GREG FELL
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I'm Greg Fell, I'm the Director of Public Health in Sheffield. I'm employed by Sheffield City Council but I am responsible to a range of organisations in Sheffield and mainly the council and the NHS, but also other organisations.

I've worked in the field, the broad field of health promotion and then public health, since 1994. So more years than I care to imagine.

Home life, I've got three kids - three, eleven and four - try my damndest to spend as much time as I can at home, clearly I spend a lot of time here but I do spend a lot of time at home. No-one wants your kids to, to get, to get grown up and they go "Who are you, we remember you from the past?"

I do a bit of rock climbing by way of spare time, but the kids have seemed to do too much of that, and I'm a moderate, below average runner, so I do my best to keep myself fit and vaguely practise what I preach.

I like my job, genuinely get up in the morning "Oh great, gotta go to work today!", and two things, I guess, got me really interested in the field. One was the variability, the wildly variable job, and what you do today will be very different to what you do tomorrow and the day after, that keeps it kind of fresh really. And the second thing is the impossibility of the challenge. I t's absolutely impossible, it's a world of impossible expectations and kind of a challenge and life would be a bit dull if it was all really, really easy. I suppose you need to have a thick skin or thickish skin, though I don't think my skin is very thick. We probably could do with having a thick skin, because invariably you inhabit a world where no one agrees with you and you often have to say things that nobody wants to hear, kind of, have to give the young a blemished an unvarnished truth. I still bear the scars of some of that, you need probably to be not overly scientific The science is important but what really matters is getting stuff done. Do you spend years building up the perfect science base or do you build up a science base for whatever it is that you want to do that's good enough, but then get the job done.

Every day is different - this morning I spent the morning at the CCG at the board meeting, and there was a series of papers about everything from in-growing toenails through to serious mental health problems. Just at lunchtime I went to see the profs at Sheffield, some of the profs at Sheffield University, and we're concocting a number of research projects. Some of which are around evaluation of interventions that we've funded, and this afternoon I've been to see a colleague of mine, and we're talking about very, very low coverage of bowel cancer screening in some parts of towns, where my colleague and I are concocting a '*What we're going to do about that is* plan' and, this evening, I'm going to talk about health and equalities with a group of GPs who are trying to develop a very different model of general practice in some parts of eastern Sheffield, and I'm going to kind of help them work through what that might look like, and how they might evaluate whether or not that's better than the current model.

So my days are wildly different. There's three or four big chunks to public health: the first chunk is around health promotion. So Stop Smoking services, Weight Management services, Sexual Health services of various types. The second chunk of public health is health protection, ensuring that we've got high rates of vaccination coverage, so high rates of MMR coverage in kids, high rates of all of the usual childhood vaccines, it's a flu vaccination in children and adults these days, but also response to outbreaks, so in the summer, when there's an outbreak of e-coli, all of the…many doctors will notice that there's a there's a spike in people attending A&E because of gastrointestinal illness. My job becomes to oversee the inquiry, how we found the source of this infection, and to put the measures in place to make sure that it stops and doesn't happen again. And the third area

of public health is around health intelligence, which is mainly concerned with demographic stuff. How many people were born. How many people died. What did they die of? what are the trends in mortality for cardiovascular disease or cancer? but also what are the risk factors for health? How many people smoke? how is that number changing? is it going up? hopefully not! Is it going down? well we hope it is, so providing the data that allows people to make decisions that should improve the health of the population. And then the fourth chunk of public health is around supporting the NHS in the social care system, so we spend significant chunks of money on the NHS, in Sheffield, it's about 1.1 billion pounds of taxpayers' money on the NHS. Is the investment improving health outcomes? In many cases the answer is *yes*, but in some cases the answer is *yes, but could do better*. So my job becomes one of encouraging, prodding, nudging, poking the NHS to do better with the investment that's put in. In the same way, the finance director hustles people to balance the books, I hustle people to make sure that we're doing the right thing with regard to the health of the population. Is it delivering health gain, basically, and is it redressing health inequalities, so, in Sheffield, the life expectancy is about 78-79. So someone who's born tomorrow can expect to live until they're about 78 or 79. But then if you look at the discrepancy in life expectancy, when you crunch the numbers in the most deprived part of town versus the most affluent parts of town, there's a 15 or so year gap. So someone born in the poshest part of town could expect to live into their early to mid 90s, that would be the standard, the average that one would expect to live. If someone lived in the poorest parts of town it would be 15 years, 15 years less than the average, where clearly you've got to ask how acceptable is that.

I'm sorry to say that we haven't made great progress on addressing health inequalities over the last fifteen or twenty years, the still large discrepancy between richest and poorest, best and worst, we know what we're doing. I think we're broadly, broadly, working in the right space but progress has been pretty slow and will continue to be pretty slow because it is difficult. People will stare at me and say “Fell, why haven't you sorted out health inequalities?” Actually, really effecting change is very, very, very difficult, it requires sustained focus over a long period of time, a large number of people in organisations to do specific things over a long period of time, and we know we're all fickle and will say the right thing today, but tomorrow we're going find something else to be interested in - well, doing that won’t solve health inequalities. It's not just about access to health care, in fact it's not really about access to health care at all, that does matter, but it's more about differences in how well educated people are, how good the schools are, how well we support people to get good education, to get a good job. The access to good jobs, the access to skilled jobs, that buys you income, income matters for health because income buys you choices, so if I live in a cold, damp house that, that will drive my respiratory disease. So my job then becomes to ask a question, actually, is the housing strategy right and are we building the right kind of houses in the right kind of quality, the right kind of standard? And if we've got a lot of people living in cold damp houses, guess what, we're going to have a lot of respiratory disease. That leads you even back a step in the causal chain, to think about the housing strategy, but then people will live in cold damp houses because they haven't got the money to buy the posh houses in the posh part of town, so you then think about, well, actually, what can we do about the poverty? So the tricky thing with regard to health inequalities, is if you take it right back. It's about the distribution of resources and money, because with that I can buy choices. What does our role become, about how we can address the issue of poverty, which is easier said than done. You’re getting into the business of policy making - in politics, so, invariably public health becomes both a scientific discipline but also an art, and a kind of political discipline, which makes it fun.

There are things that we've done in a previous job, where we worked with all of the practices in Bradford to really improve the way in which the GPs manage cardiovascular risk, and we know we saved lives. Definitely know we saved lives, because you can see the dip in cardiovascular deaths and you can, you can also, you can certainly see the dip in the number of people having a stroke and a heart attack. So there are rare occasions when you can actually count and see what you do, but they're the exception rather than the rule. If I'm a respiratory doctor I can come to work tomorrow and I can see I made Mrs Smith better, but I can't do that. It’s difficult for me to count the benefits of what I do or don't do, because inevitably it's the noble art of counting things that don't happen. The noble art of counting less heart attacks or less people with cancer or less people with diabetes and was that because of something I did or was it because of something that happened nationally or was it just random chance? Therein lay the challenges of the job, but it's still fun.