

Nobody left behind

Maximising the health benefits
of an inclusive local economy

Foreword

In the 21st century, we recognise that good health and wellbeing of the population are necessary for a flourishing economy. We also know that health, or the absence of it, results to a large extent from the social, environmental and economic conditions where people grow up, live, learn and work. Promoting conditions which protect and promote opportunities for people to be healthy, and not only to contribute but also to enjoy the benefits of a prosperous local economy, are at the heart of our work in local government.

It is not good enough to assume that where there is economic growth or development there will also be good health for all. We live in one of the richest countries in the world and yet there are still huge inequalities in health, and even in life expectancy, between regions of the country sometimes within different areas of towns and cities and between different groups of people within regions. In particular, there is still what Sir Michael Marmot has called a “health gradient”, reflecting the fact that inequalities in population health status are related to inequalities in social and economic status. To put it baldly, the better off you are, the better your health will be and the longer you will live.

This is not fair. We need to take action to ensure that all those who live in an economic area are in a position to benefit from its prosperity.

This publication makes explicit the links between health and the local economy, their interdependence, and the action that local authorities and their partners can take to ensure that health and wellbeing are key considerations in local and regional economic development strategies. Much of the work that Government can do to improve the economic prosperity of a country takes place at the national level. But the way local authorities tackle issues of local economic development can also make a positive difference to the wellbeing of the communities they serve.

I know that across the country, local authorities, supported by their public health teams, are making valiant efforts, in the face of significant financial constraints, to make this aspiration come true. I hope that the issues discussed here and the many examples of good practice will help ensure that, when it comes to our work of economic development, nobody is left behind.

Councillor Ian Hudspeth

Chairman, LGA Community Wellbeing Board

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Key messages

“The most successful levers of local economic development are those embodied in the core work of local government – ensuring people are healthy, skilled, employed, safe, mobile and engaged with their communities.”¹

- Many of the so-called health determinants are in fact economic determinants: the goals of developing the local economy to be more sustainable and productive, and of improving the health of the local population and reducing health inequalities, are interdependent.
- Health, wellbeing and economic objectives should be explicitly aligned as part of a strategic approach to the local economy. Councillors and officers both have an important role in ensuring that this happens.
- It cannot be assumed that economic growth in an area will automatically benefit the whole population or improve the health and wellbeing of everyone: strategies are needed to ensure that people across the whole of the ‘health gradient’ have opportunities to participate in the beneficial aspects of the local economy.
- Place matters: the relationship of health to economic development will vary with the industrial and employment history of an area, its geographical location, its current state of employment, unemployment and deprivation and its demographic profile. The focus should be on communities, not on organisations. Public health can play an important role in collating and interpreting relevant population-level data and supporting place-based partnerships in understanding and acting on the health impact of economic strategies.²
- The concept of anchor institutions – public sector and other organisations serving and served by the community, with a strong vested interest in its flourishing – is important for inclusive development. Anchor institutions in local authority areas should work together to maximise inclusiveness as employers, purchasers and investors in the local economy.
- Not all of the levers to affect change are in the councils’ gift. It is critical that councils know what provision is out there and can influence it.

1 Baars, S. (2014), ‘The levers of local economic development: a local government knowledge navigator evidence review’: www.solace.org.uk/knowledge/reports_guides/LGKN_NTK_ECONOMIC_GROWTH.pdf

2 ‘LGA response to Improving Lives – the Work, Health and Disability Green Paper’: www.local.gov.uk/parliament/briefings-and-responses/lga-response-improving-lives-work-health-and-disability-green

- Grow your own: policies which support local employers to develop and invest, to improve the skills of the local population and ensure they have opportunities for good quality employment are more likely to ensure that health objectives for the local population are met. Just attracting inward movements of existing capital from other areas, while important, does not necessarily 'trickle down' to local residents, especially those at the bottom end of the economic ladder.
- Community and voluntary sector involvement in developing economic strategies is needed to ensure that approaches to local economic development are beneficial to the health and wellbeing of all, looking beyond the traditional focus of economic development on the commercial and public sectors and focusing also on the role of voluntary and community organisations.
- Public health teams need to be pragmatic and professionally independent, but politically informed and committed to partnership working – the 'four Ps'. They cannot afford to shelter behind traditional narrow public health specialisms – the whole team must be engaged in brokering a health-improving local economy. This approach is supported by recent movement away from a narrow bio-medical model of health towards a social model of health, focusing centrally on the social, economic and environmental determinants of health.
- Councillors with a health brief need to act as informed ambassadors among other councils and partner organisations, bringing democratic legitimacy and therefore leverage to Local Enterprise Partnerships, unashamedly promoting good health and wellbeing as a social and economic value, being an exemplar of health-producing economic practice and an advocate of innovation. They no longer need to cling to traditional approaches for fear of acting 'ultra vires' (beyond one's legal power or authority).
- The Industrial Strategy should aim to invigorate towns and cities and support residents within them. Inclusive growth should be integral to it.

Why is inclusiveness in the local economy important for health?

“We want economic and social policy to do more than deliver economic growth. Policies should also be evaluated for their impacts on people’s lives.”³

Ensuring that the local economy benefits everyone – sometimes known as ‘inclusive growth’ – is a priority for local government. The concept of inclusive growth was originally developed by economists working in developing countries, when organisations such as the World Bank realised that economic growth was not always resulting in the reductions in inequality and increases in living standards that had been expected⁴. There is increasing evidence that the benefits of wealth and a flourishing economy will not simply ‘trickle down’ to the poorest sections of society.

Growth may not always lead to an improvement in wellbeing or an increase in the number of local people in employment. Indeed, the concept of economic ‘growth’ as an unproblematic objective is itself now controversial in the light of increasing concern about sustainability. Therefore, economic development strategies must explicitly contain measures to ensure that increases in the size and productivity of the economy benefit as many people as possible.

The OECD defines inclusive growth as:

“Economic growth that creates opportunity for all segments of the population and distributes the dividends of increased prosperity, both in monetary and non-monetary terms, fairly across society.”

For those who want to question the idea of economic growth as an ultimate objective, we could substitute the term ‘economic wellbeing’ or ‘economic prosperity’ as the objectives of economic development. Leaving this question to one side and looking at the OECD definition, it is clear that even in the most affluent countries, including the UK, the idea of inclusiveness in the benefits of economic activity is also an important one, and that, for local government, the objective of inclusivity should be central to local and regional economic development.

We know that many communities across the country feel disconnected and do not feel the benefits of economic growth in certain sectors and regions. The referendum on Brexit has highlighted this fact and provides a strong driver for inclusive economic development.

There are growing inequalities both between and within local authority areas. As the Joseph Rowntree Foundation has pointed out: “The dominance of London and the South East has led to a skewed economy, where economic opportunity is determined by where people live.”⁵ This skewing is also reflected within towns and cities, where some areas benefit from increased economic activity and others lose out and are left behind, increasing inequality.

⁵ JRF (2017) as above.

³ Marmot, M. (2015), ‘The health gap: the challenge of an unequal world’, London: Bloomsbury.

⁴ Joseph Rowntree Foundation (JRF), 24 January 2017, ‘How can cities deliver inclusive growth?’, blog post: <https://www.jrf.org.uk/blog/what-inclusive-growth-and-why-does-it-matter>. Many of the key concepts relating to inclusive growth outlined in this report are explained in this and other work by the JRF.

The economic determinants of health

Social, physical and economic environments and conditions have a far greater impact than medical care on how long and how well people live.

Poverty and deprivation have a detrimental impact on health

- There is a gap of 8.9 years between men living in the most deprived tenth of areas in England compared with those living in the wealthiest areas. For women, there is a 6.9 year gap in life expectancy between the bottom most deprived and the top.⁶
- People in the most deprived areas can expect nearly 20 years more of poor health than those in the least deprived areas.
- The figures for life expectancy, and also for healthy life expectancy, follow a straight line gradient almost exactly: on average, poor health increases with increasing economic disadvantage.⁷
- People living in the most deprived fifth of neighbourhoods have 72 per cent more emergency hospital admissions and 20 per cent more planned admissions than people living in the most affluent fifth of neighbourhoods.⁸
- Societies with greater economic inequality appear to experience worse health and wellbeing than those that are more equal. This is true not just for those at the bottom of the socio-economic ladder, but all the way to the top.⁹

“Failing to invest sustainably and equitably in local communities using local resources creates a ‘hollowing out effect’ within those communities, contributing to the risk of social isolation and uneven opportunities for health, wellbeing and development.”

Professor Dominic Harrison, Director of Public Health, Blackburn with Darwen

Poor health is bad for the economy

- Poor health reduces productivity and hampers economic growth. Estimates suggest that poor health costs over £100 billion a year in productivity.¹⁰
- Mental health issues in the workforce cost UK employers up to £42 billion a year.¹¹
- Twenty-three per cent of all working days lost are attributable to musculoskeletal health problems.¹²
- Socio-economic inequality costs the NHS in England £4.8 billion year in inpatient care, almost a fifth of the total NHS hospital budget.¹³
- 140 million working days are lost to sickness each year, costing the UK economy £15 billion.¹⁴
- Similar inequalities exist in other parts of the NHS, such as primary and specialist care: the total cost of socio-economic inequality to the NHS could be almost £20 billion a year.¹⁵

6 www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimdenland2013to2015

7 UCL Institute of Health Equity (2013), ‘Health inequalities and open space’: <http://publications.naturalengland.org.uk/file/4873926035374080>

8 Asaria M, Doran T, Cookson R (2016) ‘The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation’: <http://jech.bmj.com/content/70/10/990>

9 Wilkinson, R. G., & Pickett, K. E. (2009), ‘The spirit level: why more equal societies almost always do better’. London: Penguin.

10 Black, C. (2008), ‘Working for a healthier tomorrow’: www.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthier-tomorrow.pdf

11 Public Health England (PHE) and Business in the Community, ‘Mental health toolkit for employers’: <https://wellbeing.bitc.org.uk/all-resources/toolkits/mental-health-employers>

12 Public Health England and Business in the Community, ‘Musculoskeletal health toolkit for employers’: <https://wellbeing.bitc.org.uk/all-resources/toolkits/musculoskeletal-health-toolkit-employers>

13 Asaria et al (2016).

14 Lovell, N. and Bibby, Jo. (2018) ‘What make us healthy? An introduction to the social determinants of health’, (Health Foundation): <http://reader.health.org.uk/what-makes-us-healthy>

15 As above.

- Public Health England has estimated the financial outcomes per person of moving into employment:
 - financial benefits to the individual – £3,530
 - financial benefits to society – £23,070
 - financial benefits to the exchequer – £12,030 (of which accrue to national government £11,410, local authority £535, NHS £85).¹⁶

Learning and Work Institute calculations for the Joseph Rowntree Foundation (JRF)¹⁷ show that when a claimant moves into a job, on average:

- there are savings of £6,900 for government
- there is a £13,100 boost to the local economy
- there is a £6,500 gain to the individual.

For every £1 of direct (cashable) savings only 7p goes to the local authority, with 80p to central government and 13p to police, NHS, housing providers and others. Local government could find further indirect savings but these are more difficult to estimate, and usually can only be realised by reforming local services. Local government has neither a sufficient direct incentive to invest in services to reduce worklessness nor the control or influence over skills and employment budgets.

Economic inequality worsens health inequalities

We know that health inequalities increase under economic crisis and austerity.¹⁸ We also know from the important work of Professor Sir Michael Marmot, referred to in more detail below, that there is not a simple cut-off point below which people in poverty have worse health and lower life expectancy.

¹⁶ PHE (2017), 'Movement into employment: return on investment tool': www.gov.uk/government/publications/movement-into-employment-return-on-investment-tool

¹⁷ LGA, 'Realising talent', (2016): www.local.gov.uk/sites/default/files/documents/realising-talent-everyone-23e.pdf

¹⁸ Marmot, M. and Allen J. (2013), 'Prioritizing health equity', in 'Health in all policies: seizing opportunities, implementing policies', Ministry of Social Affairs and Health, Finland: www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf

There is a gradient in health which means that wherever someone is on the line from most to least deprived, they can expect to live longer and have more healthy years than those who are more deprived; and they can expect to live for less time and have more ill health than those who are less deprived.

Inequities in health are also higher for those who experience discrimination in access to services and in opportunities to participate fully in society, including in economic activity, based on gender ethnicity, sexuality, disability and social status. Health inequalities are not just a question of poverty but are related to broader economic inequality.

We can see from the above that the interconnectedness of health and the structural and economic conditions in which people grow up and live form a vicious circle: economic inequality contributes to poor health, and ill health holds back economic prosperity. Someone's income will determine to a considerable extent where they can live and therefore the quality of the built environment around them, their access to services, the distance they have to travel to work and their access to green spaces, all of which impact on their health and their ability to contribute to the economy.

Similarly, whether they live in a part of the country where it is difficult to find good quality work or any work at all, the type of work they do, the amount of autonomy and job satisfaction they have and their working conditions will all affect their mental and physical wellbeing. If the benefits of a flourishing economy were more evenly distributed, this vicious circle could be turned into a virtuous one, where everyone benefits and no-one is left behind.

The role of local government: a strategic approach

The connections between health and wealth described above lead to the conclusion that action on reducing health inequalities, and reducing demand on health and social care services, will not be solved by the health sector alone.

Local government has an important role to play as a key contributor to, and influencer of, the local economy and the health of the population, through its public and environmental health functions and its partnerships across the private and public sectors. Councils are uniquely placed in understanding their local economies and in their potential to link strategic infrastructure planning, land use planning and economic development with health improvement, and have established strong sub-regional partnerships with the business and public sectors.

The concept of an ‘anchor institution’ is a useful one in thinking about the role of local government, and other public sector organisations in general, in relation to the local economy. The term ‘anchor institution’ refers to large public sector or non-governmental organisations like local councils, NHS trusts and universities, whose long-term sustainability is tied to the wellbeing of the populations they serve.¹⁹ Anchors get their name because they have ‘sticky capital’ (they are unlikely to move, given their connection to the local population) and have a significant influence on the health and wellbeing of a local community through their sizeable assets and links to the community.

An anchor institution such as a local authority or an NHS trust has the ability to invest in a local area for mutual benefit, through participation in civic initiatives, through its purchasing power, through its employment decisions and pay, through working with other public sector institutions and the voluntary and private sectors on shared priorities, and through working together on an agreed local economic strategy that meets the long-term goals of both institution and region. By meeting objectives in relation to maximising local jobs, services and supplies, anchor institutions can create a ‘multiplier effect’, carrying out their core functions while at the same time contributing to an inclusive local economy.

There are a number of specific legal and policy tools available to local authorities as anchor institutions, and these are discussed further in section three below. The rest of this section considers more generally the role of the director of public health, the public health team and key councillors.

The role of the director of public health and the public health team

Across the country, many directors of public health are influencing their local authorities to take a ‘health in all policies’ or ‘health equity in all policies’ approach to their work. For directors and public health teams this has meant, in the first instance, learning about key local government functions; uncovering their impact on health; and educating councillors and senior colleagues about the social and economic determinants of health and the evidence of their impact.

¹⁹ Health Foundation (2018), ‘The NHS as an anchor’: www.health.org.uk/newsletter/nhs-anchor

It has also meant moving away from a narrower medical model of public health and being prepared to engage with politicians, specialists and staff across a wide range of local government functions. It has meant understanding the central objectives of these functions, and coming to a mutual understanding with colleagues and councillors about how these objectives can be enhanced for the wellbeing of the population by aligning them with health goals. In developing economic strategies, showing that a certain approach will help a number of collaborators meet their objectives is likely to be more successful than simply talking about health issues in isolation.

In promoting a 'health in all policies' (HiAP) approach in the context of economic regeneration, public health directors and their teams need, in a sense, to be all things to all people. They must engage a range of partners from local government, its partners and stakeholders to work together to improve health and health equity and, at the same time, advance other goals, such as educational attainment, improved housing and green spaces, environmental sustainability, promoting job creation, good quality and adequately paid work and economic stability, all of which impact on the local economy.

For example, building cycle and pedestrian infrastructure creates more jobs, decreases air pollution and greenhouse gas emissions and increases physical activity, which improves both health and academic performance of children and young people. And 'farm-to-fork' activities help to protect agriculture (which may be an important consideration in the light of Brexit), support local economies, and increase healthy eating and access to fresh food in deprived communities.

This approach is facilitated by the increasingly important role of the concept of 'place' over the last two decades, in inter-sectoral approaches to social, economic and environmental wellbeing at a local level. Different approaches to economic development are appropriate in different areas.

For example, levers for economic development need to be sensitive to the specific challenges present in rural areas. In such areas, an approach based on attracting international capital and industry-building may not be suitable. A focus on workforce development, business retention, small business incubators and job training may be more appropriate.²⁰ Similarly, the relationship of health and wellbeing to the local economy is determined to a large extent by the traditions of local industry, the history and profile of migrant populations in the area, its regional location, whether it is largely urban or largely rural and so on.

Public health teams have increasingly been included and have forged a role for themselves in place-shaping policy discussions. They are well placed to strengthen the links between local authorities and the NHS, for example, in coming together to use their power as anchor institutions, including developing plans for a two-way skills exchange. They also have a role in developing greater understanding across all partnerships of population health, for example in relation to whole-system public health approaches to health-related worklessness.

Public health teams need to be flexible in their approach, able to see opportunities for health improvement and reducing health inequalities in possibly unfamiliar areas, and able to act as leaders, influencers and innovators. They need to demonstrate that they are willing to learn from politicians and professionals and frontline staff in other fields. The economic development of an area, and the benefits that do and do not flow from it to the local population, cannot be undertaken by any one organisation alone. Effective co-ordinated action needs to be driven by political will and political priorities, as well as the commitment of national and local partners and business. Sometimes this is difficult to secure, particularly in times of economic austerity and competing priorities.

20 Baar, S. (2014) as above.

Different central government departments and their agencies – including Jobcentre Plus, the National Careers Service and the Education and Skills Funding Agency – are directly responsible for employment and skills policy, design, funding and oversight. None of them have a common plan for how to work with each other or a duty to discuss with councils and combined authorities how services will operate in their local areas. Local areas, therefore, have little ability to influence their priorities, funding or delivery.

Research for the LGA counted 20 employment and skills funding streams managed by eight departments or agencies, totalling more than £10 billion a year (2016/2017). Despite the magnitude of this spend, they often fail to meet local needs, address economic and social challenges, or make a decisive impact on outcomes.

All this means that public health directors and their teams need to see their role in ensuring that local economic development is inclusive, and that health production, as well as wealth production, should be a long-term commitment, involving allies right across the public and private sectors.

It is specifically the economic determinants of health that are relevant to the issues discussed in this guide. However, as the list of policy areas above indicates, from the perspective of the local workforce, it is impossible to divorce strictly economic issues from matters such as educational opportunities and the working and living environment, especially when trying to factor in health considerations. In looking at these issues and developing a role for public health, advocates of a HiAP approach propose starting with the policy area itself, rather than with a public health issue.²¹

The idea is that this encourages thinking about the range of potential direct and indirect benefits and risks for health that can be created from that policy, rather than ‘just’ addressing obesity or mental health, for example.

Starting with a policy issue also demonstrates that this is about the core activities in that policy area, rather than a health ‘add-on’. Developing internal partnerships across the council’s functions and external partnerships with key sectors, taking a place-based approach, can also lead to shared funding across programmes, additional staff time to support a health-informed approach, and contributions from public health experts and colleagues and partners with economic and other technical expertise.

Participating in strategic economic development therefore requires public health teams to take an approach based on collaboration, partnership, structured interaction and ongoing relationships. It is important to emphasise that such an approach is not about public health taking over the remit of other areas, but about ensuring that there is a common understanding of health and health inequalities across the council and among partners. It is about a common way of analysing the health impact of the range of council functions, a common commitment to maximising the positive health impact of all of these functions, and, very importantly, exercising them in a way that is inclusive and will reduce inequalities. It is important that this approach is led not only by the director of public health (DPH), but also by senior council officers and by all councillors, across the whole of the council’s activities.

In short, public health teams need to be pragmatic and professionally independent, but politically informed and committed to partnership working – the ‘four Ps’.

²¹ See LGA (2016), ‘Health in all policies: a manual for local government’: www.local.gov.uk/health-all-policies-manual-local-government

The role of councillors

Ensuring that everyone in the population is able to take advantage of good-quality training and employment is central to this agenda, as is ensuring that the job opportunities are there. Taking a strategic approach to these two objectives potentially calls on local authorities' functions and place in the community in a vast range of ways.

Taking action to improve the health of a population and reduce inequalities in health should not be seen as a separate health agenda, but should both underpin and build on all of local government's work to promote economic regeneration. This includes councillors playing an active strategic role in:

- the availability, variety and quality of employment, both on the supply and on the demand sides
- addressing terms of employment and employment practices, underemployment and unemployment
- education and skills training, ensuring people are ready for the opportunities that will become available to them: this has to start in the early years
- the physical environment in which people work
- the public spaces they travel through and use while carrying out their business
- the transport and communications infrastructure, including digital communications, that supports employment and training
- the availability, quality and affordability of housing that has access to centres of employment.

All of the above are central to the concept of an inclusive local economy. They are also, of course, central to the concepts of 'place' and 'place-shaping' which have provided a framework for local government's activities for some years and are recognised as significant for health and wellbeing.

The connections between health and local government's role in these activities are discussed further below. Each section concludes with a set of questions which councillors and public health specialists may find helpful in thinking about their contribution to inclusive economic development.

Taking a strategic approach: questions for councillors

1. How can you use your political leadership and democratic role to influence the development of economic strategy that is inclusive of the whole of your community?
2. Are health and wellbeing reflected in the economic plans and indicators that have been agreed for your region?
3. Have specific funds been identified for investment in economic development that will have a beneficial health impact?
4. Are you working with other anchor institutions in your area to ensure you can use your collective position to maximise local good-quality employment, your purchasing power and your assets?
5. Are you making the most of your public health team in promoting the arguments for health and wellbeing as economic objectives?
6. How can you help create a consensus in local and regional discussions of economic development that it is entirely legitimate to invest in social as well as capital programmes?

Taking a strategic approach: questions for public health

1. Has your council explicitly agreed a 'health in all policies' approach?
2. Has your public health team developed its own strategy and success measures for influencing economic planning for the area?
3. Does your joint strategic needs assessment (JSNA) include explicit references to the links between health and wealth and the need to address each in mutually reinforcing objectives?
4. Can you support your councillors in developing health and wellbeing priorities and indicators that can be included in economic plans/strategies for the area?
5. Can you support the inclusion of health and wellbeing in local economic planning with evidence that this makes good economic sense, for example by looking at the risks and benefits of taking (and not taking) this approach?

The tools in the local authority toolbox

In addition to the statutory public health powers and duties conferred with the transfer of public health to local authorities, and to the powers and duties relating to specific local authority functions, there are a number of tools which can help local authorities promote and support a local economy which is inclusive and pays attention to health.

In addition to their public and environmental health functions, these include their economic development, education, social care, housing and planning functions, provision of advice, enforcement of employer legal obligations, partnership working, incentivisation, accreditation and contractual levers of procurement. Important tools available to local government with potential to maximise the health benefits for all of local economic development are outlined below.

The power of competence

Under the Localism Act 2011, local authorities in England have a 'general power of competence' enabling them to do 'anything that individuals generally may do' (except anything that is specifically prohibited in other legislation). The purpose of introducing the power was to enable and encourage local authorities to move away from their previously cautious approach to innovation and joint action, which was seen as limiting their contribution to the improvement of the quality of life and health of their communities, among other issues.

The general power of competence provides wide scope for councillors with health responsibilities and for directors of public health to take action. The breadth of the power has removed the need for local councils to rely on other legislation in order to take particular action. Instead, councils can look to the power in the first instance – they can regard it as a 'power of first resort'. The power cannot, however, be used to raise taxes, although it has no spending limits and enables local authority funds to be spent on particular purposes.

Health and wellbeing boards

Health and wellbeing boards (HWBs) are statutory committees of upper-tier local authorities under the Health and Social Care Act 2012. Their stated purpose is to enable local authorities to improve the health and wellbeing of the people in their area, reduce health inequalities and promote the integration of services.²² Some HWBs have been more successful than others in taking an 'upstream', preventive approach to their activities. All HWBs have been, to a certain extent, preoccupied, sometimes to the exclusion of consideration of the wider social and economic determinants of health, with changes in the NHS over the last several years.

²² Section 197 to 199 of the 2012 Act: www.legislation.gov.uk/ukpga/2012/7/part/5/chapter/2/crossheading/health-and-wellbeing-boards-supplementary/enacted

Nonetheless, as bodies which are intended to work as partnerships with representation from a wide range of local organisations, they have considerable potential to raise awareness and influence local approaches to economic strategies, so that they have regard to their potential health impact and potential impact on health inequalities. For example, HWBs can include councillors with an economic brief and/or local employers among their members, and can develop their own strategies to ensure that the health of the whole population is a key issue in local economic development.

Local Enterprise Partnerships

There are 38 Local Enterprise Partnerships (LEPs) across England. They are voluntary partnerships between local authorities, the business sector and other stakeholders. They play a central role in determining local economic priorities and undertaking activities to drive economic growth and job creation, improve infrastructure and raise workforce skills within the local area. LEPs are led by a business chair and board members include local leaders of industry (including small and medium-sized businesses), educational institutions and the public sector, including local authorities.

All LEPs differ in the way they operate, which means that influencing LEPs can be a challenge. However, it is worthwhile putting some effort into ensuring a public health input into LEP deliberations because they are so influential in developing economic priorities and strategy for an area.

The Government has said every combined authority and LEP will have a local industrial strategy by 2020.

A five-point plan for influencing LEPs

1. Understand the extent of existing relationships between the local authority and the local NHS and your LEP, including who participates in meetings and who is represented on boards (including LEP-level employment and skills panels/boards).
2. Discuss informally with councillors and colleagues from across your local authority, further education, the NHS, higher education and the third sector, the level and success of their interaction and engagement with the LEP.
3. Review existing public LEP strategies around skills and employment, highlighting points of potential alignment and making your own assessment as to how far they will contribute beneficially (or adversely) to the health of your population, with special emphasis on its most deprived. Start conversations about how the local industrial strategy will be developed.
4. Collate relevant data on health and health inequalities and the impact of employment, unemployment, underemployment and skill levels on health. LEPs require a clear evidence base for their priority investment areas. The data should highlight the role of local authorities and the NHS as major employers, their employment base, skills gaps and needs and relevant demographics. 'LG Inform' (<https://lginform.local.gov.uk>) has a range of indicators on local authority-level skills/employment which can be compared to the wider LEP area.
5. Try to find a way of having direct representation on the LEP, either on the board or through any relevant sub-committees, working parties or task forces. Brief your councillors and/or officers who are already representatives on the LEP about the relevance of health issues to its work. Given that boundaries are not exact, speak to neighbouring colleagues to understand

who should approach which LEP.

Adapted from NHS Confederation 'How to influence local enterprise partnerships': www.nhsconfed.org/-/media/Confederation/Files/public-access/How-to-influence-local-enterprise-partnerships.pdf

Combined authorities

Combined authorities are a key element in the devolution of powers, funding and responsibility for public policy to local authorities and sub-national partners. Spanning local authority boundaries, combined authorities offer new opportunities for coordinated intervention in key policy areas such as economic development, transport, skills, health and social care. They are formed by councils wishing to work more closely together to support common strategic aims, often motivated by a clear functional economic geography across their shared area. The onus is on combined authorities to make the case for drawing down powers and resources and, in that respect, there is considerable potential for combined authorities to learn from each other. To date, nine combined authorities have been formed.

Devolution

City Deals are bespoke packages of funding and decision-making powers negotiated between central government and local authorities and/or Local Enterprise Partnerships and other local bodies. They are part of the localism and devolution agenda. More than 25 deals have been agreed so far (May 2018) covering the largest cities in England, and more are in the pipeline. Components of deals vary from city to city and can include any of the following, or other agreements yet to be decided:

- investment in housing, transport and infrastructure generally
- the involvement of the business community in skills provision and the creation of apprenticeships

- targets for output growth and the creation of thousands of new jobs
- targets to cut youth unemployment
- targets for public and private sector investment
- reductions in carbon emissions and investment in green energy
- investment in super-connected broadband infrastructure and digital technology
- investment in specific industry and employment sectors to enable the city in question to become known as a centre for that sector.

These deals are obviously important for the regions in question, which cover a large part of the country (including rural areas in some cases, since they cover regions and the hinterland of cities, not just the cities themselves).

The City Deals provide the potential for public health advice and involvement in the way that they are implemented. While some of them explicitly aim to increase skills, thereby increasing opportunities for local residents to participate in higher-quality, better-paid employment, there is still significant potential for people in the most deprived communities to lose out, unless their skills and employment opportunities and the impact of these on health and life expectancy are specifically addressed. Although all the City Deals include objectives in relation to skills, employment and quality of work that would have a health impact, so far none of them have included a health component in their headline targets. Working to include an explicit health objective would be a real coup for a public health team.

Cities and regions with City Deals will no doubt be learning from each other's experiences, and other areas that are not yet part of City Deals can learn from those with them.

There are opportunities here for directors of public health and their teams to share learning with each other about how best to maximise the positive health impact of City Deals and ensure they reach those who are most deprived and vulnerable, with the worst health and life expectancy prospects.

The Social Value Act 2012

The Public Services (Social Value) Act came into force on in January 2013. It requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. The Act is a tool intended to help commissioners get more value for money out of procurement, and to be more creative and less cautious in using their commissioning role. When the Act was introduced, it encouraged commissioners to talk to their local provider market or community to design better services and to find new and innovative solutions to difficult problems.

Before they start the procurement process, commissioners need to think about whether the services they are going to buy, or the way they are going to buy them, could secure additional 'social value' for their area or stakeholders.

One additional intended effect of the Act is to make it easier for small suppliers to bid for public sector contracts (for example, by abolishing complex pre-qualification questionnaires which previously tended to shut small suppliers out of bidding). Enabling small suppliers to bid, and including the possibility of assessing the value of commissions under a wider definition of value, opens up much greater opportunities for local authorities and other local 'anchor' public sector institutions, including the NHS, to let contracts go to local suppliers, including the voluntary and community sector. This helps to grow local businesses/community organisations and offers enhanced job opportunities to local residents.

It also means that local authorities and other public sector organisations can work with larger organisations to bring added value to service contracts in a variety of ways.

Clearly, there is scope here to tackle the economic and social determinants of health and to use the council's commissioning role to lever inclusive procurement which reaches out to even the most disadvantaged groups of local residents.

Creating social value has clear connections with efforts to reduce health inequalities through action on the economic and social determinants of health – for example, by improving employment and housing. Some of the ways in which local authorities can maximise the benefits of the Social Value Act are outlined below. Public health teams are well placed to use both their specialist knowledge and skills, and their networks across communities, to contribute to each of these:

- working with local businesses and voluntary and community organisations to help them to understand the purpose of the Act, how they can incorporate social value in the design and provision of services and how to bid for contracts
- working with potential contractors, both large and small, to design and introduce innovative ways of bringing added value to the commissioning process and to contracts
- writing social value outcomes into service specifications
- developing methodologies for assessing the additional value provided by social value contracts and measuring social value, including developing frameworks which show how health outcomes are a contributor to social, economic and environmental benefits
- developing processes to ensure that the social value added through commissioning is inclusive, reaches disadvantaged groups and contributes to reducing inequalities.

Examples of social value which have been included in contracts and which have a clear link to health benefits include:

- employing local residents or target groups, such as young unemployed people or people with a history of mental health problems
- building local supply chains
- procuring with the voluntary, community and social enterprise sector
- working with schools and young people
- requiring contractors to pay a living wage
- minimising negative environmental impact.²³

The Equality Act 2010

The Equality Act 2010 includes a public sector equality duty, which requires local authorities and other public bodies to have regard to reducing inequalities in outcomes as a result of socio-economic disadvantage.²⁴ This duty can be of relevance in a very wide range of local authority activity, including economic development strategies. The 'protected characteristics' defined by the Act cover significant sectors of the population who are most socially and economically disadvantaged, and hence most disadvantaged in terms of health.

The protected characteristics are:

- age
- disability
- gender reassignment
- marriage or civil partnership (in employment only)
- pregnancy and maternity
- race

²³ Public Health England/UCL Institute of Health Equity (2015), 'Using the Social Value Act to reduce health inequalities in England through action on the social determinants of health': https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/460713/1a_Social_Value_Act-Full.pdf

²⁴ Government Equalities Office (2011), 'The Equality Act 2010: public sector quick start guide to the specific duties': www.gov.uk/government/publications/public-sector-quick-start-guide-to-the-specific-duties

- religion or belief
- sex.

Of course, different groups experience different kinds and levels of disadvantage, and even within the protected characteristics there are variations in people's health. For example, among minority ethnic groups, persistent inequalities are seen in the health of Pakistani and Bangladeshi women (illness rates 10 per cent higher than white women), while people of Chinese origin have persistently better health than both white men and women; and ethnic inequalities in health are more pronounced in older ages. Since health inequalities are determined by wider social and economic inequalities, local intelligence on such inequalities gathered by public health teams, working with other local authority colleagues, should help to determine local economic strategies, as well as strategies specifically related to health.

Using the tools in the toolbox: questions for councillors

1. Is your council using each of the tools described above in furtherance of inclusive local economic development?
2. Do you understand how the tools can be used to include health as part of inclusive economic development?
3. Do you understand your area's population sufficiently to know which groups might be losing out in relation to the local economy, including particular ethnic groups, people of certain ages, types of employment, certain skills and so on?
4. Have you been able to use any of the tools in an innovative way to enhance the health benefits of the local economy?
5. Do you have evidence that the use of the tools in your area is genuinely inclusive and designed to boost the economic prosperity, and hence the health, of all your residents – including the most disadvantaged groups?

Using the tools in the toolbox: questions for public health

1. Do you understand the potential of each of the tools described above to address the economic and social determinants of health and reduce health inequalities?
2. Are you taking a strategic approach to public health involvement in relation to each of the above tools?
3. Can you assist your councillors in understanding the health status of different sectors of your population and how it relates to their economic status?
4. Can you assist councillors to make the most of the tools by devising measures to assess how inclusive they are and how they are making a difference to the economic and social determinants of health?
5. Does your health and wellbeing board include strategies to use the above tools in its health and wellbeing strategy? Does it have regular opportunities to discuss whether local use of the tools is maximising beneficial health impact across all socio-economic groups?

Action by local authorities

The following sections discuss the areas in which the inter-relationship between health and the local economy can be influenced by local government to impact as widely and deeply as possible to the benefit of the local population. The sections below follow roughly the priority areas identified in 'Fair society, healthy lives', Professor Sir Michael Marmot's 2010 review of health inequalities²⁵ in the UK, whose analysis and recommendations have been widely adopted by councils. These are:

- giving every child the best start in life
- enabling all children, young people and adults to maximise their capabilities and have control over their lives
- creating fair employment and good work for all
- ensuring a healthy standard of living for all
- creating and developing sustainable places and communities
- strengthening the role and impact of ill-health prevention.

Discussion of the sixth priority, focusing on ill-health prevention, follows in the sections below.

The best start in life

How well they are supported in their early years (from 0-5) determines, to a large extent, people's life chances, including their future employment. A child's physical, social and cognitive development strongly influences how ready they are to start school and their educational attainment, as well as their health

²⁵ Marmot, M. (2010), 'Fair society, healthy lives': www.gov.uk/dfid-research-outputs/fair-society-healthy-lives-the-marmot-review-strategic-review-of-health-inequalities-in-england-post-2010

and employment prospects as an adult.²⁶ Cognitive development in the early years is also linked to the socio-economic status of a child's parents, with implications for the child's readiness to thrive at school.²⁷

Local authorities, as public health, social care and education authorities, have a direct responsibility in relation to supporting children to thrive in the crucial early years, through:

- their health visiting and social care roles, specifically their responsibility for public health commissioning for children under the age of five and for child protection
- their responsibility to ensure that children can access free nursery education and high-quality childcare for working parents
- their role in the provision of children's centres
- their duty to improve the outcomes of under-fives and close the gaps between those with the poorest outcomes and the rest
- their public health duty to implement the national child measurement programme.

Childhood obesity, tooth decay and injuries are all associated with a range of health and psychological problems, both in the short and long term. These are all issues that are the direct concern of public health teams, but cannot be tackled without the wider support of the local authority, for example in its work to prevent traffic accidents.

²⁶ The Marmot review as above.

²⁷ National Children's Bureau (2016), 'Foundation Years and the UK Government's life chances strategy': www.ncb.org.uk/sites/default/files/uploads/documents/Policy_docs/Consultation_responses/ncb_submission_foundation_years_inquiry.pdf

The best start in life: questions for councillors

1. Do you understand the health status of children aged 0-5 in your area, the gaps between the poorest and most well-off and how this contributes to their future life chances?
2. Do you understand the full range of local authority responsibilities that can contribute to improving health and reducing health inequalities in the early years?
3. Do you understand how your council compares to comparable areas in terms of levels of school readiness?
4. What measures have you been able to take to protect the relevant services for under-fives and their parents in the face of financial stringency?
5. Do you receive regular updates to track progress towards general health improvement, but also towards closing the health inequalities gap for 0-5s?

The best start in life: questions for public health

1. Have you given key councillors the relevant facts to understand the links between early child development and future life and employment chances?
2. Is your public health team aware of the relevance of other local authority functions to early years life chances?
3. Are you proactively working with other departments, for example on traffic management, to mitigate the negative impact of economic and environmental circumstances in the early years of your population?
4. Are early years inequalities and improvements discussed by your health and wellbeing board? Do board members understand the impact of the early years on future life chances, including people's role in the local economy?

Maximising capabilities: educational attainment

We know that supporting children and young people to achieve their potential is a vital issue for the education system, for young people themselves and for their families, affecting quality of work and future earnings, involvement in crime, morbidity and death.²⁸ Yet too few young people reach that potential by the time they leave school.²⁹

For pupils leaving education, GCSEs will determine the kind of work they will be offered, while for pupils continuing in education, results will determine the courses open to them at the next level. Being eligible for free school meals is an indicator of deprivation and poverty. Only a third of those eligible for free school meals in 2014-15 achieved five good GCSEs, while nearly twice as many of those not eligible for free school meals attained this level. There has been little change in the size of the attainment gap between these two groups of young people in recent years.

Research evidence shows that education and health are closely linked:

- pupils with better health and wellbeing are likely to achieve better academically
- effective social and emotional competencies are associated with greater health and wellbeing and better achievement
- the culture, ethos and environment of a school influences the health and wellbeing of pupils and their readiness to learn
- there is a positive association between academic attainment and physical activity levels of pupils.³⁰

28 Public Health England, 'Health profile for England, 2017' (chapter 6): www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health

29 This sub-section and the next draw extensively on the 2016 response of Public Health England to the Inclusive Growth Commission.

30 Public Health England (2014), 'The link between pupil health and wellbeing and attainment': https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf

The above points indicate that whatever local authorities and their public health teams can do to assist schools in supporting the physical and emotional wellbeing of their students will help to improve both educational attainment and future life chances.

While schools themselves can do much to raise the physical activity levels of students, local authorities have a wider role to play in making the environment in which young people grow up one in which 'the healthy choice is the easy choice'. That is, it should be easier for young people to choose activities involving physical exercise than those that do not. This means making walking and cycling to and from school easy, pleasant and safe, and ensuring access to parks, green spaces, leisure and sports facilities – and in particular improving access for those from the most deprived areas.

Diet may also have an impact on young people's ability to learn – for example eating breakfast, compared to skipping it, has a positive influence on short-term cognition and memory. Breakfast clubs are perpetually short of funding, but not only can they make a difference to school students' health and attainment, they also enable some parents, in particular single parents, to enter training and achieve employment.

Many councils, with advice from public health teams, have placed planning restrictions on the number and type of fast food eating places located near schools and other areas where young people congregate. Many councils, again with support from public health, have worked to ensure greater access for families to, and understanding of, the benefits of fresh fruit and vegetables, for example through farmers' markets, community gardens and allotments.

Young people need conditions that are conducive to learning at home, as well as at school – so the local authority role in reducing overcrowding and homelessness, and in providing accessible and affordable housing for families with children, is also relevant. Public health teams have a role to play in developing strategies around health and

planning, health and leisure and health and housing.

One area in which public health teams can directly work with schools is in developing a whole-school approach to social and emotional learning.

Members of health and wellbeing boards and NHS trusts may not have had the opportunity to consider the inter-relationship between health and educational attainment and its impact on employment and the local economy. Councillors and public health members of boards have an opportunity to provide data and local intelligence linking these issues, and to promote a cross-sectoral approach to them, as part of inclusive economic development.

Educational attainment: questions for councillors

1. Do you understand how health and wellbeing are correlated with educational attainment in your area? For example, how does entitlement to free school meals correlate with educational and health indicators?
2. What measures are you taking to support the most vulnerable students – such as those with physical or learning disabilities, mental health issues or looked-after young people – in improving educational attainment and achieving health and wellbeing standards?
3. Have your health and wellbeing board or your NHS trusts, or other local employers, had the opportunity to discuss this issue and its relation to health and the local economy?

Educational attainment: questions for public health

1. Are you producing data useful to those with an interest (councillors, NHS trusts, other local employers, universities) showing graphic correlations between health and wellbeing, educational

attainment, poverty and deprivation and local employment take-up?

2. How are you monitoring these issues in relation to the most vulnerable children?
3. What are you doing to help schools support whole-school health and wellbeing policies and policies targeted at vulnerable and low-achieving school students, and how are you measuring their effect on educational attainment and ultimately employment opportunities?

Maximising capabilities: young people not in education, employment or training

There were 794,000 people in the UK aged 16-24 who were not in education, employment or training (NEET) in the final quarter of 2017, 11.2 per cent of all people in this age group.³¹ Since 2011 the number has been falling, but this is still a disturbingly large number for a country whose jobs market is likely to undergo major changes following Brexit. We know that:

- spending time not in employment, education or training has a detrimental effect on physical and mental health
- this effect is greater when the time spent 'NEET' is at a young age or lasts for longer
- being NEET occurs disproportionately among those experiencing other sources of disadvantage
- because the chances of becoming NEET follow a social gradient, reducing the number of young people in this situation could help to reduce health inequalities.³²

³¹ House of Commons Library research briefing, March 2018, 'NEET: young people not in education, employment or training': <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06705>

³² These points are made and the issue of NEETs and health are discussed in detail in: Allen, M. for IHE and PHE (2014), 'Local action on health inequalities: reducing the number of young people not in employment, education or training (NEET)': https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/356062/Review3_NEETs_health_inequalities.pdf

Local authorities have specific responsibilities to young people not in employment, education or training. Evidence of what works to reduce the proportion of young people in this group requires early intervention and working across organisational and geographical boundaries and with local employers. Tracking people and monitoring and evaluating progress are also important.

As with many of the other topics covered here, there is a role for public health in:

- providing evidence to those working with young people who are NEET, and to young people themselves, about its detrimental health impacts
- identifying cohorts of young people such as children entitled to free school meals, young disabled people, young parents and people from certain ethnic backgrounds who are most at risk of being NEET
- providing evidence of effective measures to mitigate the risks of being NEET among such groups
- developing frameworks and indicators to measure the health impact of interventions to support young people who are NEET.³³

Young people who are NEET: questions for councillors

1. Do you know how many young people in your area are not in education, employment or training (NEET), where they are and why they are NEET? Do you understand their health and wellbeing status?
2. What are you doing to support them into education, employment and training?
3. Can you involve the local community in supporting young people in danger of becoming NEET and those who already are?
4. How do you ensure that the most vulnerable are getting the support they need?

³³ House of Commons briefing, March 2018, as above.

Young people who are NEET: questions for public health

Do you have measures in place to identify those most at risk of being NEET and to assess the health and wellbeing status of young people in your area who are NEET?

Can you provide evidence to your councillors and other relevant stakeholders (such as the youth service, social services, the Department for Work and Pensions and young people themselves) about the health impacts of being NEET and what interventions are likely to work in mitigating these effects?

What measures are in place to support young people who are NEET in coping with these health impacts (for example support for resilience, physical health, access to health, sexual health and other services such as leisure services)?

Maximising capabilities: skills

The LGA has predicted that by 2024 there will be:

- more than four million too few high-skilled people to take up available jobs
- two million too many people with intermediate skills
- more than six million too many low-skilled people.

This is clearly a matter of serious concern and the Government has included skills development as part of its Industrial Strategy. The nature of work is changing with technological and other global developments and the skills required are different from those that were required even 10 years ago. There is a widespread view that people will need to change jobs and even move between different sectors in future. If this is correct, it means that access to high-quality skills training will be important not only for young people, but also for all adults of working age.

Skills policy is perhaps the most important lever for local economic development. Local authorities can play a direct role in creating apprenticeships themselves, but also in using their power of procurement and the provisions of the Social Value Act to encourage suppliers to do the same. Public health teams can support this approach by providing information on the relationships between different types of employment and their impact on physical and mental health, and by disseminating this information to local employers and LEPs. This in turn can be used, along with other considerations, to help determine the type of skills the local authority and the local economy should be developing.

The level of skills people attain affects, of course, not only whether they can get a job, but also the quality of work and the level of pay they can achieve. Both of these can affect people's mental and physical health, including how long they live, as the next section considers.

Skills: questions for councillors

1. How satisfied are you that the skills strategy for your area is giving your young people, and others, the skills to obtain good-quality employment in the world of work of the future?
2. Have you taken or can you take a lead in creating partnerships between employers and training providers, or plug into existing ones, to develop skills strategies based on the skills that employers want and that will best maintain the health of workers?
3. Is your area geared up in terms of the infrastructure and skills needed to ensure local people benefit from inward investment or investment in existing local employment? Can you facilitate partnerships between inward investors, existing employers, local universities, national government agencies and your own authority to ensure the right support services, advice, infrastructure and skills are provided?

4. Can the council, as an anchor institution and major employer, use its own employment strategies to help people develop their skills? Can you work with other anchor institutions to do this (for example by funding joint apprenticeships or other training programmes)?
5. Can the council use its procurement role to influence other employers to provide skills and other training opportunities to employees and future employees, including those whose work may change with the changing nature of employment, and small employers who may not have sufficient resources to support skills training?

Skills: questions for public health

1. Can you assist in the development of a skills strategy for the local area by identifying health-producing skills and evidence of their relationship to health and wellbeing?
2. Can you link this to information you provide to your councillors on the health impacts of different types of occupation, and hence to the type of skills training they should be encouraging and avoiding?
3. How can you use your role within the council, together with your relationship with the local NHS, to develop a strategy for using their organisational employment and training strategies to develop appropriate skills among the local workforce, including providing support for vulnerable or otherwise disadvantaged groups?

Fair employment and good work for all

“Local economic development should be about development of the community rather than development in the community”.³⁴

As with the relationship between poverty and deprivation, life expectancy and healthy years of life, there is a social gradient in employment, with those who are generally more deprived being more likely to be unemployed than those from less deprived backgrounds. Unemployed people have a greater risk of poor health than those in employment, but the way that work is organised and the environment in which people work also contribute to the social gradient in health. Lower-paid workers with fewer skills or qualifications are more likely to experience poor psychosocial working conditions and worse health.³⁵

Being in employment has health benefits: work is generally good for health

- employment is generally the most important means of obtaining an adequate income, which in itself is a determinant of health
- work meets important psychosocial needs in societies where employment is the norm
- work is central to individual identity, social roles and social status
- employment and socio-economic status are the main drivers of social gradients in health.³⁶
- In-work poverty is on the rise in the UK, in part due to low wages and insecure, part-time jobs. Over half of children in poverty now live with at least one working parent. Eight million people in poverty in the UK live in a working household, and average weekly earnings are falling in real terms (at January 2018).³⁷

³⁴ Baars, S. as above.

³⁵ Public Health England and Institute of Health Equity (2014), 'Local action on health inequalities: increasing employment opportunities and improving workplace health': www.gov.uk/government/uploads/system/uploads/attachment_data/file/356064/Review5_Employment_health_inequalities.pdf

³⁶ PHE (2014) as above.

³⁷ Office for National Statistics, 'UK Labour market statistics', March 2018: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/>

- We are increasingly learning about the detrimental health effects of working in the 'gig economy' or on zero-hours or part-time contracts, with work being handed out to a dispersed workforce, often working isolated and alone, on a job-by-job basis, with no guaranteed minimum hours or income, almost no security and none of the workplace protection won by trade unionists and politicians over the twentieth century.³⁸
 - temporary work arrangements have been associated with health problems including poor self-perceived health, liver disease, mental disorders, absenteeism, stress, and alcohol- and smoking-related deaths
 - long or irregular working hours or shift work can affect health – working more than 11 hours a day is associated with an increased risk of heart attack and type two diabetes
 - shift workers have a higher risk of cardiovascular disease, metabolic syndrome and accidents than daytime workers, particularly those who have been shift workers for longer
 - night shifts have been linked with more work accidents, cardiovascular and gastro-intestinal problems and eventually cancer³⁹
 - job insecurity can pose as much of a threat to health as unemployment.⁴⁰
- Working conditions can impact health in a number of other ways: physical, chemical or ergonomic hazards in the workplace, such as solvents, pesticides, asbestos, noise, radiation, vibration, repetition and heavy lifting, can result in a range of diseases and injuries including lung fibrosis, neuropathy, deafness, organ damage and cancers, among those who are exposed.

Work is only good for health if it is adequately rewarded, safe, fair, secure, fulfilling, supportive and accommodating⁴¹

This means that not only do local authorities need to consider the volume of employment that local economic strategies may help to deliver, but also the quality of the work available. In particular, to ensure that the local economy benefits everyone (and not just those who are best placed to take advantage of good jobs), councils need to be aware of how poor-quality work can be detrimental to health, and what they can do to make a difference. Measures to improve the quality of work and working conditions that focus more attention on workers in lower-grade occupations may help to reduce inequalities in work-related health problems.

Public health can help by providing information and evidence for the council on how the quality of work and working conditions can impact health, particularly of those in lower paid and insecure jobs, and what can be done to mitigate this; and by working with local employers to develop ways of working that will be better for the health of employees, and which may even improve productivity and the health of businesses themselves.

The local authority as an employer

Local councils are often one of the largest employers in the local area: local government in England collectively employs around one million full-time equivalent staff. Given that employment is vital to good health, and that working for a council usually provides better-paid, better-quality and more secure employment than many employers, with opportunities for promotion and wage rises, increasing the number of people a council employs locally may provide an opportunity to increase the impact that it has on the wellbeing of its community.⁴²

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38 Personnel Today (January 2018), 'How gig economy compromises health and wellbeing of workers': <https://www.personneltoday.com/hr/gig-economy-threat-zero-hours-workers-health-safety/>

39 All sources for these sub-bullet points in PHE (2014) as above.

40 Kim, T.J and von dem Knesebeck, O., 'Is an insecure job better for health than having no job at all?', BMC Public Health, 2015, Sep 29; 15:985.

41 Joseph Rowntree Foundation (August 2015), 'Work is good for your health – should we cheer or circle the wagons?': www.jrf.org.uk/blog/work-good-your-health-%E2%80%93-should-we-cheer-or-circle-wagons

42 Nearly 200 local authorities in England are committed to paying the Living Wage to their employees. In this context,

Local authorities can also act as models of healthy employment. Guided by public health teams they can develop healthy workplace strategies. The following are only some of the ways that a whole-council approach to being a healthy employer can be supported by public health teams, working with colleagues in human resources (HR) and across the council:

- outreach to disadvantaged groups in the community (for example ethnic groups whose employment rates are lower than the average for the area, or women who need to work for longer because of changes in the pension age) to promote the council as a good, equal opportunity employer
- use of positive action clauses in the Equality Act to offer training, apprenticeships (including the levy and target introduced in 2017) and so on to groups with the protected characteristics defined in the Act
- programmes that encourage exercise and fitness:
 - healthy transport to, from and between workplaces
 - a healthy eating offer, including healthy eating opportunities in off-site workplaces, such as for manual staff in depots, parks and leisure facilities
- support for those at risk of ill health
 - smoking cessation support
 - lunchtime exercise and weight-loss classes
 - blood pressure and other health checks
- breast-feeding friendly facilities
- stress management, bearing in mind that stress increases with loss of autonomy and loss of security, so is greatest among those at the bottom of the jobs ladder
- support for older workers approaching retirement age and those who want to work beyond the usual age for retirement

'Living Wage' does not refer to the national minimum wage which is a statutory requirement, but to a higher rate calculated yearly by the Living Wage Foundation, based on keep up with the cost of living.

- support for disabled staff that goes beyond the statutory minimum
- return-to-work support and specialist targeted services within the workplace, including support for those working off-site.

London Borough of Lewisham: tackling the gender pay gap

Lewisham is overcoming, through its role as a large employer, the continuing gender pay inequality that persists in many organisations across the UK and contributes, for example, to the poverty in which many single-parent families live. Fifty-six per cent of those in senior grades at Lewisham Council are female, and the pay gap across the council is slightly in favour of women. HR and diversity policies have played an important role in arriving at this position, as have training and the monitoring of diversity statistics. Equality targets are not rigidly enforced, but the data is monitored closely and regular equal pay audits have been acted on.

Lewisham also has a 'grown your own' senior talent policy, with 12 out of 26 of the most senior roles currently held by internal appointees.⁴³

The local authority as a purchaser and regulator

The total procurement expenditure of England's local government is over £60.5 billion yearly.⁴⁴ As major procurers and purchasers of services, local authorities have an indirect impact on the conditions of many more workers that they do not employ.

43 Institute for Employment Studies (2016), 'The power of parity': www.employment-studies.co.uk/system/files/resources/files/lew0716.pdf

44 DCLG (2017), 'Local government financial statistics England', No.27 2017: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/627895/LGFS27_Web_version.pdf

By sourcing more goods and services locally, and with organisations that offer a Living Wage⁴⁵, local authorities could make a significant difference to wealth generated within and going back to their communities, and to ensuring the health benefits of the local economy are spread across the health gradient.

A Joseph Rowntree Foundation analysis of the Leeds City Region found that if 10 anchor institutions (including the local authorities in the region) shifted an additional 10 per cent of their total spend locally, this could drive an additional £168-196 million into the Leeds economy.⁴⁶

As well as being a purchaser of goods and services, local authorities have an enforcement role in relation to various aspects of employment. These include issues of health and safety, environmental health, non-discrimination and standards for licensed premises.

Public health teams can help develop the usefulness of the Social Value Act to local authorities by developing a definition of what social value in employment means in relation to health, and developing quantitative and qualitative indicators against which suppliers can be assessed in evaluating their performance. They can also develop programmes of information and support, in partnership with environmental health colleagues, for local suppliers – to help them understand the benefits not only to employees, but also to their business, of meeting these indicators and employing a healthy workforce.

In relation to the enforcement role of local government, there is evidence that programmes of public accreditation and rewards for good practice (for example in relation to health and safety) can help to incentivise employers, providing them with reputational benefits and making them more attractive to potential employees and customers.⁴⁷

45 The Living Wage (as distinct from the national minimum wage, see footnote 32 above) is paid voluntarily by over 4,000 UK employers, including nearly 200 local authorities in England.

46 JRF (2017), 'Maximising the local impact of anchor institutions: a case study of Leeds City Region': www.jrf.org.uk/report/maximising-local-impact-anchor-institutions-case-study-leeds-city-region

47 PHE and Institute for Health Equity (2014), 'Increasing

In addition to working with environmental health colleagues, public health teams can collaborate with enforcement and regulatory colleagues in devising accreditation and reward systems that include a health element.

They can also use such schemes as a further opportunity to work with employers on the best way to implement their health aspects so as to obtain accreditation and receive awards for best practice. For example, some councils, such as Tower Hamlets, have developed projects working with fast food takeaways to reward healthier menus which still appeal to the tastes of different cultures.

Working with small employers is particularly important in this area, as such employers are much less likely than larger companies to have access to relevant information or trained HR staff. They may also be more reluctant to change working practices and conditions unless they are informed as to how their business, as well as their workforce, can benefit, and given support to implement action to make their workforce healthier, both physically and mentally.

Fair employment: questions for councillors

1. Is your council using its employment role and its partnership with other anchor institutions to promote the health and wellbeing of local residents who are locally employed as key outcomes of your local economic strategy?
2. How is the council reaching out to disadvantaged groups, including those with 'protected characteristics' under the Equality Act, to provide employment opportunities? Is this part of the economic strategy for the region?
3. Is the council making the best use of its purchasing and commissioning roles, including use of the Social Value Act, to promote health-producing employment opportunities and practices, including

employment opportunities and improving workplace health': https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/356064/Review5_Employment_health_inequalities.pdf

employment for target disadvantaged groups in your area?

Fair employment: questions for public health

1. Can you help the council and other employers in the area to develop a 'fair employment' policy in relation to health and wellbeing?
2. Can you assist the council in identifying target groups who do not have good access to the local employment market, such as people with disabilities, people with mental health problems and older people?
3. Can you provide evidence of what works in creating employment opportunities for such groups?
4. How can you use your partnership role to work with other anchor institutions, and other local employers, to increase health-producing employment opportunities?

A healthy standard of living: quality of work, pay and working conditions

“Better designed work that gets the best out of people can make an important contribution to tackling our complex challenge of low productivity.”⁴⁸

The current position

- One in six of the labour force is paid less than the Living Wage – the amount a representative household needs to earn to achieve life's necessities⁴⁹ (this is not to be confused with the minimum wage, which is

48 Taylor, M. (2017), 'Good work: the Taylor review of modern working practices': https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/627671/good-work-taylor-review-modern-working-practices-rg.pdf

49 JRF (2017), 'How city leaders can use the industrial strategy to create more and better jobs': www.jrf.org.uk/blog/city-leaders-use-industrial-strategy-create-more-better-jobs

considerably lower but has itself been termed the 'Living Wage' by the Government).

- The Inclusive Growth Commission found that low-skilled workers often find themselves going in and out of the labour market in low-paid, insecure jobs, under a skills and employment support system “that prioritises labour market entry rather than access to or progression into the quality skills and jobs that matter for improved living standards and economic productivity.”⁵⁰
- Women are over-represented in low-income, low-status jobs, and they often work part-time.
- One in six workers in the UK is experiencing depression, anxiety or stress. Suicide is now the leading cause of death in men aged between 15 and 49.
- The Inclusive Growth Commission's final report also concluded that people with disabilities or multiple, complex barriers to work “fail to get the integrated, wrap-around support and intensive coaching they need to find sustainable employment.”

The gig economy

An increasing proportion of the working population are self-employed or on temporary or zero-hour contracts. Such workers often receive a much lower level of care in terms of workplace precautions to protect their health and wellbeing than their co-workers in permanent, full-time jobs, despite the fact that an employer's duty of care does not vary according to the way they employ or hire their people.

A recent survey found that many gig economy workers are working when sick, working unpaid overtime and going throughout the year without a paid holiday.⁵¹ In addition, job insecurity, precarious scheduling and the instability and unpredictability it brings with it, along with the isolation and lack of social contact with colleagues, is associated with lower wellbeing and feelings of insecurity.⁵²

50 Inclusive Growth Commission (2017), 'Making our economy work for everyone' (final report): www.thersa.org/discover/publications-and-articles/reports/final-report-of-the-inclusive-growth-commission

51 Institution of Occupational Safety and Health: www.iosh.co.uk/News/Survey-of-gig-workers-health-and-wellbeing.aspx

52 Taylor, M. (2017) as above.

Local authorities can use their purchasing, commissioning and procurement powers to influence working practices and support the empowerment of employees, with advice from public health on the evidence of the detrimental effects of certain working practices and the beneficial effects of others. Councils may also be able to provide direct support, such as loans or support for social enterprises, to local employers which have innovative practices for employee empowerment and support for employees with disabilities and/or mental health problems.

The kind of health-supporting employment practice that local authorities are in a position to model themselves, to influence through their commissioning and procurement requirements, to promote through their business partnerships and to monitor through their regulatory functions, includes a number of measures recommended by the Taylor review quoted above. This review adopted six high-level indicators of quality of work:

- wages
- employment quality
- education and training
- working conditions
- work/life balance
- consultative participation and collective representation.

Public health teams are in a position to advise on the health impacts of each of these aspects of work and to point to evidence of measures that potentially have the greatest impact. This should be of real benefit to local authorities in designing policies and protocols for their own employment practices, for their commissioning and procuring roles and for their work with local and potential employers.

A healthy standard of living: questions for councillors

1. Do you understand which jobs are good quality in terms of the health benefits they provide and negative health impacts they avoid?

2. How can you use your roles as employer, commissioner, contractor and regulator to influence the quality of local employment to enhance the health and wellbeing of full-time permanent employees, but also of those working in the 'gig economy'?
3. Do your council's and your LEP's economic strategies explicitly target sectors that deliver growth in good-quality jobs?
4. Have you considered becoming an accredited Living Wage employer (as distinct from paying the statutory minimum wage)? Are there other anchor institutions or private sector employers which could help take a lead by declaring the whole area a Living Wage area?
5. Are there some services that have been outsourced that might be more effectively and efficiently directly provided by the council, with better terms and conditions, as some councils have recently found?⁵³

Given that jobs in retail, hospitality and care are currently (and for the foreseeable future) likely to be required in large numbers, how does your economic strategy address the need to improve pay, quality and physical and emotional health of workers in these sectors?

How can you encourage local businesses to adopt governance and working structures that give workers more control, given that lack of control is one of the factors contributing to stress? For example, can you support (through loans or other means) local worker co-operatives, taking advantage of your general power of competence? Can you encourage greater worker participation in governance through your commissioning and procurement? Can you support local social enterprises which are committed to empowering and supporting their staff in inclusive ways?

⁵³ The Guardian, 2 March 2016, 'Why have councils fallen out of love with outsourcing vital services?': www.theguardian.com/society/2016/mar/02/councils-outsourcing-cumbria-public-private-partnership-in-house

A healthy standard of living: questions for public health

1. Have you helped your councillors and local employers to understand the impact of poor-quality work and how physical and psychosocial aspects of working practice can be improved and can reduce sickness absence, for example by:
 - increasing employee control over their work
 - allowing participation in decision-making
 - ensuring effective leadership and line-management training
 - adoption of flexible working practices
 - interventions to reduce stress and improve mental health at work.
2. Could you do more to help your councillors and other stakeholders understand the impact of in-work poverty on health?
3. Poor working conditions are among the determinants of early retirement. Therefore, measures to improve working conditions are likely to increase the chances of retaining older staff. Can you work with your own council and local employers to promote fair recruitment practices for older people, flexible working, phased retirement and flexible retirement options and training for managers on issues of age and health?
4. Can you work with colleagues in commissioning and procurement to develop guidelines on healthy employment that can be used in the council's contracts with external employers (and followed by the council itself)?
5. Many directors of public health are either professors of public health or have other links with local universities – can you use these links to support research on the health impact of the local economy and vice versa; and to build on the role of both the council and local university(ies) as anchor institutions providing skills and employment?

A healthy standard of living: unemployment

The current position

In the last quarter of 2017 there were 1.45 million people unemployed in the UK.⁵⁴ Unemployment puts health at risk, and the risk is higher in regions where unemployment is widespread. The health effects of unemployment are linked both to its psychological impact and to the financial problems it brings – especially debt.⁵⁵

Many other potential workers are not actively searching for work, despite the fact that they do want to work, for a variety of reasons, including not being able to find suitable work due to disability or caring responsibilities. We know that:

- there are now twice as many 'underemployed' workers (about 3.3 million) as unemployed workers – people who are in work but not working as many hours as they would like⁵⁶
- there has been a 400 per cent increase in the number of people on zero-hours contracts since 2002
- one million people in part-time work cannot find full-time jobs
- half of all unemployed people do not claim out-of-work benefits and therefore do not receive any job search support from the state; for those in work, one in 10 workers are in insecure work.⁵⁷

54 ONS Statistical bulletin: www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/latest

55 Public Health Network Cymru: www.publichealthnetwork.cymru/en/social-determinants/unemployment

56 ONS Labour market economic commentary: www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/labourmarketeconomiccommentary/september2017

57 LGA 'Work Local' (2017): www.local.gov.uk/topics/employment-and-skills/work-local

These statistics suggest that chronic underemployment is slowly replacing the role outright joblessness used to play in the labour market, and that a major source of inequality in Britain today is not only traditional unemployment, but the divide between people in full-time jobs and those who are stuck in poorly paid, part-time 'gig' work.

Support for unemployed people

People who are unemployed and their families need tripartite support:

- to find employment
- to cope with finances and, in many cases, debt
- with their health and wellbeing.

Many initiatives to improve the local economy have included ways of supporting people who are unemployed, both to have a better quality of life while they are unemployed and to find employment. Even among those who are jobless and therefore at the bottom of the economic and health ladders, there is a danger of exacerbating inequality, for example by creating incentives for providers to give most help to those closest to the labour market (known as 'creaming') while committing less time and money to those who are judged to have weaker prospects (known as 'parking').⁵⁸ Public health can play a part in each of these areas.

Finding and keeping employment

An important role for public health is identifying those cohorts of people who need support, and identifying the kind of support that is most likely to be effective in relation to their health, both mental and physical, as a necessary condition for finding work. Public health specialists can also advise on the kinds of targets and performance indicators that would help measure success on the road to employment for groups such as:

- young people who are not in education, employment or training
- people with disabilities and long-term conditions

⁵⁸ McCartney, Harty, W., Taulbut, W., Michell, R., Dryden. C., Collins, C., 'Regeneration and health: a structured, rapid literature review', *Public Health*, July 2017, Vol 148, Pp 69-87.

- people with mental health problems
- single parents
- older people.

They can also work with the local authority and the NHS as employers, and with other local employers, in developing policies and programmes that will support target groups into work.

Certain groups will also need support to remain in work once they have found it or on returning to work after illness. While employers have responsibilities to ensure that people have this kind of support, they also need to understand how best to provide it. There is a role for public health here, working with colleagues in occupational health, social care and employment services.

Community involvement

A key issue is how to support the wellbeing of communities in which there are high levels of unemployment as a whole. A range of approaches are relevant, not only to working with communities for health and wellbeing, but also to improving people's chances of employment.

For example, one approach is asset-based community development (ABCD). In a health and wellbeing context, the aim of ABCD is to promote and strengthen the factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health. This approach requires a high-level commitment to put community involvement at the heart of policy and practice, including economic development. There are significant potential areas of opportunity in enabling unemployed people from within disadvantaged communities to work within the community in activities that support the wellbeing of communities. These include:

- schemes such as 'time banking' and micro-enterprise schemes which support older people to continue to live in their own homes through help with shopping and gardening or befriending
- community-building activities such as using

local government and NHS premises as community social activity hubs, using both paid staff and volunteers

- mobilising local assets to provide opportunities for small scale enterprise and job creation.⁵⁹

It will be noted that some of these schemes may provide a role for unemployed people as volunteers. This is not intended as a substitute for paid work, but may provide experience and training and help build confidence and resilience as a route to employment. Public health teams can support such place-based approaches in a wide range of ways, using both their professional expertise to identify target beneficiary groups, needs and success measures and their position within local authorities (for example to work with social care and community development colleagues). They can also use their NHS links to identify and advance potential areas for collaboration, and their community links to involve local people in deciding priorities for their community.

London Borough of Newham: smoking cessation

Newham public health talked to the community to find out why a mosque-based smoking cessation service wasn't working. They found that the service would be better taken up if it was delivered by people from within that community, and therefore trained the community to deliver the service themselves, which resulted in a 50 per cent drop in smoking rates.⁶⁰

Dealing with finances and debt

Local authorities have a long history of supporting people with low incomes in a variety of ways, from financial support through advice on welfare benefits and debt counselling to practical support such as subsidising breakfast clubs and holiday schemes.

⁵⁹ These examples are from Nesta (2016), 'At the heart of health: realising the value of people and communities': www.nesta.org.uk/blog/new-report-realising-value-people-and-communities-their-health-and-care

⁶⁰ NHS Confederation (2014), 'Comparing apples with oranges?': www.nhsconfed.org/voluntary

They also provide direct support and help in identifying potential users of the recent phenomenon of food banks – itself a demonstration of how poverty can exist in a wealthy society.

Durham County Council: support for local credit unions

Durham County Council secured financial education and support for local credit unions through its banking tender. This was possible because:

- they wrote these social outcomes into their service specification – this meant that later on, a procurement officer would just need to assess bids in the normal way against the 'fixed point' of this service specification, rather than having to make a subjective decision about incomparable social value offers
- they knew that what they were asking for was relevant and proportionate – they talked to the provider market before they started procurement and learned that banks were able to provide these social outcomes.

These social outcomes supported Durhams overall strategy – they were also therefore relevant in this sense.

There are clearly a number of roles for public health in this area, including:

- assisting in identifying where such support is most needed and what form it should take (for example providing evidence for the impact of breakfast clubs on children's wellbeing)
- working with other local government and NHS colleagues in devising multi-sectoral advice and sign-posting schemes
- working in particular with GP practices to educate staff on the help available through advice and sign-posting schemes and devising referral systems for such schemes, including forums for surgery staff to interact with advice and signposting workers.

Support for health and wellbeing

The activities described above are all, of course, forms of support for health and wellbeing, but public health teams will also want to ensure that their specific prevention and early intervention work reaches out to unemployed people in several ways.

- Ensuring that unemployed people have access to the same services as people with jobs. For example, many councils are making efforts to reach male manual workers at their workplaces with 'health MOTs'. It will be important to consider how to reach unemployed men and women as well, perhaps by working with job centres, pubs, clubs or other venues where people gather such as football grounds or places of worship. There are also likely to be specific services charged for by the local authority which could be offered free to unemployed people (such as gym and swimming pool membership).
- Ensuring that prevention and early intervention services address specific health problems associated with unemployment. For example, mental health problems are one of the big risks of unemployment, so interventions to address this issue will be key.
- Ensuring that support for unemployed people does not inadvertently create greater inequalities by 'creaming' the most employable and 'parking' the most vulnerable and least well-off people.

Redcar & Cleveland Council: support for unemployed men

Following the closure of the SSI steelworks in Redcar in 2015, more than 4,000 people, the majority of them men, lost their jobs. A task force to respond to the impact of the closure was set up, with the chief executive of Redcar & Cleveland Council as its chair.

An important contribution involved the director of public health and colleagues. After a North of England Mental Health Development Unit conference on suicide prevention, a range of stakeholders set

up a steering group to develop a new programme aimed at promoting mental resilience and wellbeing, primarily amongst males. The programme was designed to use the football fan culture as a medium to support male mental health resilience in the local community.

Redcar & Cleveland was chosen as a pilot area, with a focus on targeting men aged over 40 who had been impacted by the recent closure of SSI and the loss of their employment. 'Team Talk' was launched in 2016 in partnership with Middlesbrough Football Club Foundation and a number of local community 'boot rooms' were developed.

The model looks at tackling social isolation and loneliness by supporting men to maintain 'latent functions' such as time structure during the day, continued shared experiences with others, goal setting and continuing to be active, and by adopting co-production with participants. The project resulted in a well-established group in central Redcar, attended by 20 men, with two additional 'boot rooms' being developed.

Unemployment: questions for councillors

1. What are you doing to help people who are unemployed to find work, especially those in vulnerable groups and those groups underrepresented in the workforce?
2. What support are you giving to unemployed people in relation to their finances (for example, in supporting credit unions or community organisations to help people apply for welfare benefits, deal with debt or access support in kind)?
3. What do you know about the state of health of unemployed people in your area? What can you do to help unemployed people stay fit and healthy? Could they be referred to specialist work and health programme support?

4. Are you working with the community as a whole to support areas of unemployment, for example by providing working opportunities within community groups, support for unemployed people, identifying community assets and promoting resilience through community involvement?

Unemployment: questions for public health

1. Can you help your council identify where support is most needed among unemployed people to help preserve their health and wellbeing?
2. How can you use your links with the NHS to support local government initiatives for unemployed people, for example by helping to locate welfare advice and signposting services in NHS premises?
3. How can you ensure that unemployed people have access to the same health-promoting services as those with jobs?
4. What are you doing to support the mental health of unemployed people in the area, given that this is one of the big issues for people without work?
5. How can you work with the council, local anchor institutions, other local employers and government departments locally to mitigate the danger of 'creaming' the most employable and 'parking' the least employable? For example, can you assist with evidence of what works to help vulnerable people obtain and retain work?

Sustainable places and communities

“When the fortunes of a deprived neighbourhood are improved, the challenge is to ensure that the original residents benefit. If they are unable to access the new jobs being created, the risk is that they are simply displaced elsewhere as the area gentrifies.”⁶¹

Planning for a healthy working environment

Planning professionals, with the assistance of public health teams, have made considerable progress in the last decade or more in understanding that planning for economic development in an area can be either beneficial or detrimental to the health of the people who work there. This is not, of course, just about meeting health and safety regulations, working conditions in factories and so on, but about a much broader approach to the working environment to ensure that even low-paid people work in better environments, not just those in prestige sectors such as digital technology.

This broad understanding of what constitutes healthy infrastructure planning now includes matters such as:

- making creative use of 'Section 106' agreements and Community Infrastructure Levies to support health improvement and reduce health inequalities
- ensuring that routes to and from residential areas to workplaces facilitate, rather than hinder, walking and cycling
- improving air quality along routes normally taken by people from home to work: people living in deprived areas are more likely to be living near and journeying to work along busy main roads

⁶¹ Joseph Rowntree Foundation: 'What is inclusive growth and why does it matter?', blog by Josh Stott, 12 January 2017: www.jrf.org.uk/blog/what-inclusive-growth-and-why-does-it-matter.

- access to green spaces and leisure facilities during work breaks: again, people who are generally disadvantaged are more likely to live and work further away from such spaces and facilities than those who are more affluent
- access to NHS and other public facilities during the working day (including shops, schools, health centres and benefits advice)
- restricting the proliferation of fast food takeaways around schools and other areas where young people gather, and working with such outlets to improve their healthy eating offer
- tackling isolation of home workers, for example by providing social/internet hubs where they can access high-speed broadband and other communications facilities, such as internet conferencing, as well as have a cup of coffee and socialise with each other
- creative approaches to the problem of hollowed-out town centres, ensuring that physical regeneration delivers meaningful benefits to the broadest possible range of people and does not displace disadvantaged people to less favourable areas (see the section below on housing).

London Borough of Tower Hamlets: making healthy planning a lasting legacy

In an imaginative use of Section 106 of the Town and Country Planning Act 1990, which delivers agreements between developers and local authorities on community improvements, public health staff at Tower Hamlets Council have worked with the planning department and the local NHS to develop more health-related provision, using the evidence base for healthy planning. The public health team has not restricted the use of Section 106 monies to healthcare facilities, for which they are often used. Its analysis showed a detrimental relationship between aspects of the environment in the borough (for example limited open and green spaces) and health.

This evidence provided the impetus for a £1.4 million investment in green infrastructure projects such as ‘pocket parks’ (small areas of inviting public space for everyone to enjoy, often created on a single vacant building plot or on small, irregular pieces of land). Other initiatives include an outdoor gym and investing in a ‘green grid’ (linking green spaces across the borough). This approach has involved a move away from buildings infrastructure (such as health centres) and more towards making the environment in general a healthier one.

The public health team has fully assimilated with the infrastructure planning team, ensuring health facility and health impacts are reflected in key documents such as the infrastructure delivery plan and the local plan. Health requirements were taken into account when the authority set its Community Infrastructure Levy (CIL), and this also highlighted them as potentially requiring CIL funding once the Section 106 contributions are exhausted. This work has provided a lasting legacy for future development in terms of securing resources.

Healthy housing and regeneration

Improving skills, employment opportunities, the quality of employment and enhanced rates of pay are, of course, central to an inclusive local economy. But these elements are most effective if they are accompanied by wider policies to reduce the cost of living and improve the quality of life for the lowest paid.⁶² A key issue, particularly in the light of the current housing crisis, is the availability of affordable, good-quality housing with access to public transport, healthy travel to work (for example by walking or cycling), local facilities and green spaces.

The housing crisis illustrates how economic prosperity does not automatically benefit everyone in an area. The national map of average household incomes by neighbourhood, adjusted to reflect housing costs, shows that parts of the country with

⁶² Baars, S. as above.

strong economic growth have many people struggling.

Housing costs make up an increasing proportion of household spending, and this is more of a struggle for low-income households.⁶³

The shortage of affordable housing is a well-known feature of many city economies, but many rural areas also suffer from a shortage of affordable homes which, when coupled with higher transport costs and distances between employees and firms, can constrain local economic development and, therefore, health.

The quality of existing housing is also an important factor in relation to both health and to the local economy. Evidence suggests that poor housing is associated with increased risk of cardiovascular diseases, respiratory diseases, depression and anxiety. The greatest risks to health are related to cold and damp homes. House type and overcrowding represent further examples of risk factors.⁶⁴

Housing has a significant role to play in improving health and reducing health inequalities through the local economy. As a lever for local economic development and for health improvement, housing has much more scope than just new building. Solutions include conversions and long-term empty homes being brought back into use, as well as new properties. Upgrades to existing housing stock can have a positive impact on development as well as significantly improving health, as can increasing security of housing tenure. Social housing and private rented housing are the sectors in which people live who experience the worst aspects of health inequalities. Therefore, improvements in these sectors can directly address health inequalities.

63 Inclusive Growth Commission (2016), 'Making our economy work for everyone': www.thersa.org/discover/publications-and-articles/reports/final-report-of-the-inclusive-growth-commission

64 Public Health England (2016), 'RSA Inclusive Growth Commission: response from PHE': www.thersa.org/globalassets/projects/psc/inclusive-growth-commission/evidence-submissions/inclusive-growth-commission---phe-response.pdf

There are also dangers of increasing health inequalities in the course of measures to boost the local economy.

Gentrification may have the (intended or unintended) consequence of displacing poor communities when wealthier people arrive in renovated or renewed urban areas or towns. Some gentrification has the well-intentioned motive of creating more mixed housing areas for the avoidance of 'ghettoisation' of those who are less well-off or segregated by ethnic grouping. It can lead to improvements, for example in school standards, public safety, a fall in crime rates, the introduction of bike lanes, street markets and better parks.⁶⁵ However, it is not always those who most need these things who benefit from them, since gentrification can also lead to displacement of the least well-off, often to areas further away from employment opportunities; an influx of speculative investors making housing less affordable; and general disruption of neighbourhoods and existing communities.

Moving tenants out of existing social housing stock, in order either to demolish it and rebuild or to renovate it, may not always be in the best interests of families living there. For example, we know that children's education is vulnerable to frequent moves.⁶⁶ Such disruption to schooling and to social networks, along with the potential for increased rents following rehousing, may make maintenance and gradual renovation (while tenants remain in their homes) better options in some cases. Furthermore, there is evidence that refurbishment, rather than rehousing, is likely to lead to small improvements in health (as measured by, for example, reduction in hospital admissions).⁶⁷

65 The Guardian, 29 September 2016, 'Gentrification is a global problem. It's time we found a better solution', www.theguardian.com/cities/2016/sep/29/gentrification-global-problem-better-solution-oliver-wainwright

66 Hutchings, H. (2016), 'Moving home can affect your children's health and education': <http://theconversation.com/moving-home-can-affect-your-childrens-health-and-education-62738>

67 McCartney., Hearty, W., Taulbut, W., Michell, R., Dryden, C., Collins, C., 'Regeneration and health: a structured, rapid literature review', Public Health, July 2017, Vol 148, Pp 69-87.

A number of local authorities are using tools such as devolution and City Deals to institute innovative responses to the lack of housing for people with low and middle incomes. As housebuilders, housing enablers and landlords; as planners, place-shapers and agents of growth, transport and infrastructure; and through their duty of care to the vulnerable and homeless, councils have a very significant role to play in fostering an approach to the local economy that links health and housing.

There are several important ways in which public health can support effective approaches to improving housing and increasing availability as part of a local economic strategy. These include:

- seeking and presenting evidence as to which measures are most likely to align health improvement with housing regeneration, which measures may exacerbate health inequalities and how this may be mitigated
 - working with housing departments in both unitary and district authorities to include such measures in housing and local economic strategies
 - working with the emerging combined authorities and City Deal areas to develop innovative evidence-based housing solutions with an explicit health component, as a part of economic strategies
 - identifying those groups within the local population whose housing (or lack of it) is most at risk of adversely affecting their health, and developing support for resource allocation based on need
 - directly designing and supporting specific initiatives, such as 'warm home' initiatives, to improve existing housing stock
 - developing a framework for the evaluation of the health and health inequalities impact of housing initiatives
 - working with housing associations to help develop a systematic approach to health improvement in their housing strategies
- working with developers to help them understand the relationship between housing and health and to recognise this in their proposals (see the section on planning above).

Case example – Cambridgeshire and Peterborough City Deal

This City Deal includes specific funding for housing, with the elected mayor responsible for a £100 million housing and infrastructure fund, and the combined authority having control over a ring-fenced £70 million to meet housing needs. The combined authority will also have control of a new additional £20 million a year funding allocation over 30 years, to be invested to the Cambridgeshire and Peterborough Single Investment Fund, to boost growth.

The mayor will have a number of powers under the deal, including responsibility of a multi-year, consolidated transport budget, an identified key route network of local authority roads, and strategic planning powers.

The combined authority, working with the mayor, will receive powers including responsibility for chairing a review of 16-plus skills provision, devolved adult skills funding from 2018-19 and joint responsibility with government and other local partner organisations to co-design the new national Work and Health Programme, designed to focus on those with a health condition or disability and the very long-term unemployed.

Norwich City Council: reducing energy costs in new housing

When a plan by local housing associations stalled after the 2008 financial crisis, Norwich City Council decided to develop the site itself. Following an international architectural competition, London-based Mikhail Riches was selected, with a scheme that reinstates a terraced street pattern to an area that had been blighted by clumsy post-war planning. Due for completion in 2018, it will be the UK's largest ever 'Passivhaus' development – a standard of energy efficiency that will see heating bills reduced to about £150 a year – providing 100 new light-flooded homes, 80 per cent for social housing and the rest for private sale. This is the first project in Norwich council's new eco-homes programme.

Sustainable places and communities: questions for councillors

1. Do you understand how planning policies and decisions can have an impact on the health and wellbeing of your residents?
2. Do you have cabinet-level agreement that health and wellbeing issues should be considered as part of your planning policy? If not, can you work with fellow councillors to obtain such agreement?
3. Are you seeking advice from your public health team in using Section 106 agreements or Community Infrastructure Levy (CIL) agreements to promote health and wellbeing?
4. In relation to any regeneration projects, have you developed policies to ensure that people in lower-paid, lower-skilled jobs and less affluent housing are not displaced in favour of more prestigious and less affordable housing?

Sustainable places and communities – questions for public health

1. If your council does not already have an agreement to consider health and wellbeing (including health impact assessments and health inequalities impact assessments) as part of planning, can you work with your councillors and planning colleagues to secure such an agreement and a protocol for implementation and monitoring?
2. Does your team understand the timetable for developing planning policies, supplementary planning documents, infrastructure plans and neighbourhood plans, and the best times for public health to engage with the planning process?
3. Could you work with planning colleagues to develop some joint training for public health and planning staff, to increase mutual awareness of opportunities for public health and planning professionals to work together on planning policies and applications?
4. Can you help planning colleagues to develop Section 106 agreements (based on that section in the Town and Country Planning Act 1990) or CIL agreements in an innovative way to promote health and wellbeing, ensuring that the outcomes benefit your communities as widely as possible?
5. Is your public health team an integral part of any regeneration planning in your area?

Case studies

Blackburn with Darwen: health in all policies

Planning for prosperity

Blackburn with Darwen Council has ‘improving health and wellbeing’ as one of its five overarching corporate priorities. The borough’s ‘Plan for Prosperity’ explicitly includes a range of health and health inequality related target indicators for quality of life, employability, infrastructure and housing. These include:

- number of new affordable homes built
- employment and reduction in unemployment and economic inactivity rates
- educational attainment average increases
- increases in under-19 apprenticeship starts
- reduction in numbers of ‘NEET’ young people (not in employment, education or training) and numbers with no qualifications
- life expectancy gap reductions
- increases in gross weekly pay
- increases in volunteering.

As a small unitary authority, the opportunity for public health staff to engage and influence wider policy areas relating to inclusive economic prosperity is very significant. The public health team enjoys good relationships with all other directorates and has made significant contributions to decision-making in planning, transport, economic growth, licensing, community safety, housing, and in the revenues and benefits departments (where public health has supported welfare advice, for example for those struggling with debt). The public health team has also been closely involved in supporting Blackburn with Darwen’s role as one of five integration areas participating in the Government’s ‘Integrated Community Strategy’.

The employment power of anchor institutions

Blackburn with Darwen is currently developing and leading an initiative with WHO Europe and the Cumbria and Lancashire Strategic Transformation Partnership (STP) to explore how better to “create, identify and maximise the local economic growth and employment opportunities from local health and care system spend”. This includes:

exploring ways of developing, aligning and improving local NHS and Department for Work and Pensions (DWP) employment and skills ‘back to work’ schemes for adults of working age with long-term conditions currently out of paid employment creating new local educational and career development and guidance systems to channel local residents into local employment opportunities within the local health and care system.

Digital public health

As part of a ‘connected healthy communities’ approach, the public health team is using health-improving digital innovation to create the links between opportunities for local businesses, the production and development of products for and with the health and care sector, and local skills development. For example, the team is working in partnership with Manchester City Verve (the city’s ‘Smart City’ demonstrator), Lancaster University, Lancashire Digital Health Board and Age UK to implement low-cost passive sensors for vulnerable older adults, and development of ‘decision dashboards’ for relatives/carers, integrated locality teams and clinicians.

The public health team is also working with private sector partners and the LGA to develop a combined database of assets including local authority service provision, voluntary and community sector services and provision, health, the police, fire and rescue services. These will be integrated and delivered back to neighbourhood integrated teams and individual professionals through web-based and smartphone apps to help identify appropriate neighbourhood provision to meet individual need. This enables the development of a resource for social prescribing with links to the Smart City procurement platform.

Creating the infrastructure for social referrals and help with long-term conditions assists voluntary, community and faith sectors to develop new services to assist local residents to return to work.

A place-based alliance

Blackburn with Darwen Council, together with Lancaster University and Blackburn College, has set up a strategic alliance – a partnership designed to promote joint working between partners with the aim of improving the prosperity of the borough. The alliance recognises that working together on a basis of mutual self-interest will result in a partnership that has the potential to be greater than the sum of its parts, involving as it does the ‘University of the Year 2018’ (The Times and The Sunday Times Good University Guide) partnering with the 15th most deprived borough and one of the region’s largest further education providers. Together, the partners spend £700 million each year, employ 7,800 staff, teach 25,000 students and provide services to 146,000 residents and 5,000 businesses with 65,000 jobs.

The alliance works on a range of joint projects in public health, digital health, transport, the environment and others. One workstream brings together colleagues from across the alliance to develop the idea of a social movement for health. Examples of this approach include the ‘integrated area’ work referred to above, which is seen as a concerted attempt to link economic prosperity with social cohesion in Blackburn with Darwen. Another example is the work of a local GP and partners in developing the ‘Run a Mile’ initiative in schools. As a result of the initiative, 1,500 children are running a mile each day, 40 per cent have reported sleeping better, and teachers have noted better concentration and health and wellbeing, saying in feedback that this is the “best initiative in 25 years” that they have seen in schools.

Adding social value to procurement

As part of the Liverpool ‘Sensor City’ project, the public health team is collaborating with local universities, procurement colleagues and the private sector to develop a Smart City procurement platform. The aim is to develop improved processes for social value for drug and alcohol services, cycling, walking and active travel, social prescribing and support for frail older people.

For further information, contact Professor Dominic Harrison, Director of Public Health, Blackburn with Darwen Council: dominic.harrison@blackburn.gov.uk

Calderdale: building health into development planning and procurement

Health and the economy

Calderdale has a 'Single Plan for Calderdale', which has been signed off at health and wellbeing board level and which recognises the importance of the economic determinants of health. The public health team, influenced by the 'Due North' report on health equity in the North of England⁶⁸, has supported an analysis of the economic determinants through the JSNA. The team has contributed to the development of an emerging inclusive growth strategy which extends the previous business and economy strategy and includes a greater focus on health and inequalities. There is general recognition that the inclusive growth agenda can only be delivered through partnership.

The local plan

The draft local plan for the area, which covers the planning aspirations of the council, explicitly recognises that the built and natural environments are major determinants of health and wellbeing and that the planning system has an important role in facilitating healthy housing, active travel and a healthy environment, and that health and wellbeing are also about "living in a safe environment and feeling part of the community".

There are specific policies requiring developments to contribute to reducing the causes of ill health and reducing health inequalities, requiring health impact assessments to be carried out for larger residential developments, hot food takeaways and other developments that have a significant impact on health and wellbeing.

68 Liverpool University and CLES (2014), 'Due North': www.gmcvo.org.uk/system/files/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final.pdf

The council also makes a commitment to working with partners to create and safeguard "opportunities for safe, healthy fulfilling and active lifestyles", with detailed explanations of what that entails.

The plan also commits to safeguarding community facilities and services and to ensuring that all residential developments, with a small number of exceptions, have gardens or communal areas that can support household food production.

Adding social value to procurement

Calderdale's health and wellbeing board has welcomed the Social Value Act 2012 as "a genuine opportunity to improve health, wealth and wellbeing". The board has developed and published a detailed 'social value charter' based on the following principles:

- recognising that people are assets and individuals are equal partners in the design and delivery of services
- building on people's existing capabilities – providing opportunities to recognise and grow people's capabilities and actively support them to put these to use
- support and cooperation to engage where there are joint responsibilities and expectations
- peer support networks – engaging peer and personal networks alongside professionals
- recognising that all partners can contribute to driving change.

The charter outlines a number of local objectives including buying locally, creating employment and training opportunities (including for people with disabilities and young people and in areas of high unemployment), developing communities, being green and sustainable, supporting communities, and being a good employer by supporting staff and volunteers' development.

Success measures defined in the charter relate to seeing increases in:

- economic capital
- individual capital
- social capital
- environment capital
- identity capital
- intellectual capital.

Details are given of how commissioners will maximise social value, for example by embedding social value in policies, commissioning and goods and services specifications and contract management; and how providers will demonstrate social value, for example by embedding monitoring of social value as part of their organisational processes.

For further information, contact Paul Butcher, Director of Public Health, Calderdale Council: paul.butcher@calderdale.gov.uk

Doncaster: growing together

Doncaster Council has led the development of a new borough strategy, 'Doncaster Growing Together' (DGT), designed to support Doncaster (the place and the people) to thrive. The strategy is built around four areas: Doncaster Learning, Doncaster Working, Doncaster Caring and Doncaster Living. This is supplemented by public sector reform around a series of 'moments to shine' based on key points in people's lives. The DGT outcomes framework includes many of the measures recommended by the Joseph Rowntree Foundation in its work on inclusive growth.

The emerging inclusive growth plan binds together social and economic policy (and the scope of the DGT plan). This means addressing the five foundations for productivity in the industrial strategy, but also placing a greater emphasis on strengthening other foundations for growth – particularly health and wellbeing – by integrating health and work related interventions, recognising that they are mutually beneficial.

Doncaster's emerging 'foundations for inclusive growth'

The inclusive growth plan reflects the focus of the Government's Industrial Strategy on harnessing the power of innovation to help meet 'grand challenges' like an ageing society. It also reflects that health and social care is a major part of Doncaster's economy (jobs, gross value added, efforts to raise productivity/wages, skills strategy and so on), now and in the future, demonstrating how thinking has evolved with a real shift in focus from roads/infrastructure to people.

Programmes and initiatives

The inclusive growth plan is supported by a number of programmes, including 'Well Doncaster', one of 10 'Well North' sites which are part of Public Health England's response to the Due North report on health equity for the North of England.⁶⁹

The programme focuses on community wealth-building through entrepreneurship and reducing health inequalities. Work began in 2015 in Denaby, a village in the borough, with 'Well Denaby'.

Among the initiatives which are seen as potentially embedding health in Doncaster's drive for inclusive growth are:

- agreeing a new local plan which has health written into it from the beginning
- the launch of a virtual 'grounded research centre for nutrition and behaviour', the research arm of the Rotherham Doncaster and South Humber NHS Foundation Trust, and the potential to scale and diffuse new ideas to support community wellbeing and business growth
- a new local integration board, which is already achieving better integration between Doncaster's employment and health systems
- linking more closely with the Sheffield City Region's well-established health tech sector: this and other new sectors, such as telehealth and additive manufacturing, offer opportunities for high-quality employment in sectors advancing wellbeing for all

⁶⁹ University of Liverpool and CLES (2014), 'Due North': www.gmcvo.org.uk/system/files/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final.pdf

- piloting a trial of a locally developed motivational app as part of the employment and advancement service, supporting people with confidence and skills to achieve better employment
- becoming a sustainable food city. 'Good Food Doncaster' was initiated with joint funding from Public Health and Doncaster Council's regeneration and environment directorate. It gives equal 'billing' to health and economic concerns. The partnership enables the council to work in an agile, cost-efficient and inclusive way (for example the food poverty work currently underway is enabling the delivery of small-scale innovations led by the community and academic world, at very low cost, while learning from experts and regional peer networks). By being an equal partner alongside a range of community groups and associations, the public health team and other council departments have been able to do what they do well, but have also had the capacity to support others in doing what they do well.

For further information, contact Dr Rupert Suckling, Director of Public Health, Doncaster: rupert.suckling@doncaster.gov.uk

Gloucestershire: helping those furthest from the labour market

The 'Going the Extra Mile' (GEM) project is a partnership of around 70 community organisations, managed by Gloucestershire Gateway Trust on behalf of Gloucestershire County Council. It aims to engage and support individuals within Gloucestershire who are facing multiple barriers to employment and who are furthest from the labour market.

The aim is to build confidence, 'barrier bust' and help them move closer to or into education, employment or training. It does this by tailoring programmes to every individual, through a personalised action plan offering dedicated and specialised help, guidance and support.

The £3.2 million project, jointly funded by the Big Lottery Fund and European Social Fund, started in October 2016 and is currently funded until end of 2019. In its first two years it has supported around 750 people, half of whom had a disability or limiting health condition. Outcomes have been impressive, including 281 people going into training or education, 182 finding a job, 217 actively looking for work and 133 receiving financial inclusion support.

Tailored support

Each person on the programme is given a 'navigator developer' who works with them throughout their entire journey. They provide intensive one-to-one support in order to build their stability, confidence, motivation and readiness to learn, and ultimately move them closer towards education, training or work.

Referrals mainly come from partner organisations, Jobcentre Plus, social care or mental health services. The aim is to reach out to those who find it most difficult to find work, and so there is a particular focus to support people who have been unemployed for over six months.

However, in reality many of those who have been helped have never worked, or may have experienced difficulty in sustaining employment, due to their personal circumstances.

The support given includes interview coaching, work placements and training. GEM works closely with the council's adult education service and other community learning organisations, although there is a small pot of money available to fund bespoke courses if needed.

As well as working with the individuals to improve their skills and find jobs, the project can also help them with other barriers they may have to find work, including transport and childcare costs.

Getting businesses on board

Partner organisations, which include everything from carers' organisations and Citizens Advice to housing associations, play an important role in offering opportunities for people on the scheme, but the GEM team has also worked closely with local employers. There are 12 business leads from specific sectors including construction, health and wellbeing, retail, recreation, leisure and finance.

These leads are people who can champion the project and the concept of diversity to get others from their sector involved.

As well as offering job opportunities, employers are also asked to offer interview skills coaching, mentoring, apprenticeships and experience days.

A wide range of employers are regularly involved already, including Waitrose, Specsavers and Land Rover.

There are also two 'opportunity hunters' within the GEM scheme, who work directly with the navigator developers to help identify appropriate work placements for each individual.

Who has GEM helped?

Clients include people who have left prison, victims of domestic abuse, people with alcohol and drug problems and those with mental illnesses and learning disabilities.

There have been countless individual success stories since the project started, such as James, who has a learning disability. He had never been able to get paid work until he was accepted on to the programme.

He was given support and interview practice and was found a placement at a local Specsavers branch where he works in the lab, cleaning glasses and getting them ready for collection.

The work has really benefited James. He is now starting to recognise letters and numbers more and has been learning to read through 'Read Easy'.

Sallie-Anne, who is profoundly deaf, has also achieved success thanks to GEM. She used to work at a care home, but was unhappy in her work and suffered from severe depression.

With the help of her navigator, she enrolled on a painting and decorating course at Gloucestershire College.

After completing her course, she was keen to set up her own business and gain some work experience. She gained work experience at a local decorating business, did some training on setting up her own business and is now working for herself.

The importance of 'growing your own'

Many local authorities already play a key role in supporting existing local business and business innovation. 'Growing your own' in this way chimes well with the idea of community development as an important part of both local economic development and of health and wellbeing.

In furtherance of this approach, it is argued that employment and skills policies should focus on raising the human and social capital of the existing population in an area, rather than seeking simply to "raise the aggregate level of skills in an area by competing to bring in highly skilled workers from outside,"⁷⁰ which may make existing lower-skilled populations worse off. This approach also makes sense in the context of local authorities as anchor institutions, along with other local public sector bodies such as the NHS and universities, with which they already work in a variety of partnerships.

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Greater Manchester: ‘Working Well’, an approach to work and health

Out of Greater Manchester’s total working-age population of 1,781,000, 236,000 people are out of work. Of these, 64 per cent (150,000) are out of work because they have a health condition. Greater Manchester lags behind both the national employment rate and the employment rate for those with long-term conditions.

Reducing inequalities and increasing productivity are at the heart of the strategic intent of the Greater Manchester Combined Authority (GMCA) and the Greater Manchester Health and Social Care Partnership (GMHSCP). Greater Manchester has recognised the significant physical and mental health impacts of being out of work and the co-dependence between health and the Greater Manchester Strategy’s inclusive growth ambition, which require healthy people to support growth and productivity in the local economy and for everyone in Greater Manchester to benefit from the positive effects work can bring to health.

‘Working Well’ is a joint GMCA and GMHSCP whole-population approach to health, skills and employment. It has four strands:

care and support – for people with complex and enduring health conditions or disability: support for employability, meaningful activity, volunteering and wellbeing (currently in development)

work and health – support for longer-term unemployed people with health conditions or disability to find and sustain work (programme already in place)

early help – for employees with health problems who are at risk of falling out of the labour market: support for small and medium

businesses, self-employed people and newly unemployed people with health problems (going live in early 2019, with the ultimate aim of supporting 14,000 people in these categories)

in work – health promotion (in development) through:

- the Greater Manchester good employer charter
- public service leadership
- social value through procurement
- modernising employee assistance/occupational health.

The ‘work and health’ programme strand of Working Well has drawn on devolved powers for joint commissioning with the Department for Work and Pensions (DWP) as part of the 2014 devolution agreement. The three Working Well programmes have been funded jointly by the DWP, the Ministry of Housing, Communities and Local Government, the European Social Fund and Greater Manchester. A pilot programme from 2014-16 provided support for 5,000 employment and support allowance (work-related activity group) claimants who had not secured sustained employment through the DWP Work Programme. A further 15,000 people from a more varied but equally complex client group were referred from 2016-17 and will be supported until 2020.

A GP referral route was introduced and the commissioned offer expanded to include a bespoke ‘talking therapies’ service, as a result of the waiting times for mainstream services and the high prevalence of poor mental health among Working Well clients.

A 'skills for employment' service is also in place, to ensure that ready access to skills provision is available to secure and progress in work, creating an 'eco-system' of employment, health and skills support.

The programme is on track to significantly overachieve its target of supporting 20 per cent of clients into work. In January 2018, the third iteration of Working Well was launched as Greater Manchester's devolved work and health programme, which will run until 2023 and support 23,500 people primarily out of work due to poor health or disability.

Working Well has been developed on the basis of a number of key principles, outlined below.

- Personalised support: providers support clients to access an appropriate range of services, and provide bespoke packages of support to ensure that their personal barriers to employment and progression are tackled comprehensively and in an integrated and sequenced way.
- A new 'eco-system' of work, health and skills: Working Well has fundamentally changed how skills, health and employment services function together by offering a seamless, coordinated and sequenced package of services, enabling the achievement of multiple outcomes. Keyworker support for those with the most significant barriers to employment sits at the heart of this 'eco-system', facilitating the client journey.
- Evaluation: there is robust evaluation to ensure wider application of successful delivery and outcomes, which informs the development of future work.
- Market shaping: devolution provides an opportunity to build capacity and shape the market to provide the conditions for locally commissioned and managed services to be able to integrate and achieve better outcomes.

Impact of the Greater Manchester 'Working Well' programme on clients' health and other employment prospects. Source: Greater Manchester Combined Authority

Next steps for the Working Well system will include:

- developing a Greater Manchester approach to learning disabilities and carers
- looking at new ways to support older people to participate and progress
- challenges to public service leaders to be exemplar employers
- integrating all GP and health services in work and skills pathways
- significant further 'asks' of central government devolution of services
- continuing to test, learn and evolve.

For further information, Contact Theresa Grant, Chief Executive, Trafford Council: theresa.grant@trafford.gov.uk

Sheffield: the power of anchor institutions

The Sheffield City Partnership brings together many of the city's public, private and voluntary sector anchor institutions, and is independently chaired by Lord David Blunkett. Throughout 2017 and 2018, the partnership has been working to foster a more inclusive and sustainable economy in the city. During this time, it has been galvanising local partners and engaging with experts from across the country, to explore how the partners can work together in the city, and the city region, to actively pursue the type of growth and prosperity which could bring the greatest benefits to all.

As part of this effort, and to foster city-wide engagement with this work, Greg Fell, the Director of Public Health for Sheffield, invited Ted Howard, of the Chicago Democracy Collective, to visit and talk about the relevant activity which he has been leading in the US. Ted Howard spoke at a large public event and also lead an anchors workshop with the Health Foundation, explaining the progress the Chicago Democracy Collaborative has made in harnessing the potential of anchor institutions to foster inclusive growth in the low-income communities they serve by better aligning their institutional resources – as employers, purchasers, investors and opportunities for volunteers – with the needs of those communities.

Inspired by these discussions, the work in Sheffield around building an inclusive economy has, in large part, become focused on how local anchor institutions can harness their own resources to pursue this goal, by using public investment to deliver positive local impact.

The aim of the work is to move away from sector-specific thinking about the role and potential collaboration of anchor institutions, and to get away from writing business cases for a sector that focus on that sector's internal processes only. For example, return on investment needs to be thought about in relation to the return for a whole place, instead of just for the sector or institution doing the investing.

There is a strong commitment to exploring the different ways in which the institutions may do this over the coming years, from recruitment and training to local assets. As a starting point, there has been a particular focus on how this vision can be realised in the commissioning and procurement processes, through measures including the establishment of procurement protocols which encourage local spend, and the embedding of social and ethical value in commissioning decisions and performance monitoring.

Anchor institutions within Sheffield and the city-region are all major players in both the local and national procurement arena. In the past it has been estimated that the public sector spends in excess of £4 billion in Sheffield. Whilst some existing contracts are long-term or part of a national framework (for example the NHS national procurement arrangements), there is both the scope and the opportunity to effect real positive change and to provide greater support and opportunity to the local market.

With this in mind, procurement professionals from the anchor institutions, including Sheffield Teaching Hospitals, Sheffield City Council and both universities, have come together under the banner of ‘progressive procurement’ in order to explore the potential for greater collaboration and partnership activity in this area, with a view to achieving wider value locally and more targeted impact, as well as mutual organisational benefits. This ‘progressive procurement partnership’ has been up and running since mid-2017 and is focused on using collective capacity to ensure that spending and investment has the maximum local impact, supporting local businesses and supply chains, and embedding a set of progressive values, principles and behaviours across the city.

These principles are already informing the activities and ambitions of the individual partner institutions, but the ambition for the progressive procurement partnership is to foster a whole-city anchor institution approach to this, developing shared principles and protocols, as well as collaborative activities.

In March 2018, Sheffield City Council launched a new ethical procurement policy to ensure high standards of ethical practice in the way the council trades and works with partners, companies and inward investors across the city.

This policy establishes a series of revisions to protocols, process and tools across Sheffield City Council and its supply chain, to enable the council to “conduct business ethically, effectively and efficiently for the benefit of Sheffield”. In particular, the new policy focusses on three key tools:

- social value tests
- an ethical code of conduct for suppliers
- new, revised tender processes.

This reflects Sheffield’s stated aim to “become the fairest city in the country”, and acknowledges the important role that this has to play in developing an inclusive and prosperous local economy.

This set of principles sets out the Sheffield City Council approach, but is being shared and discussed with partners through the Sheffield City Partnership, the progressive procurement partnership and other forums. Alongside the policies and priorities of the other partner institutions, it could ultimately provide some content and ideas for a city-wide framework.

In addition to this established work around procurement, Sheffield’s Director of Public Health, Greg Fell, has drawn on the discussion and learning in Sheffield so far to inform broader and longer-term ambitions. He has identified some potential initiatives which could help anchors to maximise the economic and the linked health benefits of their activity, spending and resources, as follows.

Leadership and readiness for an anchor approach

- developing a jointly agreed ‘anchor mission’ strategy underpinned by supportive strategies for each sector
- linking local and diverse purchasing programmes to broader organisational diversity, sustainability and health goals
- committing a percentage of senior management time and a dedicated budget in each anchor institution to ‘anchor mission’ initiatives
- engaging with the local community to identify community priorities around local and diverse purchasing.

Hiring and staffing

- a commitment to an accredited Living Wage for the city, starting with an agreement among the anchor institutions
- equipping local residents for high-demand, frontline jobs that are connected to further employment prospects
- maximising apprenticeship opportunities for people from disadvantaged and diverse communities of people.

Local sourcing and procurement

- making local sourcing an explicit goal in the strategic plan and other policies, with staff posts dedicated to inclusive local sourcing
- making a commitment to building capacity in the local supply chain to access larger contracts
- assessing the full economic impact of every purchasing decision, for example the cost associated with imported versus locally produced goods
- adjusting payment periods and invoicing processes to accommodate small businesses.

Place-based investing

- develop partnerships with local majority and minority ethnic chambers of commerce, women's business organisations and other supplier diversity organisations
- foster working relationships between community outreach and investment staff
- move cash and other assets into local banks and credit unions, making a distinction between investment in, for example, hedge funds and local social capital
- community investment in land trust – purchase land to secure sustainable and affordable housing, with particular emphasis on how anchor institutions, including hospitals, manage their estates (which are often vast) for the benefit of the community.

For further information, contact Greg Fell, Director of Public Health, Sheffield City Council: greg.fell@sheffield.gov.uk

Thrive West Midlands: a commitment to workplace wellbeing for all

Poor mental health and wellbeing is a significant problem for the West Midlands, impacting on individuals and families and costing the region over £12 billion per year. The West Midlands Combined Authority (WMCA) mental health commission, chaired by Norman Lamb MP, has worked together with organisations within the WMCA, and people with personal experience of mental health problems, to develop an action plan for change – called ‘Thrive West Midlands’.

A three-year programme was launched in 2017 to trial expanding ‘individual placement and support’ (IPS) provision, available for people with severe and enduring mental health issues, to people with common mental health and chronic physical issues being treated in a primary care setting. The programme went live in May 2018 and has already seen one person being placed into a work setting.

In addition, a West Midlands ‘workplace wellbeing commitment’ was launched in 2017. Public and private sector employers are asked to sign up to this to demonstrate their commitment to the mental health and wellbeing of their staff. The new approach, ‘Thrive at Work’, was launched in July 2018. In addition, companies bidding for public sector contracts are encouraged to sign up to this commitment or to demonstrate an equivalent commitment to the wellbeing of their staff. Large companies in the region are also encouraged to secure commitment from their supply chain to such standards.

WMCA is also working with the Government to trial an innovative ‘Wellbeing Premium’ – a grant incentive for employers demonstrating their commitment to staff wellbeing.

The trial will reveal if this reduces staff sickness absence, improves productivity and prevents people leaving work due to ill health.

A number of related plans of action are also underway in different areas of provision, all designed to support people with mental health problems. These include the following.

- Housing - an innovative scheme to offer a ‘Housing First’ service with intensive mental health support for those with complex needs, or who are homeless, to move into good-quality housing and, where possible, into work.
- Criminal justice – a programme to make more regular and widespread use of the mental health treatment requirement in the Magistrates’ and Crown Courts to address the underlying causes of offending; alongside a programme of greater support for people with mental ill health leaving prison and settling back into the community, to help them maintain good mental health and gain access to accommodation, training or work.
- Health and care – the plan of action is taking a ‘zero suicide ambition’ approach, developing a new primary mental health care model for the region. This will aim to meet national standards for early intervention in psychosis and other services, significantly reducing out-of-area mental health placements, exploring alternatives to inpatient care, aiming to reduce substantially the use of restraint, improving access to perinatal mental health services for women, taking an integrated approach to health, social care and other services, and looking at why detentions under the Mental Health Act are rising and whether inequalities need addressing.

- Community involvement – an awareness-raising programme around mental health, guided by people with experience of mental ill health, along with a large public health programme to train up to 500,000 people across the region in mental health first aid over the next 10 years, and a campaign for first aid legislation for employers to include mental health.

For further information, contact
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