Name of Transcription: Regional1Pa 3.2.20

I = Interviewer, P = Participant

(*Talk about consenting etc.*)

I: So, I usually start off by asking people what they do and how they started off. What’s your role? What’s your function in [regional employer]?

P: Yeah, absolutely. I’m a Programme Lead and I work in [regional body]. That’s the centre, so I work a lot with local authorities, NHS, voluntary sector, with a focus on places as well. So, my portfolio includes health inequalities, wider determinants of health and with a particular focus on vulnerable groups. So, homeless, trafficked individuals, vulnerable migrants and I also lead on children and young people as well.

I: That’s quite a broad remit

P: Yeah, it’s so broad, and health inequalities is everybody’s business. But I think in order to get the most out of collective effort, you do need someone to provide that glue and that leadership. And I guess that’s what my role is in the centre.

I: And how long have you been at the centre?

P: Since 2015, but before that I worked for the [state department] for a long time.

I: In a similar sort of area, or was it different?

P: Yeah, a similar area. Very similar stuff.

I: And so when you started working at [reginal organisation], how did you become involved in anti-slavery work? Was it work that you’d been involved in prior to being part of [organisaion]? (no) No, okay.

P: No, it was curiosity. Opportunistic. It was actually someone that worked for me, with me, who had been attending these human trafficking network meetings as the network was called then. And that was the pre-cursor to the [regional] Anti-Slavery Network. And on one occasion she couldn’t get along and I was just inquisitive because I wasn’t quite sure where it fitted in terms of our priorities, our business plan, a public health approach. And there hadn’t been that much connect with the group apart from going, sitting round the table and coming away again. So, I went along to this meeting, not really knowing what to expect or even why I was there. But throughout the meeting, as more people discussed what they were doing, I could see obvious connects with health, wellbeing, public health priorities. Prevention. And also a role for professionals in terms of spotting the signs and supporting victims etc. So, it was really a series of lightbulb moments

I: Right, okay, can you remember some of those?

P: I do. It was – typically the public health approach. So, thinking about groups and populations and the challenges around data and the evidence base. The need to focus on upstream preventative work, making every contact count. So, I saw a synergy across with that. Obviously health inequalities and health equity considerations. And social justice, I guess, and the injustice of it all. I was, I think, quite shocked by the, you know, the poor health outcomes and impact. It’s obvious when you say it, both physical and mental, and some of the examples that colleagues around the table were discussing. So, a lot of voluntary sector organisations around the table who are in contact with service users - the people on the receiving end of this appalling treatment. And so it was that lived experience - the narratives, the stories, that really struck a chord with me, really, in terms of vulnerable groups and exploitation.

I: Can you remember which sorts of local issues there were as well? Was it particular forms of exploitation at the time?

P: There was a lot of discussion around labour exploitation, but I think that’s because [organisation], one of the big employment agencies that does lots in this space, and have done for a long time, were there and child sexual exploitation as well. Barnardo’s. But yeah, I just thought there was a place for public health and the NHS, obviously, in this agenda. Hadn’t quite worked out all of the dots and how to join them

I: So, how did you then approach joining the dots and talking to the network about it?

P: I foisted myself into their next meeting - not as sophisticated as you did, but it was – I looked at modern slavery from what I thought it worked through a public health lens, a public health approach. Pretty much what I do all the time – what I’ll be doing this afternoon. So, that strategic leadership, the advocacy, the partnerships, the networks, the sharing of resources, data intelligence, the role of professionals. And you know, bringing this to life in terms of translating it into why health colleagues should be interested and involved. And our communities as well, in terms of awareness raising really. So, yeah, it all started from there and it struck a chord with members around the table and then I just started to make myself useful. And connecting. It wasn’t particularly strategically planned at the time, and it sort of came together coherently towards the end, but it made sense at the time. And even though it felt a little bit ad hoc and in the moment and seizing those opportunities, it was an important – I think that journey probably was the best one to take, really. So, small things like sharing data from the Strategic Migration Partnership with [person] who leads in the police force. So, the police knew that there was going to be a, you know, influx dispersal of vulnerable migrants who could be at high risk of – and just simple things like that. I did a bit around the evidence and looking at what the health sector was doing and discovered that NHS England had a big push at that time through nursing, actually, to raise awareness and train staff up using E-learning resources and that kind of thing. So, the NHS were sort of leading and set an example, though that’s gone off the boil a bit recently. But I think there’s still scope – it’s simple things, I think, that you can do.

I: And at the network – just so that I have a better impression in my mind – who was around the table? And what was the kind of leadership of it?

P: Very much driven by [name], the chair.

I: And what’s his background?

P: He’s – I think he’s ex-Police, but [they’re] an independent consultant now, I think. But I think they were involved in, you know, the high end of police issues and serious crime and that kind of thing. And they get it – and coming from that background Is really useful, cause you’ve probably lived and seen the end results of being trafficked etc. That kind of angle. So, yeah, I mean [person] – but they work in a very inclusive way and often that’s why the meetings run over, I think. You know. Everyone feels comfortable to talk. It’s a flat structure and approach, very democratic; everyone has a voice. Yeah, and I think, you know, they’re very good at connecting people and communicating with people and setting direction and providing that leadership, but letting, as I say, everyone have their time, really. And I think with voluntary sector organisations, it’s really important that they’re seen as equal partners. They very much are - if not much more robust partners than some of the public sector agencies around the table. But yeah, so, [person]. But it’s supported by a strong board as well.

I: Okay. So there’s the network and then there’s a sort governance

P: There’s governance, yeah. There’s a governance structure. And there’s the accountability to funders, wherever their money comes from. I’m not quite sure. So, they have to account to that. So it’s quite a – and it’s been going for over 10 years now. They just had their 10 year celebration. So, they’re doing something right.

I: And who’s around the table then? So you’ve got Police and voluntary sector. Are there any health sector apart from you?

P: CCG. One CCG rep.

I: How many CCG areas have you got do you think?

P: I think there was 23 at the time. So, hardly representative. NHS.

I: Nothing from the trust, no?

P: No. And public health apart from me, no.

I: Not from the local authorities?

P: Not public health, no.

I: Are there other departments from the local authority around the table?

P: Yeah. I mean he’s involved – [name’s] involved environmental health officers, housing. Those kinds of children and young people’s leads etc. But I wouldn’t say that either the local authority or the health input has been, as I say, consistent and representative or as it should be, really. It’s been a gap. And it’s really hard to – one of the key success factors for this taking off in the [region] from a public health route was having the director of public health to champion. And although it was more sort of symbolic and, you know, chairing a big event to kick-start this, farther gave impetus to this joint work. It was very powerful because at the time that director of public health chaired the [regional] Association of Directors of Public Health meetings. So, I had a figurehead and they did a bit in the media and they chaired our engagement event.

I: Is that something you brokered, that relationship, so that you could get this person?

P: Yeah, yeah. I had a quick look around on the media to see if any of our local authorities had any recent incidents, challenges, around modern slavery and just stumbled upon a couple that had happened in this particular area. Then I sort of harnessed that and started a conversation with the director of public health. Yeah, they got interested. But then they left and no-one’s really picked up the mantel and yet that sponsorship, senior sponsorship, makes all the difference

I: Is that from your perspective or-

P: Everyone’s, I think. But there are other ways and other routes in. And I keep the directors of public health updated, trying to build more relationships with local NHS England improvement. But it’s hard at the moment. And there’s not gonna be a lot of new stuff happening at the moment while we’re, well, colleagues are dealing with the coronavirus cause that’s just derailing everything. But then again, thinking about this in terms of the risk for this particular cohort, however small they are reported to be. You know, these invisible populations.

I: So, thinking about how you then, taking a few steps back to where you said you found your way into the network, what kind of – how did you, if you can remember, how do you present your own interests from a Public health perspective?

P: Yeah, I’ve probably, sadly, still got the presentation, so I can send that to you. It’s terrible

I: I keep everything as well

P: Yeah, well. If I think something’s gone alright, I keep it. It’s not a very big folder, but – no, so, yeah, got to know the network, how it works. Got to know [name] a bit more and had some one-to-one meetings with them. Obviously introduced public health to the group.

I: And so what response did you get there?

P: Great! Yeah. Some of them were just silent and looked at me like “What’s she doing?” but [name of Chair] got it and then we decided to really have a more focused look at health engagement and had a big event into professional multi-stakeholder regional-wide event around health engagement and modern slavery and that’s where we had the director of public health chairing it and we had media coverage. “Health Chiefs Tackle Modern Slavery” – rather grand. And from that I produced an action plan that we focused on together, which – so, from attending the network and building the relationships and getting to understand our different agendas and, as I say, looking at this through a public health lens, that led to the health engagement event and then an ongoing collaboration, really.

I: So that sounds like it was a few years ago now, before public health approaches to XXX became something quite-

P: Yeah, I think the health engagement event was, gosh, was it ‘16 or ‘18? Can’t remember. Yeah.

I: So, ahead of the curve then, really

P: 2016? I guess so.

I: Can you recall how you managed to engage so many different –

P: It wasn’t hard

I: Was it like pushing on an open door?

P: Oh, yeah! We had, what, over 80 delegates and we could’ve had more. And, yeah, I did the usual sort of “Look at this from a public health angle” and the director of public health provided the sort of gravitas and endorsement of the partnership, if you wish. And I was just connecting in the other parts of the system and getting them to, you know, focus on the health resilience, health inequalities aspect that we were doing anyway. So, Barnardo’s, the Police, who take a very public health approach, you know. Certainly in [regional] Police anyway. They wouldn’t call it that, but they do.

I: What do they call it?

P: They just, (it’s just what they do?) yeah. Yeah. But it is, cause they’re very – they’re focused on the partnerships, the data and the information obviously, they are very interested in the evidence of what works. And they get that clearly this has significant health consequences. Also, they understand that you need to think about the local impacts and things like, you know, we’re just dealing with a safe house now around the interface with primary care. And accessing primary care. So, they’re very insightful, they’ve been doing it for a while though and it’s usually reliant on one or two very experienced officers. But they also back it up with quite good technical support. So, they do do a lot of work around the data and horizon scanning. They don’t present it in a public health way, it’s just numbers and

I: So it’s like social epidemiology

P: Yeah, yeah. But there’s, you know, it’s very powerful and impactful. And I’ve certainly – it’s in one of the slides – it’d be great to be able to work with them to look at longer-term trends and that kind of thing and get some rates around it. But then again, I don’t think other government departments do tend to work like that, cause you get the same situation with asylum seekers, refugees, the migration partnerships. There’s real, I think, scope and advantage in analysing some of this data in a public health way. Epidemiological. So, but yeah, the Police are really good.

I: So would that include linking the sort of intelligence you have around, you know, re-settlement schemes or new arrivals (yeah, absolutely) with police data?

P: Yep. And there is, as I say, that’s been done a bit, but not systematically or consistently or at scale. And the other thing, the other connections that are being made really well in our patch are around homelessness and modern slavery. There is a specific subgroup that is an offshoot of the anti-slavery network and the mayor’s work around homelessness to make those connections, which is much needed. There’s lots of differences, but lots of parallels as well, lots of learning across professions.

I: Yeah, so, when you’ve been doing this – what sounds like many, many balls juggling in the air with the work around partnerships – do you draw on any models of working? Or just your own experience to bring those partnerships together, or to make public health a voice in the discussions.

P: I think it is, it’s pretty much what I’m gonna describe this afternoon. I’ve always used this sort of quadrant approach where you’ve got your strategic leadership and advocacy, your networking and partnerships, your resources, tools, so the evidence, the data, and then I can’t remember the other one. But, yeah. Sort of connecting that system, really. System architect. Cause I think someone, somewhere, needs to pull these things together, as I said to begin with. Particularly health inequalities and these abstract concepts – you need to create a sensible narrative and that’s what I was able to do really easily with the modern slavery work. And I guess that’s why I was quite surprised at that initial meeting of the anti-trafficking network. I thought “Wow, missing a trick here”, yeah.

I: So it was just your own background and astuteness that you knew that these –

P: 2016 was the health engagement event, sorry

I: And so from there, how do you maintain engagement? I suppose your own engagement, but then the broader system. You know, keeping the broader system engaged

P: The health engagement event and being part of the network enabled me to make important national contacts. So, working with a national training delivery group, for example, enabled me to just get some health considerations into the whole suite of training resources that they were developing

I: Was this the public health training?

P: No, the Home Office. So, I think they still – they produced a whole raft of different levels of training, but it was then stored on some website. And it’s like “Why have you put it there?” No-one’s gonna see it, get it, use it. There was some peculiar registration process. People just put off straight away. So, I encouraged them to use some of our, you know, platforms, but it never really worked. But anyway, obviously links with NHS England which were always tenuous and they were just doing what they did. And clearly just keeping a line of sight in terms of national policy, so that was – the national connection was really useful. As a result of the network and the engagement event, I made several new contacts across places, some in local authorities that were doing some great work already, they had dedicated people working in [places].

I: Yes, I found a [place] document that was something to do with a strategy around modern slavery

P: Yes, [place] do some really good stuff

I: I was thinking it might be worth talking to somebody there

P: Definitely. Yeah. I know people there – I can give you their names. And then, local contacts made, across public sector and voluntary sector. I was particularly interested in the children and young people stuff. And then interestingly within Public Health England, although it was quite difficult to get national colleagues to do anymore around spotting the signs, to something simple. I tried to get it in a team talk but that didn’t work

I: That is like a PHE mechanism?

P: Yeah. Briefing staff, upskilling staff. And I just thought that was a really quick win

I: I think, remember [person] (yeah), she tried the same thing.

P: It’s a bit short-sighted, but I guess different priorities at the time. But I was – because I was involved in the wider health engagement stuff in the [region], I was asked by a national team to get involved in their work around supply chains which was something. So, they – a national team doing really interesting piece of work around looking at our top ten suppliers and making sure that they have their statements, they were sound, etc. And no risk, hopefully, in terms of labour exploitation etc. So, that was an interesting one and I was quite heartened that at least they were doing something, even though it was probably on their must-do list. But I thought that was also a potential segue to do more of the wider health inequalities stuff, but it never really. I keep trying

I: Yeah, yeah. Relentless (both laugh).

P: Relentless, yeah. They’ve bunged me in a [organisation] adding value case study stuff around – yeah, well, better than nothing.

I: But now there’s lots of interest, so, you know. Okay, you mentioned about maintaining the connections. So, want to ask a question about that, but also these sort of windows of opportunity and how you spot them. So, first of all, maintaining these quite complex collaborations – how do you do that? And have you been able to?

P: I email people a lot. I read a lot of – I subscribe to quite a few bulletins – you might have noticed. I spot and I think sometimes that article or that piece gets people thinking. I bother [name] a lot. I bother [name] at the Police a lot. No, I just keep in regular contact, I would call it. And if I see opportunities to amplify their messages or for them to come to our party, I do that. But I also keep it as a priority in our business plan, which is incredibly important. So if it’s not part of the core business

I: And you’re able to do that with no problem?

P: Yeah. And opportunities to align with national programmes of work, like Inclusion Health. So, expanding that out a bit – every year we have to report to the secretary of state for health around our legal duty to tackle health inequalities, which is always my hook and gives it real traction. So, I’ve always got an example of this in there, somewhere. And the Anti-Slavery Network are now working on their five year plan, so I will contribute to that and I will make sure that those read across and connect with our strategy, our PHE strategy 2020-2025, because there will be, even though the words might not appear in there, they definitely will be. And I think in the wider context of the NHS long term plan, our NHS colleagues are very much in conversation, extensively, with public health England at a national level around the prevention piece. I seize any opportunities I can to get, you know, to look at particularly vulnerable groups like this. They’re doing stuff locally in the [region] NHS around homeless, so it’s just grabbing those opportunities and the existing appetite, I guess.

I: How do you spot windows of opportunity?

P: I guess I’ve got – I’m quite good at networking and making connections and tend to follow through on things rather than having the idea and walking away. And “Let’s move on to the next thing.” So if I commit to something I’ll do my best to produce something as a result of it, or make something happen, and I think that makes a difference in terms of how people engage with you, because they know that – I mean lots of people have lots of ideas and you can’t do everything. But if I believe in it and I’m passionate about it, I will make something happen. And it’s just understanding the right people to have the discussions with initially. So, NHS England are all about equality and diversity, health inequalities at the moment, so let’s get in there. And also, the new tools what we’ve just – well, recently national team have put out around place-based approaches. For me, this lends itself perfectly for a road test of – it builds on [name’s] table top exercises and I think there’s real scope to have a, you know, a fresh look at this in terms of the place-based approaches to.

I: Just tell me a bit about his table top exercises

P: Oh yeah. I think it’s probably a couple of years ago now, but you’ve got – it’s a multi-stakeholder event where tables are mixed up, you know, different people from different agencies and I was invited along. A couple of local authority health colleagues as well, I think, a couple of NHS. And it was scenarios. Scenarios that – they were real. And what would each agency do? How would they respond to the victim or victims – so, it was about, you know, sharing knowledge and learning and working out how far we’d got to go in terms of understanding across the system and pathways of support and integrated working.

I: Right, okay, that sounds really interesting

P: Yeah. I asked [name], actually, cause [name] was I think talking about doing something nationally – or [name] was. So, they may be doing that and I did ask [name of Chair] for the report from the event and the format, the structure of the event. I’ll see if I can find it. He hasn’t sent anything yet. But it was really – it highlighted the challenges, cause some of it you think “Oh gosh. What do we do with this?” and “This is a safeguarding issue” and “How can that have happened?”. “Why did no-one hold the ring?” - it’s because there’s so many contacts in the system and certainly different inputs, potentially. Well, there are. And it’s everyone’s responsibility and then it becomes no-one’s to, you know, maintain that overview. So it definitely, you know, needs someone there who holds the ring on these kind of things. And there are really complex cases as well

I: Who do you think should? Just thinking in terms of, you know-

P: It depends on – I think it needs to be much more clearly aligned to safeguarding in the same way that that conversation is happening with homelessness. I mean, I think the system needs to be reminded of their responsibilities and duties. Parallels again with homeless – duty to refer, you know? It’s not something you can ignore. So, I think that the policy architecture’s really important as well. But, yeah, it depends what the issues are and they can be many, varied and complex. It’s often not a single issue - from housing to health to no recourse, to, you know, abuse. It’s really hard.

I: But what role have Public Health, then? Either whether local authority or PHE or regional centres.

P: To better understand the problem, the size of the problem, to encourage – well, to make sure their staff know about spotting the signs and what to do if they do if they think they’ve encountered a victim. And I think we need to take a much closer look and raise awareness of the settings where people are gonna present. That’s why I’m really impressed with what Barnardo’s were doing around the maternity settings. But obviously Primary Care. Issues around access to primary care and making sure receptionists don’t send people away as research demonstrated with Westminster. All the trauma-informed stuff. Really understanding the complexity and the severity of, you know, what people have been through. I volunteered – it’s an aside - but it’s illustrative of things you’ll overlook. I volunteered at a safe house recently and we had three victims in the safe house that’d recently been rescued from labour exploitation and it was my first shift, so I was very proud of myself that I found out what tea was in Romanian and went over with the cups and the sugar and managed to do that. I thought “Right, I’m gonna find some biscuits.” So, I went into the kitchen and was rifling for biscuits in the cupboard and I found biscuits in a kitchen drawer, stuffed with a loaf of bread. They just didn’t click that they would have hidden the biscuits that they’d bought, cause they’re given a bit of money. And so I liberated the biscuits and their faces when I walked in with their biscuits was like “Woah. She’s found them” and I went to the manager and said “I think I’ve made a terrible mistake. I think I’ve nicked their biscuits, now they don’t trust me.” She said “Don’t worry” so we got on the phone to the translator, interpreter and said “She didn’t mean anything by it” but you know, it’s just those – then I found defrosted frozen chips in the cupboard and I thought “They’ve put them in the wrong place.” So again, off I go, put them in the freezer and then thought “Oh no. They hid the chips as well” and then they sat in the dark and I just thought “Wow”. And it’s things that you just – it’s obvious when you see it. And staff, I think, professionals, need to be more aware of that. Some of those examples, cause it just made me think – and there’s no quick fix.

I: No, and also just relating it back to the populations and the broader kind of public, what sorts of insights did you gain from those experiences that then relates back to your interests in populations and this collaboration with the anti-slavery network? How did it help you connect, then, your public health background to these experiences of these guys in the safe house? Did it make you think any differently?

P: I think we have to be really careful about that one-size-fits-all, or making assumptions. And we talk about – I mean I talked about data and I talked about, you know, we talk about numbers and one of the big challenges to convince some of our system leaders in health to get involved is small numbers. You just think “Oh, that’s three lives” but you know, they’ve been rescued. There were another 8 that were in a hotel somewhere, not having support, not getting support. So I think it’s my value set as well, but it’s not just – it’s making explicit that there are health considerations here, but it’s – it’s around social justice as well. And everyone just taking more notice. Just taking more notice that it could be going on on your doorstep as well. Professionals, the public. Cause you do notice once you understand.

I: Yeah. I suppose I’m quite interested in the idea of framing things as well. One of the perennial problems with mobilising action of health inequalities - it’s not that the problem doesn’t exist, it’s the arguments don’t seem to have traction. Or they don’t seem to have – some of the way the arguments are presented might not meet the expectations of the person receiving it. Or it might seem too big of an issue or something. I was kind of wondering about how we frame information in these collaborative environments as a way of engaging with public health, or the wider health sector. Have you got any thoughts on that?

P: Pretty much what I’ve said already, really. That public health approach is important, but maybe if this is recorded I’ll get a P45, but it shouldn’t take the to get senior leaders in the civil service to sit around the table. Cause this is nothing new. And it’s abhorrent. You know, the media stuff as well. The terrible thing that happened in, you know, with the poor people in the lorry. That spotlighted it. But it shouldn’t take that. And I don’t quite understand - you know, it shouldn’t take people to die to sit up and take notice. I’m not saying that people aren’t, it’s just that, for me, I can’t quite understand why it’s not further up the health agenda, even if it is just making sure all our staff know how to spot the signs. Just something that – and then people get more interested and it just opens the door, really. So, it’s about responsibilities, it’s about social justice. It’s about our legal duty. It’s about all of those things. And it’s about a professional in the community as well. So, not just within the work environment, it’s happening out there in the places that we focus on so much in public health. And, you know, the many forms that it comes in, really. I mean there’s been some really good work done around things, you know, child sexual exploitation, which has got a lot of attention, but I just think we’ve still got a bit of a way to go, but this is significant today which is good

I: Is there anything we can learn from the CSE stuff? You know, all the northern towns have been a focus of that. I’m wondering about lessons learned, because Public Health are involved in that space. Is there any way that you could sort of draw parallels or…?

P: I think there was national interest and leadership. I think it was clearly articulated that, you know, health was an important part of this. It was brought to life by the media and unfortunately, you know, the lived experience of the victims. And that’s really powerful. You know, some of the programmes I know that have been on recently around victims of trafficking have pulled at people’s heartstrings, have really made a difference to their perception and understanding. Reducing people to tears. It’s sad that we have to do that, but, yeah, high profile nationally in our organisation. There was a clearly articulated health component. There was a dedicated resource in [organisation], to make things happen and to work out where they could add value. And that was the CSW suite of resources and the framework that was produced. So, there was a product. There was something to share. And, you know, this lends itself. We’ve got stuff. But it’s how you systemise it and, you know, scale it up. And for me, wouldn’t it be great if it was in – It’s everyone’s business, it’s happening out there. Signpost to some e-learning modules which are there. Cause when those kind of people start to talk about it then people take notice.

I: Yeah, that’s true. Also thinking that your involvement in the [regional] Anti-Slavery Network doesn’t seem particularly common. Is that a correct assumption, do you think?

P: Yeah, I don’t know what the situation is with other networks across the country. And there are parallels as well with the strategic migration partnerships, but that has a lot more resource and welly and focus in [organisation]. You’ve got a national team and they’re working across government as well, which I think is also a missing part of this cause this one can fall through the cracks, I think. But I don’t know about other areas. I know I’ve been contacted by peers in other centres who have – I’d say tinkered around the edges with some of this. And it’s usually the places that have hit the headlines because, you know, bad stuff’s happened in their localities.

I: Are they local authority or centre people?

P: Centre, ours, but they will have been contacted by local public health teams or local authorities saying ”What should we do now? You’ve done stuff on this, haven’t you?”

I: “You’ve got all the answers!”

P: I don’t think I’ve got all the answers. But, yeah, it’s hard to sort of describe it all neatly, really, cause it has been quite a fluid development and that’s why I thought it’s necessary to try and put it into some kind of public health language, framework. Otherwise, you know, it’s just sort of happening and you can’t really articulate what you’ve done, how.

I: I suppose when it comes to sharing that practice you’re in a position to be able to do that, but there’s not really a system of it at the moment.

P: No, and it is important to have some products, some outputs. So, things like the event that led onto, you know, farther collaboration. Couple of publications, that kind of thing, it makes the difference. And, you know, just being round the right table as well. Maintaining that contribution and input and interest and spotting “What’s the next big thing?” So, we’ve been contributing to the CQC work around the safe house and the standards around that which is great. Obviously volunteering at the safe houses is exposing me to another side aspect of this which will further edify how I approach this personally and professionally. So, it’s just what’s coming up. And as I say, the five year plan, I wanna make sure that public health, health features strongly in that. So, I’ll be talking more to [Chair of the network]. There was an HSJ thing this morning that came round I think – I might have sent it to you- that’s looking for examples of collaboration in this space through the safeguarding route, so I’ve sent that out. And I think it’s really important to showcase some of the good work and to continue to – it’s knowhow and showhow, isn’t it, I think. And some of the lightbulb moments I’ve seen around the table, I’ve done training for our staff, and they’ve asked for it. The TB nurses that are out there with people, touching flesh, literally, and they know if something’s not quite right but they didn’t know what to do about it, so just those small actions can make such a difference. But to do that with more senior support at scale, systematically, consistently, it’d be just brilliant.

I: Yeah, with resource as well

P: Yeah, with resource. And then as you know, some we evaluation of – “So what difference did it make?” You know, have you used the modern slavery helpline, have you looked at people in a different way, or spotted something? Yeah.

I: So, if you were to give some advice to other public health colleagues, either public health teams locally or in the centres about being involved in anti-slavery networks, what sort of advice would you give them?

P: Legal duty, health inequalities. Fits completely with our raison d’etre as an organisation. Vulnerable groups. We can add value by taking a public health approach and we’ve got evidence of that, which is always powerful. So, the case studies, the joint work, the being cited in one of your articles, anything, I’ll take anything. And the training resources that are on tap that we can just use without a charge, or without much effort. So, yeah, there’s a whole sort of offer there, really, that we should be harnessing more. It might come out today, who knows?

I: We haven’t talked much about prevention and how you collaborate to sort of operate across different levels of prevention. How have you communicated that with your colleagues?

P: That’s a tougher thing and I’ve tried to just start embarking on some work around county lines. And I’m leading a wider piece of work in the centre around vulnerability, what that means, what are the protective factors, but what are the risk factors? So you get into the whole sort of ACEs stuff. But I guess, you know, with this one it’s really hard and it’s as much about understanding the perpetrators as the victims, cause they’re – it’s very business-like. As I said before, if they could apply the thinking and the, you know, the assets that that undercover world to make this happen. It’s pretty astonishing. Cause this isn’t just thrown together. But yeah, so, it’s difficult and I think we need to be much harsher on the perpetrators once we’ve – cause often the sentences aren’t particularly severe. The punishment doesn’t fit the crime, really. But in terms of prevention, I guess it’s how far down the line you can go. But things like the maternity settings where young girls were coming along and claiming their benefits with their uncle or aunt in tow. Yeah, you haven’t prevented the pregnancy, the first, the second, the benefit fraud etc. But I guess you could prevent it going any further. So, I think that the ACEs piece and that trauma-informed approach, spotting those signs and understanding those risk factors. School exclusions – do you know that as a result of that they might be more risk of being subjected to the county line stuff and that kind of thing. And that’s where I think GP practices receptionists and that kind of stuff. But I don’t think we know enough about the history of the victims. Maybe we do. But I don’t think we’ve probably done enough research into that.

I: Yeah, so we could do maybe some work around profiling specific sort of characteristics that are common among population of people that become victims or are at risk of becoming victims

P: Absolutely. Cause we know, obviously, the police data and all of that shows you which the high incidence countries are. And the different types of exploitation. But that journey from A to B – and there are some really good films that have been made around that and stories to tell. But I don’t think we’ve consolidated that, and I don’t think we make best use of how it can happen and quite easily.

I: So the mechanisms – not just the characteristics, but the mechanisms

P: Absolutely. Absolutely.

I: So there’s a lot of potential kind of logic modelling or theories of change that you could include in there

P: Oh, yeah, absolutely. But I don’t know – do you know of any robust research that’s been done around the profiling?

I: No, not of victims of perpetrators I don’t. I haven’t seen.

P: And I guess it’s how much opportunity the victim has to discuss some of that, given that the victims can be treated as not victims, but as the criminals – which is another massive challenge, isn’t it?

I: Yeah. We’ll talk about some of that later on today as well – these ideas about how to progress prevention as a, you know, a core component of a public health approach. That’s probably the hardest bit to articulate, isn’t it?

P: I think it’s the hardest bit to articulate and we love our early intervention and, you know, “Start young” and all that. And I think there’s a place for that in terms of, you know, the county lines I think is a great example of having looked back at some of those – how that kid ended up there. But, when you’re dealing with, you know, the adults and – it’s a different – I guess prevention further down the line, it’s downstream isn’t it? And we’ve got – ideally we like upstream in public health – but if you can prevent them suffering any further and being exploited any further then that’s important. So, it’s finessing some of that public health approach and principles, isn’t it?

I: And working backwards from the victims and thinking about the broader, for example there’s possibly a role for systems mapping

P: Yeah. That came out of the table tops – cause it was such a complex web, as I said, and when you haven’t got clarity around leadership, ownership, as I say, holding that ring, that’s really hard.

I: How about this idea of a health in all approach? So, throughout the kind of – with all of the interest in modern slavery, which does have its own independent piece of legislature now, how a health in all approach – again, another tool in the box of public health, if you like. How that could be possibly applied to modern slavery field. Would it be a useful thing?

P: I don’t think the health in all policies approach has stuck and landed in the way that I would have expected it to. And so – and I can only speak from the [regional’ perspective, obviously. There’s a couple of our local authorities that have done some good work previously. So, [place], not in modern slavery, but just generally, you know, health in all policies through their health and wellbeing strategy. Health in all policies health impact assessments. Birmingham are doing Health Inequalities city, whatever that means, and Coventry, which I think is the best example, have used the Marmot city principles. So, it’s happening, it’s often not described as health in all policies, and sometimes when you start with health it puts people off. Cause it’s almost like you’re preaching. “You’ve got to put health in everything you do” and I think we have to be careful in the current climate where we’ve got a whole lot of decommissioning going on and, you know, services being squeezed and you name it. Cuts and all of that. And I was talking to [place] about this the other day. So, I said “What are your council’s priorities at the moment?” and “Well, it’s big push around children and young people. So, if that’s modern slavery, CSE, child trafficking. Big push around inclusive growth. So, yeah, employment. Good employment. “We’ve got people being exploited on your patch. It’s not a good look for your councillors.” Mental health was another one. “Yeah, this has a bad effect on people.” That’s what – I’d come at it the other way around. It is health in all policies, but, yeah, I just think sometimes it raises antibodies. So, in terms of, you know, as I say, it reads across – I don’t think we’ve done a proper piece of work looking at things like the long term plan or [?? 0:59:03] green paper to see how it maps onto some of that. Cause this wouldn’t get a mention in there. And workforce strategies as well –

P: Have you spoken to [name]? They’re fab – our [professional role]. So it’s a making every contact count approach, which I think still has legs and still has traction out there, but it’s called everyday interactions, I think, that they’re doing with the royal college. So, can we link it to that health policy in the broadest sense? I think the systems mapping idea is a good one. I don’t think – if we can – it’s easy to do it with the [organisation] strategy, but I haven’t actually looked at how it would map to the NHS long term plan, but it would quite simply and easily. You know.

I: And just to think about sort of going back to the anti-slavery networks. Can you think of the things that really make the network work? You talked about some of the outputs which you’ve been involved in around the table top discussions, the events, presentations. What makes, do you think from being inside the network for several years now, what makes it work for them and for you?

P: A commitment, professional and personal, value driven. Learning. We learn a lot from each other. And I would say there’s no – it’s not competitive and there’s no ego. Maybe there’ll be a bunfight next time now I’ve said that, but no, I think people generally share a lot of humility and know that none of us know everything, but together we can make more of a difference. And yet within that, we’ve also got our specialist and unique contributions, so it is about bringing that together, all of that. I think leadership through [the Chair]. Good admin support, actually. We talk about resources but [name] does an amazing job in – someone has to organise those meetings, set the agenda, get the room booked and that’s often when things fall apart too. It sounds pretty straightforward but it is true. I think the connectivity to our wider policy drivers across different organisations is really important as well and bringing that to the table. Delivery – we follow through. Yeah.

I: And for you – we talk about the added value of public health and a public health approach. What do you think you bring? You probably said quite a lot of this at the start of the interview, but what do you think you bring to the table that otherwise wouldn’t be there?

P: New understanding, new way of looking things, looking at this through a different angle, different perspective. Commitment and energy and passion I hope to get things done and to energise others to get involved. Persistence. The information sharing is important, although I do annoy people – I know I get on their nerves

I: They can always just block you!

P: They could block me – actually, that’s probably what happened on Friday! They all blocked me. “Nothing is working. Finally, now I understand this.” Yeah, they blocked me. Yeah, just – and I think that, as you said, connecting the system, spotting those opportunities, but also challenging upwards. Despite it being patchy and an achievement, there has been a lot achieved actually, but you know, just keep pushing the message up to colleagues and encouraging peers and other centres to get involved and I think there is a – there’s currently a real opportunity with the spotlight on inclusion health. You know, they say “Always the legal duty”, which we’re accountable for. So, where we’ve got teeth and can hardwire this into what we’re doing already. Yeah, it’s sort of heartening to know that you’ve made a difference. You described it as a neglected public health issue, and it is an issue for the public’s health without doubt.

I: Yeah, and if you think about broadly in terms of the – if you take away from the victim when you see things as a citizen, you know, a free citizen walking around the city and you see homelessness and you see people being quite clearly being exploited, that’s not good for the public’s health. It’s everybody’s business. And unequal places lead to sad places and unhealthy places.

P: yeah, definitely. It’s part of that narrative, isn’t it? It all contributes. And you know, there is a lot more that we could be doing around finessing the data and continuing to develop that evidence base, but also telling the stories, whether that’s one person or ten people or a hundred people or thirty people in a lorry. But even then, it’s just a statistic, isn’t it? What have we learnt from that? Bit more reflective practice, I think. I like your idea of the profiling as well – doing some more.

I: That might be possible, mightn’t it?

P: The system mapping is really important.