I = Interviewer, P = Participant

I: So, maybe if we just start by you telling me, for the record, a bit about yourself, your role, where you fit within the council structure and so on.

P: Yep. So, I work in public health and I’m public health manager. I manage the wider determinants theme in public health. So, we have – sorry

I: Is that wider factors? Is it still called wider factors?

P: Yep. Yeah. Yeah. So, we’ve got three kind of broad priorities. Housing and homelessness, poverty and place. And place includes green spaces, licencing, air quality, planning. Anything else environmental. So, it’s really broad. So, we don’t have any budget. We don’t commission any services. In my opinion it’s like the best bit of public health because everything else we do is around working across council colleagues and beyond to try and just influence – take a health in all policies approach, influence ways of working to ensure that health is embedded in other aspects of decision making and policies and ways of working. So, I get to work with people from, you know, housing, parks and open spaces, road safety, planning colleagues, environmental health, so it’s really – it’s really broad. But, it’s kind of – I think, you know, influencing the wider determinants of health is where it needs to – we do commission the services and that’s obviously helped support individual people, but the real change is with a – much longer term is with the wider determinants of health

I: Sure. Are you the only person doing this bit of the role in public health?

P: I’m the only public health manager for the wider determinants theme, but then I’ve got [name] and another colleague in the theme. So, there’s three of us within the theme and then we’ve got obviously a number of other public health colleagues within the department

I: And your director is –

P: Well, we’ve got our – our director is [name]. And then we have a consultant in public health, [name], who basically is picking up most things from [name] from a public health perspective.

I: Before we jump into the different whys and wherefores of what you’re doing – to get your own understanding of what health in all policies is and what does it bring to mind?

P: I suppose for me in my practice, traditionally you would have people making decisions that impacted upon health but without ever thinking about how fully the impact it would have on health. So, it’s about just integrating health into all of the decisions that we make. For me, like a lot of the stuff I do is within the council, but obviously there’s, thinking more broadly than that with our health partners, it’s kind of supporting health partners to think more holistically in their ways of working. You know. Obviously, the clinical aspect is vital, but thinking more holistically about a person and where they’ve come from and where they’re living and the reasons why they’re coming in with a respiratory condition repeatedly etc. So, for me, health in all policies is just about embedding health in all of the decisions which we take. Whether the health, like, health in title or not, I think people kind of traditionally see health as, you know, smoking, or drinking, or being overweight and people don’t always appreciate the connections to the wider determinants of health. So, part of what I do is also kind of enabling people to see those connections and the impact that the wider determinants of health have on our own decisions and our own health.

I: So how do you do that?

P: (*long pause*) I think making loads of relationships? Just getting out there. I just think making relationships and understanding where people are coming from and being sensitive to that. Looking, kind of looking across the horizon and seeing where you can influence. And some bits of the system have opened us with open arms and other bits of the system, for whatever reasons, they’re just more silo kind of working and they just wanting to get on with what they’re doing and not have to think about, you know, kind of public health or health aspects of what they’re doing. So, it’s – yeah, you have to tailor your approach to what you’re doing. I mean a lot of what – when I first started in this role – a lot of what I was doing was literally just going around and making relationships and introducing myself and explaining who I am. Just kind of going above and beyond. You’ve just got to get yourself known, get yourself out there.

I: And what kind of reactions did you get at that point when you first started trying to create those relationships? Can you think of an example, maybe, where it was a good kind of like open arms like you say?

P: Yeah, like housing. Quite close with housing. I think housing colleagues absolutely know the impact, the relationship between housing and health. And if anything, they were totally on board with it. If anything, it’s more working with the health side to think about the impact that housing has on health. So like GPs, for example, because GPs are so pressed for time, they’d come and they’d treat – they need to treat a condition or they might not necessarily be connecting that condition might be related to somebody’s housing, for example. So, housing totally get it and I’ve worked with housing on the housing strategy and the homelessness strategy and, you know, bids and things like that. We work really closely together. I think it’s just – what they are doing is public health, it’s just not labelled as public health. And then – so there’s housing and the people side of things, and then there’s planning colleagues as well. So, like the local plan, developments and they have been really great. So, we were heavily involved with the local plan from a health and wellbeing perspective, and then more recently I’ve worked with them to develop the SPD – supplementary planning document – for hot food takeaways. Which has included a tool around – so, when we looked at other SPDs for other areas, they all kind of cite obesity as a reason for needing an SPD, but they don’t actually use local health intelligence to help form a decision. So, we, I say we, health intelligence colleagues helped me to put together a tool which includes a lot of local health intelligence. So, obesity for adults and for children, deprivation, diabetes and CPD, I think. About seven indicators. And they’ve done something very clever and it basically weights everything and you come out with a score. So that is part of the SPD. So, that is part of the decision-making process. It’s not been signed off yet

I: It would be really good to see that when it’s there

P: Yeah. So, things like that and – cause a lot of the time I do feel like, you know, cause it’s so long term, you don’t always see the impact of what you’re doing. But there are specific examples of things where you think “That is actually a thing that we have done and contributed towards”. So, they’re two – yeah.

I: And so, taking the planning people, what do you think it is about planning or housing that makes them, or means that they’re more receptive? Or welcoming?

P: A lot to do with the people, I think. So, the guy who was heading up planning who was really great, totally gets it, has now moved over to the major projects team. And we didn’t have any great relationships with the major projects team before. It was – I just think, for whatever reasons, it was just a harder relationship to make and we had less back from them, but now he is managing it, it’s happening. So, I think a lot of it is down to the people. Again, the housing colleague, she just gets it. And I think sometimes it just – you can naturally see the links, can’t you? Housing and health, for example, it just goes hand in hand. And air quality, as well. Environmental health colleagues. There’s just – the connections are there. So, I think it’s a lot to do with the people and sometimes it just – you can naturally see the links. And other times, it just takes one person who isn’t interested.

I: Can you think of an example where someone’s given you the cold shoulder?

P: I get like some colleagues with [department] and some of the major project stuff just didn’t get anything, don’t get anything back from them. And I think a lot – sometimes it’s because they just, you know, they’re so pressured and they’ve got to do their day job, it’s not because they don’t care or anything. But sometimes it is, I think it’s just a personality thing and they just don’t want to. So, I think to work in this bit of the world you’ve got to be kind of quite persistent and quite good at making relationships. And then going like to try somebody else if that person doesn’t work. So just kind of working around people. But generally, I think it’s good in this council. I’ve got the support of my kind of senior management and it doesn’t feel – there’s no, for me, I don’t feel like there’s any major blockages that can’t be overcome. And our strategic director, if I did have any major problems, they could kind of help to unblock them.

I: So, outside of the council, obviously you’ll work with lots of other partners as well, you know, thinking about developments or the food and takeaway sort of retailers. Those sorts of things. How much do they feed into your sort of health in all policies work? Or the third sector

P: It depends. So like for example with the poverty stuff I’m doing, which is only in its infancy, the partnerships, the poverty partnership is a really important aspect, cause we know that the council does so much but there’s so much going on within the third sector. So, we’ve got a partnership event next week, actually. So that includes business, Universities, third sector organisations, food banks, faith groups, council officers. So, we’ve tried to get it as broad as possible. I can’t remember what your question was now.

I: It was about working outside of the council

P: Yeah. So, for that particular, for the poverty stuff, that’s really important. And we can’t do it without that partnership. I think it’s less so in other areas.

I: Like the commercial sector?

P: So, with the SPD, businesses will be consulted as part of the SPD, but that’s not me doing that. That’s planning colleagues who are leading on that

I: Is that like a formalised process?

P: Yeah. Yeah. Rather than speaking with businesses as part of it, that hasn’t happened. And I think, with the primary care network development, that is another opportunity to think about how we can work with primary care networks in terms of the wider determinants of health. They’ve all got data packs now with the local intelligence in, but I think – they’re all at different stages of development and we’ve all been assigned to a primary care network as a public health manager. But mine I’ve contacted several times and I’ve not heard anything back from them. And again, you just don’t know what’s happening. But ideally, I’d love – so, for example with the housing and health stuff, I’d love to get one interested primary care network to look at how kind of changes they can make within their practice, like fairly simple changes that you can make to flag up, you know if a patient comes in with a respiratory condition several times to flag, to ask the question about housing. So, for things like that it would be great to do, but we’re not at that stage yet.

I: Okay. And I had a question pop into my head then. Oh yeah, I was thinking about elected members. So, how do you work with them and how open are they to like a health in all approach to policy?

P: Yeah, so, again, I think one of the best things about where I am is because I don’t just work with the elected member for public health, the health and social care elect member, I’ve pretty much worked with all of them, because what I do crosses so much. So, pieces of work - air quality, playable spaces, strategy, poverty, the planning stuff. So, it covers – you know, it goes from environment to economy, to health, education, it covers so much. So, I think, yeah, I’ve always felt they do get it. Sometimes there’s more – like with the SPD, for example, there were concerns, I suppose. The argument about the economy vs health and that we could be stifling local business because we’re, you know, someone wants to open up in a place that’s already got loads of hot food takeaways and it’s already – the health intelligence shows that it’s, you know, really bad for all of the indicators. My feeling would be that it shouldn’t be allowed to open. But they were concerned about – “Well, what does that mean? Cause you’re stopping a local business” So there’s those kinds of – those balances to make, but there’s ways that we have overcome that. But I think, generally, yeah, I think they get it.

I: Do you have any kind of champions or, you know, people that you work with more closely to get things done?

P: I mean my portfolio holder for health and social care; she’s been the main person that I report to. The leader in terms of poverty, they’re kind of the lead for poverty. And then all the like – I think they’re all, to be honest, pretty supportive. Like environment, yeah.

I: Just thinking about other conversations I’ve had with people about health and how you introduce health into conversations when you don’t really know someone’s background or what, you know, they come from. How easy do you find it to talk about public health and the wider determinants?

P: So, I find it quite easy, I suppose, depending on the situation. But, for example, I did a housing and health meeting this week, actually, and – what did I do? I like the rainbow model of health, so normally I like to show that, cause I think it demonstrates things really nicely. Yeah, it looks good and have you seen the exploding rainbows? (No). I’ll show you one of these. So, I developed one for the SPD for that reason – for people to kind of see what we’re doing in the context of everything else. I’ll just bring it up.

I: Be interesting to know as well about if you – not only just the arguments you use but the language you use as well, cause some – we talk a lot about health, don’t we, but sometimes we’re talking about health inequalities and inequity and public health. Do you use those terms and how – you know, the sort of interchangeability of them? Or things that you might avoid or- sorry, I’m asking you questions while you’re looking something up

P: No, it’s okay.

I: Oh, right, lovely

P: So, this is like the – this is for the obese [?? 0:22:14] environment. So, just thinking about the different positive and negative influencing factors for the obese [0:22:22] environment. So, that’s gonna go into the SPD

I: This is something you’ve just created yourself?

P: No, no, not me. God no. Clever person is health intelligence. I wish I – it was my idea, but I didn’t do that (both laugh). I’m not technical at all.

I: Be lovely to have a copy of it

P: Yeah, yeah, that’s fine. I can send that. I just think it demonstrates it really nicely. So, you can see – so, with working with planning colleagues, there were some colleagues at the beginning of the SPD that were kind of like – well, “It’s people’s choice if they’re eating too many chips, that’s why they’re fat.” And so, there is some kind of re-education around that. And it’s not – if I wasn’t working in public health, that’s probably what I would think. I think unless you understand it, you do just blame, you know, blame individuals “Well, it’s your choice to smoke” and stuff. But if you explain it in the context of someone’s life and that, well, most people start smoking when they’re children and they start smoking because of like what’s going on around them. And if your parents smoke, you’re more likely to smoke. And when you’re a child it’s not really – it’s not really a choice as it would be when you’re an adult. And then using the intelligence and so like, you know, with the relationship between deprivation and health inequalities, you could say “Well why is it that people in more deprived areas are more likely to be obese?” If it was just an individual choice it would be spread evenly across all populations, but you can’t say that it’s just cause-. There’s something else going on that’s more complex, so you show people the intelligence and the complexities behind it, then I think generally you can – people understand that. Some.

I: Yeah. The intelligence side of it sounds really important in making these arguments. Do you use terms like health inequalities and health equity? Or do you talk mostly about health?

P: No, we talk about – I talk more about inequalities

I: How, generally, do people respond to those terms? Or do they not see it as anything different to health?

P: I don’t know. What do you mean?

I: Well, I suppose that there’s a question around whether or not sometimes talking about inequalities can hinder conversations as much as help them (Yeah, yeah). I just wondered if you’d ever experienced something like that.

P: Not – I think you have to be really careful with the language that you use and where you’re using it and the people that you’re with because, yeah, some people would never really have thought about what health inequality is, just because of what – you know, the job and what they’re doing. So, I think you just have to be careful to use your language and adapt accordingly to the audience. Cause some just get it and if you explain that to them it would be like patronising. And other people that would be really helpful, cause they wouldn’t have thought about it. So, if you kind of say “Well, somebody living in [place], their life expectancy might be eight years lower than someone living in another bit of [place].” I think that’s really powerful, but that’s – that’s an inequality, but you might not describe it as one. You might not say the word inequality.

I: Yeah, no, it’s interesting sort of how we use our language and how we frame arguments.

P: Yeah, I think we have to be – I think in the past maybe we’ve been a bit pompous about our language and how we describe things. But you’ve got to be careful about making just your arguments and your audience. And it just changes depending on who the audience is. And like the – you know, like the public. Say if there’s been a bad – [newspaper name] has put – that’s the local paper – has kind of- I’m trying to think of an example. You know, something about [place] or something, just reading the comments. I always like to read the comments, cause it’s just like “Oh my god”. And they’re the kind of – that’s the kind of – yeah, cause that’s what a lot of people kind of think about things and kind of that victim blaming. But not judging people for that, I suppose. I’m trying to understand what’s happening.

I: Exactly, yeah. Can you think of anything, like people or structures, that help or hinder the development of health across the board? You know, the development of health and perhaps a health in all approach across the board? You’ve talked about lots of different factors, from elected members to different kind of policy angles or thought processes. Or just down to individuals. But can you think of anything that structurally, maybe, within the council or structurally broader than the council hinders or helps a health in all approach?

P: So, I do a lot of work with the policy team. The policy team and then the transformation team. So, they can really help. So, I’ve worked with them, [name] strategy, they supported that. And trying to broker relationships between [departments] and me. Who incidentally, [departments] are another example of “Get back” that you wouldn’t think. Yeah, they really like were not happy with me

I: Do you know why?

P: I think they were like “Why has this person been brought in at this point?” they were very – they were doing a strategy, they were quite possessive over that strategy. And the strategy was – it was like War and Peace, it was 20 pages, it was really too long. And I suggested cutting it down to like 2 pages and – I did it in a nice way, but

I: Didn’t go down well?

P: They weren’t happy about it at all. And I think there was a bit of “What’s a this got to do with public health? What do you know?” kind of. You know, getting a bit precious about. I can’t remember why I was telling you this now. So, policy team were involved in that piece of work. And working jointly with policy team on the poverty stuff. So, they have just a different angle on the council and the ways of working and who needs to be involved and they’re quite – it’s the political sensitivities, if anything. So that’s really helped. And then the transformation, as well, transformation team. They’re helping with the poverty stuff, cause poverty is just so ginormously complex that it can be quite mind-blowing at times in terms of what we’re doing and how we’re gonna do it. So, they really helped with that. They’re not – they kind of sit corporately. So, they kind of act as a golden thread through lots of pieces of work. Whatever that is.

I: So how do they help? What’s the most helpful thing that they assist with?

P: So, the transformation. So, for example, thinking about poverty within the council and what the council’s doing in itself is massively – can I show you something else? Massively complex. So, they helped us with a workshop for like strategic council officers to think about how we start to map everything that’s happening. And it’s having – I suppose it’s having somebody who’s independent to what you’re doing, so they’re not from a specific service like environmental health or public health. They’re kind of independent and that’s really helpful because they see things – they can almost see the whole picture. So, they did this for us.

(Finding something on computer)

P: We had a meeting with council officers and we wanted to map everything that’s been done around poverty across the council and we mapped it against the Joseph Rowntree foundation five domains of how you prevent poverty and this is what they helped us with. I’ll have to zoom in cause it’s quite hard to read.

I: Oh right, wow. I bet this was a long meeting

P: It was, yeah. So, here – this is all the, you know, policies, strategies that are supporting it. This is the Joseph Rowntree domains – things which will kind of prevent poverty. And then this is the key to which bits of the council are doing what. So, just seeing that is really helpful and so we’ve got the partnership event next week, and so we’ve asked all of our partners to let us know what they feel they’re doing across this. And then we’ll map that on as well, so then we’ll have like some kind of picture of what’s happening across [place].

I: And then you can re-align the different parts of work that are complementary

P: Yeah and see where there might be gaps or see where things can connect up. And where we can add value to stuff that’s already happening.

I: For this example, which I appreciate is really complicated, I’m just wondering what success looks like for you as a public health practitioner working in this field.

P: I mean, it’s different things. So like ultimately, it’s how, as a – there’s the ultimate success which is thinking about how we – what we can do as a council and as partners to influence things at a local level to kind of improve the lives of people who are living in poverty. An action plan will sit under that. So, it might be improved communications around financial resilience, it might be more people are getting the right benefits that they should be entitled to. For me, there’s a big thing about people with lived experience of poverty being part of this from the beginning and helping to inform and shape our approach. So, there’s kind of – there’s big stuff like that and then there’s small things like – not small – but developing a relationship with a bit of the system that you didn’t have a relationship with before. Or understanding a bit of the world that you didn’t before. So, we’ve met with revs and bens, met with the head of care leavers team to think about care leavers specifically. Cause we know that care leavers are a specific population group that will feel poverty greater. We’ve got – there’s like good examples of we’ve negotiated for, hopefully, to have more money into the welfare budget so that we can increase money to the foodbanks, but also think about other welfare needs beyond the actual giving people things. So mental health support or other more holistic stuff as well. So, I think there’s different levels of success, yeah.

I: I’m interested in knowing how you feel this kind of approach to the wider factors is sustained. How health in all approaches is sustained in [place] and what support you might maybe like in addition to what you already do. But how is this kind of approach going to be sustained, do you think, over time?

P: I think it’s in – you know, there’s all the kind of corporate support. So, there’s the corporate plan and the health and wellbeing plan that makes reference to that. So, there’s that strategic commitment to it. I just think that the commitment is there. So, we’ve got that kind of backup, I think. And for example, [we’ve got money] to look at walking and cycling. And you know sometimes when you get money and you’re like “Oh, that’s great, but we’ve not thought about how we’re gonna spend that. And we’ve not done any kind of thinking behind it” We spent ages thinking “Oh god, what we gonna do with this money? I wish we’d not got this money”. And [name] is doing some stuff with community hubs. Schools as community hubs. So, the money’s gone – is gonna go there and so rather than us, as a council, deciding what to do, it’s kind of gone to them. We’ve given them some rough outline of the kinds of things they could do, but it’s gone to them. And they’re all doing very different things. So, some stuff is structural stuff, like roads and some stuff is buying bikes or doing a walking bus or they’re coming up with different ideas. So, I think the council’s in a place that will support this approach and they’re definitely wanting – there’s no place for kind of silo working, I don’t – you know, it’s – they’re really keen on working together, working partnership. We’ve got, in the corporate plan, we’ve got these three key principle ways of working which is people, places, partnerships. So, the people thing is just kind of – they say “It’s working with people, not doing to people.” And partnerships is obvious – that’s obvious. And place working – understanding that [place] is a diverse place, different communities etc. So I think we’ve got – the support is there, strategically, and so that means that that filters down and that I can just do my job and I’ve got the backup if I need it of my manager to kind of help unblock things.

I: So, just to pick up on that point about silos, are there any mechanisms or any instructions or something from the council about how you work across different divisions or different traditional policy areas? Or is it just a kind of – you just go for it

P: Not that I know. I mean I guess the policy team – policy and transformation teams – help to connect up all the bits of the system. Cause you can’t always know everything that’s happening. So, there is something about making sure that doing everything you can to make sure that you’re as connected as possible with everything. So, another example – I’m just doing this piece of work around playable streets. I’d love to – we don’t have any – we’ve got the mechanism for it, - people can apply for a street party – but I just think people aren’t aware of it. It doesn’t happen. So, I’ve linked in with other colleagues who are doing a bigger piece of work around how the council works with communities and kind of local assets in the community. Local spaces. And how are we making sure that we’re enabling communities to sue the local spaces – council spaces – without charging them a fortune? Cause it’s kind of counter intuitive. So, there could be a cost for applying for playable space, you know, applying for a street party. Is that gonna put communities off? So, I my director – kind of asked me to make sure this piece of work was linked in with that piece of work. But there isn’t like a set way of working. I think it’s just being sensible about what you’re doing and making sure that you – like I work closely with policy and transformation, so.

I: Do you think some people find it easier than others, or some parts of the council find it easier than others?

P: Yeah, I mean public health by its nature is very outward looking – we can’t do anything on our own. But some bits of the council, you know, it’s just so different. The council is massive, isn’t it? So, it feels really natural for us, but for other bits of the council that is like a massive culture change. And yeah, you can just tell the bits which are like a bit kind of old and rusty and need a bit of updating.

I: I was wondering how you might go about sort of trying to instil. I suppose that’s why I asked the question about, you know, any sort of guidance or advice or kind of mechanisms for getting people together, you know, formal or informal across different –

P: So, formally, we have CMG plus, that’s for like managers above a certain level that it’s like three-line whip, we have to go to that. And so, the chief exec kind of chairs that and it’s like everybody gets together in a room and you sit with different people and normally someone brings something that you talk about. So, there’s those kind of mechanisms. And then we have like a public health team meeting every six weeks. So, there’s formal things like that, but then I think a lot of it is just about who you know and making relationships.

I: I’m aware of time - don’t want to keep you too long. What sort of support do you think, if you were able to think just a bit more broadly about making health in all approaches more universal across councils, what support do you think might be needed to encourage that? And where could you see it coming from? If anywhere

P: Say it again – I feel like I’m being interviewed. Well, I am being interviewed (*both laugh*)

I: I was thinking about support mechanisms for making health in all approaches more universal. Whilst your council and the way you work is very intersectoral, there may be other places that are very not. And so, I was thinking about what support might be possible – maybe at a more regional level, or cross-county level. Even, you know, within clusters of local authorities. If there’s anything you can think of or other mechanisms that might support others

P: So, we do – so PHE we’ve got various COIs

I: What’s a COI?

P: I knew you were gonna say that. Community of (Interests?) Yeah. Yeah. So, we’ve got ones – I’m not in any, actually. So, we’ve got one for physical activity, healthy ageing, so that’s like a regional thing where everybody gets together across the region. I go to a regional – there’s like a tobacco regional group. There’s a healthy places one. Planning and healthy places. There’s the transport and health one. But they’re for public health people. So, they’re kind of good places to kind of share practice and learn from others. I don’t know if that’s really answering your-. We were never – are the other places you’ve spoken to, are they all really different in terms of – or are they all really good at health in all policies?

[discussion about other places]

P: That kind of working across complex systems. We have had some stuff around, yeah, like complex systems, you know, a workshop. And we’ve done – we hired a consultant to do a whole-systems approach to a physical activity. Someone Cavill

I: Oh yeah, Nick Cavill. Sure. So, you did some system mapping

P: Yeah, just did some system mapping with it. I can’t remember why I was telling you that now.

I: I suppose, yeah, it’s a way of supporting collaboration. One thing -final question I wanted to ask you, it’s nearly 12 actually – was about focusing on outcomes. So, you know, we talked about success and what success might mean, but do you have any kind of health outcomes, population health outcomes, that you look at to judge yourselves against? Or is that too long term?

P: I mean, yeah, we have – it’s really difficult with this, cause we’re not like a service. So, we commission the sexual health service or tobacco, drugs and alcohol, where they’ll be indicators that you can measure. But there are – there’s loads of like, the (QOF?? 0:49:40] indicators that we can use. But we could never – we would never say “Oh, that’s a direct result of what we’re doing” because it’s just too – it’s just too complex. Have I shown you the plans on the page which we’ve got for – so, we’ve got three plans on a page, which kind of demonstrates and outlines everything that we do, and we do kind of have outcomes.

I: Yeah, you did send me those. Has the poverty one changed at all since (yeah) this work?

P: Yeah, and I can send you the poverty one but it’s still not right. So, there’s outcomes in there which aren’t outcomes, but I mean I can – I think that’s like a really hard bit of, like demonstrating what difference you’re making. How you do that is really difficult, because so much of what I do is about making relationships and influencing; it’s not about a thing. But it’s really difficult to demonstrate that, especially with the poverty stuff. That has really like blown my mind in terms of what difference we’re trying to make here with this work. So that, in terms of like help and support, that always feels really difficult for me