ask companies to set out what they can add in terms of social value. We look for things like training up local people or going into schools to promote the opportunities that are available with a big construction project for example.

“Some companies do this very well, but others, particularly small companies, may need a bit of help and guidance. As part of the integrated care system, we are working with the NHS locally to do the same.

“As a commissioner of services, we can have an influence too. In a previous director of public role, we opened a sexual health clinic in a shopping centre. We knew it would bring in footfall into the shopping precinct, so it ended up being of benefit economically as well as being a convenient location for people to access a health service. Fifteen years ago, we were not getting involved in these sorts of areas or thinking like this, but the move to local government has given us more levers to pull.”

‘Public health vital to growth agenda’

Covid-19 has also had an impact in a positive way, Ms Tennant said. “It has strengthened our relationships because of how closely we worked with local businesses and the Chamber of Commerce. We did a lot of work with Jaguar Land Rover, for example. They are a really big employer and when Covid-19 hit we knew we had to support them and do all we could to keep them running.

“We piloted workplace testing with them and then we worked with them to do workplace vaccination. It was a demographic – working age men – we felt we would struggle to reach.

“As vaccination got rolled out, they actually offered one of their hangars for us to use as a public vaccination centre. And this winter, our integrated care system is also delivering a joint vaccination programme with them.

“There is so much more we could do in public health. For example, many large organisations have good workplace health schemes with good benefits and good support. But it is more difficult for smaller employers or workers in the gig economy. According to government figures, a staggering 131 million working days are lost every year due to ill health with an estimated 14.3 million working days lost per year to mental health issues, costing UK employers in the region of £7.9 billion. This needs to be tackled through more localised, multi-agency approaches which reflect specific local challenges.

“We know a significant number of people have exited the labour market because of poor health. We need to understand what is behind this and help people return where possible. This is going to be important for the levelling up and growth agendas. You cannot have a healthy economy without a healthy population.”

The role of culture in public health

Dr Debbie Chase, Director of Public Health, Southampton City Council

‘The cultural and creative industries are key partners’

Southampton has rich and varied cultural, creative and recreational sectors. From its maritime heritage and historic docks, the listed historic parks and medieval monuments to Southampton City Art Gallery with its nationally important collection and modern Premier League football club, the city has much to be proud of.

Indeed, an indication of its strengths is embodied in the fact Southampton became the first city on the south coast to reach the final four in the prestigious UK City of Culture competition this year.

There are multiple benefits of having such a vibrant creative scene – none more so than in terms of public health. “The cultural, creative and recreational sectors are vital to me,” said Southampton Director of Public Health Dr Debbie Chase. “They are at the heart of our health and wellbeing strategy and how we plan to improve the health of the population.

“Firstly, having a strong cultural and creative sector helps boost an area’s economy. Southampton is often described as a gateway to the world. Millions of people pass through the ports, but we want people to stay and enjoy what the city has to offer too. We are aiming to grow tourism to the city and for that you need a strong cultural, retail and recreational mix. Like many areas, we have significant health inequalities. Economic growth and skills development can help address that if harnessed in the right way.

“Our City of Culture bid focused on the role and impact of culture to bring about transformational change and so we are building on that legacy. We are forming the Southampton Culture Trust, which aims to provide strategic leadership across culture, tourism, festivals and events. The bid was just the start and draws upon the diverse partnerships we established.”

Bringing people together

Culture and being active are also great mediums to bring people together and develop connections, which in turn improves wellbeing and mental health.

Dr Chase said: “For example, the local cultural sector was instrumental in our work to enable and support different communities and ethnic minority groups to access vaccinations during the pandemic. Community media and radio stations worked with our diverse community to engage, listen and support local residents through development of media, including podcasts and videos. Libraries, museums and local cultural organisations and schools also used creativity and heritage as a route to engaging and learning from different age and ethnic minority groups across the city.

“Throughout the pandemic we have seen the importance of people coming together to support each other, but one of the things we lost was connections – at least face-to-face connections. That does have an impact on people and is something we can use culture, creativity and sport to address.

“We have some fantastic events in the city – Southampton International Boat Show, the Mela festival, Music in the City and those delivered by Southampton Football Club and Southampton Parkrun. In fact, Southampton Football Club is a great example of how we can work with the big clubs and organisations to benefit health.

"Through their charity, Saints Foundation, they run all sorts of exercise classes and groups for everyone from five to 96 years of age. They go into primary and secondary schools as well. The foundation is independently run, but I work in close partnership with them to provide guidance and knowledge on where to focus their efforts.

"For example, we have encouraged them to work with men in particular. They are a demographic we can struggle to reach, and while the club has a diverse range of supporters, they have a huge following among the men in the city so we asked them if they could come up with something that would get them active."

This led to the creation of Saints Goal, a 12-week programme aimed at supporting men to become more active and live healthier lives. Over the past year, more than 130 men have taken part and lost an average of 2.8kg. There is also a falls recovery programme that is run in partnership with the local NHS. "Their programmes are really popular, and they are reaching out to people in a way public health could not necessarily do. Collaboration like this is vital," added Dr Chase.

Using creative pursuits as a treatment

Dr Chase said the cultural and creative industries also have a role to play in the direct delivery of services. She gave the example of the SoCo Music Project whose work includes diversion therapy for people engaging with Change Grow Live, the city's adult drug and alcohol treatment and support service. The Council's museums and gallery deliver workshops and activities for adult learners and people with a variety of needs.

"I visited SoCo recently. They have set up a band with clients. While it is called diversion therapy, it is really much, much more than that. It is benefitting the clients, helping with their rehabilitation and providing them with an opportunity to reconnect with others and develop interests and build self-esteem.

"Change Grow Live also runs an arts therapy group that engages people recovering from drug and alcohol use, using art to explore and learn from their experiences as well as developing skills and positive, supportive relationships with others. For people who have been so marginalised, this is a key intervention, creating positive experiences for people working to re-build their lives."

The impact of this approach can be seen through the fact more than 60 per cent of people in treatment and support for opiate use disorders engage with psycho-social interventions. "Diversionary activities are a really effective part of the wide range of psycho-social interventions," added Dr Chase.

"We have lots of small creative organisations across the city to tap into. There is another group called Knit the Walls, which has been set up by a local artist, working in collaboration with God's House Tower, a newly re-developed local arts and heritage venue. The project uses knitting as a medium to get people to come together sharing stories and memories to build communities. This is also replicated in our libraries network with our Knitter and Natter groups and Rhymetime sessions with young children.

"As Director of Public Health, I want to find opportunities for us, as a city, to support all these wonderful, important initiatives. I want to learn how we can encourage more people to engage with culture, in all its diversity. We know how beneficial it can be - we can see it and we can feel it."

Dr Chase also believes there is an opportunity to make better use of our leisure services in supporting all Southampton's residents to be active. She has recently taken over responsibility for the council's portfolio of swimming pools and leisure services.

"We have traditionally taken a property-asset approach – managing the buildings and facilities. But there

is so much more we can do if we take a more strategic, people-focused approach. We can look at how we market them and what we co-locate at the facilities and how we incorporate our green and blue spaces as part of our leisure services offer.

"We also have a huge number of green spaces – one of the highest for any city area – plus the coastline. There are lots of people who use the sea for things like paddle-boarding and sailing. But much of this is the preserve of wealthier people. We want to expand access and do more to open it up to children and adults who would not normally get the opportunity to take part. If we can do this, we will have a very powerful tool in our arsenal. That's how important activity as well as culture is for public health."

Being a non-medic in a medic's world

Abdul Razaq, Director of Public Health, Blackburn With Darwen Council

'We're a broad church now, but it wasn't always that way'

Abdul Razaq has enjoyed a 30-year career in public health. He is a highly-respected director of public health, having fulfilled the role for three different areas – Trafford, Suffolk and, since April this year, in Blackburn with Darwen.

When Mr Razaq started out in the early 1990s, he was, to some degree, an outsider. A non-medic in a medic's world after graduating from university with a life sciences undergraduate degree followed by a master's in public health.

"Public health has changed immensely over the years," said Mr Razaq. "Lots of directors of public health and consultants now come from a non-medical background. However, it did not always used to be like that."

During the early period of his career, public health was based in the NHS and the route was heavily influenced by a community medical background as the established route.

"I had a scientific social and biomedical basis to my first degree and that helped as a foundation stone in gaining a foothold in the discipline. During this period workforce challenges opened up fresh opportunities for multi-disciplinary public health to grow. The seeds had been sprinkled and sown by our regional directors of public health who were supportive of creating a new horizon for public health.

"But practicing multi-disciplinary public health at a time of professional transition wasn't without significant challenges. I was fortunate to have some very good mentors and line managers who supported me through my professional development. I started in a public health intelligence role and then spent three years in a joint commissioning role before moving on to become a public health specialist in Liverpool – the birthplace of the director of public health role 175 years ago. It was very much a portfolio career."

The changing times

As more regions in England introduced multi-disciplinary public health, it started to prompt more significant change. During the early 2000s the UK public health register was established – something that made an immediate difference, said Mr Razaq.

"Doctors had the General Medical Council, dentists the General Dental Council, but until that point the multidisciplinary generalists did not have a professional register for regulation. The Faculty of Public Health acted as the professional body and oversaw CPD requirements, but nothing up to that point validated our fitness to practice. The register changed that – for the first time we had something that provided assurance and confidence that helped create more equilibrium.

"Other developments included giants in public health in the North West like Professor John Ashton and Dr Ruth Hussey who were making strides and influencing the future leadership by launching an aspiring DPH leaders programme that was open across the board. This opened up multi-disciplinary public health to senior roles."

By 2003 Mr Razaq was appointed to his first director of public health role in the Greater Manchester borough of Trafford. It was a time when there was an increasing amount of collaboration between the NHS and local authorities, foreshadowing the return of public health to local government a decade later.

Mr Razaq said: "It was actually a joint appointment – the local authority paid a third of my salary. You have to remember while public health has spent nearly 40 years in the NHS, the majority of our time had been spent in local government. There were still those close working relationships with environmental health and housing.

"I was working closely with the director of social care and other directors from the council. While there was a big focus on the more medical side of public health, such as commissioning healthcare, immunisations and screening, we were leading services and responsible for key elements of public health such as health improvement and prevention services."

As the years passed and multi-disciplinary public health became established and embedded there were more and more directors of public health being appointed that did not have that clinical background.

"It was becoming the broad church that we have today," said Mr Razaq. "In fact, in some ways it has come full circle. Public health is now positioned across several organisational footprints and with the introduction of integrated care boards, we have positions in the NHS that are becoming non-medicalised. We now have consultants in public health in NHS trusts and integrated care teams and directors of population health in some integrated care systems."

We've got to grow the leaders of tomorrow

While those barriers have been broken down, Mr Razaq believes results have been seen in promoting both gender and ethnic equality. "I think in public health we are doing very well compared to other areas and making good strides, but there's always more work to do. I think directors of public health have a vital role to play.

"We need to help grow our leaders of tomorrow and provide a training, research and innovation environment in local government – that is an important part of the job to help and support others to learn and be able to lead.

"When I look back at my first director role at Trafford, it was probably three years before I felt I was really doing it the best I could in applying public health into action. Time and experience is the best teacher.

"Not everyone will want to become a director of public health. The responsibilities and time commitments are significant and, although it will not be for everyone, we have to make sure we are giving everyone the opportunity to consider the opportunities.

"For me it was the right move. I felt I could make a different to the lives of communities. Compassionate servant leadership is a person core value set that I hold, and my work and personal relationships have inspired me to achieve the best possible outcomes in a local, regional and global context.

"At the end of the day, what makes for a 'seasoned' director of public health is the ability to build alliances, self-confidence, good communication skills and the ability to influence, collaborate and maximise resources, while making fine judgment calls and decisions to improve the health of the population. If you can manage that balance whilst juggling competing priorities, you will be a great director of public health no matter what your background is."

Public health in rural areas

Dr Tim Allison, Director of Public Health, NHS Highland

Being DPH in the most sparsely populated part of UK

The Highlands and Argyll and Bute, which make up NHS Highland, is the mostly sparsely populated part of the UK. It accounts for nearly half Scotland's land mass, but – with just 300,000 inhabitants – less than 10 per cent of the population. Or, put another way, an area equal to the size of Belgium with 40 times fewer people, some of whom are island communities. Unsurprisingly, being in charge of public health across such a rural population comes with unique challenges.

Director of Public Health Tim Allison said: "You have the usual material health inequalities and the difficulties in post-industrial communities that many areas have, but you also have quite different inequalities in terms of access. People can live an hour from the nearest big shop or town, while the islands rely on ferry services so of course there are huge issues when it comes to isolation and remoteness. Before taking up this job I was at East Riding of Yorkshire. Parts of that areas seemed remote, but you could still get to Hull in an hour. Here I can be driving four hours easily."

Dr Allison, who took up the post in July 2020, said the uniqueness of the challenges really hit him after he visited the island of Jura, off the west coast of Scotland. "It was shortly after I became director of public health. I was visiting the island and I was with a GP. She got a message that the ferry had broken down. All of a sudden there was no way off the island. It was actually fixed later that day, but it illustrated the sort of things people have to deal with in these communities. That is particularly the case in the winter when communities can get cut off because of the weather – not just on the islands, but on the mainland too.

"It creates logistical challenges when delivering services. For example, when we have a screening van visiting different areas we have to think about overnight accommodation because areas are so remote as well as ferry services to get around the islands. My team is spread out across the region, and I do spend a lot of time travelling. We have always made use of digital technologies to ensure teams are joined up – even before the pandemic – but it is important to have face-to-face time."

The recruitment issue affecting public health and wider society

Recruiting staff can also be difficult, admitted Dr Allison. "It's a challenge across all of public health, but more so in area like this. Of course, you will get people who are attracted by the countryside and location – I must say when I drive around some of the scenery is stunning – but it's not for everyone. So, we have started developing our own staff, training Highland people who do not necessarily have a public health background. For example, we have recently recruited someone from the private sector to work in the screening team. I think that is something that the whole sector could do. We need to look beyond the traditional routes in where people are trained in public health and work their way up. It's a different approach."

But recruitment is not just an issue for public health, it is something the whole local economy struggles with. Dr Allison said: "We do have an older demographic. You find young people do tend to move away to find work and that can make staffing services from care homes to all types of businesses difficult. That means developing sustainable services and communities can be difficult.

"But one advantage we do have is just how close knit the communities are. In many places everyone knows everyone, and they look out for each other. We really saw that during the pandemic. I know across the UK councils helped organise support, so medicines and food packages were delivered. Here communities added to that themselves. That community cohesion is something in public health we can really tap into.

"But we are aware we want to do more to reach into communities. We work closely with GPs. In Scotland public health sits within the NHS so of course we tap into the local NHS networks. In England there is a lot of work through council networks like libraries and leisure centres.

"I think both have their advantages. Although an elephant in the room is funding. The NHS has been where the money is, and I think in England the move to local government has meant public health has had to endure more cuts to funding, but the whole public sector now faces financial challenges. But in the Highlands, we do recognise we need to look beyond the traditional approaches especially given the challenges we face. For example, we could perhaps work more with postal workers or bin collectors. They are out there in every community and could really help us engage and reach out to communities. You have to use your local assets the best way you can."

'There's an unconscious bias towards urban areas'

Two of the biggest concerns Dr Allison has at the moment are mental health and fuel poverty. In fact, mental health was the key theme of his most recent annual report – and is intrinsically linked to the challenges facing rural communities. "There are multiple reasons behind the mental health challenges that people face, but obviously the pandemic has exacerbated many of those.

"There is though a wider issue here with the way the policy makers and attention is focused on urban areas more than rural. I think there is an unconscious bias at play. Often the assumption is what works in urban areas will work in rural when that is not necessarily the case.

"Take Covid-19 vaccination, the model was big centres and calling people by age groups. But when you have a small community coming over on the ferry to get vaccinated you can't do it by age groups, you need to do the whole community. We got permission from the Scottish government for that. We have to make sure the challenges in different areas are taken into account."

Public health on an island

Professor Peter Bradley, Director of Public Health, Jersey

‘I’m both a DPH and a CMO’

Being a director of public health of an island comes with a unique set of responsibilities – even more so when it is a self-governing territory. As Director of Public Health for Jersey, Professor Peter Bradley has to contend with those as well as effectively being the chief medical officer for what is the largest of the Channel Islands.

“There are huge responsibilities. In terms of public health, I am fulfilling both a national and local role,” said Professor Bradley. “As Jersey is not in the UK, we are not covered by the national agencies that provide so much intelligence and guidance to directors of public health in the UK.

“What’s important in my position is the personal relationships I have developed and are trying to develop. Having worked for Public Health England and for Public Health Wales I have some really good working relationships. That is vital. For example, we cannot possibly have the expertise in biological or nuclear protection here in Jersey that the UK has so we have to tap into that. You need to work hard to reach out and build networks.

‘I’m building networks with other islands’

Building networks is also important with other islands, Professor Bradley said. “We share ideas and experiences with Guernsey and the Isle of Man, and we are trying to re-establish an inter-island network with the likes of Malta and Gibraltar. Islands like us have unique challenges and so hearing from others about good practices and how they approach public health is really important.”

That is particularly the case because the role of public health is new to Jersey. Up until Professor Bradley’s appointment last June, the island had a medical officer of health, but no designated public health director.

Professor Bradley said: “That’s not to say public health was ignored or not happening, but a review which was held before the pandemic recommended Jersey create a director of public health to sharpen the focus on the issue. Before we had people doing public health work, but they were spread around the government here.

“My appointment meant we could change things up a bit. The medical officer side is not the main focus of my work, but I do still have some responsibilities that other directors of public health do not, such as providing medical advice.

“I have now recruited two public health specialists to work with me and that is going to help us meet the challenges post-Covid-19 and with the cost-of-living crisis. Recruitment is hard to island communities like Jersey. Not everyone will want to come. I would like to recruit another specialist. But we are also looking at how we can develop the talent we have here in Jersey.”

Working on an island you can act quickly

Professor Bradley said one of the big differences working on an island like Jersey is just how quickly decisions can be made and actions put in place. “I work closely with the ministers on the island and so can rapidly influence policy and decision-making. Equally I am very close to the community – members of the

public email me regularly so you get immediate feedback and clear accountability for the decisions taken.

“For example, during the pandemic we were able to move very quickly, whether it was introducing restrictions or relaxing them. We were often ahead of the UK. And when childhood vaccination was being rolled out, I had lots of questions coming in from the public – it meant we were able to respond with better communication. It is almost like getting real-time feedback. That is a real benefit, but also a responsibility. You are very visible – more so than a traditional public health director in the UK I think.

“Clearly, public health directors were very visible during the pandemic, appearing on the TV and having requests from newspapers. But that is the case as an island director of public health on a weekly basis. I’m appearing more or less every week discussing everything from drugs policy, advice on the heatwave, monkeypox and children’s health. In England requests for that would go to a range of different organisations, but here it is me who covers all those roles.

“You become very aware of your profile and the need to act professionally at all times – even in your private time. That adds to the pressure.”

‘You get the chance to do public health differently’

But Professor Bradley said the nature of being an island director of public health is also really exciting. “You get the opportunity to do public health differently. You can take a look at what is going on around the world and choose what to do – there is that level of freedom.”

To illustrate that, Professor Bradley explained how he is looking at the approaches taken by a diverse range of countries. “We are looking at how New Zealand works with its communities and Iceland’s Planet Youth programme.”

The latter is a community-based approach aiming to delay young people’s substance use through reducing risk factors by working with parents and schools and organising extracurricular and recreational activities. Information about young people’s health and wellbeing, including substance use, is gathered through surveys distributed in schools.

“We’re not constrained by the normal boundaries,” said Professor Bradley. “We don’t have other public health institutions recommending what we should do and that allows us to develop different, bespoke approaches. That is a great position to be in as a director of public health.”

So, what does he think UK directors of public health could learn from his experiences? Looking outside of the UK for inspiration and ideas is certainly one aspect. "There is a wealth of experience in the different approaches across the UK itself, but to be truly innovative you need look beyond the UK with an open mind."

As well as that he suggests making sure local knowledge informs national policy. "Policy and delivery need to be aligned to have impact. That’s much easier to do on an island with one body responsible for all aspects of public health, but in the UK a particular effort is needed to ensure that local directors inform national work.

"Insist on efficiency across the system too. On an island you have to get on with things because there aren’t many people around to do it. That means bureaucracy is limited to what is needed to keep services safe. I would encourage you to get rid of needless steps in decision-making."

And finally, Professor Bradley stressed the importance of good data. "Work together with the Association of Directors of Public Health and other bodies so that you get the data you need. And the closer you are

to the public, the more trust you can engender with respect to data sharing and linkage. If the public see the local value and benefit of how their data is used to help their communities, they're more likely to support and engage with this."

Is public health reliant on pandemics?

Teresa Owen, Executive Director of Public Health, Betsi Cadwaladr Health Board

‘Public health is about so much more than covid’

The pandemic pushed public health into the spotlight like never before. Directors of public health often became the public face of the fight against Covid-19 in their local areas.

But in many respects, it created a distorted picture in the public’s mind about what public health was about. Everything was focused on health protection as the other elements of public health came to a virtual standstill.

‘Covid-19 turned everything on its head’

Normally well over half of Betsi Cadwaladr Executive Director of Public Health Teresa Owen’s working life would be focused on health improvement work, such as obesity.

“Covid-19 turned everything on its head,” said Ms Owen. “I remember coming back from holiday in January 2020 and suddenly there was a lot of concern about Covid-19. It began ramping up very quickly, taking up more and more of my time. Then in March lockdown was announced and it was all Covid-19.

“I had staff redeployed and all the obesity work, tobacco control work and other services had to be temporarily put on hold. Initially, we were focused on creating extra bed capacity – Wales’ equivalent of Nightingale wards - then as pandemic progressed, we set up Test, Trace and Protect and then there was the vaccination programme.”

It took the best part of two years for services to return to normal. “We got extra investment and gradually services restarted after that first lockdown. It was different though; many were done remotely via Teams. But little by little it shifted back.

“We are still doing Test, Trace and Protect even now, but at the most it is at 20 per cent of the scale it was at the peak of the pandemic, and we have resourcing from the Welsh government for that so in terms of capacity for the other parts of public health I would say we are back to something close to 100 per cent.

“Health protection is probably still taking up a little more than it was before Covid as we have also had Monkeypox to deal with. The health protection work has certainly become more exciting in the way it is viewed. We have staff who have got involved in running teams and leading operations for the first time. Saying that, many were happy to return to their roles.”

‘Improving health is what motivates me’

As well as health improvement work, the team also undertakes health service quality activity, which involves helping NHS colleagues to plan and develop new services and pathways. It is an extra responsibility that many public health teams in England do not get as involved with and is a reflection of the fact that public health sits in local health boards rather than local government in Wales.

For Ms Owen, the return to normality is a chance to get back to what really motivates her. “What gets me out of bed in the morning is the chance to improve the health of the population. We have too many people smoking, too many people who are obese – we have the highest rates of childhood obesity in Wales.

“People think of North Wales and the beautiful green spaces. But we have not always got the infrastructure to encourage people to be active and healthy. I am North Wales born and bred and I want to play my part in creating a fairer society.

“We are making small steps and have to keep going. In public health we have to work hard to keep attention on prevention. It is too easy for the agenda to be dominated by treatment and hospital care. The debate can too easily end up about beds, but we have to focus on health improvement too.”

This work includes projects such as Well North Wales and the Inverse Care Law Programme, which are focused on tackling health inequalities and involve joint work with primary care and local authorities. They are based on the idea that the people most in need of support are the ones least likely to access it.

Ms Owen said: “I am proud of the work we are doing. We are making progress. But the coming years will be extremely challenging. I don’t think we have fully seen the impact of Covid-19 yet. We have already noticed with children that we are seeing something slightly different, such as, increasing rates of mental health problems.

“And we now have the cost-of-living crisis, which will have a major impact in so many ways. We will have to make sure some of the gains that have been made are not lost.

“Prevention is always better than the cure, which is why we have to make sure the voice of public health is heard as much as it was during the pandemic. Our work doesn’t stop.”