I: So, first things first then, just a little bit about your role as director of public health.

P: So, the jobs of directors of public health moved from NHS to local government in 2013, I think it was, and that fundamentally changed the brief - really, really fundamentally changed the brief. Pre-2013, ‘74-2013, the job of DPH was medical model oriented, was in the NHS, which is a medical model organisation - love of loathe that - and the start point was, I guess, NHS looking upstream. The NHS is the starting institution and then you look out from there. Move forward to a few years down the line from the transfer back to local government, and back is the important concept, because in the long term medical officers for health were always in local government. The mindset of most directors of public health has changed fundamentally and now the NHS is one of umpteen different sectors and stakeholders that the DPH would have relationships with. It would have equal relationships with those involved in the welfare system, those involved with the highways and the transport system and the spatial planning system, and the housing system, and all of those things that determine health. You know, 10 years ago I would have glibly described the determinants of health as one big nice homogenous box, but it ain’t. All of those systems, highways and transport, spatial planning, they’re all systems and you have to understand those things. So, the mindset and worldview of DPH has changed fundamentally. The job’s still broadly the same – create conditions in which people can be healthiest, minimise inequalities in health and all that kinda stuff, but the methods and the ways of doing it are massively different. Massively different. So then, in any town public health department there are three or four main responsibilities. Which again, are pretty constant, actually. There’s the health intelligence stuff – how many people die? What do they die of? Who’s poorly? What are they poorly with? What do we know about the risk factors for poor health? Both the kind of immediate stuff and then the further upstream stuff, and how’s that distributed in the town and between different population groups? That sort of stuff. Second block of stuff is the health protection stuff. We still need to make sure you’ve ran screening, that your kids are vaccinated, we respond to outbreaks of some nasty disease – monkey pox is all the rage at the moment – there’s only been two cases nationally, but, it’s all the rage at the moment, so we’re prepared for the inevitable outbreak of monkey pox etc. That kinda stuff is the second chunk, which is broadly called health protection. The third chunk is around the commissioning and or provision of those services which are deemed public health services and a block of money was carved out of the NHS and plonked into the local authority control which is called the public health grant and with that we either purchase or provide sexual health services, health visitors, school nurses, the fat police, the drugs police, the alcohol police, the tobacco police, whatever else we’ve got. And that’s where most of my budget goes, is buying those services and I’ve got a team of people who do the commissioning on my behalf – they are service commissioners. And of note, pre transfer-back-to-local-government, public health types didn’t do much commissioning, it was done by other people in the organisations, but most of us have had to learn commissioning over the past few years. Now, we integrate that into the organisation. The fourth lot, which is really the business of public health, is what you might call strategic leadership, whatever that means. But it’s working with the whole of an organisation and all of its partners of: how is it that we create better health? How should we act with regard to poor air quality? What should our policy and strategy be with regard to poor air quality? What are the government telling us to do? What’s the right thing to do? Which is, sort of, the strategy bit of public health, and when [name] says “[name] public health isn’t the narrow stuff, the public health grant, public health is everything that happens in [the place]. Your job is to work out how to influence it to make [the place] a bit healthier than they would have been by natural course. Please go off and do it”. So, technically speaking, the budget is everything that happens [here]. And, you know, he then quite rarely says “Well of course, you’ve got no real executive control over any of that. The job is to influence other people to spend their money to influence future health. We recognise that’s quite hard, that’s why we pay you a lot of money, please go forth and get on with it.” In some respects, you might say that the chief exec of the council is the director of public health, ‘cause ultimately he or she is in control of a large slice of that, both kind of executive in terms of the budgetary control, but also in terms of the [place] leadership, the civic leadership, and I just do the donkey work for [them].

I: Yeah, and I suppose that’s not necessarily a universal experience among DPH.

P: Exactly – therein lies the rub. The places I know well, I would say that about a third of directors of public health have that kind of mandate and that expectation of them, including me. It suits me. It’s exactly what directors of public health should be doing. A third have more narrowly defined responsibilities around delivering the stuff that’s the responsibility of the public health crowds and the legal expectations of a director of public health. Make sure that the Healthchecks programme is run properly, make sure you’ve done your Joint Strategic Needs Assessment, that sort of stuff and then the other third are somewhere in the middle of the two. So, what makes it work is having a chief exec and a leader who really, really get it. And both, in this town, both of them really get it. The leader interpets it differently. [They] come in, you know, [they are] a member of the public who happens to have been elected to leader of the council. So, [their] worldview is really, really different. [name] is a strategist and a really bright one as well, at that. [Fire alarm 8:40…] So, that leadership from the very, very, very top of the shop does matter, and matters a lot. So I heard [name] who’s the chief exec of [another] council yesterday, day before yesterday, talk at a [name] conference. He was the 10 minutes saving grace of the whole conference – but there you go – he gets it, there’s no doubt. He was scintillating in those ten minutes, absolutely scintillating. I would say he’s not quite as good as [name], but then I’m a bit biased in that respect (both laugh). He probably is to be fair. He was really good. There’s no doubt that [name] gets what he wants from his public health function.

I: And so bearing those things in mind, then, what would you think are your biggest policy priorities or targets?

P: Poverty. The local authority can do an awful lot around poverty. By smart use of its purchasing, smart use of its procurement policy. What we do and don’t invest in. How we do that investment. What we do with respect to our advice services and equipping people to get benefits. What we do with regard to economic policy. Jobs policy, that kind of stuff. And of note, I’m not doing a great deal, personally, all of my team are doing a great deal around poverty directly and visibly, with a big P. But we are doing an awful lot of stuff that is having an impact on poverty. But it happens invisibly, and intangibly, and there’s a bunch of really good stuff that’s happening around poverty. Its problem is that some of it is a bit invisible, some of it is not that well connected together or corralled together or hung together

I: What sort of examples are there of those things? The invisible work

P: The invisible stuff? The work we’re doing around anchor institutions and economic growth, for instance, is about poverty, ultimately. It’s others, inclusive economic growth, but ultimately it’s poverty by another name. But it’s not very visible, cause it’s all policy stuff, it’s about getting our organisations geared up to think in a certain way, to act in a certain way. But there isn’t a big programme, there isn’t a set of services we’re delivering in that context. The really visible stuff is work that we’ve done, we haven’t done, but the work we’ve paid for around Citizens Advice Bureau. A lot of the advice services are funded out of public health grant. And long may that continue, cause CAB do spectacularly valuable stuff, which directly impacts on poverty, cause it puts money into poor people’s pockets and I think that’s a good thing to do. So, poverty remains the number one challenge. Other things that are hot at the moment – air quality is very, very hot at the moment. It’s commonly said to be the new smoking – it’s not the new smoking – until we get smoking prevalence down to about 7%, smoking will probably remain the new smoking. That said, we’re all breathing illegal air, sorry about that, so what is the [place’s] response? And I’m really clear on this – this is the [place’s] response, as opposed to the director of public health’s response, is that my job is to be a bit of an influencer or an architect – very well paid one I might add – but that is not [my] job to sort out air quality and I vividly remember a conversation with [name] when it was clear that government had lost, or were going to lose, their court case against Client Earth. It was clear that the government were then going to localise responsibility for air quality and not act nationally. So, [name] and I are gonna have to get our act into gear here. Do you want to be the lead officer for air quality? I.e. the lead director for air quality? I said, “Well, no, cause if I said yes then, well what’s to say that this is the pressing public health issue and not inequality in school readiness, or educational attainment, or a lack of access to park and green space? Or any other public health issue you care to mention”. So, I’m clear that it’s the [place] response rather than the DPH response. But, all that said, air quality is still hot, remains hot, and we have a strategy, we’ve published a strategy, and we’re working through implementing the strategy. There’s some big decisions on the horizon about congestion charging – do we or don’t we go for congestion charging? Is it a good thing to do? It will probably have an impact on incentive to get in your car and drive, thus drive down particulate pollution, which is a good thing, obviously. But equally, the way we’d probably have to do it would be a tax on the poor because you do it, you set the boundaries around the ringroad, [place] motorway, and that encompasses most of the poor parts of town and I’m not sure that taxing the poor for something that isn’t really within their control is a good thing to do. So, the whole bunch of thorny, tricky stuff in. And at the same time, electric vehicles are coming in, cleaner vehicles are coming in, diesel will get phased out – there’s no doubt about the fact that diesel will get phased out. So, there’s some tricky stuff in air quality about do we or don’t we spend, probably it’ll come up to tens of millions of quid on a ginormous infrastructure project for the cameras and all of the technology which will bring forward the solution to a problem by three, four, five years. That will get us to legal, not what’s safe cause zero is safe, but we’ll probably not get there, but bring us forward to get us to legal by 5 years. Well that’ll be 10s of millions of pounds we don’t spend on social workers for your gran etc. So, air quality is quite hot, smoking remains quite hot. What else is hot at the moment? Food, nutrition. Some of the traditional stuff remains quite hot, but we’re moving away, so pick on food and smoking, we’re moving away from weight management and smoking cessation towards upstream, so we’ve taken money out of smoking cessation – who’d have thought we’d do that? – and we’ve invested it in trading standards officers who will do intelligence-led enforcement in [place], go and kick doors down in [place] and confiscate mountains of illegal cigarettes which are on sale in ones and twos at 1980s prices. Is it any surprise that five kids a day in [place] start smoking? No, ‘cause it’s really, really easily available and it’s cheap, so again, that impacts on incidence of new smoking. Can never prove it, but you’re acting on a belief there. So those traditional things remain quite hot. Spatial planning is quite hot. At the moment we’re about to publish [place] plan, a spatial plan, which is, how do we grow the [place] over the next thirty years? And that will have a bearing on where we do and don’t site new homes, whether they’re just new homes or whether they’re neighbourhoods, how we do the transport infrastructure and how we hard wire, ACT travel infrastructure and public transport infrastructure into all of that stuff. How do we or don’t we extend the tram network? So the spatial plan has a huge bearing on the wellbeing of the population and the flipside of that coin is the health of the population, and I often say to the planners, what you do and don’t do is more important to the health of the population than most of the doctors in [place]. I’ve also that the same at the CCG board, and you can see people bristle at the thought. Other people have a bearing. So those are the sorts of things that are hot.

I: Do those priorities change much, or can you see them changing in the near future?

P: No, I don’t think they will to be honest. They’ll remain an issue for quite some considerable time to come.

I: You’ve talked a bit about how the approach shifts in how you respond to those challenges. Do you see the current direction of travel, where you’re putting resources in different areas, and working with for example planners as much. Do you see that direction of travel, approach?

P: I see that accelerating, to be honest. And it’s interesting because the rate of acceleration will vary from place to place. And that’s the point of local government – it is local. And the way in which is plays out will be different from place to place. Which, if I’m in Whitehall, is really hard to deal with. Cause if I’m in Whitehall I want standardisation of approach, one way runs it all, and it won’t be like that if it’s local government, it just won’t be like that. The place and the nuances of the place and the local politics of the place, and the views, wishes, whims and aspirations of members become really, really important. So it will play out like that. But that direction will continue up and down the country and I’ve yet to find a director of public health who disagrees with that

I: And the drivers for that, or the drivers of that?

P: Well, notwithstanding the budget carnage, local authority budgets are in freefall, they’ll all be bankrupt in a few years’ time and nobody knows what happens then, to be honest. The public health grant budget’s not quite in freefall but it is being slashed pretty severely, notwithstanding that, as a sector, local government really, really wants public health back. Historically, the responsibility for the health of the population has been a local authority responsibility. The 30 years it was in the NHS, 74-13, more than 30, 40, whatever that was is an aberration in historical terms. So local government is really pleased to have public health back, and will want to strengthen the function and the responsibility throughout its ways of operating and local government is wildly diverse in terms of its responsibilities and functions. I think someone told me yesterday that collectively, local government has 3,000 legal duties and runs 900 odd different types of service up and down the country. So, really, really diverse set of stuff and the job for my type is to go and influence all of that stuff. To influence it, I need to understand it and I don’t understand it. I’ve had 20 years of experience in the NHS and I really, really, really understand the NHS and I’m beginning to get to grips with some of the other stuff. But that direction is not gonna change, it’s definitely not gonna change and nor should it. I hear a lot of rumbles from the NHS, by the way, who want public health back. “If only public health came back, we’d get back to the glory days really quickly” and I wrote a blog on it a few weeks ago which went viral. Most of these DPH who’ve been in contact with me have said “You’re absolutely on the money, there”, I’m yet to find a DPH that thinks it would be a good thing to do.

I: So, just moving onto things like the kind of data that you use, or what you see as the key indicators or outcomes of measures of success against the policies in these areas, what kind of targets on measures or outcomes are used? For example maybe one example, such as poverty or air quality

P: I’m probably not the best person to ask because I’m not close to data, I’m not clever enough to be able to count to be honest, but pick on air quality. We cannot measure the health impact of particulate matter, because the mechanisms to do it just don’t exist. You can make sort of epidemiological assumptions that x% of respiratory morbidity and mortality is attributable to poor air quality and you can do that based on the kind of burden of disease type of methodology, but there aren’t readily or routinely available indicators to say that air quality morbidity has reduced or increased or whatever. I’m fine about that

I: Do you use kind of proxies as measures?

P: No, well, we do. We do live monitoring of air quality every day in 40-odd sites across the [place], so we have a really good handle on what the air quality is. That’s a good enough proxy for me. I kind of believe that poor air is bad for you, I don’t need to do the measurement of the impact of it, so we do do a lot of air quality monitoring up and down the [place], so the measure is “What’s particulate matter in different parts of town?” and it’s of note that different Whitehall government agencies have used different methods which give different numbers. So, one of the bones of contention that government are telling us at the moment is that all of [place] has illegal air, but they’re using the wrong data, ‘cause the [specific place] is pretty good air, actually. So we do live monitoring, we also do kind of traffic counts and that kind of thing so that we can get a sense of numbers driving round the [place], and I’m pretty sure that passenger transport executive give us bus patronage so that we can get a sense of whether bus patronage is going up and down. So we can readily get a sense of transportation methods and models. Poverty, again, I’m not – someone asked me this question last week – is the health impact of poverty increasing or decreasing as we get further into…? I don’t bloody know, actually, no one measures it. The thing that probably determines more ill-health than anything else, but we don’t actually do any measurement of it. But we do have all sorts of interesting data around service use of food banks, citizens advice bureaus as markers of poverty and there’s a bunch of population surveys about numbers of kids in poverty, numbers of households in poverty, (Free school meals?) all that sort of stuff, so there’s a whole bunch of indicators that are out there which we tend to use as proxies and they’re usually good enough. (Yeah, sure) It’s fair to say we don’t use a lot of those indicators smartly as a [place]. There’s data out there, but we rarely use it half as smartly as we might.

I: What would be smart use of it, do you think?

P: Well, directly linking interventions to indicators. We tend not to do that, the world operates in a really, really messy context. We do a bunch of stuff, we never quite do the measuring, then we go off and do another bunch of stuff and we never quite get it all together, just cause we’re not clever enough to, to be honest. So, there’s more that we could probably do with the data that was already available. There’s reams of data that’s available to us. Just alone the [name] performance database, when you print it all out it’s ye thick, there’s a whole bunch of stuff there.

I: So it’s more about using the existing data, measured against the sort of outcomes you’re interested in, (correct) rather than generating new data?

P: No one has got the time or energy to create new datasets.

I: You mentioned poverty and inequalities. Are there any other organisationally agreed priorities that everyone is supposed to work to or contribute to?

P: We have a poverty strategy, I can send it to you if you want, I was looking at it the other day. It’s broadly split into four areas addressing the causes of poverty, worklessness as a good example, and what is it that we can do to improve employability, skills, lifelong learning, training, apprenticeships all that kind of stuff. Directly addressing or increasing the availability and uptake of benefits, which we all know are underuptaked (subscribed sort of thing?) yeah. Advocacy and lobbying upwards. So, there is a strategy and I can’t remember all of the details offhand, but there is an agreed… I think it’s a [place] council strategy, it’s not a [place] strategy, I think it is, I’ll check that. But we’ve all taken our eye off the ball, I think, and we know that we need to refresh that strategy – it’s a few years old, now. And then there’s a bunch of other stuff. There’s the fairness commission, there’s the poverty and inequality commission, and there’s a bunch of other stuff hanging around [place] which is in about the same space, which again doesn’t corral together that well. Because it’s difficult, it’s really difficult, and it’s a bit nebulous and it’s a bit difficult to get your fingers on. So, there is a strategy, there is an agreed set of actors and things that those actors need to do, but we’re not as good at executing it in a coordinated way as we perhaps need to be.

I: So, how much of a priority do you think it is, then, addressing social inequalities? As an organisation, as an institution

P: I’m not sure how I can answer how much of a priority. If you ask the leader of the council what [their] priorities are, she’ll say two things. [They]ll say safeguarding children - in brackets and adults - and tackling inequalities. Those are the two things that [they’ll] say are the most important things that [they] holds dearest to her heart. If you ask most officers they’ll probably say the same thing. The but is that we say those things, but then we do other stuff. We react to the day-to-day stuff and we take our eye off the most important mission, because stuff happens and you can’t not react to stuff, so yes it’s a high priority – I couldn’t quantify it on a rank of any description – but the leader is really clear on that one and [thery’re] the boss, ultimately, [they are] the prime minister, or equivalent prime minister. But, we do act in a way that isn’t always mindful of that. I’m sure [they] do, as well, [they] will react to stuff, we all do, that’s just human nature.

I: Okay, just mindful of time, I guess, we should move onto the next phase about health in all policies. So, we talked about this the other day, so you might want to repeat what you said before, there’s a lot of talk about health in all policies, can you just maybe tell me what this phrase brings to mind for you?

P: I suppose everyone likes to talk about health in all policies, talk to the transport planners, “We like health, of course we can get more health, give us some of your budget,[name], and we’ll build some more bike lanes”. No, use YOUR budget, to build bike lanes, don’t use my budget, cause my budget’s pitiful compared to the transport budget which spends gazillions of pounds on transport budget. So, health in all policies in that context is, “How do we get more health…” - or to flip it, wellbeing, cause everyone equates health equals doctors and nurses – “How do we get more wellbeing out of the existing policy commitments and/or service planning or commissioning commitments or budget commitments than would otherwise be the course?” I.e. you accelerate the path of improvement, with a particular focus on improvement in the poorest, so those who live in the crap part of town, those with mental health problems, those with learning disabilities, or those that get a rubbish deal. And you can apply that context in any policy area, but the onus is on the housing sector, or the transport sector, to work out how they do that and my job becomes to help enable, facilitate, engineer, bridge worlds together that don’t historically get bridged, all that kind of stuff. People have written books and ginormous tomes on health in all policies, ye thick – I’ve written a little bit on it, to be fair, not much – but not much. The best one I’ve seen is the WHO manual, but it’s ginormous, and it’ll never have any traction in my world cause I’m the only person in my organisation that’ll actually that document and probably understand most of the words, if not all of the words, and I haven’t got the time to kind of do the training in bringing people on. So the way in which we operationalise the concept of health in all policies in this [place], and probably lots of other places, is that we have a bunch of skilled public health professionals who get it, and I’ve got a bunch of those that are really, really skilled and really, really get it and they go out and work out how they influence the worlds that they operate in and interface with and it will look very, very, very messy and very opportunistic and they’ll either create and or take opportunities when they crop up and they’ll use all of the mechanisms that the council has available to it to try and achieve the broad goal – get more health from the various policy commitments. So what is it that we do about the licensing committee, or the planning committee, or the transport committee. The scrutiny committees, how do we get the scrutiny function to understand what we’re trying to do here? And there’s a big piece that we’re doing about the why, why is it in a [place’s] interest, and particularly a [place] council’s interests, to have a healthier population? Health in all policies should lead to a healthier population, but why is it in the [place] council’s interests? Cause if no one cycles, we’ll have loads of fat people, fat people lead to diabetes, diabetes leads to heart disease, heart disease leads to heart failure, heart failure leads to social care demand, the bit of our organisation that it all causes, and that’s a long causal chain, that, and it’s in our interest to build bike lanes for that reason. So you can’t say to the transport planners, the transport planners will say “Not my concern. Health can sort that”. Health are never gonna sort that, cause they’re always gonna be fixing up the consequences of policy failures further upstream.

I: Yeah, sure. So the next question was about whether or not the health in all approach is apparent at the council

P: No. And I’m being very deliberate about that. I’m being quite covert about it. I’m working on writing something on this. [Name], you’ll know [name], I’m sure, [name’s] observed what we’re up to from afar, and he’s said it’s kind of like guerrilla warfare this, isn’t it? I think he calls it effects-based warfare and he’s sent me a long tome of sociological stuff about the sociology of warfare that I might try and read one day. And it’s kind of guerrilla warfare. There isn’t, as [name] said, there isn’t a health in all policies unit, there isn’t a sort of a plan, it will never be written down. One, cause no one’s got the time for it, two cause I probably wouldn’t even know how to start writing it down, and three if you write it down people think they’re being influenced and nobody likes to be influenced. So we do it kind of Covertly, in the main, which is an interesting ethnographic research project in itself, cause most of those – I said this to a bunch of public health types the other day – most of those responsible for mental illness in this [place], and any other [place], don’t have the word mental health in their job title, but the way that you operationalise our response to universal credit will either make it better, or make it worse. Massive driver on mental health. They don’t do it cause it’s got mental health in the job title and it’s the same here. Most of those responsible for health don’t have health in their job title, they’ve got travel planner, or housing officer, or whatever.

I: So, the approach is more, sort of implicit, than it is explicitly…

P:A I’d be interested in places that have got an explicit approach. It’d be an interesting sort of compare and contrast study and I bet you there’s bugger all difference. At the end of the day I bet the differences between my guerrilla warfare and somebody’s formal, kind of programmatic approach

I: Yeah, [not clear 34.42] Coventry an example, or…

P: Coventry is a marmot city, it’s marvellous. And I’ve heard [name] talk about it now, he was great. I heard [them] say, and I thought, what’s going on here? Why can’t we be a Marmot city? They’re not gonna chase after the badge, being a marmot city, he’s made great play of that being a marmot city. Wigan’s got its teal, [name] who’s the DPH and, I’ve forgotten the name of the chief exec who’s coming to [name] in a few weeks time, I’ve forgotten what [they’re] called, have a deal. They’re renegotiating the compact between cities and state and what services will and won’t be provided and a bunch of really interesting stuff. And I’ve not been, and I’ve not heard [name] talk about it explicitly, but I’ve read enough about it and I think, “We’re doing all of that here”, we’re doing a lot of that stuff, but we’re just doing it. Certainly what [name] has done in Wigan has got a much clearer and more coherent narrative. [They’re] a few years ahead of me so I’ve got a few years to catch up with [them], but [they’ve] got a really clear and coherent narrative on the sort of evidential underpinning for it, which I think we do need to do a bit of retrofitting. But it would be interesting to look at the different approaches towns take. One of the things that you’ve probably read me say, you might not have heard me say, is I don’t think you can command and control your way through this one. Writing a big plan is not going to sort it. It’s kind of classic complex system kind of territory. You don’t know what’s going to happen, stuff happens, the world reacts in ways that you can’t anticipate, so do no more than set the right path in the first place and really stick to your mission. Harry [36:27] talks about one-year plan, five-year strategy, 20-year mission and he’s dead right, so I’m sticking to the mission for the time being.

I: That’s interesting, and so, I’ve got some different examples and we can stick these on here and different types of areas.

\*\* Visualising priority areas\*\* [37ish]

61 minutesish:

I: One of the questions in this is about how and if you use or build any formal theories of change, or use logic models

P: I know I should, I’m a big fan of them, I like them a lot. They’re really, really useful tools for organising the world. I don’t, because one I’m rubbish at it, my head doesn’t work in that way and two, I haven’t got the time. I really, really haven’t got the time to do it. To do that job properly does take a good bit of time.

I: Do you know of any examples of where those things have been used?

P: In this space? Inclusive growth?

I: Not necessarily – just in your experience as a DPH

P: A good example we’re doing at the moment, we’re becoming a person-centred [place], embedding person-centred care across all of our health and social care delivery. [Name] who you’ll know has been busy and pushing hard in that space at the moment with a team of enthusiastic folk who are doing a marvellous job. [Name] who is a researcher at [place], I forget what she’s a researcher, I forget where she is. Anyway, she has done us a logic model, but it’s been a labour of love for a long period. She’s done a spectacularly good job, a really, really, really good job. It ought to score a lot of brownie points with the University. But she’s done the job properly and she’s engaged with hundreds of people in developing the ideas that go into it, and that becomes the basis by which we developed. So the reason why I’ve not engaged with logic models in this or any other spaces is not because I don’t believe in it, just because I haven’t got time to do it properly, but I do think they can be incredibly powerful, but they have to be done properly.

I: Yeah, and that’s the purpose of the bid is to be able to develop those models so then you can kind of…

P: It gives, maybe in retrospect, not an evidence base, but a justification for how we’re approaching a thing and why it’s important that we approach the thing with a little bit of rigour

I: And have you commissioned or used any kind of computer modelling?

P: Good god, no. Got a health economist in my staff and anything that involves modelling gets sent to [them].

I: What sorts of things does he model?

P: What sorts of things does he model? So, a really interesting example, which was retrospective modelling a long time after the fact. A few years ago [retailer approached the place] wanting to put a store out in [place] and they were seeking planning permission. [They] said “It’ll be fine, it’ll be fine, it’ll be fine”. The response of my predecessor was that it’d cause a lot of traffic, it’d cause a lot of air pollution and people would be harmed by the air pollution and he’s dead right. He calculated that seven deaths would be caused by it, and to this day I don’t know how he did the calculation (Which seven?), I suspect he just put his finger up and guessed, but he did it with a lot of algebra and everybody believed him. The response from those, the flipside of the argument, was “Ahh, but it’ll create 480 jobs, with a good employer with career prospects and supply chain stuff and training pathways and routes out of poverty in a pretty poor part of [place]” etc. So, in the end there was a big fight, [retailer] won, as if we need any more soft furnishings in the world, but we’ve got them, the store is built. A year ago [name] did me a modelling exercise on the benefit of the 480 jobs versus the seven deaths. The jobs win, hands down, all the time. [They’re] doing some work at the moment around frailty and if we prevent and delay frailty by five years, what’s the win for the NHS and social care system? It’s a reasonably complex piece of modelling and he’s doing some work at the moment about adults with complex needs including mental health problems, alcoholism, street homelessness. If we provide a more robust package of support and case management of that group of people, what’s the win for multiple sectors, which involves modelling data and intel across a whole bunch of different sectors. So those are the kinds of things that he’s up to at the moment.

I: It might be worth talking to him. (He’s knows [person]) He’s talked to [person]? Okay, that’s fine. Brilliant.

P: Well, Robin was “He’s not proper, that work on air quality it wasn’t quite properly done”, to which Chris snorted and said “Come to our …[unclear]… where there’s bugger all data and nay time”. So, there’s some interesting space there to be had between doing the job properly and the job in a way that’s good enough to pass muster.

I: Yeah, absolutely. Are there any aspects of your job that you’ve not described that requires considered data, or evidence?

P: A joint strategic needs assessment requires the description of how healthy a population is, or not. (Descriptive statistic type stuff) Yeah, all of that kind of stuff. Probably loads of other stuff but I can’t remember.

I: yeah, no that’s fine. I think it’s impossible to cover all of the ground in terms of data, so you’ve given us lots of ideas of where to take this for the purpose of the bid, anyway. Just a bit on research and what you find, what sort of evidence you find useful, there are two separate questions, really. What’s useful research evidence for you, and what’s credible where linked but credible in a local setting?

P: So, useful is what gets the job done. Whatever the job is. Influencing somebody to do something that they wouldn’t have done by the natural course of things, changing the way that we provide the service, delivering a new intervention that we didn’t deliver before. Stopping something that bluntly isn’t working. Whatever the thing that we need to do is, the useful is the thing that provides some sort of evidential air cover, or justification to make that thing happen or not happen. I’m a magpie with evidence – I’ll take evidence from all sorts of different places and paradigms and mash it together in a way that helps me make an argument. Ten years ago I was a purist; everything had to be a randomised control trial. I’d find ways to rubbish all other forms of evidence. I’m a pragmatist now and I’ve recognised that whilst RCT is king in certain contexts, it’s nowhere near king in complex, messy systems. So, I’ll use and abuse different forms of evidence to make the case that in my judgement needs to be made. And there’s an important word there – judgement. Who am I to make the judgement? So, I have to be accountable for the judgements that I make and all that kind of stuff. But, ultimately, it boils down to street fighting with evidence. What are the pragmatic compromises and trade-offs you’re gonna make with half-baked evidential cases that you’ve pulled together, usually quickly, cause you haven’t got time to do the job properly. To fight whoever it is that the opposing side of the argument that you’re trying to make, who will equally be doing just the same thing. And there’s a bunch of kind of ethics in there and there’s a bunch of judgements in there about evidential quality. There was a really interesting conversation that I had with [name] and [name] on the burden of proof. Cause I had this conversation with [name] MP and I said “We’re gonna decommission tier three obesity services cause they don’t work and I’m gonna pull a third of a million pounds out of tier three obesity services and invest it in food policy, structural policy stuff further upstream. And [name’s] really interesting response was “So, I’ll concede that you’re saying you’re pulling out of tier three obesity and you’re giving me the premise that there isn’t enough evidence, but you’re saying that there is evidence that all of that upstream structural stuff does work.” All of that upstream structural stuff isn’t gonna be based on randomised controlled trials – the tier 3 obesity stuff isn’t based on randomised control trials either – but it’s the sort of different burden of evidential proof for interventions and initiatives in completely different paradigms. So I had this really interesting conversation with [names] on it by email and I’m desperately trying to persuade them to write it up because it’s really, really important on the evidence question. But they’re being bloody academics and they’re refusing to write it up and they’ve got navels to gaze at and Ivory Towers to polish or whatever it is you academics do, I don’t know.

I: the question of credibility then is context dependent

P: Yeah, got to be a trusted, credible purveyor of evidence. And as soon as you’ve lost that trust it takes a lot of building up. You have to be careful not to get burned by being a bit too fly-by-night with regard to your evidence and when it’s imperfect, accept it’s imperfect.

I: We’re trying to gauge, part of the plan and this is not part of my work, part of the plan for the bid overall is to have a good strand of public engagement throughout the programme and we’re trying to gain some insights from people like yourself about how we should engage with the public. So maybe learning from some of your own experiences about how public views are incorporated into decision making, in your sphere, whether that’s the political decision making process or in the executive

P: So, I think in the political decision making process, it’s done okay. But not that well and there’s always room for improvement there. You ask five different cabinet members how well they do the sort of representation of the public’s values, some of them will be honest and say we don’t do it right well, some of them will pretend they do it right well. I’m not sure that we do – I think there’s always room for improvement in there. In sort of senior manager officer types, we don’t do it right well at all, to be honest. I’m the first one to say “Well, let’s put the public back into public health”, but I know full well that I don’t do that particularly well at all. So, anything that we can do to strengthen that the better, cause it’s really not done that well. And that’s uncomfortable for people in my position, because it involves giving up power. I’m well aware that I’m in a powerful position, but however, we have to do it. But I’ll fess up and say that it’s not one of my strongpoints by a long stretch.

I: well, researchers get it wrong often too, so you have good and bad experiences of public engagement in research, as you do in policy, so we’re trying to think about what works well and what doesn’t work well. Do you have any experience of seeing good examples of researchers and policy working with the public?

P: [Name] does it spectacularly well, it’s spectacular. It is written through her like a stick of rock. [Name] is the shining example of how to do that stuff. Just build more [name].

I: we’re plugged into what she’s up to through various things. Okay, just to conclude, then, what do you think this consortium, if it were to be funded, what would it need to achieve or produce to be useful to you? Cause you’re a key partner at the council

P: What it can’t do is provide extra officers to do stuff that officers councils or similar organisations should do. It just can’t do that, and shouldn’t do that, as much as it’d be nice to. It just can’t. But what it has to do is be there and kind of be one) probably help doing the building of stuff, the consortium will come at that from a research perspective, but the spinoff of the research perspective is that we build better stuff, we build better policy, we build better interventions. So be there, and if the consortium is not there when the decisions are being formed or made, then you’ll miss it. And you can’t do that from afar, you’ve got to be onsite to do that.

I: so that’s like an embedded researcher type model, or a knowledge broker…

P: there’s something about the going both ways on that, because I think my organisation inhabits a [place] with two universities on its doorstep, both, well one of whom certainly [1.16.19 unclear] don’t know about the other one, and I won’t name which, (I’ll delete that from the transcript!). And I think our interfaces and links with those two universities are a bit weak and superficial. They work well between some individuals in both of our institutions, but they’re not very deep links. So the being there does work both ways. So, an example, [name] spends quite a lot of time in this building, well I hope [they] do cause [they] tell me [they]do (laughing). Ah, right, I shall have a word with comrade [name] later. But, [they are] supposed to be embedded here in part of the sort of woodwork here. However, it is difficult to be in two places at the same time, so there’s a bit of tricky space to negotiate there.

I: I don’t know if the idea of the embedded researcher might be part of the plans already…

P: Yeah, I think it is. I think [name] might have had that conversation.

I: That’s super and certainly as part of my fellowship there are opportunities to work with local authorities [Bit unclear]. Is there anything else you think you’d like to say that we haven’t covered? part from the stuff maybe we’ll get back to about how we might construct more meaningful models around what inclusive growth is.

P: I’ll have a think about that. It would be good, cause I’m not that close to the detail of this, so it might be good to do that with [name] who’s one of the policy guys, and/or[name]

I: I’ve been in touch with [them] and the most recent partnerships report, one of the key areas is about health and wellbeing.

P: Maybe don’t think of the health word, get rid of the health word, call it wellbeing.

I: that’s proving helpful in my initial thinking about how you might engage in this area, because there isn’t a literature base that I can refer to about it.

I: And maybe what we started the conversation with about public engagement. Maybe we need a [name] Civic Hack.

P: Yeah, maybe. Don’t think of this in the context of health or wellbeing, or whatever phrase you want to use, in a way that you’re kind of trying to measure things in individuals. The network of intervention here is about the population, so kind of think, of course healthy life expectancy is a population measure, but think of the, maybe what we’re trying to get to is structural conditions that set the right things in place to happen, rather than the end point

I: Exactly, because there’s the recursivity then of having an improved environment that then recursively acts to improve it for other, not just through the actions of people, but through the allocation of resource, or through …

P: It’s really about ecological public health, read about the stuff in ecological public health, fifth wave somebody wrote a lovely article a few years ago. But they were talking about ecological public health as opposed to population public health. It was an interesting concept. Cool, right, I’d better go.