I = Interviewer, P = Participant

I: So, maybe just tell me a little bit first about your role to remind me and how your work is structured – what sort of areas of public health you’re involved in

P: Okay. So, I joined public health when it newly transitioned over from the NHS to the council. So, I’ve been in post [time] and so public health as a team were quite new and still getting embedded into discussions and ways of working. I was assigned, initially, around [topic] and then moved on to, very quickly after that, into wider factors, which is, I feel, the really interesting bit of public health and has a place, can almost justify its place within a council setting. So, the areas of work that I work on and have been working on since I’ve been in wider factors has varied a little bit. I’ve worked on active travel, walking and cycling agenda, air quality, I’ve dipped in and out of that world of work, but still involved in some ways. Workplace health – what else is there? Kind of starting to get involved in the poverty agenda, but it’s – and planning, forgot that. Transport planning and land development planning, so I’ve been involved in that quite heavily when I newly joined the team. So, they’re the areas I’m working on.

I: And what sort of sections or departments do you work with aside from your colleagues in public health?

P: So, in terms of walking and cycling around active travel it’s road safety teams, internally it’s road safety team, transport planning, physical activity team we work closely with, or have been, what was the physical activity team – it’s now dispersed into the various bits of the system. Planning colleagues, both in terms of policy development but also the planning leads for actual development. Transport planning, again, that’s been a bit of a mismatch in terms of working with transport planning colleagues who were very heavily involved in helping us pull together the walking and cycling strategy. That was a three pronged approach pulling that strategy together for a [place] strategy that involved the physical activity team, transport planning and ourselves. So, and road safety team as well, but they – because they’re involved very much around things that enable people to increase opportunity around walking and cycling. So, particularly around schools as well, around congestion and any complaints they get around traffic management. So, they have an impact on people’s ability to travel more actively, particularly in school settings. The policy unit more recently, so that’s kind of like our transformation team, that’s becoming – that link’s becoming more and more established with ourselves and them.

I: Sorry, just to understand how it works, is the policy unit like a centralised policymaking function?

P: Yes, I would say so. And I’ve had very little involvement with them compared to other colleagues because some of my work is not in view of theirs. We have developed some strategies and policies, but then we’re starting to feed in more – we’re getting a lot of political attention around active travel, walking and cycling, on the backdrop of climate emergency more so than ever, which feels like we’re in a really good place with that. Councillors somewhat, we have a portfolio holder for health and other bits of the council as a directorate. So, we brief them on a regular basis on various aspects of our work. There are partners internally and the democracy. So, we have a team that do a lot of community engagement, citizen engagement. So, we’re involved in them to make sure we’re knitting the things together in terms of if we’re wanting to get data from our communities but also have that engagement and consultation, various bits of policy that needs to be consulted on, we would work with them as well. Schools and community hubs. Again, internally from various aspects of the priorities that they’ve identified but, again, with my work has mostly been around active travel, walking and cycling. And then externally, it’s been with our combined authority, obviously Public Health England, who have COI groups for various strands of work that fit within wider factors.

I: Communities of interest?

P: Yes. And then walking and cycling partners that actually operate on a national level, so some of the charities like [?? 0:07:09] Living Streets that operate actually across all parts of geography, but have a focus, as they do, in lots and lots of different districts. And then some time with developers themselves. We have had some exposure with that.

I: Is that like with the commercial developers?

P: When we have had the engagement, particularly around things like masterplan sites or large developments that are being proposed through the local plan, it’s been quite good. And it’s been quite good working with planning officers to really understand what the conflicts could be. The challenges are, what are the opportunities and how can we influence that a little bit. So, when we have had that time, or we’ve had a place around that table, it’s been really positive from my experience so far. I think for me what’s happened is it’s teed off that. And that’s down to the fact that we’ve had the planning team, both from policy and officers that deal with the actual development side of things, is that I think they’re kind of so stretched and that, I think we’ve had a change in staff in those departments, so they’re not really directly linked with us. So, we need to try and re-establish that. We do have ongoing communication with them to keep each other updated, and we do get things like – we have been, for some time, a consultee for planning applications and we have developed a screening tool to look at various thresholds where we would then consistently comment on planning applications. We also have got an agreement that they would involve us in major development opportunities as well. So again, I think that’s teed off a little bit because some of the work has kind of possibly come to a natural halt in their world. So, we need to – definitely something that we need to do is re-establish those. I wouldn’t say re-establish but reconnect on those things and make sure that some of the other pieces of work that public health are doing are linked up to those development opportunities as well

I: How do you connect or reconnect or build those relationships with, you know, people outside like developers, outside of the council

P: So, we don’t really get that opportunity to have that direct relationship building with developers. It’s usually through planning colleagues. And I think – I feel comfortable with that, because it’s been quite transparent and having planning officers on board engaging with us because I think they have a, they would be our voice in our absence because the more exposure they have with us and understand our kind of narrative around why we need to be involved, or why we should be involved. They pick those things up. And I think with key policy officers – uh, planning officers – that has definitely been the case where they are – we are on their radar for sure, and we do get consulted for various applications that we screen.

I: Be really interesting to see what that screening tool looks like

P: Absolutely, can share that with you. Literally, that’s the next meeting I’m going to, to update that, cause we – so, the issue that we have had with that in this instance is that it’s – it’s been part of the local plan to say that that’s something we would require for future planning applications. It has been done on a voluntary basis, and that’s the thing I think where we’ve built really good relationships with our planning officers for them to put that forward on our behalf and in our absence. Cause we can’t go to every development meeting. So, they have then put that request in to developers to say part of the kind of submissions that you make for planning applications we would want you to submit a health impact assessment. So we have got volume of HIAs coming in on that basis and so now – so the overall validation checklist that the council has for developers to refer to in terms of what the minimum requirements are for submissions, that’s never been on there, so it could excuse developers and say “It’s not on the list, I don’t have to do it.” So, this is the reason why we’re updating the – well, taking the opportunity to update and review the content of that screening tool. Make sure the health indicators are the relevant ones. We want to include in there deprivation, which we haven’t done previously, for example. And just to make sure that that is fit for purpose before it then gets included into the validation checklist. And then that would absolutely mandate developers to include that. But so far, on a voluntary basis, on a voluntary ask, we have had submissions of health impact assessments

I: That’d be great to see. Do you feel like that’s made a difference?

P: So, that’s the thing that I think I feel uncomfortable with in terms of – or uneasy about. We don’t see the impact. And that’s not immediate, because development takes time as we know. We can only make recommendations, so they’re never – and those recommendations, even if they were acted upon, it’s about how you monitor those activities that you’ve suggested. I think we, rather than spreading ourselves too thinly on lots and lots of development, we probably need to focus on the major masterplan sites, because they’re the big developments that are gonna be part and parcel of existing communities and rather than seeing them as separate entities, we’d want to make sure that they are integrated into the current makeup of those communities where those developments are happening. So, I think we’ve got to start - I think we’ve got to pick our opportunities where we’ve got the biggest impact, because we’ve got biggest population growth potential there in those masterplan sites. So, I think the impact would come later down, but it is that – it’s kind of coming at it from different angles in that it really is about the structural changes that need to happen that then, by default, those health impacts are improved. There’s an opportunity to improve. There’s an opportunity to increase health outcomes in those communities, not just the new population at those new settlements, but also the communities around them. I think that’s really important. But how we measure that right now – don’t think we’ve got that embedded into the system to be able to do that.

I: So, there’s the kind of – you don’t have a feedback system?

P: No, and I think – I think it’s capacity. We’ve talked about that. So, for example, we talked about the very fact that a mandatory requirement for all new development, housing development, is that they would have electric vehicle charging points as a mandated requirement. And we asked the question about how does that get – how do we monitor that that actually has happened and what do we do when those things don’t happen? So, at the moment there’s no mechanism or capacity in place within the planning team to police that. So, I think if that’s already mandated and it’s a requirement, what chance have we got around health impact assessments? That said, I would say that the way that we comment on health impact assessments in particular is looking at the comments that other consultees make and we – whilst we’ve got a whole range of indicators that we want the developer to look at, cause we know that those impacts would actually have a positive or negative impact, and what the mitigations, measures might be against some of them that are particularly negative. We’re reassured by the comments that other consultees make that they are the things, hopefully, that align with public health outcomes. That they responded in the way that we can then refer back to and reference them to say “Actually, we support” if it’s biodiversity issues for example, we would then validate – we would then say we support the comments that our colleagues have made, or within environmental impact assessment, we would draw out key things and point those out in our health impact assessments as a response to say we support our colleagues who made X Y and Z comments. So, it’s kind of cross referencing that so we’re not duplicating or conflicting with each other either. If we absolutely feel strongly that there is a difference in opinion, we probably have those conversations outside, before we make a submission to colleagues. But I think we’ve got to be confident enough to stand by our position. Even though it might feel like it’s conflicting with other colleagues within the system

I: Okay, we’ll probably come back to some of that and think that’s a really good example of how health is considered in other areas of practice or policy making or, you know, in that case housing development or building developments or whatever. So we might come back to that in a bit. Let’s take a step back and look at overall understandings of health in all approaches and how it sort of manifests itself here. So, what do you understand by health in all policies?

P: So, I think, again, we’re very early doors in terms of the public health team moving into the council is that we’ve made some really good inroads around pulling various parts of the system together to look at developing two key strategies. One was the economic strategy at the time and the health and wellbeing strategy. So, the two of them still exist in their own rights. They have been tweaked and adapted and reflecting current times. And I think they’re the kind of the foundations to ensure that health is integrated into all parts of the system. How that works out in practice I would question and I’d think that it’s not always understood when you trickle it down into the various parts and various layers of the system. In principle those two documents that dovetail together. So, the economy strategy talks about health wellbeing as an outcome for economy- a positive thing to do around economic growth and economic outcomes. And likewise, the health and wellbeing strategy talks about – gives that – the economic strategy and what that entails as a good foundation for improving health outcomes. So, I think they’re the foundations that are already there we kind of build from those. Like I said, I do think – so, in the circles that I move around in, I absolutely think that health is considered. How it plays out into reality in terms of what we then do I’d question. So, I think the narrative’s understood but then I think there’s conflicts with other things that come into play.

I: Can you just maybe tell me what you think the narrative is? When you say “The narrative’s understood” – what do you think a lot of people outside of say public health will think, you know, “I need to include health” what do they think of?

P: I think there’s that notion of – up until recently I’d say the notion has been around health improvement in the context of lifestyle behaviours and not the structural impacts that actually has adverse or positive impacts on health. So, I think for some time we’ve had to get that message across to say “It’s beyond lifestyle behaviours and it’s beyond an individual’s control”. So, it’s not down to an individual making – there are some choices that they absolutely make consciously and there are things that are – that make it very difficult for people to adopt healthy behaviours. So, that narrative around making sure health in policy is understood on that basis of structural changes rather than just about the individual or a community. That health in all policies is beyond health – improving health – it’s things like the wider factors of health. So in making sure that we talk – we address some of the other issues around things like poverty, you know, economic growth, good work, all those kind of larger impacts that actually then by default start to look at making improvements to someone’s health. So, understanding that

I: Do you think it’s received – like, so, you feel there’s been a change. How have you sort of been able to judge that change?

P: So very much from the top. I feel that the message is coming quite loud and clear about the way in which we frame that work around health in all policies. I think because it’s been difficult to get people’s head around – when you talk about health in all policies. I think, for me, the way it’s kind of being reframed is place-based working. And that’s the thing I think people are getting their heads around, that actually, when you start improving some of the other aspects of people’s lives, by default, even though they might not consciously understand that narrative around “actually it does improve health outcomes.” By the fact that they’re doing that and improving that system in their world of work, that in itself would make – would hopefully bring those health outcomes, positive health outcomes. So, it’s very much about looking at a place and the people that are then living and working in that area. And I feel that feels a bit more manageable and tangible when you’re looking at place-based working in terms of localities. So I feel like all the time we’ve gone quite wide saying we’ve got to look at health in a much more wider context when I think in some aspects we do, but when you’re looking at improving population health, you need to be back into kind of place-based working. And I think the primary care networks in the way that they have been divvied up around the district, we have nine. That will again provide the platform to pull together a whole range of stakeholders that contribute to people’s health outcomes, but not necessarily be delivering any health-related work. (health care) Yeah, health care. So, I think yeah, I think that’s definitely changing

I: And from the top, do you mean the top – like in terms of, you know, council offices or the politicians or both?

P: Mixture of both. I think there’s differences with members. And again, I think that’s down to votes and what would, you know, this whole narrative when we talk about air quality, it’s about keeping car users happy, but actually the narrative – I think that that’s changing because of our collective - and there’s been a cross party decision to support climate emergency. So, I think, again, public health are having a lot more exposure in those arenas around getting those members to understand what does that look like? And what are the solutions and measures that we can put in place to support climate emergency? So, I think they’re starting – so I think it’s been about how you frame, the framing of some of our work, that’s twisted and turned a little bit. But, for me, it feels that we’re starting to make some inroads. So for such a long time working on walking and cycling, it’s been really hard work trying to work with members in particular, but also officers because of capacity, members because I think it’s about votes and what their constituents want. And that drives how they then put their agendas and priorities forward. So that’s been really difficult and I think even the structural changes that don’t happen overnight really puts blocks on our ability to increase walking and cycling opportunities, both from a behaviour change point of view but also the structural change that need, that we absolutely know that needs to happen for walking and cycling to increase in this example. But I think the whole narrative around climate emergency nationally – that’s where we’ve actually got members sitting up and listening and starting to ask us questions “So, what are we doing around active travel?” Which is good cause they’ve got the interest there, but I think there’s a gap in the knowledge of their understanding that that’s not gonna happen overnight. And we’re in a position where, for example, in this case, we’ve got population groups that are just not interested in walking and cycling for whatever reason. They’ve got, you know, real and perceived barriers, and actually the starting point is not gonna then – nobody overnight is gonna ditch their car and start saying “I’m gonna start travelling actively” and younger generations – that’s not gonna happen. I think there’s a – our starting point is way down the line and us getting that narrative across to not just politicians but people that are interested in a whole-systems approach to – whether it’s physical activity or obesity. These are things in place in [place]. It’s getting that narrative across that actually our starting point isn’t going to be, in this case people travelling actively. We’ve got to generate the interest and create the environment for people to do that – the physical environment to do that – before people start saying I can do this as a journey now. So, it doesn’t address climate in that case. It doesn’t address climate emergency immediately, but it has core benefits around things like physical activity. It does have some core benefits around air quality, but it wouldn’t be hard and fast measures as the be-all and end-all to address climate emergency. Although I think it feels like the members are pinning a lot on that

I: Okay, on active travel? (Yeah) So, it’s quite interesting what you said there about framing and how you sort of – the work you’ve done has twisted and turned depending on the framing that was used. How dynamic is that? Have you been involved in different parts of public health or different parts of what the council does where there’s been – you mentioned that the cycling was a really hard one, walking and cycling, really hard one to get going until there’s this hook. Are there other examples where there’s been a change, where it’s captured the imagination? Where things have changed?

P: I don’t think they’ve changed yet. I think they’re starting to – we’re getting a lot more interest. So, it is that whole-systems-wide thing. And again, it’s been – we talk about these, you know, these – the way in which we turn things and it becomes, you know, a phrase of the moment, as it were, or a description of something as of the moment. And actually, it’s just been tweaked back to basics. So, talking about whole-systems approach. That’s where I think we’re getting people more interested in linking things together. And I think the other thing that actually has made people want to work more together around looking at systems-wide working has been austerity measures. That real narrative around the fact that we haven’t got resources individually, but pooling them together, they could be, you know, the impact’s wider and more – it feels that there’s value in coming together. And I think we’re at the very infancy stages of the primary care networks understanding that.

I: The primary care networks – do they just emerge, the 9 areas you mentioned, they just emerged recently?

P: Very, very. Early stages. They had things like data packs from us to understand what the health impacts are in their particular locality.

I: So, it’s like epidemiology stuff (yes) based around the population

P: Most definitely. But that doesn’t necessarily translate into what they think the priorities are. And that’s about – I don’t know what that is about really other than reading between the lines that it might be too hard of a nut to crack in terms of what their priorities might be. Or how do they understand, or have worked out how they might actually want to address that priority. Because it’s – it feels like it’s new to them in terms of they didn’t realise that was a priority until it’s been actually put down on paper and quite visibly you can see that is a priority. The prevalence of, for example, diabetes in a particular area is there. And actually, understanding that there’s other parts of the system that can support that work and it’s not just down to primary care to solve and support individuals in that context. So, I think they’re at the very, very early stages. Again, the whole-systems approach to obesity which we’ve got, which we kickstarted last year. We have got stakeholders and a variation of stakeholders wanting to be involved. I do feel like with the whole systems approach to obesity and things like walking and cycling that the system internally and externally feel it’s a public health – I still feel – I still get that feeling of “It’s still public health’s responsibility to lead on.” And it’s - so, there is something about public health taking a lead, and I don’t think I’ve got a problem with that so much, but it’s about then divvying up the actions that sit behind that work. And that’s the bit that I have an issue with and I’ve concerns around, that it’s still “Well, public health will do that” and not – so, they understand the narrative around system-wide working, but when it gets down to the nitty gritty of getting down with doing the do, it falls back with public health and that’s definitely been my experience around walking and cycling, for example

I: And what prevents public health from doing it?

P: Capacity. I think there’s – we have got expertise, but that expertise needs – these other parts of the system can complement that expertise and we need that. So, in terms of structural changes that need to happen to support walking and cycling, around transport planning, there’s technical aspects that we just don’t hold the expertise and we never want to – we don’t probably want to have that, but we want to work with those colleagues that have that. And I don’t think that happens effectively. But that’s not – I would say that’s not just the experience of [place], I feel that other colleagues in other places have similar experiences

I: Can you think of any ways that might free up that? So, the blockage issue or the translating the good intentions or the strategies and the initial kind of partnership working into actions that everyone can have responsibility for. Is there something in the middle there that could fire that mechanism?

P: So, when I think of transport planning in particular, I understand the absolute pressures they’re under around delivering against schemes of – particularly when they draw in funding, external funding, to deliver on schemes. The timelines. And then there’s this whole thing about – well, as long as they’re meeting the design standards then they’ve ticked the boxes. And whether they actually have the time to consider anything more than just the design standards that would enhance a place, I just don’t think they’ve got the time. They’re just under enormous bits of pressure. The thing that might flip that is probably – whether we could actually, whether we need to or should physically make ourselves available in those teams and actually integrate ourselves more. We’re working from arm’s length. I don’t know if that would actually help. Working with individuals on individual schemes feels like we’ve made some inroads. So, we understand the conflicts that they have from a design perspective, but they also understand that in order – what would make a scheme attractive or a scheme that they put forward for funding would make it attractive is kind of the thing that sits alongside it which is the behaviour change element of it. The two kind of need to run in parallel to each other. I think we need to do more of that.

I: So, embedding within teams is an option. Can you think of any examples? So, when you have – not necessarily embedded – but worked closely, what’s the kind of key characteristics of those successful collaborations? What really works well?

P: I think, so, for example, jumping back to planning. I think it’s hearts and minds. It absolutely has been hearts and minds. So, there’s been some pressures and we get that and planning are under enormous pressure again to deliver. But it feels like we’ve got a culture of officers that genuinely want to work with us and see the benefits of including not just health impacts but the wider issues that they could support a development in. I think they genuinely want to work with others. And they see the value in what we can bring to the table, you know, a different perspective. I think it’s about hearts and minds. So, even with working within other parts of the system around colleagues within road safety. Again, I feel like it’s hearts and minds. We’re constantly in communication with each other, of those offices that we do work with, where we’ve built the relationships with where we’ve made those links. It’s that constant – we’re on each other’s radars. Whereas I feel transport feels like it’s under other kinds of pressure that – I don’t think it does excuse them from not working with – and it’s not just public health, I get the impression it’s not just public health. I think they are not engaging with other bits of the system and that’s – I think that’s been definitely shared with us that that is not happening. So, it’s not – I think it’s a culture within, in this case, that particular department that there’s this pressure of getting schemes delivered in a timely manner. But also, the thing about us being on their radar to think about cross referencing and sense checking, just doesn’t happen.

I: No, I was wondering how you go about doing that

P: Still trying to work that one out. And I think one of the things that might improve that is physically spending time over there with the teams

I: What would that do? How would that help, do you think?

P: They would have somebody immediately available to them to sense-check stuff. I don’t know whether they think that actually by involving other parts of the system it just delays matters. And I have sensed that a little bit – I’ve sensed the undertones of that a little bit in things that I’ve been involved in. “Oh, it’s these guys again. That’s gonna delay what I need to deliver against” and, you know, and again, it’s this whole thing about relying on design and not thinking so much out of the box that actually the things that they might do actually will have wider benefits. I’ve got a feeling that some officers get that. I think there are a couple I can definitely think of someone now that absolutely gets that. But they’re just so constrained with the amount of projects they have to deliver against. So, I’m not sure about the solutions of that. I know it’s an issue, I don’t know how we start addressing that.

I: That’s really interesting, got lots of really good examples. You talked about the primary care networks. You said you gave them sort of information packs. I was interested to know what sort of research evidence you draw on, if any, there might be other sorts of knowledge, when you’re trying to create a convincing argument about the benefit of health in all approaches. Do you present information? And if so, how do you do that?

P: So, we work with our health intelligence team who pull those data packs together for us. In what way – do you mean practically how they pull the data together? Obviously, they look at

I: Just whether or not you use evidence at all, research evidence or intelligence, you know, data.

P: Yes, we use public health fingertips as our data source. You know, we look at primary care data, a research if it’s there and it’s relevant, although we probably rely on Public Health England fingertips as our data source for putting that across to make it kind of more translated into something that feels more tangible for them

I: I suppose also thinking about when you were talking about the wider factors and determinants of health about whether you use research or just framing arguments to get people on board with the idea.

P: I think some of – I certainly have through some of the briefing papers that I’ve pulled together particularly for council members is I’ve used research to back up something that I might have put forward, alongside the data that you have access to around prevalence. So, there’s something about prevalence, but there’s also something about using research that’s taken place to support that. And I think other colleagues do do that.

I: But it’s just part of a much bigger sort of complicated system of trying to produce messages around health. Is that right? (Yes) You say the hearts and minds arguments, those sorts of things

P: Yep, and I think for example, so, another bit of work that I’m involved in is about smoke-free environments. And so, it’s hard data around the prevalence of smoking and the impacts of people continuing to smoke. How that translates into the costs to the system. Obviously – and the wider health impacts that, in that case tobacco, has on individuals and how that impacts on the system. So, that is very data rich on that basis. So, I think it would vary. In terms of wider factors around structural stuff, I think it is more reliant on the research that has happened. And so particularly around things like active travel again, I would say that there is a little bit around research, but I think you can’t lift and shift that and contextualise it because you’ve got to understand the demographics of a particular place to then – the physical makeup, for example, they’re – some other solutions that people come up with, particularly things like NICE guidance which is very, very general It’s getting your audience to understand that whilst they are a valid recommendations, we can’t always rely on those recommendations to give us the outcomes that we’re looking for because it has to be contextualised to the needs of our population groups and the physical environment that we live in. So, you’ve got to be able to do that. So, when we – but again, particularly active travel and some of the solutions around that, I’ve been recently working with policy cause the ask has been “What have we been doing about staff active travel?” And they’ve gone away and looked at lots of different approaches and said, you know, “We should be doing, we should be investing in our comms and pushing messages out there around”, you know, “national walking week etc.” But they’re not – for me, they’re the things that are there that are drip-fed as consistent messages that are really useful for people but actually the things that enable people – it’s really unpicking what the things are that enable people towards. So, it’s not just about the comms messages that need to come through, it’s about the actual physical measures that you put in. And the things that you put in place to enable people to do those things. So, we’re constantly putting that narrative forward to say “Yes, those things are there and they’re really helpful. They’re good nudges. But that’s not the solutions to the things and we wanna create a bit of movement”

I: What sorts of responses do you get to that? Cause if you’re saying all the time – or you’re repeating the message or the narrative – do you get positive responses?

P: Mixture. I feel like sometimes it feels like that’s kind of an excuse of not doing anything. I feel those undertones. I don’t think they’ve been said explicitly to me, I think it’s like “So we can’t do this” and then when I’m thinking about workplace health now in that context as well, it feels like – you almost feel like you’re coming across saying “Yes, but” and putting a blocker on. Because fundamentally, I think about this in the context of the public person – how we use our resources. And actually, you know, those quick fixes that feel like they’re gonna be all singing and dancing, gonna change the world, they don’t. Because we, again, relied on some of the research and things, especially those research pieces that have been evaluating similar things. We can pull those out and say “Actually, yes, it works for a moment in time, but once you withdraw, what’s left?” So, it’s putting that forward to them and thinking about things differently.

I: Can you think of anything where those arguments – where you feel like you’ve really made a difference in creating some change in the system or the structure?

P: (*long pause*) I think yes, we have. So, through our walking and cycling work we’ve – we were given some funding that appeared. And if you quote me in any of this research, they’ll know it’s me! (both laugh) So, and when this money appeared overnight kind of thing, we were like “Right!” So, for some time we’ve said we’ve got no resource, we’ve not got the resource to do some of this work, then we’ve got the resource. How do we spend this? It was burning a hole in our pockets. And the kneejerk reaction was “Let’s do the things that we possibly have always done that we think might work”

(*Interruption from outside*)

I: Let’s just wrap up maybe

P: And so it’s taken us some time to spend that money because, for me, and for colleagues that understand that narrative around not doing campaigns and not doing one off events, they’re the things that are just not going to create the movement that we’re looking for, not gonna get hordes of people walking and cycling because we do these things, or getting an officer in place. So, I think the things we are now doing things with that money has happened because we waited in a frustrated way, we waited thinking how do we spend this, how do we spend this money? But by the very nature of other things in the system that now are ready to then – ready for us, as it were. So the community hubs which is a collective of schools on a locality basis, we looked at their priorities, we’ve looked at their data round some of the priorities, not necessarily walking and cycling, but actually walking and cycling could be the vehicles to support those priorities. We’ve put that across to them and they – and I think that’s where we’re starting to make some inroads. Some of the community hubs that see walking and cycling as the activities that support their priorities, but by default for us they’re the kind of things that will actually shift behaviour change and potentially we can align them to development cause we’ve got our foot in our camp with planning or transport planning to align those two things together.

I: That’s good. Cause it is quite hard, isn’t it? And I suppose that’s one of the challenges of what you were talking about – the behavioural type or campaign type stuff that’s quite popular and looks shiny but doesn’t really make the difference.

P: And I think that’s where going back to the question you asked about what’s people’s understanding of health in all policies. That could be kind of the default people’s position around let’s do that behavioural change stuff but it’s not the structural stuff which I think is a bit sometimes missing across different levels and different parts of the system

I: That’s really help, thank you very much.