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I = Interviewer, P = Participant

I: Okay, so, tell me a bit about yourself then, [name], and what you do

P: Okay. Well, I’m a Public Health Improvement Coordinator. I work in Public Health as part of [place] Council. I’ve worked in public health in some way or another since 2003, but that was mostly NHS and then we were moved across to the council in 2013. I think one of the reasons was because it was expected there could be an influence upon our council colleagues from public health. My areas of work have included mostly nutrition and obesity in the past, but also general skills-based work. I’m very interested in whole systems, interested in evaluation, health impact assessment. My current role, which has been for the last couple of years, is within the wider determinants team.

I: Right, brilliant. I was thinking you could maybe just give me a bit of a feel for the areas of work – you mentioned housing and the wider determinants field. But where you’ve worked with other parts of the council infrastructure to try and influence

P: So, housing’s a really good example of that. As part of my housing role – if you had to give it a strapline it’d be that our role is about improving health through the home. So that involves a wide range of areas – so for example, private sector housing is a good area where we can make some impacts. But also, strategic housing. So, the house building and housing design, homes for life, that sort of thing. But also fuel poverty, so I work around fuel poverty as well. And I suppose where improving health in the home is involved as well – things around information, advice and guidance. So, I’ll pick up strategic housing first, because that’s probably quite an easy one to do. So, our strategic housing people sit separately to us. They plan what will be built in [place], so they plan what council housing we’re building, what extra care and specialist housing we’ll be building. So, we might be looking at old people’s housing or they might be looking at housing for people with learning disabilities, for example. And I’ve been working with them – the first piece of work we did was look at what an approach to healthy housing would look like locally. So we came up with a set of principles, I suppose, I’d call them. A set of principles. I statements – I can share that with you (that’d be great). That’s no problem. So, it might be, I don’t know, one might be around “Homes should be affordable” – so, homes should be affordable and people should have stability and security. And that’s not one of them, but I’ve got bad memory. And then from that we kind of said “What can we do about that?” and then maybe think of a few things. It could be a project to explore it, or it could be almost like that statement is needed if we need to influence other people. I think one of the things with the council is that if you have something already to go that’s persuasive, it’s a lot easier to persuade people than to go away and develop something. So, these I statements are very good for responding to things, or trying to show people what our approach would be

I: Sorry, say that again. Did you say an “I” statement?

P: They’re not I statements at all – they’re not I statements. They are more like principles about the way the world should be.

I: So, in an ideal world, this is what it would look like in [place].

P: Yeah. So, I don’t know, “Homes should be accessible and they should be able to adapt to people’s needs as they get older as their needs change” and that sort of thing. So, they’re not I statements at all. So, I did that work and kind of did it myself, mostly, but worked with strategic housing to make sure they were on board. So, to involve them and to make sure they owned it as well. And then from that, we set up a few small exploratory projects, so one to look at intergenerational housing, intergenerational work within our extra care. So, they’ve just built a brand-new extra care housing. And we’ve started looking at ways that we can not only bring the community into that space, but also bring those residents out to the community and help them kind of build ties with the community. So, strategic housing, myself and our communities team. So, our team that do the communities kind of work, all worked together. We did a bit of an event with the residents, came up with some ideas, then COVID happened (both laugh). So, it’s all slightly - but I suppose the idea is that that’s a couple of council departments working together with those residents to think about how we can build that extra care housing to make it part of a community. And so, for example, our local family centre, children’s centre, who were really keen to come in and use the communal space for some of their sessions. So, it was basically about bringing those two together.

I: To act as a broker?

P: So, some smaller projects like that, one where we’re working with our health visitors – they’re the experts and as soon as they come down the garden path, the health assessors are already assessing where they live, from a risk point of view, but also from a support point of view. So, we’ve worked with them to create, I suppose an interactive house. And it’s not on the website yet, but you’ll basically be able to hover over different rooms and it’ll come up with something that you can change about that house to make it healthier. So, it might be some black mould on the wall and it’ll say “mould can be caused by this, this and this. Here’s some simple things you can do, here’s where you can go for extra help”. They’ve made a video now with them with the health visitors walking around the house, talking about what they look for. Very supporting and very positive. And the idea of that is so that once all that’s done, that can go to the whole workforce. So, in the NHS as well, not just the council, and commissioned services. If you visit somebody in their home you’ve got some ideas about some of the things you can do to just help people improve their health through the home very quickly. That’s not the only project we’re working on – we’re working on a range

I: Yeah. And so, you work routinely, then, with housing, is that right? (Yeah) And how did that come about? Were you there when it emerged or did you shape it?

P: I found somebody who was amenable to it. So, the particular colleague – I feel like she’s a frustrated public health professional inside a housing person’s body. And so, a colleague mentioned her and we met and I think we realised that they were waiting for something – I was the first person to even have housing as a role. So, I think they were probably really being asked quite a lot about health and housing, but not having anybody to support them through that. So actually, the fact that somebody’s coming in who’s got the knowledge but also is prepared to do a bit of the work, or most of the work. It makes them very amenable to you. So, they’ll be quite happy to work with you because you’re meeting some of their needs, I suppose.

I: And so, it sounds like that was maybe just a bit of luck or serendipity, is it?

P: Yeah, I think it might be. I think so. I think the fact that a colleague knew somebody and they hadn’t actually worked with them that much but knew them as a contact. I think it was worthwhile. But bearing in mind they were situated in the same building and the housing scheme were right behind me. If I hadn’t have had that contact, I wouldn’t have walked over and asked to speak to somebody – it wouldn’t have been a big deal. Or I would have maybe gone a bit higher up and then asked to be directed to somebody if needs be. But sometimes it is a bit about luck, about who you bump into and who can do what, I suppose

I: And so, in your role, then, have you been given an explicit remit to work across the different parts of the council?

P: Yeah. So, when I went for this particular portfolio, the remit was to work with partners within the council, you know, to embed public health into what they’re doing. And that is probably something that’s very explicit within our team as well – we don’t, for example, do planning. We don’t. I mean we actually do respond to planning requests, but our job is to influence our colleagues, so influence our colleagues in planning or in the environmental health team, for example, as opposed to doing that work. So yes, it was quite explicit that we have to make connections and influence people. But a lot of the way you do that is by supporting them, I suppose. Not necessarily persuading them

I: Yeah. Go into that in a bit about how you do that. I was wondering about where the remit comes from in the first instance.

P: I’d say our team, as a wider determinants team, is probably the team that is skilled at doing this. So, I’d be tempted to say that our team, which is a small team of about [x] of us, it’s quite clear to us that this is our job. When you think about the wider determinants of health, it’s very different from commissioning a service or doing a specific project. What your role is is to try and shape what’s happening in the world. So, it’s very hard to do that kind of project. It can be very easy to get down to the nitty gritty of doing that, but actually it’s about going to a meeting and explaining to somebody why what they’re doing might have a negative influence on health, for example, or a positive one which is even nicer. So, I think for my team, it definitely comes from our leadership, so it comes from our DPH and our senior team. Because a lot of the things we talk about, so, some of our principles around things like the creating the conditions for good health, combatting commercialism, compassionate approaches. So, all of these things are about changing, not just our organisation, but organisations in [place]. So, it comes down from our DPH, it comes down to our wider determinants team very well, but then it doesn’t necessarily fit in with the other teams. Cause if you’ve got a team which is commissioning substance misuse services, it’s not gonna be as apparent to them that they have got to increase their sphere of influence and influence people effectively. So, I think it’s partly probably cause of our team, cause if you haven’t got partners involved you’re totally ineffective. But probably because of the theme of our work

I: Yeah. And so, the wider determinants team works across different parts of the council. Apart from housing, which you’ve already mentioned, what other parts? I suppose you mentioned planning too

P: Yeah. So, planning falls into the remit of my colleagues. But planning, we do a lot of work with that. Other areas are housing enforcement, environmental health. So, we work to try and influence them. We work with HR as best we can to try and influence what they’re doing as well, cause they’ve got a bit of a health remit. I’m trying to think where – communities team. So, in the council we have a communities team, so they’ll work by locality. So, we work really closely with them because they’re almost like the feet on the ground. We probably are known within most of the council. Another big partner of mine is the energy team, because I have a remit around fuel poverty. They have a team that looks at energy usage and switching and retrofitting of houses. So, I don’t know, I actually kind of oversee one of their projects from the health point of view. So, we would do a lot of work together, applying for funding together for example. It does go on. I mean, most of the teams within [place] Council probably have come up against the wider determinants team, at least

I: Yeah. So, you really spread really broadly across anything. How do you recognize an opportunity to work across teams? Does it kind of emerge organically or is it something which is not dictated but you’re guided from leadership teams?

P: So, there’s some structured ways that we would find opportunities and then there’s some less structured ways. So, the structured ways would be, for example, we have to write health implications on all major decisions. So, if the decision fits the criteria, so say for example a service is being changed or something new’s being done or money’s being spent everywhere, it will land in public health, and quite a lot of the time that’s the wider determinants team. So, we will then have to look at that policy and comment on it. So, it could be that as a result of that, we might make a new connection. It could be that we attend a meeting because people think public health should be there. And we’ll come along to a meeting. Often things will trickle down from our director of public health, or through senior leadership who recognise that public health should be involved in something. In kind of more organic stuff, might be something’ll pop in a meeting and you’ll think “Oh my goodness, why have I never heard of that?” and we’ll say “That sounds amazing, I’d love to come and help with it”. Sometimes you’ll have to do a lot of investigating, so I heard a rumour through colleagues that there was a private rented sector strategy being written. So, I kind of asked around until I found out who was dealing with that and then contacted them and asked to be involved. It really depends, it really depends. Some of it comes from relationships. Some of it just lands on your lap. I think we don’t always get everything. Sometimes a corporate report will come up and we’ll be like “Why has nobody involved public health in this?” or somebody will go off and set up something and you’ll think “Oh no, probably shouldn’t have done that”. So, I think it’s a bit of both. I think our senior leadership have probably got quite a role in keeping an overview of things and making sure they come down to the relevant team members so that we can contribute. But I think probably doing health implications on decisions that have been made is probably very good for us cause it gives us a good overview of what’s going on. And if we need to, we can support more. But yeah, it depends. It depends. Certainly not a very structured way. I mean bear in mind, we’re still kind of new to this. I know we’ve been in the local authority for a long time, but it’s not necessarily been very structured. I’m not sure we miss loads. I think we’ve built our relationships and our connections up so much that we probably do capture most things where we have impact.

I: Yeah. And I’m kind of interested in the sort of responses you get from other areas of the council when you come along as a public health professional. Can you give me a few examples of where public health, you know, you’ve represented public health in discussions and the sorts of responses you get across the board? So, some good responses, bad responses, and what’s most common

P: So, it depends. The most positive responses are usually when you’ve decided to help with something. So, an example would be last week, the assistant director for housing was talking about the housing strategy they have to write. There’s not a lot of time to do it. And when I offered not only to kind of get on the working group to help write the strategy itself – cause we want health all the way through it – but also offered to do the health section. She was extremely happy. So, the reactions are really good when you offer to do that. That’s great because then you get to take control of something rather than try and influence it as much as you can – you can take control. So, you get some really, really positive responses. Some of the responses aren’t fantastic, but that’s not the officer’s fault. So, a good example would be I’ve had quite a few meetings with colleagues working in housing enforcement. I wouldn’t say they’re passionate about public health, but they really understand about improving health through the home. They understand that there are lots of preventative opportunities – they’re professionals, they’ve got a public health remit in a sense. But they’ve got no time. They’d love to sit and have loads of meetings, like we have the luxury of talking about what the potential things we can do and the opportunities. They’ve actually got to go out and visit people and inspect houses and do paperwork and take enforcement action against people. So, although the will’s there, the resources and the time aren’t there. So, sometimes what you get is, I think, positive to your face and then nothing comes of it, if you know what I mean.

I: And how does that relate to how you interact with the political side of the local governance structures? So, I’ve not yet managed to speak to any local councillors, although I’ve been to some cabinet meetings and looked at how portfolio leaders and stuff engage with health as a topic area in their area of portfolio. But how do the local politicians really respond to the idea of health in all policies? Or health in their policy area?

P: I think a lot of my perceptions are probably just from observations or second hand, because I don’t often liaise directly with the elected members particularly on that. But I have done in the past. But I think sometimes there is a little bit of a gap in understanding. You know, we go to university and learn about public health and we work in it for years. And actually, we still disagree on some things with colleagues. There’s still lots of things we don’t know. So, I think probably it can be difficult to A) overcome truisms and people’s – a good example might be a lot of people might not understand particularly how the system of obesity can affect an individual. What they’ll say is “all we need is medication. Or we’ll tell people to exercise more and eat healthily” and for us as public health professionals, we know that it’s loads more complicated than that. But we can’t explain that in a meeting to somebody, cause that’s something that I spend a lot of time doing – reading and doing research on. So, I think maybe the challenge is getting complexity across to people. It’s hard, isn’t it? Because people either trust you and what you’re saying – so if you say “Actually, it’s more complicated than that, this is what we need to do” then they either have to make a leap of faith and trust you and say “You’re the professional, I trust you” or they’ve got to go away and do lots of research themselves to convince themselves. Or they stick to perhaps their own personal views that are maybe not as evidence-based as yours, but they feel very true to them. So, I think from elected members’ points of view, I think a lot of my colleagues would maybe talk slightly negatively about some of their experiences. But I don’t know. I suppose my experiences are I haven’t really had that much experience talking directly with them about it. We did one really great meeting with our portfolio holder for health and we basically just presented on our little areas but used more experiential – what we didn’t do is throw a load of figures at him. We talked a little bit about social justice types of things – about why we should be doing things, about why we should not take a victim approach to physical activity, for example, and how we can shape things from more of a justice and inequalities point of view. And maybe a bit of story type stuff. Rather than saying “Okay, well if you look at this graph you can see the associations between X, Y and Z” and that sort of thing, which I don’t know. Maybe doesn’t appeal as much to people. There is a bit about winning hearts and minds and maybe not having to worry too much about winning brains, in a sense. I don’t know. It’s hard to explain, I suppose. When you’ve got to convince people of something, you can’t hand over all your knowledge to them in order to do that, you have to find a way to appeal to them.

I: Yeah. Sounds like you have to employ quite a broad range of skills, then, not just working with elected members but also when you’re in this wider determinants role. Just in your own experience, what kind of skills do you think you employ to try and work across policy and work across the political element too?

P: So, I suppose one of the skills you probably have to employ is being able to get knowledge on areas that you’re not familiar with quite quickly in order to join the conversation. So, housing’s a good example of that. I still don’t know anything about housing as far as I’m concerned. I don’t even know how a house gets built. But I’ve got a general idea. In order to be able to influence housing you have to have an idea of kind of different technicalities in relation to housing. So, a good example would be trying to get an understanding of what would make sustainable design in housing, cause if you’re trying to support colleagues who are doing work around fuel poverty or doing work around retrofitting of housing, or looking at how you design better extra care accommodation, or understanding design principles of good housing, for example things to do with light and space, accessibility standards that come within the planning guidance, if you don’t understand those basics it’s hard to have a conversation, but that’s not really your area of speciality, is it? You’re a public health worker. But what you can’t do is understand all the technicalities, cause those people have gone to university to do that. They understand it all. I think something about gathering knowledge and really quick, but being happy with going into a situation with maybe not as much knowledge as you’d like. To be honest, I feel like I know nothing about any of my areas, sometimes. I suppose skills – other skills definitely communication and relationship building skills. For me, relationship building is partly about finding things in common with people. Understanding that the vast majority of people in the council want to make people’s lives better. Sometimes that’s been covered up a little bit by processes and time and resources, but I think looking at it from their point of view understanding their motivations is really useful. Relationship building, probably the biggest thing I do is helping out with stuff. So, you know, it could be for example one of our housing colleagues wanted to do some evaluation around their new housing estates they’ve just built and I helped them with the evaluation consultation exercise because I have the public health skill. It seems silly for them to go and have to try and work out how to do that when I can very quickly help design and deliver that for them. So, they’d come to you hopefully next time they’re doing something else. And then communication and I think with your communication it’s about sometimes a bit of relentlessness. So, not expecting to fire an email off to somebody and for them to come back to you and go “Wow, fantastic, what can we do to work together on this?” It might be a few emails, it might be a conversation, it might be standing by somebody’s desk. Or it might be about bringing things up in a meeting when it’s awkward. And I think there’s something about doing that really nicely and kindly whilst being positive and not negative to people. But I think there’s something about being able to do that quite well.

I: And how do you know, when you’re sort of employing all these skills, how do you know when people have taken those ideas on board?

P: Sometimes you’ll get people asking to be involved in something. You want them to be more involved in things, so sometimes it’s like “Okay, they’re starting to think of me when they think of things in that team”. For example, I got involved in a funding bid with our social housing organisation, but that came from somebody recommending that they contact me. So, they then start recommending that you might want to be involved in something, so you’ll start seeing that. Sometimes someone hears your name mentioned positively, or you’ll start being mentioned in meetings a little bit more etc. But then it works the other way, because sometimes meetings will go on and you’ll be like “Why is nobody inviting us?” and get really offended (both laugh). It is quite hard when you realise things have been going on and you’ve not been involved. So, it works the other way. But I mean for example in housing, I’m pretty sure that most people, if they think about anything to do with health and housing, my name will be the one that pops up to people that know and they’ll say “You want to speak to [person] about that”

I: And how long do you think you need to be involved in certain areas of policy to get to that point? You know, for people to say “Oh yeah, I think of [person] when I think of housing”

P: I think for me it took – I started with relationship building and knowledge acquisition, so I started with those two things. So, my time was either spent meeting or contacting colleagues and explaining what I did. Or acquiring knowledge. So, 6 months it took me to get a good basis of different contacts in different organisations and different parts of the council. And then I built on that since then. So, I think once I’d done that for six months, I then developed our health and housing framework and principles and then used that to kind of build on those relationships. But it was quite quickly done. I mean within a week or so of starting the job I was having meetings with people etc. So, maybe six months, but I don’t think you need to have loads and loads of knowledge about an area to link the public health professional. I think all the areas I’ve worked in; it really is about using your public health skills, that’s what they don’t have. They’ve got the technical knowledge, or the knowledge of the work area, but what they haven’t got is the public health skills and that’s what you’re contributing to the relationship. So, I think probably you can, again, move to another area and within six months have built up quite a few relationships together.

I: Yeah, sure. And just thinking about the housing example that you’ve got there – do you think that the work you’ve done with housing is a good example of how public health and housing can work together? And if so, why is it a good example?

P: So, it is a good example of how public health and housing can work together, and I think the reason being is because we’ve joined up on things. So, we’ve joined up on their strategy, so joining up on their strategy. So, that’s not 100% joint work – I’m sure they’ll say they’ve done it in a sense, but we’ve joined up on strategy. They are extremely keen for the housing strategy to have, you know, health run all the way through it and for it to be about health. So, that’s a good example. We’ve got, you know, two or three joint projects that we’re working on together, you know, a couple of different staff within strategic housing are working with me on that as well. I think there’s room for improvement. So, they’re still not necessarily inviting us to do some of the discussions with developers. I think we’re clashing there. Cause I suppose part of it is, again, when you work in public health your job is to talk about public health and the opportunities and really be kind of quite strong about any decisions that are going to negatively impact on health or create inequalities. So, I can imagine they probably might be a bit worried about having a couple sat with them at a meeting with a building developer, cause they’ve got their relationships. So, their relationships are about getting decent houses built in the right places and, you know, it’s not like a one-sided relationship – they have to almost bring developers in, in a sense, and work with them. So, for me to suddenly be going “Right, let’s look at your plans. This won’t work” (both laugh). So, I think there’s a little bit more work. Is that about trust, or is it that maybe not in the right place for us? Maybe they should be our mouthpieces in those sorts – we don’t have to be involved in everything; we only really need to be involved where it’s gonna be effective. So, and maybe we don’t have the right language and knowledge to – and I say we, I mean mostly me, but my colleague who works in planning it’s probably similar. Maybe it is about them going forth and having health at the back of their mind all the time, rather than us being invited, I don’t know. But I mean, we do – I mean they will always think about me, they will invite me to meetings, I’m gonna be sitting on a housing sub group which’ll be below our strategic kind of meetings. So, I think it is successful. It could be improved, though.

I: Yeah. And do you use any techniques or tactics when it comes to being in these being cross-disciplinary in these meetings to keep on emphasising health and health inequalities? If you had a sort of example or a tactic that you employed in these settings? You know, what is it? In what way do you approach it?

P: So, I suppose my examples would be, for example, when we are talking about health impact assessment on new builds, for example, we’ve got a lot of really technical stuff. We’ve got health impact assessment, big documents that need filling out and things like that. But actually, I suppose staying away from the detail and talking about – I suppose we talk more about the actions on what needs to be done, rather than talking about the detail of what needs to be done. Because I think it can be really overwhelming for people. So, I suppose that’s one of the tactics – saying “Let’s not worry too much about the detail, but let’s just get agreement on this” and then as we move along, we’ll look at it more practically. I think I’ve got quite a logical mind. So, often I’m working my way back in a logic model sort of way when we’re talking about things. So, sometimes it helps to explain logically why something might increase inequalities. So, I suppose an example is with a housing service review that I’ve been involved in, last year I was involved in a service review. So, I was with lots of people working on the front line and then their managers etc. But they were talking about something they wanted to do that would create more barriers to people accessing that housing service. So – and very vulnerable people. And from their point of view, from a practical point of view, it seemed really logical – it’s a process as opposed to maybe giving everybody access to it. It would create inequalities and there would be a bit of an inverse care law there, because people who could navigate the system would still be able to get through and the people who are most vulnerable might not do. And I suppose explaining that from a logical point of view to them eventually worked. I tried it at first, from a bit of a social justice, “This is a right thing to do” point of view, but I think explaining it back from a logical point of view works. So, imagine if this person is facing X, Y and Z and then they come up against this part of the system then they might not – that’ll impact on them being able to access it, which’ll mean they’ll stay on a house that’s not suitable for them and then eventually they’re gonna turn up when they’ve had a fall and you’re trying to get them housed straight after hospital. I suppose maybe using more logical, practical stuff rather than talking about how it’s our job to tackle inequalities and make the world a better place.

I: Yeah. Okay, that’s a really interesting logical model sort of approach. Very public health thing to do.

P: When we talk about health inequalities, sometimes I can’t even explain what health inequalities are. And you know, when you talk about – even the wider determinants of health. When you talk about something from the point of view of a person, like trying to access something or trying to use something. Something that I’ve done quite a lot from a wider determinants point of view when talking about obesity is that if, you know – “You’re saying that the world’s fair. Well actually, imagine if you’d got three children, you live on your own, you don’t have a kitchen cause you’re in bed and breakfast accommodation, you haven’t got transport.” And then you talk through that and start talking about all the practical pressures and constrictions on people – it helps illustrate what you’re saying. Everyone has unequal access to services or to their environments. It’s very hard to show that you understand it.

I: Yeah, different level of abstraction, isn’t it? (Yeah).

P: I suppose part of my job when I’ve been building relationships with people is to help them understand a Public Health approach and how they have to have health as part of their kind of work. Or what I never do is send people research or policy or documents straight through to their inbox. A) because I know how that feels when somebody does that to you and you think “There’s an afternoon gone”. So, what I will do sometimes is I will read something myself and summarise something and share it with people which is really useful cause then they’ve got something bitesize. You know, I suppose I’ll very rarely – I’m thinking about my housing sort of stuff. Very rarely make a case using data or evidence in a sense, because A) my housing colleagues know that homes influence health and I suppose – if you think about my housing colleagues, they know that houses should be a certain way and kind of how that will influence people’s health. So, I don’t know whether they need the convincing of it evidence wise. I think what they need – I think probably sometimes what they need to be convinced of is how we can do it, how we can do it within their resources and time. I think sometimes – I don’t really imagine myself very often going and really making a case with any type of evidence, in a sense. That sounds really bad. It’s not that, it’s just because – a lot of your colleagues do know a lot of this stuff. They do know that it’s important. I think if you have to maybe utilise evidence, it’ll often just be to help them with targeting. For example, looking at where the need is, geographically. You might say “Actually, probably the best way to think about need is we can look at the age of the population, deprivation etc. and then we can probably target where you’d be expected to have people who might be of poorer health in the future. Maybe that’s where we need to focus your consultation activity, to see where you want to build extra care housing” for example. So, you might maybe help them with that, but that’s more of a practical thing.

I: Yeah, sure. Thinking as well about outcomes – so, from your point of view, what good outcomes are with these interactions. Both the kind of outcomes at the intersectoral working level - so, you know, the process outcomes - and also, the health and health inequality outcomes. What are you interested in?

P: It’s really hard when you’re thinking about health and health inequality outcomes. It’s obviously a massive problem for public health that A) outcomes can be really, really hard to measure or even recognise. And I think in our work, especially considering it’s wider determinants, it’s maybe about moving slightly along a continuum as opposed to seeing any particular change in outcomes for people, which feels really pressing. I know we’re going on the right path, but I suppose where housing’s concerned, an outcome’s getting someone to change something when they do a planning permission application. It feels so – I don’t know. For example, a school putting in an application for a new school building, we managed to get some new bike racks put in from our comments. But, to me, that’s like- it’s small fry, isn’t it? That’s really quite small stuff. And when you think about, we’re trying to change the whole of [place] and make it easier for people to actively travel, putting some bike racks in a secondary school, or getting a developer to put some new bike racks into a secondary school – that’s not a massive thing. A more tangible outcome might be if we progress with the intergenerational work for the housing. We’d have evidence, then, of actual activity that’s taking place and we’d be able to measure that and see if things have changed for people. So, if we do some pre and post measures of those residents we might find that, you know, their wellbeing improves. But again, you know, I keep going back to scalability and when you think about the scale – that again, it’s quite small stuff. But having a better relationship with our housing colleagues, bear in mind they didn’t know who we were when we were in the NHS, having better relationships with our housing colleagues – I think I know that that’s going to make a difference, but it’s very intangible. So, I suppose when we’re thinking about real outcomes and changes for the population, I think it’s very difficult to see that. And I suppose thinking about health in all policies as well, it’s really hard to see where change has taken place, or where the influence has taken place.

I: What do you think prevents that? What are the barriers to that, do you think?

P: I think it’s the nature of the council itself. So, for example, when we talk about health implications on our reports, we make the suggestions; we don’t just say “This is bad for health, you shouldn’t do it.” We might go “Well actually, you should think about X, Y and Z. We recommend that you do more of this and less of that”. We don’t necessarily, really, know what happens to that at the end of the day. So, there has been a bit of work to try and track some of those as they go back, but on the face of it, it’s a great thing, isn’t it? We’re saying “These are the health implications of what you’re doing, this is how you can improve it” but if somebody just picks up your response and goes “Oh yeah, great” and it just keeps moving down that kind of policy creation process, it’s probably not gonna make that much difference. So, I think the barriers – I suppose the work we’re doing is an intervention, as we’d understand it. A public health intervention. It’s not a project, it’s not a piece of research, it’s not a trial. So, some things, it’s just very hard to evaluate and you just can’t evaluate them.

I: Thinking outside of [place] as well, what sort of things enable or constrain a health in all approach, more generally, do you think?

P: So, more generally I’d probably say bodies of knowledge. I mean the council and the NHS are different anyway. I think in the NHs we came up against medical models a lot more and they were kind of an obstacle quite a lot, you know. They’re quite individualistic, medical approaches. In the council there’s a lack of scientific understanding and I think that’s probably the same for all councils. So, there’s a lack of understanding about science and public health in general. I think there’s a lot of politics as well and you can see how people’s attitudes and approaches align to political views as well. And I suppose fighting for equality is a political endeavour, isn’t it? So, you know, but actually it’s not necessarily everybody’s cup of tea. Like I was talking about the enforcement officers – they know they should be doing prevention and not enforcement. But who’s gonna free them up to do prevention? I can train them on stuff, but – if somebody’s home’s making them very ill and having an accident, they’re gonna respond to that before they go and do some preventative work. And I suppose that’s the same for lots of parts of the council, isn’t it? And so yes, I suppose it’s probably a little bit about knowledge but there are other restrictions on people as well

I: Yeah, that’s really useful insight that, around the sort of order of priority of activity, you know. You’ve got an enforcement role, for example, that’s a really helpful reflection.

P: We’ve got a gypsy and traveller catch up group which we set up during COVID and we have gypsy and traveller enforcement officers. And that’s all we’ve got. So, we don’t have link workers – we will have soon. We don’t have link workers, so these poor guys are going to tell somebody they have to move their horses or, you know, they have to clear up something and then we’re expecting them to then go “Oh, by the way, we’re trying to increase vaccinations for flu for this coming winter. Would you be interested in the NHS coming?” it doesn’t work, does it? It’s madness. And those poor guys come to the meetings every two weeks religiously and they’re lovely people and they really care about these communities. But they must think “What on earth is going on here? These people talking about all this stuff” and then they’re on the front line, trying to sort things out. And I think we can say the same for our communities teams, telling them to engage with the communities but also enforcing against them. So, I think there is that – kind of maybe an incongruence in the council between supporting people and telling them what to do.

I: Yeah, sure. That’s really interesting. And I’m very conscious of time, coming up to three o clock. I don’t know if you’ve got any other meetings. Just wanted to ask you to tie up, in a way, about what sustains the kind of wider determinants intersectoral work that you do and your colleagues do. So, how does it keep on going? And how will it keep on going, do you see?

P: So, I feel like every year our senior leadership are fighting for this to have a higher and higher priority. And, you know, I’ve had a peek at our borough strategy or what it might be and it is wider determinants. You can see it in there. It is about, you know, shaping our environment and making life fairer for people. So, I feel like at a senior level, as a council, they’re moving more and more towards that. And I can’t comment on the old council really, cause I’ve only been here since [date], but that feels like a really good thing, to me. It feels like there’s more and more legitimacy to our approach as we move along. And I think that, I suppose, the other thing is that again, it’s an ethical and moral endeavour, working in public health. So, if you, as much as you can know it to be true, cause actually it’s really hard to find evidence of wider determinants kind of approaches. But it’s – I feel like we believe this is the way to go and it’s the most ethical way to do things. So, I think – I don’t see us ever not moving forward with this and not carrying on fighting for it. If you feel like you’re doing the right thing it’s a right luxury, isn’t it?

I: So, in sustaining that, in terms of the research and evidence base, I suppose I’d be interested to know what you think would be the best way of building a convincing evidence base and sharing knowledge about health in all approaches or health inequalities or addressing health inequalities through wider determinants. Do you have any sort of ideas about how we could best develop and share a knowledge base?

P: I think there’s definitely something around kind of best practice and understanding what colleagues are doing elsewhere. We’ve got communities of interest in some areas, and communities of learning. But in general, it would be really nice to have something that brought us together to discuss practicalities a bit. Like lots of councils look similar – they’re definitely not the same, but to find some people are surprised that we work well with strategic housing, for example. So, I think there’d be something about getting together and sharing. But also sharing best practice. You know, cause when you get a chance to hear what other people are doing, you get excited and contact them and that sort of thing. So, I think we definitely need – I suppose we could definitely maybe do with more evidence in relation to how people have successfully changed the wider determinants of health and how that’s been measured. Like how policy change actually created outcomes for people. We know it’s the right thing to do – even if we say for example “We stopped a takeaway from opening in this area that’s got loads of takeaways” – that’s it. We’ve stopped a takeaway from opening. We then maybe assume X y and z or we can say “We know this is associated with that” but if somebody said to me “Can you prove what good you’ve done by doing that?” I’d say no. I know it’s a good thing to do. So, where that comes from, I don’t know. And whether there is evidence of that and it cumulatively we can get a lot of that together, I don’t know.

I: You mentioned it really early on about working with communities to contribute to the development of policy or change within communities. Again, that’s something that’s brought up in the literature about engagement, genuine engagement with communities. So, if you’d just allow me one last sneaky question about that. How do you engage with populations to develop this work and to sustain this work?

P: So, I suppose we don’t always develop policies ourselves, it isn’t my area, but we would be influencing other people’s policies. Sometimes all we’ll do is just point out to lots of our colleagues on the council that they haven’t done a single bit of consultation on whatever they’ve decided to do, including consultations from our most vulnerable people – they’ve just come up with something. So often it’s basically highlighting the role of – and I say consultation – I prefer something more meaningful than that. In general. But, a lot of it is pointing it out that whoever’s been making decisions hasn’t done that thing. Or the consultations have been speaking to one person who’s in a community group. So, there’ll be a lot of that. However, some of my colleagues in things like physical activity, because they’ve been investing money and they’ve developed something that’s decided where the money will be invested, their consultation has been unbelievable. So, you know, they’ve had loads and loads of coproduction work going on, they’ve had kind of community journalist type stuff. This is where you’ll realise – they’ve been basically working with lots of different members of the community to shape exactly what we’re gonna do and where they money’s gonna be spent. It’s been fantastic. So, when we do things ourselves, some of the time, I think we’re amazing. And then I suppose the rest of it is telling our council colleagues have not done it right. In fact, a really good example is with a policy that was being developed which was in relation to that service review that was talking about – they sent this policy through which I wasn’t very happy with because it was for disadvantaged people. And they hadn’t done a bit of consultation on it. So, again, I just basically said – the thing that was putting them off doing the consultation was they had no idea what to do, they had no idea how to plan it, how to deliver it. And that’s gonna put somebody off, isn’t it? So, myself and my colleague just said “Look, we’ll do it, we’ll do it for you. Or we’ll do it with you” and that’s how I get them to do it. But obviously we can’t do that – we can’t offer to do peoples jobs for them, but it depends how important it is. If we think it’s really important for the community to be involved in a decision, then we might have to help those colleagues do it. Again, they’re trying to do that in between their normal job. So, yeah, it’s funny, isn’t it? We do sometimes probably criticise people for not doing something, but I think we do a good example ourselves

I: Great, thanks.