Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Health and Wealth: Director of Public Health Report for Sheffield 2018

Governing Body meeting H

10 January 2019

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Purpose of Paper

Directors of Public Health have a statutory duty to produce an annual report on the health of the local population. This year's report focuses on the relationship between health, work and the economy. It considers how good work and inclusive economy can make a significant contribution to improvement in Sheffield's health and wellbeing and how, in turn, good health represents a key requirement for future prosperity. The report makes three recommendations to the Council, Sheffield City Partnership and the Sheffield City Region respectively in regard to promoting good work and an inclusive economy for the City. There is also a progress update on the recommendations from last year's report.

Key Issues

The report uses intelligence from the JSNA (available as an open data online resource https://data.sheffield.gov.uk/stories/s/fs4w-cygv) to consider the economic case for a healthy workforce as well as setting out the reasons why good work is good for our health. It also looks at why current economic structures aren't working for most people and how this impacts on our health and wellbeing. Finally the report focuses on how we can all benefit from an inclusive economy and the importance of the City's anchor institutions in making this a reality.

Is your report for Approval / Consideration / Noting

Consideration and Noting

Recommendations / Action Required by Governing Body

The Governing Body is asked to support the following DPH report recommendations:

- **Sheffield City Council, Sheffield City Partnership and Sheffield City Region** should align and embed action into their economic strategies to enable and encourage all local employers to recognise their role in providing good work and ensuring that the most disadvantaged in our society are not left behind in their ambitions. Practical examples of this might include all organisations working towards implementing the fair employer charter, paying the foundation living wage and being ethical procurers
- **Sheffield City Partnership**, as part of developing a strategy for an inclusive economy, should consider how best to use the resources currently available to the City, to incentivise implementation of the strategy; and

- **Sheffield City Partnership** should facilitate the public, private and voluntary anchor institutions of Sheffield to develop a collective strategy to secure and progress their contribution to an inclusive economy, underpinned by supportive strategies for each sector.

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?
To work with Sheffield City Council to continue to reduce health inequalities in Sheffield

Are there any Resource Implications (including Financial, Staffing etc)?

No

Have you carried out an Equality Impact Assessment and is it attached?

The report focuses on those groups of people who are most likely to experience poor health and wellbeing and who are most likely to benefit from help.

Have you involved patients, carers and the public in the preparation of the report?

The DPH Report is based on evidence from the JSNA. The approach taken to joint strategic needs assessment is one of a dynamic process that includes more in-depth analysis and assessment of specific issues, groups and services where consultation, asset based community development and research involving the public and the voluntary, community and faith sector is used to develop information and insight.

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1. Introduction / Background

1.1 The Director of Public Health has a statutory duty to produce an annual report on the health of the local population. This year's report focuses on the relationship between health, work and the economy. It considers how good work and inclusive economy can make a significant contribution to improvement in Sheffield's health and wellbeing and how, in turn, good health represents a key requirement for future prosperity.

1.2 The report uses intelligence from the JSNA (available as an open data online resource https://data.sheffield.gov.uk/stories/s/fs4w-cygv) to consider the economic case for a healthy workforce as well as setting out the reasons why good work is good for our health. It also looks at why current economic structures aren't working for most people and how this impacts on our health and wellbeing. Finally the report focuses on how we can all benefit from an inclusive economy and the importance of the City's anchor institutions in making this a reality.

1.3 The report makes three recommendations to the Council, Sheffield City Partnership and the Sheffield City Region respectively in regard to promoting good work and an inclusive economy for the City. There is also a short report on the progress made with the recommendations from the 2017 DPH report.

1.4 A copy of the DPH report for 2018 is attached to this paper. It may also be viewed online: http://www.sheffield.gov.uk/home/public-health/director-public-health.html

2. Key messages from the DPH Report 2018

a) The economy is everything, everything is connected.
The economy is not just about the activities of private sector business.
Investments in both public sector, voluntary sector and the actions of individuals all contribute to outcomes we individually and collectively value and thus what we consider "the economy". Sometimes measurement and valuation is difficult, but that doesn't make it less important.
Everything is connected.

b) A healthy population and productive economy are intrinsically linked
In this report I have tried to set out a case for why the economy and how we approach it is perhaps THE determinant of health and well being. I have set out some evidence on the interactions between healthy people and economic growth, and how the two are symbiotic.
The Northern Health Sciences Alliance have also recently published detailed analysis in this area. They reported in the connection between poor health and productivity, suggesting that reducing the number of working aged people with limiting long term health

conditions by 10% would decrease rates of economic inactivity by 3 percentage points in the Northern Powerhouse.
Simply, a healthier population is likely to be more economically productive (and to need less spending on healthcare and health-related benefits). This is a two way link, a more prosperous society is likely to be healthier. Just as HS2 is seen as an investment in the economy, so is investment in a healthy population.

c) Many are left behind
In my 2017 report I set out the slowing of improvements in healthy life expectancy across the population. I have also set out the inequalities in healthy life expectancy.
A baby born in Darnall can expect to get to 50 in good health, a baby born in Fulwood can expect to get to 70 in good health. This is a central challenge for NHS and Social Care demand pressures. It is also a challenge for economic productivity.
Multi morbidity (having more than one condition) is more common than having a single illness.
There are more working age people than the elderly with multi morbidity and this is very unequally spread across our population. Thus underscores the importance of the health of the working age population.
The Chief Medical Officer for England annual report, produced with the IFS provided evidence that 6% of healthy men are out of work; 25% of those with a longstanding illness. Furthermore that 28% of the sick are in poverty and those with less education educated are far more likely to be ill and on sickness/disability benefits than those with the highest levels of education. Finally the IFS chapter for the CMO report was clear that half of those in incapacity benefits have a mental health problem.

Put most simply, poor health, which is quantifiable, has an impact on economic growth. And investment in better health can have an impact on economic growth.

We should change how we measure growth. What we measure and value is important, this is one of the things that underpins calls to widen the measure of economic growth from solely GVA to a wider measure that includes social benefit. It would be easy, in narrative terms at least, to also include resilience and cohesion into the things we value in our economy.

d) However, picking up on the above, the inequality in health outcomes is also intrinsically linked to inequality in economic outcomes.
Many people and organisations have commented that the way in which the economy has developed has left people behind, often exacerbated poverty. Some are left behind in the quest for economic growth. Health inequality is intrinsically linked to wealth inequality. There is a strong research base on this, and this has led to the establishment of terms like “inclusive economy”, which describes an effort to ensure the economy works for everyone. Given that *health* inequality is essentially driven by *wealth* inequality this underscores the importance of our efforts around creating an inclusive economy as important for inequalities in health and well being.
Thus the central “health” challenge – stalling healthy life expectancy, and inequalities of that – aren’t a “problem” for the NHS, they are a problem for the whole economy.

e) Good jobs are important for health
Good jobs are good for good health, this is not news.
Thus creating good jobs is critical ensuring jobs are good jobs is critical, and systems to get people the right skills and training / opportunity so as they can access is critical, as is keeping people healthy so they can actually work.
Its all good economics.

The gig economy, and lack of normal protections and safeguards for those that work in it compared to employment, is a growing concern.

f) Sheffield has started down this path but much further to go. We should sweat our assets

We need to push hard on the notion of economic anchor institutions, at city and neighbourhood level, to ensure we capitalise on the social benefit of existing and new resource commitments across the city. Of particular importance are the high priority groups that most often are left behind by economic growth. There is an important "people and communities" element to this; progress shouldn't only rely on technical solutions but should also be based on engagement to involve communities in solutions and build on the assets that already exist.

in terms of ensuring we meet the central challenge of set up a system that promotes growth where that growth is equally shared by all and that those with most to gain disproportionately gain as they are also part of "the economy".

Obviously the publication of the Sheffield Partnership Board Inclusive and Sustainable economy framework gives a platform on which to build. We should push hard on the notion of economic anchor institutions, at city and neighbourhood level, to ensure we capitalise on the social benefit of existing and new resource commitments across the city. Of particular importance are the high priority groups that most often are left behind by economic growth.

There is an important "people and communities" element to this. progress shouldn't only rely on technical solutions but should also be based on engagement to involve communities in solutions and build on assets that already exist.

3. How healthy is Sheffield.

Director of Public Health reports should also highlight how healthy a population is. Much of this role is now fulfilled through Public Health England data tools. There is a wealth of data available on the PHE fingertips tool allowing us to get a sense of key metrics of health and well being. These provide a detailed picture of health and well being, and the factors that influence that in the city.

Life Expectancy and health expectancy (or Healthy Life Expectancy), and infant mortality provide the headline metric.

The Office for National Statistics released updated life and health expectancy data in December. The headlines are

Male LE for Sheffield at 79.2 is now on a par with UK average of 79.2. This is a slightly improved position over the previous year and is the highest of the English core cities. For females, Sheffield is still below at 82.4 compared with UK average of 82.9. This is a slight deterioration over the previous period and remains 2nd highest of the core cities. Male HLE for Sheffield at 62.5 is below the UK average of 63.1. This represents an improvement over the previous period and is the highest of the core cities. For females, Sheffield is still below at 60.1 compared with UK average of 63.6. This represents an improvement over the previous period and is the 3rd highest of the core cities.
So, we are seeing continuation of a slow-down rather than spiralling down or a recovery. We have seen female HLE improve over the last period following a period of decline. Nevertheless, we remain concerned about women's health in this particular instance.

Our ranking among the core cities is also better for both men and women across both measures. Nevertheless men in Sheffield spend 16.7 years of their life in poor health and women 22.3 years. We don't have small area data yet so I can't calculate the slope index.
The other important indicator of population health is the infant mortality rate.
This is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. The trend has been downwards in Sheffield and nationally for some time. For us this reflects the work done through the Best Start programme and other initiatives. However over recent years the trend has been reversing. The reasons for this are not yet known but it is unlikely there will be a single reason.

Worryingly there is some national analysis indicating that the trend in rates is still downwards in the most affluent but more sharply upwards in the least affluent groups. This analysis hasn't yet been done with local data but there is no reason to think this wouldn't apply locally.

Other metrics are available
The Wider Determinants tool gives comparative data on a range of indicators across many domains – natural and built environment (shown below), work & the labour market, vulnerability, income, education.

The Marmot indicators are updated biannually and give data on indicators directly relevant to the marmot report on health inequalities.

The LA Health Profile gives a picture of people's health in Sheffield. It is designed to help local government and health services understand their community's needs.

Finally the public health dashboard gives a narrower view of the performance of some (not all) of the services funded by the Public Health Grant.

6 Action for Governing Body / Recommendations

6.1 The report makes three recommendations to the Council, Sheffield City Partnership and the Sheffield City Region respectively in regard to promoting good work and an inclusive economy for the City.

6.2 **Sheffield City Council, Sheffield City Partnership and Sheffield City Region** should align and embed action into their economic strategies to enable and encourage all local employers to recognise their role in providing good work and ensuring that the most disadvantaged in our society are not left behind in their ambitions. Practical examples of this might include all organisations working towards implementing the fair employer charter, paying the foundation living wage and being ethical procurers

Broadly the ingredients for this are already in play and need to be brought together into a strategy to improve and maintain the health of the working age population as an economic investment.
For those in work and well, obviously keeping well is the goal. Taking a structural determinants approach this might include working towards implementing the fair employer charter, to pay the foundation living wage and be ethical procurers.
Strategies might also focus on traditional wellness in work approach, and a health promoting environment.

For those in work but poorly, good quality occupational health access and supportive sickness management is important. For those out of work and poorly the city is already trialing IPS as a means to directly address illness related reasons why people are out of work. We know there is more to do in this area.

6.3 **Sheffield City Partnership**, as part of developing a **strategy for an inclusive economy**, should consider how best to use the resources currently available to the City, to incentivise implementation of the strategy; and

6.4 **Sheffield City Partnership** should facilitate the public, private and voluntary anchor institutions of Sheffield to develop a collective strategy to secure and progress their contribution to an inclusive economy, underpinned by supportive strategies for each sector.
The Democracy Collaborative, and others, have written extensively on this and published a toolkit with a wealth of practical ideas

Paper prepared by: Louise Brewins
On behalf of: Greg Fell
20 December 2018

Public Health Dashboard – narrow set of measures

Figure 11: Public Health Dashboard (Sheffield)

Indicator	Rank (out of 16 where 1 is best and 16 is worst)	Position
Child Obesity (2016-17)	4	Best
NHS Health Check (2013-14 to 2017-18)	13	Worst
Tobacco Control (2016-17)	4	Best
Alcohol Treatment (2016-17)	11	Average
Drug Treatment (2016-17)	9	Average
Best start in life (2016-17)	4	Best
Sexual & reproductive health (2016 -17)	7	Average
Air Quality (2017) - INTERIM MEASURE	12	Worst

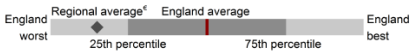
Source: Public Health England https://healthierlives.phe.org.uk/topic/public-health-dashboard/area-details#are/E08000019/par/nn-1-E08000019/sim/nn-1-E08000019

LA health profile

Health summary for Sheffield

The chart below shows how the health of people in this area compares with the rest of England. This area's value for each indicator is shown as a circle. The England average is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator. However, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



	Indicator names	Period	Local count	Local value	Eng value	Eng worst	Eng best
Life expectancy and causes of death	1 Life expectancy at birth (Male)	2014 – 16	n/a	79.0	79.5	74.2	83.7
	2 Life expectancy at birth (Female)	2014 – 16	n/a	82.6	83.1	79.4	86.8
	3 Under 75 mortality rate: all causes	2014 – 16	4,542	350.8	333.8	545.7	215.2
	4 Under 75 mortality rate: cardiovascular	2014 – 16	1,021	80.4	73.5	141.3	42.3
	5 Under 75 mortality rate: cancer	2014 – 16	1,849	146.2	136.8	195.3	99.1
	6 Suicide rate	2014 – 16	132	9.0	9.9	18.3	4.6
Injuries and ill health	7 Killed and seriously injured on roads	2014 – 16	534	31.2	39.7	110.4	13.5
	8 Hospital stays for self-harm	2016/17	797	132.1	185.3	578.9	50.6
	9 Hip fractures in older people (aged 65+)	2016/17	557	582.5	575.0	854.2	364.7
	10 Cancer diagnosed at early stage	2016	1,081	51.7	52.6	39.3	61.9
	11 Diabetes diagnoses (aged 17+)	2017	n/a	76.8	77.1	54.3	96.3
	12 Dementia diagnoses (aged 65+)	2017	4,894	79.8	67.9	45.1	90.8
Behavioural risk factors	13 Alcohol-specific hospital stays (under 18s)	2014/15 – 16/17	81	23.3	34.2	100.0	6.5
	14 Alcohol-related harm hospital stays	2016/17	3,575	695.3	636.4	1,151.1	388.2
	15 Smoking prevalence in adults (aged 18+)	2017	77,719	17.0	14.9	24.8	4.6
	16 Physically active adults (aged 19+)	2016/17	n/a	63.8	66.0	53.3	78.8
	17 Excess weight in adults (aged 18+)	2016/17	n/a	60.7	61.3	74.9	40.5
Child health	18 Under 18 conceptions	2016	186	21.2	18.8	36.7	3.3
	19 Smoking status at time of delivery	2016/17	782	12.9	10.7	28.1	2.3
	20 Breastfeeding initiation	2016/17	5,047	78.3	74.5	37.9	96.7
	21 Infant mortality rate	2014 – 16	103	5.2	3.9	7.9	0.0
	22 Obese children (aged 10-11)	2016/17	1,219	21.2	20.0	29.2	8.8
Inequalities	23 Deprivation score (IMD 2015)	2015	n/a	27.6	21.8	42.0	5.0
	24 Smoking prevalence: routine and manual occupations	2017	n/a	27.3	25.7	48.7	5.1
Wider determinants of health	25 Children in low income families (under 16s)	2015	21,610	21.9	16.8	30.5	5.7
	26 GCSEs achieved	2015/16	2,879	54.0	57.8	44.8	78.7
	27 Employment rate (aged 16-64)	2016/17	256,800	69.0	74.4	59.8	88.5
	28 Statutory homelessness	2016/17	472	2.0	0.8		
	29 Violent crime (violence offences)	2016/17	10,226	17.9	20.0	42.2	5.7
Health protection	30 Excess winter deaths	Aug 2013 – Jul 2016	748	16.4	17.9	30.3	6.3
	31 New sexually transmitted infections	2017	2,330	608.0	793.8	3,215.3	266.6
	32 New cases of tuberculosis	2014 – 16	218	12.8	10.9	69.0	0.0

For full details on each indicator, see the definitions tab of the Health Profiles online tool: www.healthprofiles.info

Indicator value types

1, 2 Life expectancy - Years 3, 4, 5 Directly age-standardised rate per 100,000 population aged under 75 6 Directly age-standardised rate per 100,000 population aged 10 and over 7 Crude rate per 100,000 population 8 Directly age-standardised rate per 100,000 population 9 Directly age-standardised rate per 100,000 population aged 65 and over 10 Proportion - % of cancers diagnosed at stage 1 or 2 11 Proportion - % recorded diagnosis of diabetes as a proportion of the estimated number with diabetes 12 Proportion - % recorded diagnosis of dementia as a proportion of the estimated number with dementia 13 Crude rate per 100,000 population aged under 18 14 Directly age-standardised rate per 100,000 population 15, 16, 17 Proportion - % 18 Crude rate per 1,000 females aged 15 to 17 19, 20 Proportion - % 21 Crude rate per 1,000 live births 22 Proportion - % 23 Index of Multiple Deprivation (IMD) 2015 score 24, 25 Proportion - % 26 Proportion - % 5 A*-C including English & Maths 27 Proportion - % 28 Crude rate per 1,000 households 29 Crude rate per 1,000 population 30 Ratio of excess winter deaths to average of non-winter deaths (%) 31 Crude rate per 100,000 population aged 15 to 64 (excluding Chlamydia) 32 Crude rate per 100,000 population

Director of Public Health Report for Sheffield 2018

HEALTH & WEALTH

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Key messages

The economy is everything - “the economy” is not the product of a set of activities of private businesses; rather everything is “in” including the private sector, public sector and the voluntary, community and faith sectors. The actions of individual citizens are also within what should be considered as the economy. Thus everything is connected;

A healthy population and productive economy are linked - the economy and how we approach it is perhaps **the** determinant of health and wellbeing. There is evidence on the interactions between healthy people and economic growth, and how the two are symbiotic;

Good jobs are good for health - creating good jobs, helping people acquire the right skills through training and creating the opportunities for accessing good work are critical to people keeping healthy so they can all actually work and be productive. This represents good economics.

Many have been left behind - a number of commentators have set out how the way in which the economy has developed has left people behind and exacerbated poverty. Some are left behind in the quest for economic growth. There is a strong research base on this, and this has led to the establishment of terms such as “inclusive growth”; which describes the effort to ensure the economy works for everyone. Thus the central “health” challenge of stalling healthy life expectancy and inequalities aren’t a problem for the NHS, they are a problem for the whole economy;

Change how we measure growth - poor health and health inequalities, which are quantifiable, impact on economic growth. Investment in better health can also impact on economic growth. What we measure and value is important; this is one of the things that underpins calls to widen the measure of economic growth from solely GVA to a wider measure that includes social benefit. It would be easy, in narrative terms at least, to also include resilience and cohesion in the things we value in our economy;

“Sweat our assets” - we need to push hard on the notion of economic anchor institutions, at city and neighbourhood level, to ensure we capitalise on the social benefit of existing and new resource commitments across the city. Of particular importance are the high priority groups that most often are left behind by economic growth. There is an important “people and communities” element to this; progress shouldn’t only rely on technical solutions but should also be based on engagement to involve communities in solutions and build on the assets that already exist.

1. Introduction

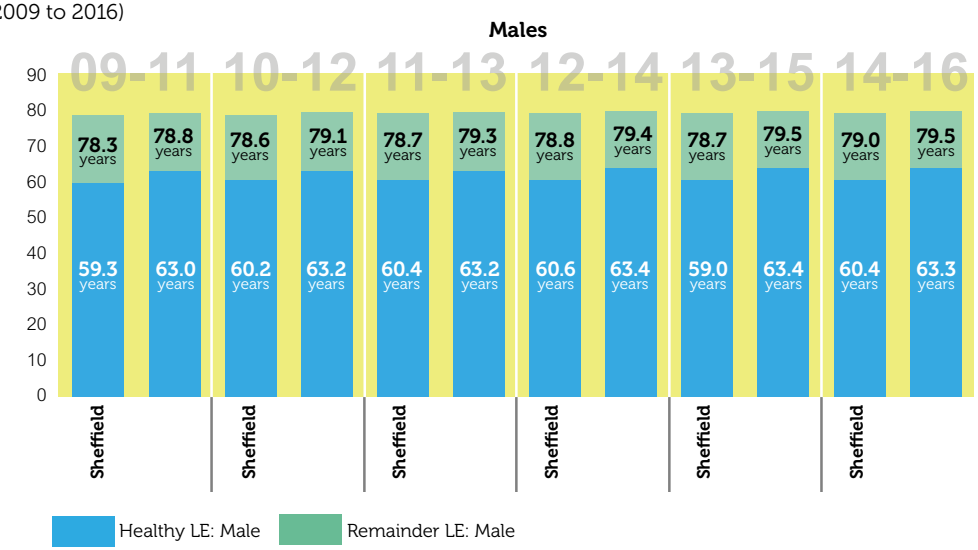
Work is a critical determinant of good health and wellbeing. This is not just about paid employment, but could also be described as any meaningful activity that provides us with a sense of purpose.

Similarly a healthy population is a critical determinant of high productivity and a flourishing economy, in the same way that a good transport network underpins economic growth. Health and wealth go hand in hand and it is why I am focussing on work, the economy and health in this year's report.

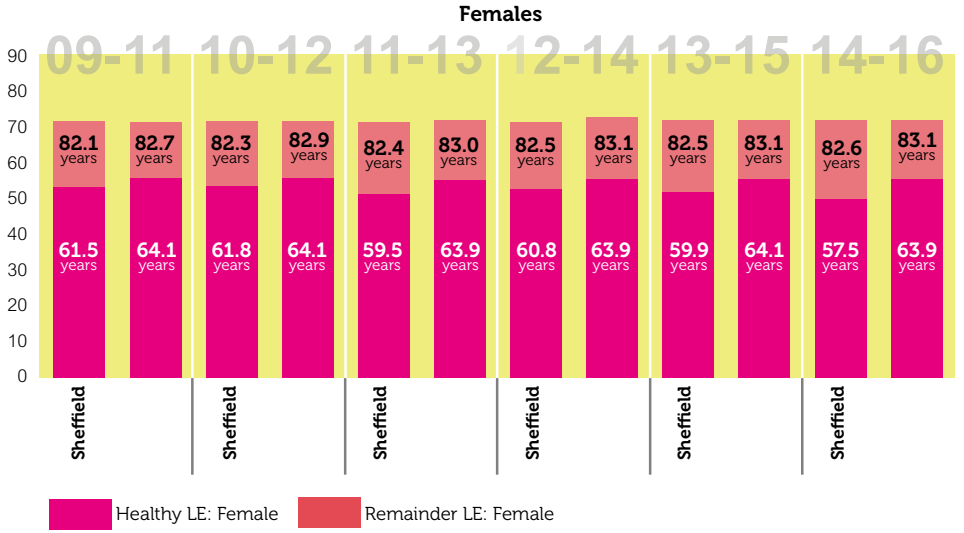
Almost two thirds of people in Sheffield are aged between 16 to 64 years and constitute the majority of what is known as the working age population. We are seeing more and more people of working age develop long term conditions, including mental ill health and musculoskeletal problems that are affecting their chances of finding and staying in meaningful employment or activity.

As the two graphs in Figure 1 show, the amount of time we can expect to live in poor health is increasing, especially for women, and this period of poor health is starting earlier than ever, before retirement age.

Figure 1: Life expectancy and healthy life expectancy for men and women in Sheffield and England (2009 to 2016)



PHOF Indicator s0.1(i) & 0.1(ii) Public Health Intelligence Team, SCC



PHOF Indicator s0.1(i) & 0.1(ii) Public Health Intelligence Team, SCC

Whilst the figures in Sheffield reflect the national trend, the position is worse in Sheffield; worse for women; and worse among people who are deprived.

For example, strokes, which we tend to associate with old age, are in fact more common in people under the age of 65. Stroke victims often lose significant function in terms of the activities of day to day living and do not return to work. Their partner or relative may also have to give up work or other activities in order to provide full time care for their loved one. The evidence clearly sets out there are more people of working age with multiple illnesses than in the older population. This cannot be solved by more or better health and social care services alone and serves to underscore the importance of prevention across the life course. A critical element of that prevention effort is work.

For work to be beneficial to health it needs to provide adequate pay, acceptable hours, good health and safety, job security, job progression and opportunities for employees to participate in decision making. But with the rise of the "gig" economy and self-employment, the opportunities for good work are diminishing. We are seeing too many people becoming trapped in low paid, unskilled and unstable work, often interspersed with periods of unemployment. This is double-jeopardy. There are significant health inequalities in the working age population, most notably between those who are employed and those who are unemployed. There has also been an increase in the number of households who experience in-work poverty and disparities in health outcomes between skilled and unskilled workers, between black and minority ethnic communities and the white population and between men and women.

If average life expectancy and healthy life expectancy are to continue to increase and the gap in life expectancy and healthy life expectancy between the best and worst off is to narrow, we must prioritise the development of an inclusive economy and good work. Equally, if the local economy is to grow and flourish we must prioritise improvements in the health and wellbeing of our population.

Health and good work go hand in hand

In the first chapter of this report I look at the economic case for a healthy workforce as well as setting out the reasons why good quality work is beneficial to health. High levels of chronic ill health, deprivation and low skills means we have a long way to go yet in terms of a healthy and happy workforce. Although the facts are worrying, there are actions we can take but these will need to be systematic and at scale. All employers have a significant contribution to make.

Health and economy go hand in hand

The second chapter of the report looks at the relationship between health and the economy. I suggest that current economic structures simply aren't working for most people (with the exception of the highest 1% earners) and may even be impacting adversely on our health and wellbeing - leading to entrenched patterns of inequality and disadvantage. A difference can be made but the approach should co-ordinate across all sectors of the economy, take a medium to long term view and incorporate a large enough economic footprint.

Anchor institutions bring health and wealth together

In the final chapter of the report, I bring the two perspectives of health and wealth together and explore in more depth what we need to do to ensure we all benefit from an inclusive and sustainable economy. In doing so I highlight the pivotal role anchor institutions will play in making this approach a reality.

Recommendations

I make three recommendations for supporting and encouraging the development of an inclusive and sustainable economy for Sheffield:

1. **Sheffield City Council, Sheffield City Partnership** and **Sheffield City Region** should align and embed action into their economic strategies to enable and encourage all local employers to recognise their role in providing good work and ensuring that the most disadvantaged in our society are not left behind in their ambitions. Practical examples of this might include all organisations working towards implementing the Fair Employer Charter, paying the foundation living wage and being ethical procurers;
2. **Sheffield City Partnership**, as part of developing a strategy for an inclusive and sustainable economy, should consider how best to use the resources currently available to the city, to incentivise implementation of the strategy; and
3. **Sheffield City Partnership** should facilitate the public, private and voluntary anchor institutions of Sheffield to develop a collective strategy to secure and progress their contribution to an inclusive economy, underpinned by supportive strategies for each sector.

Greg Fell
Director of Public Health for Sheffield

Acknowledgements

Reports such as this are always the result of many people's work.

I am grateful this year to the following contributors: Louise Brewins, Dale Burton, Kieran Flanagan, Chris Gibbons, Debbie Hanson, Joanna Rutter, Chris Shaw, Dan Spicer, Sarah Stopforth and Laura White. Final responsibility for the content rests with me.

2. Work & health

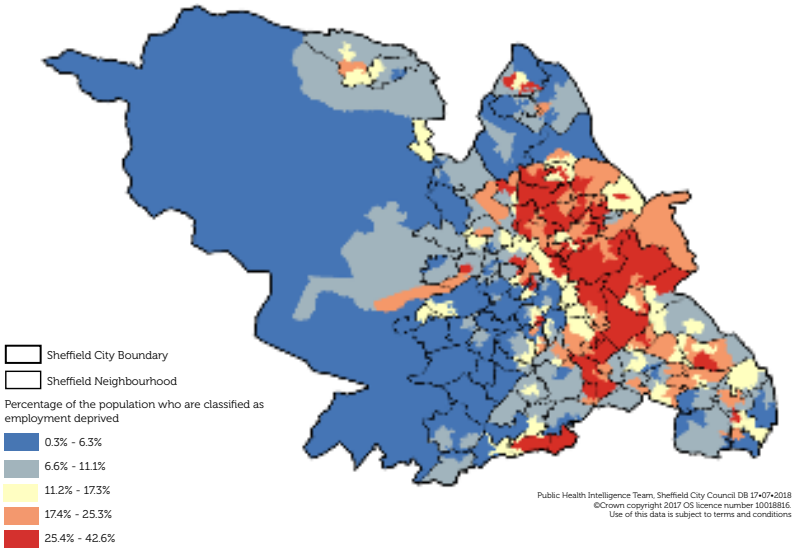
Work and health

Work is important to our health and wellbeing, and not just for material reasons.

Employment is a primary determinant of health, impacting both directly and indirectly on the individual, their family and community. Unemployment is associated with an increased risk of illness and early death. Whether we are in or out of work and for how long, as well as the type of work we do, can have a significant impact on our mental health, leading to increased feelings of lack of control, insecurity, anxiety and social isolation. There is an unequal distribution of unemployment and the type of work available across Sheffield. This in itself contributes to inequalities in health.

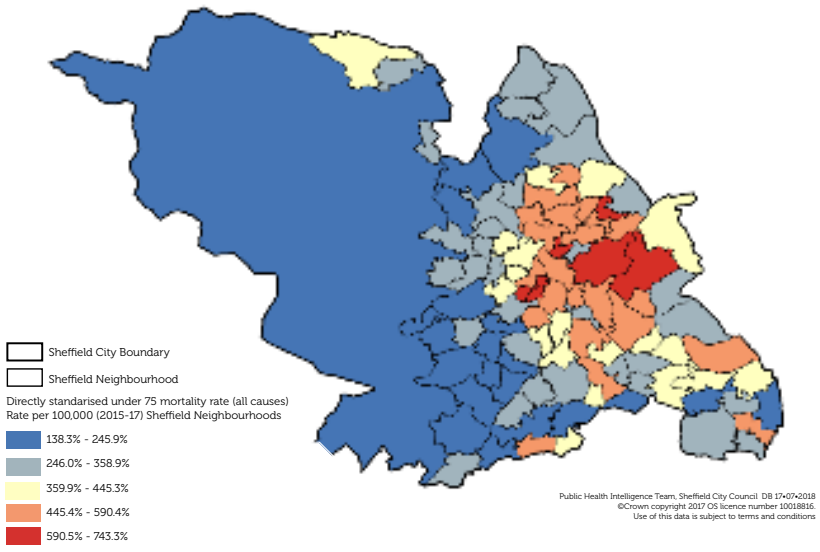
For example, the maps in figures 2 and 3 below show there is a strong association between poor health outcomes (in this instance we look at early death) and unemployment. For virtually any adverse health outcome we choose to look at, we find a similar association with unemployment.

Figure 2: Map of Employment domain from IMD 2015



Source: Index of Multiple Deprivation 2015; ONS - Mortality and population data

Figure 3: Map of under 75 all-cause mortality 2013-2017



The cost of poor health at work

There is also significant inequality in the employment rates between those with a health illness, condition or disability and the rest of the population, as shown in Figure 4[1].

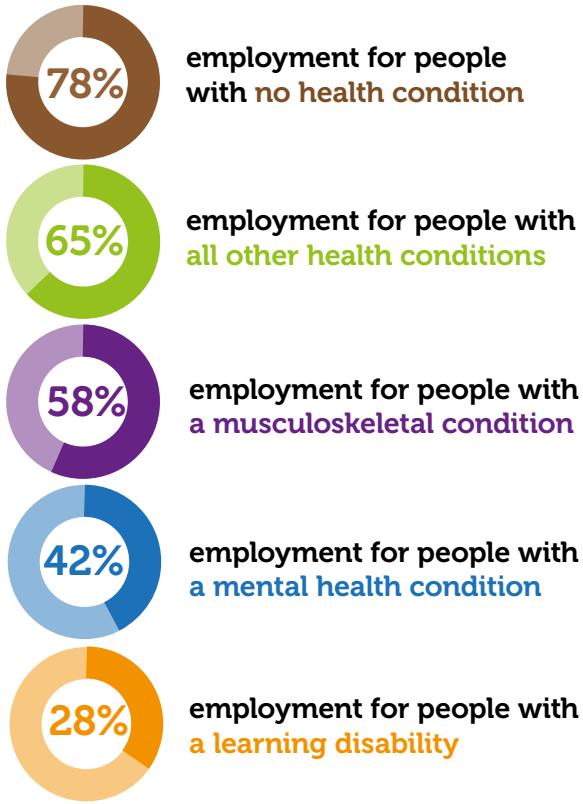
The combined cost of sickness absence, lost productivity through worklessness and health-related productivity losses are estimated to be over £1 billion annually in Sheffield alone. This is around the same amount as it costs to run the local NHS for a year.

The cost of poor mental health and addiction on work and the economy can be particularly high given that onset is often early in a person's working life or even during adolescence. This is disruptive to employment patterns and career aspirations, life chances as well as being a cost to the benefit system.

It is estimated that the cost of poor mental health alone to local employers is as much as £420 million a year with over half of this cost resulting from people who are less productive due to poor mental health in work, with additional costs from sickness absence and staff turnover.

Whilst employers may argue that the taxes, business rates and pension contributions they pay are sufficient and it is for the public sector to provide a healthy, well trained workforce, there seems to be a clear case for a significant return on investment for employers to improve the health of their workforce as well.[2]

Figure 4: Employment rates between those with an illness, condition or disability and the rest of the population



Source: Public Health England

1 Public Health England (2018) Work, Worklessness and Health: https://www.gov.uk/government/publications/health-and-work-infographics

2 Koss 2005 Sick on the Job , Myths and Realities about Mental Health and Work. World Health Organisation:

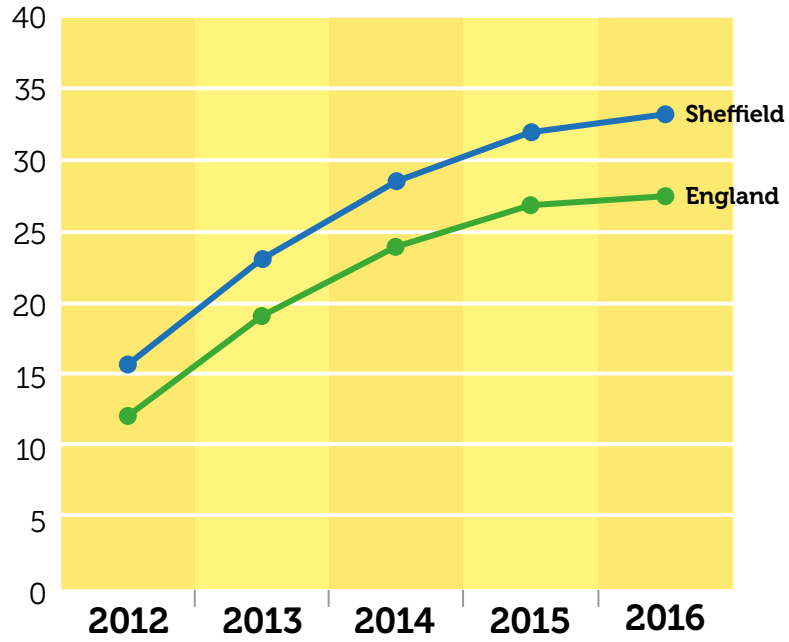
Mental health matters

The high prevalence of mental illness in the Sheffield population is a particular concern, not least because of the adverse impact on people's lives, employment outcomes and the economy. For example, among the working age population 42% of those who report mental illness as their main health problem[3] are in employment compared to 78% for the total population.

Similarly, we are seeing an increase in the number and proportion of people who identify mental health as the main health reason for requiring employment support allowance. As the graph in Figure 5 shows, whilst this increasing trend reflects the national picture, it is consistently higher in Sheffield in comparison with the England average and the gap between the city and the rest of the country is widening.

For those **in** work, poor health has a substantial impact on their ability to retain work. 19% of long-term sickness absence in England is attributed to mental ill health. It is a particular concern that some of these trends are going in the wrong direction. For example in 2014, based on national sources, over 150,000 working days were lost in Sheffield due to stress, depression and anxiety, an increase of over 24% since 2009[4]. Each year poor mental health costs the Sheffield economy around £700 million through lost productivity, social benefits and healthcare.

Figure 5: Employment Support Allowance (ESA) claimants for mental and behavioural disorders. Rate per 1,000 working age population in Sheffield and England (2012 to 2016)



Source: Public Health England

https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/data#page/4/gid/1938132922/pat/6/par/E12000003/ati/102/are/E08000019/iid/92621/age/204/sex/4

3 Includes: mental illness, phobia, panic, nervous disorders, depression and anxiety

4 There are 260 working days per year

Opportunities for young people

There are currently over four times more economically inactive people in Sheffield than there are unemployed. Within the economically inactive population in 2015, some 48% of people in receipt of Employment and Support Allowance (ESA) had a mental or behavioural disorder as their primary condition.

Research shows that these health categorisations 'hide' unemployment, and that Sheffield's unemployment rate, as elsewhere, is greater than national data indicate. Unemployment is calculated on the basis of the assumption that people claiming ESA are not able, or indeed do not want to work. Local research has shown that if these people had lived in wealthier areas they would have been able to secure and prosper in work[5]. This suggests that Sheffield has almost twice the unemployment rate suggested by national data.

Future trends in workforce health will also impact on our ability to maximise employment and productivity over the coming years. Currently 30% people of working age in Sheffield have a long-term health condition. This is expected to grow to 40% by 2030 (without intervention) with serious consequences for future economic productivity. Of these people, over half say their health is a barrier to the type or amount of work they can do. The distribution of this barrier to employment (and better health and wellbeing) is not equal; the most deprived people in the city have a 60% higher level of long term conditions than the least deprived[6].

Young people are a particularly important group to consider in this context. We know that around half of mental health conditions start before the age of 14 years. If we put this together with the data above we can see that addressing and preventing poor mental health in young people is a critical factor in developing a successful workforce and economy. The opportunities for young people with disabilities to participate in employment are especially challenging. Young people with disabilities account for 7% of the 16-24 population in Sheffield but make up 16% of the total number of this age group not in education, employment or training. The employment rate gap between people with and without disabilities widens after education from 27.8% at the age of 23 to 36.2% at the age of 24.

Obviously economic inactivity starting at such a young age has enormous implications for the life chances of those affected **and** for their longer-term ambitions and health and economic outcomes. The annual cost to the state of the average claimant receiving ESA is £8,500. Conversely, whenever an out-of-work claimant moves into a job at the "Living Wage"[7], the local economy benefits on average by £14,436 annually, or 40 times this over an employment lifetime.

5 Beatty, Fothergill and Gore (2017). The Real Level of Unemployment. Centre for Regeneration and Economic Sustainability Research (Sheffield Hallam University) and Joseph Rowntree Foundation (York)

6 PHE and Work Foundation (2016).Health and Work Infographics - A snapshot of the Health, Work and Worklessness Landscape

7 https://www.livingwage.org.uk/what-real-living-wage?gclid=CjwKCAjw1ZbaBRBUEiwA4VQCIQFksCO1N-EkNAGZFJU4GbheqSmk-_kyB93hgS2V6XAbovsjF58hkBoCMNoQAvD_BwE

Good jobs are good for our health

We cannot simply consider increased number of job opportunities as the sole route to economic prosperity and improved health. As we have seen, work can be a cause of various health problems: 'bad' jobs make us ill. A local study by Sheffield Citizens Advice for example, clearly shows the adverse impact insecure employment can have on people's health and wellbeing.[8]

The changing face of employment in the UK is an important factor in this, particularly in regard to the rise in self-employment and the "gig" economy.[9] There has been a significant increase in the number of Sheffield people reporting as self-employed. This may be down to increased innovation and entrepreneurship, but it could also be an indication of the rise in the gig economy.

The proliferation of low skilled, low paid, part-time and zero hours contracts is leading to an alarming increase in the number of households living in poverty who are in work. Put simply work, in and of itself, isn't working for enough people and it certainly isn't working for health. Low pay, low security and low status jobs can adversely affect health. The productivity challenge has both a supply and a demand side therefore; skills shortages are a significant factor, but so too is the proliferation of low-skilled jobs.[10] The picture we see emerging in Sheffield is one of an increasing number of people working increasing numbers of jobs and hours.

We are learning more and more about the link between good work and better health. Nationally, the Work and Health Unit is seeking to make "work" a clinical outcome. Similarly, our voluntary and community sector not only provides significant support to the people of Sheffield, it also provides numerous opportunities for people to contribute to the development of their community and to get involved in meaningful activity. We need to generate more, clear pathways for such people to progress into paid employment if they so wish. We are beginning to see this happen in relation to helping people with a health condition or disability to either return to work or remain in work. There are also opportunities for closer working between job centres, local health and social care services and education and skills training to improve employment outcomes.

For every job to be a healthy job it needs to be a good job. This means that every employee must be paid fairly, work in a safe and healthy workplace, be treated decently and with respect, have guaranteed hours, have the chance to be represented by unions and be consulted on what matters at work and have the chance to progress in work and get on in life. Too many jobs in Sheffield, as well as the UK more widely, aren't providing this.

That's why it is essential for the city to find ways of enabling and encouraging all employers to recognise their role in providing **good work**. The TUC's "Great Jobs Agenda" is an excellent example

8 https://citizensadvicesheffield.org.uk/news/insecure-employment-report/

9 https://www.parliament.uk/business/committees/committees-a-z/commons-select/work-and-pensions-committee/inquiries/parliament-2015/self-employment-gig-economy-16-17/

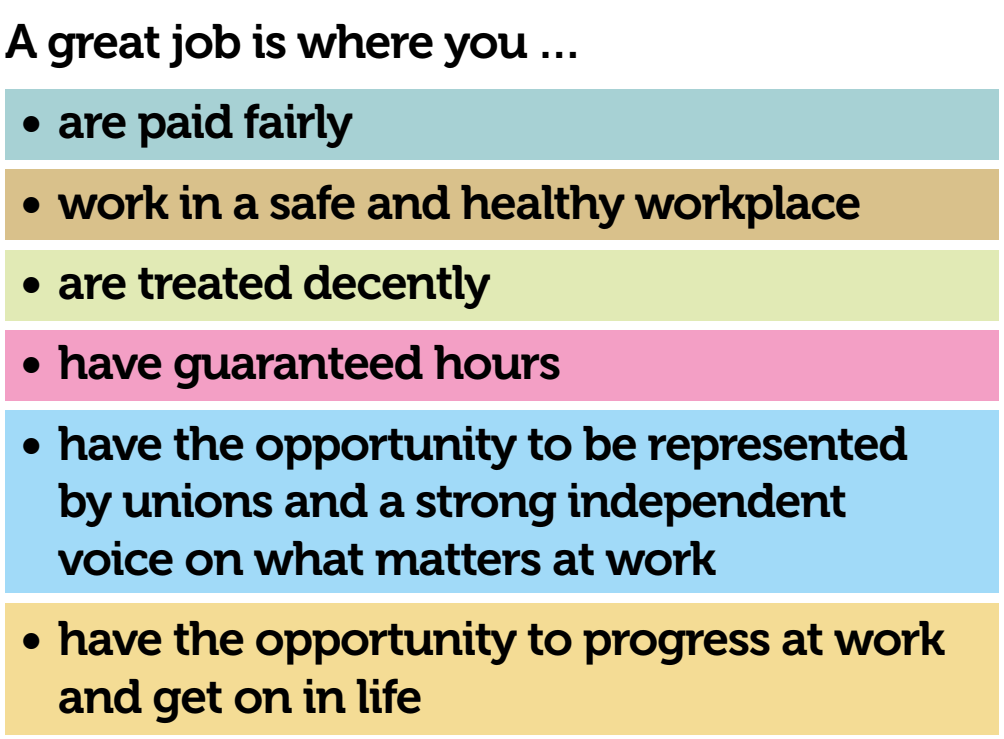
10 RSA Inclusive Growth Commission 2017 https://www.thersa.org/action-and-research/rsa-projects/public-services-and-communities-folder/inclusive-growth-commission#

of this, and needs to be progressed; the recommendations within the Sheffield Citizens' Advice report on insecure employment also deserve support.

Recommendation

Sheffield City Council, Sheffield City Partnership and **Sheffield City Region** should align and embed action into their economic strategies to enable and encourage all local employers to recognise their role in providing good work and ensuring that the most disadvantaged in our society are not left behind in their ambitions. Practical examples of this might include all organisations working towards implementing the fair employer charter, paying the foundation living wage and being ethical procurers.

Figure 6: A Great Job



Source: https://www.tuc.org.uk/publications/great-jobs-agenda

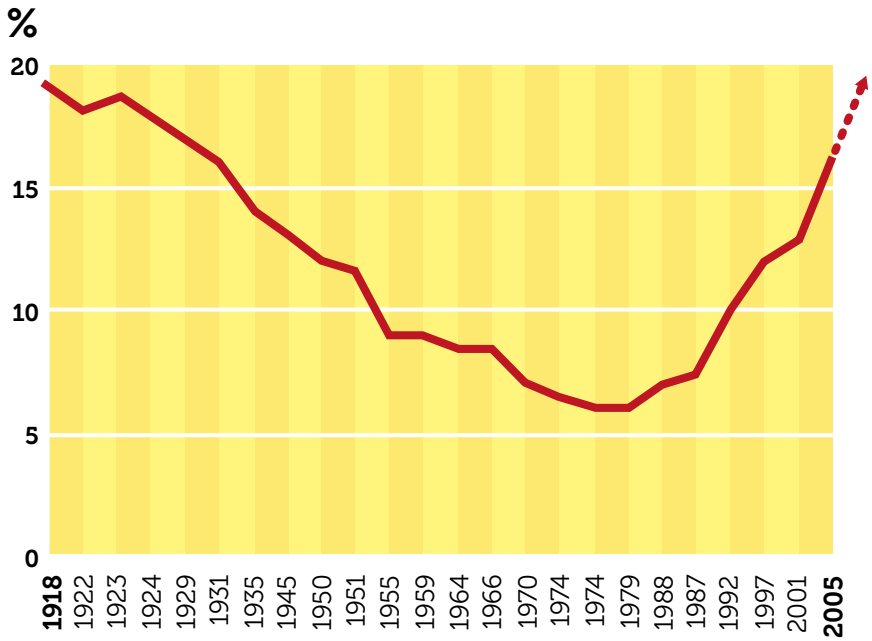
3.

Economy and health

Economy and health

Figure 7: The shape of income inequality over the last 100 years in Britain

Share of all income received by the richest 1% in Britain



Source: Policy Press 2012 and Semantic Scholar

The economy matters to the health and wellbeing of the population, but much depends on the size, shape and type of economy and the growth it experiences. There is growing recognition that traditional models of economic growth have simply failed to address inequalities, and may have exacerbated them, as is suggested by the World Economic Forum.[11]

As the graph in Figure 7 shows the share of all income received by the richest 1% of people in Britain has quadrupled over the last 30 years, widening the income inequality gap back toward levels that existed before the turn of the 20th century.

In the financial year ending 2017, before direct taxes and cash benefits, those in the top fifth income group had an average income of £88,800 per year, compared with £7,400 for the poorest fifth - a ratio of 12 to 1 (income includes earnings, private pensions and investments).[12] There is no evidence to suggest the local position is any different to this.

For previous generations, the risk of and exposure to mass unemployment was the main economic challenge faced. Employment is now comparatively high but real wages have stagnated and the quality of work transformed, resulting in a greater number of people detached from the benefits that economic growth is supposed to deliver.

11 World Economic Forum (WEF) Inclusive Growth and Development Report 2015 http://www3.weforum.org/docs/WEF_ForumIncGrwth.pdf

12 ONS, 2018 Household disposable income and inequality in the UK: financial year ending 2017 available online at: https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/bulletins/householddisposableincomeandinequality/financialyearending2017

The case for an inclusive economy

What became clear after the financial crash of 2007-08 was that the UK economy was overly dependent on London for its economic success and placed insufficient importance on the role of local economies (especially core cities such as Sheffield) in creating a more economically resilient and cohesive country.[13] The concept of an "inclusive economy" emerged from this understanding.[14]

Characteristics of the local population such as health and well-being, social cohesion, isolation and poverty all impact on opportunities to participate in and benefit from the economy and economic growth. In Sheffield, wide inequalities in healthy life-expectancy, long-term ill health and deprivation are the defining factors of economic exclusion and represent significant challenges for developing inclusive economic policies.

There are a number of different ways to define and measure the inclusiveness of an economy and the type of growth it experiences, but the common factor in all of these measures is the emphasis placed on the need to balance economic prosperity with the ability of all parts of society to participate in and benefit from it. This means giving **equal** weight to economic, health and social factors. The 2018 State of Sheffield report[15] attempted to do just that. Specifically the report used the Grant Thornton Vibrant Economy Index as a measure of inclusive economy[16]. This combines indicators from the following six domains:

- Prosperity
- Dynamism and opportunity
- Inclusion and equality
- Health, wellbeing and happiness
- Resilience and sustainability
- Community, trust and belonging

According to the Grant Thornton Vibrant Economy Index, Sheffield was ranked in the bottom 40% in the country in 2013.

Although this position has improved significantly over the last 5 years (Sheffield is now around average - see the map in Figure 8), the city still scores low in relation to the inclusion and equality domain. This is being driven, in the main, by high deprivation, low aspiration and long term ill health preventing people from accessing the labour market. Without a healthy and well workforce, any growth will be unequal, less sustainable and will not generate health improvement.

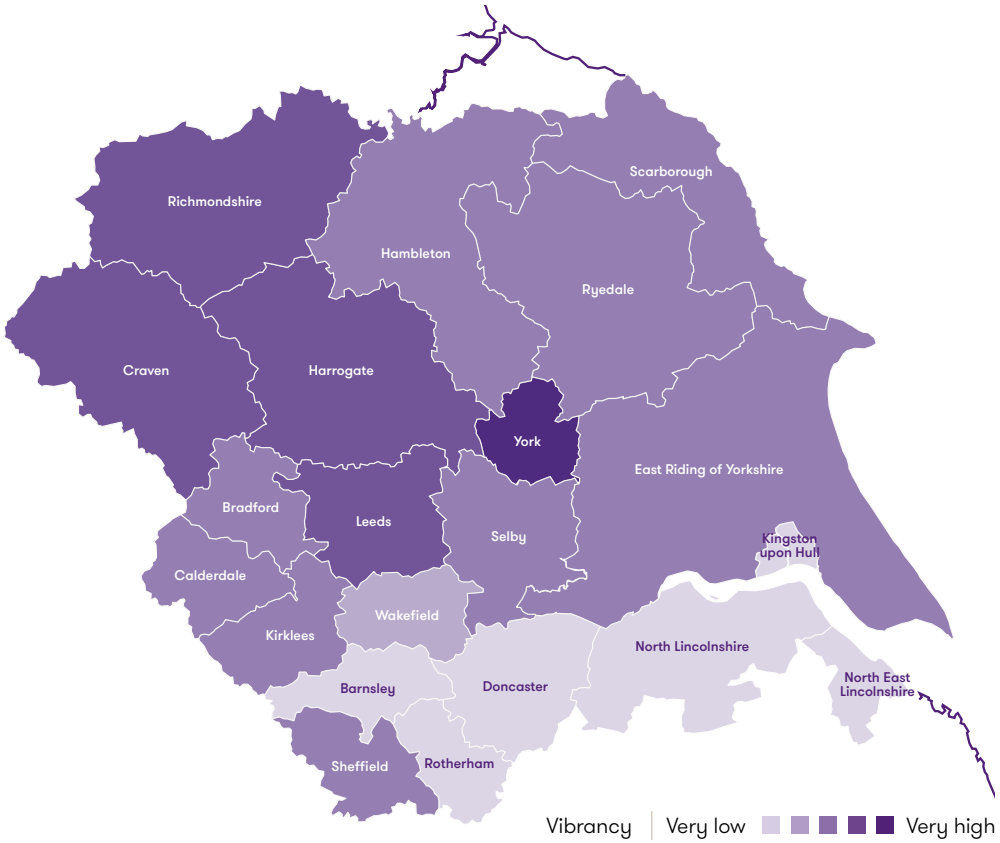
What this tells us is that if Sheffield is to be a place where all of its residents flourish and thrive the key agencies and institutions of Sheffield across the private, public, academic, voluntary, community and faith sectors must work together to shape the economic future of the city.

13 Regional Studies Association (2015) Spatially rebalancing the UK economy: the need for a new policy model. http://www.regionalstudies.org/uploads/documents/SRTUKE_v16_PRINT.pdf

14 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'. http://www.oecd.org/inclusive-growth/

Health is an asset to the economy

Figure 8: Map of Vibrant Economy Index in Yorkshire and the Humber in 2017



Source: Grant Thornton

While there is ample focus on what ill health costs us both as individuals and as a society, there is rarely acknowledgement of the converse: that good health is an asset, essential for a flourishing society and economy. Good health and an inclusive economy, that shares the benefits of growth and good work across all groups in the population, go hand in hand. On this basis, a strategy for an inclusive economy could be regarded as one of the most important and effective approaches to improving health and wellbeing in a population.

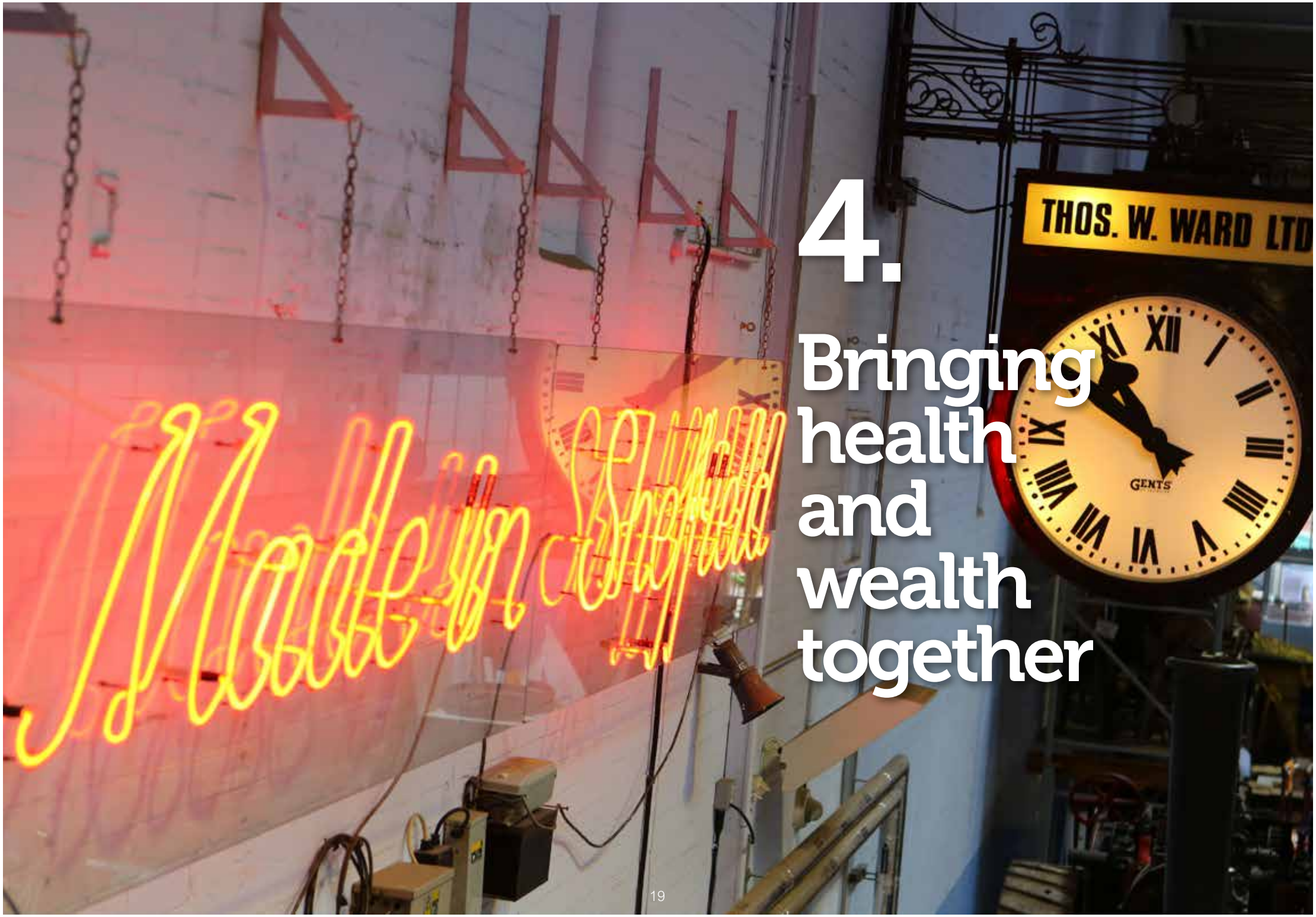
Recommendation

Despite years of austerity, there is still funding coming into Sheffield to support business investment and economic growth. These resources represent an important contribution to health improvement. For this reason the:

Sheffield City Partnership, as part of developing a strategy for an inclusive and sustainable economy, should consider how best to use the resources currently available to the city to incentivise implementation of the strategy.

15 https://www.sheffieldcitypartnership.org/scp-reports/2018/3/5/state-of-sheffield-2018-report-tyte2

16 Grant Thornton Vibrant City Tool https://www.grantthornton.co.uk/en/insights/vibrant-economy-index



4.

Bringing health and wealth together

Bringing health and wealth together

There is a growing city-wide commitment to fostering a more inclusive and sustainable economy for Sheffield.

The State of Sheffield 2018[17] report drew together a range of data and insights about life in Sheffield with the aim of building a local evidence-base for how and why we should pursue an inclusive economic approach for the city. The Sheffield City Partnership[18] is now using this evidence to help it develop a framework for an inclusive and sustainable economy for Sheffield. The aim is to build on what makes Sheffield special, nurturing the city's tradition as a collection of friendly, unique and diverse local communities, at the heart of a thriving, open and trailblazing global city. Across these communities, we need to ensure every citizen has the best chance of participating equally in and benefitting from success. Put simply, Sheffield's economy should work for us all, to help us lead happier, healthier and more fulfilling lives.

We shouldn't underestimate the size of the task however, either in terms of the resources that will be required to achieve change; agreeing the shape and nature of the changes we need to make (or how we will measure them); exactly how to achieve change; or the time all of this will take. It is also clear that we will need to make sure this plan aligns with Sheffield City Region's economic strategy as well as those of individual organisations such as Sheffield City Council. It is in this regard in particular that the anchor institutions of Sheffield have a pivotal role to play.

The UK Commission for Employment and Skills[19] describes an anchor institution as one that, alongside its main function, plays a significant and recognised role in a locality by making a strategic contribution to the local economy. In Sheffield anchor institutions include Sheffield City Council, the two local universities and the Sheffield Clinical Commissioning Group along with local NHS providers. These are organisations that are rooted in their local communities by mission, invested capital, or relationships to customers, employees, and vendors. Anchor institutions share a number of key characteristics:

- **Spatial immobility:** strong ties to the geographic area in which they are based through invested capital, mission and relationship to customers and employees
- **Size:** large employers with significant purchasing power. Both these factors influence the level of impact these institutions can have on the local economy
- **Non-profit:** tend to operate not-for-profit; it is much simpler for private businesses to move, meaning there is no guarantee they will continue serving the local community in the long-term. However, there are examples of for-profit organisations playing the role of an anchor.

17 https://www.sheffieldcitypartnership.org/scp-reports/2018/3/5/state-of-sheffield-2018-report-tyte2

18 https://www.sheffieldcitypartnership.org/

19 https://ukces.blog.gov.uk/2015/03/19/ukces-explains-what-is-an-anchor-institution/

The role of anchor institutions

At city level the combined impact of the voluntary, community and faith sector is included on the list of anchor institutions (see Figure 9) because they are increasingly connected to each other and have a significant amount to offer in terms of buying power and as a shaper of local communities. At community level, community and voluntary sector organisations are often **the** anchor organisation, along with GP practices, pharmacies and libraries.

Figure 9: Anchor Institutions

Source: Sheffield City Council

The City Partnership Board has started work across all the big public sector anchor institutions in Sheffield on social value. The role of anchor institutions is to move away from sector-specific thinking and focus on developing the "return on investment" case for a whole place.

Sheffield City Council, for example, is leading on ways of using the power of procurement of goods and services to spread the influence of anchor institutions. It has revised protocols, processes and tools across the organisation and its supply chain to enable it to conduct business ethically, effectively and efficiently for the benefit of Sheffield. In particular, it has adopted three tools: social value tests; an ethical code of conduct for suppliers; and revised tender processes. But we can and must go further than this. The table in Figure 10 sets out the four elements of the anchor institution role that we need to align and promote across the public, private and voluntary sectors in Sheffield.

Recommendation

The **Sheffield City Partnership** should facilitate the public, private and voluntary anchor institutions of Sheffield to develop a collective strategy to secure and progress their contribution to an inclusive economy, underpinned by supportive strategies for each sector.

A strategy for anchor institutions

Figure 10: The four key elements of a strategy for anchor institutions

Leadership and readiness for an anchor approach

- developing a jointly agreed Anchor 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

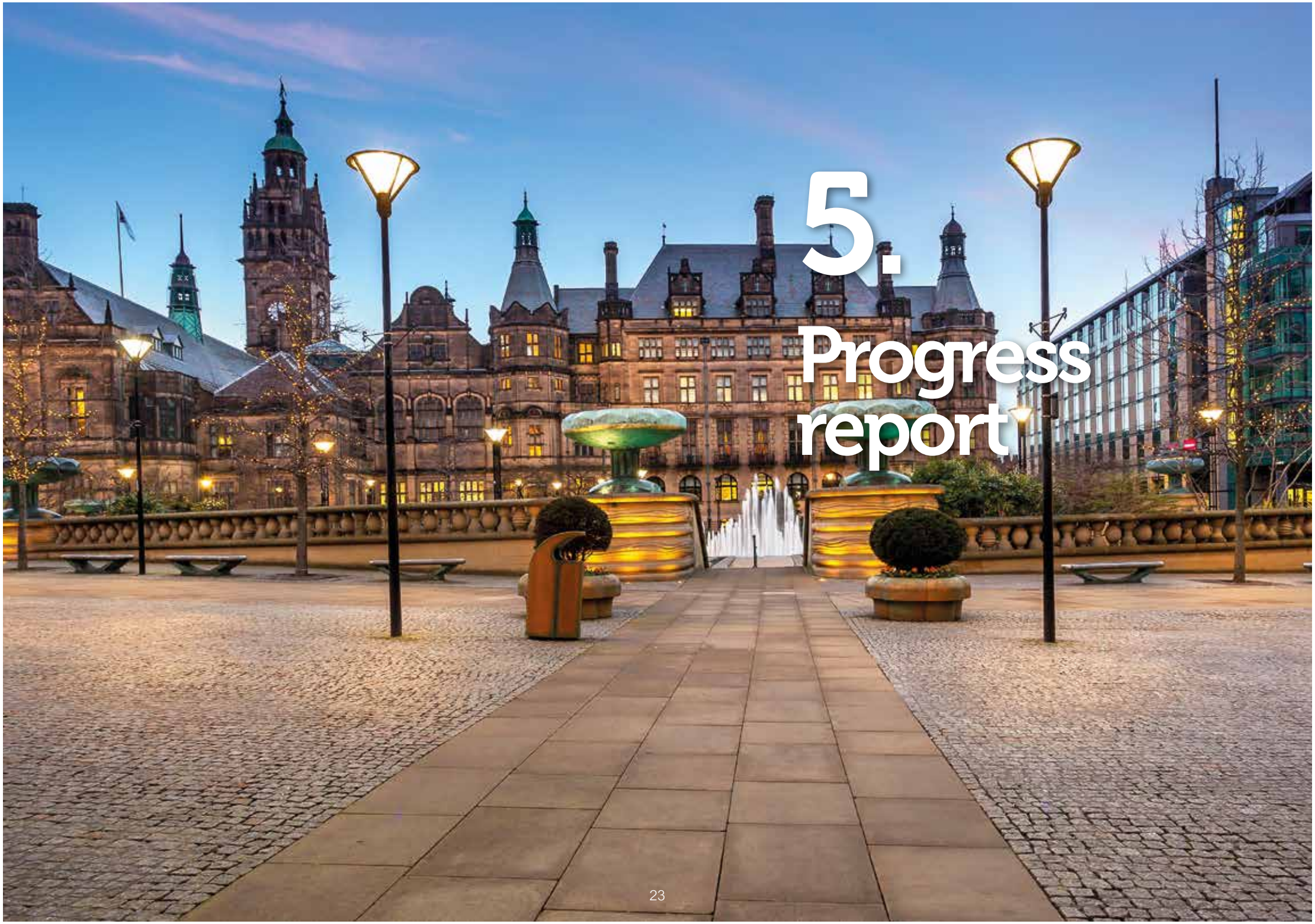
- a commitment to an accredited living wage for the City, starting with an agreement among the anchor institutions
- equipping local residents for high-demand, frontline jobs that are connected to further employment prospects
- maximising apprenticeship opportunities for people from disadvantaged and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

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
- 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 hedge funds and local social capital
- community investment in land trust. Purchase land to secure sustainable and affordable housing, emphasising how anchor institutions manage their estates for the benefit of the community



5. Progress report

Progress report

Health and wellbeing in Sheffield

Public Health England produces a dashboard of key public health indicators for all local authorities in England. The indicators are focussed on the mandated elements of the Public Health Grant.

Each local authority is ranked out of 16 similar local authorities using the latest data available. The rank rates 1 as the highest or best and 16 as the lowest or worst.

Sheffield's ranking is set out in the table in Figure 11. This shows a very mixed picture with Sheffield ranked among the best in terms of child obesity, tobacco control and best start in life; broadly average in relation to sexual and reproductive health and drug and alcohol treatment; and among the worst for NHS Health Checks and air quality (although it should be noted that the air quality measure remains under development).

Figure 11: Public Health Dashboard (Sheffield)

Indicator	Rank (out of 16 where 1 is best and 16 is worst)	Position
Child Obesity (2016-17)	4	Best
NHS Health Check (2013-14 to 2017-18)	13	Worst
Tobacco Control (2016-17)	4	Best
Alcohol Treatment (2016-17)	11	Average
Drug Treatment (2016-17)	9	Average
Best start in life (2016-17)	4	Best
Sexual & reproductive health (2016 -17)	7	Average
Air Quality (2017) - INTERIM MEASURE	12	Worst

Source: Public Health England https://healthierlives.phe.org.uk/topic/public-health-dashboard/area-details#are/E08000019/par/nn-1-E08000019/sim/nn-1-E08000019

Last year's DPH report recommendations

Each year the Director of Public Health Report makes a set of recommendations for improving health and tackling health inequalities within the local population.

Here I summarise the progress made on the recommendations I made in last year's report.

Recommendation	Progress
The Council and the CCG should request Public Health England to co-ordinate further research on identifying and describing the long term return on investment and effectiveness of primary and secondary prevention models for tackling Adverse Childhood Experiences (ACEs).	The research assembled to date indicates that the most cost effective approach to take strategically would be one which seeks to reduce the number of adversities experienced by people in Sheffield and build resilience to prevent the negative impacts in children before they experience ACEs and to mitigate the negative impacts (as soon as possible) for children and adults who have already experienced ACEs.
The Council and the CCG should review the mental health strategy and evaluate the City's approach to mental health and wellbeing against the current evidence base for high impact/high value interventions, including the economic case for investment on good mental health.	The mental health strategy has been reviewed against the latest economic and effectiveness evidence base and is currently in draft form awaiting consultation with stakeholders and communities. It is likely to be published later in the year.
The Council and the CCG should commission more in-depth epidemiological analysis of changes in multi morbidity and enhance their approach to healthy ageing, including care of people who have multiple illnesses.	A range of analyses and strategic developments are being taken forward to support greater understanding of and response to multi morbidity in Sheffield including commissioning more detailed prevalence estimates from Public Health England and further analysis undertaken for the Accountable Care Partnership. In relation to developing our approach to healthy ageing and care of people with multiple illnesses, we are currently re-shaping our approach to a City for all Ages; Social Prescribing; and Person Centred City, in addition to developing a prevention framework for the Council and renewing the Health and Wellbeing Strategy using a life course approach.

Further information

For more information on health and wellbeing outcomes in Sheffield you can access various data, maps and graphs, in-depth health needs assessments and other resources from our online JSNA resource, although please be aware this is still a work in progress and there will be many more topics to be added over the rest of the year:

https://www.sheffield.gov.uk/jsna

You can download a copy of this report here:

https://sheffieldcc.maps.arcgis.com/apps/Cascade/index.html?appid=5b4391e4e6b7447682d088ed29943356

We're keen to hear your views on this report and in particular on the themes and issues we've raised. You can contact us directly using the following details:

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