Name of Transcription: LA1PB 17.12.19

I = Interviewer, P = Participant

*Introduction to study*

I: So, do you want to start by telling me a bit about yourself and your role here? How long you’ve been here, those sorts of

P: Okay. So, I’m [name], I work in the public health team here at [place] council and I’m lead for [role]. So, that responsibility revolves around [lifestyle/health] behaviours. I’ve been in the public health team now for about [duration], but previous to that I’ve always worked in local authorities for a long time. Primarily – mostly in [role] and then latterly working embedded in [specific] team around working on healthy lifestyles and areas of deprivation in [place]. So, I’ve been in local authorities but not in [function] for that long.

I: And remind me of your title again

P: I’m [role]. So, we’ve got a number of programme leads here in public health and I report into [person]

I: How big is the public health team? Is it a team or is it a division?

P: So, the public health team. How big it is. I think we’ve got about [several] programme leads covering different areas and then a number of staff underneath. So, I don’t know the numbers, but probably about [number] people. So, it’s not huge, but it’s, you know, compared to other directorates in the council. But obviously we’re trying to be more strategic etc. So, it’s very different

I: Great. So, as you know, I’m doing this piece of work around health in all approaches to health and health inequalities. So pretty much the first question I ask everyone is what you understand by health in all policies

P: Okay. So, in terms of health in all policies, how I see that is looking. Well, just from a council perspective, but obviously health in all policies could apply, you know, does apply to wider systems. But from a local authority perspective it’s literally the policies, the strategies, trying to make sure that there’s a health – an element of health and recognition that health is important across all the different policies. So rather than public health just in isolation, it’s actually how is health thought about in the children and young people’s plan? How is health thought about and recognised in corporate plans? In, you know, investment plans and regeneration plans. How is health thought about in the planning decisions and procurement decisions? So actually, from a council perspective it – in my perspective – it is literally health in the whole policies of the entire council. But then taking a step out of the local authority it’s actually health in all policies across different system leaders. So, public health policies – a lot more work can be done in the NHS – I know that’s a health body. But also around, you know, businesses, so, yeah, so first of all local authority, getting our own house in order but then trying to influence other system leaders.

I: And so that’s how you kind of see it in your local authority. How do you think others see health in their domain outside of the public health remit?

P: So, I think in terms of like the local authority, in other directorates and systems and possibly the elected members, I don’t feel that health is yet – is probably not the most common thing that comes to the top of their priority list. So, I think there’s still some work to be done. Like some bits of the council kind of really get it and embrace it. And then I think some others don’t. Like “What’s it got to do with me? It’s not a priority. My priorities are X, Y and Z.” I think there’s some decision makers and elected members who embrace health. I think probably some other elected members that are perhaps more – decision makers, potentially, I feel don’t maybe have health as a, you know, a thing they think about straight away.

I: What do you think is the place of health in the hierarchy? What’s at the top? What’s at the –

P: Well, I guess. I think, well, it kind of links, doesn’t it? Cause obviously if – I think one of the biggest things for the council, strategically, is around regeneration. So, like new buildings, the place looking nice, investment into, you know, leisure centres and infrastructure. City of culture etc. really brought that home. And also, a massive drive on employment. But obviously we know if people are in employment then they’re more likely to have better health. But, so, yeah, so I guess the wider determinant side of it, something that is up there if you’re thinking about it, employment is one of our key priorities in the city. But then our – is everybody getting equal access to that employment? Is everyone getting equal access to the investment in the buildings and the infrastructure? Cause a lot of it’s happening in the [place] centre, but actually [place], you know, you go up to [area] – where’s the investment? You know. Some of our estates where deprivation is highest. So, there is, you know, are the people benefitting from the jobs that are being created from the areas of deprivation? That’s some of the ideas around this idea around the [place] commission, to try and address some of that health inequalities.

I: And sort of following on from the distinction between the decision makers and the elected members. Can you think of – in terms of how high up the agenda health or population health, I suppose, might be for those different categories of people? I mean, different positions, I suppose – how are the elected members, for example, engaged with the health agenda?

P: Obviously you’ve got some key elected members like the chair of the health and wellbeing board, Councillor Bridges, she’s obviously massively engaged cause it’s part of her function. You’ve got Councillor Lunn who is a portfolio holder for public health. And she’s obviously got adult social care. So, they’re really, really engaged. And Councillor Lunn is a cabinet member. But I do feel she’s probably a kind of quite a quiet voice potentially in, you know, against the other elected embers. I don’t know how strongly the health message is getting through. But, as I say, with regeneration the jobs messages is getting through which does support the wider determinants of health. So, it’s maybe not dressing it up as a health message – it’s maybe dressing it up as a – you know, economic regeneration, or air quality’s quite high on the agenda at the moment. So not going in with a health message, it’s going in with an air quality message which we know we can link into active travel which can link into people increasing physical activity and tackling obesity. So, yeah, I think there’s different levels of understanding and prioritisation. And it’s kind of a difficult thing to get your head round some of the population level health. So, we’ve had a number of childhood and obesity conversations and we’ve had okay attendance from elected members but it’s not been the, you know, it’s not been like the leader of the council or to that level. It’s been, you know, on the periphery.

I: So, what is the level of importance of articulating the health message or the health inequalities messages in these other policy areas? So, regeneration and shiny buildings is a priority. Does health have to be part of that conversation and how up front does it have to be?

P: I think it’d be better if public health were, or health, was part of everybody’s thinking. Obviously, there’s not enough of the public health team for us to be part of every possible decision across the whole local authority. So, I guess it’s how we influence other directorates to understand health inequalities and to prioritise it. But equally then, you know, you might – so, there’s massive inequalities in educational attainment for our children and young people. So, education really interests me. And that, obviously that chimes with areas where health inequalities are greatest. So, it’s – people probably do understand it – it’s just using their terminology more so to get our agenda across. And I think in terms of the practicality in terms of some of the regeneration stuff, if health was more engaged in some of that then it could help with some of the active building designs and where buildings should be. Obviously we’re trying to influence that with some of the healthy places sort of financial planning document that we’re working on so that could be, you know, if we can pull that off that could be really good and it could eventually influence a local plan. So, trying to implement at a policy level is probably where public health needs to be more so and pushing that to influence wider determinants, cause as I said there’s only so many of us – we can’t possibly be everywhere. But we did – I did – we did try and take something through cabinet around the whole food charter which is looking at food poverty and sustainability of food and a whole broad brush around food and what food should be in the city. We got it through all the way and then it fell at the final hurdle at cabinet who kicked it out. That would have been wider population health and then it suddenly failed. Well, the issues that got entrenched with was around food poverty and food insecurity. Cabinet didn’t feel we had enough focus on that, but it’d been through quite a few meetings. A lot, you know, to get a decision through you have to take it to senior leadership and DMT and then it goes to like all the directors in the local authority meeting and then it goes to an overview and scrutiny commission. It goes to the cabinet, the shadow cabinet. So, we kind of got it all the way through and then at the last minute it failed and that was a bit like “Oh gosh” you know? Do people really get what we’re trying to do in influencing some of the wider determinants?

I: Why do you think it failed?

P: Probably politics. Maybe we in public health hadn’t done enough work with our elected members, you know, on the softer stuff and getting them engaged. But it was a big learning curve for me, really, and it did just feel at the time like “Oh gosh – we’re not gonna get anything through”. So that’s kind of just taken a back burner now, some of that work, cause council couldn’t agree to adopt a [place] food charter and it was quite, quite a nice thing to do, really. Could have just shown the council’s commitment to healthy food.

I: What sort of soft things, skills, or whatever, do you have to engage with elected members?

P: Well, I think one of my previous bosses is quite good at this and I think it’s – to me, in my mind, it’s having working relationships with the elected members. It’s knowing about their wards. You know, what’s their priorities? It’s knowing a bit about their history. It’s them knowing you and trusting you. So that chance to have a relationship is not necessarily down to data and evidence and facts. I think, you know, being able to go up to an elected member and say “Oh, how’s that project going on in your ward?” or “That building” or “That problem”. Yeah, having that personable relationship probably helps move quite a few things. But that takes time. It takes trust. It takes, you know – is it the right or wrong thing? But I don’t think data and facts and evidence, which is what public health are good at, doesn’t just automatically mean you get the decision through

I: No. You said you had an example of someone who was really good at that. What were their sort of characteristics?

P: Yeah. [They’re] my ex-boss and, yeah, she was – [they are] still working in the field. So I was in a meeting with [them] the other day and [they’re] – you know, [they’ve] got that relationship with the elected members, [they were] like “Oh yeah, hi” you know “councillor such-and-such”, you know, “How’s it going?” and they kind of respected [them]. [They] respected them. [They] dealt with them very well – [they] didn’t over promise and one of them was trying to get [them] to do all sorts but [they] kind of side stepped and stuff. You know? It gets into like, at one point it was like, this is like quite a senior person with one of the elected members and it gets – they seem to be quite parochial and it’s like, you know “such and such, I’m thinking about designing – I’d really like a Christmas card design for us for our next ward”, you know, “next year. Can you sort out getting a local school to design a Christmas card for us for next Christmas?” and we were going in and we were talking about healthy holiday scheme and we were putting a big bid in to department for education for this year to do healthy holidays which is all around food insecurity, children on free school meals provided meals and stuff. And so, you know, the level of conversation – and it’s not being derogatory at all, but it’s literally you going off on that complete tangent. But [they] dealt with it really well and [they’re] like “I’m sure we’ll talk to schools” and [they] managed to sidestep sorting out a Christmas card for next year. But yeah, I think – and [they’ve] been around a lot, [they] know [place]. Knowing street names, knowing names of stuff and having that personal relationship I think can help smooth the decision-making process. And not being – just recognising, yeah, it’s not just data and stats, it’s kind of stories with statistics, with evidence, but the story telling, I think, is quite critical working with elected members

I: Yeah, yeah, sure. No, that’s really interesting cause it kind of raises the point about public health advocacy. So how do you see advocacy as operating within this kind of health in all approach? Yourself as a public health specialist – what sort of role does it play in -

P: What do you mean?

I: So, just thinking about advocating for populations or for the issue of health inequalities in the city. How do you go about using those topics as a message to advocate?

P: Do you want me to give you an example with the obesity stuff?

I: Yeah, sure, talk about

P: Sure, so childhood obesity – big issue in [place]. And when you look at the deprivation quintiles it’s an obvious health inequality issue as well. You know, children living in the most deprived quintile are a lot more likely to be overweight and obese. So, what we’ve been doing is starting these whole system conversation using the Leeds Beckett Public health England work

I: You mentioned it before

P: Yeah. We’re having our fifth conversation in the new year. And how that started was, you know, having the data, having the evidence, telling the story, you know. Saying it’s unjust. And I think people want to help children and young people. It’s like, you know, we can’t let this happen to our young people. What can we do as a system to help fix this type of message? From a public health perspective it was great cause our director of public health did a DPH report about childhood obesity at a similar time to when we started this work and the invitation for some of the original work came from [person]. It’s like “Right, come and be engaged in this whole system, this conversation about obesity” that’s how we – conversation about childhood obesity. And we got all sorts there from across the system and elected members in the local authority and different people in the local authority from different directorates but the wider system as well across [place]. And having somebody like [name] kind of fronting on it. And we also got the cabinet member for public health to front it as well, and the chair of the health and wellbeing board. So, kind of having that out there and then obviously kind of working through it, but we did a lot of work around, you know, the causes of obesity and why it isn’t just an easy thing to fix. What we need to do across the system to help address it. So actually working through it – we’re on our fifth in January – but actually taking the people with us on the process and doing a staged approach to help people understand the causes, what the actions are, what the actions could be, how we need to address it as a collective. Rather than it just being “Public health, we’re commissioning this and we’re gonna sit in our little box and we’re gonna tackle it on our own” It’s actually “No, we haven’t got the answers, how can we sort this out together?”

I: How have people responded to that?

P: Yeah, so it’s, well, I’m obviously a bit biased – you’re probably better off speaking to some other people (*laughs*) – but no, we’ve had good engagement. We’re still getting good footfall through. People are starting to take on actions. It’s opened some doors to us, so like the healthy places, the SPD type of work is starting to come out of that. Cause planners were originally around the table. It’s like planners – “what could we be doing?” The, recently we’ve been working with procurement in the council who are just – we’ve managed to make sure health is part of the new vending machines procurement processes and we’re on about – Joe from our public health team has helped some of the procurement stuff. And they actually came to us rather than us trying to find our way. So, some of that has come from the obesity work and just saying “Right, as a system, what can we do? This is the issue – what can we do together?” and we’re, “we haven’t got the answer” type approach. So that’s been quite good about developing relationships with new people across the system. The other day we had one of our local GPs sent a big email around the food offer in [place] Hospital and was like, just sent this big email saying “Look at all these pictures of all this snack food and cakes and stuff. What can we do about it?” So now actually that might open up a conversation with [name] CCG to influence a food provision in the hospitals. So, kind of like influencing these different partners across the system to help us do something. And I think the conversation events have helped us open some of them doors.

I: And so who is it – you mentioned different directorates. You’ve got three important leaders there for the events. Who else is involved?

P: Yep. So obviously we’ve got – so, children and young people’s, well, children and young people’s services are really involved. We’ve been working on them on all the healthy holiday type stuff. We had the chair of the Primary Heads Association attended and they’ve taken on an action to try and coordinate the physical activity offer in primary schools themselves. So, that’s – yeah. It’s kind of like – it’s letting go. It’s not public health having to be involved in everything and control everything and do everything. It’s actually “Yep, brilliant you’re doing that. Crack on and get on with it” type of thing. So, that was quite positive. Air quality – we keep talking to – they sit in the public health. They sit under Tim Fielding and trading standards and air quality people

I: Is he the deputy?

P: So, Tim fielding is the deputy director of public health but, so he’s got public health under him, but he’s also got this big trading standards arm which includes air quality. But it’s helped us open up some doors to air quality so they’re coming to us and saying “Oh, we’ve got these local communities who want to put in air quality monitors cause they think air quality’s bad, so can we do something on playing out?” I think we’re lacking in the business side of stuff and the regeneration engagement. But, yeah, I think it’s gonna be a long process, tackling obesity

I: Thinking about business, why are business important?

P: Well, business are important because they promote the food angle around what food is happening, being offered across the city. How are they supporting their work force to be healthy? So, I think there’s probably –yeah, quite a bit of work to be doing on the business side really

I: How do you engage with business? Is it any different to how you would engage across directorates?

P: I think it’s not an area I’ve been involved in much. There is a city leadership board which had businesses on it and we presented the [place] food charter to that to try and encourage businesses to take and sign up to the [place] food charter in their own right. Not sure how successful that was. So I think with businesses it’s, yeah, where do you go? What can we get them to do? I think some of the fairer [place] stuff might start to address some of the business stuff that Ali’s on with, so we’re probably waiting for some of that to pan out.

I: So, just thinking about within the – it was a really good example, the obesity work that you’ve been doing, and I was thinking about how – sorry – whether there are any, so, that sounds like a new initiative. Are there any other formal mechanisms that you use or others use to engage other policy partners in health inequalities or population health approaches to policy issues?

P: So, other policy partners, like who?

I: Like transport or-

P: Yeah, transport’s a good one, actually. (housing) Housing. Yeah. Well, there’s a couple of examples. So, housing one – we have worked at policy level, but we’ve tried to work with housing on tobacco, cause that’s in my portfolio as well. So, we met with the assistant director of housing and talked about, you know, obviously smoking rates are highest in areas of deprivation – which then links to - some people who are living in council housing and private housing. So, he was really – he wasn’t appreciative of that conversation, but we did manage to train some of his housing staff up in some brief smoking advice. I think he thought it was a little bit pointing the finger, you know? Cause there’s some new work from ASH talking about rates in housing and if people are smoking in housing then it’s not very good for the next tenant coming in. So, is there any policy changes we can effect at a local authority level to encourage people not to smoke in their council houses? But then he was very much like “Well, that’s discriminatory” so that was quite an interesting conversation. So, I think there’s still opportunity there – we’ve done some periphery stuff, giving out leaflets on smoking and training some housing staff, but ASH kind of saying “there is more we could be doing on a policy level with housing”. But it was, it wasn’t well received, really. Cause he was sticking up –

I: How do you handle those sorts of situations where you’ve got maybe competing agendas?

P: Well, what we tried to do is tried to think about it from their perspective and try and think “Well, actually, it’s not very nice for the next tenant to come in if it’s been a really smoky house. It’s gonna cost you more cause you’re gonna have to like proper clean the house. You’ve got fire” you know “fire risks” the fire thing did resonate with him cause I think there’d been a number of fire issues in housing. So that’s how we tried to just think about it from his perspective. Not bang on about “Smoking kills so many people in [place] and it’s a significant cause of health inequality”. (*both laugh*) No, so not that language, just trying to sell it from his perspective. So that was kind of quite interesting.

I: Then after, do you have any kind of follow-up to those sort of encounters?

P: Yeah, we had some email follow-ups and he was a little bit grumpy. So, and the other thing is they’re just going through a restructure as well, so we’ve said actually let’s just leave them be for a little bit. Do a bit of training, leaflets then actually it might be a conversation to pick up again. But I think there’s more opportunities there. On the active travel one, that’s been really interesting. So, we have got a physical activity strategy in the city and part of the obesity work as well. Tim Fielding has been, our assistant director has been pulling together kind of the strategic people in the active travel world which has been fascinating, cause we’ve all just been working in silos. So, you’ve got obviously Transport and, you know, you’ve got air quality people with their air quality agenda and “we’re gonna be carbon neutral by so and so.” You’ve got transport colleagues working in silo doing kind of big transport plans for the city. Not even thinking about public health. You’ve got us in the physical activity group going “More people need to be active. We know where our inactivity is greatest, we know where cycling and walking is a big opportunity for us” You’ve got kind of people in street scene are looking after the cycle lanes and making sure are they clean? etc. And then that links again into the bus and public transports and the trains cause it all, you know, if you’re trying to get people to actively travel it’s still about buses and the wider stuff. So, Tim Fielding, at his level, managed to get some of these key hitters and players in the room together. It’s a slow burner because I think people are so busy. They’re like, just on with their own little thing in their own little patch but we’re trying to influence, can’t remember their name, it’s quite a big strategy document. The transport plan? (*sounds unsure*). The transport plan for [place] is getting renewed and it’s being led by Highways? (*sounds unsure*). So, we’ve said “How can we make sure health, you know, facts and figures and priorities were in this plan?” And they initially said “Yep, that’s fine” and in past iterations they’ve just done it and not even really consulted with that many people. So, Tim’s trying to influence it to make sure we can be a, you know, be consulted on it. I still haven’t seen the draft, but I know there’s a draft knocking around. So, in my mind, it feels like a no brainer, but it’s still trying to build relationships and convince some of these really busy people in different directorates that we’re better together. I think Tim’s maybe taken that conversation up to an even higher level. [?? 0:30:31], I don’t know, I think he’s a director, but he’s got a passion for cycling. So it’s kind of finding, you know, it’s, he’s a legal type person but I understand he’s really into cycling, so he’d be able to be at that level and bash some heads together to make us work together. But it’s kind of finding out somebody at a senior level who is into cycling that, you know, doesn’t come as naturally. And whether maybe other directorates don’t know that public health exists, I don’t know do they know what we do? Do they know how we can help? Do they know all the JSMA information we’ve got? Cause that is so good for strategies, isn’t it? All that data we’ve got. So, the active travel one is a good example and it’s work in progress. We’ve been meeting now for about the last seven months on the back of the physical activity strategy and obesity work. But strategically, we’re still not there. But we are trying to make sure public health is embedded in some of that transport policy stuff. And also, Tim’s really trying to get a collective vision for the city, like an overarching vision on active travel – what do we actually want? Cause it is quite a popular idea and, you know, popular thing, I think the deputy leader of the council has talked about [place] being a cycling [place], but then actually who’s responsible for delivering on that vision? Where does it sit? Doesn’t really sit in one directorate. So, yeah, work in progress. But maybe whether people see public health as being new, I don’t know. Departments like that. I mean if you’re obviously building roads all day do you really think about?

I: Good question. How do you think people understand or make sense of public health?

P: I don’t know. I guess in the past, in the PCT land where the public – obviously I’ve mainly been in public health for so long, so whether people just, sort of like big budgets, commission, possibly. Now we haven’t got big budgets (both laugh). So, it’s, we’re obviously public health are trying to work differently by infiltrating other areas and trying to work with a health in all policies approach. But, yeah, maybe we’re just a lot more relationship work to be done. But I’m assuming [name] – obviously [name] our director of public health is high profile. [They] just got [role] job, so that’s, yeah, you know, so, public health -

I: How do you think that changed things? Do you think it will?

P: I don’t know. I think it’s gotta be good having public health, somebody, a director of public health at that level in the organisation, hasn’t it? Cause that’s like the top, top decision makers with the chief executive. So, just having a public health brain up in that decision-making process has surely got to help with the health in all policies perspective, cause [they’re] at that level where she can, [they’ll] be seen right across the organisation now. So, it’s just gotta be a positive thing, surely, having [them] up there. Cause I guess some directors of public health might not have as big a visibility in portfolio and that. So, it’s gotta be good

I: Yeah. So, just thinking back to the transport strategy and doesn’t matter if you don’t really have an answer for this, but I was wondering what would a good transport strategy look like to you? And is that a question that’s ever been asked? Cause you say you haven’t seen a draft yet – what would your draft be?

P: Yeah. I think on the transport plan or whatever the name is, sorry, I can’t remember. I think, I get the feeling it’s quite a – it feels like it’s quite a highways-based document. I’ve seen the old one and it feels like it’s gonna be in a – it’s been the same format for a while. That’s just been reiterated and redeveloped. Whether that’s a format that they need to meet their national guidelines, I don’t know. But I think in terms of a thing for me, I would want to see not only where the infrastructure should be but how we’re gonna get people more so on like bikes and travelling actively. And I’d want to see some of the physical activity inequality rates in the city and looking at is investment going to where it’s needed? You know, is the investment of money in the city centre or is it getting out into Orchard park and Bransholme? So, I’d want to see data around that. I’d want to see a levelling up of investment to make sure those bits of the city were well connected and – cause otherwise you’re just gonna increase health inequalities if you put all of your investment into one certain area. So that’s – you know, I’d want to see it with a data lens on and an evidence lens on. You know, there’s quite a lot of good practice around active travel, but I’d also want to see it not just being about roads. It’s how do we encourage, you know, what marketing will we done, how do we encourage people in, you know, the areas of greatest deprivation to actually use these routes? Have they even got bikes? Are we putting too much emphasis on biking? Should we be putting more emphasis on walking? Cause that’s actually, you know. Anybody can do that. You don’t need a bike. So, yeah, I’d want to see how it was addressing health inequalities and where those health inequalities lie from a travel perspective.

I: You say you don’t think that that’s really – it’s not evident in previous documents (no). It’s not a conversation that you’ve been regularly been having (no) with transport?

P: No, so it’d be interesting to see what kind of comes out. And I’ve asked a few times to see a draft of it and they seem to be keeping it really closed at the moment. So, it’s whether we’ll be too late to add any of that stuff or whether it is relevant or needed. That would be an example of health in all policies if we could get something priority in those areas. Or whether if it’s just happening naturally, by accident. I don’t know. Are those areas of inequality when you think about it from a transport lens? Cause it does seem – it is similar areas, isn’t it? It’s education, possibly transport, health inequalities. It’s the same - unfortunately, it’s the same wards, often, from whatever angle you look at it from. It’s not suddenly, you know, smoking rates and education rates and I don’t know about travel but possibly the travel infrastructure.

I: So, you’ve got two really good examples there. So, your childhood obesity example of where you used a discursive approach (yeah) a conversation approach from the beginning. And then you’ve got the transport example of where you’ve got a specific department sort of drafting something and then you might have the right to amend or shift. So, you’ve got two different versions of collaboration there, or partnership (I guess so, yeah). So, from those two experiences, how then do you sort of understand collaboration in its best form? And in its worst form. Or in a way that could be made a lot better. Is there a really good and a really bad, or is it just a - can they both work, those forms of collaboration?

P: I don’t know. I think collaboration needs to be, you know, everybody’s an equal partner. You’re involved from the start. The key people are involved from the start of initiating ideas and projects and then we all have got joint ownership of it. It’s not a thing being done over there by that department. I know that's not always practicable though, is it? So, I think joint ownership, everybody on the same level, working together from the start and seeing it through. People having, you know, the same – kind of like the same kind of end goal in mind, you know, what we’re trying to achieve. So setting some of that stuff out first of all and not being little public health dictators (*both laugh*), cause like, you know, I don’t know - “We’ve got all the evidence and facts and listen to us and ‘Do as I say, not as I do’”. So, actually no, we’re all the same, we’ve got brilliant experiences, just how can we join together as a whole to make a difference and kind of keeping our eye on the bigger vision of what we’re trying to do. Cause otherwise you can get into little arguments and stuff. But actually, we’re trying to help children in [place] have a healthier life, help them to live longer and be happier and healthier. So, yeah, just that joint aim. The bigger picture. And the belief that we can – we’re better working better together than in silos, so kind of trying to keep building that side of things, really.

I: Can silos ever work? Can they work well?

P: I don’t know. There’s a good saying isn’t there. “If you want to do something quickly, do it by yourself, but if you want to do something that’ll last, do it together.” So, on the healthy places SPD it’d have been quite easy for Joe and Kate [?? 0:39:53] one of our keen planners to just go off and do that and get it developed and done and adopted. Actually, we think by doing that GRIP workshop and by working together as a full, you know, as many people from different kind of perspectives as possible working together developing it, we’ll have greater traction, greater ownership, greater influence and greater impact. By getting as many people as possible. The disadvantage is it’s gonna take a lot longer to tick that box to say it’s done. But I believe it’ll be done to a higher standard and ultimately have more ownership. Or, if they wanted to do it quickly, Joe and Kate could have just done it probably last week and got it agreed but nobody would have known about it, it would have just been their thinking, so it might not have got everybody’s ideas and it probably just would have ended up being a document that just was sat on a shelf. And the same with the childhood obesity stuff, it’s been – I’m trying to get to my mind, “God, this could be like years, ten years” you know, whatever, really long process, but if you want true system change it’s not gonna happen in six months, a year, is it? So –

I: And what do you need sort of looking forward to support that systems change through having this kind of health in all sort of underscoring approach?

P: I think we need some strong leaders who’ve got a strong vision and a strong belief who are not happy to take a quick fix, quick option, quick solution, which is difficult cause sometimes that’s maybe where elected members are pushing us more towards. So I guess being true to this grander vision. Being able to articulate it, to be able to articulate it from other people’s perspectives, not just from public health lens, to be good at storytelling and letting people try new things. Don’t worry about failing, you know? We’re a – you know, that influencing, population level. Just keeping that belief that we can make something happen, with the leaders being inspiring and letting us guys get on and do. And, yeah, I guess just keeping that bigger vision really, that bold and bigger vision. And obviously bumps will happen along the way but it’s just keeping us on the same path. And kind of, you know, like one of my favourite phrases is “You can’t commission your way out of obesity”. I love that. I think, you know, “You can’t commission your way out of health inequalities.” It’s the same thing. Understanding our roles as, public health role, as system leaders and system influencers and not be “Oh, we’ll just commission” you know “this service and it’s solved” So, yeah, really allowing us to stretch into other realms that we haven’t done before

I: And how do you, and how does the system push back against that short term thing that you talk about with elected members?

P: I think another example – so, was at the health and wellbeing board. Tim and I were articulating our grand vision for obesity and it was a big system change and da da da da da. We had this massive conversation, it was really good, and then at the end of it the action that fell out of it was “Right, action, I want the daily mile to be in all schools in [place]” and we’d just gone on around policies and I was like “Oh, gosh” you know. It is – daily mile is good – bla bla bla bla. But it’s not gonna solve, necessarily, obesity. And that was the only action that came out. I don’t know where I was going there, what was I saying?

I: Don’t know how you came to that action

P: Yeah! So that was kind of a short termism thing. It was a child health and wellbeing board, quite an easy thing to understand, “Yep, daily mile, in schools, quite a short term thing. Quite an event-level type of activity. It’s done, dusted, obesity is sorted” So, you’ve kind of got that and then you’ve got the political cycle, so obviously people are thinking about when the elections are coming up. And in [place] we have a lot more elections – we have them every, I think there’s one every, they have four years, you get one every year and then you have your fourth year as fellow cause they elect in thirds. So you’ve kind of got that, so the elected members are quite keen for probably quicker wins and hits. But I think it’s just a game going back and explaining to them “Look, things like health inequalities, obesity, are a long term vision. It’s gonna take a long time to get there.” It’s just telling that story again and trying to get them on board, but it was interesting at this health and wellbeing board thing. We banged on about it and then we just got that action, it was like “Oh, okay, we’ve missed the point here". But then again I guess it’s reflecting on that and going “Right, okay, we didn’t hit the mark. How can we educate? How can we convince?”

I: How would you change the narrative then, do you think?

P: On that one? (Yeah) Don’t know.

I: Have you tried lots of different things?

P: We probably just had – no. It’s interesting cause she’d been involved in the conversation event etc. as well and obviously we had chair of the CCG etc. were there. And it just ended up like with that action. So obviously we didn’t tell a good enough story. But I guess she’s been involved in other events and hopefully she’s starting to come with us. We have had a few one off sessions with her as well to, you know, chat to her. The chair of the health and wellbeing board. But I guess on the health and wellbeing board front there’s a big plan of work around actually trying to change what it’s doing and how it’s set up. Trying to become more strategic and focusing on a few things rather than in heaps. So, I think the health and wellbeing board is evolving as well and I think she was just a new chair when we went and, but, yeah, it was just interesting cause you were trying to do this population bigger, grander stuff and then it just was like “Oh, just do the daily mile”

I: So what does success look like for you then with the obesity work? Even just like, you know, in the distant future

P: National [?? 0:46:12] results reducing. Reducing quicker in the areas of greatest deprivation. But it’s a real tough nut to crack. So ultimately, that’s what we want to see

I: Do you have any intermediate steps to the grand vision?

P: Well, it’s – with the conversation side of stuff and this systems working, it’s recognising, you know, there isn’t – we’ve been back and forth with this. But there isn’t like a traditional action plan where we do X, Y and Z. So that’s been really weird as well cause normally that’s what you would do – da da da da – we’re doing this. So, at the moment, actions are falling out and we’ve been having conversations recently and the biggest thing, the big thing we need to do this year is community consultations. So, we’ve had a lot of professionals around the table, but actually in our areas where obesity rate is the highest and areas of greatest deprivation, what our community members actually want. We’re just off on a tangent doing our own little thing with professionals. Actually what could make a difference in Marfleet Ward, which has like got really high deprivation, really high obesity rates. So, community side of things is like a next big focus for us to check and challenge what we’re doing and to get their input around how we can work with communities. So, that’s a big focus, and then the other element that we need to do around this is we’re doing like, you know, big prioritisation on food. So, it’s – haven’t got an action plan. I can show you. We do an X, Y, Z. But it’s kind of keeping the system going, keeping that inspiration going, keeping people working on the agenda, keeping it high on people’s profiles. Not for us to go “Oh, it’s done now”. No, it’s how do we get it in the new health and wellbeing board strategy, which is being developed? How do we get it into the fairer [place] commission’s work? So, yeah.

I: And how do you feel you do that?

P: Well, I think the fairer [place] stuff, I’m pretty sure we’re gonna have a big priority around food insecurity. So, and that’s a massive one, you know? Food poverty, food insecurity, areas of deprivation have got highest obesity levels. So I think there’s a big piece of work coming around that, but [inaudible] are still emerging. And then I can’t remember what I was going to say. Probably something irrelevant.

I: So you’ve chosen sort of fields where there’s influence (yeah) rather than sort of taking the whole system, you choose your-?

P: And, you know, hoping and thinking that other people will be taking action as well, so that GP emailing about the hospitals. Brilliant. And then this GP has managed to get us a PTL session, you know, for all the protected type of learning, all the GPs across the city are coming on the 11th of February for a session all about healthy weight. So, that wasn’t – would never have worked if I’d asked it, but we’ve got this brilliant GP who’s really into it, really gets it. He has managed to make that happen. So, you know, it’s kind of like coming in from other angles as well and trying to say “Yeah, that’s fine. That’s fine. Do. Get on and do system, just do what you need to do” and it’s gonna evolve and it’s not being worried that we don’t exactly know where it is, but where we’re going with it all, but it’s actually, you know, bit opportunistic, you know, working with a coalition of the willing and hoping by the power of that work will influence others. Probably a bit of a woolly answer

I: No, how do you record or document your influence?

P: Well, internally, you know, we’ve got report in to management. So, they obviously are aware of what’s going on and they’re, Tim Fielding is really engaged in the healthy weight agenda for example, so like 1:1s. We have these conversation events. So the next one 29th of January, so we’ll be feeding back on some of the key work areas, key actions. Also as part of that we did, recently we’ve just done a survey monkey across the system so, you know, “What have you been doing to affect the childhood obesity agenda? What has been good? What has been bad? What are you doing next?” type of questions across the system. So that’s been collated and taken, presented back to the system on the 29th. We’ll probably do those every 6 months, cause it’s not just about our actions, it’s about the system as well as our physical actions in public health. So, yeah, I guess we’re being held to account by management and the systems and also another good one is scrutiny. So, I’ve got yearly updates going to health and overview wellbeing scrutiny commission, whatever it’s called. So last one I did a couple of months ago and that’s brilliant cause they – it gives me a chance to influence their thinking and they can influence what we’re doing and I personally said “I want to keep coming back to you every year” even though it’s a little bit woah. The other one which I’ve mentioned is that it’s a priority for the health and wellbeing board, so Tim and I are doing a presentation in the January meeting around what we’ve done so far, what we need to do. So, hopefully it’ll continue to be a priority for the health and wellbeing board – I’m slightly concerned it might not be. And also we’ve met with the chair of the CCG and the chair of health and wellbeing board, cause she wanted an update on what we were doing as well. So, yeah. So, yeah, updating formally through the scrutiny commissions and formally through the health and wellbeing board, formally through line management and formally through the conversation events. And then informally if, you know, people are asking, elected members want a briefing etc. So, yeah, that type of way, really. It’s a little bit organic, opportunistic, you know?

I: Sure. Recognise that you’ve got a team meeting. Just one quick question about support. So, what support do you feel that you would benefit from? Or that the public health section would benefit from to carry on doing work around promoting population health and health inequalities messages through policy? Through different areas of policy. What kind of support would you like?

P: I think probably examples from other areas. Like practical examples around what other areas have done. So it’s always good to know that this local authority’s done it and then it’s like “Actually, we can” would be good. I think the GRIP workshop was quite a good example. So, you had public, you know, national public health people presenting with national town and country planning association people and having that joint mix was really useful. So, it’s not just public health banging on, it’s actually advocates within their, you know, the field of planning, or the field of transport, so when you’re talking to planners, they’re actually “Oh look, there’s somebody from the town and country planning association. They know what I do” cause obviously being from public health, I don’t really know that world, so that kind of gives it credibility. So I think examples from other areas. Yeah, more evidence around how it’s making a difference, so say if X, Y, Z local authorities have implemented these policies, what does it mean? What difference does it mean? Has it addressed health inequalities? So, that gives us more ammunition to do it ourselves.

I: Where do you see that kind of support coming from?

P: Oh, sorry, I was thinking about Public Health England then, really. Public Health England. And the world of academia. And people like Local Government Association. So, you know, anything – yeah, academia, PHE, local government association. And also I guess the world – there must be like planning associations and transport associations and goodness knows what else. So, I guess –

I: The broader kind of systems infrastructure

P: Yeah, if we can get them on board with the health messages then it makes our lives easier, doesn’t it, if they already get it from their lens? “What’s in it for me? I’m a planner. What’s in it for me? What’s in it for me? I’m a transport person”, but I think it kind of needs to come from, you know, so we meet halfway. So it kind of comes from them as well as us. Just helps, doesn’t it? But yeah, I guess, you know, any training for public health practitioners on how we develop some of these relationships, how we knock on closed doors, anything like that from Public Health England. Like practical training opportunities. Stuff like that really