Who are we?

The Health and Wellbeing Board is a joint board of the Council and CCG which provides the strategic leadership for the health and social care in the city. Meetings are open to the public and everyone is welcome.

Where and when is the Board meeting?

This next meeting will be held in the **Council Chamber, Hove Town Hall, Norton Road, Hove, BN3 4AH** on **Tuesday, 20 September 2016**, starting at **4.00pm**. It will last about three hours.

There is public seating and observers are welcome to attend.

What is being discussed?

There are **six** main items on the agenda:

- Sustainability & Transformation Plan
- CQC Inspection of Brighton & Sussex University Hospitals Trust
- Single Homelessness and Rough Sleeper Accommodation & Support Services
- Remodelling and Tender
- CQC/Ofsted SEND inspection
- Food Poverty Action Plan and Nutrition and Older People
- Fuel Poverty and Affordable Warmth Strategy

Health & Wellbeing Board

Geoff Raw
Chief Executive - BHCC
(Non-voting)

Cllr Yates
Chair
(Voting member)

Natasha Watson
Lawyer BHCC

Giles Rossington
Secretary - BHCC

Dr. Christa Beesley
CCG
(Voting member)

Cllr K. Norman
(Voting member)

Cllr Brown
(Voting member)

Peter Wilkinson
Acting Director of Public Health
(Non-voting Statutory member)

John Child
CCG
(Voting member)

Dr. Manas Sikdar
CCG
(Voting member)

Graham Bartlett
Safeguarding Children's & Adults
(Non-voting co-optee)

Pinaki Ghoshal
Director Children's Services - BHCC
(Non-voting Statutory Member)

Lead Member
(In attendance - Non-voting)

Cllr Penn
Lead Member for Mental Health
(In attendance – Non-voting)

Cllr Barford
Lead Member for Adult Services

Cllr Page
(Voting member)

Dr. George Mack
CCG – Lay Member
(Voting member)

David Liley
Healthwatch
(Non-voting Statutory member)

Pennie Ford
NHS England
(Non-voting co-optee)

Dr Xavier Nalletamby
CCG
(Voting member)

Brian Doughty
Acting Statutory Director Social Services BHCC
(Non-Voting co-optee)

Presenting Officer
or
Public Speaker

Presenting Officer
or
Public Speaker

Press

Public Seating

Officers and Representatives attending

Health & Wellbeing Board
20 September 2016
4.00pm
Hove Town Hall Council Chamber, Hove Town Hall, Norton Road, Hove, BN3 4AH

Who is invited:

Voting Members: Cllrs Daniel Yates (Chair), Karen Barford, Vanessa Brown, Ken Norman and Dick Page; Dr Christa Beesley, John Childs, Dr George Mack, DR Xavier Nalletamby and Dr Manas Sikdar (Brighton & Hove Clinical Commissioning Group).

Non-Voting Members: Geoff Raw, Chief Executive; Brian Doughty, Acting Statutory Director of Adult Services; Pinaki Ghoshal, Statutory Director of Children's Services; Peter Wilkinson, Acting Director of Public Health; Cllr Caroline Penn (BHCC); Graham Bartlett (Brighton & Hove Local Safeguarding Adults and Children's Boards); Pennie Ford (NHS England); and David Liley (Brighton & Hove Healthwatch).

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This Agenda and all accompanying reports are printed on recycled paper

Date of Publication - Monday, 12 September 2016


Health &
Wellbeing

AGENDA

Formal matters of procedure

This short formal part of the meeting is a statutory requirement of the Board

Page

26 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

The Chair of the Board will formally ask if anyone is attending to represent another member, and if anyone has a personal and/or financial interest in anything being discussed at the meeting. The Board will then consider whether any of the discussions to be held need to be in private.

27 MINUTES **1 - 34**

The Board will review the minutes of the last meeting held on the 12th July 2016, decide whether these are accurate and if so agree them.

28 CHAIR'S COMMUNICATIONS

The Chair of the Board will start the meeting with a short update on recent developments on health and wellbeing.

29 FORMAL PUBLIC INVOLVEMENT

This is the part of the meeting when members of the public can formally ask questions of the Board or present a petition. These need to be notified to the Board in advance of the meeting. Ring the Secretary to the Board, Mark Wall on 01273 291006 or send an email to mark.wall@brighton-hove.gov.uk

The main agenda

Papers for Discussion at the Health & Wellbeing Board

30 Sustainability & Transformation Plan (STP) **35 - 38**

Ward Affected: *All Wards*

31 CQC Inspection Report on Brighton & Sussex University Hospitals Trust (BSUH) **39 - 44**

Ward Affected: *All Wards*

Health & Wellbeing

32	**Single Homeless and Rough Sleeper Accommodation & Support Services Remodelling & Tender (HWB Sept 2016).**		45 - 100
	Contact:	*Jenny Knight*	*Tel: 01273 293081*
	Ward Affected:	*All Wards*	
33	**CQC/Ofsted SEND Inspection Report**		101 - 116
	Contact:	*Regan Delf*	*Tel: 01273 293504*
	Ward Affected:	*All Wards*	
34	**Food Poverty Action Plan and Nutrition and Older People**		117 - 184
	Contact:	*Becky Woodiwiss*	*Tel: 01273 296575*
	Ward Affected:	*All Wards*	
35	**Fuel Poverty and Affordable Warmth Strategy for Brighton & Hove**		185 - 244
	Contact:	*Miles Davidson*	*Tel: 01273 293150*
	Ward Affected:	*All Wards*	

WEBCASTING NOTICE

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For further details and general enquiries about this meeting contact Democratic Services, 01273 2910386 or email democratic.services@brighton-hove.gov.uk

Health & Wellbeing

Public Involvement

The Health & Wellbeing Board actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public.

If you wish to attend and have a mobility impairment or medical condition or medical condition that may require you to receive assisted escape in the event of a fire or other emergency, please contact the Democratic Services Team (Tel: 01273 291066) in advance of the meeting. Measures may then be put into place to enable your attendance and to ensure your safe evacuation from the building.

Brighthelm has facilities for people with mobility impairments including a lift and wheelchair accessible WCs. However in the event of an emergency use of the lift is restricted for health and safety reasons please refer to the Access Notice in the agenda below.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter and infra-red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

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- You should proceed calmly; do not run and do not use the lifts;
- Do not stop to collect personal belongings;
- Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and

Do not re-enter the building until told that it is safe to do so.

Health & Wellbeing

1. Procedural Business

(a) Declaration of Substitutes: Where Members of the Board are unable to attend a meeting, a designated substitute for that Member may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest:

(a) Disclosable pecuniary interests
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members of the Board should seek advice from the Lawyer or Secretary preferably before the meeting.

(c) Exclusion of Press and Public: The Board will consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, that the press and public should be excluded from the meeting when any of the items are under consideration.

NOTE: Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.

A list and description of the exempt categories is available from the Secretary to the Board.

4.00pm 12 July 2016
Auditorium - The Brighthelm Centre

Minutes

Voting Members Present: Councillors Yates (Chair), K Norman (Opposition Spokesperson), Brown, Page and Barford. Dr. Christa Beasley, John Child, Dr. George Mack; Dr. Manas Sikdar, Dr. Xavier Nalletamby.

Other Members present: David Liley, Health Watch; Graham Bartlett, Adult and Children's Safeguarding Boards; Pinaki Ghoshal, Statutory Director of Children's Services; Denise D'Souza, Statutory Director of Adult Social Care; Dr. Peter Wilkinson, Acting Director of Public Health; Cllr Penn

Part One

14 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

14.1 There were no substitutes. Apologies were received from Pennie Ford.

14.2 Cllr Yates declared an interest in Item 23 (Sustainability & Transformation Plan) as he is an employee of an NHS Trust based in Sussex. Cllr Yates has received a dispensation enabling him to take part in this and related items.

14.3 It was agreed that the Press & Public should not be excluded from the meeting.

15 MINUTES

15.1 RESOLVED – that the minutes of the meeting of May 25 2016 be agreed subject to an amendment proposed by Cllr Page: that the record of members present at the meeting should differentiate between 'voting members' and 'others'.

1

16 CHAIR'S COMMUNICATIONS

16.1 Welcome to the meeting. It is a busy agenda and the chairs communications will be noted in full in the minutes.

I would like to welcome David Liley, the new Chief Officer of Healthwatch. I would also like to thank Fran McCabe, the Chair of Healthwatch for her contribution to the Board. Fran, who has attended these meetings up to now but is going to be a co-opted member of our Health Overview and Scrutiny Committee.

In addition I would like to welcome Wang Jing and Liang Chen who are in the audience today. Wang and Liang are researchers at the Institute of Sociology and Social Policy Research Centre of the Chinese Academy of Social Sciences (CASS), a major Chinese government research institute with a mandate to provide support to policy formulation.

Finally I would like to say good bye to Denise D'Souza, the Executive Director of Adult Services. Denise is retiring at the end of August and this means it is her last Board meeting. Denise has been part of the city services for many years, working in several roles before becoming Executive Director. We wish her a very happy retirement.

Residential Rehabilitation Services Contract for Substance Misuse
In October 2015 the Health and Wellbeing Board agreed that commissioners could seek to negotiate new four year residential rehabilitation contracts with current providers, with the option of moving to a competitive process if negotiations failed.

Commissioners were successful in negotiating contracts with the existing providers, and signed contracts are now in place for the next four years. Residential rehabilitation services will continue to be provided by Brighton Housing Trust, and Change, Grow, Live (known as Crime Reduction Initiatives at the time of writing the October 2015 report).

TakePart
TAKE**PART** is an award winning festival, celebrating sport, dance and active lifestyles in Brighton & Hove. The two week celebration has involved over 100 organisations engaging families, children and adults of all ages, many offering free taster sessions throughout the city. The aim is to support people to engage in healthy activity.

Hove Medical Centre
As you may have seen in the local press, CQC has recently inspected the Hove Medical Centre and rated it as inadequate. This does not mean the surgery will be closing down. The surgery has to prepare a robust action plan and demonstrate improvement. The matter is already being dealt with by HOSC.

City Plan consultation
Leaflets will be on the Board table and also on public seating. A copy will be attached to the minutes

The council has started work on the City Plan Part Two (CPP2) and is consulting on a Scoping Paper - consultation runs 30 June to 22 September 2016. The quick guide provides a summary of all the topics and policy issues covered in the full Scoping Document. Responses to this consultation will help shape the content of the plan.

To find out more about the issues and view City Plan Part Two Scoping consultation documents please visit www.brighton-hove.gov.uk/cityplan-part2

Action on Elder Abuse

As you may already be aware, Action on Elder Abuse has launched a new national campaign, calling for an aggravated offence of elder abuse.

Information will be added to the minutes about the campaign and how to get involved.

BSUHT

As you may be aware the hospital has also had a CQC inspection. Brighton and Sussex University Hospitals NHS Trust has been issued with a Warning Notice by the Care Quality Commission (CQC) under Section 29A of the Health and Social Care Act. The Notice requires the Trust to make significant improvements to the quality and safety of care and privacy and dignity of both inpatient and outpatients in a number of key areas. It also highlights a failure to provide treatment and care that is in line with national timescales and standards. The Trust is required to make the necessary improvements by 30 August 2016.

The Notice comes following the CQC's full inspection of the Trust in April and the report from this will be published later in the summer.

The Trust is already working hard on delivering an improvement plan designed to address the issues raised by the CQC and has taken action on the most immediate concerns since their April visit.

HOSC will be leading on this work.

A report will come to the September Health and Wellbeing Board.

16.2 A number of Board members joined with the Chair in praising Denise D'Souza's contributions to the city and wishing her a happy retirement.

17 FORMAL PUBLIC INVOLVEMENT

17.1 Question from Valerie Mainstone

17.1.2 Ms Mainstone asked the following question:

"At the June Health and Wellbeing Meeting you stated, in answer to a question, that the Healthy Child Programme (HCP) was being put out to tender because of legal requirements.

Given the fact that other areas, such as our near neighbours in West Sussex, are not putting their services out to tender and that you also stated that a service provided by the current provider has a number of benefits, why do you not stop the tendering now? You will also have seen the results of the first Citizens' Health Services Survey - 90% of people want these (HCP) services to stay with the NHS."

17.1.2 The Chair responded:

"Thank you for your question.

The report on the Public Health Community Nursing Commissioning strategy presented to the Health and Wellbeing Board on 15th March 2016, explains that Brighton and Hove City Council is subject to the Public Contracts Regulations 2015 and must comply with the overriding principles of transparency, non-discrimination and equality in the process of procuring and awarding all contracts including Public Health contracts.

The value of the services for the Public Health Community Nursing services exceeds the threshold of £589,148.00 and were therefore advertised in the Official Journal of the European Union (OJEU) by way of the placement of a Prior Information Notice (PIN) as per the regulations. The regulations state that if providers come forward as a response to the PIN then a tender process should be undertaken.

Failure to advertise the contract would have been a breach of the Public Contracts Regulations 2015 and the Council's Contract Standing Orders. Such a breach could result in any contract awarded directly being declared ineffective and a fine being imposed, or the Council being open to a claim for damages

The Health and Wellbeing Board delegated authority to the Director of Public Health to place a PIN pursuant to the requirements of the Public Contracts Regulations 2015 and to carry out to a competitive procurement process if alternative providers come forward.

We cannot comment on the commissioning process of neighbouring local authorities, however for the record West Sussex County Council has indicated that there is no decision as to their intentions to re procure the Healthy Child Programme services or otherwise."

17.1.3 Ms Maidstone asked a supplementary question, about the likely costs of the procurement exercise. Peter Wilkinson responded that the main cost, aside from the cost of advertising in the European Journal,

would be in terms of staff time. It was difficult to estimate this as this point, as it would depend on the level of interest in the contract. However, this would likely be in the £100s or £1000s rather than tens of £1000s.

17.2 Question from Mr Kapp

17.2.1 Mr Kapp was not able to attend the meeting; Ms Mathers asked a question on his behalf:

"Will the HWB and CCG follow the lead of Swindon CCG who have the shortest referral to treatment (RTT) waiting time in the England for talking therapies?

Notes to this question
1 In August 2013 Channel 4 News covered award-winning Swindon, who have provided the best mental health service in England by providing free courses since 1993 to teach patients how to look after themselves better. I attended a study day with them, and wrote it up in paper 9.63 of www.reginaldkapp.org dated 9.9.13, titled 'Report on LIFT psychology. Creating a patient -centred mental health service Swindon fashion.'

2 Last Tues, 5.7.16, I attended a conference in London 'Psychological therapies for severe mental illness' at which the following people presented papers on how they provide the most cost effective service in the country. Thomas Kearney, Associate Director of Commissioning, Urgent Care Lead, Swindon CCG, thomas.kearney@swindonccg.nhs.uk, and Dr Sarah Hunt, clinical psychologist, LIFT, sarah.hunt10@nhs.net"

17.2.2 The Chair responded:

"Thank you for your question.

When we re-commission services we will ensure that the new service design reflects national best practice."

17.2.3 Ms Mathers asked a supplementary question about how long it would take for services to stop failing people with mental health issues? The Chair replied that it was very important that there were high quality mental health services available. This is not simply about providing rapid access to services, but about ensuring that treatment delivers the best possible outcomes and that there is preventative work to stop people becoming unwell in the first place. John Child added that when mental health services were re-procured commissioners would ensure that the new service design reflects national best practice, potentially including learning from Swindon.

17.3 Deputation – Carl Walker

17.3.1 Mr Walker presented his deputation to the Board:

"Deposition- Findings from the first Brighton Citizens Health Services Research

- First of all I would like to thank the board for the opportunity to feedback the findings of this project. I would like to start with providing a very brief academic background to this project.
- In key guidance documents issued to CCGs on governance, it is recommended that CCG's have a responsibility to ensure that patients and the public are actively involved in commissioning arrangements. However CCGs are also accountable to multiple other agencies (Checkland, 2013).
- Recent reports from clinicians across England, documented in the British Medical Journal, describe dysfunctional commissioning processes in areas undergoing competitive tendering, with compromised patient pathways and where cost-efficiency seems to be the overriding quality (BMJ 2015; 350:h149).
- Very recent research suggests that, for a second year in a row, health care professionals, including commissioners, do not feel CCG policies reflect their own views and that they have very little chance to impact CCG's policy decisions (Murphy, 2015).
- There is however strong evidence that patient participation is linked to better treatment results, higher patient satisfaction and more responsive services. It is suggested that there is a need to look for additional ways through which to engage with the public, beyond the traditional set-piece consultations (Hudson, 2015).
- With this in mind, the first Brighton Citizen's Health Services Survey (BCHSS) was conceived by academics at the University of Brighton to explore some of the broader questions about healthcare commissioning that often get missed during traditional consultation. Such questions are important and can relate directly to the quality of services that people experience.
- The project has been developed using a distinctive approach to survey design that is aligned to public engagement, participation and critique rather than toward the more typical production of a validated instrument and knowledge form. Hence to ask people questions about things they 'may not know'.
- These consultations are not about patients' experience of their local services directly but rather seek to capture rich data representing the voices of the people of Brighton and Hove on important topical health issues like funding cuts, NHS privatisation and the broader link between local commissioning and national funding policy directives.
- 1,300 residents of Brighton and Hove were asked to take a survey of 8 questions based on key current and upcoming commissioning issues. These focussed on core values on health commissioning, current commissioning issues and future commissioning plans.

The key findings were as follows-

- When asked who they would prefer to be treated by, almost **88%** of the respondents said the NHS. This compared with **9.1%** who had a preference for a private healthcare company.
- When asked whether people believed that "health companies should not make financial profit from people's health problems", **92%** strongly agreed or agreed with this statement.
- Participants were asked whether, in light of Optum's international legal difficulties, there should have been a full public consultation on Optum. **93%** said that there should have been.
- Over **93%** of people said that they were concerned or very concerned about the award of the Optum contract locally.

- The council recently revealed an intention to cut £21.9 million over the next 4 years from the Adult Social Care budget. Over **97%** of people were either very concerned or concerned about these cuts.
- **97%** of people either strongly agreed or agreed with the following statement, 'The council should be actively resisting these latest cuts by evidencing their impact and sending the messages back to central government'.
- In 2016 and 2017 the Brighton and Hove Clinical Commissioning Group (who buy in local health services) are considering inviting health providers to bid to run a primary care mental health service. **93%** of people would be very concerned or concerned if this contract was given to a private provider.
- Similarly, regarding the potential contract for NHS 111 service for non-emergencies, **85%** of people would be very concerned or concerned if this contract was given to a private provider.
- The Public Health contract for Health Visiting, School Nursing and other children's community health services is due for renewal by the end of March 2017. **90%** of people said that they would prefer that this stayed with the NHS.

There were four key conclusions-

1. This report shows that the public in Brighton and Hove hold clear and compelling values on the way that they want their health services to be commissioned. There is a need for space where these can be explored and reflected on.
2. In the city of Brighton & Hove, a vast majority of the public are against the use of private companies in the local health economy and very concerned about some recent decisions that have been made to commission private companies to undertake certain services.
3. We hope that in future Brighton CCG will reflect these public needs and values in their commissioning decisions.

- So is it intended that this deposition, and the project on which it is based, constitutes an attack on Brighton & Hove CCG and Healthwatch? Most certainly not. It is simply to use the University's public education remit to provide a space to ask questions that the current national commissioning infrastructure makes it difficult for other organisations to ask. It is intended that the Brighton Citizens' Health Services Survey will continue as the beginning of a broader project where the CCG and local council can hopefully benefit from a University platform which hosts innovative ways to reflect on the disparity that has arisen between the CCG commissioning infrastructure and public values."

Bibliography

Checkland, K, Allen, P, Coleman, A, Segar, J, McDermott, I, Harrison, S, Petsoulas, C, Peckham, S. (2013). Accountable to whom, for what? An exploration of the early development of CCGs in the English NHS. BNJ Open, 3, doi: 10.1136BMJ Open-2013-003769

Deith, J. (2013) A Healthy market? Lack of transparency raises doubts about NHS commissioning BMJ 2013; 347

Hudson, B. (2015). Public and patient engagement in commissioning in the English NHS. Public management Review, 17(1), 1-16.

Murphy, E. (2015). Primary concerns 2015. Cogora. Com

17.3.2 The Chair thanked Mr Walker for his deputation and welcomed the Brighton Citizen's Health Service Survey, noting that the University of Brighton's imprimatur was a guarantee of the survey's rigour. It was important that the Board thought hard about how best to engage with local people at this time of cuts to services, and the survey would be a useful tool in this work.

17.3.3 Dr Nalletamby added that there was no dissonance between the survey findings and the attitude of many people working locally in the NHS. However, health services are managed according to nationally imposed rules, and the public needs to recognise that it is national Government they need to lobby if they are unhappy with these rules.

17.3.4 Cllr Barford noted that the Social Value Act provides local council and NHS bodies with a potentially useful tool to help ensure that contracting delivers the best outcomes for local people. Geoff Raw added that the Act enables commissioners to include social value as a criterion in procurement alongside cost and quality.

17.3.5 John Child stated that the CCG welcomes the survey. However, it is also important that the public understands the restrictions that commissioners work under.

17.3.6 David Liley told members that Healthwatch supported the survey and would welcome the creation of a space to discuss dysfunctional commissioning, although he noted that this was by no means a problem exclusive to independent sector contracts.

17.3.7 The Chair added that, whilst the survey was clearly not a perfect piece of work, it was important to see it as the first stage in an iterative process which could prove valuable. The Board recognises that the local health and care system has to move from doing things to people to doing things in collaboration with them. The Board is developing an engagement strategy which will seek to explain the restrictions that commissioners work under as well as exploring some of the ways in which procurement might be made better – for example through using social value or by adopting the 'fair tax mark'.

17.3.8 Dr Walker thanked members for their comments and said that he welcomed moves to develop a space for further discussion of NHS contracting and related issues.

18 MOTOR NEURONE DISEASE (MND) CHARTER

18.1 John Child told the Board that the Motor Neurone Disease (MND) Charter emphasised early diagnosis, quality of care, dignity & respect, quality of life, and support for carers. The CCG supports all the Charter's aims.

18.2 Cllr Brown commented that MND is a devastating condition and that she welcomed the Charter, particularly in terms of the emphasis it places on carers.

18.3 Cllr Barford declared an interest in this item, since she is professionally involved in the delivery of palliative care. She welcomed the Charter.

18.4 The Chair thanked everyone from the MND Association who had attended the meeting. He told the Board that it was important that we support people with MND, especially in terms of ensuring that services respond swiftly to the speed at which MND can progress, so that there is no lag in the support that people with MND receive.

18.5 RESOLVED – that the Board agrees to adopt the MND Charter.

19 FEES TO PROVIDERS (CARE HOMES) 2016

19.1 Jane MacDonald, Adult Social Care Commissioning Manager, introduced the report, telling members that this was the most important such report to date. Currently, the local care home provider market is extremely fragile and it is important that commissioners take every step to ensure its sustainability. It is also the case that the fees paid by the public sector for care home beds are insufficient, meaning that publicly-funded care home beds are effectively subsidised by private funders. This is an inequitable situation and one which must be addressed.

19.2 It has therefore been decided to provide an uplift in fees and to simplify the fees system. The premium for people with dementia has also been discontinued as the majority of care home residents have dementia, meaning that dementia-sensitive care is now the norm. The increase in costs will be funded by the 2% Council Tax precept.

19.3 The planned changes are intended to stabilise the local care home market, maintaining city capacity and ensuring that local people continue to have a choice of provision.

19.4 Cllr Barford told the Board that she fully supported these plans. It was important to note that officers had worked closely with providers in formulating the plans. There is still an aspiration to move in time to a funding level that will enable care home workers to be paid the Brighton & Hove Living Wage, although this is not immediately achievable.

19.5 Cllr Norman told the Board that he fully supported the recommendations. Cllr Norman queried where the decision to raise fees would ultimately be taken. Denise D'Souza explained that it would be for Budget Council.

19.6 In response to a question from Cllr Page on how far behind the Laing Buisson calculations of sustainable fees the uplift would leave us, Ms MacDonald noted that this information was included as Appendix 2 to the report. It was important to recognise that we are moving in the right direction here, even if we have not yet achieved the Laing Buisson recommendations.

19.7 In reply to a question from Cllr Page on whether increasing fees to providers might help reduce delayed transfers of care from hospital, Ms D'Souza told the Board that the more local providers who could be persuaded to stay in the market the better. However, this is not just about fee levels, but also about additional support for providers which is not necessarily available in other local authority areas. Providers and ASC and CCG officers should be commended for the way that they work constructively together.

19.8 The Chair endorsed this sentiment, thanking the Brighton & Hove Residential Care Association, as well as Peter Kyle MP for his recent work on this issue.

19.9 RESOLVED – the Board agreed that:

(1) the fees payable to care homes and care homes with nursing providers be increased as set out below with effect from 5 September 2016

£543 per week care homes
£656 per week care homes with nursing (including Funded Nursing Care)

(2) the payment of premium rates for dementia in care homes and care homes with nursing is discontinued.

(3) the Council when making a placement outside the city match the applicable host authority's set fee rates for new and existing registered care home and care home with nursing placements.

(4) the Executive Director of Health and Adult Social Care be authorised to initiate a procurement exercise in order to identify suitable providers of care homes and care homes with nursing to be appointed to a framework or contract and to enter into all agreements and undertake any ancillary matters necessary to achieve the award of contracts for care for eligible persons on appropriate terms.

(5) the Executive Director of Health and Adult Social Care be authorised to award block contract(s) to care homes and care homes with nursing.

(6) the Council continues to provide additional benefits currently available to providers free of charge which include the provision of a range of training and targeted advice sessions eg fire evaluations and health and safety support and advice.

(7) the Board notes that it is the intention of officers to recommend a further increase in the rates set for care homes and care homes with nursing to be applied from April 2017 when it is anticipated a further increase in the National Living Wage to £7.70 will take effect. This is dependent on funding being agreed by the Council from the Adult Social Care Precept. A further paper on fees will be brought to the Health & Wellbeing Board with appropriate recommendations.

20 SUPPORTING CARERS - CARERS RAPID NEEDS ASSESSMENT; CARERS STRATEGY; AND CARERS COMMISSIONING INTENTIONS

20.1 Gemma Scambler, Joint Carers Commissioning Manager, introduced the report, emphasising the financial value that carers provide both in national (£136B per year) and in local (£437M per year) terms.

20.2 Cllr Brown welcomed the report, singling-out work to identify carers who aren't currently known to services, particularly you ng carers.

20.3 Cllr Barford welcomed the exciting report and told members that, in her professional role, she meets a number of carers and recommends that they undertake carer assessments. Recent feedback from carers has been that they have found the assessments, and the subsequent support they have received, to be highly beneficial.

20.4 Pinaki Ghoshal stressed the importance of maintaining good liaison with children's services.

20.5 RESOLVED – That the Board approves the new Carers Commissioning Strategy and grants delegated authority to the Director of Adult Social Care to conduct a procurement process for the provision of a Carers Hub and to enter into the subsequent contracts.

21 HIV PREVENTION AND SOCIAL CARE SERVICES

21.1 Stephen Nicholson, Lead Commissioner for Sexual Health and HIV, introduced the report.

21.2 Cllr Page told members that he was uneasy about the decision to reduce funding for this service. Given the financial costs to the health and care system if an individual contracts HIV, he wondered whether there was not a case for more funding to be found. Mr Nicholson replied that attempts will be made to mitigate the impact of funding reductions by prioritising those services with the best outcomes.

21.3 The Chair noted that he has been having conversations with commissioners and with the Martin Fisher Foundation to try and plot how best to continue to provide high quality HIV services in the light of unfortunate NHS funding reductions.

21.4 RESOLVED – that the Board grant delegated authority to the Director of Public Health to conduct a procurement process for the provision of HIV prevention and social care services and to enter into the subsequent contracts.

22 TRANSFORMING CARE: UPDATE

22.1 Soline Jerram, CCG Lead Nurse/Director of Clinical Quality & Patient Safety; Natalia Garzon; and Cameron Brown, Brighton & Hove Community Disability Team, introduced the report. The Transforming Care Programme (TCP) was launched in response to the Winterbourne View scandal and was initially focused solely on people with both Learning Disabilities and autism who were being kept in hospital. However, the programme's remit has subsequently widened. TCP is delivered on a Sussex-wide footprint. Although TCP is expected to involve budget-pooling at some point, this is not currently being recommended.

22.2 TCP aims to reduce reliance on hospital beds in favour of community-based care. However, Sussex has historically been a low user of beds in any case. There are currently 8 Brighton & Hove residents in hospital placements – a significant reduction from the 14 or so who previously occupied beds.

22.3 Dr Mack noted that the TCP project was transformational, but queried whether there were concerns about community safety. Mr Brown replied that the discharge of people from the criminal justice system was very carefully managed, with multi-agency buy-in. Discharge was under licence, and some clients have been recalled.

22.4 Denise D'Souza commended the work to date, but commented that it was vital that we secured NHS England funding to cover the very high costs involved in supporting some of the individuals covered by TCP. Ms Jerram noted that the footprint had not been successful in bidding for transformational funding, but had succeeded in some smaller bids.

22.5 In response to a question on equality and diversity from Dr Beesley, Ms Jerram told the Board that no issues had emerged at local level to date, but that she would check whether there was anything across the region.

22.6 In response to a question from Graham Bartlett on the involvement of MAPPA, Mr Brown told members that MAPPA is fully involved in discussions when people are released from prison.

22.7 Denise D'Souza told the Board that a key issue was housing: we need to find appropriate accommodation for this client group, which can be difficult. Mr Brown agreed, noting that housing clients in appropriate accommodation can significantly improve their behaviour and reduce support costs. The Chair suggested that the question of whether there was enough suitable supported housing in the city to cope with this and other demands should be explored as part of the debate around City Plan.

22.8 RESOLVED – that the Board endorses the Sussex Transforming Care Partnership Plan.

23 SUSTAINABILITY & TRANSFORMATION PLAN

23.1 John Child told the Board that there were no significant Sustainability & Transformation Plan (STP) developments to report. The initial 'plan of plans' submission was made at the end of June, and there had been some positive informal feedback, although formal feedback will not be until the end of July. There is also recognition of the scale of the challenges facing Sussex and East Surrey, particularly across primary care, in terms of quality, and in terms of financial challenges. STP plans will be locality focused and will build on existing locality system planning.

23.2 Mr Child stated that the financial planning to date forecast a reduction in the system deficit (C£700M over the next five years if nothing is done) to around £60-70M. However, Denise D'Souza noted that this did not include ASC pressures.

23.2 Ms D'Souza told the Board that here is broad recognition of the need for more public engagement. An FAQ has been drawn up and plans are in place to establish a STP presence on the websites of member organisations. Stakeholder engagement events have started and more will follow soon. Dr Beesley commented that it was important to talk to staff as well as to the public – if the STP is to be effective it must be led from the front-line. Ms D'Souza agreed that we need to engage staff at scale and pace, preferably via the Better Care Board.

23.3 In response to a question from Cllr Page on the governance of and elected representation in STP localities, Mr Child told members that there were four: Coastal West Sussex, East Sussex better Together, A23 North and A23 South. These were essentially designed around hospital catchment rather than being intended as governance entities, and there are currently no STP-specific locality 'Boards'. He added that, to date, STP planning has not addressed issues of hospital reconfiguration..

23.4 In response to a question from the Chair on engagement with primary care practitioners, Mr Child agreed that this was crucial. There was a recent meeting of GPs across A23 North and South, at which there was considerable agreement about the primary care model going forward.

23.5 RESOLVED – that the Board note the STP update.

24 SUGAR SMART BRIGHTON: DEBATE AND ACTION PLAN

24.1 Katie Cuming, Consultant in Public Health Medicine, introduced the report. In response to a question from Cllr Barford, Ms Cuming confirmed that the Sugar Smart programme was funded from ring-fenced Public Health budget.

24.2 RESOLVED – that the Board note the Sugar Smart update.

25 BRIGHTON & HOVE ROUGH SLEEPING STRATEGY 2016

25.1 Andy Staniford, Housing Strategy Manager; Alistair Hill, Public Health Consultant; and Brian Doughty, Head of Adult Assessment, introduced the report.

25.2 Cllr Barford asked a question on behalf of Cllr Penn (who had left the meeting) about housing support for patients in acute mental health beds prior to their discharge. Mr Doughty replied that the Mental Health Homeless Team liaises with colleagues at Mill View hospital, and that delivery of the Rough Sleeper Strategy will include the active involvement of Sussex Partnership NHS Foundation Trust (SPFT). Mr Hill added that the support provided by the pathway programme in place in Royal Sussex County Hospital will be rolled out to Mill View also. There had also been a recent focus on providing mental health support in hostels. This included a focus on staff support needs and a focus on creating living environments that are not injurious to clients' mental health. John Child added that there is a well-established discharge team at Mill View and an SPFT worker embedded in the council's Housing Options team.

25.3 In response to a question from Cllr Barford about support for people leaving detox, Mr Doughty did not have the information to hand but agreed to provide it subsequent to the meeting.

25.4 Pinaki Ghoshal commented that there appeared to be little in the strategy addressing the needs of care leavers, but that this was an important issue that needed addressing.

25.5 Graham Bartlett told members that he would bring a desktop review of rough sleeper safeguarding to the Board in due course, but that it would initially be presented to the council's Rough Sleeper Strategy Group. A Safeguarding Adults review concerning a homeless person will be reported to the Board in the autumn.

25.6 Denise D'Souza commented that key to the success of any strategy would be getting clients to actually move-on from hostel accommodation. Currently this does not always happen as it should.

25.7 RESOLVED – that the Board endorse the Rough Sleeping Strategy 2016.

26 PART TWO MINUTES

27 PART TWO PROCEEDINGS

The meeting concluded at 6:45pm

Signed Chair

Dated this day of 2015

14

The key Heritage issues for the CPP2 are:

- **To decide a policy approach for different types of heritage assets focusing on vulnerabilities and opportunities to ensure the long term conservation of the city's heritage;**
- **Whether there are some important groupings of heritage assets that might require a site specific approach (e.g. Royal Pavilion);**
- **What are the gaps in our knowledge and understanding of some of the city's heritage assets and how can policy could help to address this;**
- **Whether there should there be specific design policy for historic areas and heritage settings; and**
- **How to promote or reinforce local distinctiveness through planning policy.**

Community facilities

The term 'community facilities' is used to describe a wide range of facilities and local services including those required for health, education, social and cultural well-being. There is a need both to plan for new community facilities and to protect existing facilities where important needs are being met.

The key issues for the CPP2 are:

- **The range of community facilities to be addressed through CPP2;**
- **The need to respond to recent legislation and initiatives, including the Community Right to Bid, Assets of Community Value and Neighbourhood Plans;**
- **Potential approaches for planning policy to address different types of community facility; and**
- **Whether there are any sites that could be considered for community facilities through CPP2.**

Student accommodation

The city's two universities and other educational establishments make an important contribution to the city's economic and cultural life. However, there is a need to consider further opportunities for purpose built student accommodation and particularly to consider different locational options both around the city and within the wider sub-region.

The key issues for the CPP2 are:

- **Whether to establish a target for the amount of student housing needed to be met through purpose built student accommodation;**
- **Whether there are any additional sites or locations that could be considered for purpose built student accommodation;**
- **Whether to seek a more dispersed approach to locations for purpose built student accommodation away from the Lewes Road academic corridor; and**
- **How can the cumulative impacts of purpose built student accommodation be assessed and mitigated.**

Traveller accommodation

The council aims to promote community cohesion and protect the rights and needs of both the settled and travelling communities. Twelve new permanent pitches have recently been built at Horsdean as an extension to the city's transit site. An updated local needs assessment indicates there is a need to make additional site provision to meet the accommodation requirements of Travellers either living in or passing through the city.

The key issues for the CPP2 are:

- **Whether it is better to try and make provision for smaller Traveller sites based on family units (3-4 pitches) or whether larger sites capable of accommodating a number of families should be sought;**
- **Whether any new site provision should be public or private or both; and**
- **Whether Traveller site requirements might be better planned for through a separate focussed plan or jointly with neighbouring authorities.**

To find out more about the issues and view City Plan Part Two Scoping consultation documents please visit www.brighton-hove.gov.uk/cityplan-part2

Have your say

City Plan Part Two Scoping Document

Quick guide

June 2016

The council has started work on the City Plan Part Two (CPP2) and is consulting on a Scoping Paper - consultation runs 30 June to 22 September 2016.

This quick guide provides a summary of all the topics and policy issues covered in the full Scoping Document. Responses to this consultation will help shape the content of the plan.

The City Plan Part Two follows on from the recently adopted City Plan Part One and will include the remaining development sites, especially sites for new housing, and detailed policies against which planning applications for all types of development will be assessed.

City Plan Part Two Scoping Paper

The Scoping Paper is organised around 12 topics, (e.g. housing, retail, heritage and community facilities) each with a number of questions to prompt your comments and views.

You can also put forward sites for us to consider for development.

We have also prepared a **Sustainability Appraisal (SA) Scoping Report**. This sets out a proposed 'assessment framework' to consider all the likely significant effects that the City Plan Part Two may have on various environmental, economic and social factors.

To find out more about the issues and view City Plan Part Two Scoping consultation documents please visit www.brighton-hove.gov.uk/cityplan-part2

Topics covered in CPP2 Scoping Paper

Housing

The council wants to improve the supply of housing in the city and particularly the supply of more affordable housing and housing for key groups such as families and older people. The city's housing target is for 13,200 new homes to be provided by 2030.

The key issues for the CPP2 are:

- **The need to identify and allocate further housing sites;**
- **The need to make full and effective use of the city's brownfield sites for new housing but in addition some urban fringe sites will also need to be allocated for housing in CPP2;**
- **How to make sure that new housing development meets local needs for housing - particularly in terms of a mix of housing sizes and types and housing for particular groups in our communities e.g. family housing and housing for older people;**
- **Introducing space standards and standards for access and adaptability in new housing; and**
- **How to manage houses in multiple occupation (HMOs) around the city and how to address some of the negative impacts associated concentrations of HMOs.**

Brighton & Hove City Council

Economy and Employment

The council and its partners want to support local businesses in the city and further build on the success of the city's local and regional economy. The role for CPP2 is to identify further sites to ensure employment land delivery is maintained across the plan period.

The key issues for the CPP2 are:

- **Identifying further sites and opportunities that could deliver a range of size and type of new office developments;**
- **Whether a mix of employment uses can help deliver more office delivery in the city;**
- **Whether further protection is needed for some types of employment and in some areas of the city; and**
- **Whether there are any opportunities to bring forward new industrial floorspace in the city.**

Retail and town centre uses

Making sure shopping centres remain attractive and vibrant places that businesses want to invest in and people want to visit and use for shopping and socialising is key to the city's success as a place to live, work and visit.

The key issues for the CPP2 are:

- **Whether some of the city's shopping centre 'boundaries' need changing;**
- **Whether different approaches are needed to manage the mix and balance of retail uses in shopping centres;**
- **Whether there are 'special' retail areas (e.g. the Lanes and the North Laine area, the Marina and/or the seafront) that might need their own type of planning policy;**
- **Where new 'local centres' could be designated through CPP2;**
- **Whether some local shopping parades should be protected because they have an important neighbourhood value; and**
- **Whether there is scope for any additional permanent markets in the city.**

Tourism

Part One of the City Plan already sets out how improvements to the city's existing tourism facilities and new tourism facilities will be encouraged and supported. It provides an overarching strategy for the Seafront and allocates major development sites (e.g. King Alfred and Black Rock).

The key issues for the CPP2 are:

- **Whether there are any further seafront development sites that could be allocated through CPP2;**
- **Whether further planning policy is needed to guide seafront development proposals; and**
- **How further hotel accommodation in the city could be accommodated should need be identified.**

Transport and Travel

Transport and travel is a key issue for Brighton & Hove. We need to facilitate and accommodate planned development by providing an integrated, safe and sustainable transport system to improve air quality, reduce congestion, reduce noise and promote more active travel around the city.

The key issues for the CPP2 are:

- **Whether more detailed policy might be required to help address air quality and noise issues;**
- **Whether more guidance is needed regarding requirements for Transport Assessments, Statements and Travel Plans;**
- **Whether further policy or guidance is required which would help promote and enable greater active travel;**
- **How to secure improved mobility and access for an many forms of transport as possible; and**
- **Whether there might be any justification for any site specific allocations to meet identified sustainable transport priorities. This could include, for example, facilities for park and ride and coach and lorry parking.**

Biodiversity and Open Spaces

We need to protect, restore and enhance the city's natural environment, recognising its role for biodiversity, recreation, quality of life and health benefits. Through the City Plan we need to ensure that new development mitigates for any harm to the natural environment and contributes to the provision of additional features and spaces to help create and maintain sustainable communities across the city.

The key issues for the CPP2 are:

- **Opportunities for a 'landscape-scale' approach to biodiversity and green infrastructure*;**
- **How to set out detailed criteria-based planning policy to distinguish between the hierarchy of different nature conservation designations;**
- **Whether to update locally designated Sites of Nature Conservation Importance and rename them Local Wildlife Sites; and**
- **Whether there are any opportunities to designate new open space in the city including 'Local Green Spaces' and Gateways to the National Park.**

* Green Infrastructure refers to a network of multi-functional green space, urban and rural, which is capable of delivering a wide range of environmental and quality of life benefits for local communities.

Pollution, water and energy resources

A key aim of the City Plan is to ensure new development minimises pollution and seeks improvements in water, land and air quality and reduces pollution. There is also the need to protect and enhance the coastal and marine environments, to contribute to a reduction in the ecological footprint of Brighton & Hove and to champion the efficient use of natural resources.

The key issues for the CPP2 are:

- **The need to address air, land and water pollution and noise nuisance through planning policies;**
- **Whether policy is required to support the provision of water and wastewater infrastructure;**
- **Whether a policy is required on sustainable drainage;**
- **Is further policy required to protect and enhance the coastal and marine environments;**
- **Whether there are further opportunities to incentivise delivery of low carbon and renewable energy; and**
- **Whether there are any sites that could be considered for renewable and low carbon energy generation, storage or networks**

Design

A key objective for the City Plan is to raise the standard of architecture and design in the city so that the delivery of growth is matched by high quality new development and a public realm that contributes to its attractiveness.

The key issues for the CPP2 are:

- **The potential for a new detailed 'Place Making' policy focussing on street and site scale features in assessing development proposals;**
- **Whether to include guidance for new and emerging design issues such as expert design review and integrated infrastructure design;**
- **Improving detailed planning policy for residential and commercial extensions and alterations; and**
- **Introducing a single, consolidated policy to address all amenity issues when considering development proposals.**

Heritage

Brighton & Hove's heritage is rich and extensive and one of the things that makes the city so special and distinctive. The City Plan aims to promote the city's heritage, through partnership working, and to ensure that the historic environment plays an integral part in the wider social, cultural, economic and environmental future of the city.

motor neurone disease association

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HRH The Princess Royal

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Councillor Daniel Yates
Chair of the Health and Wellbeing Board
Brighton and Hove City Council
Kings House,
Grand Avenue,
Hove, BN3 2LS

12 July 2016

Dear Councillor Yates

We are delighted that your council has adopted the MND Charter and committed to making a difference to people with motor neurone disease (MND), and their carers in your community – thank you.

The MND Charter sets out what good care looks like for people with MND, and can serve as a guide to all those involved in providing services and supporting people living with the disease and their carers. With your support, we can make sure all those working for, and with, the council are better informed and more understanding of the needs of people with MND.

Now that you have adopted the MND Charter, we would like you to put it on display and promote it among your colleagues. This pack includes some resources to help you get started. Please see below just a few ideas on how you can use the resources.

To get started:

- Keep copies of the full MND charter in common areas of your offices for colleagues to read.
- Disseminate the 'Guide to MND for councillors' booklets to all your elected councillors.
- Use the template press release, sample wording for your website and social media channels to promote your support to a wider audience.

For more ways to promote the Charter, and other actions you can take, please read the 'Bringing the MND Charter to life: Ideas for action after adoption' guide within this pack.

...cont/

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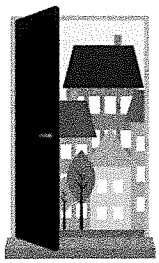


CHAMPION THE CHARTER ON YOUR DOORSTEP

mnda
motor neurone disease association

The MND Charter states:

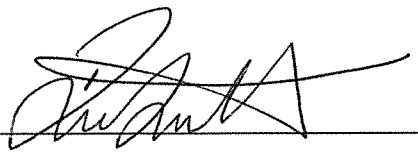
1. People with MND have the right to an early diagnosis and information.
2. People with MND have the right to access quality care and treatments.
3. People with MND have the right to be treated as individuals and with dignity and respect.
4. People with MND have the right to maximise their quality of life.
5. Carers of people with MND have the right to be valued, respected, listened to and well-supported.

This is to certify that

Brighton and Hove

Council has adopted the MND Charter.

By doing so, the council is helping to promote the MND Charter to help influence positively the quality of life for people with MND and their carers in their community.

Signed: 

Full name: Rae Martin-Smith - Campaigns Manager South.

Date: 12th July 2016.

If you have any queries about promoting the MND Charter and further actions, then please do get in touch with the MND Association, by email campaigns@mndassociation.org or by phone on 020 7250 8447.

Thank you for your support.

Sally Light
Chief Executive
MND Association

NHS
Brighton and Hove
Clinical Commissioning Group

Sustainability and Transformation Plan Update

John Child
June 2016

National context

- Population increasing
- People living longer with long-term conditions
- Health inequality gap
- Health and care funding not increasing in line with increasing demand

Five Year Forward View sets out how health services need to change over the next five years in order to improve public health and service quality while delivering financial stability by 2020/21.

Local context

- Long waits for planned care services
- Pressures on A&E and 18 weeks
- Pressure on Primary Care & GP practice closures
- Poor health outcomes (e.g. Cancer, stroke, mental health)
- Challenges in health and care finances (Acute hospital deficit ~£37m in 2015/16)

The STP – how we deliver the Five Year Forward View

- The STP is our opportunity to work together to:
  - improve population health
  - improve our approach to prevention
  - make the best use of the resources we have including estates, workforce and finance
  - improve quality of services

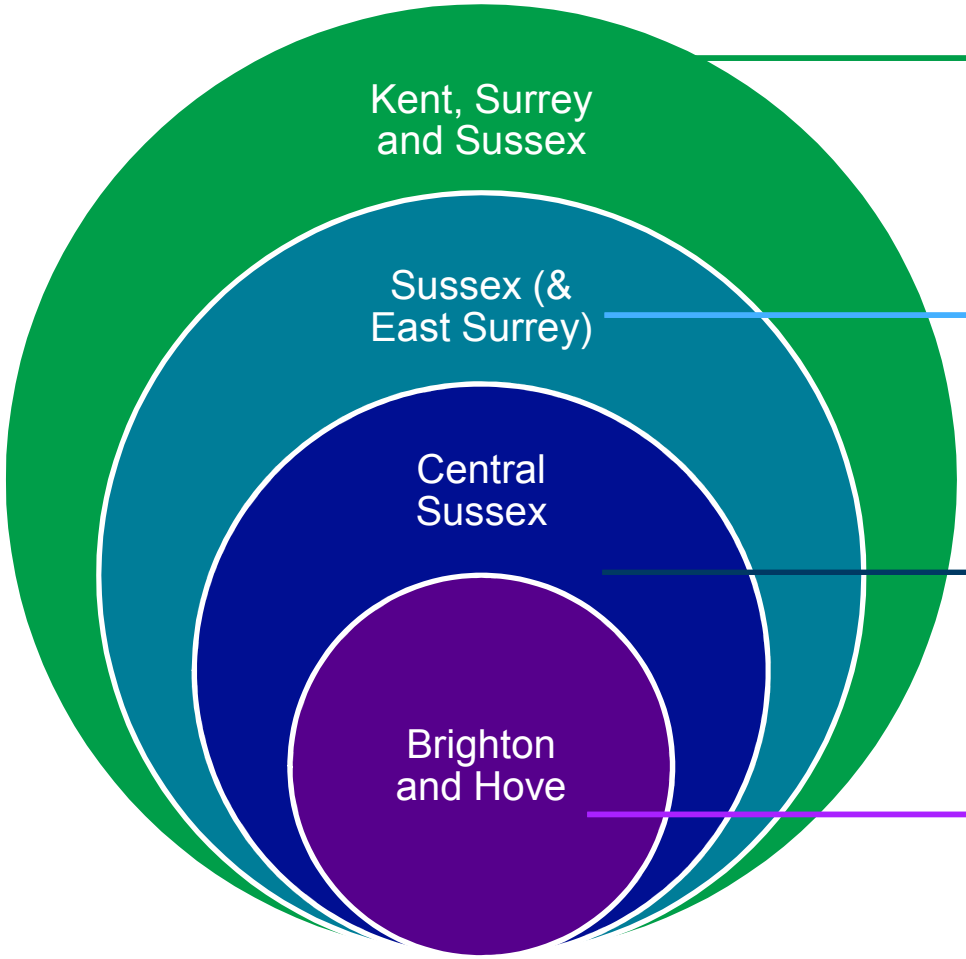
Developing our STP

- We are in the early stages of development. So far we have:
  - Agreed our footprint with NHS England
  - Assigned a Chair and Senior Responsible Officer
  - Set up governance structure and workstreams
  - Drafted a work in progress document across our footprint which identifies the gaps/issues that would benefit from an area wide solution

Our STP

- Our footprint is comprised of 23 partner organisations and serves a population of around 2 million people.
- Chaired by Michael Wilson, Chief Executive Surrey and Sussex Healthcare Trust (SASH)
- A Programme Board has formed, constituted of the Chief Officers/ Chief Executives of all partner organisations
- Sub-groups have been formed and tasked with defining the performance gaps:
  - Health and Wellbeing is led by the local Public Health leads,
  - Care and Quality by partner quality leads and
  - Finance and Efficiency by partner Directors of Finance.

Our STP -The STP builds on the local plans



Regional plans to ensure that specialist care is delivered to a high standard in a sustainable way.

County plans to ensure that hospital based care is modernised and delivered to a high standard across 7 days in a sustainable way. (Sustainability and Transformation Plan)

Working with our neighbouring CCGs to modernise mental health and district general hospital services

Improving health and wellbeing of Brighton and Hove. (Joint Health and Wellbeing Strategy, Clinical Strategy, Better Care Plan)

Key aims of the STP

Improved approach **to prevention and self-care** including public health

- **Reduces growth in numbers of patients requiring GP services**

Place-based model of care integrating primary, community, social care, mental health and 3rd sector

- **Reduces increase of patients requiring hospital services and helps reduce length of stay for patients who are admitted to hospital**

An **acute service & network** that supports quality, performance, and provider financial sustainability

- **Provides foundation for productivity savings**

Provider productivity improvements supported at STP level

These big changes are supported by:

Sustainable **workforce** | **Estates** strategy aligned to new care models | **Digital** strategy | **Engagement** strategy | Organisational incentives & **governance**

Common themes - Clinical pathways

Six clear care and quality priorities have been developed through review of key quality indicators, Right Care data analysis and discussion with partner organisation's quality leads

1. Cancer outcomes
2. Stroke outcomes
3. Mental health access and outcomes
4. Management of long term conditions
5. Support to the frail and elderly
6. Maternity and children's services

Prevention and Self Care- key areas

These are the most significant factors driving poor health across the footprint, and will be addressed through a Prevention and Self Care plan:

- Smoking
- Diet
- Exercise
- Alcohol
- Emotional Wellbeing and loneliness

A population based approach will be taken for children, working age adults, and the frail and elderly.

STP Funding

- For the first time, local NHS planning will have significant central money attached to it via a national Sustainability and Transformation Fund:
  - £2.9bn in 2017/18
  - rising to £3.4b in 2020/21

- STPs will be the single application and approval process for health economies to receive funding for transformation programmes and local deficits. For example, to fund:
  - improved access to GP services
  - diabetes prevention
  - support for people with learning disabilities
  - improved cancer and mental outcomes

Consultation and Engagement

- In Brighton and Hove transformational work is already underway – and something we have been consulting local patients, partners and clinicians on for some time

- STP Engagement:
  - –Our Programme Board membership includes GPs and we are engaging with the Sussex Clinical Senate
  - –As emerging solutions are developed we will engage more broadly with patients and the public (a Communications and Engagement strategy is being developed)
  - –Healthwatch (East Surrey) have a seat on the Programme Board

§Local (B & H) information event June 2016

Next steps…..

- Our first submission has been sent to NHS England for consideration
- Discussion documents published in September/October 2016
- Patients, carers and public will then be involved in more detailed work to develop plans in a robust engagement programme.

Any Questions ?

(please see CCG website for ongoing information and today's slides:

http://www.brightonandhoveccg.nhs.uk/your-services/sustainability-and-transformation-plan)

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Sustainability and Transformation Plan - update

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 20th September 2016

1.3 Authors: Brian Doughty, Acting Director Adult Services, BHCC
Dr. Christa Beesley, Chief Clinical Officer, CCG
John Child, Chief Accountable Officer CCG

2. Summary

2.1 The Sustainability and Transformation Plan (STP) is a new planning framework for health and care services. It is based on a regional footprint.

2.2 The Health and Wellbeing Board has asked to receive regular updates during the development process. This is therefore a standing item on the agenda.

2.3 This report provides the latest updates in the process.

3. Decisions, recommendations and any options

3.1 That the Board notes this report.

4. Relevant information

4.1 Significant work has continued over the summer period.

4.2 From the first week in September there are further formal meetings and given this a verbal update will be provided at the Board to cover any additional information.

4.3 As reported at the last Board there is an STP communications and engagement work stream. Work on an 'e' based web page / link that we can all access to get up to date information via each organisation within the sub regional footprints websites is continuing.

4.4 As the Board is aware all STP areas had to submit their working drafts to NHS England as part of the national review. Feedback has recently been received. It is clear more work is needed prior to formal submission. Further update can be provided verbally at the Board.

4.5 Currently we are working to submit the STP on 21st October as nationally required. This will then have to be followed up with CCG and NHS providers providing two year operational plans around the end of the calendar year.

5. Important considerations and implications

5.1 In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. Under the guidance every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years. STPs footprints are not statutory bodies, but described by NHS England as collective discussion forums which aim to bring

together health and care leaders to support the delivery of improved health and care based on the needs of local populations. They do not replace existing local bodies, or change local accountabilities. This report contains no direct legal implications as the report is an update report.

Lawyer consulted: Natasha Watson Date: 09.9.16

5.2 This report contains no financial implications as the report is an update report

.

5.3 This report contains no equalities implications as the report is an update report

Sustainability:

5.4 This report contains no sustainability implications as the report is an update report

Health, social care, children's services and public health:

5.5 None identified

6. Supporting documents and information

6.1 None included

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. CQC Inspections and Monitoring Quality Improvements

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on 20th September 2016.

1.3 Author of the Paper and contact details:
Ian Wilson – Clinical Quality and Patient Safety Lead, Brighton and Hove CCG.
Ian.wilson7@nhs.net

2. Summary

2.1 This paper gives an overview of the role of the CQC, the inspection criteria and the process for monitoring action plans occurring from inspections, where providers are found to have not met all requirements. The paper also refers to the CQC inspection of Brighton & Sussex Universities Hospital Trust (BSUH) which took place in April 2016.

3. Decisions, recommendations and any options

3.1 That the Board note for information

4. Relevant information

4.1 The Care Quality Commission (CQC) is the independent regulator of health and social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high quality care and encourage care services to improve.

They monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and publish what they find, including performance ratings to help people make choices about care they receive.

4.2 A CQC inspection involves collation of information and data from a range of sources including from commissioners, the public, patients and carers and via complaints and performance data. There is then a visit by an inspection team - the numbers of people in the team and the skills of the inspectors are commensurate with the size and services delivered by the provider. Inspection teams will include CQC employees (i.e. full-time inspectors) as well as members from other sectors, such as specialist advisors employed in other areas with specific clinical knowledge of a particular area, social care colleagues and lay individuals.

4.3 CQC inspections focus on quality standards within five domains or 'key lines of enquiry', i.e. they look to see if services are:

- Safe
- Effective
- Caring
- Responsive
- Well-led

A full list of what comes under these headings can be accessed at http://www.cqc.org.uk/content/brief-guides-inspection-teams#safe (accessed Aug 2016).

Following an inspection, the initial draft of the CQC report is shared with the provider, after which there is a period of time allowed for clarifying factual accuracy, prior to a report being made public.

The outcome of inspections is for service providers to be given an overall rating, which will be one of the following:

- Outstanding
- Good
- Requires improvement
- Inadequate

4.4 CQC has legal powers to:

- Register organisation to enable them to provide health and social care
- Powers of entry to inspect services
- Make requirements for improvement
- Issues notices which have to be adhered
- Remove the registration of providers and close services

The CQC has the power to issue a Section 29 'Warning Notice' to a registered person where the quality of the care they are responsible for falls below what is legally required. Legal requirements can include the Health and Social Care Act 2008 ('the Act') and the regulations made under it, but also other legislation that registered persons are legally obliged to comply with in delivering the service. The discretionary power to issue a Warning Notice is conferred by section 29 of the Health and Social Care Act 2008 Act. A section 29 Warning Notice will be used for all sectors apart from NHS trusts (including foundation trusts). There is, however, additional provision in section 29A of the Act for a Warning Notice that is addressed to NHS trusts or foundation trusts. CQC may issue such a notice where it appears that significant improvement is required. Significant improvement is not necessarily restricted to breaches of legislation but could be broader.

4.5 A comprehensive inspection of Royal Sussex County Hospital (RSCH), Royal Alexandra Children's Hospital (RACH) and Princess Royal Hospital (PRH) was undertaken from April 5th to April 8th 2016. Following this inspection, the Chief Executive Officer of BSUH was issued with a Warning Notice under Section 29A of the Health and Social Care Act, which was made public on 20th June 2016.

The notice identified three main areas for improvement:

(i) Systems to assess, monitor, and mitigate risks to people receiving care and treatment as inpatients and outpatients

were not operating effectively. Patients were being put at unnecessary risk because they were not being dealt with properly or in appropriate areas.

(ii) Ineffective systems were in place to ensure privacy, dignity and confidentiality was met for people attending both RSCH and PRH hospitals as inpatients and outpatients.

(iii) Failures to ensure patients were seen in line with national timescales for diagnosis and treatment. In many services, too many patients were on waiting lists which failed to meet national standards.

The Trust was given until 30th August to address the immediate concerns outlined in the warning notice.

The full response to this by BSUH Chief Executive can be found on the following link:
https://www.bsuh.nhs.uk/about-us/news-and-media/latest-news/brighton-and-sussex-university-hospitals-nhs-trust-has-been-issued-with-a-warning-notice-by-the-care-quality-commission/
(Accessed Aug 2016)

4.6 The full report of all the findings from the April inspection was published on 17th August 2016. It provided an overall rating of the Trust as 'inadequate' and recommended the Trust to be placed in 'special measures'.

The inspection rated urgent and emergency services, critical care and outpatients/diagnostic imaging as 'inadequate'; medical care, surgery and maternity/gynaecology services were rated as 'requires improvement' and end of life care was rated as 'good'. Services for children and young people were rated as 'outstanding'.

The report praised staff at the hospitals for their care and commitment, with the 'Caring' domain of the inspection being rated as 'good' in almost all areas.

The full reports can be found on the following link:
http://www.cqc.org.uk/provider/RXH

4.7 Following publication of a final inspection report, the organisation concerned is required to submit an improvement plan against the areas identified as needing improvements. The plan is required to

be outcome focussed, to be clear about the actions to be completed, who is responsible for the actions, and with timescales for achievement.

Although the action plan is for the CQC, service providers are expected to share any improvement plans with their commissioners. BSUH had shared their initial improvement plan, based on the Section 29A warning notice, with the CCG, NHS England and NHS Improvement.

4.8 The first stage in the process for review and monitoring improvement is a Quality Summit, convened by the CQC, which also involves the Trust, Clinical Commissioners (CCGs), NHS England (NHSE), NHS Improvement (NHSI) and Health Watch. For BSUH, this took place on 15th August, prior to the full report being made public on 17th August.

There is already in place a weekly monitoring and review group including representatives of the above organisations monitoring the BSUH action plan which was immediately drawn up following receipt of the section 29A warning notice. This level of monitoring will continue until all parties are in agreement that improvements are being made and sustained.

This is over and above the business as usual system performance and quality monitoring meetings which commissioners manage with providers, and the system-wide resilience groups in place.

5. Important considerations and implications

Legal:

5.1 The body of the report refers to the scope of the inspection and the powers of the CQC. The CQC report describes their judgement of the quality of care at the trust.

5.2 Brighton and Sussex University Hospitals NHS Trust have been issued with a Warning Notice by the Care Quality Commission (CQC) under Section 29A of the Health and Social Care Act. This identifies fundamental standards that were not being met. As a result the provider must send CQC a report that says what action they are going to take to meet these standards.

5.3 The body of this report sets out the resulting action and review arising from the Warning Notice.

Lawyer consulted: Natasha Watson; Date: 09.09.16

Finance:

5.4 There are no financial implications for the Board arising from this report for information.

Equalities:

5.5 There are no implications for the Board arising from this report for information.

Sustainability:

5.6 There are no implications for the Board arising from this report for information.

Health, social care, children's services and public health:

5.7 There are no implications for the Board arising from this report for information.

6. Supporting documents and information

http://www.cqc.org.uk/content/brief-guides-inspection-teams#safe
(Accessed Aug 2016)
https://www.bsuh.nhs.uk/about-us/news-and-media/latest-news/brighton-and-sussex-university-hospitals-nhs-trust-has-been-issued-with-a-warning-notice-by-the-care-quality-commission/
(Accessed Aug 2016)

1. Single Homeless and Rough Sleeper Accommodation & Support Services Remodelling & Tender

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the
Health & Wellbeing Board meeting on the 20th September 2016

1.3 Author of the Paper and contact details
Jenny Knight, Commissioning & Performance Manager, Adult Social Care
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2. Summary

2.1 Given the changing demand for services and the increased complexity of need, it has now become essential to have a new model of accommodation and support for single homeless people and rough sleepers.

A new model would respond to this changing need by seeking to provide improved outcomes for individuals and better value for money. It would also provide an opportunity for experienced service providers to bring new ideas and ways of working to the city.

The current accommodation and support model for homeless people and rough sleepers has been in place since 2007. The needs of homeless people in the city have changed over the past 9 years and the city is seeing increased numbers of rough sleepers, an increase in demand for supported accommodation services and increasing numbers of homeless people with multiple and complex support needs. This paper details the proposed remodelling and retendering of services to meet the changing needs of homeless people, target resources and improve the outcomes for this section of the population.

This remodelling proposal includes

- Commissioned accommodation and support services for homeless people and rough sleepers.
- Hostel accommodation and support services which are directly provided by Brighton & Hove City Council.

3. Decisions, recommendations and any options

3.1 That the Health & Wellbeing Board note the contents of the report which is provided for information.

3.2 That the Health & Wellbeing Board note the information provided within this report to remodel and procure accommodation and support services for single homeless people and rough sleepers.

3.3 That the Health & Wellbeing Board notes that commissioning and procurement plans from October 2016 will be aligned with priorities within the Rough Sleeping Strategy 2016, Council's Housing Strategy 2015, Homelessness Strategy 2014-19, and the Council's priorities for the integration of social care and health through Better Care.

4. Relevant information

4.1 Background

Housing Related Support Services (previously Supporting People) are commissioned to provide accommodation and support to vulnerable people. This report deals solely with the procurement of services designed for single homeless adults and rough sleepers.

The majority of accommodation and support services for people who are homeless are provided in the independent sector. The services currently provided as part of the pathway are included in **Appendix 1**.

The current accommodation and support services for homeless people & rough sleepers are referred to as the Integrated Support Pathway. The services within the pathway include outreach services, hostels and supported accommodation and were designed to move individuals from rough sleeping and homelessness towards independent living. This group of people tend to be non-statutory homeless.

The contracts for the majority of single homeless and rough sleeper services come to an end on the 31st March 2017. Some services such as the Rough Sleeper Outreach Service, Housing First Service and Floating Support Service for those in independent accommodation have already been re-procured.

4.2 Significant work has been undertaken to ensure that the new model will address the changing needs and demographics of people who are homeless. This has been based on analysis of needs, national good practice and consultation with partners and stakeholders. This includes the:

- Rough Sleeper & Single Homeless Needs Assessment 2013
- Homeless Health Audit 2014
- Homelessness Strategy 2014-19
- Overview & Scrutiny Report on Homelessness & Rough Sleeping 2014
- Rough Sleeping Strategy 2016

4.3 The work identified a number of gaps in service delivery and indicated the following areas for development:

Need Identified	Development Required
Lack of appropriate facilities to assess the needs of rough sleepers	Develop a Safe space for people to have an assessment within 72 hours to ensure their needs are met in a timely way, and individuals can be supported to reconnect to areas where they can access accommodation and support.
Lack of flexibility in the pathway meaning service user needs are not met	Develop a more flexible referral and hostel allocations system to make sure people are supported in the right accommodation that meets their needs
Difficulty for service users moving from high 24 hour support services to low support services.	The introduction of medium support accommodation. This will ensure that provision for people with higher needs is appropriately targeted.
The needs and safety concerns of women could be better met in women only accommodation.	Women only accommodation
Cohort of older long term residents whose needs could be better met in	Development of a specialist service for older individuals with physical

a more appropriate accommodation service.	health and substance misuse needs
The need for peer support for vulnerable women and those with complex needs.	Develop a new model of peer support.
High levels of unmet physical and mental health needs	Ensure the new services are integrated with the Better Care model to reduce health inequalities for single homeless people.
High levels of substance misuse	To ensure that services support people in their recovery from substance misuse
High levels of trauma and other mental health needs in the homeless population.	People get access to Psychologically Informed Environments see 6 (c).

4.4 Aims

It is important to address the gaps in services above to ensure that:

- Rough sleeping in the city is reduced.
- Single homeless people receive personalised multi agency support.
- Outcomes for homeless people are improved and that they are supported to develop the skills for independent living.
- Health outcomes are improved, and deaths are prevented.
- People are supported to recover from homelessness, substance misuse, ill health and mental ill health.
- The number of people experiencing revolving door (repeat) homelessness will reduce.
- The efficiency of accommodation and support services is improved.
- Services are aligned with the Better Care Integrated Homeless Health Model.

4.5 Proposal for Retendering

As contracts for current services for single homeless people are coming to an end and gaps in our current provision have been identified it is the right time to address these issues through the procurement of new services.

Timetable for Retendering

A process including three distinct procurement projects has been designed and is recommended to minimise the disruption to service users and support the move to the new way of working as follows:

- Stage 1: tender assessment and high and medium supported accommodation. These services are integral to the success of the model and involve large accommodation services which may have complex mobilisation arrangements.
- Stage2: tender women's service and low support accommodation. Potential providers may wish to apply as a consortium or a partnership and will need time to develop and explore the options available to them.
- Stage 3: tender for support services including the provision of education, peer support and lifeskills as well as the service for those with long term physical health needs. These services have been placed in stage 3 to enable time to develop the models of support for these services in consultation with partners.

- It is proposed Stage 1 will be tendered at the end of October 2016 subject to committee approval; Stage 2 in February 2017 and Stage 3 in May 2017 with a view to all new services being in place and operational by November 2017. These stages are detailed in the table at 4.6.

4.6 Accommodation & Support Services Tender Timetable

The following table is an outline of the services due to be tendered. An overview of the full model of accommodation and support including existing services is attached as **Appendix 2**

Tender	Description	Units / Beds
Tender Stage 1		
Assessment Beds	**Assessment Beds:** • Assessment Beds will enable people to access short term accommodation for up to 6 weeks. The service will provide level access for those with disabilities or health needs, facilitating hospital discharges where appropriate. The service will be scaled up from around 12 beds initially as the model is mobilised and developed to a possible 24 beds dependent on evaluation of the model. • The Assessment service will also provide up to 5 safe spaces (nightly emergency sleeping facilities in the form of a sit up chair or fold out bed) either within the hostels common area or a separate building as emergency provision for rough sleepers. This safe space acts as a place of safety for up to 72 hours to enable the assessment of rough sleepers and facilitate reconnections for non locally connected rough sleepers.	12 assessment & 12 hostel beds + 5 safe space places
High & Medium Support Accommodation	• Services will provide accommodation for people who have a mixture of high and medium support needs, allowing service users to move through an internal pathway which reduces the levels of support they require. • The services will provide personalised asset based key work support and day time activities. • The services will operate Psychologically Informed Environments. The services will make space available and encourage external services (e.g community groups/ counselling/ food projects) to come in and offer groups and activities to improve health and wellbeing, lifeskills and education and training opportunities. • Services will focus on recovery from	160-200 (80 high / 80 – 100 medium)

	substance misuse, mental and physical ill health and homelessness.	
Tender Stage 2		
Women's Service	• Trauma informed specialist accommodation service for women with multiple and complex needs. • Offering strength based and personalised key work support and case coordination. • Accommodation that allows women to move on as independence grows and their support needs reduce.	20-25 (approx 10 high / 10 -15 med
Low Support Accommodation	• Short term accommodation for those with low support needs who are reaching readiness to move on to independent accommodation. • The service will offer low level floating support in independent or shared accommodation. • The Accommodation will offer support to move on and sustain independence, including work, learning and employment, resilience and building links within the community.	80-100
Tender Stage 3		
Substance Misuse & Physical Health	• Specialist support for older people with alcohol issues and long term physical health needs. • The service will operate from a council owned HCA funded building subject to committee approval for use of the building (21/9/16). • The service will allow a longer term stay than other hostel accommodation but will have a focus on recovery from substance misuse and reintegration into the wider community.	12 TBC
Peer Support / Work & Learning / Lifeskills / Education	• Model still being developed through evaluation of service needs and gaps and feedback from Stakeholders. • We will commission a peer support model to work with individuals with multiple and complex needs to look at recovery and reintegration within the community, accessing services as well as community	TBC

	groups and activities. • We intend to procure services which offer a personalised education, lifeskills and employment service to support people to live independently and move away from homelessness.	

5. Internally Provided Council Services

5.1 Brighton & Hove City Council currently provides a number of accommodation and support services within the Integrated Support Pathway. These services are included in the remodelling proposal.

It is proposed that external providers are sought for New Steine Mews Hostel, The West Pier Project (which is part of the Mental Health Pathway), Lifeskills and Business Action on Homelessness as part of the tender process. The market for providing accommodation and support services for homeless people both within the city and nationally is diverse. There are a range of services currently operating within the voluntary sector which specialise in training, development and innovation in the delivery of homeless services and have a proven track record of running specialist assessment services, hostels for people with multiple and complex needs and support services for the homeless. These organisations have infrastructures which focus on developing expertise, innovation and improving services for homeless people. They have a knowledge and skills base in homelessness which the local authority cannot match within its current resources.

5.2 Specialist providers in the independent sector can offer added value which includes opportunities to explore and expand funding sources. They can provide a quality service based on a clear service specification, supported by a robust contract management function through the Adult Social Care Commissioning team.

5.3 The remodelling proposal detailed in this paper includes the provision of services for homeless people which are directly provided by Brighton & Hove City Council. These services are detailed below:

Service	Service Description	Staffing (July 16)
New Steine Mews	24 beds of 24 hour supported	10.2 FTE (full

Hostel	hostel accommodation	time equivalent)
Glenwood Lodge Hostel	47 beds of 24 hour supported male only hostel accommodation.	13 FTE
West Pier Project	25 beds of 24 hour supported accommodation with those with mental health & substance misuse needs within the mental health pathway.	12.3 FTE
Lifeskills Project	Offering one to one and small group work with hostels residents to develop the skills needed for independent living	2 FTE
Behaviour Support Service	Psychology service offering case work support to individuals, and support to staff within adult and youth homeless services.	2 FTE
Business Action on Homelessness	Support into work service – currently not staffed.	0 FTE

5.4 The proposals for the services are as followings:

New Steine Mews Hostel
It is proposed that New Steine Mews is subject to an external tender as part of Stage 1. The building is owned by the council can provide mobility accessible rooms, food and has an additional building suitable for the safe space places and its use by the successful Provider will form part of the tender package.

West Pier Project
It is proposed that the West Pier Project is subject to a joint external tender with the CCG who joint fund the service. The service would remain part of the mental health pathway as a service for those with severe and enduring mental health needs and substance misuse issues. It is proposed that the West Pier Project be tendered as part of Stage 2.

Lifeskills & Business Action on Homelessness
It is proposed that these services are included as part of a wider education and work and learning tender which is still in

development. The tender for this service would be included in phase 3 of the tender process.

It is proposed that **Glenwood Lodge Hostel and the Behaviour Support Service** remain as council provided services pending further work on the future model of these services.

Staff and Managers within these services have been made aware of the proposals and will be kept up to date with ongoing developments.

We are commissioning outcome focused services, so only the minimum requirements are set out in the specification. The detail of the model will be developed as part of the quality evaluation of the tenders, based on the proposals submitted by bidders. This means that the required staffing structure, roles and numbers to deliver the new model of support have yet to be determined and the impact and implications for existing employees delivering current services are not yet known. At this stage existing employees may see their employment and role either TUPE transfer to a new provider and/or be retained & reviewed by their current employer and/or ended as existing services cease. The implications for existing staff will be communicated in due course as they emerge in the procurement process.

5.5 Feedback from Staff & Trade Unions

Unison and the GMB are being consulted on the proposed changes to in-house homeless services provision.

6. New model will require changes in 3 key areas:

6.1 Change of approach to providing accommodation

6.1.1 The new model of accommodation and support will require a significant shift in working practices for all providers as we move towards a psychologically informed, personalised, asset based model of support which minimises evictions and reduces the number of 'revolving door' clients (people who move between services without reaching a positive sustainable outcome), increases multi agency and integrated working. The Commissioning Team intends to work closely with providers as part of the transition and on an ongoing basis to create flexible services which are able to change and adapt based on needs and emerging good practice.

6.1.2 The new accommodation services are being developed in order to increase flow and enable more individuals to be helped away from rough sleeping and homelessness towards independent living or to access services that best meet their needs. This means that more people will be able to access accommodation services. The total number of beds in the new model will be dependent on the winning tenders; however a minimum number of beds will be specified for each tender to ensure value for money.

6.1.3 Current model:

Service	**Beds in Current Model**	**Beds in New Model (pending award of new contracts)**
24 Hour Supported Accommodation	273	161
Medium Support Accommodation		102-127
Low Support Accommodation	157	80-100
Other High Risk Offenders & Housing First	13	13
Total:	443	356 – 403

6.1.4 In addition to this a further 53 beds of low support accommodation was commissioned in June 2016 which supports move on from single homeless accommodation and the mental health pathway.

6.2 Infrastructure that supports Homeless people in the city

6.2.1 As the Integrated Support Pathway is being remodelled, a review of the working groups and infrastructure which has supported the Integrated Support Pathway will be undertaken. This will enhance the integration of services and expand multi agency working in line with new models of working in with homeless people, new strategies and the Homeless Better Care programme.

Links to Better Care

6.2.2 ASC and local health services have been working together since 2014 to integrate and align services for homeless people with health needs. A new model of service provision is in development and will be in place from 2017. This will be a healthcare hub with co location of services. The aim is for these services to deliver integrated and specialist health and care service for the city's

homeless population to address health inequalities and reduce unplanned admissions to hospital and attendance at A&E.

6.2.3 Central to the model is a specialist primary care led multidisciplinary team (MDT) including:

- Specialist Homeless General Practice
- Community health services (nursing, OT, physiotherapy, mental health)

6.2.4 The community health services have been 'in reaching' into hostels since 2014 delivering health care, Occupational Therapy and physiotherapy services to residents. They have uncovered a large amount of unmet health needs and work with hostel staff to ensure people access their GP and other mainstream services.

Referral and Assessment

6.2.5 Placements into supported accommodation are currently managed through the Allocations Team within Housing. This team assess an individual's needs through a matrix system and makes placements via a weekly panel meeting. The proposed new model of accommodation will require a review of the referral & assessment process in line with the Rough Sleeping Strategy to ensure the delivery of effective support planning for individuals.

6.3 Innovation in Service Delivery

6.3.1 As part of the new service model a number of developments are already taking place in line with national good practice and locally identified need these include:

- A bespoke IT system to support referrals and client data collection is in development. Subject to data and information protection legislation, this will enable Commissioners to closely monitor services, trends, client journeys and identify gaps. It will also enable services to share information and prevent service users having to repeatedly tell their stories to different services.

- Working with staff to embed Psychologically Informed Environments (PIES); PIES were developed as a way of working with individuals who have experienced trauma to give them a route out of homelessness. PIES concentrates on staff support and training, personal relationships, the physical environment

and the psychological needs of both staff and service users. Further information on PIES can be found at https://www.mentalhealth.org.uk/sites/default/files/pies-literature-review.pdf

- Working with Housing and Voluntary Sector partners to support access into private rented sector accommodation.

- To pilot the safe space 72 hour assessment service within a current accommodation service with St Mungo's rough sleeper outreach service. This pilot will take place over 4 weeks in two, two week periods.

- Embed service user consultation and involvement through work with the Fulfilling Lives service user group and the CGL Peer Mentors. Fulfilling Lives is a lottery funded project to work with homeless people with multiple and complex needs. The service works with Commissioners around whole system change and has a service user group available to support commissioning and service development. CGL provides a group of Peer Mentors who work across the city including in hostel accommodation. The aim of this work is to consult with service users on the development of services and the assessment and referral process.

- To develop partnerships and support integrated working and 'in reach models' which will expand the services which are on offer in supported accommodation such as leisure activities, staff training, health care, health promotion, healthy eating and substance misuse services. This work will be aligned with the Better Care Model.

7. Important considerations and implications

Legal:

7.1 The purchase of services by a public body is subject to the Public Contracts Regulations 2015 (PCR) where they meet the applicable threshold and unless they are expressly excluded from the regulations. Certain services are excluded from the full procurement regime and those services, which include health and social care, are listed in Schedule 3 to the PCR. The services described in this report fall with Schedule 3 and are therefore subject to a "light touch" process. This requires the services to be procured transparently and without discrimination and where their

value exceeds the threshold of Euros 750,000 or the sterling equivalent of £589,148.00 the opportunity must be advertised by the placing of a Prior Information Notice calling for competition or a Contract Notice in the Official Journal of the European Union. The award of a contract without prior advertisement will render the contract open to challenge by an economic operator which as a result suffers or risks suffering, loss or damage.

7.2 Contracts below the threshold must be awarded in accordance with the Council's Contract Standing Orders. Contracts valued in excess of £250,000 to comply with Contract Standing Orders must be in a form approved by the Head of Law and shall be given under the Common Seal of the Council.

Lawyer consulted: Judith Fisher Date: 29/07/16

Finance:

7.3 The contracts for providing Single Homeless and Rough Sleepers Accommodation Support Services noted within this report are included within the Housing Related Support budgets. The revenue targeted budget management (TBM) net budget for the Integrated Support Pathway contracts is £2.678m in 2016/17 and £7.945m across 2016-2019 which includes savings identified in the 4 year Integrated Service Financial Plan and a 2% inflation year on year.

7.4 It is anticipated that the new tender for services will be delivered from within existing budgets.

7.5 This paper notes the potential external tender of internal provided council services. The revenue targeted budget management (TBM) net budget for internally provided hostel accommodation for 16-17 is £1.107m and this is likely to be increased by 2% inflation year on year, any reprovision of this service will need to be managed within the existing budget.

7.6 The financial implications from this will be made separately in a report for the Policy, Resources and Growth Committee.

Finance Officer consulted: Neil J Smith Date: 28/07/16

Equalities:

7.7 An Equalities Impact Assessment has been completed and is under regular review in relation to the tender and remodelling process. The tender and remodelling aims to tackle a number of equalities issues including the lack of women only accommodation and specialist services for those with physical health issues.

7.8 The client group for these services tends to experience multiple exclusions, and have multiple and complex needs and the aim of the newly commissioned services is to improve service models and ensure they provide better outcomes for the most vulnerable.

7.9 The full Equalities Impact Assessment is available as additional information.

7.10 Full consultation was undertaken as part of the development of the Housing, Homelessness and Rough Sleeper Strategies which included service users and stakeholders.

7.11 Consultation was undertaken with partners, stakeholders and providers prior to the development of the model to identify service demand, gaps and barriers. This consultation has continued through working groups and with individuals on the new model and on the proposed tender process.

7.12 Consultation and engagement is part of an ongoing process and will continue after the tender process as services mobilise and develop.

7.13 We are working with the Fulfilling Lives Service User Group and CGL Peer Mentors to ensure we have ongoing structures in place to consult with service users on the development of the new services. The Fulfilling Lives group is part of the group developing referral and assessment forms and will be providing support with the tender evaluations.

Sustainability:

7.14 Procurement processes are taking into account the sustainability of housing stock and the principles of social value in order to achieve best value for money and sustainability of services.

Health, social care, children's services and public health:

7.15 Single homeless people are subject to multiple disadvantages in terms of mental and physical health, substance misuse and worklessness. As part of the new assessment model we will be working with partners to ensure health, substance misuse, mental health and social care assessments are undertaken at an early stage so that service users are provided with the support that they need to recover and move towards independence. Some of this work is already in progress with the development of the Homeless Better Care programme. In the short term this process of assessment may increase the demands on health, substance misuse and social care services through increased assessment, identification of needs, and engagement in services. However in the long term it will prevent the worsening of physical and mental health conditions, reduce the demand of crisis intervention services and prevent deaths.

8. Supporting documents and information

8.1 Appendix 1 – Current Service Provision
8.2 Appendix 2 – Model Graphic
8.3 Equalities Impact Assessment

Current Service Provision September 2016

Those services highlighted in the table will remain in place as part of the new model of accommodation and support.

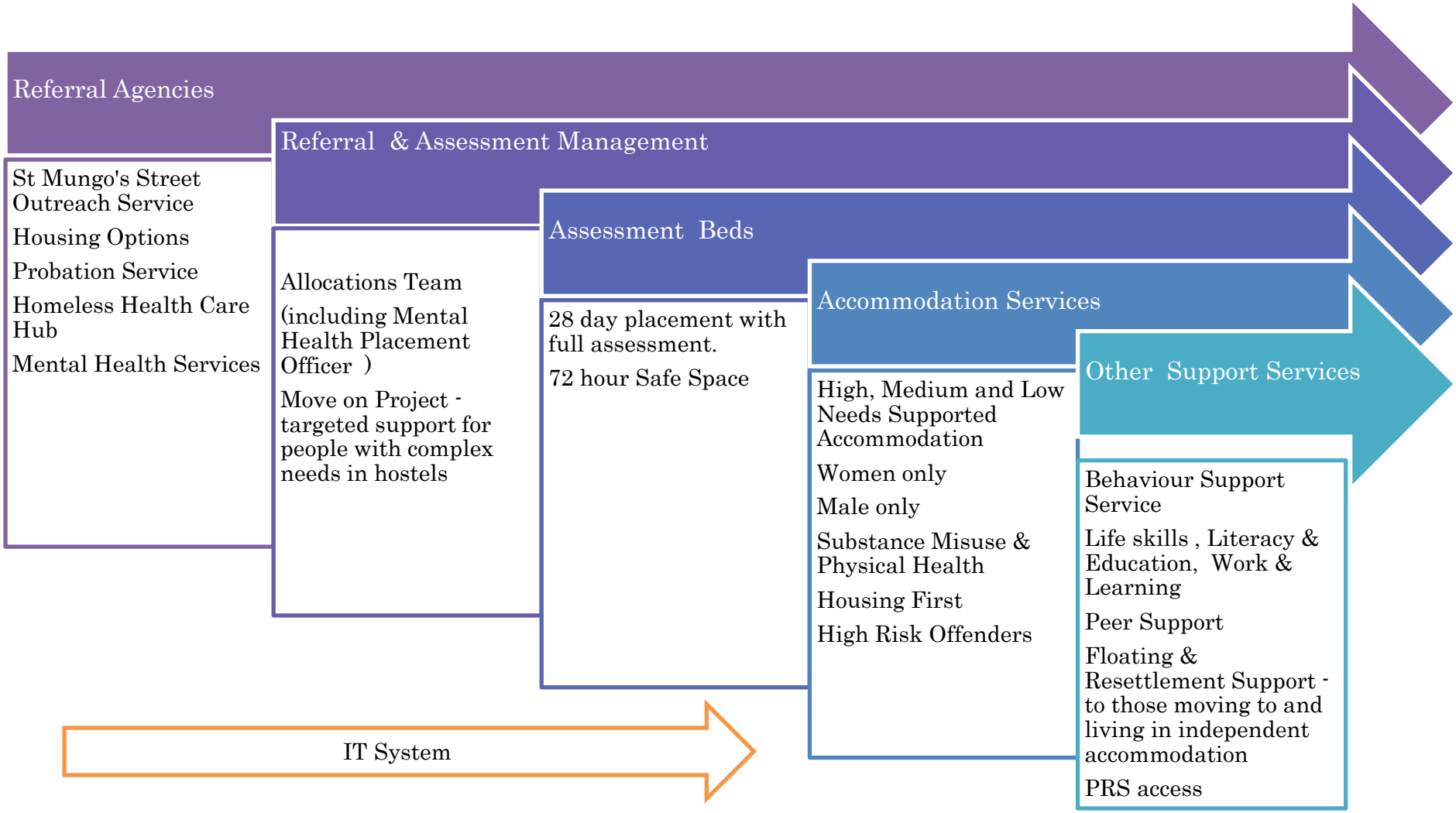
Current Services	Provider	No of Beds	Provision
24 Hour Supported Hostels:			
Phase One	Brighton Housing Trust	52	24hr Supported Hostel
St Patricks	Riverside	29	24hr Supported Hostel
George Williams Mews	Brighton YMCA	25	24hr Supported Hostel
William Collier House	Brighton YMCA	96	24hr Supported Hostel
New Steine Mews	Brighton & Hove City Council	24	24hr Supported Hostel
BHCC Glenwood Lodge	Brighton & Hove City Council	47	Directly provided in house 24 hour hostel service taking a large number of probation referrals. To be remodelled into a specialist psychologically informed environment for male offenders in consultation with the Probation Service. Offering day time activities and specialist key work support Harm reduction approach
Low Support Accommodation:			
George Williams Mews	Brighton YMCA	37	Low support accommodation
Fred Emery Court	Brighton YMCA	32	Low support accommodation
Stanley Court	Brighton YMCA	31	Low support accommodation
Leslie Best	Brighton YMCA	11	Low support accommodation
BHT Low Support	Brighton Housing Trust	17	Low support accommodation.
Sanctuary Low Support	Sanctuary Housing	11	Low support accommodation
Southdown Low Support	Southdown	18	Low support accommodation
Community Moves	Southdown	53	Successfully tendered and awarded in June 2016 this service offers short term low support accommodation for those from single homeless or mental health supported

			accommodation. This service supports individuals through courses and one to one work to accessing work and learning opportunities and private rented sector accommodation.
Other Accommodation Services:			
High Risk Offenders	CGL	5	This is an existing therapeutic high risk ex-offenders service supported by the probation service and specialist staff. This service is under contract until the 31st March 2018.
Housing First	St Mungo's	8	This service provides intensive support to people who have multiple and complex needs and a history of homelessness who live in independent accommodation. This was tendered in 2015 and commenced in January 2016.
Floating Support Services:			
Street Outreach Service	St Mungo's	Outreach service for Rough Sleepers successfully tendered and awarded in September 2015. This service works on the streets with rough sleepers assessing needs and supporting individuals into accommodation or to reconnect outside of the city.	
Community Connections	Southdown	Floating Support Service successfully tendered and awarded in October 2015. The service offers short term resettlement support to those exiting supported accommodation services, flexible support to those struggling to maintain tenancies and crisis response to those at risk of eviction from private rented sector accommodation.	
Life Skills	Brighton & Hove City Council	Support with developing life skills for those in hostels	
Literacy & Numeracy	Friends Centre	Literacy, Numeracy and IT courses - 1:1 and group work	
Behaviour Support Service	Brighton & Hove City Council	Existing service offering trauma informed interventions to individuals within both adults and young people's	

		services. The service also provides training and support to staff within homeless services to work with people with complex needs who may have experienced severe trauma.
Business Action on Homelessness	Brighton & Hove City Council	Supporting people into work and learning opportunities.
Other Ongoing Contracts:		
First Base	Brighton Housing Trust	Day Centre for Rough Sleepers offering case work support, health care and work and learning.
SWEP	Brighton Housing Trust	Severe Weather Provision for Rough Sleepers.

Single Homeless Accommodation & Support Model

Appendix 2



Appendix 3 Equality Impact and Outcome Assessment (EIA) Template - 2015

EIAs make services better for everyone and support value for money by getting services right first time.

EIAs enable us to consider all the information about a service, policy or strategy from an equalities perspective and then action plan to get the best outcomes for staff and service-users[1].They analyse how all our work as a council might impact differently on different groups[2]. They help us make good decisions and evidence how we have reached these decisions[3].

See end notes for full guidance. Either hover the mouse over the end note link (eg: Age[13]**)** or use the hyperlinks ('Ctrl' key and left click).

For further support or advice please contact the Communities, Equality and Third Sector Team on ext 2301.

1. Equality Impact and Outcomes Assessment (EIA) Template

First, consider whether you need to complete an EIA, or if there is another way to evidence assessment of impacts, or that an EIA is not needed[4].

Title of EIA[5]	Remodel of supported accommodation and related services for single homeless people – implementation and procurement	**ID No.[6]**	AS52
Team/Department[7]	ASC – Commissioning		
Focus of EIA[8]	This is the first EIA and will be continuously reviewed until the model is fully embedded; and after that as part of the business and commissioning planning process each year. This EIA is intended to cover service users and council staff working in homeless services. We recognise that we have a duty to ensure that our services prevent discrimination and promote positive community relations and equality.		

2. Looking at the evidence

1. Please summarise the purpose of the proposal, project or policy and its desired outcomes:

National context

Homeless levels have been increasing in recent years. Health and wellbeing needs are high among the single homeless population which includes rough sleepers.

People who are homeless often have complex and tri-morbid care needs with a high prevalence of mental ill-health, physical ill health and drug and alcohol dependency.

The national average age of death for a homeless person is 47 years old compared to 77 for the general population, with death from drugs and alcohol being particularly common.

Local context

The JSNA highlights that Brighton & Hove has a younger than average population with high mental health and substance misuse needs, which can be risk factors for and are associated with homelessness.

Homeless levels have increased in recent years with the loss of private rented accommodation a significant factor.

The city has seen an increase in the official count for rough sleeping from 14 in 2010 to 50 in 2013 (3rd highest in England). Services estimate that over 80 people are rough sleeping in the city (November 2015). There is a flow currently of approximately 20 new rough sleepers into the city every week (June 2016).

In 2014/15 the rough sleeping outreach service worked with 1,129 people involving 775 different people (around a third of cases relate to people seen more than once).

There are also approximately 400 households in emergency and temporary accommodation of which approximately 30% are single people or couples.

The city has 272 hostel places for single homeless people, with a current waiting list of 162 people (July 2016).

Demands on our services have changed since the existing supported accommodation pathway was set up in 2007. We are experiencing increasing numbers of people sleep rough, longer accommodation waiting lists and higher complexity (of needs) from service users alongside reduced funding and service provision. People who enter the current supported accommodation pathway are finding it harder to move through the pathway and access independent private rented accommodation.

2. Who should benefit from the proposal, project or policy and in what way?

This proposal is for remodelling the supported accommodation services for single homeless people and rough sleepers with support needs and other related support services.

Following initial feedback from service users & stakeholders we have been developing a new model for accommodation and support services. This is also informed by other strategy developments e.g. Rough Sleeper Strategy 2016.

Given the changing demand for services, and the increased complexity of need, it has now become essential to have a new model for accommodation for people who are homeless.

Our aims with the remodelling of service are:

- To reduce rough sleeping and support individuals through personalised services which better meet their needs.
- Improving people's health, building their resilience and community links and supporting them to move on to independent living.

3. Is there any evidence or reason to believe that in relation to this proposal, project or policy, there may be a difference between certain groups and communities in relation to:

- **Levels of participation**
- **Uptake**
- **Needs or experiences**
- **Priorities**

Referrals into supported accommodation are currently received from Probation, Housing Options and the Rough Sleeper Outreach Team. Demand far outweighs the number of properties which become available.

The referral and assessment process will be reviewed to revise prioritisation of those on the waiting list. Following needs analysis and consultation with service users and stakeholders, we will be commissioning services to meet specific needs.

3. Review of information, equality analysis and potential actions

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
Age[13]	*The average age of death for a homeless person nationally is estimated to be 47 years old compared to 77 for the general population.* *Nationally, it is estimated that the use of inpatient hospital care by people who are sleeping rough or living in insecure accommodation (such as hostels) is eight times higher than in the general population aged 16-64.* *The vast majority of rough sleepers are aged between 25 and 49 years old.* *Information from the rough sleeping outreach service July – August 2015:* *63 people were under 25 years old* *42 people were over 50 years old* Out of a total of 284 people *Children and young people under 18 years will not be the target group for the service (YoungPpeoples services are subject to a separate EIA)*	*Increasing numbers of people with multiple and complex needs both sleeping rough and in emergency accommodation and hostels.* *Homelessness increasing due to the lack of accommodation across all tenures, with younger people encountering more barriers to finding accommodation.* *Rising numbers of older people in hostel accommodation with physical health and substance misuse needs who are unable to move on to greater independence.*	*Benefit reforms are disproportionally affecting young people, leading to increasing numbers of young people becoming homeless and/or rough sleeping.* *Increased older residents with long term and complex health needs reduces throughput in accommodation.* *Older individuals are usually unable to access mainstream sheltered accommodation.*	*Ensure a robust multi-agency approach to commissioning and providing services.* *Commission services which can adapt and be flexible to meet changing needs, improve throughput and aim for sustainable outcomes for service users.* *Commission a service for older individuals with physical health needs and substance misuse in order to support them to greater*

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
		Earlier interventions are more likely to prevent entrenched homelessness and patterns of behaviour to develop and become embedded.		*independence.* *Housing, health and social care are to work together to provide a holistic approach to improving people's health and wellbeing.*
Disability[14]	Significant numbers of people in non-specialist Mental Health Supported Accommodation have low to moderate mental health needs or multiple complex needs (e.g. Mental Health, Substance Misuse, Reoffending and Rough Sleeping). Within the Integrated Support Pathway in 2015, 48% of people were reporting mental health needs, this is an increase from 2011/12 which was 30%.	Potential increase in complex enduring health and social care needs in ageing homeless client group, including end of life care, Alcohol Related Dementia and Korsakoff's Syndrome, learning disabilities and physical disabilities related to or	Housing, health and social care are to work together to provide a holistic approach to improving people's health and wellbeing.	New service specifications to ensure accessible facilities as part of the tender process. Services to further develop and maintain excellent links with mental health, substance misuse services.

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	51% of people living in hostels reported that they were either disabled or long term sick in 2015/6, June 2016, there were 8 people waiting for level access accommodation. Vacancies tend to arise at one every 3 months. These are often people being discharged from hospital. There are currently 23 level access hostel rooms.	arising from long term alcohol and drug use. Increase in mental health needs. People with a learning disability find it more difficult to move out of hostel accommodation into independent accommodation and may not be accessing services appropriate for their needs. Significant and growing demand for level access	Longer waiting lists for those with physical health needs	Services to be aware of local support services (inc CVS) for disabled people. Services to ensure they deliver a Psychologically Informed service and that flexible and creative engagement models are explored so that a person centred approach does not exclude people with multiple and complex needs. Increase the numbers of level access properties through the re-procurement process.

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
		accommodation.		
Gender reassignment[15]	The JSNA 2014 reported that 2% of people who were rough sleeping or single homeless identified as Trans*, an increase in the number reported in 2013. In 2015/6 there were 23 Trans people across all support services, an increase from 11 in 2012/3	The Brighton & Hove Trans* Needs Assessment 2015 reported that Trans* people experienced discrimination and/or abuse from other homeless people when rough sleeping and felt that hostels were unsafe.for trans* people particularly in respect of appropriate male/female sleeping arrangements and discrimination from other hostel users.	Trans* people find there are more barriers in accessing services and may feel their needs are not met by generic homeless services. Although the numbers are small it is important to engage with and support Trans* people at the earliest opportunity	Ensure service specifications embed the need for an inclusive approach. Ensure all commissioned providers implement recommendations of Stonewall Housing LGBT* report and encourage non commissioned services to also sign up Service to be aware of local CVS support services for trans people and mechanisms for

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
				reporting hate incidents
Pregnancy and maternity[16]	There are low numbers of homeless people who are pregnant who rough sleep or live in hostels. This group are likely to be accommodated in emergency accommodation under a statutory homeless duty. The instances of pregnant females sleeping rough at the annual count was 8 in 2013/14. We do not have data on the number of women in supported accommodation services who are mothers however anecdotally trauma from having children taking into care or no longer having access to children is a significant support need among women.	No specific feedback received relating to this. Numbers of women becoming pregnant while living in a hostel is extremely low. They are expected to move out of the hostel before they are 6 months pregnant, usually through the statutory homeless route. That trauma related to lack of contact with children is a significant support need.	Pregnant women will be able to register with a GP of their choice or with the homeless practice.	Although the numbers are small it is important to engage with and support them at the earliest opportunity. Ensure that accommodation services are skilled in linking pregnant women in with appropriate support services to best ensure that they are able to establish themselves as effective parents. Tender a women only support service which meets the

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
		.		support needs of women with complex needs. Monitor the numbers of service users who are parents (both male and female) and develop services and staff training accordingly. Ensure that floating support services workwith women leaving hostel/supported accommodation due to pregnancy and that they receive a robust tailored service to enable them to engage with specialist services and best meet the needs of their child.

<table>
<tr><th>Protected characteristics groups from the Equality Act 2010</th><th>What do you know[9]?
Summary of data about your service-users and/or staff</th><th>What do people tell you[10]?
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All potential actions to:
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• eliminate discrimination, and
• foster good relations</th></tr>
<tr><td>Race[17]</td><td>A total of 296 people (98%) indicated their ethnicity during the Brighton & Hove Homeless Health Needs Audit 2014.

Out of these, 212 were White British (72%) and 84 were from Black and Minority Ethnic (BME) groups (28%) which includes all individuals who classified their ethnic group as something other than White British. These figures suggest that the homeless population is more ethnically diverse than the general population in Brighton & Hove.

Data from the rough sleepers outreach service Sept 2015-January 2016:

<table><tr><th colspan="2">Ethnicity</th></tr><tr><td>White British</td><td>225</td></tr><tr><td></td><td></td></tr><tr><td>White Other</td><td>54</td></tr><tr><td>Mixed</td><td>3</td></tr><tr><td>Arab</td><td>5</td></tr><tr><td>Asian or Asian British</td><td>7</td></tr><tr><td>Black or Black British</td><td>11</td></tr></table></td><td>Increasing numbers of non white British people becoming homeless. Supported housing services have no choice but to evict foreign nationals when they cease to be eligible for public funds (for age or other reason)</td><td>Although no specific impacts identified from data and feedback for race, however, when looking at nationality, many rough sleepers are not British citizens and therefore will not have a local connection and will not be entitled to access some services provided in the city such as Housing and support.</td><td>Regarding nationality rather than race, ensure those with no recourse to public funds are signposted to agencies that can offer advice, advocacy and support (eg Doctors of the World, Brighton Voices in Exile)

Ensure links to local support groups are established to support individuals and the wider model.

Continue to monitor the ethnic background of services users and ensure</td></tr>
</table>

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	Rough Sleeper Annual Report 2014-15 recorded 1,129 cases of rough sleeping (involving 775 people). Of these 19% (212 cases) were not from the UK with the largest group from central or eastern Europe (86 cases, a 50% increase from this region on 2013/14)			commissioned services are monitored around policies and practice around racial harassment, hate crime and inclusion. Services will be linked with the BHCC Community Safety Team for support and advice around dealing with hate incidents. Ensure collection of data on hate crime in homeless services
Religion or belief[18]	The Brighton & Hove JSNA 2011/12 data suggests that of the rough sleepers and single homeless people in Brighton & Hove - 52% had no religion with 20% self classifying as Christian, 3% Muslim, 2%	No specific feedback received relating to this	No detrimental discrimination is likely to be relevant with the new service model.	Ensure links to local faith groups from the range of faith communities are established to

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	Buddhist and less than 1% Jewish.			support individuals and the wider model. The commissioning of new services will be developed with a focus on supporting service users to develop community links which will include links to religious or belief groups. Services will be monitored on reported hate incidents. Services will be linked with the BHCC Community Safety Team for support and advice around dealing with hate incidents.

Protected characteristics groups from the Equality Act 2010	What do you know[9]? Summary of data about your service-users and/or staff	What do people tell you[10]? Summary of service-user and/or staff feedback	What does this mean[11]? Impacts identified from data and feedback (actual and potential)	What can you do[12]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
				Monitor levels of hate crimes.
Sex/Gender[19]	Women are a minority amongst the single homeless population. The 2014/15 Rough Sleeper Annual Report recorded 1,129 cases of rough sleeping (involving 775 people). Of these 83% were male and 17% were female. Figures of female rough sleepers for July - August 2015 known to the street outreach team: Men 246 Women 38	Women rough sleepers feel more vulnerable and at risk. There is no specific or specialist homeless service for women, so they continue to be a minority in the generic male dominated homeless services. Homeless women are also more likely to have had children removed, sex worked and experienced DV and sex based violence.	Single males are less likely to be accepted as unintentionally homeless and in priority need and therefore at greater risk of becoming street homeless. There is a smaller number of women but they are more likely to feel isolated and vulnerable therefore at risk of becoming a victim of crime or becoming involved in inappropriate relationships to feel safer on the streets.	The delivery of services for women in certain settings requires careful planning to ensure privacy, confidentiality and to ensure that they have full access to the interventions relevant to their health and wellbeing. Ensure Safeguarding protocols include specific awareness of violence against women in new service contracts including financial and emotional

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
				abuse and pimping. A women only service to be commissioned to meet the complex needs of vulnerable women who feel at risk in mixed sex services. Develop the current male only service to be a psychologically informed environment. Develop male only low support accommodation.
Sexual orientation[20]	The findings of the Stonewall Housing Finding Safe Spaces project identified that, for LGBT* individuals sleeping rough in the city, this often related to their sexual orientation or gender identity, having a detrimental and often irreversible effect on their support systems after coming out to	The findings of the Stonewall Housing Finding Safe Spaces project identified that, for LGBT* sleeping rough in the city, many did not feel safe in	Some people may feel their needs are not met by generic homeless services. Service users may feel discriminated against	Ensure all commissioned providers implement recommendations of Stonewall Housing LGBT* report and encourage non

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<tr><td></td><td>friends or family.

Many LGBT* people sleeping rough do not have a local connection and therefore are not entitled to some statutory services provided in the city.

Data from the rough sleepers outreach service Sept 2015-January 2016:
<table><tr><th colspan="2">Sexual Identity</th></tr><tr><td>The number of Service Users who describe themselves as</td><td></td></tr><tr><td>Heterosexual</td><td>199</td></tr><tr><td>Lesbian/ Gay</td><td>9</td></tr><tr><td></td><td></td></tr><tr><td>Bisexual</td><td>12</td></tr><tr><td>Unsure</td><td></td></tr><tr><td>Do not wish to disclose</td><td>8</td></tr><tr><td>Not asked / recorded</td><td>119</td></tr><tr><td>Total not known</td><td>127</td></tr></table></td><td>hostels or on the streets. Drugs, alcohol, sex work or sex in exchange for accommodation was used as a way to secure a place to sleep, despite the great risk to safety as well as to their mental, physical and sexual health.</td><td>or isolated because of their sexuality.</td><td>commissioned services
to also sign up

Ensure services are monitored on support provided to LGBT clients and on the tackling of hate incidents.

Monitor hate crimes.</td></tr>
</table>

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
Marriage and civil partnership[21]	The number of couples sleeping rough on the streets is relatively low but is a factor is couples sleeping out if one is accommodated and the other not accommodated.	Relationship breakdown is a known reason for people ending up sleeping rough. Some individuals choose to sleep rough to stay with a partner who has not been offered accommodation.	Lack of supported accommodation for couples detrimentally affects some couples who are sleeping rough to be together.	Although the numbers are small it is important to engage with and support them at the earliest opportunity. Hostels and the Allocations Team to continue to accommodate couples within the same service where possible. Accommodation for couples will be requested in new service specifications.
Community Cohesion[22]	There is lack of understanding of the difference between the street community and rough sleeper groups. Those sleeping rough are more likely to be	Anecdotally, there are high numbers of ambulance call outs for street community people due to	People accommodated in hostels and emergency accommodation that spend time on the	Multiagency approach for those on the streets who have complex needs is part of

Protected characteristics groups from the Equality Act 2010	What do you know[9]? Summary of data about your service-users and/or staff	What do people tell you[10]? Summary of service-user and/or staff feedback	What does this mean[11]? Impacts identified from data and feedback (actual and potential)	What can you do[12]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	the victim of crime than the general population. Whilst the street population is often associated with crime and anti-social behaviour, it is estimated that only half of those on the streets are sleeping rough, with the other half housed. The street population is a diverse collection of groups and can be defined as people having one or more of the following attributes: rough sleeping; street drinking / begging; antisocial behaviour; insecurely housed (e.g. hostel or temporary accommodation) and spending a high level of time in street based activities, which may have a negative impact on other members of the public.	intoxication, perceived risk and concerns from members of the public.	streets will not be excluded from this service model. Street outreach is an important element of the new model and has links with the drug and alcohol outreach team. This is now part of priorities identified in the Rough Sleeping Strategy.	existing service outcomes. Commissioning of new services will include the engagement of the BHCC Community Safety Team and their support in the evaluation of tenders. Newly commissioned services will have a focus on supporting service users to access the local community and create networks and interests outside of the street community. Newly commissioned

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
				services will increase activities and support offered during the day to relieve boredom and reduce the numbers of individuals on the streets.
Other relevant groups[23]	**Ex Offenders** and prison leavers. 10% of hostel residents in 2015/6 had left prison or were ex offenders. **Military Veterans-** 1% of hostel residents had previously been in the armed forces from 2015-6 data. **People have experienced DV**. 5% of hostel residents reported that they were at risk of DV in 2015/6. **Gypsies and Travellers** 2015-6 there were 117 unauthorised encampments in the city. 1% of hostel residents identified themselves as Gypsies or Travellers in 2015-6. **People with an Substance Misuse issue.** 73% in hostels have an SM issue from	People with Multiple & Complex needs need an MDT(multi disciplinary team) joint working approach to address their needs. There remains a lack of reliable information about the hidden homeless. e.g. whose living in squat, sleeping on sofas, staying with friends and family. A flexible approach from services on engagement models is	Other groups will not be excluded from the new service model.	New service specifications will ensure that services can be delivered to people with communication barriers, and have access to accredited and independent interpreters. MDT working to continue to be developed and embedded. Data will be collated on a wide range of groups who access

Protected characteristics groups from the Equality Act 2010	What do you know[9]? Summary of data about your service-users and/or staff	What do people tell you[10]? Summary of service-user and/or staff feedback	What does this mean[11]? Impacts identified from data and feedback (actual and potential)	What can you do[12]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	2015-6 data. This is an increase from 60% in 2012-3 **People with a learning disability.** 9% of people living in hostels in 2015-6 had a learning disability. This is an increase from 4% in 2012-3. **People with multiple and complex needs.** There is no accurate data for this group. However there were 90 people who had been living in a hostel for more than 2 years in 2015-6. This has doubled from the previous year. **People with language or communication barriers.** No accurate data. **Refugees and asylum seekers.** This group are more likely to be rough sleeping. Negligible numbers access hostels. **People with literacy issues**. 20% of hostel residents reported literacy issues in 2015/6. **People with caring responsibilities.** There is no accurate data for this group.	required to deliver a personalised service offer.		the support services. Develop integrated joint assessments and support planning across housing, care and health and the third sector. Services to develop approaches to ensuring they are meeting the needs of different vulnerable groups, including assessment, data collection/monitoring and pathways to statutory sector and CVS partners. A newly developed IT system will map service user

Protected characteristics groups from the Equality Act 2010	What do you know[9]? Summary of data about your service-users and/or staff	What do people tell you[10]? Summary of service-user and/or staff feedback	What does this mean[11]? Impacts identified from data and feedback (actual and potential)	What can you do[12]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	National research shows that 48% of homeless males reported experiencing a **traumatic head injury.** **Sex workers.** Applying national estimates of the percentage of sex workers proportionately to the local resident population produces an estimate of 350 sex workers in total. However, there are factors associated with Brighton & Hove to suggest that actual numbers are somewhat higher in the city. Public Health are producing a rapid needs assessment which has highlighted the link between sex work and homelessness and the recommendations should be considered by commissioners and providers when published later in 2016. **Worklessness.** 2% of people living in hostels in 2015-6 were in paid employment. 3% in training and 8% volunteering. The majority, 60% were not seeking work or disabled. **Care Leavers**. Many adult service users			journeys and identify needs in order to allow for services to change and develop with the changing demographics and needs of this population.. Work and learning services will be remodelled to ensure they meet local needs. Monitor sex workers in homeless services. Expand work and learning and life skills services.

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	are care leavers,			
Cumulative impact[24]	Robust monitoring systems will be in place with the IT system tracking referrals and service user journey. Service user involvement is part of the remodelling process.	Feedback from service users will inform service delivery for all groups. Data from the new IT system will inform future commissioning priorities.	Robust equality data monitoring to be embedded in new service contracts. . Feedback from the service users will inform the service delivery for all groups.	Ensure alignment of data collection with third sector and statutory providers. Collate and respond to complaints, reflect and learn as an on-going PIE way of working for the integrated services.
Assessment of overall impacts and any further recommendations[25]				

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations

Key risks identified with the project (based on protected characteristics):

Processes and procedures

- *The new model may not have sufficient resources to address the diverse needs of single homeless people.*

Service Delivery

- *Homeless service users are from diverse backgrounds and the new service providers may not have operational resource to provide impartial treatment regardless of the patient's race, gender, sexuality, religion etc.*
- *Levels of support and care needs will be potentially high and increasing amongst an aging population of service users over 50 e.g. increased mobility issues, multiple and complex needs and increasing levels of homelessness. Plus lack of access to Sheltered accommodation and Extra Care services.*

Other risks:

Moving of service users during remodelling / loss of bed spaces / potential changes to HB eligibility / increasingly unaffordable private rented accommodation market with rising prices in neighbouring areas / staff TUPE and disruption leading to unmotivated and unsupported workforce (mitigation to be tested through tender evaluation for staff support, training etc) / reducing resources in other services i.e. substance misuse

- *Potential language barriers (amongst a growing non UK national population) when delivering services*

Staffing - managing change for in-house hostel staff

Mitigations

- *Recording methods to be agreed during the procurement phase and routinely reviewed during contract management meetings.*
- *Demand for services will be mitigated by improving the transition of service users between services.*
- *Pilot projects have identified approximate levels of health care needs.*
- *Service specification of the primary care service requires the service to ensure language is not a barrier to access the service.*

Protected characteristics groups from the Equality Act 2010	What do you know[9]? Summary of data about your service-users and/or staff	What do people tell you[10]? Summary of service-user and/or staff feedback	What does this mean[11]? Impacts identified from data and feedback (actual and potential)	What can you do[12]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
• *the findings of this EIA can be built into the commission and are assessed as part of the process of deciding the provider, then you can ensure that all potential bidders consider these needs and how they will meet them. If it's a statutory duty, then we must ensure that they can do this.* • *Close liaison with Unions regarding staffing matters.* • *Setting up an interim support service to provide bespoke support to managers of services affected by the remodelling.*				

4. List detailed data and/or community feedback which informed your EIA

Title (of data, research or engagement)	**Date**	**Gaps in data**	**Actions to fill these gaps: who else do you need to engage with?** (add these to the Action Plan below, with a timeframe)
Annual Update on the Scrutiny Panel on Homelessness	**September 2015**	**None**	
Brighton & Hove Homeless Health Needs Audit	**February 2014**	**Current data required to update report from 2014**	**Schedule a homeless health audit in 2017/8**

Brighton & Hove Homelessness Review 2013	**2008-2013**	**None**	
Brighton & Hove Homeless Integrated Health and Care Workshop	**July 2014**	**None**	
Finding safe spaces – Understanding the experiences of lesbian, gay, bisexual and trans* rough sleepers	**2014**	**None**	
Head Injury and Mortality in the Homeless Population	**2014**	**No local data**	
Healthy Hostels Crisis Report	**2001**	**None**	
Homelessness Strategy 2014 – 2019	**June 2014**	**None**	
Hostels and Housing Report- R Cook	**2014**	**None**	
Hostels Nursing Team Evaluation Report	**2015**	**None**	
Joint Strategic Needs Assessment: Rough Sleeping and Single Homeless	**2014**	**None**	

Joint Strategic Needs Assessment: Gender Identity and Trans People	**2014**	**None**	
Nurse Led Street Medicine Pilot Evaluation	**June 2016**	**None**	
Repeat Homelessness in Brighton, Homeless Link, 2015	**2015**	**None**	
Rough Sleeping Strategy: Position Paper	**Autumn 2015**	**None**	
Rough Sleeping Strategy	**June 2016**	**None**	
Rough Sleepers Street Services and Relocation Team: Annual Report 1st April 2014 to 31st March 2015	**2015**	**None**	
The Unhealthy State of Homelessness- Homeless Link	**2014**	**None**	
Update on Better Care Homeless Programme	**March 2015**	**None**	
The Hidden Truth about Homelessness – Experiences of Single Homelessness in England,	**May 2011**	**None**	

Hard Edges – Lankelly Chase	**2015**	**Numbers of people with multiple and complex needs is not quantified locally**	

5. Prioritised Action Plan[26]

Impact identified and group(s) affected	Action planned	Expected outcome	Measure of success	Timeframe
NB: These actions must now be transferred to service or business plans and monitored to ensure they achieve the outcomes identified.				
Disability/other relevant groups	Ensure services are flexible and accessible and do not exclude people with any special requirements	No inaccessible services to service users based on disability or multiple and complex needs	Feedback from service user consultation confirms responsive services are in place.	Start from May 2017
Disability	Ensure an increase in level access supported accommodation properties	No service users waiting longer for services than others due to mobility issues Increase in number of level access properties available as supported accommodation	Reduced waiting list and waiting time for level access properties	May 2016
Sexual orientation	Implement recommendations of Stonewall Housing LGBT* report	Recommendations are part of integrated working	Recommendation of Stonewall Housing LGBT* implemented Feedback from service users Monitoring data	March 2017
Sex/gender	Consultation with homeless women and other groups regarding service delivery models which best meet their needs	Responsive and tailored services. Some women only specialist provision of services	Feedback from service user consultation confirms responsive services are in place	May 2017
Sex/gender	Awareness in all services of Safeguarding protocols relating to violence against women	Responsive and tailored services.	Feedback from stakeholder and service user consultation	May 2017

Gender reassignment	Implement the recommendations of the Trans* Needs Assessment	Multi agency needs assessments are in place	Positive feedback from service users and the LGBT Health and Inclusion Project Monitoring data	On-going quarterly monitoring data reports March 2017
Age	Develop consultation with young people regarding service delivery models which best meet their needs when they are placed in adult services	Responsive services based on consultation findings	Feedback from service user consultation confirms responsive services are in place	October 2017
Age	Ensure recommissioned services meet the needs of older service users and can access appropriate services	Bespoke services for older people	New services in place	June 2017
Community cohesion	Joint outreach and assessment work with the street community and rough sleepers	Multi agency needs assessments are in place	Positive feedback from stakeholders and service users Logged on the new IT system	June 2017
All	Ensure that no one is excluded from services due to a language or other communication barrier	No services are inaccessible to people with a language or communication barrier	Recording is in place to monitor this in new contract and to ensure equality of access	May 2017
All	Monitor hate crimes	Track level of issue in services	Once we have a baseline, work to reduce incidents	April 2017
All	Monitor numbers of sex workers	Ensure we have the services in place to support this group	recording is in place and feedback from stakeholders is positive	April 2017
All	Develop integrated joint assessments and support planning across housing, care and health services	All service users to have an identified lead care coordinator	Integrated support for people with a clear lead as reported from monitoring data and stakeholder feedback	May 2017

All	Robust MDT approach to commissioning and providing services	Alignment of service contracts across sectors to support integrated working	Services working in an integrated way	Developed and embedded through interrelated commissioning plans throughout 2017
All	Complete a homeless heath audit, updating the 2014 data	Update of health needs	Data collated from all supported accommodation service with a high % of respondents	2017/8

EIA sign-off: (for the EIA to be final an email must sent from the relevant people agreeing it or this section must be signed)

Lead for the Equality Impact Assessment: **Date: 27 July 2016**

Head of Service: **Anne Hagan** **Date: 27 July 2016**

Guidance end-notes

[1] The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the council must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the council is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EIA in itself does not meet the requirements of the equality duty. All the requirements above must be fulfilled or the EIA (and any decision based on it) may be open to challenge. Properly used, an EIA can be a tool to help us comply with our equality duty and as a record that to demonstrate that we have done so.

[2] **Our duties in the Equality Act 2010**

As a council, we have a legal duty (under the Equality Act 2010) to show that we have identified and considered the impact and potential impact of our activities on all people with 'protected characteristics' (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and marriage and civil partnership).

This applies to policies, services (including commissioned services), and our employees. The level of detail of this consideration will depend on what you are assessing, who it might affect, those groups' vulnerability, and how serious any potential impacts might be. We use this EIA template to complete this process and evidence our consideration.

The following are the duties in the Act. You must give 'due regard' (pay conscious attention) to the need to:

- **avoid, reduce or minimise negative impact** (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately).
- **promote equality of opportunity**. This means the need to:
  - Remove or minimise disadvantages suffered by equality groups
  - Take steps to meet the needs of equality groups
  - Encourage equality groups to participate in public life or any other activity where participation is disproportionately low
  - Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary
- **foster good relations between people who share a protected characteristic and those who do not**. This means:
  - Tackle prejudice
  - Promote understanding

[3] EIAs are always proportionate to:

- The size of the service or scope of the policy/strategy
- The resources involved
- The numbers of people affected
- The size of the likely impact
- The vulnerability of the people affected

The greater the potential adverse impact of the proposed policy on a protected group (e.g. disabled people), the more vulnerable the group in the context being considered, the more thorough and demanding the process required by the Act will be.

[4] **When to complete an EIA**:

- When planning or developing a new service, policy or strategy
- When reviewing an existing service, policy or strategy
- When ending or substantially changing a service, policy or strategy
- When there is an important change in the service, policy or strategy, or in the city (eg: a change in population), or at a national level (eg: a change of legislation)

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Assessment of equality impact can be evidenced as part of the process of reviewing or needs assessment or strategy development or consultation or planning. It does not have to be on this template, but must be documented. Wherever possible, build the EIA into your usual planning/review processes.

Do you need to complete an EIA? Consider:

- Is the policy, decision or service likely to be relevant to any people because of their protected characteristics?
- How many people is it likely to affect?
- How significant are its impacts?
- Does it relate to an area where there are known inequalities?
- How vulnerable are the people (potentially) affected?

If there are potential impacts on people but you decide not to complete an EIA it is usually sensible to document why.

[5] **Title of EIA:** This should clearly explain what service / policy / strategy / change you are assessing

[6] **ID no:** The unique reference for this EIA. If in doubt contact Clair ext: 1343

[7] **Team/Department:** Main team responsible for the policy, practice, service or function being assessed

[8] **Focus of EIA:** A member of the public should have a good understanding of the policy or service and any proposals after reading this section. Please use plain English and write any acronyms in full first time - eg: 'Equality Impact Assessment (EIA)'

This section should explain what you are assessing:

- What are the main aims or purpose of the policy, practice, service or function?
- Who implements, carries out or delivers the policy, practice, service or function? Please state where this is more than one person/team/body and where other organisations deliver under procurement or partnership arrangements.
- How does it fit with other services?
- Who is affected by the policy, practice, service or function, or by how it is delivered? Who are the external and internal service-users, groups, or communities?
- What outcomes do you want to achieve, why and for whom? Eg: what do you want to provide, what changes or improvements, and what should the benefits be?
- What do existing or previous inspections of the policy, practice, service or function tell you?
- What is the reason for the proposal or change (financial, service, legal etc)? The Act requires us to make these clear.

[9] **Data:** Make sure you have enough data to inform your EIA.

- What data relevant to the impact on protected groups of the policy/decision/service is available?[9]
- What further evidence is needed and how can you get it? (Eg: further research or engagement with the affected groups).
- What do you already know about needs, access and outcomes? Focus on each of the protected characteristics in turn. Eg: who uses the service? Who doesn't and why? Are there differences in outcomes? Why?
- Have there been any important demographic changes or trends locally? What might they mean for the service or function?
- Does data/monitoring show that any policies or practices create particular problems or difficulties for any groups?
- Do any equality objectives already exist? What is current performance like against them?
- Is the service having a positive or negative effect on particular people in the community, or particular groups or communities?
- Use local sources of data (eg: JSNA: http://www.bhconnected.org.uk/content/needs-assessments and Community Insight: http://brighton-hove.communityinsight.org/#) and national ones where they are relevant.

[10] **Engagement:** You must engage appropriately with those likely to be affected to fulfil the equality duty.

- What do people tell you about the services?
- Are there patterns or differences in what people from different groups tell you?
- What information or data will you need from communities?
- How should people be consulted? Consider:
    (a) consult when proposals are still at a formative stage;
    (b) explain what is proposed and why, to allow intelligent consideration and response;
    (c) allow enough time for consultation;
    (d) make sure what people tell you is properly considered in the final decision.
- Try to consult in ways that ensure all perspectives can be considered.
- Identify any gaps in who has been consulted and identify ways to address this.

[11] Your EIA must get to grips fully and properly with actual and potential impacts.

- The equality duty does not stop decisions or changes, but means we must conscientiously and deliberately confront the anticipated impacts on people.
- Be realistic: don't exaggerate speculative risks and negative impacts.
- Be detailed and specific so decision-makers have a concrete sense of potential effects. Instead of "the policy is likely to disadvantage older women", say how many or what percentage are likely to be affected, how, and to what extent.
- Questions to ask when assessing impacts depend on the context. Examples:
    - Are one or more protected groups affected differently and/or disadvantaged? How, and to what extent?
    - Is there evidence of higher/lower uptake among different groups? Which, and to what extent?
    - If there are likely to be different impacts on different groups, is that consistent with the overall objective?
    - If there is negative differential impact, how can you minimise that while taking into account your overall aims
    - Do the effects amount to unlawful discrimination? If so the plan must be modified.
    - Does the proposal advance equality of opportunity and/or foster good relations? If not, could it?

[12] Consider all three aims of the Act: removing barriers, and also identifying positive actions we can take.

- Where you have identified impacts you must state what actions will be taken to remove, reduce or avoid any negative impacts and maximise any positive impacts or advance equality of opportunity.
- Be specific and detailed and explain how far these actions are expected to improve the negative impacts.
- If mitigating measures are contemplated, explain clearly what the measures are, and the extent to which they can be expected to reduce / remove the adverse effects identified.
- An EIA which has attempted to airbrush the facts is an EIA that is vulnerable to challenge.

[13] **Age**: People of all ages

[14] **Disability**: A person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. The definition includes: sensory impairments, impairments with fluctuating or recurring effects, progressive, organ specific, developmental, learning difficulties, mental health conditions and mental illnesses, produced by injury to the body or brain. Persons with cancer, multiple sclerosis or HIV infection are all now deemed to be disabled persons from the point of diagnosis.

[15] **Gender Reassignment:** In the Act a transgender person is someone who proposes to, starts or has completed a process to change his or her gender. A person does not need to be under medical supervision to be protected

[16] **Pregnancy and Maternity:** Protection is during pregnancy and any statutory maternity leave to which the woman is entitled.

[17] **Race/Ethnicity:** This includes ethnic or national origins, colour or nationality, and includes refugees and migrants, and Gypsies and Travellers

[18] **Religion and Belief:** Religion includes any religion with a clear structure and belief system. Belief means any religious or philosophical belief. The Act also covers lack of religion or belief.

[19] **Sex/Gender:** Both men and women are covered under the Act.

[20] **Sexual Orientation:** The Act protects bisexual, gay, heterosexual and lesbian people

[21] **Marriage and Civil Partnership:** Only in relation to due regard to the need to eliminate discrimination.

[22] **Community Cohesion:** What must happen in all communities to enable different groups of people to get on well together.

[23] **Other relevant groups:** eg: Carers, people experiencing domestic and/or sexual violence, substance misusers, homeless people, looked after children, ex-armed forces personnel, people on the Autistic spectrum etc

[24] **Cumulative Impact:** This is an impact that appears when you consider services or activities together. A change or activity in one area may create an impact somewhere else

[25] **Assessment of overall impacts and any further recommendations**

- Make a frank and realistic assessment of the overall extent to which the negative impacts can be reduced or avoided by the mitigating measures. Explain what positive impacts will result from the actions and how you can make the most of these.
- Countervailing considerations: These may include the reasons behind the formulation of the policy, the benefits it is expected to deliver, budget reductions, the need to avert a graver crisis by introducing a policy now and not later, and so on. The weight of these factors in favour of implementing the policy must then be measured against the weight of any evidence as to the potential negative equality impacts of the policy,
- Are there any further recommendations? Is further engagement needed? Is more research or monitoring needed? Does there need to be a change in the proposal itself?

[26] **Action Planning:** The Equality Duty is an ongoing duty: policies must be kept under review, continuing to give 'due regard' to the duty. If an assessment of a broad proposal leads to more specific proposals, then further equality assessment and consultation are needed.

1. The outcome of the Ofsted/Care Quality Commission (CQC) inspection in May 2016.

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 20 September 2016

1.3 The author of the paper is:

Regan Delf
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Brighton & Hove City Council
Kings House, Grand Avenue, Hove BN3 2LS

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2. Summary

2.1 The purpose of this report is to inform the Board of the outcome of the recent joint inspection by Ofsted and the CQC of the local area's effectiveness in identifying and meeting the needs of children and young people who have special educational needs and disabilities.

3. Decisions, recommendations and any options

3.1 The Board is asked to note the positive contents of the letter from Matthew Barnes, Her Majesty's Inspector, and be assured there is a plan to take forward the small number of areas for further development as identified in the attached action plan.

4. Relevant information

4.1 The inspection took place between 23 and 27 May 2016, led by one of her Majesty's Inspectors from Ofsted, with team inspectors including an Ofsted inspector and two children's services inspectors from the CQC.

4.2 The purpose of the inspection was to:

- assess how well the local area is meeting the needs of children and young people with special educational needs and/or disabilities, and how well service providers work together to deliver positive outcomes
- evaluate how well the local area is performing its role in line with its statutory responsibilities and the Code of Practice
- promote improvement
- consider action necessary to address any issues identified.

4.3 The inspection evaluates the effectiveness of the local area as a whole. The local area includes the local authority, clinical commissioning group and NHS England (for special services), early years settings, schools and the further education sector.

4.4 This was the first inspection of its kind nationally. Two local areas were in the first tranche: Brighton and Hove and Bolton.

4.5 Inspectors spoke with children and young people who have special educational needs and/or disabilities, and their parents and carers. They visited a range of providers (schools, nurseries and health settings) and spoke with leaders, staff and governors about how they are implementing the special educational needs reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors reviewed performance information and evidence relating to the local offer and joint commissioning arrangements, and met with leaders for health, social care and education.

4.6 Whilst no formal Ofsted style judgements are made, the outcome of the inspection was very positive. See attached letter.

4.7 The findings of the inspection identify a significant number of strengths across health, education, social care and the voluntary sector in how Brighton and Hove identifies and meets the needs of children and young people with special educational needs and

disabilities.

4.8 The quality of leadership and the effective planning, commissioning and the delivery of services, is highlighted, alongside the commitment to put children and young people and their families at the centre of the vision to improve services.

4.9 The inspection noted that leaders in Brighton and Hove know what is going well and where further improvement is needed. Many of the areas for development identified in the inspection feedback are already built into existing planning documentation. Steps are being taken to address those issues where further work is needed, for example, extending the reach of support to those families currently below the threshold for services via links with the Parent and Carer Council. See attached Statement of Action.

5. Important considerations and implications

Legal:

5.1 There are no legal implications arising from this report.

Lawyer consulted: Serena Kynaston Date: 16/08/16

Finance:

5.2 There are no direct financial implications as a result of the outcome of the inspection. Provision for children and young people with special educational needs and disabilities will continue to be met from available resources.

Finance Officer consulted: Steve Williams Date: 05/08/16

Equalities:

5.3 Making appropriate provision for children and young people with special educational needs and/or disabilities is key to enabling them to achieve their potential.

Sustainability:

5.4 Improving provision across health, social care and education will help build more sustainable communities and will boost health and wellbeing amongst children and young people and their families.

Parent/carers who are more aware of services on offer, can play a role in their development and review, and can ensure that their children access the services that they need. Budget pressures create challenges, but the objective of the ongoing SEND review is to ensure that services provided are effective, offer value for money and are sustainable into the future.

Health, social care, children's services and public health:

5.5 The CCG and Public Health Directorate worked in partnership with Children's Services throughout the inspection and development of the action plan, and will continue to monitor progress against the relevant actions in the plan with along with health providers.

6. Supporting documents and information

Appendices:

Appendix 1 - Joint Local Area SEND Inspection in Brighton & Hove, 23 - 27 May 2016

Appendix 2 - Post SEND Inspection Statement of Action

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13 July 2016

Mr Pinaki Ghoshal
Executive Director of Children's Services
Brighton and Hove City Council
Bartholomew Square
Brighton
BN1 1JA

Mr John Child, Clinical Commissioning Group Chief Officer
Ms Regan Delf, Local Area Nominated Officer

Dear Mr Ghoshal

Joint local area SEND inspection in Brighton and Hove

Ofsted and the Care Quality Commission (CQC) conducted an inspection to judge the effectiveness of the local area of Brighton and Hove in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with team inspectors including an Ofsted Inspector and a children's services inspector from the CQC.

Inspectors spoke with children and young people who have special educational needs and/or disabilities, parents and carers. They visited a range of providers to speak with leaders, staff and governors about how they are implementing the special educational needs reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors reviewed performance information and evidence relating to the local offer and joint commissioning arrangements, and met with leaders for health, social care and education. The local offer sets out, in one place, information about the provision expected to be available across education, health and social care for children and young people who have special educational needs and/or disabilities.

This letter outlines our findings from the inspection, including strengths and areas for further improvement.

Main findings

- Brighton and Hove local area puts the child or young person who has special educational needs and/or disabilities and their family at the centre of its vision to improve services. Consequently, children and young people who have special educational needs and/or disabilities achieve strong outcomes and their families are very well supported. Families benefit from services that work

very cohesively together. This ensures that children's needs are usually identified early and that provision is effective in meeting those needs.

- Leaders evaluate the local area's effectiveness exceptionally well by assessing services' strengths and weaknesses precisely. Consequently, leaders know clearly what is going well and where further improvement is needed. For example, the recent refreshment of the joint strategic needs assessment (JSNA) and aligning of the child and adolescent mental health services (CAMHS) transformation plan is beginning to drive forward positive change.
- Of particular strength is the local area's approach to joint commissioning, without the need for legal arrangements between the local authority and NHS services, known as section 75 agreements. Services buy into leaders' strong vision to be family-centred. The effective working relationships between services are productive, so they ensure that identified needs in the local area are appropriately prioritised. Furthermore, strong working relationships ensure that safeguarding arrangements for children and young people who have special educational needs and/or disabilities are effective.
- Co-production, where services and families work together to review and plan provision, is well embedded. Children and young people and their parents attend local area planning meetings, such as the Learning Difficulties Project group, where they have a clear voice. The local advocacy and support organisations, known as Amaze, and the Parents and Carers Council (PaCC), provide a particularly valued service to support families. They have strongly influenced the local area to improve services for families, for example in the development of a disability register by Amaze and commissioned by the local authority that is used by services to improve provision.
- The impact of services for care, education and health is consistently reported by parents as improving the lives of children and young people who have special educational needs and/or disabilities and their families. This is particularly the case for families with children or young people who require a health plan, child in need plan, an education, health and care plan (EHCP) or statement.
- Leaders know there is more to do for families who do not meet thresholds for formal plans, particularly for those who have children and young people in mainstream education who present with mental health difficulties. This is reflected in the views of a minority of parents who report variability in the support offered. Leaders are already taking action to strengthen the role of primary care within the special educational needs and disabilities population, to address this need.

The effectiveness of the local area in identification of children and young people's special educational needs and/or disabilities

Strengths

- Early identification of children and young people's special educational needs and/or disabilities is a strength; parents and carers are closely involved with this process.
- There is excellent delivery of the healthy child programme. All statutory visits for the under-five population take place with robust arrangements to ensure that all new families moving into Brighton are visited. Consequently, families with children who are not meeting their early milestones are identified in a timely manner.
- Health commissioners ensure that robust screening supports early identification. For example, where an infant is identified as having, or likely to have, special educational needs and/or disabilities, immediate referral is made to the Seaside Child Development Centre. This leads to timely support offered from the specialist health visitor both prior to and after birth. Similarly effective are hearing screenings for new-born babies, carried out by midwives. These ensure that children who have hearing difficulties gain early access to more specialist assessments. Parents report positively about the specialist advice and support they receive during this early period of diagnosis. Families who meet key thresholds also appreciate the early support they receive from care services.
- Services demonstrate an unwavering focus on the overall needs of children and young people who have special educational needs and/or disabilities. They work very effectively with parents to co-produce new EHCPs. Medical advice for statutory assessments is timely and ensures that accurate identification leads to early help for children and their families. Early identification training for social workers has enabled them to contribute usefully to early planning of assessment and support.
- Children and young people up to the age of 16 who require specialist assessment are referred to the Seaside Child Development Centre. Practitioners work in a cohesive and flexible way to meet the needs of families, children and young people, including through multi-disciplinary assessments. As a result, waiting times to access therapy services and autistic spectrum condition diagnosis have improved and for children under 11 are now a strength.
- School nurses act effectively on information gathered through health questionnaires for children in their first year of primary or secondary school. Where necessary, well-coordinated healthcare plans are drawn up to support individual children's identified needs. These plans are discussed appropriately with parents and school staff.
- Services provide very useful proportionate support to schools to improve identification. School leaders have a strong understanding of the requirements

of the statutory special educational needs code of practice. They make useful decisions about how to strengthen identification in schools. The early years support team regularly visits schools and nurseries to improve families' experiences when children move from the early years into schools and to strengthen staff expertise in identification through training and support. School special educational needs coordinators (SENCos) work together in established clusters to share practice and strengthen their own knowledge. Consequently, schools are increasingly adept at identifying need early.

- Educational psychologists in the local area are rightly highly valued by school leaders and parents. They work collaboratively with schools, nurseries and children's centres to ensure that identification is timely and accurate. This is particularly the case for those children and young people who present with more complex special educational needs and/or disabilities. The educational psychology service links very well with the autism support service, which also provides excellent support to schools where the need has been identified.

Areas for development

- Currently, childcare providers and health services are carrying out the health development checks for two-and-a-half-year-olds separately. Some progress is being made to share assessments. However, the plans in Brighton and Hove to implement integrated checks for two-and-a-half-year-olds could be accelerated.
- Leaders in the local area have rightly recognised that some children on the autistic spectrum are not always identified during their primary education, because of successful inclusive practice. Some of these children struggle to make a successful transition into secondary education. Assessment and diagnosis through CAMHS for these children is then too slow.
- Parents have not been sufficiently involved in the development of the care pathway for supporting children with Down's syndrome.

The effectiveness of the local area in assessing and meeting the needs of children and young people who have special educational needs and/or disabilities

Strengths

- Many parents report positively about their experiences of the support they have been offered by different commissioning services prior to, during and after identification of need. Similarly, the vast majority of pupils were positive about their experiences in the local area, particularly the support they receive in school.
- The proportion of schools that are good or better in Brighton and Hove is higher than the national average. All special schools in the local area are

judged to be at least good and many are outstanding. In all schools, leaders are clear about their role within the local area and show commitment to improve provision for children who have special educational needs and/or disabilities. For example, there is an area-wide drive to ensure that children access lessons successfully by receiving effective support, regardless of their level of need, rather than be withdrawn from classes to learn on their own or in small groups.

- Co-production between services, schools at all stages and parents is very strong. For example, cooperation between the educational psychology service, the autistic spectrum condition support service, school leaders and parents has led to high-quality work to improve support for pupils who have anxiety difficulties. The virtual school provides excellent support for children and young people who have special educational needs and/or disabilities who are in the care of the local authority.
- The co-production of new EHCPs is very effective. Parents report that their views are taken seriously and that they contribute fully. Parents of pupils who have special educational needs and/or disabilities whose needs do not require a formal plan share similar views. Parents' strong relationships with school leaders and staff ensure that there are useful opportunities to discuss what is going well and what could be better for children. Pupils are also able to make a useful and valued contribution because school leaders work effectively to ensure that the pupils have a voice.
- Pupils, both in special and mainstream schools, are overwhelmingly positive about how they are supported to make progress. Pupils are encouraged to be self-aware, which allows them to develop independence as they increasingly identify what helps and hinders their learning.
- The vulnerability tracker and special educational needs or disability transfer forms effectively support children with identified need to move from early years settings into schools successfully. Parents appreciate how well this works. Parents also report positively about how they are supported by the robust transfer arrangements from the health visiting service to school nursing service. Secondary leaders also value the information the tracker provides as children move into key stage 3.
- The early help service includes a good range of services for young families through the children's centre, which is highly valued by parents. All families with children under five who speak English as an additional language and require a translator are offered enhanced health visiting support. This helps to quickly identify and support families of children who have any emerging health need and ensure that the most vulnerable families are very well supported in a timely manner.
- Children's social care services provide excellent, graduated support to families that have a child who has special educational needs and/or disabilities. Key workers are allocated to families if they do not meet the threshold for a social worker. Parents for whom this is the case report they value their key workers

because of the useful support they provide during a typically difficult time following early identification.

- The speech and language therapy service is cohesive and strong. Exceptional leadership and management mean there are full complements of therapists who support schools very effectively to deliver excellent programmes for children.
- The independent advice support service for parents provided by Amaze is highly effective. As a result of its work, together with that of the various special educational needs services, appeals against placement decisions are very rare and mediation effective. Local area leaders make very good use of the disability register developed by Amaze to evaluate the effectiveness of services in meeting needs and to plan improvements.
- Children and young people who have special educational needs and/or disabilities benefit from strong support from the health service. For example, health passports ensure that practitioners are aware of children and young people's needs, and how to communicate with them. There are also effective specialist dental and continence services available to families in Brighton and Hove. Families were very positive about their experience of these services.
- The specialist CAMHS 'Team to Adult Personal Advisors' is persistent and positive in reaching out to young people who are difficult to engage with a more traditional model of service. It offers a highly flexible and mobile service and supports the young people through timely transition into adult services.
- Social care services provide well-targeted and useful support to families whose children or young people have profound or complex special educational needs and/or disabilities. For example, respite care provision has been judged as good or better by Ofsted. The decision to extend the compass scheme (a passport to access leisure facilities such as local sports centres) to young people up to the age of 25 is very popular and demonstrates the local area's continued implementation of the new code of practice.

Areas for development

- Local area leaders have rightly identified that the local offer is not easy enough to use. Many parents are not aware of what the local offer is and very few use it to help them. Instead, they use the Amaze website, which is much easier to navigate and includes the information they need.
- Currently, those children and young people who are home-educated do not benefit from the same proactive school nursing support that is given to their peers accessing formal education.
- Parents and practitioners have rightly identified the difficulties in sharing information and coordinating care when a child or young person is receiving support from tertiary specialist hospitals.

The effectiveness of the local area in improving outcomes for children and young people who have special educational needs and/or disabilities

Strengths

- Parents and carers comment positively about how well their children are prepared for adult life. As one parent expressed, 'Brighton and Hove accepts you for who you are'.
- Children and young people who have special educational needs and/or disabilities develop into self-motivated and self-aware contributors to their own local area. They experience success at the appropriate level for their ability. For example, internships developed through joint commissioning have supported some young people to secure employment. Others access appropriate placements in further education or training, where they rapidly develop skills that help prepare them for the world of work. Many report positively about how services, including Amaze, have helped guide them into pathways that allow them to succeed. This reflects how the local area is very successful in preparing children and young people for adult life.
- Academic outcomes for those who have special educational needs and/or disabilities are improving because they are making increasingly rapid progress. The attainment gap between those identified as 'special educational needs support' and their peers is narrowing. This is particularly the case in English.
- Outcomes for those educated in special schools are also strong. Pupils are prepared well for the next stage of their education, employment or training because they benefit from bespoke programmes of study that are linked to their interests and areas of strength.
- The proportion of young people recorded as not in education, employment or training (NEET) after the age of 19 has historically appeared relatively high. However, there are no young people who have special educational needs and/or disabilities whose pathway is 'not known'. Leaders have already taken effective action and so levels of NEET have fallen. Pathways chosen by young people are typically successful and appropriate for their level of need, demonstrating the strength in support they have been given earlier by services. Young people report enthusiastically about the support they have been given by services to secure clear pathways into their adult lives.
- School SENCOs have a clear understanding of children's holistic needs, including their health and care needs. Children and young people typically meet, or are on track to meet, the suitable targets set in their EHCPs.
- The number and frequency of exclusions of pupils who have special educational needs and/or disabilities are rapidly declining. This is because of the effective use made by school leaders of very strong locality authority services in this area.
- Children and young people who have special educational needs and/or disabilities who are educated out of the area are carefully tracked because

services attend their review meetings. Their placements are regularly reviewed to ensure that outcomes are in line with the local area's expectations. Placements are changed if problems arise.

Areas for development

- Leaders have rightly recognised that there is more to do to secure better outcomes for those White British pupils whose primary need has been identified as social, emotional or mental health.

Yours sincerely

Matthew Barnes
Her Majesty's Inspector

Ofsted	**Care Quality Commission**
Bradley Simmons HMI Regional Director	Susan McMillan Deputy Chief Inspector, Primary Medical Services (North), Children, Health and Justice.
Matthew Barnes HMI Lead Inspector	

CC: Clinical commissioning group(s)
Director Public Health for the local area
Department for Education
Department of Health
NHS England

Appendix 2

Ofsted/CQC inspection of Special Educational Needs and Disabilities (SEND) - May 2016

Post Ofsted Statement – action on identified areas for development

	Area for development identified by Ofsted/CQC	Lead agency	Action/response	By when
1	*There is more to do for families who do not meet thresholds for formal plans, particularly for those who have children and young people in mainstream education who present with mental health difficulties*	Council	It was been agreed with the AMAZE and the Parent and Carers' Council (PACC) that SEN caseworkers and specialist SEN staff will attend PACC parent coffee mornings across the city offering 'drop in' advice and support to parents of children with SEN who do not meet thresholds for Education, Health and Care plans. Parents will also be reminded of the AMAZE information, advice and guidance service commissioned by the council, which includes a telephone helpline.	From Autumn term 2016
		Council, Clinical Commissioning Group (CCG), and Public Health	A whole school approach to mental health (Primary Mental Health Worker in 3 secondary schools) pilot will be rolled out across the city in 2017/18 including special schools.	

2	*Childcare providers and health services are carrying out the health development checks for two-and-a-half-year-olds separately. Some progress is being made to share assessments. However, the plans in B & H to implement integrated checks for two-and-a-half-year-olds could be accelerated*	Council, Sussex Community Foundation Trust (SCFT) and Public Health	The LA will continue to improve information sharing between health visitors and nurseries and develop integrated checks for Universal Partnership Plus children attending children's centre nurseries. Public Health will address this area within the imminent re-commissioning of the health visiting service. The new service is planned to begin in April 2017.	April 2017
3	*Leaders in the local area have rightly recognised that some children on the autistic spectrum are not always identified during their primary education, because of successful inclusive practice. Some of these children struggle to make successful transition to secondary education. Assessment and diagnosis through CAMHS for these children is then too slow*	Council, CCG	The CCG has added some additional psychology resource to the autistic spectrum condition (ASC) pathway to address access and waiting times for assessment and diagnosis. A review of the ASC pathway is taking place 2016/17 with recommendations available early 2017. Any changes or developments will need to involve the LA and include LA and CCG responsibility and remit.	March 2017
4	*Parents have not been sufficiently involved in the development of the care pathway for supporting children with Downs Syndrome*	Sussex Community Foundation Trust (SCFT)	An update of the health care pathway will be shared with all parents of children with Down Syndrome and a focus group will be arranged.	November 2016

5	*Local area leaders have rightly identified that the local offer is not easy enough to use. Many parents are not aware of what the local offer is and very few use it to help them. Instead they use the Amaze website, which is much easier to navigate*	Council	This area is already being addressed in the SEND service business plan (item 2.2). The LA is working with AMAZE to make improvements to the local offer and to ensure strong links between and across the LA and AMAZE platforms.	April 2017
6	*Currently those children and young people who are home educated do not benefit from the same proactive school nursing support that is given to their peers accessing formal education*	Public Health	This area will be addressed as part of the procurement of the Healthy Child Programme. The new service is planned to begin in April 2017.	April 2017
7	*Parents and practitioners have rightly identified the difficulties in sharing information and coordinating care when a child or young person is receiving support from tertiary specialist hospitals*	NHS England, CCG	This area will be discussed between the relevant health services to improve information sharing and care coordination. The CCG's investment in extra children's community nursing is also expected to support this.	April 2017
8	*Leaders have rightly recognised that there is more to do to secure better outcomes for those white British pupils whose primary needs has been identified as social, emotional and mental health*	Council, CCG	The LA had already identified this area as part of its self-evaluation to Ofsted in terms of academic outcomes for pupils – this is being addressed via the LA's 'Closing the Gap' Strategy. A whole school approach to mental health (Primary Mental Health Worker in 3 secondary schools) pilot will be rolled out across the city	On-going

			in 2017/18 including special schools. This is a universal offer to all children in schools, but awareness will be raised within this of the social, emotional and mental health needs of this group.	

1. Formal details of the paper

1.1. Title of the paper
Brighton & Hove Food Poverty Action Plan and **Healthy Ageing and Food – bringing a food focus to Brighton & Hove as an 'Age Friendly City'.**

1.2 Who can see this paper?
The contents of this paper can be shared with the general public.

1.3 Date of Health & Wellbeing Board meeting
20 September 2016

1.4 Author of the Paper and contact details
Becky Woodiwiss, Public Health Specialist
Brighton & Hove City Council, Tel 01273 296575,
Becky.woodiwiss@brighton-hove.gov.uk

2. Summary

2.1 Provide a short summary of the paper
The paper presents for information both the **Food Poverty Action Plan** and **Healthy Ageing and Food – bringing a food focus to Brighton & Hove as an 'Age Friendly City'.**

The **Food Poverty Action Plan** (FPAP) is a multi-agency citywide initiative owned by the strategic partners of BH Connected.
The overall aims of the FPAP are to;

- reduce the impact of food poverty on the health and wellbeing of local people,
- mitigate against the likely impact on future health and social care budgets if food poverty is not addressed,
- focus the city's limited resources on the most effective solutions

The FPAP was accepted at the Neighbourhood Equalities and Communities Committee Nov 2015. It is both pragmatic and aspirational. It contains 80 actions, over half of which build on existing Brighton & Hove City Council and partner services or functions. Delivery of these is achievable within current resources. Additionally, there are aspirational actions where external funding is being sought by community partners.

Healthy Ageing and Food (HAF) is a scoping report that sets out to identify what an 'Age Friendly City' might look like in relation to food. It links closely with the Food Poverty Action Plan, and supports the aims of 'Spade to Spoon' - the city's food strategy and is a work-stream within the Public Health Older Peoples Programme.

3. Decisions, recommendations and any options

3.1 The Health and Wellbeing Board is asked to note the **Food Poverty Action Plan** (Appendix 1); that food poverty is unacceptable and that collective strategic action should be taken to prevent and address this issue in Brighton & Hove.

3.2 The HWB is asked to note the recommendations in the **Healthy Ageing and Food report** (Appendix 2) outlined in 4.9 below.

3.3 The HWB is asked to accept a progress report on the **Food Poverty Action Plan** at the end of the 3 years; and on **Healthy Ageing and Food** after 3 years.

4. Relevant information

These two pieces of work are important as good nutrition supports both mental and physical health across the life course. The city's Joint Strategic Needs Assessment (JSNA) sets out key information about the importance of good nutrition. A focus on food will contribute to other citywide priority outcomes around health, wellbeing and addressing inequalities.

a. Food poverty is 'the inability to afford or to have access to the food necessary for a healthy diet'. Food poverty does not exist in isolation from other forms of poverty nor do food prices exist in a vacuum from other household expenses such as rent, fuel and water. Food poverty is not just about hunger – it is about difficult choices ('food v

fuel'; 'skipping meals', 'trading down') and long term unhealthier food choices.

Food poverty is an increasing problem in the city. There are 14 areas of Brighton & Hove in the poorest 1% for income deprivation nationally, and it is an expensive place to live[1]. Data related to premature deaths in England shows that Brighton and Hove ranks 98th worst out of 150 local authorities. Cancer, liver disease and heart disease are key contributors. Poor diet and obesity are key factors in the causes of these deaths. [2] It has been estimated that malnutrition costs UK health services up to £7.4 billion a year. [3] Both the FPAP and the HAF contribute towards addressing this.

It is difficult to measure the exact number of people experiencing food poverty in the city as there is no fixed definition and food poverty can arise for different reasons. It is not just about money but may also be about food access, skills, equipment or be complicated by personal circumstances such as needing a special diet.

Food bank use is often used as a way to measure levels of food poverty but in practice only identifies the tip of the iceberg of people in crisis. The number of food banks in Brighton & Hove has more than doubled in the last two years. New research by BHFP shows there are now fifteen food banks in the city which together give out an average of 289 food parcels a week, an 8% increase compared to 2014. Two thirds of food banks (67%) say that they have noticed an increase in demand over the last year.

The Local Discretionary Social Fund (LDSF) provides payments for those on low income with an unforeseen emergency or financial crisis. In 2015-2016, Food related LDSF grants totalled over £60,000. 886 LDSF applications were made for 'food expenses' of which 372 were funded. Additionally 994 applications made for cooking equipment (kitchen ware, cooking facilities, fridges) of which 483 were funded.

The **Food Poverty Action Plan** (FPAP) principles are to:

[1] Indices of Multiple Deprivation 2015
[2] http://www.bhconnected.org.uk/sites/bhconnected/files/jsna/jsna-6.4.6-Good-nutrition-&-food-poverty1.pdf
[3] http://www.bapen.org.uk/pdfs/economic-report-short.pdf

- reduce the impact of food poverty on the health and wellbeing of local people,
- mitigate against the likely impact on future health and social care budgets if food poverty is not addressed,
- focus the city's limited resources on the most effective solutions,
- take a preventative approach by addressing the underlying causes of food poverty,
- measure, monitor and understand food poverty levels in the city.

b. The FPAP aims to:

- Tackle the underlying causes of food poverty in the city.
- Ensure that every child, and every vulnerable adult, can eat one nutritious meal a day, as a bare minimum.
- Make Brighton & Hove a city that cooks and eats together.
- Ensure there is crisis and emergency support so that people do not go hungry, when prevention is not enough.
- Commit to measuring levels of food poverty so we know if we are being effective.

c. The FPAP was developed by Brighton & Hove Food Partnership & Brighton & Hove Connected. It is owned and delivered by over 50 partners, including the City Council, CCG and voluntary, community and faith groups and implementation is underway. It is included (as number 57) in the Fairness Commission recommendations report. There are a range of actions identified within the Action Plan addressing the needs of older people, adults, families and children. [4] Progress on implementation of the FPAP is being reviewed autumn 2016.

5. **Healthy Ageing and Food – bringing a food focus to Brighton & Hove as an 'Age Friendly City'** (HAF) scopes the existing work in the city around food and older people; and identifies what an 'Age Friendly City' might look like as regards food. The report was prepared by the Brighton & Hove Food Partnership for the city's Age Friendly Steering Group and Brighton & Hove Public Health as part of the Public Health Older Peoples Programme. It was developed in parallel with and relates to the FPAP for example, in promoting shared community meals for older people.

[4] http://bhfood.org.uk/reports-publications/food-poverty/32-food-poverty-action-plan-final/file

There are currently 38,300 people aged 65 or over in Brighton & Hove, based on 2015 mid-year estimates. This is projected to increase to 40,400 people by 2020.[5]

a. It identifies key themes of;

- Access to tasty and nutritious meals - these can also be an opportunity to socialise, share and enjoy.
- Choice and taste are important when considering options for food provision.
- Innovation - There are opportunities especially for the voluntary and community sector to provide some of the options around food. For example, adding to existing lunch club provision with new models so that people feel they are 'for them'; or developing new methods of delivering cooked meals.
- The importance of a 'living well approach' – to prevent isolation, food poverty, dramatic changes in quality of diet in the first place. The limited support available should target times when people are especially vulnerable (e.g. following bereavement and hospital discharge).
- Recognising that older people are a community resource - opportunities for older people to cook/share meals and volunteering are essential.

b. The report makes a series of recommendations relevant to commissioning decisions across the city and for other healthy ageing preventative work streams.

It considers food issues for;

- those living independently at home, who shop and cook for themselves,
- those people supported in their own accommodation, any initiatives also need to include paid and 'informal' carers,
- people living in a residential care setting, nursing home or in hospital – and work in these setting needs to target staff in addition to the older residents.

5.3 The recommendations are grouped to cover:

[5] Projecting Older People Population Information http://www.poppi.org.uk/

- Information - nutritional needs, equipment, ready meals, home delivery and shared meals outside the home, in a range of formats and media, for both public and workers.
- Training - on nutrition and cooking skills for family carers, paid care workers residential staff and older 'new' cooks and adapting to changed mobility or sensory impairment. Extend the Healthy Choice Award in residential accommodation
- Community meals - nutritious meals at home, training and time scheduled where cooking is offered via care package.
- Shared meals in the community - improve information about availability and options for eating outside the home. Consider the gaps e.g. In the East and North of the city and at weekends.
- Food poverty and access – food access increasingly associated with food poverty in older people. Retirement financial planning advice to include food/shopping/cooking issues.
- Isolation - Sensory impairment and 'entrenched' isolation are particular barriers to good nutrition. Befriending and targeted support at times of change or increased vulnerability e.g. bereavement, to help prevent isolation.
- Food and nutrition to be included in the Dementia Strategy.

The HAF report recommendations will be taken forward by the Age Friendly City Steering group – a partnership of statutory, community and voluntary sector organisations working with older people.

Both pieces of work have been recognised as national good practice and build on city's track record of pioneering food work including its silver Sustainable Food City Award.[6]

6. Important considerations and implications

a. Legal

There are no specific legal implications arising from the report recommendations. General issues relating to equality are addressed below.

Lawyer Consulted: Judith Fisher Date: 08/09/2016

b. Finance

[6] http://bhfood.org.uk/bhfp-case-studies/sustainable-food-cities/23-final-application-feb-2015/file

There are no direct financial implications arising from the recommendations made in this report.
Finance Officer Consulted: Mike Bentley Date: 07/09/2016

c. Equalities

The Food Poverty Action Plan targets population groups in the city that are particularly vulnerable to food poverty so has equalities at its heart. These are;

- Disabled People (including people with learning disabilities) and people experiencing long term physical or mental ill health.
- Large families, single parent families and families with disabled Children.
- Working people on a low income, especially younger working age people.
- Vulnerable adults - including older people; those who are isolated; digitally excluded; or who are experiencing transition e.g. bereavement/ becoming ill/ leaving hospital and people moving from homelessness, offending or addiction.
- 16-25 year olds especially those who are unemployed, vulnerable and/or leaving care.
- Black and minority ethnic people and migrants who have limited recourse to funds.

As per BHCC guidance an Equalities Impact Assessment was carried out in 2015.

Look Inequality – the Annual report of the Director of Public Health 2014-2015 focusses on inequalities in the City and includes a chapter on food and hunger. [7]

Healthy Ageing and Food - this considers specific needs and actions for certain groups of the older population with higher levels of vulnerability to malnutrition, food poverty such as those experiencing entrenched isolation[8], financial poverty[9] , with sensory impairment or recently bereaved.

[7] http://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove/annual-report-director-public-health-2014-15

[8] 6 - 13% of older people say they feel very or always lonely. Campaign to End Loneliness. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141895/uk-advisory-forum-230512-tackling-loneliness-isolation.pdf

[9] See Older Peoples Locality Profiles; http://www.bhconnected.org.uk/content/reports

An Equalities Impact Assessment has been done for the overarching Public Health Older Peoples Programme.

d. Sustainability
Financial: These initiatives take a preventive approach which supports the delivery of sustainable health and social care provision.

Environmental: these two reports come under the umbrella of *Spade to Spoon*, the City's Food Strategy; and the *Brighton & Hove Sustainable Community Strategy*; which are both key sustainability strategies

e. Health, social care, children's services and public health
These are covered within the paper.

6. Supporting documents and information

The following two reports are included with this paper:
Brighton & Hove Food Poverty Action Plan
Healthy Ageing & Food Report

6.1. Additional information is also available from the lead officer or online:

- Case study on developing the Food Poverty Action Plan: http://bhfood.org.uk/case-studies
- Brighton and Hove Food Strategy 'Spade to Spoon': http://bhfood.org.uk/food-strategy
  Director of Public Health's annual report, chapter 7 on food and hunger: https://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove/annual-report-director-public-health-2014-15

Brighton & Hove **Food Poverty Action Plan** 2015-2018

"Food poverty is unacceptable in our city"

Food poverty is 'the inability to afford, or to have access to the food necessary for a healthy diet'. Food poverty does not exist in isolation from other forms of poverty nor do food prices exist in a vacuum from other household expenses such as rent, fuel and water. Food poverty is not just about hunger – it is about difficult choices ('food v fuel'; 'skipping meals', 'trading down') and long term unhealthier food choices. Food poverty results in diet related diseases including obesity, diabetes and heart disease. For most people, the main cause of food poverty is low income in relation to their household costs– not inability to manage money or food however for some people food skills and a lack of access to shops or equipment play a part.

Good nutrition supports both mental and physical health and evidence demonstrates the impact of nutrition on educational attainment in children.

"The first thing you have to say is that food poverty is not OK."

We heard this time and again when developing this action plan. And so this statement became the first principle of the plan.

However what can you actually do when food poverty is such an overwhelming issue where the causes and solutions are intertwined and complex?

This three year plan answers this question by providing both a list of actions and a set of principles for guiding future decisions. This plan is a living document – it will change and develop over time.

As the city has proven before when it comes to delivering on ambitious food work, the success of this action plan will be as much about 'how' as 'what'.

Delivered together. We cannot succeed if we leave all the 'solutions' to voluntary and faith groups nor can increasingly stretched health and social care services be expected to solve this alone. And at the heart there needs to be a focus on empowerment - ensuring that people who are experiencing poverty are engaged in designing the solutions and that their voices are heard.

Co-ordinate action and be willing to try new approaches. This plan is definitely not starting from scratch and brings coordination and focus to what is already going on at both a policy and frontline level. But it is also about being willing to try out new ideas and work in partnerships. Voluntary sector organisations have already begun to work more closely together (for example bringing advice services into food banks). Statutory partners have committed to rethinking their services through a food poverty perspective, which in the absence of additional money in budgets, means being genuinely willing to do things differently.

Food is about more than nutrition. Becoming *'the city that cooks and eats together'* is an important theme of this action plan as we seek to support and build on almost half a million shared meals served every year in the city. Lunch clubs and 'shared meals' that quietly and with very little public recognition get on with not only providing healthy food at an affordable cost but reduce isolation and – we discovered – act as a gateway to advice and further support.

Seek to influence other agendas – so much of what needs addressing is not about food. It's about housing, jobs or benefits. Some issues can only be addressed at a national level, whilst this plan is by definition a local one. We will use evidence from this work to respond where this is relevant; but focus what we can do locally; on what is within our control. We will share what is in this plan via the Fairness Commission and partnership boards. Nationally by submitting it as one of the All-Party Parliamentary Inquiry into Hunger's **Feeding Britain** pilots.

Thank you to everyone who has taken part in developing this plan and has committed to working on delivery.

Vic Borrill

Vic Borrill, *Director Brighton & Hove Food Partnership (BHFP)*

Food poverty: A preventative approach

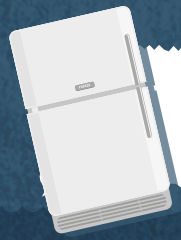
Crisis food poverty

Food banks and hunger are **just the tip of the iceberg**

Long term food poverty

Our approach focuses on the **much larger** group of people struggling **long term** to eat a healthy diet, and aims to **prevent** them reaching crisis point.

What prevents food poverty?



Cooking equipment

LIVING WAGE BRIGHTON & HOVE

Employment

Access to low cost healthy ingredients

Cooking skills

Benefits and pensions

Financial inclusion (e.g. savings, money advice)

Affordable housing, fuel, transport

Healthy food in health/social care services

Community networks

Shared meals & eating together

Crisis support for when prevention doesn't work

Brighton & Hove FOOD Partnership

www.bhfood.org.uk

Principles for food poverty work in the city

These principles encapsulate the collective thinking that went into developing the action plan, and partners are asked to make them a basis for planning future work in the city which addresses food poverty; and for prioritising resources when difficult decisions need to be made.

1. Collectively agree that food poverty is unacceptable in Brighton and Hove.
2. Reduce the impact of food poverty on the health and wellbeing of local people, leading to better mental and physical health, reduced obesity, higher educational attainment and longer, healthier lives.
3. Mitigate against the likely impact on future health and social care budgets if we do nothing about this issue.
4. Focus the city's limited resources on the most effective solutions.
5. Take a preventative approach and address the underlying causes of food poverty, even if this means thinking beyond food (e.g. employment, benefits, and housing and fuel costs).
6. Recognise that food poverty is not just about food banks – focus on how people in 'long term food poverty' can avoid reaching crisis (though we still need emergency provision when things do go wrong).
7. Focus on groups which have been locally[1] and nationally[2] identified as the most vulnerable to food poverty. [see right]
8. Involve people experiencing food poverty in the design of solutions.
9. Ensure that food is at the centre of policy making, not an 'add on'.
10. Commit to measuring and monitoring, so we know if food poverty is increasing and why.

People who are most vulnerable to food poverty

a. Disabled people (including people with learning disabilities) and people experiencing long term physical or mental ill health (1a, b, c, d, e)

b. Large families, single parent families and families with disabled Children (1b, d) (1b, d)

c. Working people on a low income, especially younger working age people (1a, b, c, d)

d. Vulnerable adults - including some older people - who are isolated or digitally excluded – or who are experiencing transition e.g. bereavement/ becoming ill/ leaving hospital and people moving from homelessness, offending or addiction (1d, e)

e. 16-25 year olds who are vulnerably housed and care leavers (1b 1c ; discussions during research for this action plan)

f. BME people and migrants who have limited recourse to funds (1d, discussions during research for this action plan)

1 Priority groups identified from the following:
(a) City Tracker survey (see BHFP briefing *Food poverty in Brighton and Hove*) (2014)
(b) Public Health's *The impacts of welfare reform on residents in Brighton and Hove* (2015) (c) *The Director of Public Health's report* for 2015
(d) BHFP's *Report on identifying food poverty in Brighton & Hove* (2013) (e) Public Health/ BHFP's Healthy Ageing and Food (2015-pending)

2 E.g. *Feeding Britain* – The report of the All-Party Parliamentary Inquiry into Hunger in the United Kingdom (2014); *Walking the Breadline* (2013) and follow up *Below the Breadline: The relentless rise of food poverty in Britain* (2014); *Hungry for Change, The final report of Fabian Commission on Food and Poverty (2015)*

What is the extent of the problem?

There are 14 areas of Brighton & Hove in the bottom 1% for income deprivation nationally,[3] yet it is an expensive place to live.

Data related to premature deaths in England shows that Brighton and Hove ranks 98th worst out of 150 local authorities. Cancer, liver disease and heart disease are key contributors (2,185 deaths of under-75s). Poor diet and obesity are key factors in the causes of these deaths.[4]

It is difficult to measure the exact number of people experiencing food poverty in the city as there is no fixed definition and food poverty can arise for different reasons. It is not just about money but may also be about food access, skills, equipment or be complicated by personal circumstances such as needing a special diet.

Food bank use is often used as a way to measure levels of food poverty but in practice only identifies the 'tip of the iceberg' – people in crisis or emergency food poverty – as most households will only use them as a last resort. There is a much larger group of people who are living in long term food poverty or household food insecurity – for example skipping meals, being forced to make unhealthier food choices, or having to choose to 'heat or eat'.

Indicators of food poverty at the crisis level are:

- The number of food banks has more than doubled in the last two years. New research by BHFP shows there are now fifteen food banks in the city which together give out an average of 289 food parcels a week, an 8% increase compared to 2014. Two thirds of food banks (67%) say that they have noticed an increase in demand over the last year.
- The Local Discretionary Social Fund (LDSF), provides payments for those on low income with an unforeseen emergency or financial crisis. In 2013-2014, 480 LDSF payments for food were made and a further 1140 made for cooking equipment.

Data on ongoing food poverty

- The Brighton & Hove City Tracker in 2014 asked about local people's level of concern in meeting basic living costs in the next 12 months. Almost one in four respondents (23%) disagreed with the statement that they 'will have enough money in the next year to cover basic living costs including food, fuel and water'. The groups most likely to strongly disagree were women compared with men, 18-34 year olds compared with 35-54 year olds, and people with a long-term health condition or disability.
- In 2015, 23% of people calling the Brighton & Hove Moneyworks helpline stated that they had to skip or reduce meal size in the last 6 months. Amaze, who work with families who have children with disabilities or special needs found in 2014 that 15% had reduced the size of meals or skipped meals during the last two months.

There is some good news however

Universal Infant Free School Meals mean that at least 7,200 pupils across the city now have a healthy lunch. Breastfeeding levels are the highest in the country[5] and childhood obesity levels are below the national average (although again rates vary between more and less deprived households).[6] Research by BHFP[7] uncovered that almost half a million (462,334) shared meals take place each day, playing an important and largely uncelebrated role around food poverty. This plan seeks to recognise and build on some of these success stories

This is just a snapshot of extensive research undertaken to inform this plan – some references are included in the 'Research and Evidence' section.

3 Indices of Multiple Deprivation 2015

4 *http://www.bhconnected.org.uk/sites/bhconnected/files/jsna/jsna-6.4.6-Good-nutrition-&-food-poverty1.pdf*

5 *https://www.brighton-hove.gov.uk/content/press-release/brighton-hove-best-breastfeeding*

6 *http://www.hscic.gov.uk/ncmp*

7 *http://bhfood.org.uk/downloads/downloads-publications/99-eating-together-report-final/file*

How the plan came about – and where it will go

Brighton & Hove Food Partnership (BHFP) led on the development, drafting and consultation using funding from the Esmée Fairbairn Foundation with support and input from a range of council staff, Brighton & Hove Connected and voluntary, community and faith groups.

The plan, which sits under the city's food strategy[8] was developed using a participatory approach to ensure wide ownership of the actions, and that the action plan is embedded in city policy and practice at different levels, including at senior decision making level. As well as a formal adoption by Brighton & Hove City Council (BHCC), the Health and Wellbeing Board and other partners, it will feed directly into the city's Joint Strategic Needs Assessment (JSNA) and Fairness Commission.

This plan was developed over a year following a city council commitment to work on a plan with partners in November 2014. As well as research into national good practice, we engaged with many local people and organisations via consultation events and also numerous individual conversations.

Key stakeholders are:

- Strategic decision makers and budget holders
- Community, voluntary and faith groups
- Food banks – via the Food Banks & Emergency Food Network
- Shared meals/settings – via survey and research project
- Advice services – via Advice Services Network & Partnership
- Organisations working with older people – via Healthy Ageing research project
- Gardening projects – via Harvest Evaluation
- Focus groups with people experiencing food poverty

This is a partnership plan and we would like to thank the many people who have been part of drafting the plan and who will be partners in delivering it. There are sure to be organisations and individuals that haven't been included and we urge you to get involved going forward.

Consultation events in 2015 included:

- Action Plan consultation session at Community Works conference
- Food Poverty Strategic Round Table with Brighton & Hove Connected
- Presentations at Advice Services Network (2015) and Advice Services Partnership
- Food Poverty Action Plan stakeholder 'finalisation' event

8 *Spade to Spoon, Digging Deeper: A food strategy for Brighton & Hove, 2012*

Brighton & Hove FOOD Partnership

Esmée Fairbairn FOUNDATION

BRIGHTON & HOVE CONNECTED

How will we know we have succeeded?

This plan has an overall aim: to **reduce food poverty.** However there are real challenges to knowing what success should look like. There is no one defined measure nationally or locally and there is a lack of data. Aim 5 of the action plan seeks to address this gap – but it is important to recognise the limitations, especially as food is rarely 'a thing on its own'.

Additionally the external environment is changing. For example further welfare benefit changes and cuts, and a continuing increase in housing costs, might mean that success might actually be **a slower rate of increase in food poverty,** rather than an actual reduction, and the following measures should be seen in this context.

Overall aims (outcomes)	How it will be measured (subject to resources)
There is reduction (or slower growth) in **'emergency'** or **crisis food poverty** i.e. the number of people experiencing hunger or seeking emergency assistance – and we are able to measure this.	Local Discretionary Social Fund (LDSF) figures & collated food bank figures (see Aim 5)
There is a reduction (or slower growth) in **long term food poverty** i.e. the number of 'coping but struggling' people on a low income being forced to make unhealthier food choices, skipping meals or reducing portions on an ongoing basis – and we are able to measure this.	City Tracker figures; data from city services & voluntary & community groups (see Aim 4)
Food poverty awareness is embedded in **policy and in service planning** – especially in housing, fuel poverty, Public Health, social services, and hospital care and discharge – with a focus on prevention.	BHFP to monitor policy. Action plan partner to monitor their own service provision (see Aim 1)
Brighton & Hove becomes **the city that cooks and eats together.** 'Shared meals' are thriving and celebrated in the city, strengthening community networks which are themselves a resource in hard times. People are able to find out about and get to them; and new ways of sharing food are explored.	BHFP & Federation of Disabled People to monitor shared meals settings and alternative models.

How will we track progress?

All actions in the plan have identified a tracking or monitoring mechanism, and a lead partner. Subject to securing funding, BHFP will keep an overview of progress (alongside the city's Food Strategy) and where possible will help to facilitate progress e.g. by bringing relevant partners together.

Stakeholders will be invited to come together half way through the 3 year plan to hear about progress; and refresh or refocus actions. Lead partners will also come together after year 1 and finally at the end of year 3, to report back and agree any evaluation plus next steps.

Brighton & Hove Food Poverty Action Plan

The plan has been arranged under the following five aims, although in line with our cross-cutting approach, many actions will add value in more than one of these aims i.e. there is overlap – which is a good thing!

Aim 1: Tackle the underlying causes of food poverty in the city

Embedded in the principles for food poverty work, a preventative approach which focusses on the 'coping but struggling' with a view to avoiding the need for emergency food is key.

Aim 2: As a bare minimum, ensure that every child, and every vulnerable adult, can eat one nutritious meal a day

In some ways this is a shockingly low aim, but it would make a huge difference to many people in the city.

Aim 3: Brighton & Hove becomes the city that cooks and eats together

Having the skills and equipment to cook is vital to eating well on a budget. A thriving climate for shared meals contributes to reducing isolation, and number of people needing crisis support (as family and community networks are the first place we turn when our finances are under stress).

Aim 4: When prevention is not enough – ensure there is crisis and emergency support so that people do not go hungry

For when all the efforts at prevention do not work. This should not be reliant purely on voluntary, community and faith groups.

Aim 5: Commit to measuring levels of food poverty so we know if we are being effective

We need to do this or we will not know if we are succeeding.

"It's such a treat to get food like this ... if you're living on a tight pensioner's budget there just isn't anything left to spend on good food"

– Hove Methodist Church lunch club attendee

"I wouldn't have survived without it ... all my money was being spent on my son's medical care"

– Food Bank Client

"I know I won't go to sleep hungry tonight"

– Participant at Young People's Centre

"I don't eat this well the rest of the week. I try to come every week if I can"

– Migrant English Project attendee

Summary of Actions *A full version is also available, with details of leads, partners & timescales*

Aim 1: Tackle the underlying causes of food poverty in the city

1A	Actions which address the broader or underlying causes of food poverty
1A.1	Provide information relating to 'solutions' including a web page plus non-digital resources (e.g. leaflets) to guide both people experiencing food poverty and those who advise them.
1A.2	Better integrate food poverty into money advice programmes: • See where food can add value to advice or engage people e.g. food as a 'safe' way to talk about budgeting • Include food ordering/ budgeting/ preparation in other financial capability training sessions, digital inclusion programmes etc. *(See also 3A)* • Explore how lunch clubs / shared meals (as well as food banks - see below) can become a site for money advice
1A.3	Paradoxically many people experiencing food poverty are working in the food industry; yet food has huge potential as an employment option. Explore the following opportunities (*See also 1B for broader employment actions)*:
	• Better/ fairer paid staff e.g. good practice on tipping in restaurants; reduced use of zero hours contracts; supermarkets becoming living wage employers
	• More apprenticeships with a food element *Initially arrange for BHFP to present this work to Learning, Skills and Employment Partnership to develop understanding of overlaps in work*
	• Primary and Special School Meals Service becomes a Living Wage Employer as a beacon for other large catering employers
	• A role for new apprenticeships e.g. in social care which include cooking skills (double win – increase employment in a shortage area/ better care for vulnerable people- see below)

1A.4	Reduce the impact of benefit issues, which currently contribute to a large proportion of food bank use[1] /crisis food poverty • When there are delays/refusals/ sanctions, DWP automatically gives information about what the issue is and clear guidance on how to resolve it. DWP also provides information on hardship payments e.g. short-term benefit advances; and signposting to advice services and other support in the city • DWP to run awareness sessions on understanding hardship routes for Advice and Food Bank workers & volunteers, so they can better advise their clients
1A.5	Raise awareness in frontline workers and volunteers via food poverty awareness training/ sharing information. Also encourage two way process where 'intermediary' organisations share their information on food poverty issues with BHFP.
1A.6	Given the synergies with the Housing Strategy and the Food Poverty Action Plan, run a workshop with BHCC housing staff and BHFP to scope how to make the most of the overlaps in this work.
1A.7	Raise awareness of food poverty issues and this plan in other strategies, and in policy service planning – especially in housing, fuel poverty/ affordable warmth, Public Health, social services, and hospital care and discharge.
1A.8	Raise awareness and seek to engage further partners in development of this action plan, especially those who work with the groups identified above as most vulnerable to food poverty.
1A.9	Share the learning from developing this plan locally and nationally, and respond to both national and local campaigns and consultations.
1A.10	Submit the evidence which has informed this action plan to the Fairness Commission; and continue to liaise with Commissioners to ensure that food poverty is fully integrated as an issue.

[1]Perry, J., Sefton, T., Williams, M. and Haddad, M. (2014). Emergency Use only: Understanding and reducing the use of food banks in the UK. http://www.trusselltrust.org/resources/documents/press/foodbank-report.pdf

1B	Broader 'bigger picture' actions - influencing elsewhere to ensure that people have an adequate income in relation to their household expenditure.
1B.1	Promote Brighton & Hove as a 'Living Wage City' at the level calculated by the Living Wage Foundation (£7.85 p/h in 2015). Encourage larger employers including national ones to sign up.
1B.2	Via delivery of Economic Strategy and Learning and Skills work develop a thriving economy with secure, living wage employment opportunities. Ensure people can develop the skills needed to access good employment – including disabled people and other 'at risk of food poverty' groups listed above. Deliver a programme of work on apprenticeships. (*see also 1A for actions linking employment and food*)
1B.3	Via delivery of the key priorities in the Housing Strategy – improving supply, improving quality and improving support - develop actions to increase the affordability of housing, reduce failed tenancies and reduce fuel poverty (food vs fuel pay-off major cause of food poverty) - especially in the private rented sector.
1B.4	Promote the local financial inclusion agenda and actions to tackle the 'poverty premium' whereby those on the lowest income end up paying the highest prices • **Advice** (see directly below) – including debt & benefit maximisation • **Banking** - access to cheaper means of payment e.g. direct debits • **Credit -** so people are not reliant on loan sharks or payday lenders, if an emergency occurs • **Deposits** - to allow a savings 'buffer' against things going wrong • **Education** including **digital inclusion -** to access food for home delivery and other goods at the best prices* (see also below) • **Fuel poverty** reduction/ energy efficiency – keeping fuel bills low* • **Food** – uniquely, Brighton & Hove includes 'food' under financial inclusion **as food is the flexible item in people's budgets, reducing other outgoings helps to free up spend for food. Food and fuel poverty are interlinked.*

1B.5	Identify those who will be most affected by future rounds of Welfare Reform and prioritise for support (all tenures i.e. private rented as well as social housing tenants). Share information about the impact of benefit changes e.g. how the changes to working tax credit will affect eligibility for free school meals.
1B.6	Undertake research to better understand the poverty premium in terms of food shopping (for example to include the price difference of healthy / unhealthy food) and the impact of local shops vs internet shopping / large retailers.
1B.7	Ensure people can access advice about money at an early stage - *before* hitting crisis – including: • Benefit maximisation & debt advice • Building savings (to have a buffer in case of crisis) • Planning for later life (thinking now about how to have an adequate income in later years)

Aim 2 – As a bare minimum, ensure that every child, and every vulnerable adult, can eat one nutritious meal a day

2A	There is more creative use of existing support to parents of under 5s including breastfeeding, food poverty advice and Healthy Start vouchers & vitamins
2A.1	Continue existing good practice in achieving high overall levels of breastfeeding with continued focus on deprived areas.
2A.2	Improve healthy eating advice to families with young children and link to cookery/shopping skills. Increase uptake of Healthy Start vouchers amongst eligible families, by ensuring they are included in conversations with Health Visitors.
2A.3	Increase uptake of healthy start vitamins • Clinical lead to provide teaching session to Children's Centre reception staff to increase awareness of importance of Vitamin D & Healthy Start scheme • Clinical lead to undertake audit of Health Visitor records to establish if Healthy Start vouchers and vitamins are being discussed • Guidance to be written for Health Visitors • Continue to work with Community Pharmacists and work towards distributing vitamins from them • Repeat update on vitamins (lunch-time seminar)

2B	A greater number of families with children eligible for free school meals are accessing them. Schools embed initiatives which help to alleviate food poverty including 'holiday hunger' schemes
2B.1	Provide information and training to schools about using breakfast clubs to alleviate food poverty. Share good practice information with learning mentors on using breakfast clubs to support learning. Support breakfast clubs to achieve the Healthy Choice Award to demonstrate that the food they are serving is healthy and age appropriate.
2B.2	Continue to deliver Universal Infant Free School Meals (UIFSM) at Silver Food for Life standard. Keep prices of school meals for other age groups low by keeping uptake high. Arrangements for school meal provision when contract changes in 2017 to consider food poverty issues.
2B.3	Increase uptake by those who are signed up for free school meals but don't choose to eat one (both UIFSM and FSM).
2B.4	Maximise the number of eligible families who are signed up to receive free school meals, learning from any developments in best practice nationally.
2B.5	Explore and share good practice on using pupil premium for healthy food related activity in schools.
2B.6	Raise awareness in primary schools of Chomp holiday lunch clubs for families, and improve referrals.
2B.7	Pilot a holiday lunch club taking place on at least one school premises (ideally in Portslade or Hangleton) via existing Chomp model and/or in partnership with school meals service.
2B.8	Contact projects providing food for children during term time to see if they are interested in expanding holiday provision.

2C	Vulnerable adults have their food needs automatically considered during assessments. There is meal delivery provision for those who need it – but people are able to choose alternatives out of the home such as shared meals. *See also 2.E for residential settings.*
2C.1	Explore if / how nutrition and hydration can be introduced to the checklist for Care Assessments as part of the Better Care agenda; and whether this can be an opportunity to give people info on 'shared meals' and other ways to access healthy food.
2C.2	Develop possibilities of shared food in terms of Adult Social Care services e.g. whether people can eat with a neighbour/ friend/family member/ at a lunch club as part of a care package; and/or whether eating together might allow people to combine their care packages allowing more time with care worker and/or reducing social isolation.
2C.3	Ensure that Community Meals are available, affordable and offer a range of options to meet and maintain people's nutritional needs. Explore options for April 2016 (current contract end date March 2016) to ensure further choice and control for people using the service. Ensure that people are also aware of the alternatives (such as shared meals) which reduce social isolation and engage people back in communities.
2C.4	Adult Social Care is currently re-commissioning the Home Care contract provision - meal preparation to be considered as part of this process.
2C.5	Take steps to make nutrition and hydration a priority by mainstreaming into thinking and across contracting. Initial meeting with CCG / BHFP to understand what information there is already available about the scale of problem/ budget implications (including possible cost savings from preventative approach).
2C.6	Invite BHFP to give a presentation to the Home Care Provider Forum on nutrition and preparation of nutritional meals for vulnerable people.
2C.7	BHFP to offer the learning from developing this action plan into the Home Care recommissioning process – e.g. the importance of including enough time for preparing a simple nutritious meal– not just microwaving/ 'taking off the foil'; and importance of paid care workers understanding nutrition & having cooking skills.

2C.8	Explore provision of training for paid care workers on both nutrition and cooking - explore the 'cooking together' model (carer and client learn together).
2C.9	Ensure hospital discharge procedures include a 'nutrition and hydration' check i.e. that appropriate food arrangements are in place (e.g. someone will be able to help with shopping/cooking/special diet if needed). Ensure that hospitals provide information at discharge about food options including 'shared meals' such as lunch clubs and/or referral to befriending organisations if people need support to attend them.
2C.10	Explore whether 'food to go bags' can be provided to people who won't be able to immediately access support with shopping (if needed) when they are discharged from hospital, so they don't go home to an empty fridge.
2C.11	Develop a trigger mechanism if a meal service for vulnerable people is under threat, i.e. ensure that a range of options is available so that people will have their needs met.

2D	Older people's experiences of food poverty are considered – including increased risk of malnutrition; and issues around food access. *For more detail see also Public Health/ BHFP's Healthy Ageing and Food report (November 2015)*
2D.1	Explore how older people can best be supported especially at key 'transition times' including hospital discharge (see above) and bereavement to prevent long term food issues / entrenched isolation developing.
2D.2	Fully embed the MUST (malnutrition screening) tool in hospitals and beyond e.g. in GPs, via health checks and in care homes (as many hospital admissions from care homes are related to malnutrition). Also engage with private sector home care agencies & discharge agencies around training/ embedding.

2D.3	Noting lower levels of internet access / confidence amongst some older people, ensure: • Digital inclusion courses for older people include food shopping *(see also 3A below)* • Information is provided non digitally –around changing nutritional needs with age, cooking in response to changed mobility, choosing a ready meal, home delivery of pre-cooked meals, how to find lunch clubs/ shared meals etc. *(see also below and 'Healthy Ageing and Food' report, November 2015)*

2E	Food in residential settings such as hospitals and nursing homes is palatable and nutritious, and where possible sustainable: reducing levels of malnutrition and improving clinical outcomes
2E.1	Improve hospital food at Royal Sussex County Hospital in terms of nutrition, sustainability and palatability, exploring the potential to work in partnership with other local NHS Trusts around a joint catering production unit.
2E. 2	Adult Social Care and the Clinical Commissioning Group (CCG) to work together to explore how nutrition and hydration can be improved in care homes.
2E.3	Deliver training on nutrition and cooking skills to staff in care homes via the BHCC core training programme. Undertake programme of work to encourage wider uptake of the training.
2E.4	Promote the Healthy Choice Award to encourage good practice in residential settings; include as part of Adult Social Care audit/review process; share good practice at relevant forums/through relevant communications. BHFP to give presentation at the city-wide Care Home Forum on the Healthy Choice Award.

Aim 3 – Brighton & Hove becomes the city that cooks and eats together

3A	Brighton and Hove becomes 'The city that can cook' : Part A *Skills*
3A.1	Expand the number of classes on offer in cooking and shopping skills, for both general public and specific groups e.g. people with learning disabilities; single men; older/bereaved men ('Old Spice') and the groups identified above as at risk of food poverty including young working age people[2]. Explore how budgeting, numeracy etc. can be embedded within cookery sessions. Explore how cookery sessions can be better linked with community cookery/shared meals groups e.g. Chomp holiday lunch clubs for children and families.
3A.2	Develop specialised training courses and/or written 'Tip sheets' – for people in particular circumstances (and those who support and advise them e.g. support workers, paid carers and family/unpaid carers) • Adapting cooking to disabilities/sensory impairments (plus how to access cooking equipment/ adaptations –see below) • Lacking cooking equipment e.g. in temporary accommodation or bedsits • Mental health condition (e.g. cooking in advance for bad days) • Cooking for one • Older people's nutritional needs (these change as we age) • Choosing a healthy ready meal in a supermarket/ options for home delivery (many people are reliant on pre-cooked meals)
3A.3	Include food ordering/ budgeting/ preparation in financial capability training sessions. Also in 'getting online' training. e.g. How to set up a 'favourites list' for food shopping on-line.

[2] See for example http://www.independent.co.uk/news/uk/home-news/16-to-24-year-olds-spend-more-on-food-than-any-other-age-group-says-research-a6678596.html

3B	Brighton and Hove becomes 'The city that can cook' : Part B *Equipment* (fridge/freezer/cooker/saucepans/storage)
3B.1	Improve access to equipment that will help people with sensory impairments or other disabilities to cook, initially by exploring wider roll out of Independent Living Centre and/or re-ablement services similar to those available after a stroke.
3B.2	Explore whether Sheltered Housing refurbishments/ developments can include a fridge/freezer rather than a fridge with icebox as this is important for budget cooking for one or two people.

3C	Brighton & Hove becomes 'the city that eats together'. Shared meals are thriving, and people can find out about and get to them. Offers of new venues and storage spaces help keep costs low. *Sharing food is a an effective means for people to eat well – including (but not only) those who are vulnerable e.g. don't have the mobility, equipment or skills to cook. They help strengthen community networks which are themselves a resource in hard times. Cost, access and (especially) transport are key factors in accessing them*[3].
3C.1	Recognise the role that shared meals e.g. lunch clubs are playing in improving the health, nutrition and mental health of the city; increase their role as a site to deliver advice or be a 'safe place' to raise other issues. Ensure that projects can keep up with increasing demand e.g. explore creative commissioning arrangements (see also 'care packages' below) and/or new micro funding to test new models of provision/ meet gaps /increase sustainability. *NB - gaps are at **evenings/weekends** and in the **East and North of the City** –52% of people accessing shared meals live nearby*
3C.2	Explore whether existing projects can add *cooking and eating together* to their existing services - e.g. community groups; school holiday activities such as Playbus; 'trusted' providers such as food banks (See also Aim 4 below).

[3] See BHFP's 'Eating Together' report for more detail about the role of Shared Meals in tackling isolation, food poverty and acting as a gateway to advice and support

3C.3	Explore in-kind support for shared meals e.g. use of council premises for shared meals and/or for storage of ingredients/ surplus food • Sheltered / seniors housing (for residents also for wider community) • Schools and children's facilities (for family meals and/or holiday lunch clubs) • Council storage spaces and community rooms e.g. in housing estates (especially ones with kitchens) • Faith groups/ community groups/ facilities in private sector e.g. care homes
3C.4	Secure a premises so that a 'pay as you feel' meal is available 7 days a week - ideally own premises but if shared then focus on evenings & weekends (identified as a gap).
3C.5	Explore whether BHFP can support shared meal projects with recruiting volunteers and/or other development support e.g. around management/fundraising.
3C.6	Provide 3 x initial training sessions – including food safety and creative cooking with surplus foods/cooking for groups - as a cost effective way to support shared meal projects.
3C.7	Recognise the 'infrastructure' role of FareShare and grassroots surplus food distributors in supporting shared meal settings (plus food banks – see below – and other food services for vulnerable/ disadvantaged people) to keep their costs low and accessible – support via direct funding and/or in-kind support especially storage facilities for surplus food.
3C.8	Make information about shared meals more accessible via an easier search mechanism on the 'It's Local Actually' directory and by non-internet methods e.g. printed list /radio – promote in other settings (e.g. hospital discharge, care assessments, via GPs and other health professionals, e.g. Community Navigators).
3C.9	Support initiatives which encourage neighbours to connect, with potential to share e.g. 'Know my Neighbour Week' May 2016; Neighbourhood Care Scheme.

3D	It becomes easier access to low cost food in the city, whether this is ingredients or shared meals – making it easier to make healthier choices
3D.1	Explore options to increase access to fresh low cost ingredients at a local level for example: • link existing local grocers van or with food banks, lunch clubs; community venues • encourage new individual or community run low cost food outlets in community spaces or sheltered housing (offering free use of space to keep costs down) e.g. low cost veg; bulk buying clubs or food co-ops *See also digital inclusion – improving access to home food delivery*
3D.2	Deliver a programme of work with outlets to offer healthier options in restaurants, cafes and takeaways; including healthier cooking techniques and achieving the Healthy Choice Award.
3D.3	Explore how City Plan Part 2 and economic planning processes can encourage local shops and market stalls selling fresh ingredients; and encourage healthier takeaways.
3D.4	Recognise the role of community kitchens and venues in addressing the impacts of food poverty and explore protection through existing and future planning policy frameworks (e.g. City Plan Pt2).
3D.5	Via Transport Strategy ensure accessible affordable public and community transport is promoted and provided, enabling people to travel to local and main shopping areas and/or access shared meal settings. Transport is an important factor in food poverty, especially to those with disabilities.
3D.6	Shared meal settings refer to the Federation of Disabled People's 'Out and About' guide for information about informal shared transport options and other useful examples and guidance on ensuring effective (free) insurance provision for volunteer drivers: http://www.thefedonline.org.uk/citywide-connect.

Aim 4 – When prevention is not enough - ensure there is crisis and emergency support so that people do not go hungry

4A	Food Banks are supported to operate effectively as an emergency option and to widen their services to help address underlying causes of food poverty – and they are not the only option in a crisis
4A.1	Advocate and provide planning options for the continuation of the Local Discretionary Social Fund (LDSF) or similar form of crisis support by a statutory organisation - so that people experiencing an emergency are not reliant purely on the voluntary/community or faith sectors. Options for continued funding are creatively explored before current provision ends in 2017.
4A.2	FareShare and other food surplus organisations continue to redistribute surplus food effectively, underpinning the work food banks do in the city. Focus on securing more fresh/ healthy food + expanding to meet demand - whilst acknowledging that food waste is never the 'answer' to food poverty. The debate around food surplus issues to be explored via food surplus network and future city waste strategies. *NB affordable surplus food also supports 'shared meals' as well as food banks– see above*
4A.3	Food Banks and emergency food providers ensure that people receive holistic support to tackle the underlying causes of the emergency including access to the city's advice services (either on site or by referral). Advice services continue to better integrate their services with food banks.
4A.4	Food banks continue to look at how they can offer longer term support which goes beyond emergency food/ is preventative • Digital access ideally with support • Shared meals / other 'longer term' options • 'Cooking and Eating Together' sessions and/or cookery classes • Access to low cost ingredients for cooking at home (e.g. food buying groups, link with local grocers) alongside healthier food within food banks
4A.5	BHFP secures funding to develop its work to support Food Banks & Emergency Food providers; and continue the food banks network as a collective space for food banks to work together and meet with advice providers and the City Council.

Aim 5: Commit to measuring levels of food poverty so we know if we are being effective

5A	Existing monitoring mechanisms are used to gather better info on food poverty
5A.1	BHFP to continue to measure crisis or emergency food poverty by providing an annual snapshot of food bank use in the city.
5A.2	Continue to gather information on longer-term or chronic food poverty in the city; also on national good practice/ 'solutions'.
5A.3	Explore how information from MUST (malnutrition screening) can inform understanding of food poverty in the city, in parallel with wider use of MUST outlined in Aim 2.
5A.4	Use breastfeeding rate data to track rates of breastfeeding, taking note of trends in more deprived wards.
5A.5	Use child measurement programme data to track rates of childhood obesity in different income groups.
5A.6	Food banks commit to measuring the reasons people are accessing them, using 'Trussell Trust' categories so that the data can be compared.
5A.7	Organisations and services track food poverty levels amongst their service users using question(s) already piloted by BHFP or including the broader city tracker food/fuel question; or 'innovative' methods e.g. video/visuals - BHFP to collate data.
5A.8	Universities strengthen their research partnership with BHFP and/or Food Matters, including at least one joint project around understanding or tracking food poverty or food prices/availability in the city (See also Aim 1A).
5A.9	The City Council measures on-going levels of long term or chronic food and fuel poverty via a question in the annual weighted 'city tracker' survey, Clinical Commissioning Group (CCG)/ BHCC explore whether contracts for health and social care services can help with measuring levels of food poverty (by requiring data collection); or whether they can share existing data e.g. from health visitor assessments.

Research and evidence

A huge amount of research went into developing this plan – most importantly talking to local people and organisations. These are just some of the some key documents

Research and evidence: Local (BHFP publications reports and research all downloadable at http://bhfood.org.uk/resources)
• BHFP overview briefing on **Food poverty in Brighton and Hove** includes data from the recent city tracker question on food and fuel poverty • **The Director of Public Health's report** for 2015 includes a specific chapter on food poverty • **The impacts of welfare reform on residents in Brighton and Hove** (2015) identifies the most vulnerable residents & also looks at food including coping strategies, importance of wider networks etc. • BHFP's **Eating Together: Exploring the role of lunch clubs and shared meals in Brighton & Hove** (2015) explores the 'hidden' role of shared meals in generating community resilience as well as access to nutritious food • BHFP's **Identifying Food Poverty in Brighton & Hove** looks at groups most at risk of food poverty using existing data

Research and Evidence: National
• **Feeding Britain - The report of the All-Party Parliamentary Inquiry into Hunger in the United Kingdom** (2014) is a detailed analysis with recommendations. The development of this action plan is itself a 'Feeding Britain' pilot and will feature in the **'one year on'** report due December 2015 • **Sustainable Food Cities "Beyond the Food banks"** national campaign (NB ***Brighton and Hove is the country's only silver sustainable food city***) suggests actions to focus on with examples from **different cities; also has a comprehensive list of resources arranged by topic** • **Walking the Breadline** (2013) and follow up **Below the Breadline: The relentless rise of food poverty in Britain** (2014) • (Church Action on Poverty and Oxfam) provides a detailed analysis of food poverty issues • The **interim report from the Fabian Society's commission into Food and Poverty** has a range of evidence and is strong on 'trading down' and unhealthy food choices and the final report Hungry for Change is also strong on long term food poverty or 'household food insecurity' and recommends local authorities should create a food access plan (2015) • **Joseph Rowntree Foundation** has just announced new Minimum Income Standards defining 'acceptable' income for different groups in the UK

Action Plan Partners

A huge thank you to the partners, many who have helped to develop, or committed to delivering, actions in this plan

Age UK Brighton & Hove
BHESCo (Brighton & Hove Energy Services Co-operative)
BHT (Brighton Housing Trust)
The Big Fig
Brighton & Hove Chamber of Commerce
Brighton & Hove City Council [4]
Brighton & Hove Connected (Local Strategic Partnership)
Brighton & Hove Food Partnership
Brighton & Hove Living Wage Campaign
Brighton & Hove Strategic Housing Partnership
Brighton & Sussex University Hospitals Trust
Brighton and Sussex Universities Food Network
Brighton Unemployed Centre Families Project (BUCFP)
British Red Cross Brighton
Carers Centre for Brighton & Hove
Chomp lunch club
City College Brighton & Hove
Clinical Commissioning Group (CCG)
Community Works
Department for Work & Pensions (DWP) & Job Centre Plus
East Sussex Credit Union
Economic Partnership
FareShare Sussex Brighton & Hove
Federation of Disabled People (The Fed)
Food Matters
Food Waste Collective
Hangleton & Knoll Project
Healthy Ageing Partnership/ Forum
Hove Luncheon Club
Learning, Skills and Employment Partnership
Lunch Positive
Mind
Migrant English Project
NEA
Neighbourhood Care Scheme
One Church Brighton
Private home care providers & discharge agencies
Prof Martin Caraher, City
Real Junk Food Project
Sussex Partnership NHS Foundation Trust
Sustain
The city's advice services – individually and via Moneyworks, the Advice Services Network & Advice Services Partnership
The city's befriending organisations
The city's food banks – individually and via the Brighton & Hove Food Banks & Emergency Food Network
The city's lunch clubs and shared meal settings
The many other community & voluntary groups who are part of this plan

A longer 'delivery' version of this action plan is also available, which includes details of partners and timescales for each action

[4] With particular thanks to:
Adult Social Care, Children's Services , Housing, including Seniors Housing, Planning, Policy, Public Health, School Meals Service, Transport, Welfare Reform

advice Brighton & Hove

Brighton & Hove age UK

b h t

BRIGHTON & HOVE CONNECTED

FOOD BANK BRIGHTON

NHS Brighton and Hove Clinical Commissioning Group

Brighton & Hove CHAMBER OF COMMERCE

Brighton & Hove FOOD Partnership

Brighton and Sussex University Hospitals NHS Trust

carers centre

COMMUNITY WORKS

jobcentreplus
Department for Work and Pensions

EAST SUSSEX CREDIT UNION

Brighton & Hove City Council

ef Esmée Fairbairn FOUNDATION

FareShare Sussex

the Fed centre for independent living

The Hangleton & Knoll Project
Working for a better community

Hove Luncheon Club

Lunch POSITIVE

TMEP Migrant English Project

mind for better mental health in Brighton and Hove

MONEYWORKS Brighton & Hove

LET'S REALLY FEED THE WORLD
THE REAL JUNK FOOD PROJECT
BRIGHTON
EST. 2014

Healthy Ageing and Food – bringing a food focus to Brighton & Hove as an 'Age Friendly City'

February 2016 / update June 2016 following further consultation

The aim of this report is to scope the existing work in the city around food and older people and to start identify what an 'Age Friendly City' might look like through the lens of food.

This report has been prepared by the Brighton & Hove Food Partnership (BHFP) for the city's Age Friendly Steering Group and the Brighton & Hove Public Health Commissioner at Brighton and Hove City Council. It has been based on a series of interviews, desk research and workshops. Thank you to everyone who gave their time to talk to us.

The report makes a series of recommendations to inform various bits of work including:

- The 'healthy older people' preventative approach the City Council is developing in relation to commissioning services.
- The actions relating to older people in the city wide Food Poverty Action plan, which the Food Partnership is coordinating along with the City Council.
- The development of neighbourhood hubs
- Progress in delivering the city's food strategy
- Project development / funding bids
- Relatively few Age Friendly Cities focus on food so this scoping exercise may be of interest to other cities nationally and internationally.[1]

The context of this work is Brighton and Hove's ongoing activity to become an ***Age Friendly City*** in line with the approach advocated by the World Health Organisation (WHO). Age Friendly Cities have at their core "the desire and commitment to promote healthy and active ageing and a good quality of life for their older residents"[2]. An underpinning principle is that older people should be seen as active contributors to, not just recipients of services.

[1] A notable exception is Udine in Italy where a quarter of the population are over 65 and against a backdrop of recession an army of volunteers have set about to offer a range of services including food and shopping

2 http://www.who.int/ageing/projects/age_friendly_cities_network/en/

Contents

Process

The background research for this report was put together from March to May 2015, as a deliberately time limited scoping exercise. It was based on desk research, structured interviews, informal conversations and visits to a range of different settings which relate to food and older people in the city. The report is designed to provide an overview and some guidance on future directions - it is not exhaustive and in particular does not pretend to include a full range of voices of older people, though opportunities were taken to consult with older people where possible.

The WHO Active Ageing Policy Framework. The underlying approach to the report has been taken from the WHO Active Ageing policy framework areas, taking a positive 'life course' approach to healthy and active ageing[3]**.** The WHO identifies that good nutrition is important for preventing ill health - especially the impact of chronic disease - in older people[4].

a) **Promoting good health and healthy behaviours** at all ages to prevent or delay the development of chronic disease. Being physically active, **eating a healthy diet**, avoiding the harmful use of alcohol and not smoking or using tobacco products can all reduce the risk of chronic disease in older age. These behaviours need to start in early life and continue into older age.

b) Minimizing the consequences of chronic disease through early detection and quality care (primary, long-term and palliative care). While we can **reduce the risk of chronic disease through a healthy lifestyle**, many people will still develop health problems in older age. We need to **detect** metabolic changes such as high blood pressure, high blood sugar and high cholesterol **early** and **manage them effectively**. But we also need to **address the needs of people who already have chronic disease**, **care for those who can no longer look after themselves** and ensure that everyone can die with dignity.

c) Creating physical and social environments that foster the health and participation of older people. Social determinants not only influence the health behaviours of people across the life course, they are also an important factor in whether older people can continue to participate. It is therefore important to create physical and social environments that are **"age-friendly" and foster the health and participation of older people.**

d) Reinventing ageing – **changing social attitudes to encourage the participation of older people**. Many current attitudes to ageing were developed during the 20th century when there were far fewer older people and when social patterns were very different. These patterns of thinking can limit our capacity to identify the real challenges, and to seize the opportunities, of population ageing in the 21st century. We need to develop new models of ageing that will help us create the future society in which we want to live.

- *A life-course approach to healthy and active ageing - Framework for report taken from Good health adds years to life – briefing for world health day 2012, WHO*

[3] http://whqlibdoc.who.int/hq/2012/WHO_DCO_WHD_2012.2_eng.pdf

[4] "Healthy ageing is a lifelong process. Patterns of harmful behaviour, often established early in life, can reduce the quality of life and even result in premature death. Poor nutrition, physical inactivity, tobacco use and harmful use of alcohol contribute to the development of chronic conditions: 5 of these (diabetes, cardiovascular diseases, cancer, chronic respiratory diseases and mental disorders) account for an estimated 77% of the disease burden and 86% of the deaths in the European Region. The most disadvantaged groups carry the greatest part of this burden." http://www.euro.who.int/en/health-topics/Life-stages/healthy-ageing/data-and-statistics/risk-factors-of-ill-health-among-older-people

A first draft of this report was discussed at a workshop with the Age Friendly City Steering Group on the 8th June 2015 (see Appendix 1 for list of participants) and the recommendations were updated to take into account their feedback. Between July and September 2015 further consultation work was undertaken including a focus group with Age UK's Age Friendly City Forum and at 6 workshops on healthy eating for older people delivered by BHFP. More detail was gathered on the role of the hospital dietetics team in treating malnutrition. This report has been deliberately designed as a scoping exercise. It contains an ambitious mix of principles and practical recommendations.

At the suggestion of the Age Friendly Steering Group the recommendations in the original report on food and dementia were fed back to the CCG commissioner responsible for the city's dementia strategy with the aim of embedding food in strategic wok on dementia rather than having the information within this report. This happened and work to embed food into the city's work on dementia will continue via the newly commissioned dementia alliance and dementia activities services.

In November 2015 Brighton & Hove Council's Neighbourhoods Equalities and Committees Committee and the Board and AGM of the Food Partnership adopted a **Food Poverty Action Plan** for the city taking on board many of the findings and recommendations from this report.

Underlying principles for an Age Friendly 'food' City

From the research and workshop with members of the Age Friendly City Steering Group we have drawn together some underlying principles.

ACCESS TO TASTY, NUTRITIOUS MEALS: Food should be looked at in a holistic way, recognising that meals can be an opportunity to socialise, share and enjoy. Food is vital for good mental health and wellbeing as well as good physical health. Whilst good practice on supplements should be followed (e.g. Vitamin D supplements) and other vitamin intake as recommended by health professionals, in general the vision for a Healthy Ageing City should be that everyone is able to access tasty and nutritious meals.

CHOICE and TASTE: 'Older people' are primarily 'people.' Everyone is different, and people's relationship to food is complex. As with other provision relating to older people, and in a climate of personalised budgets and increasing individual choice, we should avoid 'one size fits all' food answers and recognise people have different cultural traditions, their own styles and preferences, so a range of provision is vital. A Healthy Ageing City should encourage and enable choice.

INNOVATION: There are opportunities especially for the voluntary and community sector to help provide some of these options around food; whether that is adding to existing lunch club provision with new models so that people feel they are 'for them', or developing new methods of delivering cooked meals. There is a danger that if local organisations don't rise to these challenges then choice will be much more restricted to national commercial chains rather than local provision.

A 'LIVING WELL APPROACH': The most effective mechanism is a preventative approach so that people don't become isolated and/or vulnerable to food poverty / a dramatic change in quality of diet in the first place. The limited support available should target times when people are especially vulnerable (e.g. following bereavement and hospital discharge).

OLDER PEOPLE ARE A COMMUNITY RESOURCE: They should be seen as active participants - not passive recipients. A Healthy Ageing City should ensure that opportunities for volunteering are made available and accessible to older people, whether on gardening projects, community lunch clubs or in other settings.

How old is old? Who are these "older people"?

Activities in the city use different definitions of 'older' e.g. some defining 50+ and some 60+. Nutritionists look at a likely shift in nutritional needs at around 75+ but stress that in practice this depends on the individual.

For this report we have chosen to think in terms of the individual as age brackets do not seem to be all that helpful e.g. nutritional guidance would be very different for someone who is overweight compared to someone who is underweight whatever their age; and people's experiences of ageing happen very differently. We have put a focus instead on different settings in relation to older people.

3 different settings this report looks at in relation to older people and food Because this research was undertaken in the context of the Age Friendly City agenda we have been able to consider the needs of all older people not just those with vulnerabilities or people receiving services		
(1)Older people living at home independently Cooking and shopping for self Older people living alone may have particular needs / vulnerabilities	**(2) People supported in their own accommodation** As well as older people themselves, focus for messages is on carers paid and unpaid Informal (partner / family/ neighbour/ volunteer) Formal (paid carers) Sheltered / Seniors housing staff Intermediate care / Independence at Home teams etc Occupational Therapists	**(3) People in a nursing home / residential care setting / hospital** Less control by older people themselves, focus for messages is staff (+ suppliers if meals bought in) Care homes Nursing homes Hospital or rehabilitation Hospice/end of life

This grouping is in order to think in a practical way about where any information or support may need to be targeted. These categories are to help with thinking through the issues, they are not hard and fast, and there is of course overlap between them e.g. someone may be living at home independently but have a small amount of formal or informal care support.

Residential care is not covered in detail in this report, as the 'active ageing' focus is all about a preventive approach to help people to remain well and at home. However, it was felt important that people in residential settings were included as they are a group with the least control over how they eat and a small number of recommendations have also been made regarding this group.

Food and nutrition - and food beyond nutrition

Older People and malnutrition

As people age they may not eat well or get all the energy and nutrients from the food they eat. Whilst in the general population, there is concern about obesity, in relation to older populations there is greater concern about people who are "undernourished" or eating inadequately[5]. Confusingly malnutrition is an umbrella term, which is mainly used for under-nutrition, but can also include over-nutrition and an imbalance of nutrient intake.

Malnutrition is caused by either an inadequate diet, poor appetite or a problem absorbing nutrients from food. There are many reasons why this might happen, including a recent stay in hospital, a long term health condition, lack of mobility, low income, bereavement or social isolation.

As well as impacting on someone's quality of life under-nutrition greatly increases the local and national cost of providing health and social care, as people that are malnourished can experience

- increased ill health
- muscle weakness
- increased length of stay in hospital
- increased risk of infection
- slow recovery after surgery
- poor wound healing
- increased risk of mortality

"Under-nutrition in later life is very common and affects over a million older people. It increases the risk of ill health and infections and can result in a longer recovery time from surgery and illness"

Malnutrition Task Force, 2014[6]

Under-nutrition is often both the cause and consequence of disease and ill health and the contributing factors can be complex and arise for many different reasons. Some of these reasons are associated with ageing itself. A reduced appetite due to less energy expenditure, deterioration in taste and smell (which can be exacerbated by some medications) or eating problems due to difficulty chewing or swallowing will all reduce the enjoyment of food and may lead to a reduction of overall food intake. Illness and medication can impact on the way the body absorbs vitamins and micro-nutrients.

Dehydration is also a common risk, as many older people with diminished appetites or poor nutrition may miss out on their fluid intake from food, therefore need to increase their liquid intake.

[5] More than 3 million people in the UK are either malnourished or at risk of malnutrition at any given time. The majority of these are living in the community, with 5% in care homes and 2% in hospitals (BAPEN, 2012) http://www.bapen.org.uk/professionals/publications-and-resources/commissioning-toolkit

[6] http://www.malnutritiontaskforce.org.uk/wp-content/uploads/2014/07/Prevention_Early_Intervention_Of_Malnutrition_in_Later_Life_Local_community.pdf

What are the other nutritional recommendations?

In the process of this research it became apparent that there is a lot of confusion with regards to nutritional messages for older people. The nutritional requirements of older adults are mainly the same as those for the rest of the population; therefore the general healthy eating recommendations for fat, salt, sugar, carbohydrate and fibre apply. Unless they are at risk of malnutrition, older people should aim to meet all of the evidence based recommendations set by the UK government.[7] There are also, however specific recommendations that need considering:

- Energy requirements decrease with age due to changes in body composition. Muscle mass decreases whilst fat mass increases, resulting in a reduction of basal metabolic rate. Population "Estimated Average Requirements" (EAR) for energy are therefore lower for the 65-74 age group, with a further reduction for those 75 years and over.
- In the UK the majority of people obtain most of their vitamin D through the action of summer sunlight on the skin. However, older people make vitamin D less efficiently, may wear more clothes when they go outside, or may go outside less often due to mobility issues. It has been recommended that everyone considers taking a Vitamin D supplement over the winter months. However, adults over the age of 65 are at **higher risk** of vitamin D deficiency, so are advised to take a supplement of 10ug/day throughout the year. Adults of this age should speak to their GP to discuss the option of vitamin D on prescription. Those in residential care or with darker skin (African, Afro Caribbean or South Asian) have an increased risk of deficiency.

Overweight / obesity

Maintaining a healthy weight throughout the ageing process by eating a healthy, balanced diet and exercising regularly can help in the prevention and management of diabetes and other diseases. It can also reduce the risk of surgery, including routine surgery and improve surgery outcomes.

> ***'My cholesterol is down to 5 from 5.4. My painful joints are much less painful'***
>
> Shape Up Participant

20% of people seen in 2014/15/16 by Brighton & Hove Food Partnership (BHFP)'s Community Nutrition service for one to one and group weight management programmes were aged 55-64 years and 15% were 65 years and over. Older participants are often the ones that report a reduction in a secondary medical condition eg arthritis and medication as a result of the intervention.

Recommendation:

- **BHFP to promote healthy weight programmes in ways that encourage older people to participate and to consider running a specialist Shape Up group for people over 65 yrs old so the dietary advice and activity can be tailored to meet their needs.**

The needs of individuals at either end of the dietary spectrum are relevant

- **Healthier choices -** food that is moderate in salt, sugar, total fat and saturated fat is important for people with diabetes (or at risk of diabetes), people who are overweight, have high cholesterol or high blood pressure.

[7] By COMA in 1991 and the subsequent update by SACN 2001. https://www.gov.uk/government/publications/sacn-dietary-reference-values-for-energy . https://www.gov.uk/government/publications/sacn-update-on-vitamin-d-2007

- **Higher energy -** options are needed for those who require extra calories.

If someone is at risk of under-nutrition they need to eat an energy and nutrient dense diet i.e. choose foods that are higher in fat and protein (for example full fat milk, peanut butter, cream, mayonnaise), a message that does not seem to be widely understood and appreciated.

The Malnutrition Universal Screening Tool (MUST).

Malnutrition is often unrecognised. About 40% of people who are admitted to hospital or care homes are malnourished (BAPEN report, 2008)[8]. Regular screening is the most effective way of ensuring that malnourished individuals can be identified and appropriate action taken. Moreover, effective management of malnutrition will reduce the burden on health and care resources for example from delayed recovery and complications from surgery.

Nutritional screening is a quick, simple procedure that should be undertaken as part of the admission or initial assessment of a person on hospital admission, on arrival in a care setting or if a GP or Practice Nurse has concerns about a person from observations (for example loose fitting rings, reporting lack of appetite, evidence of muscle waste or dental pain/ broken teeth).

It is not clear to the extent to which this tool is being used by staff in care home settings in Brighton & Hove and this question should be part of the review of the training and support needs of care home staff that will be led by the CCG in 2016. A first step would be to undertake a mapping exercise of health and social care settings to understand if / where the MUST tool is / isn't being used.

A concern that was raised during the consultation was that GPs will only screen for malnutrition is a person is ill and that this misses opportunities to spot malnutrition at an early stage and take steps to address this and prevent ill health.

Brighton & Sussex Universities Hospital (BSUH) Quality Account 2013/4 identified that they had failed to reach their own target of improving nutrition screening and treatment rates. They were aiming for 98% compliance with Malnutrition Universal Screening Tool (MUST) but in only 90.5% of the notes reviewed had the patient received a full nutritional review using the MUST score (BSUH Quality Account 2013-14). If a person is highlighted as under-weight using the MUST tool during a visit / stay at BSUH they are referred to the Dietetics team. If they don't get seen a letter is sent to their GP highlighting their MUST score. Performance on this issue has not been reported in the more recent Quality Accounts.

Recommendation:

- **CCG and Adult social Care to review use of the MUST tool in care homes settings, including review of the training and support needs of care home staff**
- **Nutritional screening / MUST tool to be used pro-actively in primary care (ie not just when people are ill) and where malnutrition identified referrals to the Dietetics team made**

[8] www.bapen.org.uk

Self screening

BAPEN (British Association for Parenteral and Enteral Nutrition) is a charitable association that raises awareness of malnutrition and works to advance the nutritional care of patients and those at risk from malnutrition in the wider community. BAPEN raises awareness and understanding of malnutrition in all settings and provides education, advice and resources to advance the nutritional care of patients and those at risk from malnutrition in the wider community.

They have produced a self-screening tool http://www.malnutritionselfscreening.org/self-screening.html to help people concerned that they or a family member are malnourished. They also have a fact-sheet http://www.malnutritionselfscreening.org/pdfs/advice-sheet.pdf. In conversations with organisations that work with older people and carers awareness about these resources was limited.

Where older people should turn for advice / support about nutrition

It became clear during the research that there was a lack of clarity about where older people or their carers should turn to for age appropriate nutritional information or advice if they were concerned about malnutrition. Many people said that they would turn to their GP for advice.

If a GP considers someone to be malnourished they should make a referral to the Dietetics Department at the hospital. People are seen in a weekly outpatient clinic for nutrition support or a home visit can be arranged in more exceptional circumstances.

The Dietetics Department are able to assess the person and identify any other factors that may be contributing to the problem. Treatment will be tailored and if the person is able to eat then the first step will be to support them to address their malnutrition using a food based solution (one that suits their diet and lifestyle) but this can also include food supplements such as Complan or Build Up. The plan will including monitoring to see if treatment goals are being met.

A conversation with a dietician with experience of working in the clinic highlighted that some GPs will automatically prescribe nutritional supplement drinks instead of making a referral to the hospital which means that the opportunity to support the person to address the cause of their malnutrition can get missed.

Recommendation:

- **Need to raise awareness with health / social care professionals about appropriate nutritional information for older people**
- **Identify opportunities to raise awareness on how to spot the signs of malnutrition (for older people, carers and health professionals) and clarify referral pathways**
- **Consider opportunities to provide advice / information about malnutrition in community settings alongside the advice offered by the hospital.**

Training for health, social care and community based staff

In 2013 NICE recommended the use of training (either face to face or e-learning) on nutritional screening using 'MUST' for staff working in hospitals, primary care and care homes to aid implementation on the new NICE Quality Standard for Nutritional Support of Adults: http://guidance.nice.org.uk/QS24

Up until 2106 the Food Partnership's Community Nutrition Team was commissioned to deliver training for support staff on behalf of the Council for 5 years (about 40 people a year come on the courses).

Food and Nutrition for Support staff is an introductory level course and includes portion size, label reading, the Eatwell model and using the malnutrition universal screening tool (MUST). There is a more detailed course for care home staff that covers **meeting individual needs** including dietary implications of common medical conditions including dysphagia and dementia.

Key thoughts and observations from the trainer:

- A surprising number of support staff (working in the community homecare team and residential settings) haven't seen the 'eat well plate' and are not sure of the key nutrition messages if they have
- A high number of staff working with older people are not aware of the MUST tool

There are also in-house training courses run by care agencies and national bodies that provide training in these areas. The co-ordinator of Time for Me Befriending felt that their volunteers would benefit from and be interested in training around food and nutrition for older people and in tips and techniques around using food memories to engage older people.

Recommendation:

- **Establish a unified set of training outcomes for training on nutrition and dehydration across health, community and social care settings to improve quality and consistency of messages.**
- **Roll out training to primary care, hospital teams, frontline staff and volunteers across the system**

Nutrition and the role of meals

A recent study[9] concluded that whilst good nutrition is fundamental to active and healthy ageing, much research into nutrition has focused on what happens if food supplements (e.g. vitamin supplements) are taken, rather than looking at what people actually eat.

> ***"It's such a treat to get food like this…If you're living on a tight pensioner's budget, there just isn't anything left to spend on good food" –***
>
> Hove Methodist Church attendee.

Going beyond nutrition, Brighton & Hove's food strategy[10] and the overall approach of the Brighton & Hove Food Partnership is to emphasise that meals play an important social and cultural function. Research for the Food Partnership's Shared Meals Report'[11] included visiting various settings, where researchers heard that shared meals encourage people to eat more nutritionally. People said how they would not go to the effort of making as many food options/variety of foods if just cooking for themselves. Instead, often people eat a sandwich. This anecdotal evidence supports the current nutritional research; eating with familiar others increases food intake; indeed energy intake increases 18% when eating with friends compared to baseline[12&13].

[9] JRC Science and Policy reports - The Role of Nutrition in Active and Healthy Ageing, Tsz Ning Mak & Sandra Caldeira, 2014
[10] http://bhfood.org.uk/food-strategy
[11] Eating Together: exploring the role of lunch clubs and shared meals in Brighton and Hove, Brighton and Hove Food Partnership 2015
[12] Burke, D; Jennings, M; McClinchy, J; Masey, H; Westwood D; Dickinson A. 2011. 'Community luncheon clubs benefit the nutritional and social wellbeing of free living older people', Journal of Human Nutrition and Dietetics, 24, 277-310.
[13] Wallace, C; Wiggin P. 2007. The Role and Function of Lunch Clubs for Older People, Welsh Assembly Government New Ideas Fund, University of Glamorgan/Concord Associates.

That food is 'not just nutrition' also came out as a theme in the consultation work with older people including them noting that the dietary preferences for older people are becoming more diverse (eg more Halal, vegetarians, gluten free) a trend that any setting serving food to older people will need to be aware of and respond to.

Recommendation:

- **Promote shared meal settings to people who are at risk of only eating alone**
- **Settings providing food / shared meals should ensure they offer a diverse range of options.**
- **Provide information, recipes and training for volunteers / staff running shared meals projects to help them offer a diverse choice and promote their projects widely**

Issues and barriers – food access

1. People living at home

1a Shopping

Being able to shop for food is an important part of staying well and independent. However according to Age UK 19% of people aged 65 or over report they have a longstanding illness that prevents them from shopping or makes it difficult for them.[14]

Living alone in itself can be a barrier. We heard that food is often sold in quantities which are unsuitable for single people on their own, or that smaller quantities are more expensive with people unable to access 'buy one get one free' deals and 'family size' discounts. The preference for purchasing smaller quantities weekly is also a barrier to online shopping for some people, as the delivery cost adds to the cost of food.

Other barriers include age unfriendly packaging, store layout (include height of shelves, deep trolleys and freezers) and lack of rest spaces. Getting to shops was also seen as a barrier in certain areas of the city.

Digital inclusion (access to the internet) is lower amongst older people than in the general population, making it harder to shop without leaving the house and also to find information. Digital inclusion projects should use internet shopping as a practical focus during courses with older people so that people learn how to do it including how to set up 'favourites lists' etc which will help them shop in future. Communications work should take into account different 'levels' of IT confidence for example people may be happy to receive and read information but be less confident about shopping or paying for things online for fear of 'scams'.

1b Cooking for yourself

We heard that whilst many people continue to shop and cook well into older age, others experience barriers such as a change to physical mobility, or a sensory impairment (especially becoming blind). There is however some very good practice around 're-ablement' for example when people have had a stroke there is a service to help them to relearn cooking skills and build confidence, using different methods and equipment.

There is a range of specialist equipment available to help e.g. appliances which have been adapted; and saucepans that are lighter and easier to grip. However it is hard to know if all the people who would benefit are aware of where to get these tools.

> ***"I live on my own. My husband passed away 10 years ago… I'm a widow who doesn't have anyone to cook for"*** – Holland Road Baptist Church attendee

In reality the greatest barrier is that many people simply aren't motivated to cook and eat well if they are eating alone. This feeling can be especially prominent following the loss of a partner. It seems that in contrast with previous comfort and sociability of eating together, food and meal times can exacerbate feelings of isolation for those on their own. An additional practical issue is if the 'lost' partner had been the one who cooked - the remaining partner may not have the skills or confidence to cook for themselves. The 'Old Spice' programme run by the Food Partnership and subsequently picked up by other organisations in the city has had some success in reaching older men who have lost partners but provision of this training is patchy.

[14] Food Shopping in Later Life Age UK (June 2012)

Another successful course has been cooking with a microwave sharing tips and recipes on the wide range of meals that can be cooked in this way.

We also heard that many people - not just single people - are using ready meals from supermarkets, whether prepared by themselves or heated up by a carer. This seems to be a developing market with Marks & Spencer's recently launching a range aimed at 'mature' customers[15]. Whilst some people are reportedly very happy with ready meals as a staple diet it seems that others are less so. There seems to be little guidance on choosing a ready meal which is nutritionally appropriate, and as with other prepared food there can be concerns about nutritional content, sugar and salt levels[16]. Indeed some of the 'healthy' guidance on ready meals (e.g. 'low fat') might actually be inappropriate for someone at risk of malnutrition who should be looking for high fat or protein alternatives.

"We were contacted by the daughter in law of an older man who had lost his wife and was not thriving…. Our carer discovered that he wasn't eating well because he couldn't bear to go into the kitchen. It reminded him too much of his wife. The carer started to go to the shops with him and together they gradually reintroduced cooking. She rang the office excited one day to say that he was peeling carrots in the kitchen and whistling - he had got his mojo back" - Local private care agency

Recommendations:

- **Raise awareness of specialist equipment available to help with cooking**
- **Ensure consistent provision of cooking courses eg Old Spice to help people gain confidence to cook for themselves**
- **Develop guidance on choosing nutritionally appropriate ready meals**

2. People supported in their own accommodation

2a. Carers (unpaid family members / friends)

According to the 2011 Census, almost 24,000 people of all ages in Brighton & Hove provide some informal care, much of which will entail looking after older people. Many older people themselves are also carers. The peak age for caring in Brighton & Hove is 50-64 years (25% of people in this age group are carers) although even among people over 85 years, 5% are providing some form of unpaid care.

The national organisation Carers UK acknowledges that nutrition is an important but often hidden issue for carers and their families, with 60% of carers worrying about the nutrition of the person they care for.[17] Caring can be very demanding and may also result in the carer neglecting their own diet due to their caring responsibilities. Carers UK produce guidance for carers on eating well for their own health[18].

The Shape Up Wellbeing Coach Service (delivered by Albion in the Community) offers carers above an ideal weight one to one support in their own home or a suitable nearby community venue to help them manage diet and exercise.

[15] http://www.independent.co.uk/life-style/food-and-drink/features/many-elderly-people-turn-to-ready-meals-but-can-they-compete-with-a-proper-dinner-10153295.html
[16] http://news.bbc.co.uk/1/hi/health/3756451.stm
[17] http://www.carersuk.org/help-and-advice/health/nutrition/
[18] http://www.caerphilly.gov.uk/CaerphillyDocs/Adults-and-older-people/Carers/Eating_Well_Leaflet_Carers_UK.aspx

Practice nurses are responsible for undertaking health checks for both carers and older people's. They need to be well trained in how to identify people who may be neglecting their diet and sign post people to support.

Locally there is very little information about food available for people caring for older people although interviews with the Carers Centre confirmed that shopping and cooking are key roles of carers. They felt that more information, support and advice would be beneficial especially if the focus was on healthy eating on a budget (either at home or at community venues) given the tight financial situation many carers are in, especially carers of pension age who are not entitled to carers allowance. They suggested that printed information would be useful for example a '5 points' fact sheet - not just aimed at carers but also for older people themselves. They also felt that practical tips or demonstrations on skills for shopping / cooking for someone else would be helpful.

Help for carers and older people to be more digitally included to benefit from online food shopping (saving time), was also identified as a gap. This echoes conversations with Age UK that IT training for older people should include tutorials on doing online supermarket shopping and helping people to set up 'favourite item' lists. Carers are also a good route for raising awareness about lunch clubs and other community meal provision and may provide the means of getting people to activities. The network of carers' coffee mornings and meetings provide an opportunity to reach older carers and those that care for older people.

Additionally the importance of respite for carers is well documented and any work on food and carers (of older people and older carers) could consider options for food related respite activities such as those provided by the Carers Centre Allotment or food related carers breaks / 'time for me' sessions.

Recommendations:

- **Train practice nurses how to identify people neglecting their diet and sign post people to support**
- **Digital inclusion training to include how to do online supermarket shopping**
- **Respite offers for carers to include food related activities**
- **Use carers networks (eg Carers Centre) to share information about older people and nutrition including details about shared meal settings**

2b. Paid Care workers

For many older people (and this trend is likely to increase) cooking and shopping are carried out by a paid care worker. There are a number of barriers to healthy meals here, including whether the paid care worker understands the nutritional needs of older people; and whether they have the knowledge and skills to cook. However the primary barrier seems to be the time allowed for visits (which may be as little as 15 minutes) which make it impractical to do much more than heat up a ready meal in a microwave.

The consultation focus group reported that now many people are self-funding and choose from a range of different agencies, it has become more difficult to measure quality and accountability. Engaging with the home care companies was seen to be vital in the success of achieving a vision of an age friendly food city.

Recommendation:

- **Engage home care providers in this work. Any information materials produced should be circulated widely including via paid care agencies.**

2c. Delivered meals/ meals on wheels/ Community Meals

Nationally, the number of people receiving 'Meals on Wheels' has tumbled by over 80% in 10 years. The Malnutrition Task Force reveals that older people are either losing their meals on wheels provision because of local authority budget cuts or face extremely steep price increases, which can make the 'Meals on Wheels' service unaffordable for pensioners living on a low fixed income. If healthy, affordable community meal options are not provided there is a risk that people may end up with health conditions that cost more to treat than the cost of subsidising good food in the first place.

From April 2016 Brighton & Hove City Council changed their Community Meals (Meals on Wheels) provision to one where only a very small number of people receive a paid for service from them (these are people who have relied on Meals on Wheels in the past and have no funds to pay for their own food).

The Council has moved to a 'preferred providers list', so that people in need of a meal are able to choose from a range of different options available to them. The average cost of a meal on the 'preferred providers list' is £6/£7 and the person delivering the food will also provide a 'safe and well check'.

Although we don't have figures, there appears to be much use of private meal delivery services ranging from local takeaways which offer delivery; to companies specifically set up to deliver frozen meals for microwaving e.g. Cook (www.cookfood.net) which has an emphasis on taste / 'home cooked' quality and Wiltshire Farm Foods (www.wiltshirefarmfoods.com), which has an emphasis on nutrition and catering for older customers and special diets e.g. soft, pureed meals and 'reformed' meals where the puree is reshaped to look more appetising. Newhaven firm Brilyn (www.mealsonwheels.uk.com) delivers freshly cooked meals on plates for reheating to residents in the East of the city e.g. Woodingdean and include a 'safe and well' check and cater for special diets. These companies provide food which can be frozen and either open or microwave heated. Average meals costs £4-£6.

The council has made a number of positive commitments around the provision of Community Meals within the city's Food Poverty Action Plan. The new system must include providers that can deliver a hot, nutritious, affordable meal 365-days a year alongside the 'safe and well' check that is so vital to the well-being of those that are vulnerable.

As the city moves towards a system of preferred suppliers there are opportunities to expand the offer to include local provision. It is possible. Fair Meals Direct is a not-for-profit scheme started up in April 2014 when it took over from Cumbria County Council's 'Meals on Wheels' service. The meals are freshly prepared using locally-produced food (under a 30-mile radius of Carlisle) in a previously underused kitchen in a hostel which provides emergency accommodation for families. The residents take part in preparing the food, providing useful kitchen skills that they can take with them and a team of volunteers deliver the meals so the clients get the much-needed social contact as well as a hot meal. This video tells their story.

Elsewhere, in Plymouth the provision of Community Meals moved from Adult Social Care to being provided by their School Meals Team. This successful scheme now provides adults with the same freshly cooked hot meals that the children get at school. Plymouth Community Meals has also been awarded the Soil Association's Food for Life Gold Catering Mark.

Recommendation

- **With the ending of Meals of Wheels it is important that older people are given good information / advice about the range of options to get food in the city and what to look out for when making choices. Provision of this information should be part of care assessments.**
- **New opportunities to join the 'preferred providers' list for Community Meals should be promoted to community based organisations.**

2d. Support from neighbours and networks

There is of course a great deal of informal unrecorded activity from family, friends, neighbours and other communities such as faith groups, where people may provide or share a meal. Nationally franchises such as 'Casserole Club'[19] can act as a bit of a halfway house between informal and more structured community activity, using a web based platform to help "people share extra portions of home-cooked food with others in their area who are not always able to cook for themselves". Locally, Know My Neighbour encourages links at neighbourhood level e.g. Xmas Mince Pie meet up. The Neighbourhood Care scheme and other befriending schemes in the city provide companionship to hundreds of older people. Conversations have started between Impetus, the Brighton & Hove Food Partnership, FutureGov (owners of Casserole Club) and some local digital marketing experts on introducing Casserole Club to Brighton & Hove.

Recommendation:

- **Explore the potential for Casserole Club in Brighton & Hove**

3. Care homes - Healthy Choice Award – Residential Care Settings

The Healthy Choice Award is a joint initiative from the Food Partnership and Brighton & Hove City Council, which looks at meals and snacks offered in breakfast clubs, nurseries and residential care homes. Working together, the aim is to award settings which serve varied, nutritious and age appropriate menus. Further recognition is given through the Healthy Choice Award Gold - to those settings working towards nine key sustainability standards. Residential care homes can receive support and advice on menu planning from the Food Partnership's nutritionist. 15 residential care homes in the city currently have the award (2 Gold) which is only a small proportion of the total number of care homes in the city. There have not been resources to undertake targeted promotion work to these settings in recent years although the award is well received by places that find out about it.

Recommendation:

- **Explore the potential for rolling out targeted health promotion work, including around the food agenda, with care homes across the city**

[19] https://www.casseroleclub.com/

Eating outside the home - lunch club, shared meals and restaurants and cafes

Restaurants and cafes

We heard that many of those who are mobile i.e. have cars or can use buses or who have support with transport, prefer eating outside the home in restaurants and cafes, and that the cost can be comparable to home delivery of meals. There are special OAP meal deals in some settings, which help to keep the prices down. Some people would prefer smaller portions and it was noted that some settings which offer a children's menu won't let older people order from it, even if requested.

For many people retirement means more time and more freedom. One of the messages we repeatedly heard is that older people are primarily people and not everyone wants a special OAP deal or lunch club - they want to eat in places with people of different ages in 'normal' settings.

Recommendation:

- **Explore the potential for working with the restaurant sector to offer smaller portions to older people, along the lines of children's menus**

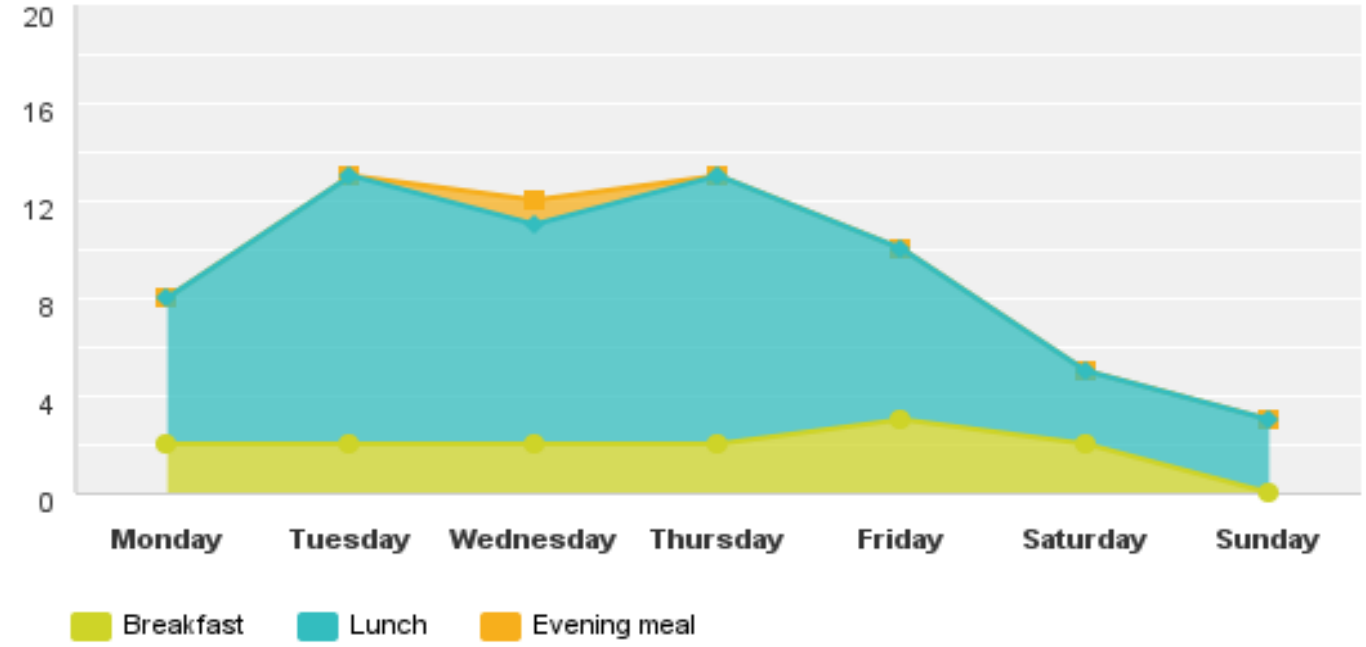
Shared meals

In parallel to this report, the Food Partnership has been exploring the role of 'Shared Meals' in Brighton & Hove. **1,265 shared meals take place each day, or almost half a million a year** and these shared meals play a vital role in the wellbeing of our city's residents, including those who are at greatest risk of isolation, poor nutrition and food poverty. As well as food and company, they nearly all offer support and advice, and often act as a gateway into other services. Shared meals take place in lunch clubs, day centres, and community growing projects and increasingly in private care homes, who are responding to a gap in the market by offering meals for non-residents. There are also shared meals in settings such as seniors housing, where they tend to be resident organised - for example 'fish and chip clubs'. Changes to the way that that social services funding is allocated means that in future more people will receive 'individual budgets' or be entirely self-funding. For some people, so long as they are accessible and there is the right transport and support, '**meals in the community'** options might be preferable to 'community meals' i.e. people might prefer to experience a shared meal such as a lunch club, or a café, pub or restaurant rather than receive a 'meals on wheels' meals package to their home in isolation. We noticed that some people are already 'serial lunch clubbers' visiting a different lunch club on different days of the week in preference to cooking / eating at home. However there are gaps in provision, with lunch clubs in particular running less at weekends.

Local provision was seen to be successful and projects such as the Hangleton and Knoll Project cite their strong links with community as key to success in their food projects. However there is also a significant gap in provision identified in the **North and East** of the city - often in areas where access to shops is also tricky creating a double barrier.

Good Practice Example: In Somerset Day Centre, a local greengrocer takes orders for fresh fruit, vegetables and eggs, which some members find very convenient. This may be a good service to offer in other settings?

Lunch club provision by day of the week and area of the city



Source: http://brighton-hove.communityinsight.org/

Interested parties should note there are gaps in shared meal provision (especially lunch clubs) at weekends and in the East and North of the City. As local provision is the most successful model (52% of people accessing shared meals live nearby) this is likely to be a barrier to access. Additionally groups such as the Hangleton and Knoll project suggest that their community focus and links strengthened their food work, as they knew their

neighbourhood well and had effective reach. Opportunities for intergenerational shared meal options for example schools inviting older people to join the school lunch should be considered (School Meals Service) There is also a perception barrier. Although it was hard to get clear data on this, it seemed that a preconception of place might prevent some people from using lunch clubs (It's "not for me"). Alongside more traditional provision of lunch clubs there is potential for other options for meal sharing for example learning from high profile/ social media savvy profile shared meal organisations such as The Real Junk Food Project. Some quite subtle changes of wording (eg changing 'lunch club' to 'shared meal' or 'social meal' and meeting people's 'interests' rather than providing 'activities') might help to do this.

An important finding was that providers are facing an increase in demand which they may lack capacity to meet. For more details on shared meals see the Food Partnership report[20].

Older People as active participants: As with gardening projects (below) older people should be seen as a resource, with skills, wisdom and time to share; rather than as passive service users. Many lunch clubs and shared meal settings rely on older people as volunteers – we saw a whole range of volunteers up to 95 years old, and most reported great satisfaction from their experience of volunteering - "keeping going keeps you going!" It was noted that in particular what people called the 'younger older' - or more active - volunteers play a key role and that this pool may get smaller in future as people have to / or want to keep working for longer.

Recommendation:

- **Explore the potential for addressing the gap in provision of community meals and fresh food provision in the north and east of the city**

Gardening and food growing

There is strong evidence for the physical health benefits of gardening, especially in later life summed up popularly as 'Gardening linked to longer lives'[21] due to the beneficial effects on cardiovascular health. One study suggested being active reduced the likelihood of a heart attack, stroke or angina by 27% and death from any cause by 30%[22].

Locally the evaluation of the Harvest project[23], which was a four year Lottery-funded project to encourage people to grow their own food, offered compelling evidence that, as well as physical health, gardening is highly beneficial for mental health and wellbeing.

> ***"Older people reported greater benefits from gardening than other respondents. 93% said they gardened to access fruit & veg, 52% did so in order to be physically active, 42% did so to improve their mental health and 24% to meet other people."*** - Harvest evaluation survey

An extensive survey of allotment usage in Brighton & Hove showed that older people, who currently benefit from a discount in allotment rental, rate their allotments particularly

[20] Eating Together: exploring the role of lunch clubs and shared meals in Brighton and Hove, Brighton and Hove Food Partnership 2015
[21] E.g. http://www.bbc.co.uk/news/health-24710089 http://www.express.co.uk/life-style/health/570786/Gardening-key-longer-life-Doctors-prescribe-health-boosting-hobby
[22] http://www.nhs.uk/news/2013/10October/Pages/Can-DIY-and-gardening-help-you-live-longer.aspx
[23] http://bhfood.org.uk/food-strategy

highly as contributors to both health and happiness[24].

> *"An allotment is a 'social service' too and helps to avoid loneliness and isolation, so therefore the cost of the service cannot be estimated in traditional ways"* - Plot holder survey

In 2014 a survey of 800 plot holders 209 responses were from people over 60. Of these 80% said that having an allotment was important / very important for their health and happiness.

There is also participation by older people in the city's 70+ community gardening projects, either specifically for older people (e.g. in Hangleton and Knoll) or mixed age. Anecdotal reports and observations by Food Partnership staff suggest older people make up a significant proportion of participants at these garden projects.

In 2014 a pilot 'Fit for Gardening' training day organised by Active for Life and the Food Partnership had high interest. Attendees were mainly older people (67% 50-64 yrs old and 17% 65 and over), the majority of whom have long-term health conditions and wanted support to get back into gardening safely. The focus was on stretches to help with things like back pain, aches and pains. Helping people to keep gardening as long as possible means these people continue receiving the physical and mental health benefits that gardening brings.

Reduced mobility can be a barrier. The Food Partnership previously ran a 'Grow Your Neighbour's Own' project which put people who wanted to grow food in touch with people who needed help gardening, but this ceased due to difficult logistics in making matches across a large city (with gardens concentrated on the outskirts and gardeners in the centre). AgeUK Brighton & Hove's 'Help at Home' scheme matches older people with vetted, freelance gardeners that they can pay to maintain their spaces. Brighton & Hove City Council tenants who are over 70 or have a disability can also apply for free gardening help. The allotment strategy includes plans to increase the number of smaller and accessible mini allotments which could help some older people to keep gardening even if a regular plot becomes unmanageable.

Both allotments and community gardens have benefits around reducing isolation and seem to help in building cross-generational communities for mutual benefit, with some participants in the allotment survey noting older people often act as a source of knowledge around growing which is highly prized by younger people.

Participation in food growing has an obvious benefit, in that people are able to access fresh nutritious produce, and in the case of community growing projects, often a shared meal cooked on site. However the food access benefits are almost an 'added extra' compared to the physical and mental health benefits.

The "Growing Health[25]" report takes an evidence-based approach to summarising the health and wellbeing benefits of food growing for different groups and provides a useful summary of relevant studies.

Recommendation:

- **A concession rate linked to pensionable age should be retained for allotment rents in the city**
- **Easy access allotment plots should be provided for people with limited mobility**
- **Opportunities to volunteer on community food projects should be promoted to older people**

[24] Brighton & Hove Allotment Strategy 2014-2024, Brighton & Hove City Council & Brighton & Hove Allotment Federation http://www.brighton-hove.gov.uk/content/leisure-and-libraries/parks-and-green-spaces/allotment-strategy-2014-2024

[25] **Growing Health: Food Growing for Health and Wellbeing,** Garden Organic and Sustain, April 2014 www.growinghealth.info

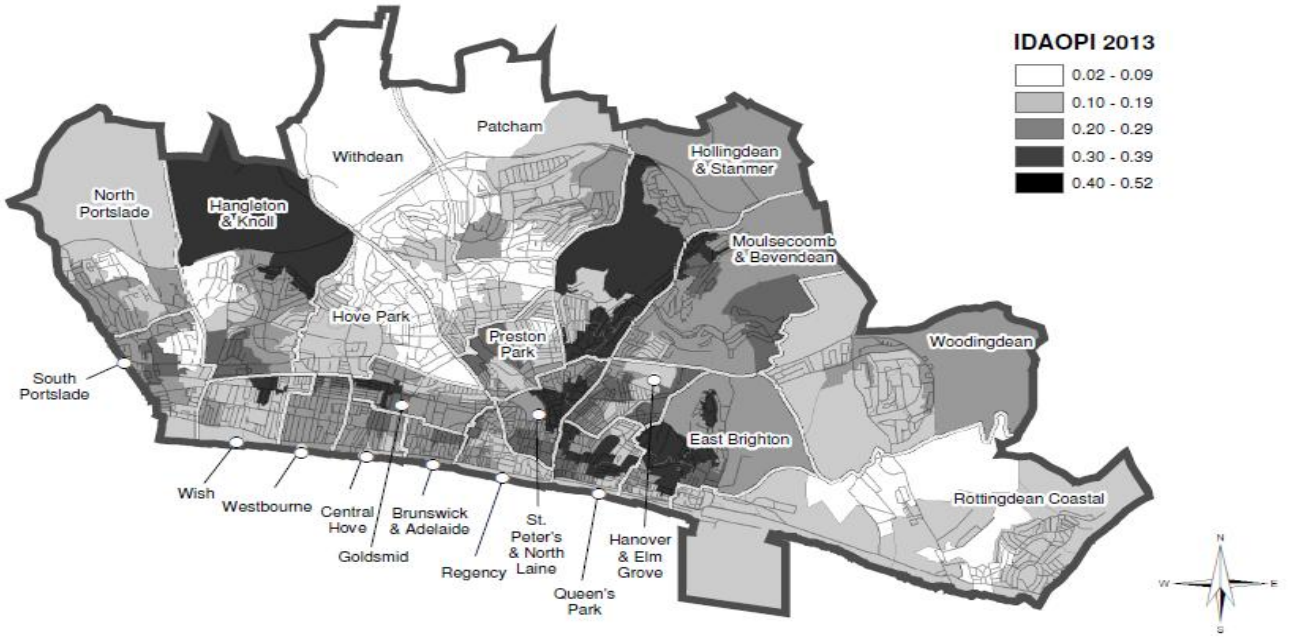
Food poverty & food access; digital access; transport

Whilst there is no single definition of food poverty, definitions stress that food poverty is about more than hunger and most definitions focus on being able to eat nutritiously, rather than just to eat[26]. It is clear that food poverty is increasing both nationally and in Brighton &Hove, with both the 2014 and 2015 City Tracker surveys showing that nearly a quarter of the city anticipate difficulty paying for food/fuel, with particularly high levels of insecurity for those with a disability or long term health condition.

As people grow older they typically spend an increasing proportion of their income on food, domestic energy bills, housing and council tax; in households headed by someone aged 75 and over this amounts to 40% of their weekly expenditure. This makes them particularly vulnerable to price inflation such as those seen in recent years for food and energy.

The table below illustrates the percentage of adults aged 60 years or over living in income deprived households (IDAOPI).

IDAOPI 2013



Public Health Intelligence, Brighton and Hove
© Crown copyright and database rights 2011 Ordnance Survey 100050518

Food poverty is a complex area and is about more than money. Several interviewees stressed that for many older people the issues may be as much about **food access** as about income. Barriers to eating well include:

- a lack of transport
- shops that are not well laid out for accessibility

[26] The evidence review for the **Feeding Britain, the Parliamentary Enquiry into Food Poverty and Hunger** published in December 2014 *selected* this definition: "Food poverty can be defined as the inability to afford, or to have access to, foods which make up a healthy diet. Those experiencing food poverty may have limited money for food after paying for other household expenses; live in areas where food choice is restricted by local availability and lack of transport to large supermarkets; or be lacking in the knowledge, skills or cooking equipment necessary to prepare healthy meals. *Written evidence from the Public Health Nutrition Team, Central London Community Healthcare NHS Trust*. https://foodpovertyinquiry.files.wordpress.com/2014/12/food-poverty-appg-evidence-review-final.pdf

- limited provision of local shops particularly those selling food ('food deserts') and/or high cost and limited choice of food items in local shops
- 'digital' exclusion or inability to access the internet for shopping
- lack of time for shopping/preparing food e.g. people with extensive caring responsibilities
- access to adapted cooking equipment
- cooking skills

Having said that it is clear that a number of older people are living on a reduced income, in a climate of rising prices [27] and lack of money is a major barrier to eating well for many people. The 'heat or eat' dilemma is a particular issue for older people who may require higher levels of heating for longer in the day.

Food poverty is about much more than money, but having an adequate income in retirement was seen as vital to avoiding food poverty. Therefore Money Advice Services in the city may need to become better at helping people plan retirement / finances in older age. Age UK offer financial / legal advice – demand is growing and they plan to extend this. Advice about planning for retirements should include consideration of food arrangements not just financial planning.

Free bus passes were widely praised, but if people are unable to access buses then taxi fares are relatively high. The Carers Centre raised concerns about any reductions to carers allowance and/or changes to benefits for disabled people that would reduce household incomes.

Some older people may be reluctant - due to perceived stigma or lack of knowledge - to access the welfare benefits they are entitled to. Food banks nationally and locally report low usage by older people, both due to stigma and lack of accessibility.

- Older people's spending decreases as they age, although certain specific areas of expenditure increase, most notably food and non-alcoholic drink (12% to 19%) and housing, fuel, and power (12% to 24%) (Collard & Hayes 2013).
- Almost one in ten 70-74 year olds face difficulties when shopping because of 'a physical, mental, emotional or memory problem', rising to 60% of those aged 90 or over, Atkinson & Hayes 2010.[28]
- The probability of an older consumer making a purchase on the internet declines markedly with age, such that only 23% of 60-64 year olds were found to have made an online purchase in a 12-month period, which reduced to 13% in the 65-69 year old group. [28]

Transport emerged as the key issue for both shopping for ingredients and for accessing cooked food outside the home, especially for those without or with limited access to online shopping options. We noticed that the most popular lunch clubs (50+ attendees) are either on main bus routes (free bus passes play an important role), or provide transport options via arrangements with volunteers, or community transport minibuses or both.

[27] **Feeding Britain, the Parliamentary Enquiry into Food Poverty and Hunger** published in December 2014 shows that food, energy and housing prices have risen disproportionately in the UK to other European countries, and incomes have not kept pace. https://foodpovertyinquiry.files.wordpress.com/2014/12/food-poverty-feeding-britain-final.pdf

[28] Population Ageing & the Voluntary Sector: Key Figures & Projected Trends April 2014 https://cvsanpc.files.wordpress.com/2014/03/population-ageing-the-voluntary-sector-key-figures-projected-trends.pdf

The survey for the 'Shared Meals' report found that:

- ***61%** of projects find **'transport'** the biggest barrier to people accessing the project*
- ***32%** of projects find **'accessibility'** the biggest barrier to people using the project*

Recommendation:

- **Groups should refer to Possability People's (rebranded Federation of Disabled People) 'Out and About' guide for useful examples and guidance on ensuring effective (free) insurance provision for volunteer drivers http://www.thefedonline.org.uk/citywide-connect .**
- **During the research for this report it was identified that people may need help to go shopping if they are to avoid costly local stores. More discussion should take place with partners to establish if there is a need for a food shopping service?**

Additional health factors which need considering

Dementia

Dementia is a major barrier to eating well, and can also be a factor in dehydration. It can lead to changes in food preferences, in particular a liking for sweeter foods, and people who are confused may miss meals, forget to eat or forget they have eaten already, resulting in under or over nutrition. The Alzheimer's Society produces a useful overview and a practical factsheet[29].

People may need specialist eating equipment or support to eat and they (or their carers) may not know how to access this. Additionally, we heard that some people with dementia may have very limited cooking facilities at home if these have been removed because of concerns about safety.

Sensory impairment

This has been mentioned above, noting that blindness can be a barrier in connection with cooking and shopping; and some interviewees also picked this up as a major factor in increasing isolation. Both blindness and deafness can be a barrier to shopping; and to attending community activities such as lunch clubs.

'Entrenched' Isolation

Research demonstrates that loneliness is felt particularly acutely by older people: almost one in ten people aged 65 and over report regularly or always feeling lonely[30]. 41% of people over 65 in Brighton & Hove live on their own - 10% higher than the UK average (Census 2011)

Staff, volunteers and service users in local lunch clubs talked about isolation itself becoming one of the factors in generating isolation. Once people start to get isolated, they can quickly lose confidence in socialising. It is also easy to lose motivation for cooking and eating, and quickly become depressed. There can be vicious circle here as good

> ***"I don't get depression now that I come here. I used to just sit at home, between the four walls in front of the telly – same in, same out… Now I come and see my friends every week"*** – Somerset Day Centre attendee

[29] http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=149
[30] Social Exclusion Unit, A Sure Start to Later Life, 2006

nutrition is vital for good mental health, yet depression can make it hard to cook and eat well. There seems to be a number of people in extreme isolation, not in touch with services or even with anyone, who are in a sense the 'hardest to reach'. Even knowing about these people is a challenge and the 'City Wide Connect' project is engaging police and fire service staff in helping to identify them.

Yet food itself is a way to bring people together, and a number of service users (especially in day centres) stressed that attendance had turned around their depression and transformed their lives. Crucially in a day centre setting this had come about with support - attendance arose via a referral from a doctor or social services, and often with transport provision. Some lunch clubs are working with befriending groups to support very isolated people to attend, and this seems very successful, although currently only reaching a small number of people.

Commissioners and other decision makers should recognise the major but largely unrecognised role that shared meals e.g. lunch clubs are playing in improving the health, nutrition and mental health of the city – tackling isolation, food poverty and acting as a gateway to advice and support - and help ensure that projects can keep up with the increase in demand identified in this report. Cost, access and (especially) transport are key factors in people accessing them

The most effective intervention regarding extreme isolation is to prevent people becoming cut off in the first place. This was a cross cutting theme which emerged from many conversations and it is recommended that commissioners look at ensuring support is targeted at the most vulnerable times (e.g. bereavement and hospital discharge) and good practice elsewhere e.g. in providing 'food bags' for people to take home from hospital, so they are able to eat during the gap before a care package is put in place.

Recommendation:

- **Targeted information and support should be provided at times that people are most vulnerable to becoming socially isolated eg bereavement or following a hospital visit / fall or major illness**

Practical Recommendations / next steps

The recommendations have been grouped together for convenience, but ***please read them in relation to the main body of the report above which outlines the barriers to accessing a healthy diet, and looks at the evidence of what works***. During the consultation on this report and the subsequent work on the food poverty action plan the role of diet in preventing ill health (including life limiting diseases such as Diabetes, cancer and heart disease) and both the human and health care costs associated with diet related ill health was repeatedly mentioned as was the importance of food as a means of achieving wellbeing. This approach chimes with the policy context of the Care Act / Better Care with the focus on person centred care and a preventative approach.

Recommendation 1: Knowledge and Information for older people	**Progress August 2016**
1a) Identify where older people would like to find more information eg as part of health checks, at pharmacies, in newspapers, libraries etc.	Question asked as part of consultation on this work and a survey of older people by Age UK. GPs and Libraries were ID as two key locations
1b) Develop locally relevant printed / web based information that covers information about how nutritional needs change as people age, options to access shared meals in the city, how to spot signs of malnutrition, home delivery, guidance on choosing nutritionally appropriate ready meals and equipment and adaptions that can help with food preparation	BHFP have drafted text waiting for findings of Age UK research to finalise. Will seek funding to produce and circulate.
1c) Run an awareness raising campaign with older people and the agencies that support them around the nutritional needs of older people and how to spot malnutrition. Communications channels should include non-internet methods as well as web based info	Will be linked to the above. Will make info available as a PDF / web resource to partners as well as in printed format

1d) Ensure that digital inclusion training includes a focus on how to do online food shopping (for example how to set up favourites shopping lists)	No progress yet – need to identify who delivers training currently and take this suggestion to them
1e) BHFP to promote healthy weight programmes in ways that encourage older people to participate and to consider running a specialist Shape Up group for people over 65 yrs old so the dietary advice and activity can be tailored to meet their needs.	Idea of specialist group will be fed into programme planning for 2017. Ongoing monitoring of participation by people 65+ will take place via contract monitoring processes between BHFP and Public Health
1f) Increase the options for people to learn skills and confidence to cook for themselves whether this is cooking from scratch for people who don't know how to cook (e.g.cookery classes for older men) or learning about how to adapt existing skills and use different equipment in response to reduced mobility or sensory impairment.	No progress yet – need to identify resources
1g) Respite offers for carers to include food related activities	No progress yet – need to identify resources
Recommendation 2: Training and support structures	**Progress August 2016**
2a) Establish a unified set of training outcomes on nutrition and dehydration across health, community and social care settings. Roll out training to primary care, hospital teams, frontline staff and volunteers from across the system	No progress to date – BHFP, Public Health and CCG to meet to agree way forward
2b) Improve knowledge amongst professionals about appropriate nutritional information for older people, how to signpost to community based shared meal options, how to spot the signs of malnutrition and appropriate referral pathways.	Once booklet has been produced circulate to professionals as well as older people

2c) Provide/continue training on nutrition and cooking skills for family carers and staff in health and social care settings • In particular ensure that Practice Nurses receive training to identify people who may be at risk of malnutrition and how to refer to support and that employees of care agencies who are increasing responsible for putting food on the table are trained in preparing food for older people. This should cover an understanding of nutrition but also should ideally cover basic cooking skills for simple home cooking and given the limited time available could include top tips for microwave cooking.	BHFP putting on a one day training course for support staff on older people and nutrition in October as BHCC has not commissioned this course this year. Will review if this is an effective way to offer training
2d) Use (unpaid) carers network to share information about older people and nutrition including details about shared meals	When booklet is produced use the Carers Centre to circulate
2e) CCG to review use of the MUST tool in care homes settings, including review of the training and support needs of care home staff. MUST tool to be used pro-actively in primary care (ie not just when people are ill) and where malnutrition identified referral to the Dietetics team made. Consider opportunities to provide advice / information about malnutrition in community settings alongside the advice offered by the hospital.	No progress to date – to be discussed as part of meeting re 2a
2f) Extend the number of residential settings with the Healthy Choice Award (or other standard of appropriate / nutritious food provision). Explore the potential for rolling out targeted health promotion work, including around the food agenda with care homes across the city	Promotion to 110 care homes in the city started in July 2016 with mailing (covering both HCA and training available). Follow up calls started in August 2016. Progress report will be made to Public Health in Jan 2017 as funding for this work is via BHFPs contract to deliver healthy weight work in the city
2g) Explore if there is potential to work with supermarkets on 'what makes an age friendly shopping experience	No progress to date

Recommendation 3: Meal provision as part of a care package	Progress August 2016
3a) High quality nutritious food provision at home should be available for people who are housebound or who don't want to go out even if they are offered support to do so. The Council's Preferred Providers for Community Meals list should include only nutritious options and delivery services that include a safe and well check	Current providers offer self and well check
3b) Adult Social Care commissioning should have clear arrangements for ensuring accountability in terms of quality of food provision as part of care packages.	To be explored
3c) If food at home is offered via a care package rather than via community meals, then there should be adequate training for carers, and sufficient time allowed for each visit.	As above
3d) There is an opportunity for the city via market development around alternative 'meals on wheels' models (perhaps using the city east/west/central 'hub' division) which could offer greater choice e.g. existing or new voluntary or community groups or social enterprises; other potential providers such as Sussex Partnership NHS Trust, or private companies. There should be an exploration of whether existing kitchens could be used for meal preparation e.g. in day centres, community buildings, school kitchens	There was some interest when there was a tender to be included on the preferred providers list however the timeframe was not long enough to allow for community providers to bid. There may be more interest in a future round
3g) New opportunities to join the preferred providers list for community meals should be promoted to community based organisations	Dates tbc

Recommendation 4: Food outside of the home	Progress August 2016
4a)Link should be made with Brighton & Hove City Council's Healthier Catering Project to explore how work with fast food take aways / neighbourhood cafes can take into account the food and nutrition needs of older people.	No progress to date
4b) Improve the availability and support for voluntary and community sector / neighbourhood level food activity – including gardening projects and shared meal projects. • Future planning on support for food groups such as 'shared meals' providers (e.g. micro- finance, management, help finding volunteers) should take into account the support needs identified by current groups outlined in the Food Partnership's 'Eating Together' report and help these groups to continue to thrive in the face of increasing demand. The Food Partnership and others should develop a project proposal on how best to support this section of the community food sector including support with volunteer recruitment, access to low cost premises and sourcing of affordable healthy food. • Settings providing food in a shared meal setting should ensure they offer a diverse range of options to widen participation eg vegetarian food • Provide information, recipes and training for volunteers / staff running shared meals projects to help them offer a diverse choice and promote their projects widely. • Explore the potential for addressing the gap in provision of shared meals and fresh food provision in the north and east of the city	BHFP secured some funding via the Mental Health Innovation Fund to develop support for volunteer led shared meal providers which covers some of these points – funding report due January 2017

4c) Providers and funders should consider opportunities for providing shared meals / community food activity in new settings within existing resources - for example the new focus for seniors housing as community hubs could provide a setting for residents and/or others in the community.	Hen power established in Rose Hill Court Sheltered Housing BHCC Seniors Housing offering support for Casserole Club and shared meals Some early conversations have taken place with the school meals service about opening up the school lunch to older people in the neighbourhood
4d) A lot of shared meal activity is informal e.g. between neighbours. There should be support for initiatives such as 'Know My Neighbour Week'. Further work to understand the potential to operate a 'Casserole Club' scheme (to facilitate neighbours sharing extra portions of food with vulnerable people) should be explored (BHFP and Impetus). If funded pilot is successful partners to investigate ongoing funding for programme	KNMW took place including promotion of food sharing. See later for progress on Casserole Club
4e) Food growing whether at home, via community growing projects or allotment growing has well evidenced positive impacts on health and wellbeing as well as food access, and should be encouraged and supported. Opportunities to volunteer on community food projects should be promoted to older people A concession for allotments for people of retirement age should be retained and easy access plot provided	BHFP Harvest Project promotes opportunities to get involved in food growing projects including for older people. A dementia gardening project has been established. Concession for retirement age plot holders part of proposals being negotiated by Allotment Federation and BHCC
4f) Could/should there be a city wide campaign on the rights of older people to order smaller/ cheaper portions (where they are on offer) in restaurants and/or clarify whether people have the right to order children's portions if they are on offer?	No progress to date

Recommendation 5: Food Poverty	Progress August 2016
5a) Recommendations from this report should be fed into the Food Poverty Action Plan that is being developed for the city noting that in relation to older people food poverty is strongly related to food access	Achieved. The Food Poverty Action Plan has been adopted by the city council and has an annual process for monitoring progress. Organisations represented on the Healthy Ageing Steering Group to be engaged in delivery of FPAP
5b) Providers of furnished housing for older people, whether local authority (e.g. sheltered housing), housing association or private, should be encouraged to offer fridge freezers rather than a fridge with a small icebox, to help with food storage and freezing portions (especially useful for single people) and if appropriate to consider offering specially adapted appliances.	Recommendation passed to Housing team
5c) More discussion should take place with partners to establish if there is a need for a food shopping service	No progress to date. Food Matters have done a bit of research into the 'poverty premium' associated with using local shops. Could be that a shopping service works best in food deserts.
Recommendation 6 – food and social isolation	**Progress August 2016**
6a) Entrenched isolation is especially hard to identify and tackle. Befriending organisations and GP based community navigators play an effective role for helping some of the 'hardest to reach' so should be supported, along with neighbourhood initiatives that promote shared meals to people who are at risk of only eating alone. Increase awareness of shared meal options for those supporting isolated people	Shared meal options will be promoted via the Autumn 2016 Citywide Connect meetings

6b)Pilot Casserole Club for the city to assess the level of interest	Funding for a pilot of Casserole Club was secured by BHFP / Impetus and Brightdials for June – Sept 2016. As of August there were 155 cooks and 40 diners signed up. Ongoing funding required to deliver this work in the city and the partners are working on a longer term funding strategy
6c)With reference to hospital discharge a further meeting should be held with those involved in hospital discharge work at the moment (see notes from steering group meeting) in order to identify where food work and hospital discharge work could be better joined up.	Meeting date agreed for 17th October 2016
Recommendation 7	**Progress August 2017**
Work from this study should be used to inform the city's Dementia Action Plan to ensure that the messages around food, nutrition and dementia are integrated in the overall strategy for dementia.	Information from this report was shared with the CCG Commissioner responsible for work on dementia. The new Dementia Activities Commission included 3 year funding for a project on food growing and cookery for people with dementia and their carers

Appendix 1: Age Friendly City meeting participants

Annie	Alexander	Public Health Programme Manager	Brighton & Hove City Council
Steve	Andrews	Community Participation Worker	The Trust For Developing Communities
Simon	Anjoyeb	Equality Project Manager	BSUH
Vic	Borril		Brighton & Hove Food Partnership
Claire	Corbin		Impact Initiatives
Jules	Dienes	Director	Somerset Day Centre
Linda	Hastings		Impact Initiatives
Ellie	Katsourides	Public Health Team	Brighton & Hove City Council
Tory	Lawrence	Public Health Improvement Specialist	Brighton & Hove City Council
Tracey	Mailtland	Citywide Connect Programme Facilitator	The Fed
Penny	Morley		Older People's Council
Emily	O'Brien		Brighton & Hove Food Partnership
Jo	Lewin		Brighton & Hove Food Partnership
Jess	Crocker		Brighton & Hove Food Partnership
Caroline	Ridley		Impact Initiatives
Lynne	Shields		Age Friendly City Forum
Jess	Sumner	Chief Executive	Age UK
Lizzie	Ward		University of Brighton
Becky	Woodiwiss	Public Health Programme Specialist	Brighton & Hove City Council
Jo	Martindale	CEO	The Hangleton & Knoll Project
Harriet	Knights	Health Catering Project Officer	Brighton & Hove City Council
Keith	Beadle		The Fed
Natasha	Lee	Support Worker	Hanover Housing

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Title of the paper

1.1. The contents of this paper can be shared with the general public.

1.2. This paper is for the Health & Wellbeing Board meeting on the 20th September 2016.

1.3. Contact officer:
Name: Miles Davidson Tel: 29-3150 E: Miles.davidson@brighton-hove.gov.uk
Name: Sarah Podmore Tel: 29-6578 E: Sarah.podmore@brighton-hove.gov.uk

2. Summary

2.1 As previously reported to the Health and Wellbeing Board in October 2015 a Fuel Poverty and Affordable Warmth Strategy for Brighton & Hove has been developed by the Housing and Public Health departments, in consultation with key partners in the city.

2.2 The strategy (attached as Appendix 1) has been developed in response to National Institute for Health and Care Excellence (NICE) guidance released in March 2015 entitled 'Excess winter deaths and morbidity and the health risks associated with cold homes' and the national fuel poverty strategy for England, 'Cutting the cost of keeping warm'. The NICE guidelines propose that year

round planning and action by multiple sectors is needed to reduce these risks and that Health & Wellbeing Boards are best placed to develop a 'strategy to address the health consequences of cold homes'.

3. Decisions, recommendations and any options

3.1 That the Board note the content of this report.

3.2 That the Board approves the draft strategy attached at appendix 1 and the objectives outlined.

4. Relevant information

4.1 Public Health England's 2015 Cold Weather Plan states that cold and winter weather have direct effects on the incidence of: heart attack, stroke, respiratory disease, flu, falls and injuries and hypothermia. Indirect effects include mental health problems such as depression, reduced educational and employment attainment, and risk of carbon monoxide poisoning.

4.2 A wide range of people are vulnerable to the cold, including:

- people with cardiovascular conditions
- people with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma)
- people with mental health conditions
- people with disabilities
- older people (65 and older)
- households with young children (from new-born to school age)
- pregnant women
- people on a low income.

4.3 The UK has a relatively high rate of Excess Winter Deaths (EWD), based on international comparisons that use this definition. The EWD Index expresses excess winter deaths as a percentage increase of the expected deaths based on non-winter deaths. The number of EWD varies between years with an average of 25,000 in England each winter. The Brighton & Hove Joint Strategic Needs Assessment (JSNA) 2015 identifies the health risks of cold homes including winter deaths. For 2012-13 the EWD Index in Brighton & Hove was 19%, equivalent to 130 Excess Winter Deaths.

4.4 According to the World Health Organisation an estimated 40% of all EWD are attributable to inadequate housing. The majority of EWD occur in those aged 65+ with 93% of EWD in England occurring in this age group during 2012-2013.

4.5 The NICE guidelines make recommendations, with the aim to:

- Reduce preventable excess winter death rates
- Improve health and wellbeing among vulnerable groups
- Reduce pressure on health and social care services
- Reduce fuel poverty and the risk of fuel debt or being disconnected from gas and electricity supplies
- Improve the energy efficiency of homes.

4.6 A household is defined as being in fuel poverty if it;

- has an income below the poverty line (including if meeting its required energy bill would push it below the poverty line); and
- has higher than average energy costs.

4.7 In Brighton & Hove the 2015 Housing Strategy aims to create 'Decent Warm & Healthy Homes' under the priority of improving housing quality; however the housing stock in Brighton & Hove presents a number of challenges to improving it's energy efficiency. The 2008 House Condition Survey showed that the age profile of the total private housing stock differs from the average for England in that there is a substantially higher proportion of pre 1919 stock at 40% compared to the national average of 25%. Many private sector properties are labelled 'hard to treat' (e.g. those with solid walls) in relation to standard energy efficiency measures.

4.8 The 2011 census showed that the size of the private rented sector in Brighton & Hove has increased by 37% since 2001 with an extra 10,691 homes. Two out of every seven households in the city are now renting from a private landlord, with the city having the 9th largest private rented sector in England & Wales with a total of 34,081 private rented homes.

4.9 The factors outlined above can consequently impact on the ability of homeowners, landlords and tenants to improve the energy efficiency of properties and therefore on occupiers to live in warm and healthy homes. The most recent annual fuel poverty statistics report estimated that over 15,000 (12.3%) of the city households were estimated to be living in fuel poverty in 2014, higher than the average for the south east region (8.3%). The report also estimated that across England as a whole the level of fuel poverty is

considerably higher in the private rented sector (20% of all households in this tenure are estimated to be fuel poor). This tenure is associated with relatively poor energy efficiency ratings and relatively low incomes which are key drivers of fuel poverty.

4.10 To support the recommendations within the NICE guidelines and subsequent objectives in the draft strategy, along with partners across the city, we continue to look for possible funding streams to support and escalate work to support vulnerable householders across the city. A successful bid, co-ordinated by Brighton & Hove Citizens Advice Bureau, to the British Gas Energy Trust Warm Homes Fund 2015-16, secured £395,000 for work in this area throughout 2016. The Council supported this bid to ensure it fits with the strategic challenges and approach outlined within the strategy.

4.11 Further to the NICE recommendations, addressing energy inefficient housing and bringing homes up to a minimum standard of thermal efficiency would have the greatest impact on the most vulnerable households. The Council continues to explore options and different models for the delivery of investment into the city's housing, across all tenures. This includes the work we have carried out with partners in Your Energy Sussex and emerging models that enable the Council to lever in new investment outside of both the general fund and HRA capital investment programmes. Many private sector landlords in the city are keen to work with the council to increase investment in the local housing stock to improve quality; we will work closely with this group to explore the most effective way to achieve this.

4.12 The Public Health funded Warm Homes Healthy People Programme currently operates annually on a limited budget, addressing risks to the most vulnerable groups. Continuation of this programme will be subject to future budget allocation.

4.13 Cold homes pose a significant risk to vulnerable residents' health; this has an impact on people's lives, contributes to preventable winter deaths and creates significant pressure on a variety of services, including the NHS, which is estimated to spend £1.36bn every year treating illnesses caused by cold homes.

4.14 Consultation and feedback from residents and partners from previous projects and programmes has been used to inform the development of the draft strategy. A consultation workshop was held with key partners in January 2016, using knowledge and

experience from all sectors to inform the development of the strategy and ensure a good representation of community views. In addition some specific briefings and meetings have been carried out. A report on the consultation is attached as Appendix 2.

5. Important considerations and implications

5.1 Legal

The Housing & New Homes Committee has delegated power to discharge the council's functions in relation to the council's Housing Strategy. It is appropriate for the Committee to review the draft Fuel Poverty & Affordable Warmth Strategy as it supports the Housing Strategy.

The HWBB are asked to approve the strategy referred in the report. The report sets out that the strategy has been developed against the NICE guidelines referred to. Addressing the issues arising from fuel poverty identified in the report will assist the Council and other agencies to meet their statutory duties to a range of vulnerable people.

Lawyer Consulted: *Liz Woodley & Natasha Watson*
Date: 09.09.16

5.2 Finance

A successful bid, co-ordinated by Brighton & Hove Citizens Advice Bureau, to the British Gas Energy Trust Warm Homes Fund 2015-16, secured £395,000 for work in this area throughout 2016. Any costs to the Council associated with implementing the Fuel Poverty and Affordable Warmth Strategy will be met from current Council budget resources although the Council, with its partner organisations, continues to look for possible funding streams to support and escalate work to support vulnerable householders across the city.

Finance Officer Consulted: Monica Brooks *Date: 09/08/16*

5.3 Equalities

A full Equalities Impact Assessment has been carried out alongside the development of the Fuel Poverty & Affordable Warmth Strategy (attached at Appendix 3).

In 2013, households in England where the oldest person in the household was aged 16-24 were more likely to be fuel poor. However

people aged 75+ experienced the deepest levels of fuel poverty. The vast majority of EWD in England occur among those aged 65 or over. As in previous years in England and Wales, there were more excess winter deaths in females than in males in 2012-13.

Fuel poverty is a contributor to social and health inequalities. In 2013, all fuel poor households in England came from the bottom four income decile groups. Unemployed households in England have the highest rates of fuel poverty across all economic activity groups and lone parent households have consistently been more likely to be in fuel poverty. People who have a long term illness or disability are also more likely to be fuel poor than those who do not.

Some groups at risk of fuel poverty lack awareness and/or understanding of existing sources of support and programmes to help improve home energy efficiency. Lack of understanding can restrict those that are aware to adopt such interventions. This is likely to vary across different groups, for example for people with language barriers (such as minority ethnic communities), and those who have limited social networks and connections with their local community, such as isolated older people and people with learning disabilities.

5.4 Sustainability

The most effective way to tackle fuel poverty and address the issue of cold homes and impacts on health for the long term is to improve the energy efficiency of the city's homes. This also has the potential to reduce CO2 emissions from the city's housing, which currently makes up the largest proportion (42%) of the city's total emissions.

The aims and objectives of the strategy have a significant impact on improvements to the health and wellbeing of some of the city's most vulnerable residents.

5.5 Health, social care, children's services and public health

Strategically addressing cold homes and fuel poverty in vulnerable groups will contribute to the prevention of ill health and excess winter deaths, reduce health and social inequalities, and improve wellbeing and quality of life. The importance of tackling fuel poverty is reflected by its inclusion in the Brighton & Hove Health and Wellbeing Strategy.

6 Supporting documents and information

N/A

Brighton & Hove City Council

Brighton & Hove

Fuel Poverty and Affordable Warmth Strategy

2016-2020

Foreword

The 2015 national fuel poverty strategy for England; 'Cutting the cost of keeping warm' is based on the ambition that;

'A home should be warm and comfortable and provide a healthy and welcoming environment that fosters well-being', and that it is 'unacceptable that many people are prevented from achieving such warmth due to the combination of having a low income and living in a home that cannot be heated at reasonable cost'.[1]

Such ambitions also underpin this strategy for the City of Brighton & Hove. During every winter, people in Brighton & Hove suffer from the adverse effects of cold homes. Many subsequent deaths and hospital admissions are preventable with systematic and co-ordinated action. They are not inevitable and, with ever-rising fuel bills, now is the time to act.

This strategy and the objectives contained, outline the risks to vulnerable people of living in a cold home and how these risks can be addressed. It builds on the 2015 National Institute for Health and Care Excellence (NICE) guideline 'Excess winter deaths and morbidity and the health risks associated with cold homes', with a tailored approach for Brighton & Hove, building on previous work and current established programmes.

This approach requires partnership working across a number of agencies in the city from all sectors. We know which groups are most at risk, which service providers work with them and the types of interventions that can have the greatest impact. The aim of this strategy is to bring together our knowledge and resources to support our residents to live in warm and healthy homes.

[1] Cutting the cost of keeping warm, A fuel poverty strategy for England, March 2015

Contents

Appendices

1. Executive Summary

This strategy has been developed in response to the release of the National Institute for Health and Care Excellence (NICE) guidance released in March 2015 entitled 'Excess winter deaths and morbidity and the health risks associated with cold homes'. The guidance provides evidence based recommendations on how to reduce the risk of death and ill health associated with living in a cold home. The health problems associated with cold homes are experienced during 'normal' winter temperatures, not just during extremely cold weather, and winter death rates across England increase at temperatures below about 6°C. The NICE guideline recommends that year-round planning and action by multiple sectors is undertaken to reduce these risks. Accordingly, the guideline is aimed at commissioners, managers, housing providers and health, social care and voluntary sector practitioners who deal with vulnerable people who may have health problems caused, or exacerbated, by living in a cold home.

With the NICE guideline as a basis, this strategy has been developed to address the general risks associated with cold homes and fuel poverty, whilst taking into account the local challenges, resources and opportunities in Brighton & Hove. The strategy has been developed based on a partnership approach, acknowledging the knowledge and expertise of local organisations and their networks engaged in day to day support of some of the city's most vulnerable residents. This approach aligns with the ambition for Brighton & Hove to be a 'connected city' and with the priorities in the city's Sustainable Community Strategy, in particular around health and wellbeing and the aim that;

'We will work collaboratively with public, private and voluntary care providers to meet the needs of the population in an innovative, effective and efficient way as possible.'[2]

This strategy presents the national and local context and relevant drivers for action, describes the risks to health from cold homes and outlines how, as a city, we can tackle this issue under six key objectives:

[2] Sustainable Community Strategy for Brighton & Hove
http://www.bhconnected.org.uk/sites/bhconnected/files/Introduction%20to%20SCS%20doc..pdf

1. **Increase the energy efficiency of the city's housing stock**
2. **Support residents struggling to pay their energy bills**
3. **Improve awareness and understanding of fuel poverty**
4. **Work together to tackle fuel poverty through partnership and learning**
5. **Increase effective targeting of vulnerable fuel poor households and those most at risk of the health impacts of cold homes**
6. **Maximise resources and opportunities for tackling the causes fuel poverty**

2. Fuel Poverty & Affordable Warmth

The struggle to affordably heat homes is not a new issue, however the term ‘Fuel Poverty’ and it’s distinction from ‘poverty’ in general began to be more widely acknowledged through the 1980’s. The first Fuel Poverty Strategy for the UK, adopted in 2001, set out a way that fuel poverty could be measured. Known as the ‘10% definition’, this indicator considered a household to be fuel poor if it needed to spend more than 10% of its income (measured before housing costs) on fuel to maintain an adequate standard of warmth. For the purpose of this strategy '**Affordable Warmth**' means a household is able to afford to heat their home to the level required for their health and comfort without entering into fuel poverty.

Significant fluctuations in the numbers of fuel poor households through the late 1990’s to 2010 made it clear that the 10% indicator was very sensitive to energy prices. High prices were bringing some people who were reasonably well-off but lived in large, inefficient homes into the fuel poverty statistics. There was concern that there was a danger of both underplaying the effectiveness of support schemes and undermining good scheme design, to ensure that the most vulnerable households were targeted.

In response to these concerns, Professor Sir John Hills of the London School of Economics undertook an independent review of fuel poverty, to assess its causes and impacts and to make recommendations on a more effective way of understanding and measuring the problem. Professor Hills made two key recommendations, both of which were adopted by the Government:

- to adopt a new Low Income High Costs indicator of fuel poverty; and
- to adopt a new fuel poverty strategy for tackling the problem.

Consequently fuel poverty in England is measured using the Low Income High Costs indicator, which considers a household to be fuel poor if:

- they have required fuel costs that are above average (the national median level);

- were they to spend that amount, they would be left with a residual income below the official poverty line.

The Low Income High Costs (LIHC) indicator allows the measurement of not only the extent of the problem (how many fuel poor households there are) but also the depth of the problem (how badly affected each fuel poor household is). It achieves this by taking account of the 'fuel poverty gap', which is a measure of how much more fuel poor households need to spend to keep warm compared to typical households.

The three key elements which affect whether a household is fuel poor or not are:

- Household income
- Fuel bills
- Energy consumption (dependent on the lifestyle of the household and the energy efficiency of the home)

The national fuel poverty strategy for England 'Cutting the cost of keeping warm' showed the characteristics of a typical fuel poor household;

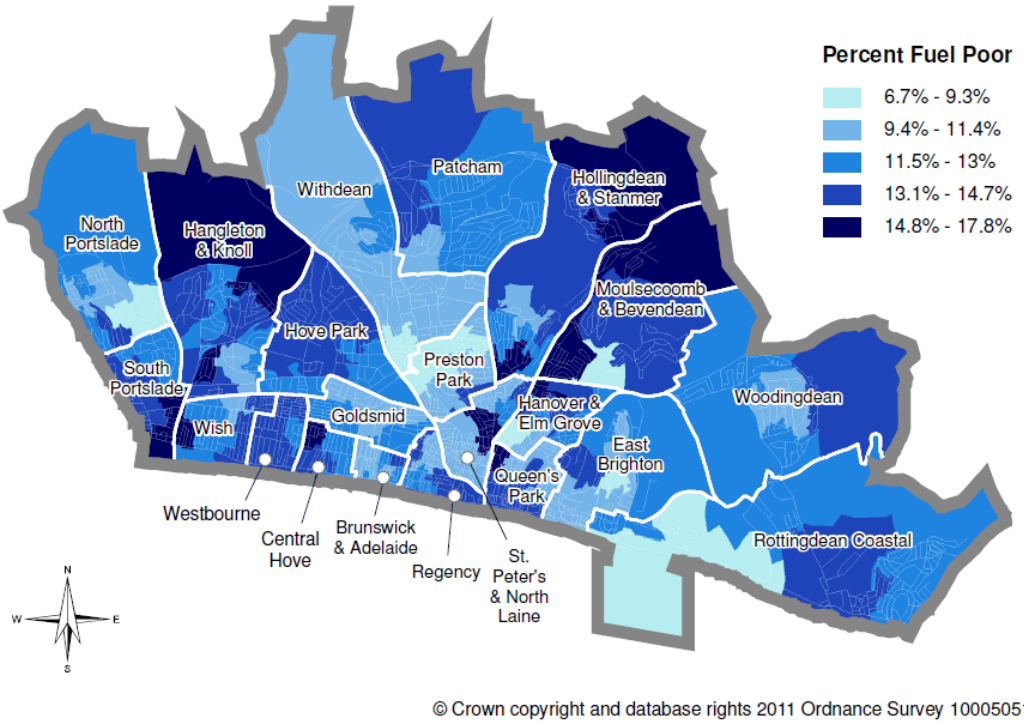
- Mainly families
- Living in larger homes
- Usually private tenure
- Living in older dwellings

It is worth noting however that the characteristics of a fuel poor household can change over time, depending on a number of factors such as fuel prices, changes to household incomes influenced by welfare reform and changes in the housing market. The latest available statistics (for 2014, released in 2016) identified, in terms of household characteristics, that lone parent households are the most likely to be in fuel poverty (22% of this group), with couples without dependent children (of all ages) and single elderly households the least likely groups to be fuel poor (approximately five per cent of these groups). However, as the age of the oldest person in a household increases, so does the average fuel poverty gap.

The Annual Fuel Poverty Statistics Report (2016) estimated that in 2014, 2.38 million households in England were in fuel poverty, representing approximately 10.6% of all households in England. In the South East region fuel poverty was estimated to affect 8.3% of households and in Brighton & Hove the figure was estimated to be 12.3% (15,459 households), higher than both the national and regional averages.

In England, the average fuel poverty gap in 2014 was £371. There are no figures available for the average fuel poverty gap in Brighton & Hove.

The map below shows the estimated distribution of fuel poor households in Brighton & Hove in 2013. However, caution should be exercised when viewing fuel poverty statistics relating to a geographical area smaller than local authority (see note below).



Source: Department of Energy and Climate Change (2015) Sub-regional fuel poverty levels, England, 2013

Note: estimates of fuel poverty are robust at local authority level, but are not robust at very low level geographies. Estimates of fuel poverty at Lower Super Output Area (LSOA) should be treated with caution. The estimates should only be used to describe general trends and identify areas of particularly high or low fuel poverty. They should not be used to identify trends over time within an LSOA, or to compare LSOA's with similar fuel poverty levels.[3]

[3] Department of Energy & Climate Change, Annual Fuel Poverty Statistics Report 2015

3. Health Impacts of Cold Homes

Public Health England's 2015 Cold Weather Plan states that winter weather has a direct effect on the incidence of heart attack, stroke, respiratory disease, flu, falls and injuries and hypothermia. Indirect effects include mental health problems such as depression, reduced educational and employment attainment, and the risk of carbon monoxide poisoning if boilers and appliances are poorly maintained or poorly ventilated.

Extreme cold can kill directly through hypothermia, however, this is rare. Diseases of the circulation, such as heart attack and stroke, account for around 40% of excess winter deaths while respiratory illness accounts for approximately one third of the excess deaths. The onset of cold weather leads to an almost immediate increase in weather-related deaths, which can remain raised for up to four weeks. Negative health effects start at relatively moderate outdoor mean temperatures of 4-8°C. Although the risk of death increases as temperatures fall, the higher frequency of days at moderate temperatures in an average winter means the greatest health burden, in absolute numbers of deaths, occurs at more moderate temperatures.

The UK has a relatively high rate of Excess Winter Deaths (EWD), based on international comparisons that use this definition. The EWD Index expresses excess winter deaths as a percentage increase of the expected deaths based on non-winter deaths. Overall, the number of EWD varies between years with an average of around 25,000 in England each winter. The majority of EWD occur in those aged 65+ with 92% of EWD occurring in this age group during 2011-2013 in England and Wales. The Brighton & Hove Joint Strategic Needs Assessment (JSNA) 2015 identifies the health risks of cold homes, including winter deaths. For 2008-11 the EWD Index in Brighton & Hove was 20%, equivalent to an average of 135 EWD per year.[4] However, local excess winter mortality is highly variable year on year and shows no clear trend. ‘Cutting the cost of keeping warm: A fuel poverty strategy for England’ (Department for Energy and Climate Change, March 2015) states:

[4] Office for National Statistics. Excess Winter Mortality in England and Wales, 2014/15 (Provisional) and 2013/14 (Final); 2015.

‘The link between fuel poverty and health and well-being is recognised and we are committed to developing a means of measuring this. There is no reliable indicator that can be used at this stage. The oft-cited rate of Excess Winter Deaths is not a reliable measure of the success or failure of fuel poverty policy. This is because there are many factors that determine these figures, such as how cold a specific winter is, whether there were any flu epidemics over that winter and how severe they were. Indeed, analysis of the Excess Winter Deaths data for England shows the most recent peak of 29,500 in 2012/13 was immediately followed by 17,000 in 2013/14, the lowest rate on record.’

EWD are almost three times higher in the coldest quarter of housing than in the warmest quarter. According to the World Health Organisation, between 30% and 50% of all EWD are estimated to be attributable to cold indoor temperatures.[5] In the recent past, the rate of EWD in England was twice the rate observed in some colder northern European countries, such as Finland. The NHS is estimated to spend £1.36bn every year treating illnesses caused by cold homes.

The risks of cold homes and the resulting impact on health are recognised by Brighton & Hove City Council and this has been reflected in:

- Excess Winter Deaths and Fuel Poverty Joint Strategic Needs Assessment section
- Director of Public Health Annual Report 2015
- BHCC Housing Strategy 2015

The National Institute for Health and Care Excellence (NICE) guideline makes recommendations on how to reduce the risk of death and ill health associated with living in a cold home. The guideline acknowledges that the health problems associated with cold homes are experienced during 'normal' winter temperatures, not just during extremely cold weather. They propose that year-round planning and action by many sectors is needed to combat these problems. Accordingly, they are aimed at commissioners, managers and health, social care and voluntary sector practitioners who deal with vulnerable people who may have health problems caused, or exacerbated, by living in a cold home.

[5] World Health Organisation ‘Environmental burden of disease associated with inadequate housing’ – 2011 http://www.euro.who.int/__data/assets/pdf_file/0003/142077/e95004.pdf?ua=1

The NICE guideline identifies a wide range of people as vulnerable to the cold, including:

- people with cardiovascular conditions
- people with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma)
- people with mental health conditions
- people with disabilities
- older people (65 and older)
- households with young children (from new-born to school age)
- pregnant women
- people on a low income.

The guideline makes recommendations, with the following aims:

- Reduce preventable excess winter death rates
- Improve health and wellbeing among vulnerable groups
- Reduce pressure on health and social care services
- Reduce ‘fuel poverty’ and the risk of fuel debt or being disconnected from gas and electricity supplies
- Improve the energy efficiency of homes

4. National Policy Context

The legal framework for tackling fuel poverty in England is laid out in primary legislation through the Warm Homes and Energy Conservation Act 2000 and in secondary legislation, by the Fuel Poverty (England) Regulations 2014.
This set of regulations, which became law on 5 December 2014, gives effect to the new fuel poverty target;

'to ensure that as many fuel poor homes as is reasonably practicable achieve a minimum energy efficiency rating of Band C, by 2030.'

The regulations also set some interim Milestones:

(i) as many fuel poor homes as is reasonably practicable to Band E by 2020 and
(ii) as many fuel poor homes as is reasonably practicable to Band D by 2025

Minimum Energy Efficiency Standards

These regulations that introduce minimum energy efficiency standards on the private rented domestic property sector in England & Wales were approved by both Houses of Parliament in March 2015, as part of the Energy Act 2011.

From April 2018, private landlords will be required by law to ensure their properties meet an energy efficiency rating of at least Band E. From 1 April 2016, tenants living in F and G rated homes will have the right to request energy efficiency improvements which the landlord cannot unreasonably refuse, providing they do not present 'upfront costs' to the landlord.

Predicted future need

Over the next 40 years, global temperatures are set to rise. Even with climate change, however, cold related deaths will continue to represent the biggest weather-related cause of mortality.

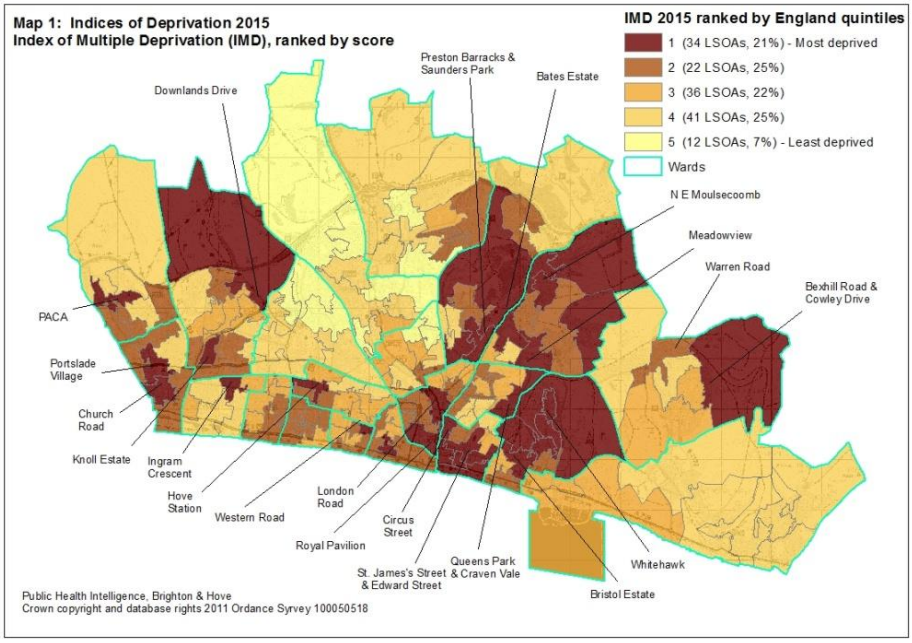
The number of fuel poor households in England is projected to fluctuate slightly during 2015 and 2016, with a slight drop in 2015, before increasing back to levels similar to 2014 in 2016.

The long-term trend in energy prices is likely to be one of continual increase and rising housing costs represent a constant challenge to the reduction of fuel poverty. Addressing energy inefficient housing and bringing all homes up to a minimum standard of thermal efficiency would have the greatest impact on the most vulnerable households.

5. Challenges in Brighton & Hove

Brighton & Hove is a popular place to live, work and visit. However, it is also a place of contrast, with areas of affluence and areas of deprivation, where residents can experience significant inequality compared to others in the city in terms of access to suitable housing, employment, health and life expectancy. Pressures from an increasing population, high property prices, pockets of poor quality housing, limited opportunities for new development and the effects of welfare reform are impacting on many families, particularly the most vulnerable people living in the city. The city has one of the highest average house prices outside London, coming within the top 10 local authorities and high rents in the private rented sector making rent unaffordable for many households.

We know from the Index of Multiple Deprivation 2015 (IMD 2015) that out of 326 authorities, Brighton & Hove is ranked the 102nd most deprived authority in England (using the most commonly used summary measure, average score). This means the city is among the third (31%) most deprived authorities in England. Under the IMD at the Lower Super Output Area (small areas of around 1,500 residents / 650 households) level there are 17 neighbourhoods (10%) in Brighton & Hove in the 10% most deprived in England. In total, 34 LSOAs in Brighton & Hove (21%) are in the 20% most deprived areas in England.



In the IMD ‘Barriers to housing and services’ domain, of 326 local authorities in England, Brighton & Hove is ranked 73 most deprived, meaning that we are ranked just in the second quintile (22%) of most deprived authorities in England for barriers to housing and services. This domain is split into two sub-domains; the ‘Geographical sub-domain’ and the ‘Wider barriers sub-domain’. Whilst the city fairs relatively well in terms of ‘geographical barriers’ in comparison with other areas the wider barriers sub-domain identifies relatively higher levels of deprivation. Measuring housing affordability, homelessness and household over-crowding, more than two thirds of Brighton & Hove’s LSOAs (116, 70%) are in the most deprived 20% for the wider barriers (housing) sub-domain.

Through measuring housing in poor condition and houses without central heating, IMD also compares ‘Indoor living environment’ of different areas. When combined with outdoor living environment, the IMD shows that of 326 authorities in England, Brighton & Hove is ranked 36 most deprived, meaning we are the in the first quintile (11%) of most deprived authorities in England for our living environment.

The Private Sector House Condition Survey 2008 reported that a third of the city’s housing stock (up to 37,000 homes) is considered to be non decent. The survey also showed that the age profile of the private stock differs from the average for England in that there is a substantially higher proportion of pre 1919 stock at 39.8% compared to the national average of 24.9%. Overall the stock profile is older than the national picture with 65.7% built before 1945 compared to 43.4% in England as a whole. There are in excess of 30 conservation areas in the city where planning controls are tighter in order to protect its special character. The city is known internationally for its extensive Regency and Victorian architecture and has around 3,400 listed buildings. These factors can consequently impact on the ability of home owners, tenants and landlords to improve the energy efficiency of homes and consequently on residents to live in warm and healthy homes.

The 2011 census showed that the size of the private rented sector in Brighton & Hove has increased by 37% since 2001 with an extra 10,691 homes. Two out of

every seven households in the city are now renting from a private landlord, with the city having the 9th largest private rented sector in England & Wales, with a total of 34,081 private rented homes. In England (2014), 20% of all private rented households were in fuel poverty, compared to 7% of owner occupiers and 11.5% of social renters.[6]

The 2015 Housing Strategy aims to create 'Decent Warm & Healthy Homes' under the priority of improving housing quality, however the housing stock in Brighton & Hove presents a number of challenges to improving its energy efficiency. The last few years have seen significant changes to the funding available to deliver the objectives outlined in the housing strategy, which means looking at new ways of working to support local people. These changes include the removal of private sector renewal funding that helped owners and landlords improve the quality of their homes. This funding enabled significant numbers of energy efficiency improvements in the housing stock, with a particular focus on our more vulnerable residents.

[6] Department of Energy and Climate Change. Fuel Poverty Trends 2003-2014; 2016.

6. Achievements & Opportunities

Through a number of measures, the city council has worked to improve the quality of homes in the city by increasing energy efficiency and reducing the city's carbon footprint. A number of initiatives have been successful;

Private Sector Renewal: From 2009, more than £9m has been invested in enabling over 4,500 homes to be made decent or moved towards decency. This included 2,438 energy efficiency measures installed and 1,592 tonnes of CO_2 saved.

Brighton & Hove Warm Homes, Healthy People Programme: Since 2011, the Public Health and Housing teams have overseen this annual programme of support to some of the city's most vulnerable residents. Initially funded by bids to the Department of Health totalling £200,000 in 2011 and 2012, the Brighton & Hove Warm Homes, Healthy People Programme is currently funded by Public Health. Delivered through a range of partner agencies across the city, this annual programme has to date delivered:

- 33 fuel poverty awareness training sessions to 235 front line workers
- 150 winter home checks to make homes safer and warmer
- 198 home energy advice and assessment visits
- 25 emergency home visits to check welfare and deliver 59 emergency warmth packs
- 215 warm packs to rough sleepers
- 33,500 awareness raising leaflets and 17,500 room thermometers to residents
- 15 community outreach workshops and 2 affordable warmth information events
- 186 emergency winter grants totalling £32,225
- 434 financial inclusion checks

The financial inclusion checks have resulted in a total of £734,415 in confirmed and likely annual income increases for residents – an average of around £1,700 per household, per annum.

Government funding: £411,000 was secured for energy efficiency improvements to vulnerable householders in the private sector through a joint bid with Eastbourne Borough Council. Through the 'Your Warm Home' project 100 vulnerable households

in the city were assisted by a case-worker to improve the energy efficiency of their home through insulation and heating upgrades. The Your Warm Home project, delivered with partners, also funded energy cafes in communities across the city, providing advice to residents about behaviour change and measures they could take to improve the energy efficiency and thermal comfort of their homes. Through Green Deal Pioneer Places, £221,000 was secured for 100 free Green Deal assessments, and retrofits to 10 houses across the city.

Council housing stock has achieved 100% decency through an intensive programme of improvements undertaken via a long term partnership between Mears and the council. Energy efficiency of homes has improved and residents heating bills have been cut by replacing boilers and installing insulation such as solid wall, cavity wall, loft and floor. There has also been significant investment in renewable heat and electricity installations.

Working with private sector landlords: Through the Strategic Housing Partnership we are working with landlords through both the Southern Landlords Association and the National Landlords Association to explore ways to improve the energy efficiency of privately rented homes. We are assessing models that can deliver investment that is affordable for both tenants and landlords.

Your Energy Sussex: The city council continues to explore options for improving the energy efficiency of the city's housing stock, including exploring different investment opportunities and other funding streams. With this in mind we have worked closely with Your Energy Sussex, a partnership of local authorities, to develop models for energy efficiency, energy generation and supporting residents across the region to reduce their energy bills.

Local expertise: We have two local universities well positioned to support organisations to meet the challenges outlined within this strategy. Through both the University of Brighton Green Growth Platform and Sussex University's Social Policy Research Unit, we have a number of local experts and academics with whom we look to work collaboratively.

There is a vibrant SME sector in the city, working across the sustainability agenda including energy efficiency. There are two energy co-ops based in the city working on projects to increase renewable energy generation, community ownership of energy and energy efficiency. Both Brighton Energy Co-op and Brighton & Hove Energy Services Co-op have had success in raising and bidding for funding for local projects.

There is an engaged and active community and voluntary sector in the city supporting residents around different vulnerabilities, financial inclusion and housing issues. The city council partners with these organisations wherever possible to ensure the reach of programmes of support to our most vulnerable residents. Our previous work and the input of partners has been reflected throughout this strategy.

Warmth For Wellbeing is a significant programme of work to address the health impact of cold housing on vulnerable residents in the city during 2016. Following a collaborative bid to the British Gas Energy Trust's 'Healthy Homes' fund, a local partnership led by Citizens Advice Brighton and Hove was awarded £395,158 to establish a Single Point of Contact Affordable Warmth Referral System. Targeted to those most at risk from adverse health effects of cold homes, a partnership of 14 community and voluntary sector organisations offers holistic support to those referred, including:

- in-depth financial and housing advice and casework
- small grants to make homes warmer
- home energy assessment and provision of low cost energy efficiency measures
- single point of contact Freephone advice line

A central, electronic referral system ensures that those referred are supported to access all elements of the programme as appropriate. The programme is also providing fuel poverty and energy awareness training for front line workers across the city and a fuel poverty online learning module.

7. Objectives of Strategy

Through working in partnership across the city and the wider area we want to ensure that households, and in particular those considered to be most vulnerable, are able to live in warm homes that support good health and wellbeing.

With consideration of both the NICE guideline referred to in Chapter 3 and the ambitions contained in the national Fuel Poverty Strategy 'Cutting the Cost of Keeping Warm', the objectives below have been drafted based on input and feedback from key partners across the city. In considering what the council and the wider city partnership can do, we need to recognise the challenges all partners face in the context of the current economic climate and welfare reform.

The funding challenges faced by the city council, wider public sector and third sector need to be addressed by making the best use of the resources available across organisations. This strategy comes at a time where the council is required to save £102m over the period 2015/16 to 2019/20 and follows the removal of private sector renewal funding that helped owners and landlords improve the quality of their homes. Recognising the challenges we face, the city council wants to support communities to realise their potential and to create a cultural shift from reliance on traditional support. The partnership approach proposed within this strategy reflects this and the diversity of our city.

We will look to build on the current partnership with the local Clinical Commissioning Group, as part of the Warmth for Wellbeing project, to ensure that our interventions are targeted at those residents in the city most at risk from the health impacts of living in a cold home, working through the GP clusters specifically.

Aligned to the recommendations contained within the NICE guideline and our previous experience and learning, this strategy contains a number of objectives to address the causes of fuel poverty and the impacts on residents lives from living in cold homes. In developing the strategy and its objectives, we have taken into account the significant equalities considerations that impact on these issues. These considerations have been identified through the related equalities impact assessment; however it is worth highlighting some specific issues here.

Poor home energy efficiency affects people with low incomes more severely because it affects life chances and how they spend disposable income on other essential items such as food and clothing. Fuel poverty and cold homes can have an even greater health impact on a range of people, including those with disabilities and long-term health conditions and older people.

The council has a legal duty under the Equality Act 2010 to show that we have identified and considered the impact and potential impact of our activities on all people with 'protected characteristics' (age, disability, gender reassignment, pregnancy and maternity, race/ethnicity, religion or belief, sex, sexual orientation, and marriage and civil partnership). Through the strategy and looking forward to future action, we will pay due regard to these duties, including to:

- remove or minimise disadvantages suffered by equality groups
- take steps to meet the needs of equality groups
- encourage equality groups to participate in public life or any other activity where participation is disproportionately low, and
- consider if there is a need to treat disabled people differently, including more favourable treatment where necessary.

The council will also look at how we can foster good relations between people who share a protected characteristic and those who do not, including tackling prejudice and promoting understanding.

The Brighton & Hove Warm Homes Healthy People Programme 2013-14 found that 84% of programme recipients who completed the evaluation form got into debt or cut down on buying essential items in order to heat their home. 51% stated that they or other people in the household had reduced the size of meals or skipped meals in the last six months because there wasn't enough money for food.

In 2014, households in England where the oldest person in the household was aged 16-24 were more likely to be fuel poor. However, older people had a larger average

fuel poverty gap, meaning they experience the deepest levels of fuel poverty. Unemployed households in England have the highest rates of fuel poverty across all economic activity groups. Lone parent households have consistently been more likely to be in fuel poverty. However, the depth of fuel poverty is lowest in lone parent households. People in England (2012) who have a long term illness or disability are more likely to be fuel poor than those who do not.

The objectives below are aimed at supporting all residents in the city struggling to affordably heat their homes, with a specific focus on those most at risk as outlined throughout the strategy. They have also been developed in the context of the wider priorities the council has identified, grounded on delivering the following ambitions;

A good life: Ensuring a city for all ages, inclusive of everyone and protecting the most vulnerable.
A well run city: Keeping the city safe, clean, moving and connected.
A vibrant economy: Promoting a world class economy with a local workforce to match.
A modern council: Providing open civic leadership and effective public services.

These objectives and the ambition of the strategy must be considered in light of the challenges faced by the council and the city, reflected more widely across the country, about what councils should be doing and how they should be doing it. The dilemma is that councils and public services more generally cannot continue in the same way, since public spending is reducing, populations growing and costs are rising. These challenges place even greater emphasis on the need for a partnership approach, reflected through the NICE guideline and reflected throughout this strategy. In light of these challenges, the city council has recognised that by 2020 it will:

- become a **smaller**, more efficient organisation, working as one, with a reduced budget, fewer employees and fewer directly provided services;
- **collaborate** more with other public services, the community and voluntary sector and businesses to find common and jointly owned solutions;
- **positively** enable more citizens to play an active role in the creation and

provision of services for their local community;

- create a more **connected** council with more shared services, with other providers and other places.

Evaluation and Reporting

Annual updates will be provided to both the Housing and New Homes Committee, and the Health and Wellbeing Board, on the strategy and progress against the objectives outlined below. A more detailed action plan will be developed and monitored in collaboration with partners to track and review progress.

Objective 1

Increase the energy efficiency of the city's housing stock

What we intend to do

1.1 Support and encourage residents to access advice and support to improve the energy efficiency of their homes, including access to local and national funding opportunities

1.2 Continued investment into the council's own housing stock through available grant funding and the HRA capital programme in line with the HRA Asset Management Strategy

1.3 Work with registered housing providers, private landlords, letting agents and tenants to improve the energy efficiency of homes

1.4 Work with private landlords, letting agents and tenants to ensure compliance with Minimum Energy Efficiency Standards guiding the energy efficiency of private rented homes

1.5 Continue to work with local partners through the Your Energy Sussex partnership to identify models and funding opportunities that enable all householders to make energy efficiency improvements to homes that provide affordable warmth

1.6 Through existing schemes and services overseen by the council's Private Sector Housing Team (e.g. Housing Health and Safety Rating System, Houses of Multiple Occupation Standards), work with landlords to ensure quality housing in the private rented sector

1.7 Through planning processes, ensure standards in new development supports households to achieve affordable warmth

Objective 2

Support residents struggling to pay their energy bills

What we intend to do

2.1 Support the ongoing development and resourcing of a Single Point of Contact Affordable Warmth Referral System

2.2 Support the provision of tailored solutions via the Single Point of Contact Affordable Warmth Referral System for people living in cold homes

2.3 Explore effective methods to assess heating needs of those most at risk who use primary health and home care services

2.4 Explore opportunities for a switching scheme for Brighton & Hove / local area that involves a process to support and encourage vulnerable residents to access less expensive energy tariffs and methods of paying for energy

2.5 Work with local advice agencies to ensure residents have access to advice on housing, benefits, money and energy

2.6 Ensure signposting is in place to national and local schemes designed to support people struggling to pay for energy / keep their homes warm

2.7 Where resources are available, support programmes of behaviour change across housing tenures aimed to reduce energy bills and keep warm affordably through energy saving advice

Objective 3

Improve awareness and understanding of fuel poverty

What we intend to do

3.1 Improve communication and promotion to the general public of the health risk of cold homes, to increase awareness of risks and the support available

3.2 Train health and social care practitioners to identify and support those residents most at risk from cold homes

3.3 Provide easy to understand and accessible information to professionals, front line workers and volunteers to support and refer people in fuel poverty and living in cold homes

3.4 Train housing professionals and faith and voluntary sector workers to help people whose homes may be too cold for their health and wellbeing

3.5 Increase understanding of the issue for front line workers across all sectors through sharing of resources and learning tools, in particular develop an accessible online learning tool

Objective 4

Work together to tackle fuel poverty through partnership and learning

What we intend to do

4.1 Establish cross sector Fuel Poverty & Affordable Warmth steering group to deliver related action plan, monitor progress against strategy objectives and coordinate a city wide response.

4.2 Build upon existing networks to promote available support to all sectors, relevant organisations and communities across the city

4.3 Work alongside community groups to reach isolated individuals and communities across the city

4.4 Through the Health & Wellbeing Board and constituent organisations, explore how the objectives and actions related to this strategy can work with and complement other programmes aimed at improving the health and wellbeing of local people

4.5 Explore through the Strategic Housing Partnership how the housing sector can work in partnership with health, social care and voluntary sector providers to tackle fuel poverty

Objective 5

Increase effective targeting of vulnerable fuel poor households and those most at risk of the health impacts of cold homes

What we intend to do

5.1 Work with the CCG and NHS partners to identify those groups highlighted in the NICE guideline as most at risk of ill health and morbidity linked to cold homes, exploring potential use of existing patient risk stratification tools and methods

5.2 Work with Community and Voluntary Sector organisations to identify and support those groups highlighted in the NICE guideline as most at risk of ill health and morbidity linked to cold homes

5.3 Work with social care providers to identify and support those groups highlighted in the NICE guideline as most at risk of ill health and morbidity linked to cold homes

5.4 Explore how CCG and local authority commissioning can incorporate relevant NICE recommendations and strategy objectives

5.5 Work specifically with teams involved in the discharge of vulnerable people from health or social care settings to ensure they return to a warm home

Objective 6

Maximise resources and opportunities for tackling the causes fuel poverty

What we intend to do

6.1 Through a partnership approach and city wide steering group, coordinate bids and business cases for additional funding to support work in this area

6.2 Working in partnership, coordinate and share resources to ensure assistance is targeted and maximised to the benefit of the most vulnerable residents

6.3 Ensure meaningful links to other strategies and work streams across all sectors**,** coordinating with other financial inclusion / poverty work and wider wellbeing work to maximise opportunities, value for money and impact

8. Links to other relevant strategies

2015 Housing Strategy

The housing strategy aims to create 'Decent Warm & Healthy homes' under the priority of Improving Housing Quality.

2015 Joint Strategic Needs Assessment - Excess winter deaths and fuel poverty

The JSNA is an ongoing process that provides a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities. To do this, needs assessments gather together local data, evidence from the public, patients, service users and professionals, plus a review of research and best practice.

Financial Inclusion 2013-16

The strategy defines financial health as "Having enough resources to meet basic needs adequately and to be able to make choices over a prolonged period to maintain physical and mental well being and participate in community and society." It has established a Community Banking Partnership to deliver a number of elements through an integrated seamless service model, including Food & Fuel.

Food Poverty Action Plan

Food is the flexible item in people's budgets; reducing other outgoings helps to free up spend for food. Food and fuel poverty are interlinked.

Cold Weather Plan for Brighton & Hove

Sustainable Community Strategy for Brighton & Hove

Health & Wellbeing Strategy (Draft)

Fuel Poverty & Affordable Warmth Strategy 2016-2020

Consultation Report

Stakeholder Consultation Workshop

A wide range of individuals and organisations from the community and voluntary sector, the NHS, emergency services and within the Council were invited to attend a consultation workshop. The workshop was held at the Brighthelm Centre on 7th January 2016. Invitees and attendees were also offered the opportunity to discuss the strategy and issues separately to the consultation event.

The consultation workshop was attended by 29 people from the following organisations;

Brighton & Hove City Council (BHCC) – Public Health	Citizens Advice Bureau
BHCC – International & Sustainability Team	AgeUK Brighton & Hove
Brighton & Hove Food Partnership	Specialist Older Adults Mental Health Service
BHCC – Housing	Trust for Developing Communities
BHCC – Financial inclusion	Healthwatch Brighton & Hove
Older LGBT Project Switchboard	Southdown Housing
East Sussex Association of Blind and Partially Sighted	BHCC –Welfare Reform
BHCC – Stronger Families, Youth & Communities	Moneyworks
Money Advice Plus	BHCC – Adult Social Care Commissioning
Brighton Housing Trust	Brighton & Hove Energy Services Coop
The Fed Centre for Independent Living	

Attendees received a presentation on fuel poverty, excess winter deaths and the health risks of cold homes in both the national and local context. The attendees were then asked to discuss and feedback on a series of consultation questions framed around some broad draft strategic objectives;

Objective 1	Increase the energy efficiency of the City's housing stock
Objective 2	Support residents struggling to pay their energy bills
Objective 3	Improve awareness and understanding of fuel poverty for residents in all tenures
Objective 4	Work together to tackle fuel poverty through partnership and learning
Objective 5	Increase Effective targeting of vulnerable fuel poor households
Objective 6	Maximise resources and opportunities for tackling the causes of fuel poverty

Groups provided the following feedback that has been reflected in the final drafting of the strategy where possible and will be influence delivery of future actions;

1. How can we reach / engage the vulnerable groups that you work with?

Importance of face to face support to help people, i.e. if they are reluctant to put their heating on, need to be aware of the health risks via health workers	Target large families and single parent families (impacted by welfare reform)
GP surgeries (new outcomes framework for GPs)	Need to reach people in private rented accommodation
Care coaches	Through temporary accommodation team
Floating support services	Training for frontline workers
Local Discretionary Social Fund and Welfare Reform teams	Publicity – Adverts, on-line, social media
Meals-on-wheels	Care providers (private and public)
Through landlords and their associations	Advise tenants how to approach their landlord
Befriending services	Tenancy enforcement officers
Use face to face contacts that all agencies do to include checks on fuel poverty	Share info. via newsletters (incl. audio newsletters)
Through early help hubs	Through schools
Foodbanks	Family Information Service
Day centres	Health visiting service
Existing groups/meetings	City-wide connect hubs
Children's Centres (current review re. integrated hubs)	Try and attend meetings to talk about issues
GP clusters/locality hubs	Health visitors

2. What do you believe to be the key existing strategies, work and services we should be linking into?

   Services & Existing work

All housing related services including tenancy sustainment officers or equivalent across all housing providers i.e. BHT, Southdown Housing	Through services supporting 16-25 year olds, vulnerably housed, care leavers
City-wide connect hubs (March)	AgeUK are a key partner
Befriending services allied to faith groups	Services supporting people with mental health issues
Try and include in assessment processes i.e. hospital social worker	Low income families
Through existing local services at community level i.e. Hangleton & Knoll project, Trust for Developing Communities	All agencies that complete financial assessments

Through the Fed 'It's local actually'	Move on mentors
Poverty Action Groups	All warmth for wellbeing agencies
Tenant forums	Temporary Accommodation team
Local Action Teams	BHCC Revs & Bens team
BHESCO	Libraries
NHS organisations including CCG	Work with energy companies
Police and fire service	Build into CCG commissions
BME, refugee and EU migrant support groups	Through foodbanks
Link with faith based groups	

Strategies

Housing strategy	Fairness Commission
Your Energy Sussex	Food Poverty Strategy & Action Plan
Financial Inclusion Steering Group	City Employment and skills
Better Care	Health & Wellbeing Strategy

3. a. Would you suggest any amendments to the below objectives?
   b. Are there further objectives you think should be included in the strategy?
   c. Are there specific actions, linked to the objectives, that you think should be included?

Reducing the need for fuel use is key	Target the worst quality housing
In general - set goals and hold someone to account for achieving these	Bulk buying of energy? Getting a better deal for energy
Advice and education	Basic energy advice
Work in partnership	Source funding to support the work
New buildings need to be more sustainable/energy efficient	Community owned renewable energy should be promoted and invested in
Take the emphasis of it being an individual problem and make it collective responsibility	Need a 10 year plan and needs to be a priority, be creative
Communication is key as knowing what's out there continues to be difficult	Link to universities and their own accommodation strategies
Need a focus on how we work with and engage landlords, including focus on possible reaction to changes i.e. risk of rent increases if improvements are made, greater regulation of landlords and ensuring standards are met. Also opportunity to see them as an asset, a way of increasing investment	Communicate relevant legislation through objectives in particular Minimum Energy Efficiency Standards
Objectives need to be more targeted and specific, 'they're very vague'	Ensure objectives and actions are sustainable beyond the 'Warmth for Wellbeing' funding period
Need to link to new regulations re. energy efficiency standards	Explore private sector partnerships

Need to link to new bill re. de-regulation & retaliatory evictions	Link to 'poverty premium', digital inclusion and wider social isolation agenda
Need to link to licensing of Houses of Multiple Occupation and the Housing Health and Safety Rating System	Obj. 3 should be frontline workers and community groups as well as residents
Re. Objective 3 – enable quick and easy referral processes	Raise awareness via a clear, simple and consistent message

In addition to the consultation workshop the following consultation and briefing sessions were held through the strategy development;

- Strategic Housing Partnership 7th July 2015 & 26th January 2016

Reports were provided to the Strategic Housing Partnership on the NICE guidelines and the developing Fuel Poverty & Affordable Warmth Strategy.

- Reports updating on strategy development and context for Brighton & Hove were presented to the Housing & New Homes Committee 23rd September 2015 and the Health & Wellbeing Board 20th October 2015

- Meeting with Brighton & Hove Food Partnership 11th January 2016

Due to the clear link between Food & Fuel and the choices some families have to make between heating and eating we are keen to ensure that strategy aligns to the work of the partnership and the Food Poverty Action Plan 2015-18.

- Briefing for BHCC Private Sector Housing Team 19th January 2016

Equality Impact and Outcome Assessment (EIA) Template - 2015

EIAs make services better for everyone and support value for money by getting services right first time.

EIAs enable us to consider all the information about a service, policy or strategy from an equalities perspective and then action plan to get the best outcomes for staff and service-users[1].They analyse how all our work as a council might impact differently on different groups[2]. They help us make good decisions and evidence how we have reached these decisions[3].

See end notes for full guidance. Either hover the mouse over the end note link (eg: Age[13]**)** or use the hyperlinks ('Ctrl' key and left click).

For further support or advice please contact the Communities, Equality and Third Sector Team on ext 2301.

1. Equality Impact and Outcomes Assessment (EIA) Template

First, consider whether you need to complete an EIA, or if there is another way to evidence assessment of impacts, or that an EIA is not needed[4].

Title of EIA[5]	Fuel Poverty & Affordable Warmth Strategy	**ID No.[6]**	PH25
Team/Department[7]	Housing & Public Health		
Focus of EIA[8]	Assessment of equalities implications of the new Fuel Poverty & Affordable Warmth Strategy, to ensure it comprehensively addresses the consequences and impacts of fuel poverty and cold homes, and the specific challenges faced by protected characteristic groups.		

2. Update on previous EIA and outcomes of previous actions

What actions did you plan last time? (List them from the previous EIA)	**What improved as a result?** What outcomes have these actions achieved?	**What <u>further</u> actions do you need to take?** (add these to the Action plan below)
N/A First iteration of strategy		

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
Age[10]	13.4% of the city's population are aged 65+ (ONS 2014). There is a clear pattern of increasing depth of fuel poverty in older households (Annual Fuel Poverty Statistics Report 2015). In 2013, people in England aged 75 or over had the largest average fuel poverty gap. Excess winter deaths (EWD) are higher among people aged 65+. In 2013/14 51% of cold-related deaths were among people aged 85 and older; 27% were among those aged between 75 and 84;22% were among people under 75. ('Statistical bulletin: excess winter mortality in England and Wales, 2013/14'). In Brighton & Hove (for the three years of 2010/11 to 2012/13) 50% of EWD were in people aged 85 or over. In 2013, households in England where the oldest person in the household was aged 16-24 were more likely to be fuel poor. Local Health Counts data (2012)	Feedback and equalities monitoring data from annual Brighton & Hove Warm Homes Healthy People Programme service users, service providers and evaluation. Feedback from the 2015 Warmth for Well-being pilot project service users and service providers Feedback and views gathered from key partners at strategy consultation workshop January 2016.	Older people (aged 65 and older) and young children (from new-born to school age) are identified as groups who are vulnerable to the cold in the National Institute for Health and Care Excellence (NICE) 2015 guideline, 'Excess winter deaths and morbidity and the health risks associated with cold homes'	• Through working with key partners in the city e.g. Age UK and the Brighton Unemployed Centre Families Project, available support and advice can be targeted at residents aged 65+ and under five. • BHCC commissions provide services for residents aged 65+ and under five; relevant information and training is provided to front-line workers engaging with these age groups. • The potential to include assessment of the risks to older residents and the requirement for agencies to signpost to further support is being considered for inclusion in pertinent service specifications. • The 2016 Warmth For Wellbeing (WFW) project, coordinated by CAB, is providing funding to Age UK to identify 100 vulnerable older residents who would benefit from the support available. Further projects (depending on available funding) can also explore this approach. • Brighton Unemployed Centre

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	suggested that the youngest age groups in Brighton & Hove are most likely to be unable to keep their homes warm enough in the winter most of the time or quite often. Children under five are in a high risk category for ill health due to cold weather (Cold Weather Plan for England, 2015) and are identified as a group who are vulnerable to the cold by the National Institute for Health and Care Excellence (NICE)			Families Project (BUCFP) is a key delivery partner for the 2016 WFW project • The annual Public Health 'Warm Homes Healthy People' (WHHP) Programme distributes information and advice resources directly to organisations who work with residents aged 65+ and under five (e.g. day centres and Children's Centres) • Engage with organisations supporting residents aged 16-24 to ensure they are able to identify fuel poverty, provide initial advice and signpost to support.
Disability[11]	People in England (2013) who have a long term illness or disability are more likely to be fuel poor (12%) than those who do not (10%). In Brighton & Hove, Health Counts Survey respondents who had a limiting long-term illness or disability were significantly more likely to be unable to keep their home warm in winter. 16.3% of people living in Brighton & Hove have their daily	Feedback and equalities monitoring data from annual Brighton & Hove Warm Homes Healthy People Programme service users, service providers and evaluation. Feedback from the 2015 Warmth for Well-being pilot	Disabled people are identified as a group who are vulnerable to the cold in the associated NICE guideline and people with chronic and severe illness are in a high risk category for ill health due to cold weather (Cold Weather Plan for England, 2015)	• Through working with key partners in the city e.g. The Fed, available support, and advice can be targeted at disabled residents • Working through organisations and agencies providing care and supporting carers, awareness of risk and support can be raised. • The WHHP Programme 2015/16 is funding The Fed to identify 25 vulnerable disabled residents who would benefit

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	activities limited a little or a lot by a long term health problem or disability (Census 2011). Nationally, disabled people are more likely to live on low incomes and experience poverty than non-disabled people. Some groups at risk of fuel poverty lack awareness and/or understanding of existing sources of support and programmes to help improve home energy efficiency. Lack of understanding can restrict those that are aware to adopt such interventions (e.g. people with learning disabilities).	project service users and service providers. Feedback and views gathered from key partners at strategy consultation workshop January 2016.	Disabled people are more likely to need a warmer home environment to maintain their health; some disabled people may need to use benefits intended to support their independence to ensure their home is warm enough.	from the support available through the Warmth For Wellbeing project. Further projects (depending on available funding) can also explore this approach. • Ensure programmes of support such as Warmth for Wellbeing include wider financial, benefit and debt advice to maximise income, ensure links are established to generic financial inclusion work and commissions. • The annual WHHP Programme distributes information and advice resources directly to organisations who work with disabled residents (e.g. SCOPE) • Provide information and awareness training to practitioners who work with disabled people
Gender reassignment[12]	The Brighton & Hove Trans Needs Assessment found that the trans community; • Have more people with a disability or long term health need than the general population. 44% of respondents reported that	Feedback and views gathered from key partners at strategy consultation workshop January 2016. Information gathered	Trans community may be at higher risk of fuel poverty as they are more likely to live in the private rented sector. Increased likelihood	• Ensure engagement of local groups to engage clients in programmes of support, particularly where other factors such as age or disability increase risk • Ensure the annual WHHP Programme distributes

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	they have a limiting long-term illness or disability, compared with 26% of all respondents to the Health Counts Survey. • Are more likely to live in the private rented sector (47% of community survey respondents reported they rent from a private landlord, compared to 28% of general population (2011 Census). In England (2013), almost 19% of all private rented households are in fuel poverty, compared to 8% of owner occupiers and 10% of social renters	through Trans Needs Assessment	of disability or long-term health condition may make the Trans community more vulnerable to the health risks of cold homes.	information and advice resources to organisations who work with trans people • Provide information and awareness training to practitioners who work with trans people
Pregnancy and maternity[13]	Pregnant women are identified as a group who are vulnerable to the cold within the associated NICE guidelines	Feedback and views gathered from key partners at strategy consultation workshop January 2016.	Pregnant women are identified as a group who are vulnerable to the cold within the associated NICE guidelines	• Engage with key staff and raise awareness among primary health care professionals (midwives and health visitors) of the risks and support available. • Explore sharing Fuel Poverty E-Learning module with local NHS Trusts to train their staff. • Provide information and awareness training to practitioners who work with pregnant women

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
Race[14]	Black and minority ethnic (BME) families are likely to experience housing inequalities (de Norohna, 2015; Finney, 2013; Chouhan et al., 2011) and live in poorer housing with many residing in pre 1919 cold homes (Garrett et al., 2014). People in England (2013) who are of minority ethnic origin are more likely to be fuel poor (18%) than people who are of white ethnic origin (9%) (Dept. of Energy and Climate Change 2013). In Brighton & Hove nearly twice as many BME residents (45 per cent) were renting their homes from private landlords than White UK/British residents (24 per cent) were in 2011 (Census 2011). National Fuel Poverty Statistics Report 2015 estimates that 19% of those households living in the private sector are in fuel poverty. Travellers may be at increased risk due to poor insulation and high cost of gas. Data collected by London Gypsy Traveller Unit showed a high incidence of health problems and that most	Feedback and equalities monitoring data from annual Brighton & Hove Warm Homes Healthy People Programme service users, service providers and evaluation. Feedback from the 2015 Warmth for Well-being pilot project service users and service providers. Feedback and views gathered from key partners at strategy consultation workshop January 2016.	The link between some minority ethnic groups and deprivation may mean that some of these groups are more likely to live in cold homes. Other groups, such as recent immigrants, including those from warmer climates, could also be particularly vulnerable during their first few years here. For example, they may be more likely to live in poor quality housing and they face an unusually complex energy market.	• Through working with key partners in the city e.g. BMECP available support and advice can be targeted at BME residents in the city. • Work with BHCC traveller liaison team to provide advice and guidance • Design material to be accessible regardless of language and consider use of translated material where feasible • Ensure the annual WHHP Programme distributes information and advice resources to organisations who work with BME people

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	households had difficulty keeping warm. Ability to claim winter fuel allowance requires a permanent address. Some groups at risk of fuel poverty lack awareness and/or understanding of existing sources of support and programmes to help improve home energy efficiency. Lack of understanding can restrict those that are aware to adopt such interventions (e.g. people with language barriers).			
Religion or belief[15]	No specific data identified at a local or national level.	Feedback and equalities monitoring data from annual Brighton & Hove Warm Homes Healthy People Programme service users, service providers and evaluation.	No specific impacts identified	• Ensure engagement of local faith groups to engage clients in programmes of support, particularly where other factors such as age increase risk
Sex/Gender[16]	In Brighton & Hove (for the three years of 2010/11 to 2012/13) there were 373 EWD. Of these, 58% were female. Of EWD in Brighton & Hove of people aged 85 years or over, 79% were female.	Feedback and equalities monitoring data from annual Brighton & Hove Warm Homes Healthy People Programme service	Higher proportion of older women at risk due to increased life expectancy compared with men.	• Ensure engagement of local groups to engage clients in programmes of support, particularly where other factors such as age identify risk

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	The 2014-15 Warm Homes Healthy People programme evaluation showed that of the 60 recipients of emergency grants who replied to the survey 53% were female and 47% were male. There is a gender divide in average weekly earnings with full-time female earners averaging lower earning than males in the city. However, the differential is much lower in Brighton & Hove than across Great Britain (JSNA 2015)	users, service providers and evaluation. Feedback and views gathered from key partners at strategy consultation workshop January 2016		
Sexual orientation[17]	No specific local data available. Local estimates suggest that 11% to 15% of the city's population aged 16+ are lesbian, gay, bisexual or other sexual orientation.	Feedback and equalities monitoring data from annual Brighton & Hove Warm Homes Healthy People Programme service users, service providers and evaluation.	No specific impacts identified	• Ensure engagement of local groups, such as LGBT switchboard, to engage clients in programmes of support, particularly where other factors such as age identify risk
Marriage and civil partnership[18]	No specific data identified at a local or national level.	Feedback and views gathered from key partners at strategy consultation	No specific impacts identified, the highest proportion of fuel poverty is among lone	None identified at this stage

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
		workshop January 2016	parents with dependent children - on average more than a quarter of households in this group are fuel poor, (Annual Fuel Poverty Statistics Report 2015).	
Community Cohesion[19]	No specific data identified at a local or national level.	Feedback and views gathered from key partners at strategy consultation workshop January 2016		Through engagement with relevant community groups opportunities for community cohesion can be increased. Work through local community development organisations and workers to engage with residents.
Other relevant groups[20]	Lone Parent households are more likely to live in fuel poverty (25% of this group at a national level). However, they have smaller average fuel poverty gaps than other household types. Unemployed households in England have the highest rates of fuel poverty across all economic activity groups, but have smaller average fuel poverty gaps. The depth and likelihood of	Feedback and equalities monitoring data from annual Brighton & Hove Warm Homes Healthy People Programme service users, service providers and evaluation.	Increased risk, particularly where other risk factors such as disability are also present.	Work with local agencies who may be supporting lone parents and unemployed people e.g. BUCFP

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	being fuel poor increases markedly with lower SAP scores (how energy efficient a building is). People living in dwellings built before 1964 are more likely to be fuel poor than those in more modern dwellings. A similar pattern is seen in the fuel poverty gap which decreases from approximately £500 in pre-1919 homes to £250 in homes built after 1945.			
Cumulative impact[21]				

Assessment of overall impacts and any further recommendations[22]

In 2013, households in England where the oldest person in the household was aged 16-24 were more likely to be fuel poor. However people aged 75+ experienced the deepest levels of fuel poverty. The vast majority of EWD in England occur among those aged 65 or over. As in previous years in England and Wales, there were more excess winter deaths in females than in males in 2012-13.

Fuel poverty is a contributor to social and health inequalities. In 2013, all fuel poor households in England came from the bottom four income decile groups. Unemployed households in England have the highest rates of fuel poverty across all economic activity groups and lone parent households have consistently been more likely to be in fuel poverty. People who have a long term illness or disability are also more likely to be fuel poor than those who do not.

Poor home energy efficiency affects people with low incomes more severely because it affects life chances and how they spend disposable income on other essential items such as food and clothing. Low income households face the choice to “heat or eat”: either less money can be spent on basics such as a sufficient, healthy diet, or less can be spent on heating their home to an adequate temperature to maintain good health.

Some groups at risk of fuel poverty lack awareness and/or understanding of existing sources of support and programmes to help

Protected characteristics groups from the Equality Act 2010	Data that we have/what do we know	Community engagement exercises or mechanisms	Impacts	What can you do[9]? All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
improve home energy efficiency. Lack of understanding can restrict those that are aware to adopt such interventions. This is likely to vary across different groups, for example for people with language barriers (such as minority ethnic communities), and those who have limited social networks and connections with their local community, such as isolated older people and people with learning disabilities. Programmes of support and advice are delivered in conjunction with a wide range of local community and voluntary sector organisations and other statutory services e.g. NHS and East Sussex Fire and Rescue Service to ensure engagement with vulnerable and hard to reach groups.				

3. List detailed data and/or community feedback which informed your EIA

Title (of data, research or engagement)	**Date**	**Gaps in data**	**Actions to fill these gaps** (add these to the Action plan below)
Consultation Workshop	07.01.2016	Local data could be more robust / complete	Further evaluation of schemes such as Warmth for Wellbeing running throughout 2016 and the annual Warm Homes Healthy People programme
Annual Fuel Poverty Statistics Report 2015 (DECC)	2015		
Department of Energy and Climate Change: Detailed Tables, England 2013, LIHC definition.	2015		
Cold Weather Plan for England 2015: Protecting health and reducing harm from cold weather (Public Health England)	2015		
NICE Guidelines – Excess Winter Deaths and morbidity and the health risks associated with cold homes - NICE guideline nice.org.uk/guidance/ng6	Published: 5 March 2015		
Health Counts 1992-2012 (NHS Brighton & Hove and Brighton & Hove City Council)	2013		
Brighton & Hove Warm Homes Healthy People Programme Evaluation Report, 2014-15	May-Sept. 2015		
Brighton & Hove Citizens Advice Bureau – Warmth for Wellbeing Evaluation Report	Oct. 2015		

4. Prioritised Action Plan[23]

Impact identified and group(s) affected	Action planned	Expected outcome	Measure of success	Timeframe
NB: These actions must now be transferred to service or business plans and monitored to ensure they achieve the outcomes identified.				
Older and younger residents at risk of health impacts from cold homes	Through working with key partners in the city e.g. Age UK and BUCFP, available support and advice can be targeted at older and younger residents.	Improved targeting of support to those most at risk	Referrals and support provided	As part of Warmth for Wellbeing project by October 2016
Disabled residents at risk of health impacts from cold homes	Through working with key partners in the city e.g. The Fed, available support, and advice can be targeted at disabled residents	Improved targeting of support to those most at risk	Referrals and support provided	As part of Warmth for Wellbeing project by October 2016
Trans residents more likely to have long term health conditions or be disabled	Ensure engagement of local groups supporting members of the Trans community to engage residents in programmes of support, particularly where other factors such as disability identify risk	Improved targeting of support to those most at risk	Increased referrals (self or professional) from trans community	Ongoing, to be reflected in evaluation of Warmth for Wellbeing and future programmes of support
People with long term health conditions, disabled people, pregnant women and all vulnerable groups accessing health services	Engage with key staff and raise awareness among primary health care professionals (midwives and health visitors) of the risks and support available.	Raise awareness of more professionals and volunteers across a range of agencies	Referrals and support provided	Ongoing

As above	Explore sharing Fuel Poverty E-Learning module with local NHS Trusts to train their staff.	Raise awareness of more professionals and volunteers across a range of agencies	Increased awareness amongst all staff and volunteer groups, increased referrals from these staff teams to programmes of support	E-learning module in development due for completion March 2016 use will be ongoing

EIA sign-off: (for the EIA to be final an email must sent from the relevant people agreeing it or this section must be signed)

Lead Equality Impact Assessment officer: **Miles Davidson** **Date: 5th February 2016**

Directorate Management Team rep or Head of Service: **Andy Staniford** **Date: 5th February 2016**

Communities, Equality Team and Third Sector officer: **Sarah Tighe-Ford** **Date: 5th February 2016**

Guidance end-notes

[1] The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the council must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the council is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EIA in itself does not meet the requirements of the equality duty. All the requirements above must be fulfilled or the EIA (and any decision based on it) may be open to challenge. Properly used, an EIA can be a tool to help us comply with our equality duty and as a record that to demonstrate that we have done so.

[2] **Our duties in the Equality Act 2010**

As a council, we have a legal duty (under the Equality Act 2010) to show that we have identified and considered the impact and potential impact of our activities on all people with 'protected characteristics' (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and marriage and civil partnership.

This applies to policies, services (including commissioned services), and our employees. The level of detail of this consideration will depend on what you are assessing, who it might affect, those groups' vulnerability, and how serious any potential impacts might be. We use this EIA template to complete this process and evidence our consideration.

The following are the duties in the Act. You must give 'due regard' (pay conscious attention) to the need to:

- **avoid, reduce or minimise negative impact** (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately).
- **promote equality of opportunity**. This means the need to:
  - Remove or minimise disadvantages suffered by equality groups
  - Take steps to meet the needs of equality groups
  - Encourage equality groups to participate in public life or any other activity where participation is disproportionately low
  - Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary
- **foster good relations between people who share a protected characteristic and those who do not**. This means:
  - Tackle prejudice
  - Promote understanding

[3] EIAs are always proportionate to:

- The size of the service or scope of the policy/strategy
- The resources involved
- The numbers of people affected
- The size of the likely impact
- The vulnerability of the people affected

The greater the potential adverse impact of the proposed policy on a protected group (e.g. disabled people), the more vulnerable the group in the context being considered, the more thorough and demanding the process required by the Act will be.

[4] **When to complete an EIA**:

- When planning or developing a new service, policy or strategy
- When reviewing an existing service, policy or strategy
- When ending or substantially changing a service, policy or strategy
- When there is an important change in the service, policy or strategy, or in the city (eg: a change in population), or at a national level (eg: a change of legislation)

Assessment of equality impact can be evidenced as part of the process of reviewing or needs assessment or strategy development or consultation or planning. It does not have to be on this template, but must be documented. Wherever possible, build the EIA into your usual planning/review processes.

Do you need to complete an EIA? Consider:

- Is the policy, decision or service likely to be relevant to any people because of their protected characteristics?
- How many people is it likely to affect?
- How significant are its impacts?
- Does it relate to an area where there are known inequalities?
- How vulnerable are the people (potentially) affected?

If there are potential impacts on people but you decide not to complete an EIA it is usually sensible to document why.

[5] **Title of EIA:** This should clearly explain what service / policy / strategy / change you are assessing

[6] **ID no:** The unique reference for this EIA. If in doubt contact Clair ext: 1343

[7] **Team/Department:** Main team responsible for the policy, practice, service or function being assessed

[8] **Focus of EIA:** A member of the public should have a good understanding of the policy or service and any proposals after reading this section. Please use plain English and write any acronyms in full first time - eg: 'Equality Impact Assessment (EIA)'

This section should explain what you are assessing:

- What are the main aims or purpose of the policy, practice, service or function?
- Who implements, carries out or delivers the policy, practice, service or function? Please state where this is more than one person/team/body and where other organisations deliver under procurement or partnership arrangements.
- How does it fit with other services?
- Who is affected by the policy, practice, service or function, or by how it is delivered? Who are the external and internal service-users, groups, or communities?
- What outcomes do you want to achieve, why and for whom? Eg: what do you want to provide, what changes or improvements, and what should the benefits be?
- What do existing or previous inspections of the policy, practice, service or function tell you?
- What is the reason for the proposal or change (financial, service, legal etc)? The Act requires us to make these clear.

[9] Consider all three aims of the Act: removing barriers, and also identifying positive actions we can take.

- Where you have identified impacts you must state what actions will be taken to remove, reduce or avoid any negative impacts and maximise any positive impacts or advance equality of opportunity.
- Be specific and detailed and explain how far these actions are expected to improve the negative impacts.
- If mitigating measures are contemplated, explain clearly what the measures are, and the extent to which they can be expected to reduce / remove the adverse effects identified.
- An EIA which has attempted to airbrush the facts is an EIA that is vulnerable to challenge.

[10] **Age**: People of all ages

[11] **Disability**: A person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. The definition includes: sensory impairments, impairments with fluctuating or recurring effects, progressive, organ specific, developmental, learning difficulties, mental health conditions and mental illnesses, produced by injury to the body or brain. Persons with cancer, multiple sclerosis or HIV infection are all now deemed to be disabled persons from the point of diagnosis.

[12] **Gender Reassignment:** In the Act a transgender person is someone who proposes to, starts or has completed a process to change his or her gender. A person does not need to be under medical supervision to be protected

[13] **Pregnancy and Maternity:** Protection is during pregnancy and any statutory maternity leave to which the woman is entitled.

[14] **Race/Ethnicity:** This includes ethnic or national origins, colour or nationality, and includes refugees and migrants, and Gypsies and Travellers

[15] **Religion and Belief:** Religion includes any religion with a clear structure and belief system. Belief means any religious or philosophical belief. The Act also covers lack of religion or belief.

[16] **Sex/Gender:** Both men and women are covered under the Act.

[17] **Sexual Orientation:** The Act protects bisexual, gay, heterosexual and lesbian people

[18] **Marriage and Civil Partnership:** Only in relation to due regard to the need to eliminate discrimination.

[19] **Community Cohesion:** What must happen in all communities to enable different groups of people to get on well together.

[20] **Other relevant groups:** eg: Carers, people experiencing domestic and/or sexual violence, substance misusers, homeless people, looked after children, ex-armed forces personnel, people on the Autistic spectrum etc

[21] **Cumulative Impact:** This is an impact that appears when you consider services or activities together. A change or activity in one area may create an impact somewhere else

[22] **Assessment of overall impacts and any further recommendations**

- Make a frank and realistic assessment of the overall extent to which the negative impacts can be reduced or avoided by the mitigating measures. Explain what positive impacts will result from the actions and how you can make the most of these.
- Countervailing considerations: These may include the reasons behind the formulation of the policy, the benefits it is expected to deliver, budget reductions, the need to avert a graver crisis by introducing a policy now and not later, and so on. The weight of these factors in favour of implementing the policy must then be measured against the weight of any evidence as to the potential negative equality impacts of the policy,
- Are there any further recommendations? Is further engagement needed? Is more research or monitoring needed? Does there need to be a change in the proposal itself?

[23] **Action Planning:** The Equality Duty is an ongoing duty: policies must be kept under review, continuing to give ‘due regard’ to the duty. If an assessment of a broad proposal leads to more specific proposals, then further equality assessment and consultation are needed.