Public Document Pack

Shropshire Council

Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: Wednesday, 5 September 2018

Committee:
Health and Wellbeing Board

Date: **Thursday, 13 September 2018**
Time: **9.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Wellbeing Board

VOTING
Shropshire Council Members
Lee Chapman – PFH Health and Adult Social Care (Co-Chair)
Nicholas Bardsley – PFH Children's Services and Education
Lezley Picton – PFH Culture & Leisure

Prof Rod Thomson - Director of Public Health
Andy Begley - Director of Adult Services
Karen Bradshaw - Director of Children Services

Shropshire CCG
Dr Simon Freeman – Accountable Officer
Dr Julian Povey – Clinical Chair (Co-Chair)
Dr Julie Davies – Director of Performance & Delivery

Jane Randall-Smith – Shropshire Healthwatch
Rachel Wintle – VCSA

NON-VOTING (Co-opted)
Neil Carr - Chief Executive, South Staffordshire & Shropshire Foundation Trust

Simon Wright - Chief Executive, Shrewsbury & Telford Hospital Trust

Jan Ditheridge - Chief Executive Shropshire Community Health Trust

Dr Tony Marriott - Chair GP Federation

David Coull – Chairman, Shropshire Partners in Care (Chief Executive Coverage Care Services)

Mandy Thorn - Business Board Chair (Managing Director Marches Care)

Bev Tabernacle – Director of Nursing, Robert Jones & Agnes Hunt Hospital.

Your Committee Officer is: **Shelley Davies** Committee Officer
Tel: 01743 257718 Email: shelley.davies@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

To receive apologies for absence and any substitutions notified to the clerk before the meeting.

2 Disclosable Pecuniary Interests

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

3 Minutes (Pages 1 - 8)

To confirm as a correct record the minutes of the meeting held on 5 July 2018.

Contact: Michelle Dulson Tel 01743 257719.

4 Public Question Time

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14.

5 System Update (Pages 9 - 52)

Regular update report to the Health and Wellbeing Board is attached:

i. The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin
A report is attached.

ii. Future Fit
A verbal update will be given.

iii. Shropshire Care Closer to Home
A report is attached.

Contact: Phil Evans, STP Director, Telford and Wrekin CCG / Lisa Wickes, Head of Out of Hospital Commissioning and Redesign, Shropshire CCG

6 Report from the HWB Joint Commissioning Group

Regular update reports will be made to the Board on:

i Better Care Fund Update & Performance – Report to follow.
Contact: Penny Bason, STP Programme Manager.

7 STP Estates update (Pages 53 - 78)

A report is attached.
Contact: Becky Jones, Strategic Estate Advisor, Community Health Partnerships

8 Transforming Care Partnership (TCP) update

Report to follow.
Contact: Di Beasley, Head of Transforming Care Partnership, Telford & Wrekin CCG

9 Food Poverty Alliance - Action Plan (Pages 79 - 160)

A report is attached.
Contact: Chris Westwood, Service Delivery and Improvement Manager, Shropshire Council

10 Technology Enabled Care Projects (Pages 161 - 164)

A report is attached.
Contact: James Warman, Assistive Technology & Telecare Co-ordinator, Housing Services, Shropshire Council

This page is intentionally left blank

Committee and Date

Health and Wellbeing Board

13 September 2018

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 5 JULY 2018
10.30AM – 12.45PM

Responsible Officer: Michelle Dulson
Email: michelle.dulson@shropshire.gov.uk Tel: 01743 257719

Present

Councillor Lee Chapman (Co-Chair)	PFH Health and Adult Social Care
Dr Julian Povey (Co-Chair)	Clinical Chair, Shropshire CCG
Nicholas Bardsley	PFH Children's Services and Education
Lezley Picton	PFH Culture and Leisure
Andy Begley	Director of Adult Services
Dr Julie Davies	Director of Performance and Delivery, Shropshire CCG
Jane Randall-Smith	Shropshire Healthwatch
Irfan Ghani	Public Health
Neil Carr	Chief Executive, SSSFT
Kathy Riley	MD, Coverage Care Services Limited

Also in attendance:
Penny Bason, Pam Schreier, Val Cross, Lisa Wicks, Stewart Smith, Gordon Kochane, Laura Fisher, Tanya Miles.

18 **Apologies for Absence and Substitutions**

The following apologies were reported to the meeting by the Chair

Neil Nisbet	Finance Director and Deputy Chief Executive, SATH
Karen Bradshaw	Director of Children's Services
David Coull	Chief Executive Coverage Care Services Limited
Sarah Hollinshead-Bland	Service Manager for Adult Safeguarding
Phil Evans	STP Director
Rod Thomson	Director of Public Health
Simon Freeman	Accountable Officer, Shropshire CCG

The following substitutions were also notified:

Irfan Ghani substituted for Rod Thomson, Director of Public Health.

19 **Disclosable Pecuniary Interests**

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

20 Minutes

It was confirmed that Dr Julie Davies had tendered her formal apologies for the meeting.

RESOLVED:

That the Minutes of the meeting held on 24 May 2018, be approved and signed by the Chairman as a correct record, subject to the above.

21 Public Question Time

The Chairman drew attention to a letter received from NHS England which was a formal request for a review of a controlled locality following receipt of an application to open a new pharmacy in a controlled locality, namely Baschurch.

Councillor Bardsley explained that this matter had been discussed by both Baschurch and Ruyton XI Towns Parish Councils, and although it was accepted that the area was growing rapidly, and at some stage it may no longer be appropriate to remain a controlled locality, at the present time, it was felt to be very much a rural area with the vast majority of patients coming from the rural area and as such should remain a controlled locality.

The existing GP practice had a dispensary from which it relied upon to subsidise the income of the practice and it was felt that this would be jeopardised if there was a competitor within the locality.

The Chairman informed the Board that the matter had been discussed with the Director of Public Health who confirmed that Emma Sandbach would be meeting with the author of the letter following which the Health and Wellbeing Board would have an opportunity to make written representations, subject to the outcome of that meeting.

Board Members agreed for a response to be sent along the lines discussed.

Mr John Bickerton referred to questions he had asked at previous meetings to which he felt he had not received satisfactory responses. The Chairman felt that Mr Bickerton's questions had been fully answered by the Director of Public Health via letter and in person. He confirmed that the Better Care Fund was on today's agenda and Mr Bickerton's concerns would be taken on board.

22 System Update

22.i The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin

Penny Bason, the Health and Wellbeing Co-ordinator introduced and amplified the STP Programme update (copy attached to the signed Minutes).

She reminded the Board of the priorities for STP that had been agreed and touched on the timeline of key STP activities.

The Health and Wellbeing Coordinator drew attention to the STP System thinking which included national leads engagement, developments in the system governance framework, the better use of data and partnership working. She then highlighted the Key Progress since the last review meeting.

Finally, the Health and Wellbeing Coordinator touched on the System Organisational Development & Leadership and the NHS England Dashboard which was included for information.

Concern was raised that an executive lead had not yet been identified for the digital roadmap work. It was felt that the STP Programme Board needed to mobilise that work stream. In response, the Health and Wellbeing Coordinator reported that work was ongoing to identify a lead and she would take the comments back to the STP Board.

The Health and Wellbeing Coordinator answered a number of queries and confirmed that there was a significant amount of work still to be done. In response to a query the Health and Wellbeing Coordinator explained that the market place event had been cancelled due to capacity and officer time, and it was felt to be a step too far at the present time.

22.ii Future Fit

Pam Schreier, the Communications and Engagement Lead for Future Fit gave an update (copy of slides attached to signed Minutes). She informed the Board that they were 5 weeks into a 14 week consultation and she drew attention to the key activities to date which included the following:

- Four well attended public exhibitions;
- Pop up displays;
- Meetings with seldom heard groups;
- Engagement with patient groups and GPs;
- Local Joint Committees;
- Involving Councillors, MPs and Welsh Assembly Members;
- Ongoing staff engagement;
- Media liaison.

The Communications and Engagement Lead confirmed that all comments and feedback were being captured. She informed the Board that 1050+ completed surveys had been received, with 3,400+ visits to the website and more than 110,000 impressions on twitter.

She reported that a mid-point review would be taking place to analyse the data received to date in order to assess and inform future engagement activities.

RESOLVED: That the updates be noted.

23 **Report from the HWB Joint Commissioning Group**

23.i Better Care Fund Update & Performance

Penny Bason, the Health and Wellbeing Co-ordinator introduced and amplified the report (copy attached to the signed Minutes) which provided an update on the progress on the Better Care Fund (BCF) development and development of the section 75 Partnership Agreement (pooled budget), it also sought delegated authority to the HWB Joint Commissioning / Delivery Group to take the detailed work forward.

It was confirmed that at the last meeting the S75 Partnership Agreement had not yet been signed off and it was confirmed that the agreement was still being worked through and that a revised draft was attached at Appendix A of the report. The key differences to the previous draft agreement were set out at Paragraph 1.4 of the report, whilst paragraphs 1.5 to 1.20 set out the schedules to the agreement which required further work.

The Health and Wellbeing Coordinator informed the Board that there were three options for risk sharing however, it was not clear whether the three alternatives had been agreed as acceptable to each organisation.

The Chairman expressed his concern that agreement had not yet been reached especially on the Terms of Reference and although it was clear that work needed to be done, there was no clear mandate setting out what work the Board was being asked to delegate to the HWB Joint Commissioning / Delivery Group.

It was suggested that an Extraordinary meeting of the Health and Wellbeing Board could be arranged in order for the Terms of Reference to be agreed if the Board felt delegation was not appropriate.

The Chairman proposed that the Health and Wellbeing Board impose a timeline of four weeks for completion of the Agreement and if progress was not achieved within four weeks then a letter of concern would be written to NSH England in order to escalate the situation.

RESOLVED:

a) That the HWBB approve the Draft Partnership Agreement found in Appendix A, and delegate Authority to the HWB Joint Commissioning / Delivery Group to determine the detail of the schedules as described in Paragraphs 1.5 to 1.10 of the report; and
b) That work be taken forward on the schedules and recommendations as set out in report.
c) That if progress was not achieved within four weeks then a letter of concern would be written to NSH England in order to escalate the situation.

23.ii Healthy Lives

Val Cross, the Health & Wellbeing Officer and Healthy Lives Co-ordinator gave a presentation (copy attached to the signed Minutes) which provided an update on the Healthy Lives Programme and covered the following areas:

- Upscaling the Healthy Lives Programme for 2018/19;
- Communications Strategy;

- Shropshire Visibility at regional and national level;
- Social Prescribing;
- Carers;
- Cardio-Vascular Disease (CVD);
- Diabetes (pre-diabetes);
- Mental Health;
- Musculoskeletal system (MSK), Falls and Physical Activity;

RESOLVED: That the update be noted.

24 **Shropshire Care Closer to Home**

24 Lisa Wicks, the Head of Out of Hospital Commissioning & Redesign Shropshire Clinical Commissioning Group introduced and amplified her report (copy of report and slides attached to the signed Minutes) which provided an update on the Shropshire Care Closer to Home project. She informed that Board that the objective of the project was to provide greater care to people in their homes where appropriate.

The Head of Out of Hospital Commissioning & Redesign informed the Board that Governance underpinned the programme board which was made up of key stakeholders across the health economy and enabled its work to be open and transparent. A detailed SWOT Analysis had provided the programme board with real learning about gaps in their Commissioning Strategies.

The Head of Out of Hospital Commissioning & Redesign briefly touched on system integration and planning and informed the Board that a further stakeholder event was being held on 25 July 2018. She then went on to explain that the programme was divided into three phases, the first of which was presently operational in the form of the Frailty Intervention Team based at the Royal Shrewsbury Hospital. Phase 2 concerned the development of a model for case management for primary care, which had just been completed, whilst Phase 3 would introduce a model for Hospital at Home along with a crisis response team and the provision of step-up beds.

In response to concerns that the VCS had not been involved, the Head of Out of Hospital Commissioning & Redesign gave assurance that the VCS would be involved and an invite to the Stakeholder event on 25 July had been extended to them. The Chairman paid tribute to Rachel Wintle for her hard work with the VSCA and hoped that a suitable replacement would be chosen as soon as possible.

The Head of Out of Hospital Commissioning & Redesign confirmed that a further update would be provided to a future meeting of the Board later in the year.

RESOLVED: That the contents of the report and presentation be noted.

25 **Partnership Summit**

25. Stewart Smith, the Personalisation Development Officer introduced and amplified his report (copy attached to the signed Minutes) which gave an update on the recent Partnership Boards Summit meeting which brought together a wide range of experts

from Adult Social Care, Children's Services, Health and the voluntary sector. The focus of the event was co-production and discussion took place about how to create the right culture and environment for effective co-production and how to ensure people were at the heart of all we do.

The Personalisation Development Officer informed the Board that a meeting of the Partnership Board Chairs had taken place on 20 June 2018 where four key actions were identified, set out in Paragraph 2 of the report.

The Chairman was pleased that the Summit had been so well attended and that there had been a good discussion on co-production. He felt that the next item to address would be the 'So what?' questions and whether it would make a difference to how business was conducted.

The Personalisation Development Officer hoped that if the different organisations were sighted on what each other were involved with then there would be no duplication. They would therefore be hard pressing the Board Chairmen to get together on a quarterly basis to discuss the work each were doing.

RESOLVED: That the contents of the report be noted.

26 **Suicide Prevention Strategy**

26. Gordon Kochane, the Public Health Speciality Registrar introduced and amplified his report (copy attached to the signed Minutes) which provided an update on the work of the Suicide Prevention Action Group including delivery of the Suicide Prevention Strategy.

The Public Health Speciality Registrar highlighted the Mental Health Needs Assessment quick notes which he recommended people read in full. He reported that a meeting of the Mental Health Strategy Task and Finish Group was taking place that afternoon in order to shape what the Suicide Prevention Strategy would look like. He also informed the Board of a Suicide Prevention event taking place on 11 September at Shrewsbury Football Club which was open to the wider community and was looking to identify the hidden population, look at what could be done to help spread the message in order to reduce the stigma, raise awareness of the risk and to reach those in crisis as early as possible.

The Public Health Speciality Registrar drew attention to the work of the Suicide Prevention Action Group in relation to its communications plan and work to produce a 'z' card which would be discrete and include various information about who to contact in a crisis, with the tag line 'Pick up the phone, you're not alone'.

The Public Health Speciality Registrar requested assistance from the Board in identifying any groups / guest speakers / those affected / representatives from high risk groups etc that could be invited to the Suicide Prevention network meeting in order to talk about their experiences and help to identify the hidden populations at risk.

Concern was raised that the impact on primary care was not being considered as a high percentage of mental health was managed at a primary care level. The Public

Health Speciality Registrar felt that it would be helpful to have a GP Practice representative at the event also.

RESOLVED: That the contents of the report be noted.

27 **HOST provision and Homeless Reduction Act**

27. The reports of the Director of Adult Services had been received for information (copy attached to the signed Minutes). Laura Fisher, the Housing Assistance Manager introduced and amplified the reports which updated the Board on changes brought about by the Homeless Reduction Act 2018 and the work being undertaken in regard to rough sleeping in the county including the Homeless Outreach Triage Service.

The Housing Assistance Manager gave a brief summary of the most significant changes brought about by the Homeless Reduction Act 2018 and reported that this had led to a significant increase in workload for all officers due to an increase in the number of clients presenting as having a housing need, an increase in the length of time to interview and the ongoing reviewing of personalised housing plans for all open cases. She then touched on the three elements of funding and answered a number of queries.

The Housing Assistance Manager informed the Board of the work being done by the Rough Sleeper Task Force and the Host service, a multi-agency approach to support those identified rough sleepers.

The Board felt that a multi-agency approach worked extremely well and had the best opportunity for success.

28 **Tech Severn Event**

28. The report of the Director of Adult Services had been received for information (copy attached to the signed Minutes) which informed the Board of the first Tech Severn Conference taking place on 17 July 2018 at Theatre Severn. The event would be looking at how technology may help solve many of the challenges facing councils and local businesses in the future and would concentrate on four centres of excellence, namely: Assistive technology; Digital Health; Eco technology and modern methods of constructions.

It was hoped that by looking at these areas it would begin to help address the increasingly older population and their helathcare needs in a very rural county by turning towards technology to see how care could be delivered more efficiently and effectively. A number of such projects would be showcased at the event.

Signed …………………………………………………… (Chairman)

Date:

This page is intentionally left blank

Health and Wellbeing Board
Meeting Date 13th September 2018

Item Title: Shropshire, Telford & Wrekin STP updates

Responsible Officer: Phil Evans, STP Director, Telford & Wrekin Clinical Commissioning Group

Email: phil.evans1@nhs.net

REPORT

A presentation of Shropshire, Telford & Wrekin STP updates will be given. Copies of the slides are provided.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices

This page is intentionally left blank

Shropshire, Telford & Wrekin STP

Sustainability and Transformation Plan

Footprint Name and Number:
Shropshire and Telford & Wrekin (11)

Region:
Shropshire and Telford & Wrekin

STP Directors Update

August 2018

Our vision for health and care services in Shropshire, Telford & Wrekin

https://www.england.nhs.uk/systemchange/view-stps/shropshire-and-telford-and-wrekin/

Priorities

•Focusing on neighbourhoods to prevent ill health and promoting the support that local communities offer to help people lead healthier lives and encourage them to care for themselves where appropriate.

•Multi-disciplinary neighbourhood care teams working closer together supporting local people with long-term health conditions, and those who have had a hospital stay and return home needing further care.

•Ensuring all community services are safe, accessible and provide the most appropriate care.

•Redesigning urgent and emergency care, creating two vibrant 'centres of excellence' to meet the needs of local people, including integrated working and primary care models.

•Making the best use of technology to avoid people having to travel large distances where possible – especially important to people living in the most rural communities in Shropshire and Powys.

•Involving local people in shaping their health and care services for the future.

•Supporting those who deliver health and social care in Shropshire, Telford and Wrekin, developing the right workforce, in the right place with the right skills and providing them with local opportunities for the future.

Timeline of key STP activities June 17 – Dec 17

Pre -June 17
- STP Submission April 2017
- System OD Diagnostic undertaken
- 4 previous Interim STP Programme Directors

June - July 17
- STP Partners agreement to fund System PMO Resource
- Initial Governance structure published
- Programme Director appointed 1.0wte
- Head of PMO appointed 1.0 wte

Oct 17
- STP PMO Team approved
- First Directors Report published
- Kings Fund OD Phase 1 commences with system leaders
- Substantive PMO appointed 4.0 wte

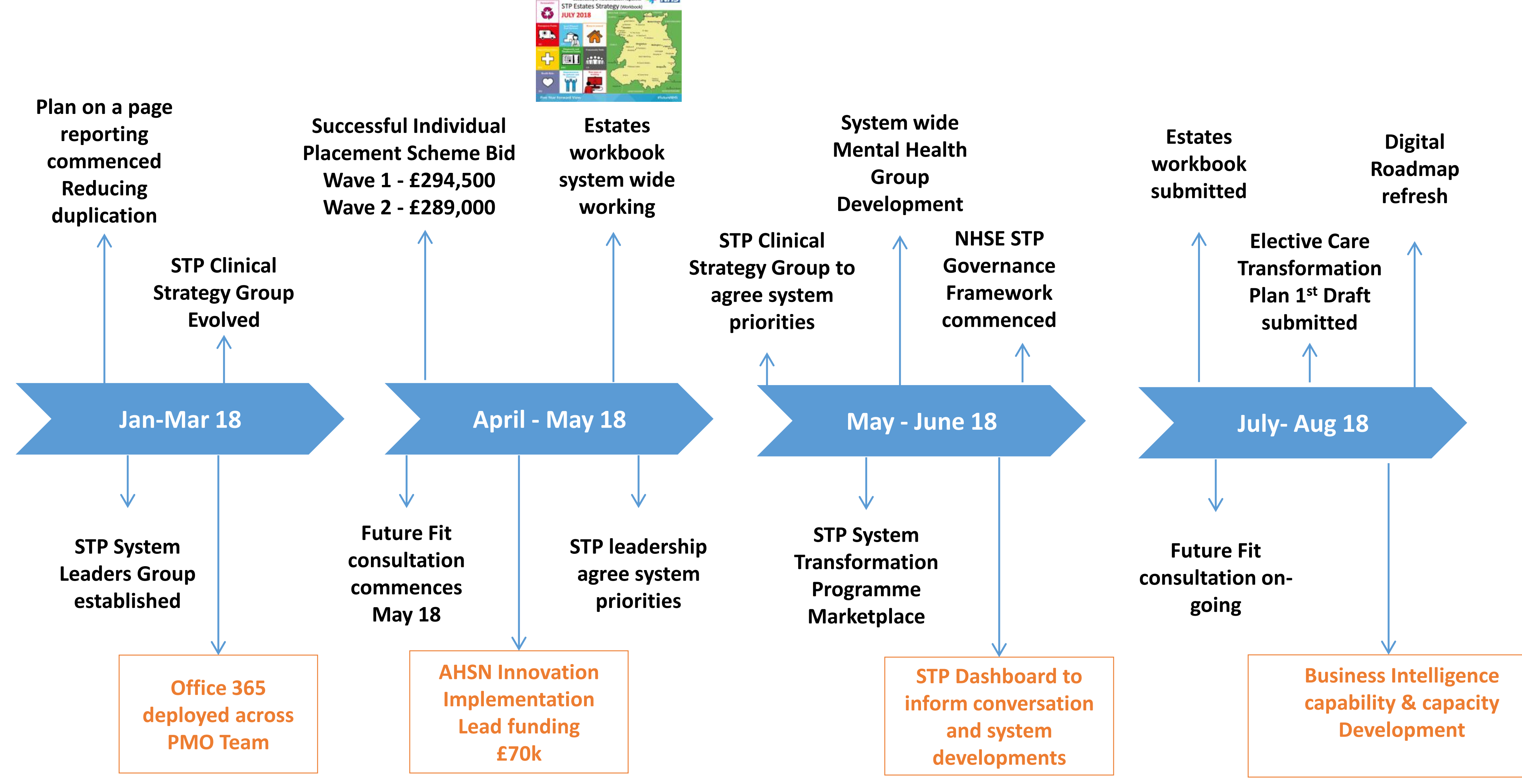
Nov 17
- STP Delivery Group workshop with Kings Fund
- Review of Delivery & Enablement Groups
- Each work Programme offered STP Resource
- System UEC Director appointed 0.8wte

Dec 17
- STP PMO aligned to Delivery or Enablement
- STP Governance structure refreshed
- Awaiting outcome of Future Fit Capital investment
- System Finance PMO appointed 1.0wte

Key appointments to enable System Development / Improvement

Page 13

Timeline of key STP activities Jan 18 – Aug 18



Timeline of key STP activities July 18 – Aug 18

July-August 18

- SharePoint established for Shropshire Care Closer to Home Programme
- System Wide Elective Care Transformation Programme commences
- STP Clinical Strategy Group Work Programme agreed
- System Mental Health Lead identified

August – Sept 18

- System wide Mental Health Programme initiated
- Future Fit Consultation concludes
- Community Services Review Programme on-going
- Community Services Review concludes
- Business Intelligence capability & Capacity Development

Sept - Oct 18

- Future Fit Consultation analysis commences
- SharePoint established for Elective Care Transformation
- System Pharmacia Programme to commence
- STP Dashboard to inform conversation and system developments

Oct – Nov 18

- System Winter Planning
- SharePoint established for Clinical Strategy Group
- SharePoint established for Urgent Care Tracker
- SharePoint offered as system way of working across a number of programmes supporting "Virtual" collaboration

Page 15

Shaping STP System Thinking

- STP Review meetings with NHSE & I
  - Next review meeting is 6th Sept, we continue to be "Level 3" – making progress
- System wide working gaining momentum – next slide shows system wide groups
  - STP Leadership Group – Integrated Care System / Partnership developments
  - Clinical Strategy Group – meeting bi-monthly and work programme developing around STP Priority areas
  - Mental Health Group – just being establish
  - Elective Care Transformation – established and work programme drafted
  - Digital Enablement – Roadmap and work programme being reviewed
  - Population Health & Prevention – being established, system leads identified
  - Urgent Care, Frailty, Winter Planning – established and work programme underway
  - System wide Estates – submission completed
  - System Wide Pharmacia – draft formed and work programme being developed
  - Strategic Workforce Partnership working for our system transformation
    - Strategic planning
    - Organisational development
    - Education & training
  - Secondary Care reconfiguration (Future Fit) – consultation ongoing
  - Shropshire Community Services Review – work programme with GE Finnemore / Neil McKay
  - Out of Hospital Programmes
    - Shropshire Care Closer to Home
    - Telford & Wrekin Neighbourhood working

System Wide Working

Strategic Development & Leadership

Recruitment of independent STP Chair

STP System Leaders Group

Local Workforce Action Board (LWAB)

STP Clinical Strategy Group

Health & Well-being Boards

Community Services review work programme

System Communication & Engagement

System wide consultation and feedback through existing mechanisms

Strategic Enablement

Strategic Estates Group

Strategic Back Office

Digital Enablement Group

Strategic Workforce Planning

Strategic System Finances

System population health & prevention

System Business Intelligence

Strategic Delivery of change

Hospital reconfiguration (Future Fit)

Urgent & Emergency Care

- Winter Planning
- High Impact Changes
- Frailty
- IUC / 111

Out of Hospital Care Delivery

- Shropshire Care Closer to Home
- Telford & Wrekin Neighbourhoods

Primary Care Transformation

Mental Health Transformation

Cancer & End of Life

Elective Care Transformation – 8 workstreams identified
1.Procedures of Limited Clin Value 2. MSK
3. Ophthalmology 4. Diabetes 5. MRI
6. Out-Patients 7. Neurology 8. Dermatology

Pharmacia Programme

Local Maternity Services

STP Dashboard – Midlands & East only
– no new report since April 2018 – awaiting refresh

STP Progress Dashboard
April 2018 update

Key:

- Highest performing
-
-
- Lowest performing

Page 18

STP	Region	July 2017 baseline assessment	A&E waiting time performance	Referral to Treatment waiting time performance	Providers in special measures	CQC hospital performance	Healthcare associated infections - MRSA	Healthcare associated infections - c. difficile	Extended access	Patient satisfaction	Improving Access to Psychological Therapies recovery rate	Early Intervention in Psychosis 2-week waits	% of cancers diagnosed at stage 1 or 2	Cancer one-year survival	62-day waits	Cancer patient experience score	Emergency admissions rate	Emergency bed days rate	Delayed Transfers of Care rate	System-wide leadership	CCG/Trust performance vs. financial operating plan
			Hospital Performance						Patient Focused Change								Transformation				
			Emergency	Elective	Safety				General practice		Mental health		Cancer				Prevention			Leadership	Finance
			Mar-18 YTD	Feb-18	Apr-18	Q2 1718	Q4 16 - Q3 17	Q4 16 - Q3 17	Oct-17	2017	Oct-17 to Dec-17	Mar-17 to Feb-18	2016	2015	17-18 Q3 YTD	2016	Mar-17 to Feb-18	Mar-17 to Feb-18	Mar-17 to Feb-18	Jun-17	16/17
Derbyshire	M&E	Category 2 - advanced	91.1%	91.8%	No	58	0.3	15.9	30.7%	86.3%	54.4%	88.9%	48.7%	71.5%	78.2%	8.8	102	490	82	2 - Established	0.9%
Shropshire and Telford and Wrekin	M&E	Category 3 - making progress	78.7%	90.3%	No	60	0.0	10.5	49.6%	85.9%	55.7%	35.9%	50.0%	71.7%	83.7%	8.7	92	414	96	2 - Established	-1.2%
Leicester, Leicestershire and Rutland	M&E	Category 2 - advanced	84.5%	88.1%	No	50	0.6	13.2	65.2%	81.8%	51.2%	72.7%	50.3%	71.3%	79.9%	8.6	97	501	112	1 - Advanced	0.5%
Mid and South Essex	M&E	Category 2 - advanced	86.2%	85.3%	No	60	2.6	14.1	21.8%	81.1%	50.6%	77.1%	54.2%	71.8%	72.6%	8.8	95	440	113	2 - Established	0.2%
Nottinghamshire	M&E	Category 2 - advanced	86.6%	92.4%	No	58	0.6	17.2	26.1%	85.7%	54.0%	73.0%	50.0%	71.5%	83.2%	8.6	93	492	124	1 - Advanced	0.8%
Milton Keynes, Bedfordshire and Luton	M&E	Category 1 - outstanding	94.3%	90.2%	No	66	0.9	4.5	27.2%	81.2%	48.7%	89.4%	55.0%	71.4%	85.5%	8.6	109	521	127	1 - Advanced	0.6%
The Black Country	M&E	Category 3 - making progress	87.2%	90.6%	Yes	59	0.3	10.7	61.2%	80.9%	55.4%	81.3%	52.1%	70.0%	82.3%	8.7	110	538	133	2 - Established	-0.1%
Norfolk and Waveney	M&E	Category 2 - advanced	87.8%	84.9%	Yes	52	0.0	15.7	1.6%	86.7%	34.3%	65.3%	53.9%	72.3%	84.6%	8.8	88	380	143	3 - Developing	-0.2%
Lincolnshire	M&E	Category 3 - making progress	87.2%	86.7%	Yes	58	1.1	19.2	0.0%	83.9%	52.4%	72.4%	48.2%	71.4%	71.4%	8.5	88	434	152	2 - Established	0.0%
Suffolk and North East Essex	M&E	Category 2 - advanced	90.8%	88.2%	No	51	1.0	15.7	65.3%	85.9%	50.0%	76.1%	55.5%	72.0%	80.0%	8.8	91	411	152	2 - Established	1.4%
Hertfordshire and West Essex	M&E	Category 3 - making progress	80.4%	88.1%	No	57	0.9	14.4	34.5%	84.7%	51.6%	72.5%	54.8%	72.8%	82.5%	8.6	88	448	171	2 - Established	-0.7%
Coventry and Warwickshire	M&E	Category 2 - advanced	86.5%	86.5%	No	53	0.2	7.6	39.6%	85.6%	50.1%	56.0%	47.6%	71.5%	84.6%	8.8	99	520	187	2 - Established	1.1%
Herefordshire and Worcestershire	M&E	Category 2 - advanced	79.8%	83.5%	Yes	53	0.6	13.1	62.9%	88.3%	51.9%	80.0%	53.4%	72.5%	74.3%	8.7	83	385	190	1 - Advanced	-0.4%
Cambridgeshire and Peterborough	M&E	Category 2 - advanced	85.1%	89.7%	No	63	0.8	17.4	28.0%	85.9%	52.3%	78.4%	56.1%	74.0%	85.1%	8.8	89	444	192	1 - Advanced	-1.2%
Birmingham and Solihull	M&E	Category 2 - advanced	88.6%	91.0%	No	56	0.5	14.1	19.6%	82.4%	53.2%	71.6%	55.5%	70.7%	83.0%	8.77	126	566	209	2 - Established	1.1%
Staffordshire	M&E	Category 4 - needs most improvement	81.9%	82.5%	No	59	0.7	16.0	18.2%	84.6%	56.1%	66.1%	53.3%	70.9%	78.6%	8.7	111	515	227	3 - Developing	-4.1%
Northamptonshire	M&E	Category 4 - needs most improvement	87.2%	86.7%	Yes	58	0.0	10.1	0.0%	82.6%	43.4%	91.7%	46.3%	71.7%	81.8%	8.6	110	663	301	4 - Early	-0.3%

STP are working with CSU to develop a “System” reporting Dashboard, bespoke to the Programme of work
More details to follow in next update.

Aristotle Business Intelligence

Dashboard: ICS Priority Metrics

MIDLANDS AND LANCASHIRE COMMISSIONING SUPPORT UNIT

Dashboards | Levels | Options

Dashboard Chosen: ICS Priority Metrics
Area Chosen: Lancashire & South Cumbria
Tile View Options

U&EC
- 4 Hour A&E Waits
- % Amb handover 15
- % NE acute admissions via A&E

Enhancing Quality of Life for People with Long Term Conditions
- % CPA 7 Days

RTT
- % Incomplete 18 Wks RTT
- % Dementia Prevalence
- % IAPT Access
- % IAPT Recovery
- % IAPT 6 Weeks Waits
- % IAPT 18 Weeks Waits
- Crisis Support Unit in Place
- IAPT Roll Out
- Number of CYPED Routine 4 Wks
- Number of CYPED Urgent 1 Wk

General Practice
- Convenient Access to GP Services
- Evening and weekend GP Appts
- Additional Drs in General Practice
- Additional GP trainees per year

Ensuring that People Have a Positive Experience of Care
- % Admitted completed 18 wk

Cancer
- % Cancer 2 Wks Breast
- % Cancer 31 Days Radiotherapy
- % Non Admitted Completed 18 Wk
- > 52 Wk Waits
- % Cancer 31 Days Surgery
- % 2 Wks Cancer Urgent

ICS Level: Lancashire & South Cumbria

4-Hour A&E Waiting Time Target (Monthly Aggregate based on HES 15/16 ratio)

Provider		
Value	Jul-18	83.39%
Target	Jul-18	95.00%
Forecast	Aug-18	83.69%

Commissioner		
Value	Jul-18	83.37%
Target	Jul-18	95.00%
Forecast	Aug-18	83.60%

4 Hour A&E Waits

Organisation

Actual | Linear Forecast

Provider | Commissioner

Apr-16, May-16, Jun-16, Jul-16, Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17, Jan-18, Feb-18, Mar-18, Apr-18, May-18, Jun-18, Jul-18, Aug-18, Sep-18, Oct-18

ICS | Integrated Care Partnerships \ Integrated Care Organisations

	Provider	Commissioner
Lancashire & South Cumbria	83.39%	83.37%
Bay Health & Care Partners	87.21% UHMB	87.09%
Central Lancashire	85.16% LTH	85.05%
Fylde Coast	80.66% BTH	80.74%
Pennine Lancashire	82.51% ELHT	83.00%
West Lancashire		85.77%

ICP	CCG	Value
Bay Health & Care Partners	Morecambe Bay CCG	87.09%
Central Lancashire	Chorley & South Ribble CCG	85.15%
Central Lancashire	Greater Preston CCG	84.97%
Fylde Coast	Blackpool CCG	80.67%
Fylde Coast	Fylde & Wyre CCG	80.87%
Pennine Lancashire	Blackburn With Darwen C..	82.52%
Pennine Lancashire	East Lancashire CCG	83.21%
West Lancashire	West Lancashire CCG	85.77%

Page 19

Transformation Delivery Programmes

The next set of slides show key programmes through a simple set of slides that captures high level programmes plans.

Commissioner Led Transformation Programmes

Shropshire – Care Closer to Home

Phase 1

- Phase 1 is operationally functional, it is the Frailty Intervention Team (FIT) based within our local general hospital.
- The FIT works with frail patients to ensure that they experience as efficient an in-patient service as is possible.
- The FIT helps us to understand the scale of the problem we need to address as a health economy, and the potential impact that can be achieved through getting things right in the community for our population.

Phase 2

- Phase 2 is about introducing Case Management to primary care.
- This will enable risk-stratification of our patients.
- This will enable those most at risk of acute admission to be pro-actively managed.
- This will enable a clear understanding of what the requirements of the models in phase 3 are.
- This will enable effective, fit for purpose strategic workforce planning.

Phase 3

- Phase 3 will introduce a Hospital at Home Model, a Crisis Response Team and the provision of Step-up beds capable of managing high levels of need acuity.
- Phase 3 will enable the full benefits of case management to emerge.
- Phase 3 will provide for significant market-place development.
- Most importantly Phase 3 will enable us to serve our populations in a far more patient centred way than we can possibly achieve at this time.

NHS
Shropshire
Clinical Commissioning Group

Shropshire – Care Closer to Home - Progress

Phase 1 - update

- This remains operationally functional, it is the Frailty Intervention Team (FIT) based within our local general hospital.
- FIT requirements in SaTH should taper off and reduce in time with the implementation of Phase 2. Positive impact reported with plans being developed to expand and rollout to PRH.

Phase 2 - update

- scoping and design work on Phase 2, risk stratification and case management has been completed
- Final preferred model for risk stratification and case management has been agreed. Being presented to the CCC for consideration in August.

Phase 3 - update

- Scoping and design of possible model options for Phase 3 (Crisis intervention, Rapid Response and Hospital at Home) has commenced.

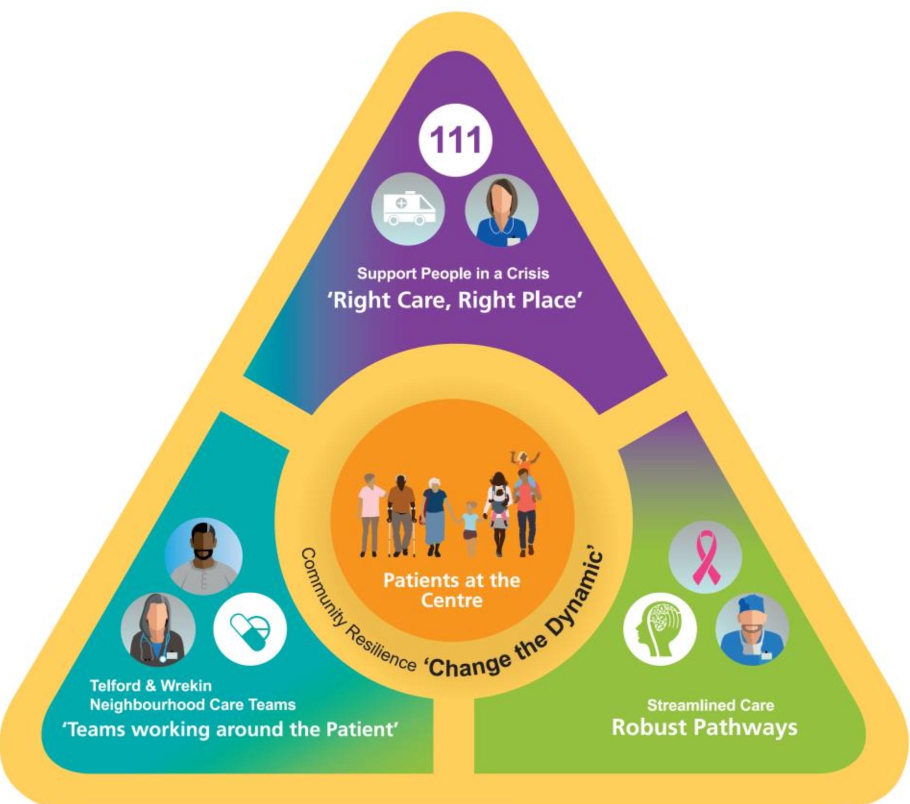
Telford & Wrekin Neighbourhood Programme

Exec Lead – Anna Hammond

Project Lead – Ruth Emery

Programme needs to:

1. Improve availability and access to activities that will prevent the development of poor health
2. Improve early identification of illness to stop further deterioration
3. Promote self-care/self-management
4. Demonstrably increase effective community support available to support out of hospital care
5. Enable Primary Care Resilience (feeds into Primary Care local strategy)
6. Reduce dependency on statutory services
7. Develop a sustainable workforce
8. Reduce social isolation
9. Empowerment for people and professionals
10. Introduce new roles and ways of working
11. Ensure robust information accessible for communities and the professionals working with them
12. Ensure there are services and activities available closer to home
13. Develop well connected services and communities



System Partners / Enablers need to:

All stakeholders in the Telford and Wrekin area need to be open to change and new ways of working

<u>Estates</u>

- Support to ensure suitable estates to enable delivery, maximising to use of current resources available in addition to the development of new facilities

<u>Communications</u>

- Support with health literacy including mental health awareness

<u>Digital</u>

- Solution needed for shared patient records in particular those patients at risk
- Expertise/input regarding optimal use of assistive technology and how this can support the programme, and how IT can be utilised to work more effectively
- Develop data sharing agreement required across organisations

<u>Workforce</u>

- Supporting teams to develop a shared vision – neighbourhood working requires "virtual" teams and expertise on how this can work optimally is needed

<u>Prevention</u>

- Prevention is embedded throughout the programme, ensure awareness of programme and link where required

<u>Out of Hospital</u>

- Support with delivery of projects within programme – practical support needed

<u>Mental Health</u>

Development of STP wide strategy and governance .

Practical project support for AC OOA framework for 0-25 mental health (must do quickly) amd OOA adult mental health placements (longer term QIPP)

Crisis pathway for 16-18 year old children (including children who don't meet tier 4 threshold, those who have challenging behaviour and setting up PARA registers)

Encouraging Healthy Lifestyles

Targeting obesity, smoking and alcohol

Community Resilience

To support strong communities and improving access to community resources, including drop in service for mental health crisis, support for carers, the development of wellbeing hubs

Direct Care in the Community

To include the introduction of a dedicated care homes team, development of integrated neighbourhood teams, and review of intermediate care beds

Specialty Review

To include Diabetes and Respiratory

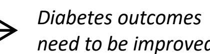
What the neighbourhood Programme Looks like for a single locality – an example

Using the data to drive the change

Description of Neighbourhood Working has fed into the Pre Consultation Business Case, including 5 year activity profiling for the acute

↑

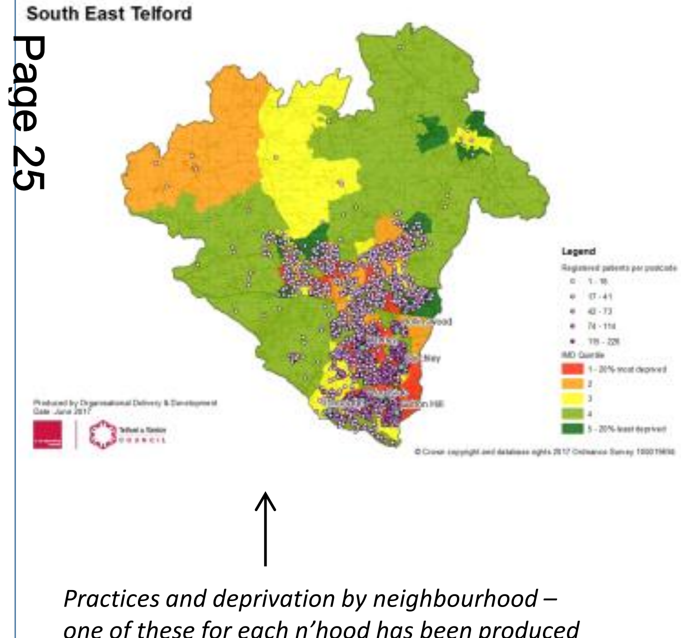
Dementia diagnosis rate (add more context)
Rising hospital admissions (add more context)



→ *Diabetes outcomes need to be improved*

Between 2016 & 2031 the T&W population is expected to increase by 23,300 (13.4%). Over half of these are 65 and over, with the 85+ ages more than *doubling* (117.6%) and the 65-84 ages increasing by 33.1%. All England is expected to grow 10.2%, a slower growth than T&W(13.2%). The largest difference is seen in the T&W 25- 44 age group which expects 11.6% growth compared with just 3.2% for England.

↓



↑

Practices and deprivation by neighbourhood – one of these for each n'hood has been produced

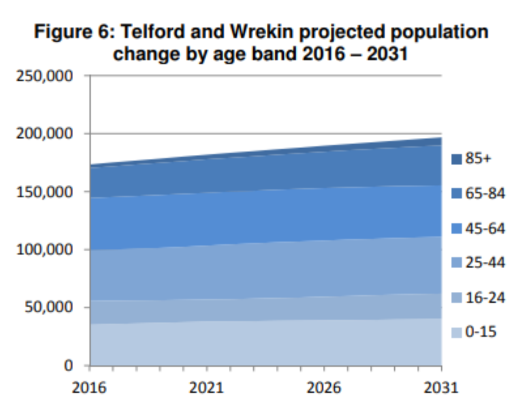


Figure 6: Telford and Wrekin projected population change by age band 2016 – 2031

NEWPORT LOCALITY: NEIGHBOURHOOD WORKING PROGRAMME PLAN ON A PAGE 2018/19 DRAFT

Neighbourhood Priorities	Neighbourhood Vision
To support the frail elderly population of Newport to stay well in their own homes To improve wound healing rates	For Newport Cottage Care to be a neighbourhood hub, hosting integrated teams, wound healing clinics, early help and support, social groups and more; strengthening the community and reducing dependency on GP practices for non medical issues

Key Projects	Who?	When?
	Public Health	
Neighbourhood "Hub" at Newport Cottage Care *To include:* *Voluntary organisations* *Early Help and Support Workers* *Assistive Technology* *Sight and hearing impairment* *Public Health*	Dr Aidan Egleston – Wellington Road Surgery Julie Smith T&W Council	Planned "go live" May 2018
Development of Integrated Team *To include:* *Social Workers* *Community Matrons* *District Nurses* *Therapy* *Mental Health*	Dr Aidan Egleston Anna Hammond - CCG Ruth Emery - CCG Sarah Dillon / Victoria Worthington – T&W Council Yvonne Gough/Sam Townsend – ShropCom	Staff fully allocated to neighbourhood: April 18 Continuation of MDT working – 18/19 ongoing
Wound Healing *Pilot neighbourhood for dedicated wound healing service taking on all complex wound care activity from practcies and disntrict nurses*	Dr Aidan Egleston Anna Hammond - CCG Yvonne Gough - ShropCom Ruth Emery - CCG	Commence pilot service: April 2018 Review of outcomes: January 2018

Programme Links

1. **Encouraging Healthy Lifestyles** – *Targeting obesity, smoking and alcohol*
2. **Community Resilience** – *To support strong communities, including drop in service for mental health crisis, support for carers, the development of wellbeing hubs*
3. **Direct Care in the Community** – *To include the introduction of a dedicated care homes team, development of integrated teams, and review of intermediate care beds*
4. **Specialty Review** – *To include Diabetes and Respiratory*

Success Measures

Neighbourhood	Start of phasing	Point at which they will be achieving 3 per week	April	May	June	July	August	September	October	November	December	January	February	March	Total	Savings based on Avg Cost NEL
Newport	April	Spells Avoided per Week	1	1	2	2	2	2	3	3	3	3	3	3	28	
		spells avoided per month	4	5	8	8	8	8	12	12	12	15	12	12	116	£ 197,200

Quality:

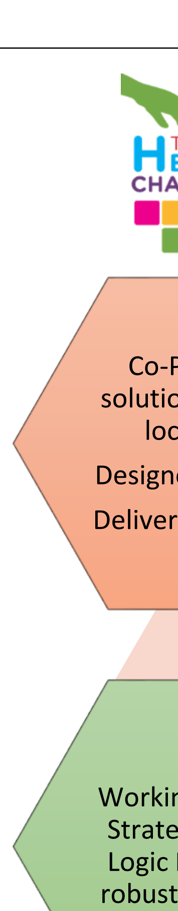
Please see individual projects for specific quality indicators

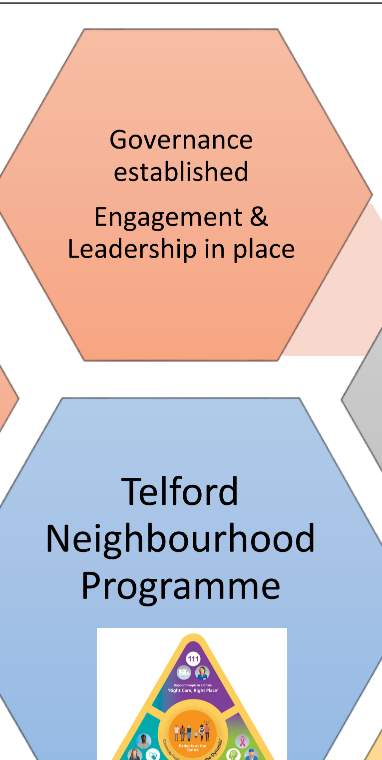
Telford Neighbourhoods – how it all fits together – delivering transformation

Case Study Examples to showcase progress

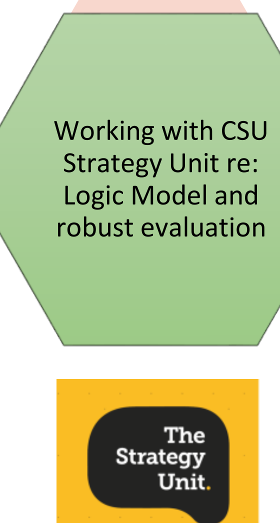
- Diabetes Management
- Hypertension Management
- Mental Health Hub – Branches
- Citizens Advice – Virtual Team
- Wound Healing project
- Community Information Portal
- Health Champions

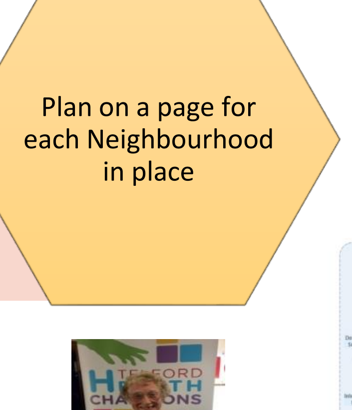
Page 26

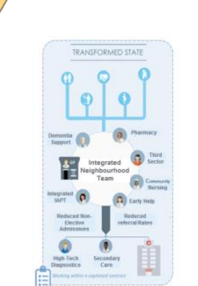


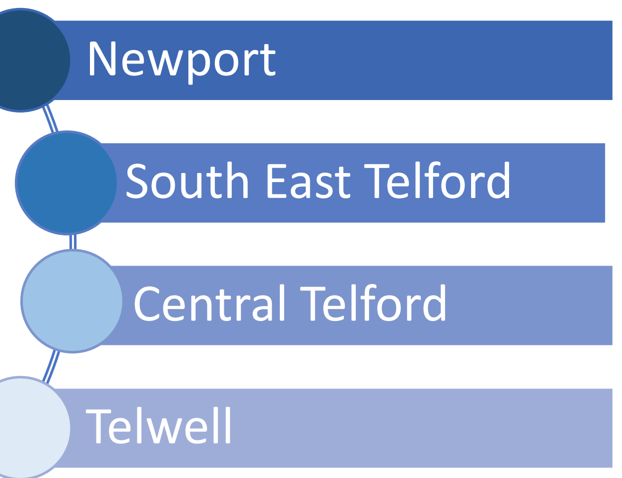


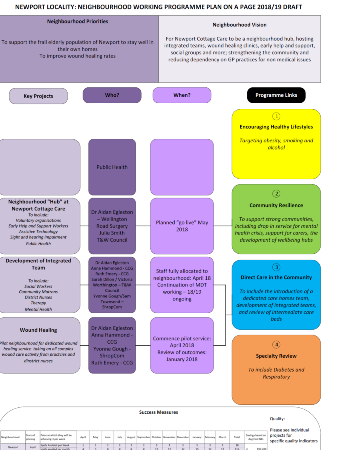
4 Neighbourhoods Formed











Primary Care Programme – GPFV

Updated Aug 2018
Next update– Oct 18

Exec Lead – Nicky Wilde & Rebecca Thornley

Project Leads – Phil Morgan

Programme needs to:

The GPFV programme has five main elements:

New models of care

- Developing an approach to "working at scale" among practices using the guidance from NHS England to define and establish local "primary care networks"
- Linking practices working at scale to wider new models of care – i.e. Care Closer to Home (SCCG) and Neighbourhood Working (TWCCG)

Extended Access

- Ensuring that 100% of the population has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at weekends/bank holidays (subject to local need) by Oct 1st 2018

Workforce

- Meeting national targets for increases in the number of GPs and other clinicians
- Retaining existing GP and other clinical staff in practices
- Developing at-scale approaches to workforce

Resilience/Workload

- Using the Resilience Fund to deliver practical, local solutions to increase resilience
- Implementing the 10 High Impact Actions

Estates and Technology Transformation Fund

- Delivering against key physical and digital projects, funded through the ETTF

In addition, CCGs are required to **invest** £3 per head, over two years, to enable Primary Care transformation.

System Partners / Enablers need to:

There are a number of enablers that would assist in the successful implementation of the GPFV programme:

Workforce

- The CCGs need to work with other health stakeholders to increase and improve the integration of workforce across different providers.
- The Care Closer to Home and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation

Digital Information and Technology

- Key projects within the GPFV, particularly extended access and implementing the 10 High Impact Actions, are dependent on IT/digital solutions

Estates Investment

- Working across key STP stakeholders (local authority, public health, secondary and community providers) to utilise and develop the current and future estate

The progress:

New models of care

- Practices in both CCGs are increasingly working in groups/localities – further work is being planned with NHS England, including attending a conference on Primary Care Networks in September
- Primary Care is inputting into the development of both Care Closer to Home (SCCG) and Neighbourhood Working (TWCCG)

Extended Access

- Current provision of evening and weekend appointments covers over 90% of the population
- Local pilots are being developed to ensure that the 100% target is met by October 1st

Workforce

- An STP Workforce Plan has been submitted with projects designed to address the recruitment and retention targets
- The CCGs are working with the STP workforce group to explore the possibility of developing banks for GPs and other clinicians.

Resilience/Workload

- Successful bids to the Resilience Fund have helped to increase resilience
- The CCGs are working with the national Time for Care team around the 10 High Impact Actions

Estates and Technology Transformation Fund

- A programme to install VOiP, VDI and WiFi across practices is being implemented
- Funding for 2018/19 projects (Skype and Telehealth) has been agreed
- Good progress has been made on a number of estates projects to address growing population GMS needs and to link with hospital service transformation

Interventions and process change milestones

- Increased levels of working at scale between practices
- 100% of the population having access to GP appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need
- Targets for workforce recruitment and retention across primary care met
- Successful implementation of the GPFV 10 High Impact Actions
- Successful implementation of ETTF funded IT and estates projects

Risks to delivery

Risks

1. Lack of alignment between the at-scale primary care plans and the Care Closer to Home /neighbourhood plans
2. Continued uncertainty around continuation of funding for extended access pilots and the post-October 1st scheme(s)
3. Inability of CCGs/GP practices to attract new GP and non-doctor clinicians to the local area
4. Pressure on revenue budgets from ETTF-funded capital estates projects
5. A change in historical culture is required to enable transformation and collaborative change in Primary Care which will take time to embed
6. Difficulty in accessing up to date and meaningful data to identify unsustainable practices who need support with resilience funding

Data

Extended Access

- Over 90% of the registered population currently has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at need – both CCGs are confident of achieving 100% access by 1st October 2018

Workforce

- NHS England targets for Shropshire STP are for 101 GPs and 47 non-Doctor clinicians to be recruited/retained by September 2020

Resilience/Workload

- Each of the practices across the STP need to implement at least two of the 10 High Impact Actions during 2018/19

Estates and Technology Transformation Fund

- VOiP Telephony Project – T&W - 16 sites now live for VOiP and Wi-Fi; SCCG – 16 sites now live for VOiP and Wi-Fi

Mental Health

Exec Lead – Clinical Lead - Professor Tony Elliot Project Lead –

Programme needs to:

1. Deliver the implementation plan for the Mental Health Forward View, ensure delivery of the mental health access and quality standards, increase baseline spend on mental health;
2. work to eliminate out of area placements and reduce PICU spend
3. Improve access to psychological therapies and ensure at least 16.8% of the population access IAPT in 2018/19 rising to 19% in 19/20 and 25% by 20/21 a key milestone under 5YFV
4. Eradicate legacy issues in CAMHS around access, backlogs and reduce waiting lists whilst also providing specialist help to Looked After Children placed in the area and overall improve delivery and efficiency
5. Provide one stop coordinated service for Adult Autism and stepdown beds for Learning Disability patients from Tier 4

System Partners / Enablers need to:

1. Work across all systems to consider mental health needs of individuals
2. Ensure services all are trauma aware
3. Focus on prevention and early intervention
4. System has a clear understanding of reasonable adjustments for individuals with mental health or learning disabilities issues
5. Close gaps in provision of Autism services for adults as there is no commissioned pathway in Shropshire
6. Improve provision and support for out of area Looked After Children
7. Eliminate inappropriate access arrangements ,improving multi-agency working and enhance understanding amongst other agencies of role of core CAMHS team and lead overall improvement of service
8. reduce treatment time in Early Intervention In Psychosis, reduce inequity in LD services
9. Have provision of both acute and PICU MH beds locally to avoid spot purchasing out of area based on competitive tariffs

The progress:

1. Extra Funding has been extended to current Provider to enable increase of Mental Health patients receiving employment support (IPS) under 5YFV
2. Scoping is now complete for the Commissioning of a clear integrated pathway for Adult Autism Disorder Spectrum, next stage will be moving into procurement process (April 2018)
3. Equity access to LD respite agreed with Local Authority
4. Scoping underway to reduce PICU bed use out of area and improve quality, QIPP benchmarking in progress
5. Delivery issues in CAMHS being addressed via a Remedial Action Plan with clear milestones and objectives. Operational Group in place monitoring progress
6. Dementia diagnosis rate for Shropshire is presently at 69.9% against the national benchmark of 66.7%.
7. CCGs meeting entry, recovery and waiting times targets for Access to Psychological services

Key Interventions / Milestones

- Contractual talks pencilled for March 18 with aim to increase IAPT access
- Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete
- Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete
- Development and delivery of new models of integrated care for MH and LD services
- Benchmark and scope likelihood of having local PICU beds to reduce OOA placements

Risks to delivery

Risks

1. Legacy issues and backlogs in CAMHS require more resource in terms of workforce to eradicate. Provider currently running extensive recruitment process, Risks of serious incidents, safeguarding issues as a result of service problems with recruitment.
2. NHSE requirement that IAPT interventions be clustered and each treatment be tariff based will likely push contract prices up based on national reference costs which means there is a financial risk to the CCG to meet the required IAPT access targets mandated under the Five Year Forward View
3. Burden on financial resources due to spot purchasing of beds for female PICU
4. Gaps in provision, adult ASD (no LD), some patients might not receive required support.

Data

Mental health MDS (MHMDS) - difficult to manipulate
IaPTUS- IAPT service only

Elective Care Transformation – full details in next update

Exec Lead – Julie Davies PMO Contact – Jill Barker

Programme needs to:

8 workstreams identified

Work Stream 1 – PLCV Policies
Work Stream 2 – MSK
Work Stream 3 – Ophthalmology
Work Stream 4 – Diabetes
Work Stream 5 – Outpatients
Work Stream 6 – MRI
Work Stream 7 – Neurology
Work Stream 8 - Dermatology

System Partners / Enablers need to:

The progress:

- Initial draft submission to NHSE

Key Interventions / Milestones

- Timely direct access to MSK therapies operating under a single specification (April 2018) and central booking (Sept 2018)
- Shropshire Patients have access to services compliant with NICE OA Quality Standards , in Primary Care from September 2018
- SOOS established as Countywide community based specialist MSK assessment and treatment service from March 2018 & providing MSK triage by April 2018
- All routine MSK direct access to be coordinated through SOOS, the specialist access route April 2018
- Aligned incentives contract in place with RJAH from 1st April 2018

Risks to delivery

Acute Reconfiguration - Future Fit

Executive Lead – Debbie Vogler   Programme Manager – Andrea Webster

Programme needs to:

- Ensure safe progress towards a formal public consultation, including developing effective relationships with scrutiny bodies
- Once approval received, deliver a formal public consultation, analysis of data, final report and decision making process
- Ensure implementation of the action plans arising from the Clinical Senate Review and NHSE Assurance Panel feedback
- Co-ordinate the development and delivery of a robust IIA Mitigation Plan before the end of the consultation period
- Ensure the completion of a ambulance and patient transport impact modelling exercise prior to the end of the consultation period
- At the end of the consultation period, ensure robust analysis and full report to inform next phase of decision making

System Partners / Enablers need to:

- Support the effective delivery of the consultation with relevant clinical and managerial support to key events
- Contribute to the development of the IIA Mitigation Plan
- Ensure delivery of actions to timescale arising from external review exercises where individual stakeholder organisations are nominated as lead officers
- Develop and implement robust out of hospital/neighbourhood models which will support the required reduction in demand on acute hospital services in line with the Future Fit Activity and Capacity modelling and which also delivery effective and seamless integrated pathways between acute and community
- The OOH and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation

The progress:

- The consultation process commenced on 30th May and will run until 11th September having been extended by one week to support additional requested engagement events.
- Public exhibition and Pop-up events have been held across Shropshire, Telford and Powys engaging with the public and raising awareness of the consultation.
- A mid point review took place in July to determine progress
- All key priorities and Leads to support development of the DMBC have been identified and working with the Programme Director to evidence plans and progress is being made.
- Ambulance modelling work being completed by ORH with all providers fully engaged supporting delivery of the work.
- Formal post consultation process is being formalised with advice from NHSE

Key Interventions / Milestones

- Approval to proceed to formal consultation by NHSE and commenced on 4th May
- Consultation exercise completed and results analysed and report available to inform DMBC (Consultation ends 4 September 2018). Date for analysis and report TBC
- IIA Mitigation Plan and Ambulance Impact Modelling completed prior to the end of the consultation period in order to inform DMBC
- All key actions arising from external reviews of the programme completed
- Development of DMBC (date tbc)

Risks to delivery

Risks

FF Team capacity and resource needs to be maintained to support delivery of the programme – current capacity is at acceptable level.
Significant political and campaign opposition to the proposals, impacting on programme reputation in the media with significant resource required to manage emails, letters and media responses – Additional resources have been identified and a media plan is in place to ensure factual and correct information and responses are readily in the public domain
The Care Closer to Home and Neighbourhood working models and the Future Fit strategy need to formally report on progress of alignment to primary care strategic planning when considering workforce mobilisation and out of hospital activity modelling.

Data

Urgent and Emergency Care

System Improvements

Plan on a Page

Mixed formats of plan on a page to reduce duplication

Urgent & Emergency Care – Transformation Programme

Implementation of UEC High Impact Changes

- Demand & Capacity Review
- Stranded Patients
- ED Systems & Processes
- Red2Green / SAFER
- Integrated Discharge Team
- IV Therapies in the Community
- Frailty
  - Frailty Team at ED front door
  - Reduce admissions / readmissions from care homes
  - Trusted Assessors

- Further details around the Urgent & Emergency Care work programme are available by contacting maggie.durrant@nhs.net

Stranded Patient Flash Report

Project Overview				Overall Project Status
Project Title:	Stranded patient	Deadline:	02/07/2018	AMBER
Exec Lead:	Edwin Borman	Project Lead:	Gemma McIver	
Clinical Lead:		Project Group:	Improving patient flow	
Date of Report:	21/08/2018	% improvement in admitted performance target 4%		

Progress, Issues/Risks, and Decisions Key Items completed this week/since the last report

Current Position

- **Monday 20/08/2018 – 233 lowest 'Monday' figure since the improvement work commenced on average same period as last year was 275 – August tends to be historically the lowest point we have de creased this to date however seasonal trend indicates that by September the stranded patient number does increase**
- **Weekend figures fell below 200 for the third consecutive week**
- **COP Friday 17/08/2018 – number was 188**
- **Super Stranded 30/31st the Super Stranded went up to 66 however this has now reduced to 51 this week maintaining the 39% improvement against the NHSE 23% improvement target – this is in Summer so we need to continue to sustain efforts in order to still meet the target set for April.**
- **Model Hospital have released data up to May 2018 for patients with LOS over 6 days performance nationally shows that SaTH are in the first Quartile (this is positive) 4th against our 'peers'**
- **For Super Stranded performance in Model Hospital- SaTH are again in the First Quartile showing over a 25% improvement and as such are ranked number 14 in the country.**
- **Model Hospital data reflects that LOS for >75's is also below national average at 8 days across RSH and PRH this places SaTH as the best performers against our peers and ranked number 13 nationally.**

Progress

- **Production boards now in place across all USC wards**
- **Drive to reduce days to hours has now commenced to support pre 12 discharges**
- **Continued to lower the threshold for case management from 21 to 18 days for USC**
- **Value stream aligned to this work on-going focus on board round and afternoon huddle**
- **Consistent support from Shropshire council and CCG at Super Stranded however due to commitments across the system attendance at these meetings is continuing to dwindle which will put a risk on maintaining the NHSE improvement target**
- **Stroke Therapist now reporting 3 longest lengths of stay at Super Stranded**
- **Ward 21 evaluation progressed with plan to present at execs for planning/ sign off**
- **Dr Eardley has supported with drive for Clinical Criteria for Discharge across medicine going into the weekend**

Stranded Patient Flash Report

Project Overview				Overall Project Status
Project Title:	Stranded patient	Deadline:	02/07/2018	AMBER
Exec Lead:	Edwin Borman	Project Lead:	Gemma McIver	
Clinical Lead:		Project Group:	Improving patient flow	
Date of Report:	21/08/2018	% improvement in admitted performance target 4%		

Cont.

Key Issues/Risks

- Medical capacity to engage and support to challenge/ explore medical decisions is an area that is needed to fully achieve a reduction and sustained improvement
- Challenges with joint care arrangements peer to peer planning - speciality referrals – IT solution required
- Inconsistent use of PSAG on board rounds –delay in patients declared MFFD in medical notes being flagged on PSAG
- Therapy cover/ vacancies across all wards impacting on discharge planning and goal setting
- Discharge to Assess culture not supported for pathway 3 patients requiring EMI environment
- FFA completion and ownership remains a challenge
- Frequent discharge pathway changes due to gaps in community provision (example: patient waiting 5 days for rehab bed improving and then needing pw1)
- Powys engagement and support is limited
- Criteria for accessing Pathways is different across local authorities impacting on decision making and trusted assessor model
- CHC at Telford and Shrewsbury have built in a brokerage model to source care that adds multiple days to LOS for fast tracks and PW1 patients (mitigated by S2H)
- Lack of community IV pathways
- No pathway 2 bed forward view for Telford to plan weekend discharges
- Pathway 1, 2 and 3 delays continue for Telford patients impacting on LOS and flow
- Challenges for Frailty Team and nursing staff when referring to community hospitals from ED
- Frailty funding decision pending for workforce recruitment

Key Items for next week

- Progressing phase 2 of stranded patient plan – invite case managers to the Super Stranded hubs
- PDSA stranded at RSH now standing and takes place around the PSAG – roll out to PRH on going
- Share ward 21 evaluation
- COE and Cardiology continue with AEP audit – Cardiology scheduled for next week

Taskforce- Steering Group Report

Project Overview				Overall Project Status
Project Title:	**Improving ED Processes**	Deadline:	06.04.18	AMBER
Exec Lead:	Nigel Lee	Project Lead:	Rebecca Houlston	
Clinical Lead:	Dr Kumaran Subramanian	Project Group:	Urgent Care Improvement Programme	
Date of Report:	22nd August 2018	% improvement in admitted performance target		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- **Daily cross site huddles continue – circulated to Execs daily**
- **External Exec level huddles with external attendance**
- **ED summit internal clinical summit group and external risk summit group**
- **ED recovery document developed – inclusive of action plans (also revised to include recent NHSI visit)**
- **Weekly ED performance meeting to review further actions**
- **Weekly report describing minors performance for w/c 13/08/18**
- **Acute Medicine Workforce review**
- **Review of Medical Staffing deep dive with Katy Molland – job plan/DCC review of middle grade doctors and consultants**
- **Paediatric review of attendances**
- **Audit of patients that leave without being seen**

Key Issues / Risks

- **ED middle grade overnight gaps continue to be a significant issue – next gap from 27th August at RSH continuing through the rest of August/early September on both sites, solution to cover PRH with SHO's only overnight is not supported by Paeds, Anaesthetics or Radiology. Gaps during the day are occurring more often with some days left without any cover.**
- **Since April 2018 there have been 44 night shifts where there has been no overnight middle grade**
- **External reporting minors vs non admitted**
- **Data quality including ECDS acuity issues – Ongoing risk due to lack of changes on SEMA**
- **Data quality – ambulance breaches**
- **ED workforce status – impact upon ability to deliver required process changes**
- **Operational Team capacity to deliver required process changes**
- **Constant changes to medical rota to cover key shifts resulting in gaps 'within hours' is resulting in significant delays to be seen**
- **Financial impact of highly escalated salaries for overseas doctors and locums**
- **Additional physio clinics following the ED clinics no longer being in place – increased attendances under review and now added to the risk register**
- **Admin backlogs in both ED – quality and financial risk**
- **Nursing gaps – average of 44% agency used per week**
- **Await confirmation from Exec meeting as to funding for streaming nurse and if the service can continue**

All risks mitigated where possible.

Taskforce- Steering Group Report

Project Overview				Overall Project Status
Project Title:	**Improving ED Processes**	Deadline:	06.04.18	AMBER
Exec Lead:	Nigel Lee	Project Lead:	Rebecca Houlston	
Clinical Lead:	Dr Kumaran Subramanian	Project Group:	Urgent Care Improvement Programme	
Date of Report:	22nd August 2018	% improvement in admitted performance target		

Cont.

Key Items for next week
• **Progress actions in recovery plan** • **Review key actions from medical deep dive** • **Deliver any changes to pathways following decision around business continuity** • **All patients to be managed against professional SOP's/ professional standards – circulation of SOP required to all clinicians** • **On-going recruitment drive and review of potential locums and nurses** • **Continue to push internal ED actions to improve non admitted and minors performance** • **Review next steps for business continuity**

Red2Green/Safer

Project Overview – IMPROVING FLOW STEERING GROUP				Overall Project Status
Project Title:	Objective 3 - Red 2 Green/SAFER	Deadline:		AMBER
Exec Lead:	Deidre Fowler	Project Lead:	Rachael Brown	
Clinical Lead:	To be agreed for each site	Project Group:	Improving patient flow	
Date of Report:	22nd August 2018	% improvement in admitted performance target 4%		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- Project / kaizen in place which incorporates SAFER principles under standard work. Task and finish group meeting fortnightly. First set of re-measures show improvements in some areas.
- Corporate nursing Nightingale project to be developed as part of standard work plan regarding safety huddles.
- Weekly data shows a slight dip against trajectory for this week. Currently at 14% against a trajectory of 16.4%
- As part of Kaizen plan board rounds and huddles established as priority areas, ward plans in place.
- Baseline metrics recorded for USC wards and in progress of collection SC wards.
- Buddy system of support in place and meetings held.
- SC engagement event to held 15.8.18. Good engagement from ward areas.
- Further masterclasses held this week for production boards / people link boards.
- Further Kaizen events identified / scheduled for September to address some issues that need further exploration e.g. FFA
- Super - stranded patient reviews continue to take place on a weekly basis for both care groups across both sites. LOS threshold reduced to 18 days
- Red2Green function and clinical reasoning for changes to EDD live on psag. Developing tolerance reporting in line professional standards, to be in place end of September
- Check, chase, challenge process in place across both sites, all care groups. Production board developed to provide visibility of daily metrics.

Key Issues / Risks

- Discharge planning process and med fit category, changing of pathways, and ability to 'flag' complex patients earlier in the patient journey.
- Internal blocks: doctor review / specialty referrals and FFA completion still highlighted as areas of concern
- Lack of red2green completion leading to insufficient and potentially misleading data on some wards. Weekend completion remains poor. About half of all wards consistently submit data.
- Dip in performance against baseline measure / trajectory
- Pace of change
- Medical engagement

Key Items for Next Week

- Continue to work with the identified wards to understand processes, key issues and effectiveness with a view to making further improvements
- Stranded patient reviews both care groups, with weekly metrics, and escalation.
- Check, chase, challenge approach and process.
- Ward manager meetings

Integrated Discharge Team

Exec Lead – Programme Leads – Sara Dillon & Tanya Miles

Health and social care system needs to:

1. Ensure an integrated team discharge team approach continues to develop.
2. Continue to support the admission avoidance pathway provided by Rapid Response nursing and social care teams.
3. Review current team scope to further improve performance.
4. Improve flow through discharge process to maintain performance by improving the level of rigour particularly in the intermediate care bed process.
5. Haver a single narrative in the form of a system wide operational framework for intermediate care in Telford.

System needs to:

1. Increase membership and increase input to the current integrated discharge processes particularly enabling SaTH therapy directed transition planning for discharge.
2. Further develop towards an integrated discharge team using the guidance on the High Impact Change Model, Jan2018 (Slide 6)
3. Support the current demand and capacity modelling across the system.
4. Implement the aspiration target of 21 days length of stay inn the intermediate care beds to improve flow and access.
5. Further develop the system wide assistive technology offer.

The progress:

1. Review day held 5/2/18 for all system partners in discharge and intermediate care planning including; SaTH/SSSFT/SCHT/TW CCG/TWC/third sector/independent sector.
2. System wide operational refresh intermediate care framework agreed by all partners.
3. Review of intermediate care beds provision and process carried out by CCG quality Lead Nurse and improvement action plan developed as a result.
4. Visit booked to Warwickshire to view best practice model.
5. From 26/2/18 British Red Cross will be seeing all PW 1 patients before discharge on the ward and once home if required.
6. Since Jan 18 specific OT to support patients being discharged from intermediate care to prevent re-admission.
7. Well-being sessions being offered to those on GP Frailty list following MDT to prevent urgent admissions to hospital.
8. NHS Digital bid submitted to join up partner discharge planning

Interventions and process changes

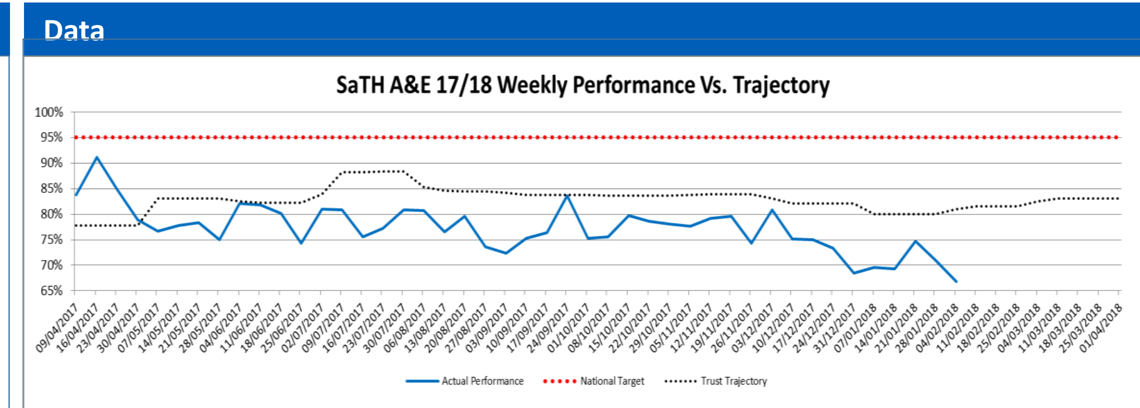
- Set criteria met nurse discharge especially at weekends
- Operational intermediate process and framework review and system wide agreement to new framework.
- Training across all partners regarding new intermediate care process.
- Red, amber, green process for all intermediate care pathways with twice weekly monitoring and MDT's. tracker post out to advert.
- Point prevalence/audit to review progress against new framework
- SaTH therapists to goal set for minimum 72 hours post discharge
- Transfer by relative/Red Cross should be default unless otherwise indicated
- Anticipatory equipment planning and prescribed meds with person day before discharge

Risks to delivery

Risk

- **Provider failure dom/bed based care. Mitigation plan in place**
- **Lack of collaboration between partners. Framework in place across all partners including training and routine consultation and collaboration.**
- **BCF sufficiency to meet demand. New governance structure to support BCF board to monitor performance.**

Data



UEC - IV Therapies

Updated May 2018

Exec Lead – Steve Gregory   Project Board Chair – Yvonne Gough   Project Lead – Mandee Worrell

Programme needs to:

- Develop a plan for delivery of IV therapy in community settings, with 4 phases;
- IV antibiotic therapy in MIU/DAART/Community Hospitals for patients on pathways for bronchiectasis, diabetic foot, UTI, cellulitis
- Patients on pathways as per phase 1 but requiring domiciliary delivery
- Non antibiotic IV therapy within community settings (eg iron)
- Self administration of IV antibiotics via pump therapy

System Partners / Enablers need to:

- Understand the potential need for funding to expand community capacity
- Support workforce development and competency
- Commit to review and consider commissioning additional service hours for DAART and MIU in key locations
- Support governance and accountability arrangements for medication and medical responsibility

The progress:

- Initial meeting held 30/4/18 to define scope of project and themes
- Good representation from SaTH and Shropcom
- Leadership and reporting arrangements defined
- High level output dates agreed

Key Interventions / Milestones

Phase 1;
Business case and plan to be presented July 2018

Phase 1;
Commence delivery October 2018

Phases 2,3,4
Dates to be determined

Risks to delivery

- Workforce – skills, competency and capacity
- Governance – medical responsibility, accountability, licencing
- Finance – redirection of resource to expand community provision, cost of medication
- Cultural change – to transfer patients to the community
- Limitations of currently commissioned opening hours of DAART and MIU centres

Data

Data is being collected to inform phase 1 of the delivery by Shropcom and SaTH and identify the following from April 2017-April 2018;

1. How many bed days occupancy in SaTH for patients only for antibiotic therapy for each of the 4 identified conditions
2. How many patients does this represent and their demographic
3. How many patients seen by Shropcom in DAART for antibiotic therapy for each of the 4 identified conditions and their demographic
4. How many patients seen by Shropcom in domiciliary settings for antibiotic therapy
5. Project group members are collating existing pathway information for the 4 initial therapies, for discussion and review of potential relevance or need for change.

Frailty Programme

Exec Lead – Fran Beck   Programme Lead – Michael Bennett / Emma Pyrah

Programme needs to:

- Implement Frailty Front Door at RSH in line with the AFN model
- Develop and implement Frailty Front Door at PRH by October at the latest
- Develop Inter-Disciplinary Teams to have robust MDT approach to complex discharge and achieve target of 136 complex discharges a week
- Support home First and achieving 60:30:10 for pathways 1/2/3
- IDTs support and wider ICS/ICT support SATH Red2Green/ SAFER through in-reach support
- Reduce admissions from Care Homes through specific dedicated Teams or focus
- Provide overview and scrutiny of the DTOC High Impact Changes progress across the economy in achieving Mature RAG rating by end of Quarter 4 reporting.
- Reduce and maintain DTOC target levels and reduce length of time of patients on the work list

System Partners / Enablers need to:

- Clinical and managerial support from all organisations to ensure prioritising programme of work
- Collaborate to maximise the effective utilisation of learning from PDSAs, and audit in order to create behaviour and system change
- Clearly define objectives, activity, resource, milestones within each program work stream to enable accurate assessment of progress
- Accessibility of clinical expertise to support programme development including ECIST and AFN

The progress:

- Frailty Front Door at RSH Evaluation Action Plan in place; monitored through the Frailty Task and Finish Group
- 6 As Audit completed highlighting potential for reduced admissions, reduced length of stay, improvements in clinical and care pathways
- PDSA for Frailty at Front Door at PRH completed 25-27th July to develop model and improve existing pathways. Evaluation highlighted need for additional medical and therapy capacity – within Winter Plan
- Inter-Disciplinary Teams (Clinical Hub) in place on both sites seeking to achieve target of 136 complex discharges/ week. IDTs engaged in weekly Stranded Patient reviews
- Trusted Assessors in place facilitating early discharge to care homes
- Care Home MDT in place in T&W. Commenced piloting Emergency Passports in six care homes in conjunction with WMAS. Preparing to launch Red Bag Scheme
- Shropshire Deep Dive of Care Homes including review of CHAS and potential for piloting Miralife
- Relaunch of NHS 111*6 clinical advice line for care homes
- Developed DTOC High Impact Changes Action Plan to achieve Mature by end of Quarter 4 RAG rating

Key Interventions / Milestones

- Further develop Frailty at Front Door to maximise avoidable admissions and reduce length of stay on RSH site
- Develop and implement Frailty at Front Door at PRH to maximise avoidable admissions and reduce length of stay on PRH
- Implement DTOC High Impact Changes Action Plan to ensure achieving a Mature RAG rating by Q4
- Care Homes actively utilising the NHS111 * 6 line for telephone clinical advice from the NHS111
- Funding for Frailty team at Front Door at PRH to enable implementation and evaluation

Risks to delivery

- Current funding for Frailty at Front Door at RSH is based on local tariff Agreement. Risk that not agreed putting funding from April 2019 into question
- Current RSH infrastructure does not support working more upstream in ED to prevent admissions which limits to Service's impact on admission avoidance and potentially duplicates clinical input
- Additional capacity for Frailty at Front Door at PRH identified through PDSA. Needs approval through Winter Plan. Evaluation is needed to develop a Business Care for funding post April 2019
- Additional Domiciliary care capacity in both Boroughs to maximise complex discharges home for Pathway 1 and long term care at home supporting Home First and reduce length of time on the work list and recordable DTOCs

Data

- SATH reporting on Frailty at RSH highlighting impact on admissions and length of stay of Frail patient
- Need to develop methodology for monitoring impact at PRH
- Weekly reporting to A&E Delivery Group on performance related to complex discharge
- A Frailty dashboard is in place to monitor performance across both CCGs. This is being updated

Transformation Enablers

System Improvements

Plan on a Page

Digital Enabling Programme

Exec Lead – Clinical Lead - Programme Lead – Rob Gray

Programme needs to:

- developing the Local Digital Roadmap (LDR) - draft for NHS Digital Review October.
- Improve Connectivity : Provide seamless access networks and efficient procurement of new connections / wifi access for staff and citizens at all locations– close of financial year
- Populate Information sharing Gateway with agreements to allow sharing of information between organisations.
- Formulate an STP-wide plan for Cybersecurity: Ensure records and systems are secure.
- Improve Collaboration - Licensing future proof and cost efficient route for Microsoft and Office upgrades (towards O365 and CloudFirst)
- Identify & support digital requirements for all other programme groups
- Improve Digital Maturity Assessment scores to support programme success.
- Develop business cases as appropriate for possible future funding availability
- Analyse options for an Integrated care record across health and social care settings.
- Ensure and assist organisations within the STP to capture information electronically at point of care
- Identify the capability for Interoperability across the STP area.

System Partners / Enablers need to:

1. Ensure "Right Information available to the right person in the right time and location" enabling better outcomes for citizens.
2. Clarify the end vision and the level of commitment required from organisations.
3. Act as One! Agree the objectives of the enabling group with in the strategic governance process at exec level
4. Standardise on clinical coding (SNOMED-CT) for all organisations.
5. Provide resource (inc funding, project management etc) to define and plan programmes and projects
6. Involve digital solutions in all workstreams. Promote the modernisation and efficiency of paperless processes to increase efficiency through a digital programme
7. Conform to cyber-security requirements – and resource specialist support
8. Provide Strategic direction for an STP solution to enabling a system wide approach to an infrastructure that enables the use of all modern technologies to improve frontline patient care.

The Progress:

- Universal Capabilities: target to significantly deliver by March-18 – successful. (9/10 see data below). New programme items to be decided in refreshed LDR.
- Continue direct engagement with NHS England, and NHS Digital for strategic direction.
- LDR refresh process started
    - Core team brainstorming
    - Full PB session with James Seaman - (worked on Manchester devolution) to help formulate.
    - Evaluation of some early infrastructure projects to enable future progress.
    - Owners nominated to define project scopes.
- Further meetings scheduled to refine vision, to support future plans.
- Agreement reached to utilise Summary Care Record with Additional Information (eSCR) to provide core GP info to all care settings.
    - Project 1. enhance SCR to near 100%.
    - Project 2. enable access in SaTH to eSCR with smartcard authorisation.

Key Interventions / Milestones

- Oct-18. LDR refreshed and new Digital Programme defined. GP IT Forum also follows lead of LDR.
- Nov-18. Summary Care Record enhancement initiative started, and visible in secondary care, starting with A&E.
- Dec-18. Network - shared procurement in place. Corporate Wifi access for all orgs at all sites
- Jan-19. Procure started for Electronic Patient Record systems for SaTH and RJAH to support shared access to Integrated care records.

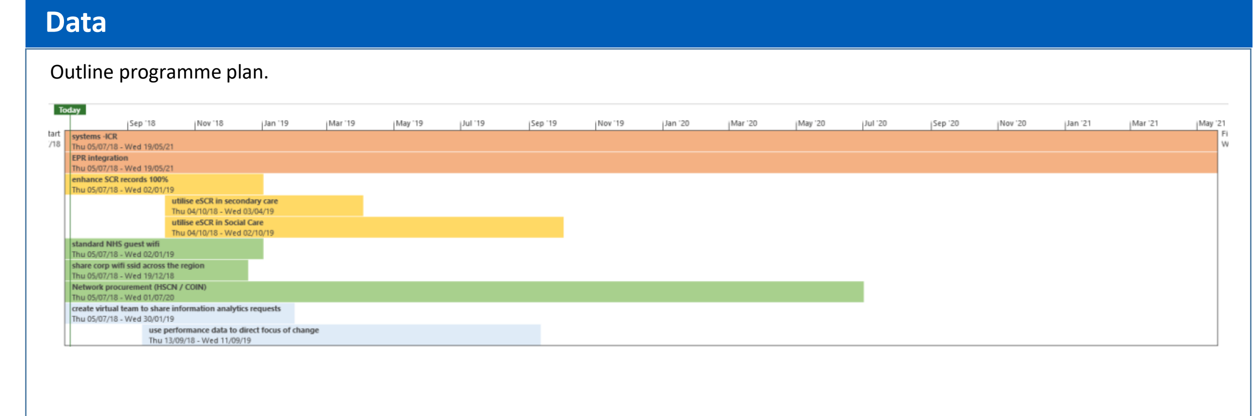
Risks to delivery

Resources – (lack of funding, governance and leadership to progress strategic planning, and availability. commitment from senior management to release or increase resources)
Lack of Technology standardisation - Action :Identify interoperable platforms and recommending their use across the STP
Licencing costs are set to increase with a requirement to migrate to a supported set of office applications with revenue costs instead of capital.
Executive Strategic Direction is unclear.
Lack of clear co-ordinated approval processes for schemes with a cross-organisation impact.
Complex governance arrangement (STP is not an executive group with delegated authority.)
Uncertain leadership of the DEG. No Exec or clinical leads, and no DEG CCIO position defined.

Actions:

Data

Outline programme plan.



Strategic Estates Programme

Updated August 2018
Next update– October 2018

Exec Lead – Clive Wright

Programme Lead – Becky Jones

Programme needs to:

- Use data in geographic layers at a very local level as evidence of emerging community need, & how or if they are being addressed
- Identify opportunities for developing community hubs, housing solutions or projects to support economic growth, where a local need is present.
- Inform the requirements for future service provision and ultimately guide the utilisation of the public estate
- Ensure estate is accessible, efficient and safe.
- Engage the expertise and knowledge of public sector delivery leads in developing community needs-based projects stemming from opportunities created by the One Public Estate work-stream.

System Partners / Enablers need to:

- Provide an integrated and co-ordinated healthcare estate relevant to redesigned patient /service user and staff pathways under the STP
- Deliver a reduction in estate
- Reduce / plan removal of backlog maintenance
- Support Estate aligning with and utilising the One Public Estate agenda
- Utilisation aligned with Carter review
- Deliver a Reduction in annual revenue costs
- Provide flexible estate that will enhanced a dynamic healthcare economy
- Develop local solutions drawing on all the assets and resources of an area
- Build resilience of communities.

The progress:

- Estates Workbook/Strategy completed and submitted on time and now a living document
- Capital bid for Shawbirch submitted
- Project pipeline in early stages of development
- Joint OPE/STP Programme Delivery board established
- Whitchurch Project Board up and running and Shropshire Council Cabinet report approved. Continuing on road to delivery
- Asset Mapping & data layering work with Shropshire Council going well, producing evidence base & assisting to inform opportunities with regular meetings taking place to ensure co-ordination between Council and health future planning needs
- Early stages of planning for OPE 7 projects
- Engagement with Telford and Wrekin Council and aiming to continue engagement with Council and CCG to deliver joined up working opportunities

Key Interventions / Milestones

- Circulate workshop outcomes , feedback through STP/Council/OPE partners/Local Councillors. Market Town specific Workshops to inform next steps
- Run Telford & Wrekin Workshop, identify opportunities and then bring together all opportunities into one whole system approach
- Overarching and adopted Estate Strategy aligning with the estate outcomes and key STP outcomes
- Outline rationalisation plan, with better use of void space, shared/bookable space, joint utilisation, extended opening hours, energy efficient
- Evidence using Geographical Intelligence Systems applied in layers ; to include Voluntary Sector services

Risks to delivery

Risks

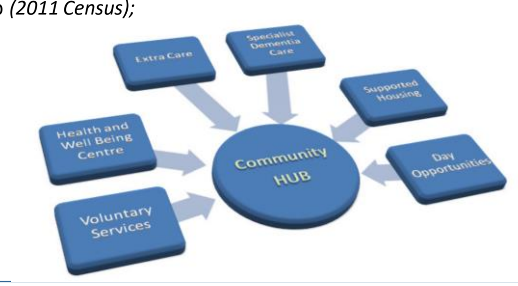
- Timelines for funding bids vary across different organisations; aligning for cross-organisational estate projects difficult to achieve.
- Aligning existing projects and agreement on potential future opportunities
- Engagement not fully embraced
- Rejection of future capital bids through omission of estate projects/concepts from STP Estates Strategy
-

Actions:

- Transparency and awareness of funding timelines between organisations
- Agreed approach to partnership working
- Identify and Plan for interim arrangements
- Comprehensive links across all STP workstreams/enablers to include their known and anticipated estate implications

Data

- Validation and updates of SHAPE database (Health Service Estates) by all relevant organisations; ongoing requirement to maintain accuracy
- Property and Estates (Shropshire and Telford), Freehold land, Leasehold land, Leased land;
- Transport , Shropshire and Telford Bus routes 2016, Car and Van ownership *(2011 Census);*
- Demographic (covers Telford and Shropshire) *(2016 MYE ONS) ,*
- Deprivation (2015 IMD, DCLG)
- Community Facilities (e.g. libraries/schools)
- Older People,
- Health, including long-term illness & disability; health deprivation
- Planning Themes (Planning and Land Use Monitoring
- systems, Planning Policy Team
- Economy
- Housing Affordability



Strategic Estates Progress so far

The STP Estates Strategy has been a key piece of working with:
"ALL SYSTEM PARTNERS"

Through facilitated workshops, shared conversations recognising system interdependencies, increasing knowledge and understanding of Estates requirements across the system both now and in the future.

This strategy is facilitating system change through encouraging work to be done once by involving all partners in initial discussions, thus looking at the bigger picture and understanding the wider implications of organisational decisions….

Page 44

- Demonstrates STP footprints priorities and how the estate will help to deliver on these
- Agreed prioritisation process has been put in place to identify the preferred projects
- linkages between the wider Future Fit programme are clearly made
- This document is helping to bring different work programmes together
- links are established into the wider work in terms of the One Public Estate
- opportunity to link whole system together through effective partnership working
- Sustainable Services Programme, Neighbourhood Working and Care Closer to Home projects

Shropshire, Telford & Wrekin Sustainability & Transformation Programme
STP Estates Strategy (Workbook)
JULY 2018
Five Year Forward View
#futureNHS

Programme needs to:

- Update the planning assumptions made in the 5 year STP financial plan and identifying a more robust view on the scale of savings in the following areas;

Corporate services savings in the health economy, using recent benchmarking data,
Shared recruitment processes (by the Workforce Work stream)
Procurement savings through model hospital and PPIB data
Estate rationalisation (developed by the STP Estates Work stream)

- Develop an over view that makes it clear what exists in plans already and whether the programme can stretch the thinking to gain more operational and financial value (e.g. target set to drive costs to the national median).

IT foundations to ensure the groundwork is most effectively procured to support the STP digital agenda.

System Partners / Enablers need to:

1. Support a level of ambition proposed by the programme – ie. drive costs to the national median (where there is one or other agreed benchmark where there isn't),
2. Sponsor and support the collaboration on key priorities, initially by sponsoring the CSU's diagnostic and option appraisal process.
3. Have an 'open book' approach to data and information to enable opportunity assessment,
4. Develop the relationship with other STP stakeholders to assess the opportunity for wider public sector benefits,
5. Agree a change programme in due course.

The progress:

- The work stream has demonstrated good practice in collaborating and sharing information between NHS providers and the Local Authorities although LA engagement has diminished recently.
- Underpinning case for change still holds true, although it will be refreshed through the review detailed in the next bullet point to ensure this is the case.
- The group, on behalf of the STP health partners have commissioned a piece of 'value added' work via Midlands and Lancs CSU to appraise the options for rationalising the 'back office' in health organisations. Time scales are yet to be determined.
- Individual STP work streams are working on discrete aspects of rationalisation or collaboration (estates and workforce)
- All providers are using benchmarking data to support decision making, with the most recent national submission for corporate benchmarking (Model Hospital) due to be submitted by STP health providers by the 17th July.
- Further thinking has been done on where other opportunities could also be possible in areas loosely named 'middle office', which link strongly into the estates and IT agenda as well as the workforce with regard to admin and reception functions.

Key Interventions / Milestones

- Initial exploration of the Model Hospital opportunities for Providers, including corporate services and ambition set – February 18
- Initial discussion with Midlands and Lancashire CSU Value Add proposal to pump prime further review and option appraisal – March 18
- Commence CSU diagnostic – Summer 18
- Evaluate CSU diagnostic conclusions and agree programme of change – Summer 18
- Implement change programme – Autumn 18 onwards

Risks to delivery

Risks
The scale of opportunity will not be realised due to;

1. Lack of collaboration beyond health on procurement.
2. Capacity to drive ideas forward across organisations at pace
3. Lack of willingness to collaborate on a joint agenda and give or pass on sovereignty by individual organisations.
4. A Shropshire centric preference not accessing the opportunity where it is at its greatest on a wider footprint (ie out of STP boundaries)

……….
Actions:
A review of the effectiveness of the existing county wide Procurement Group
Using the CSU diagnostic and option appraisal process to increase pace, draw conclusions and propose a change programme which will require tangible agreement.

Data

Model hospital (Carter)
Corporate services data (Model Hospital)
NHS Efficiency Map
Procurement data (PPIB)

Strategic Workforce Programme

Updated August 2018 Next update - October 2018

Exec Sponsor – Jan Ditheridge Exec Lead – Victoria Maher Programme Manager – Sara Edwards

Programme needs to:

1. Develop a system-wide **Strategic Transformation Workforce Plan** which supports Future Fit options linking acute and community models.
2. Develop and implement a system **Organisational Development Plan** to support new ways of working.
3. Develop **workforce sustainability** through the identification of learning and development, education and training needs and through supporting system programmes to implement change and support transformation.

System Partners / Enablers need to:

- **Work closely to share workforce intelligence**, undertake workforce modelling and strengthen system ownership of workforce strategies.
- **Work collaboratively** to attract, recruit and retain the current and future health and care workforce.
- **Agree system-wide requirements** in order to maximise the education, development and training opportunities for our workforce.
- Lead a **system programme** that delivers transformation and sustainability taking into account Future Fit options.
- Lead **cultural change** through health and care that supports **integrated working** which prioritises patients resulting in improved population health and wellbeing.
- Deliver **system-wide workforce solutions** and improvements in response to the system workforce challenges.

The progress:

- Agreement between STP partners on **priority areas** through the Strategic Workforce Group .
- **System-wide Workforce Strategy** – Baseline data being worked up via HEE.
- **Mental Health Workforce Plan –** Submitted with no requirement to resubmit. MH Delivery Plan now being addressed.
- **STP OD Group -** now set up with priorities being planned**.**
- **Local Maternity Services (LMS) Transformation Plan** developed. First draft of WFP taken to LMS Board and WF sub group meetings in progress. Leadership & Cultural Development Plan to follow in Autumn 2018.
- **GP Forward View Workforce Plan** has identified projects to address recruitment and retention targets and bids have been submitted to support GP recruitment, retention and resilience programmes.
- **2017/18 workforce investment programme** of £817,600 covering both primary care and acute services being delivered.
- **2018/19 workforce investment** scoping exercise in progress.
- **STP/LWAB** relaunched with priorities refreshed.
- **Education & Development Group** – Identification of priorities and development of Multidisciplinary Preceptorship Framework, Shared Learning Assets and Shared Statutory and Mandatory training projects.
- **Training Hub** – Re-establishment of the Shropshire and T&W Training Hub provision within the STP PMO.

Key Interventions / Milestones

- Complete the **workforce profile data** gathering and individual specialist workforce plans. Aligning with Future Fit Programme.
- **Leadership and OD Programme** with the King's Fund completed. NHSI (ACT Academy) **TCSL Programme** change management tools being used.
- Development of **Shared Recruitment** project and **Collaborative Bank –** Project Briefs developed with partner engagement.
- Implementation of a pilot **Rotational Apprenticeship Programme** with September 2018 start.
- Delivery of 2018/19 **STP/LWAB funded priority areas** and development of a **shared training/learning** offer to meet system needs and promote integrated working.

Risks to delivery

Risks:

- Planning without knowledge of future finances and service redesign/configuration. Future Fit Consultation ends in September 2018.
- Varying levels of stakeholder engagement driven by different approaches to Workforce and access to data.
- Ability to fund workforce development activities both in terms of finance and time.
- Risk to quality of STP submissions due to a lack of clarity around requirements .
- Timely decisions in respect of funding which affects education, development and recruitment.

Actions:

- Ensure strong workforce links with STP clinical /service priorities reporting into the Strategic Workforce Group.
- Continue to build relations through working together on identified projects/ task & finish groups.
- Identify priority development areas and align through STP PMO processes.
- Collaborating with HEE to access support and align programmes.
- Piloting areas of work to test outcomes.

Data

Shropshire Workforce Baseline:

STW system workforce baseline developed by HEE Workforce Intelligence Team utilising data from NHSI operational plans (workforce plan) for acute/community and mental health services, NHS Digital for primary care and NMDS for social care.

Data presented at July meeting of Strategic Workforce Group and LWAB. The data provides demographic information, nurse to bed ratio and a comparison with the 17 LWABs across Midlands and East. A focused session with workforce planners to review the data and provide a response to HEE is currently being arranged.

Individual areas of workforce:

- **Mental Health Workforce** data included in the submission of the MH Workforce Plan in March.
- **Local Maternity Transformation Plan (LMS)** developed with workforce analysis being undertaken to inform WFP. Financial analysis underway with STP Finance Lead for LMS. WF risk register updated to include financial risks.
- **Primary Care workforce data** has been collated as part of the GPFV Workforce Plan.
- Cancer Alliance now linked into Collaborative Cancer Group to progress Cancer Workforce Plan.

Population Health & Prevention

System Leads –Kevin Lewis / Helen Onions

Programme Lead – Penny Bason

Updated April 2018 Next update– June 2018

NHS England

The programme needs to:

1. Develop our wider workforce to 'make every contact count' (MECC+) / proactive identification of people at risk of ill health and behaviour change conversations, brief interventions
2. Prevent harm due to alcohol, obesity and CVD
3. Support culture change and new working practices that help people at the earliest opportunity
4. Support active signposting and develop a good understanding of how communities support people – linking to Social Prescribing
5. Work across organisations (including the VCSE) to prioritise support for key population groups – address inequity and inequalities
6. Support and embrace the role of the VCSE and communities to drive forward prevention activity
7. Focus on developing a good understanding of need – continual information provision for the JSNA
8. Improve communication between organisations

System Partners / Enablers need to:

1. Systematically raise awareness and deliver lifestyle advice, signposting and referral by healthcare and other professionals, e.g. through MECC +, PHE's One You, including for:
   - Stop Smoking Support
   - Weight management
   - Physical activity programmes
   - Immunisation opportunities, e.g. flu
2. Improve the prevention, detection and diagnosis of CVD, specifically diabetes and hypertension
3. Radically upgrade the role of the NHS in tackling harmful alcohol consumption, through screening, identification, brief advice and referral into treatment services
4. Deliver prevention expectations of the national Cancer Strategy
5. To ensure the systematic delivery of mental wellbeing services, including identification of mental ill health and prioritisation of emotional support
6. **Work together to make best use of resource and expertise**

The progress:

STP

Mobilisation of the National Diabetes Prevention Programme March-May

Neighbourhood working to build community capacity- focus on Healthy places, Active and Creative communities

Delivery of Social Prescribing initiatives and infrastructure

Supporting Carers through all age strategies and Dementia Companions

Delivery of Fire Safe and Well Visits (since July 17)

Develop and deliver a system prevention framework for all pathways

Developing very positive joint working across health and care

Individual Placement Support Service for those in secondary MH services

Telford & Wrekin – Healthy Telford

Borough-wide lifestyle offer

Twitter and blog – using social media to inspire behaviour change

Developing and nurturing our community health champions

Public Health Midwife, stop smoking support and maternal health advice

Shropshire – Healthy Lives

Development of an Integrated Care Navigation Programme

Delivery of Healthy Lives Programme and prevention services

Opportunities

- Smoke free hospital and brief interventions in hospital
- Connecting to workforce (and funding) to support development of staff (link to MECC plus)
- Mental health hubs, MH support in Local Maternity hubs, Early help for children and young people, link to Estates
- Healthy hubs and social care support/ advice and guidance in hospital
- Risky behaviour CQUIN - link to MECC Plus

Key Interventions / Milestones

- Health & Wellbeing Intelligence Population health management
- Develop and Deliver System CVD & Diabetes Strategy
- Deliver the prevention expectations of cancer strategy
- Develop system social prescribing infrastructure
- Develop and Deliver System Obesity Strategy
- Development of a system plan to reduce harm related to alcohol
- Develop the system MECC Plus proactive approach, including training and delivery plan

Risks to delivery

1. Lack of buy in by partner organisations
   - Risk to strategy delivery
   - Risk to culture change needed
2. Investment in prevention programmes (national and local)
   - Local Authority Public Health Grant challenges
   - Lack of NHS investment in prevention
3. Medical and nursing capacity
   - NHS Trusts (SaTH, SSSFT, ShropCom, RJAH)
   - Primary Care

Outcomes – how do we know it's working? DRAFT

Public Health Outcomes Framework

- Healthy life expectancy
- Health Equity
  - Smoking rates
  - Obesity – children and adults
  - Physical activity
  - Wellbeing measures – Social Prescribing
  - Reduction in GP attendances
  - Reduction in unplanned hospital admissions
  - Cancer rates
  - Harm due to alcohol – alcohol admission rates

Connecting to other programmes

- Health and Wellbeing Boards Strategic Planning (both T&W and Shropshire)
- Better Care Fund (T&W and Shropshire)
- Rightcare
- STP Neighbourhoods and Out of Hospital Programmes – community development,
- GP 5 Year Forward View –
- Mental Health 5 Year Forward View – preventing
- Maternity Services Transformation
- Workforce – developing our
- Estates Partnership
- Musculoskeletal and Falls System Planning

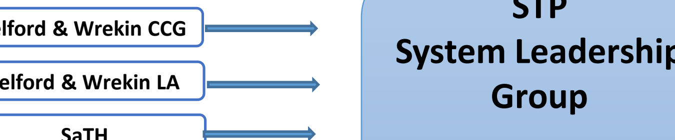
Updated Version 4.0
August 2018

Shropshire, Telford and Wrekin
Sustainability & Transformation Programme Governance Structure

Draft – tba - changes

STATUTORY ORGS
Requirement to adhere to own governance procedures

Provider Boards
Commissioner Boards
Local Authority Cabinets



- Telford & Wrekin CCG
- Telford & Wrekin LA
- SaTH
- RJAH
- ShropCom
- SSSFT
- Shropshire CCG
- Shropshire LA

STP
System Leadership Group

(System CEOs)

Health & Wellbeing Boards

Joint Health Overview Scrutiny Committee

STP
Clinical Strategy Group

(System Clinical Leads)

STP Transformation Programme Delivery Board

Strategic Workforce Group

Communication & Engagement

System Back Office

Strategic Estates Group

Digital Enablement Group

System Finance Group

Population Health & Prevention

Telford & Wrekin

1. Community Resilience & prevention
2. Neighbourhood Teams
3. Systematic Speciality Review

Urgent & Emergency Care
High Impact Changes
Frailty

Acute Hospital Reconfiguration
Future Fit
Sustainable Services Programme

Local Maternity Services

Development of Primary Care

System Mental Health Programme

Elective Care Transformation Programme

Strategic System Pharmacia programme

System Cancer

System End of Life programme

Shropshire

Neighbourhoods & Prevention

Care Closer to Home

1. Frailty Front Door
2. Primary Care Development
3. Hospital at Home / Crisis intervention

System Partners On Programme Delivery Board

- Health Watch Telford & Wrekin
- Local Pharmacy Committee
- Shropshire Partners in Care
- Powys Teaching Health Board
- Severn Hospice
- ShropDoc
- West Midlands Ambulance Service
- Patient Groups
- Voluntary Sector
- Welsh Ambulance Service
- Wider independent organisations
- System Neighbours
- Health Watch Shropshire
- Subject Matter Experts

Integrated System Working, the transition from STP to ICS / ICP

In 2018/19, all STPs are expected to take an increasingly prominent role in planning and managing system-wide efforts to improve services.

Integrated Care Systems / Partnerships – Shropshire, Telford & Wrekin Update

- *System working will be reinforced in 2018/19 through STPs and the voluntary roll-out of Integrated Care Systems.*
- *Integrated Care Systems are those in which commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility*
- *The term 'Integrated Care System' as a collective term for both devolved health and care systems and for those areas previously designated as 'shadow accountable care systems'. An Integrated Care System is where health and care organisations voluntarily come together to provide integrated services for a defined population.*
- Integrated Care Systems are seen as key to sustainable improvements in health and care
- *Integrated Care Systems will be supported by new financial arrangements*
- *It is anticipated that additional systems will wish to join Integrated Care System development programme during 2018/19 as they demonstrate their ability to take collective responsibility for financial and operational performance and health outcomes. It is envisaged that over time Integrated Care Systems will replace STPs*
- *As systems make shifts towards more integrated care, they are expected to involve and engage with patients and the public, their democratic representatives and other community partners.*
- *Engagement plans should reflect the five principles for public engagement identified by HealthWatch and highlighted in the Next Steps on the Five Year Forward View.*

Further Information:

https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

Our ambition is simple:

We want everyone in Shropshire, Telford and Wrekin to have a great start in life, supporting them to stay healthy and live longer with a better quality of life.

Our STP is the culmination of a wide range of local organisations, patient representatives and care professionals coming together to look at how we collectively shape our future care and services.
This strong community of stakeholders is passionate, committed and realistic about the aspirations set out in this document.

Our thinking starts with where people live, in their neighbourhoods, focusing on people staying well.
We want to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we improve access when its needed.

We want care to flow seamlessly from one service to the next so that people don't have to tell their story twice to the different people caring for them, with everyone working on a shared plan for individual care.

Prevention will be at the heart of everything we do –
from in the home to hospital care. In line with the GP Five Year Forward View priorities, we plan to invest in, reshape and strengthen primary and community services so that we can provide the support people in our communities need to be as mentally and physically well as possible.

Health and Wellbeing Board
Meeting Date: 13th September 2018

Item Title Shropshire Care Closer to Home – Update Report

Responsible Officer Lisa Wicks Shropshire Clinical Commissioning Group
Email: Lisa.Wicks@nhs.net

1. Summary

This paper provides an update on Shropshire Care Closer to Home.

2. Recommendations

The Health and Wellbeing Board is recommended to note the information in the report

REPORT

Communication & Engagement

Stakeholder engagement
At the launch of the programme, a public and stakeholder event was held and feedback from this event has been taken into consideration when considering the models of care required to deliver Shropshire Care Closer to Home (SCCtH). During March 2018, another stakeholder event was undertaken inviting members of the public to attend with a view to developing a strategy for communication and engagement; this has shaped how SCCG are delivering this important programme function. A further stakeholder event took place on 25th July 2018 and was well attended.

Communication & Public Engagement
The public-facing information leaflet previously presented to this board was released for circulation to the wider public and media on 1st August 2018 and a dedicated section on the CCG website has been developed allowing a route for anyone to submit comments, feedback and queries.
http://www.shropshireccg.nhs.uk/get-involved/engagement-and-consultation/shropshire-care-closer-to-home/
A comprehensive communications and engagement strategy and plan is currently being finalised.

Programme Phases

Phase 1
Phase 1 is presently operational in the form of the Frailty Intervention team (FIT) who are based at the Royal Shrewsbury Hospital and the team are looking to expand their service and implement the same in Princess Royal Hospital, Telford.

Phase 2
Phase 2 concerns the development of a model for case management of our population incorporating locality-level GP input. The preferred model has now been agreed and discussions can commence around implementation and mobilisation.

Phase 3
A long list of Phase 3 model options is presently being worked up by SCCG in preparation for work with various stakeholders, patient representatives, GPs and providers to agree a preferred model for Crisis Intervention, Rapid Response and Hospital at Home.

Programme Summary & Update

Since the last report, scoping and design work on Phase 2, risk stratification and case management, has been completed. The final stages of exploring model options took place at GP Locality Task & Finish Groups, the patient and provider stakeholder workshop and via the Programme Working Group.
As opposed to the previously expected longlist of Phase 2 model options what emerged was one commonly and consistently agreed core model with some areas of variability. The Programme Working Group decided through majority on the options to proceed with and concluded with the final and agreed model for risk stratification and case management which was presented to and approved by the Clinical Commissioning Committee on 15th August.
An IT Task & Finish Group has been established to explore the IT and data infrastructure required to support the programme including shared data and the development of an electronic shared Care Plan.
Discussions continue on the possibilities around an Alliance Partnership that could support the delivery of the programme.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices

Health and Wellbeing Board
Meeting Date 13th September 2018

Item Title: Shropshire, Telford and Wrekin – a community focused estates approach.

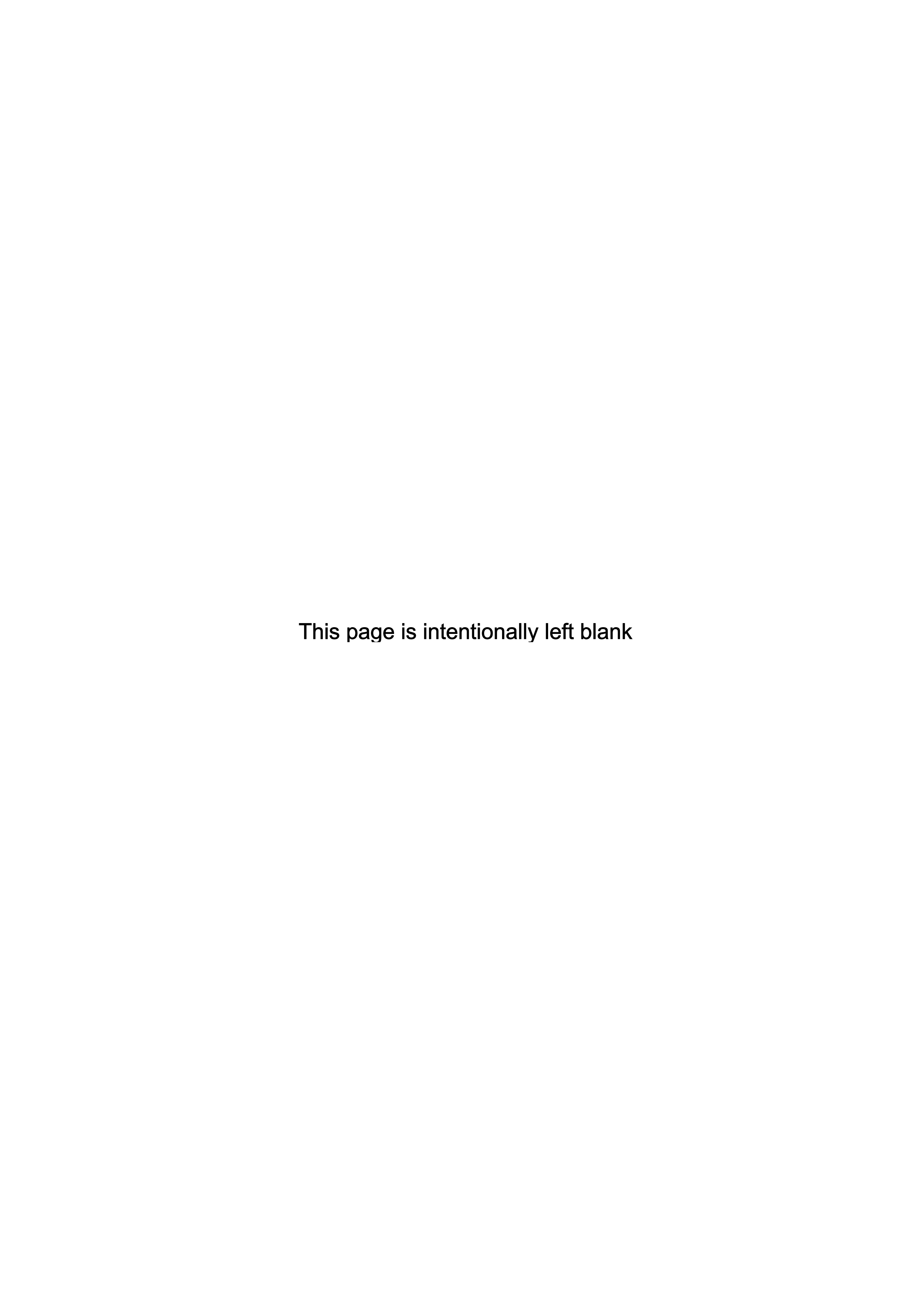
Responsible Officer: Becky Jones, Community Health Partnerships

Email: b.jones@communityhealthpartnerships.co.uk

REPORT

A presentation 'Shropshire, Telford and Wrekin – a community focused estates approach' will be provided. A copy of the slides are attached.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices


This page is intentionally left blank

Shropshire, Telford and Wrekin – a community focused estates approach

Health and Wellbeing Board, 13th September 2018

Enabler for change

- Enabler for change.
- The estate has the possibility to **change lives** through transforming the way we approach service delivery.
- Viewing the rationalisation of the estate through the **lens of community need**, rather than short-term location of services and enabling self-sufficiency and resilience to grow within communities, thus reducing the reliance on public services.

Transformation - General estate principles

General Principles

- Rationalisation
- Better use of void space
- Better use of shared/bookable space
- Extended hours / longer opening hours less buildings
- Joint use of space across NHS organisations
- Joint use of space across public sector organisations – One Public Estate (OPE)
- Modern fit for purpose infrastructure
- Energy efficient low carbon buildings

The approach - transformation

The proposed approach is one of prevention and wellness, building up communities, developing resilience and reducing the future cost of care with a clear focus on housing. This is based on the 'Northfield Principles'.

Northfields

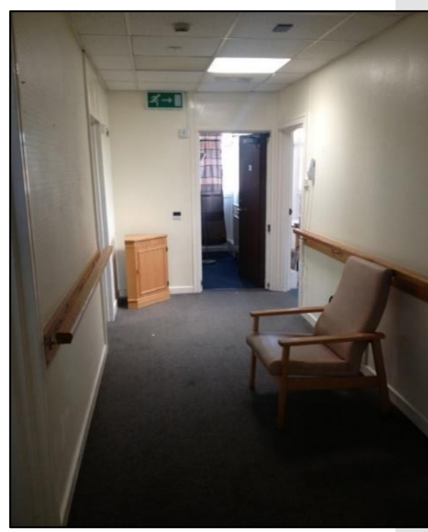
- Northfields is a health village in Stafford, which has received University of Stirling Gold Award for dementia care, has extra care housing, integrated GP and pharmacy, affordable housing, women's refuge and a community hub and café.

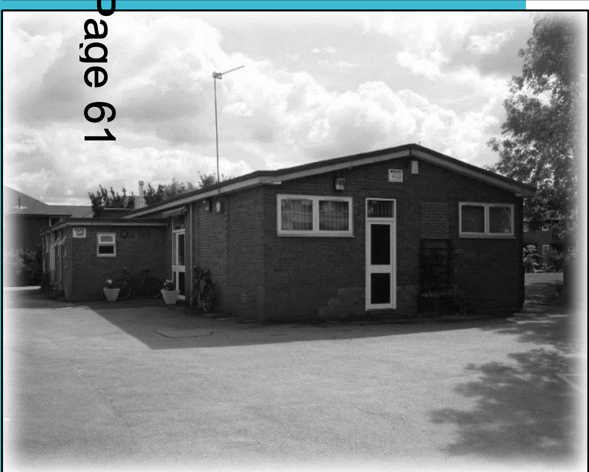
- The financial model is built up to make the development viable, through using grants, disposals from premises that become redundant and investment from housing associations and local Councils, together with the revenue from the primary care element.

Northfields Principles – a community centric approach

Principles of the community centric approach

- To put people at the heart of decisions
- Understand the needs of the people in each area
- Empowering the community to support itself
- Enabling a change in community culture
- Supporting people through social action
- Building capacity within the voluntary sector offer space to deliver
- Targeting the specific needs of individual communities
- Providing new models of 'wrap around care'
- Developing the 'Community Hub'
- Up-scaling and enhancing the primary care offer
- Providing joined-up public services delivered at a local level
- Incorporating specialist housing
- Developing housing models for step down care





Key benefits

- Increase capacity for older peoples care
- Excellent facility for service users, Dementia services achieve gold standard
- ExtraCare model estimated at £1,115 per person NHS saving pa.
- Between 17.8% and 26% saving to social care
- Hub generates a wide range of activities delivering a Social Return on Investment of £5.90 per £1 spent
- Primary care now able to accommodate increasing patient list, and has seen a notable improvement in staff morale
- Women's refuge have seen significant improvement in outcomes and reduced level of mental health issues

Dove Service
Carers in the workplace

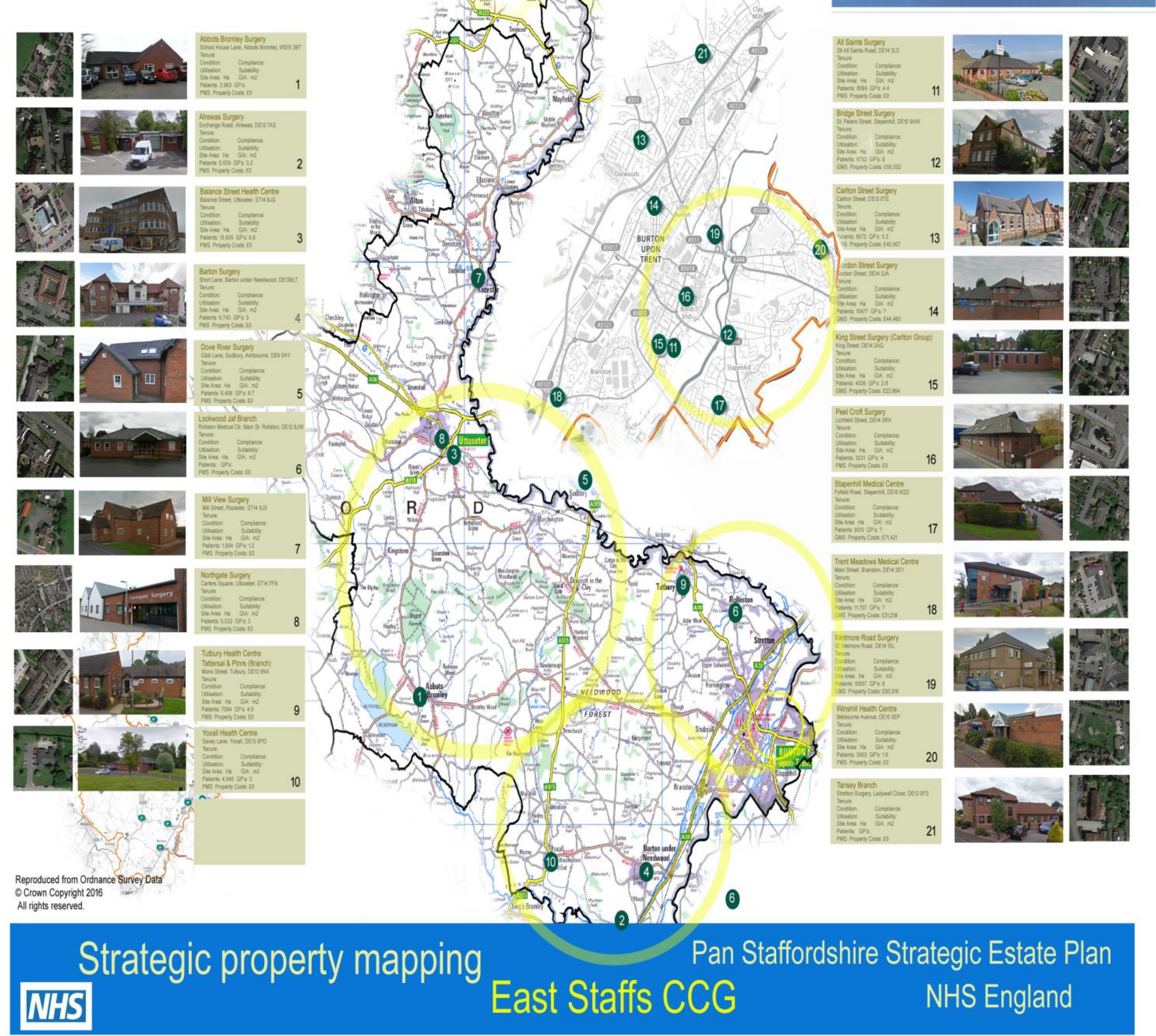
Approach

- Create independent living opportunities and appropriate housing to give people the lives they want

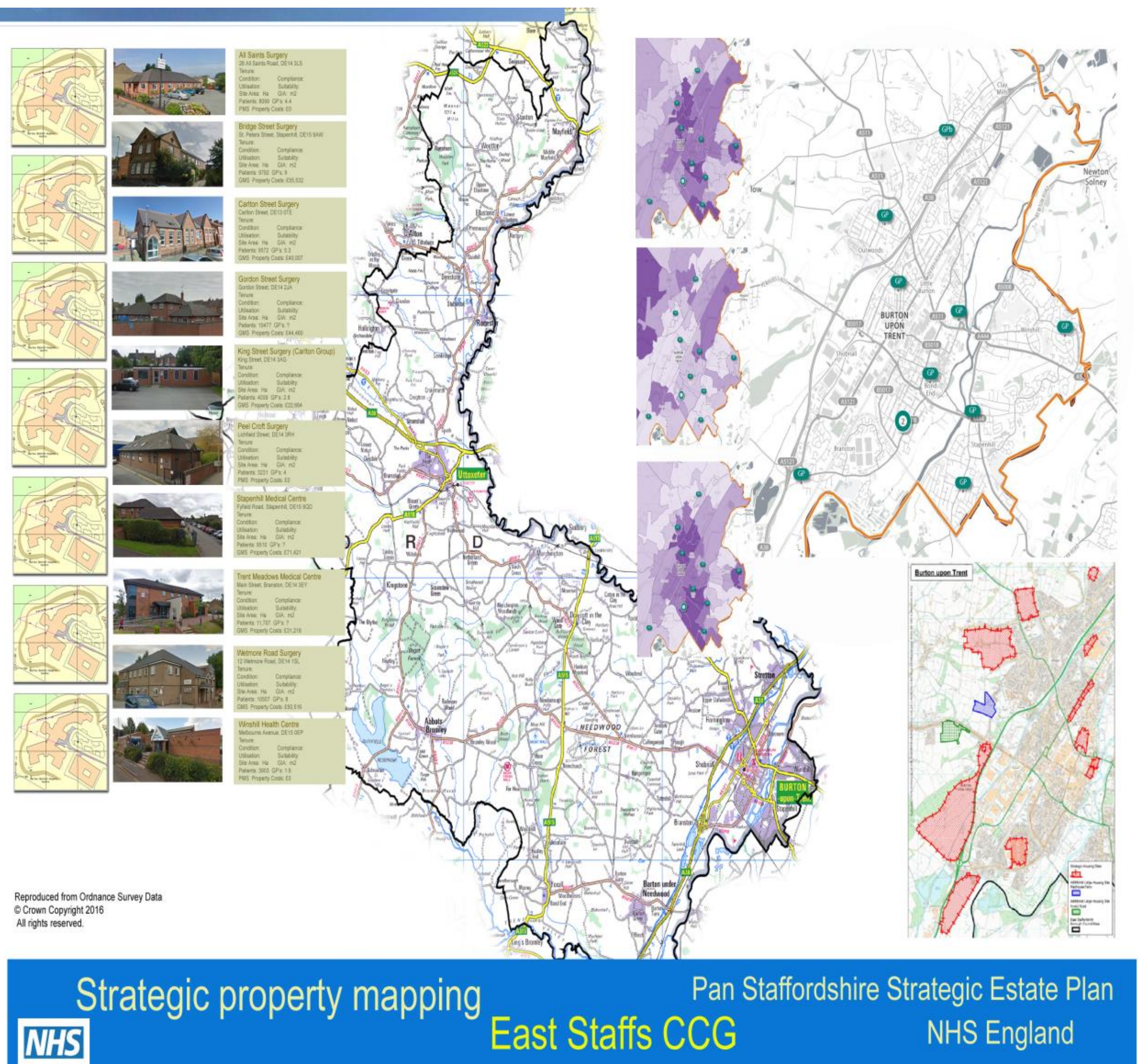
- Enable people and organisations to integrate, work together, share problems and solutions, all in one place – through **partnership** working

- Allow generational change to occur whereby people look to their own community for support, not to the public services

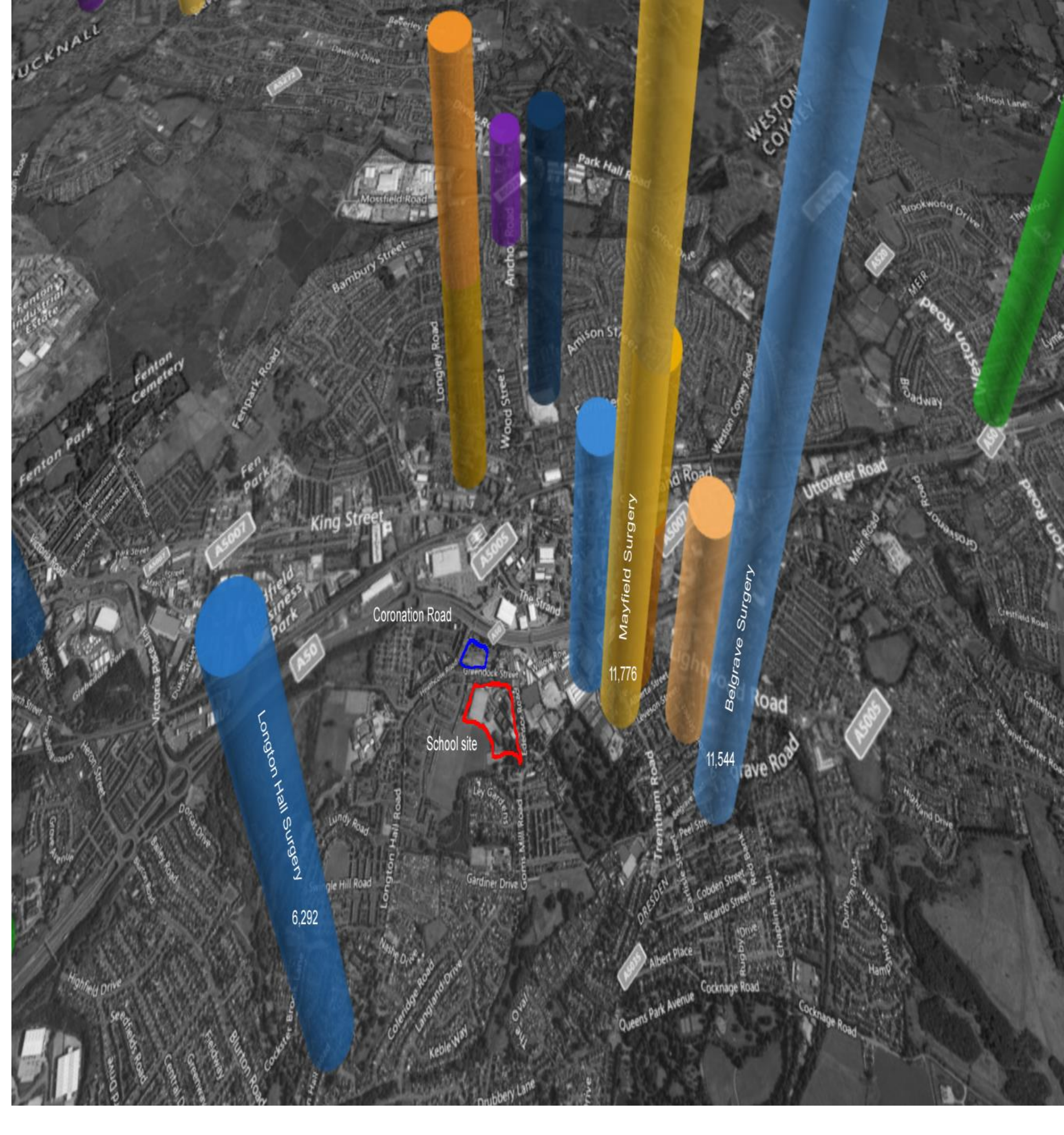
How can this be delivered?



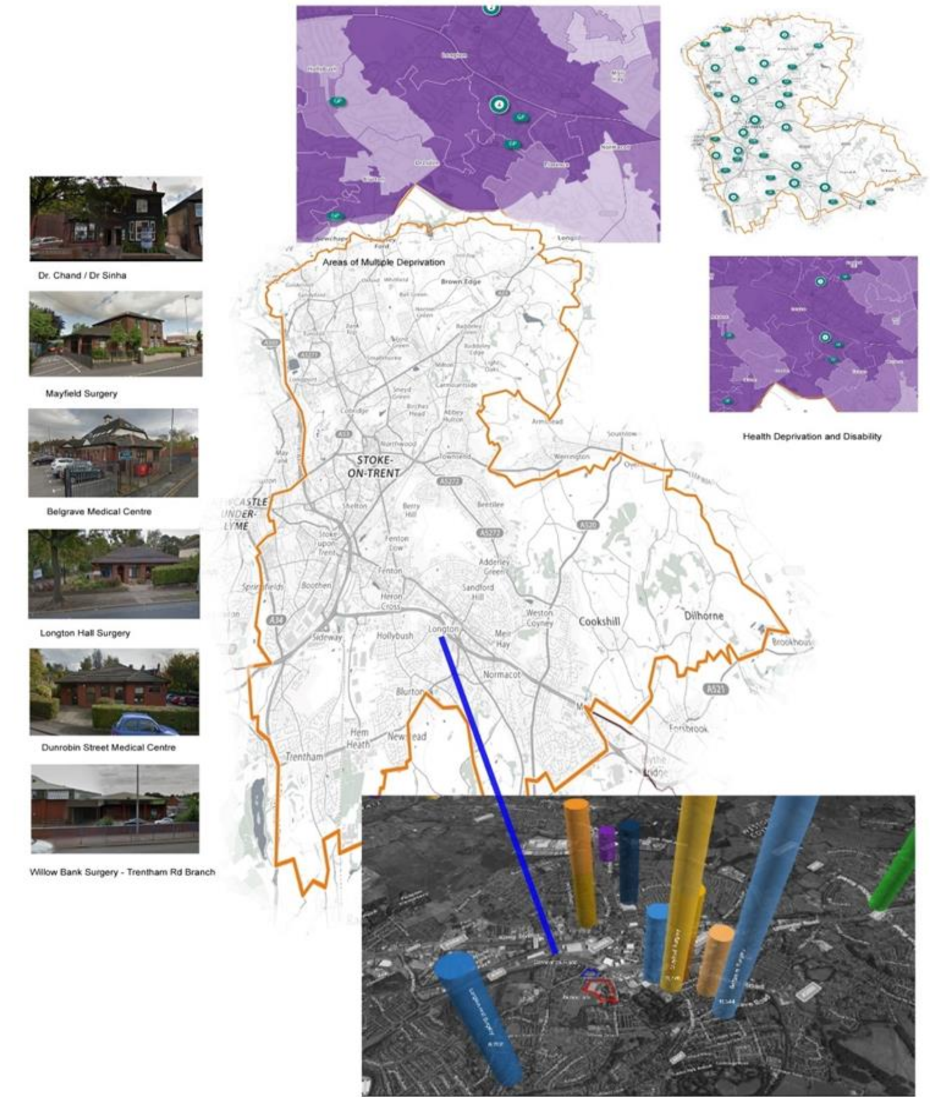
Delivering future change



Understand current situation and identifying future opportunities



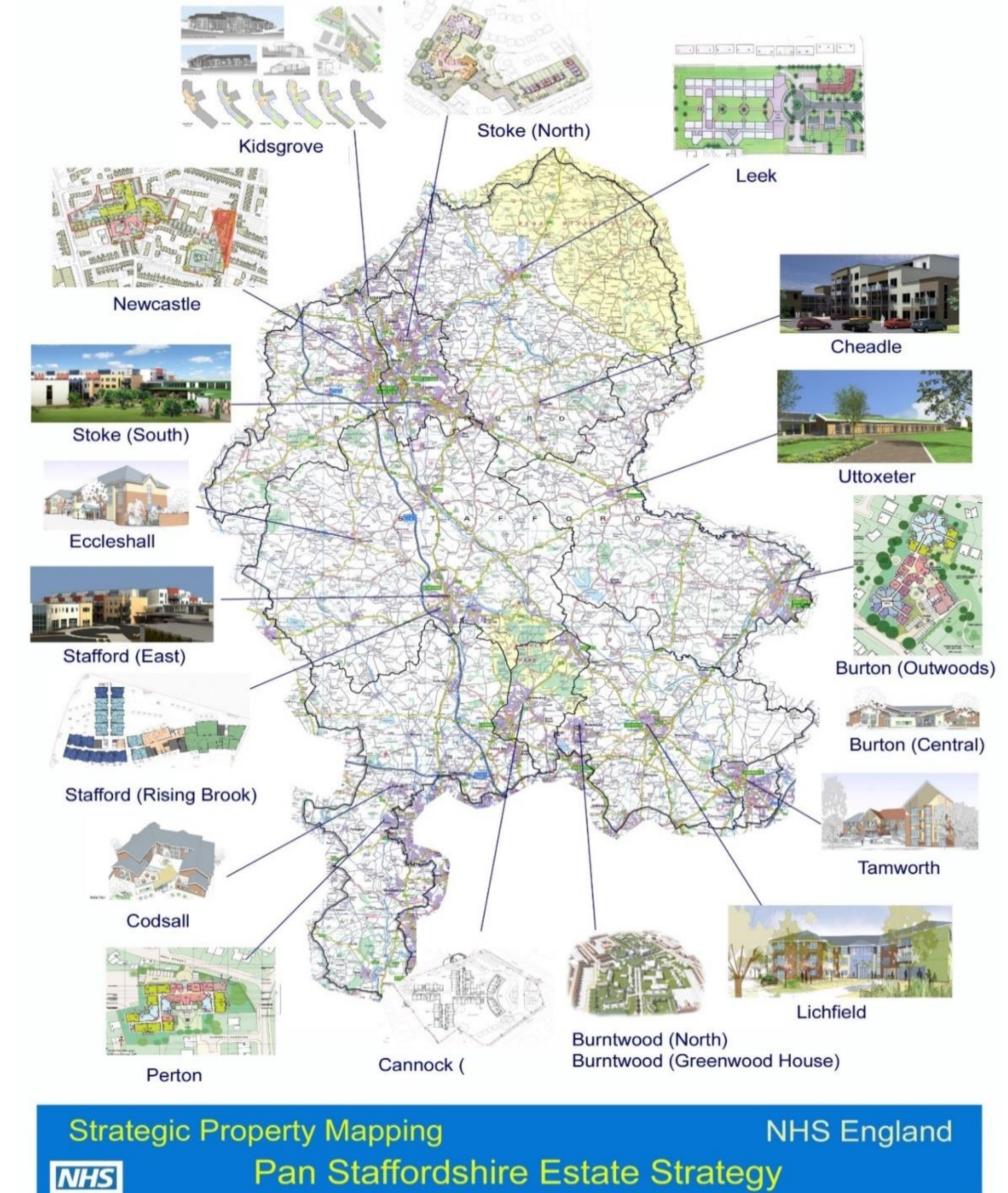
Mapping the whole process



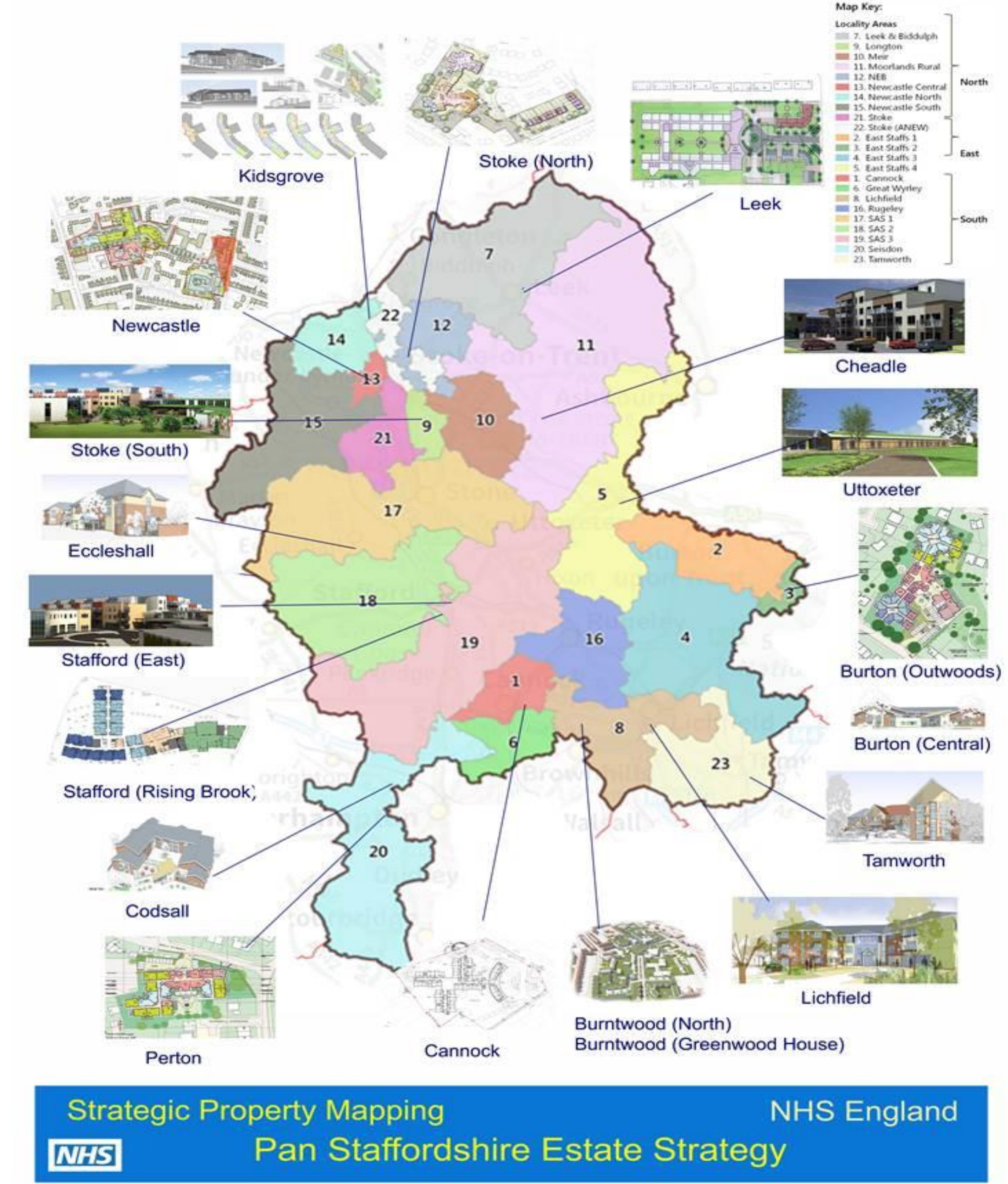
NHS England
Strategic property mapping
Pan Staffordshire Strategic Estate Plan
Stoke on Trent CCG
NHS

NHS England
Strategic property mapping
Pan Staffordshire Strategic Estate Pla
Stoke on Trent CCG
NHS

Identified opportunities



Opportunities mapped against STP localities



Shropshire, Telford and Wrekin – what's possible?

SHREWSBURY

TELFORD

Opportunities

Current position

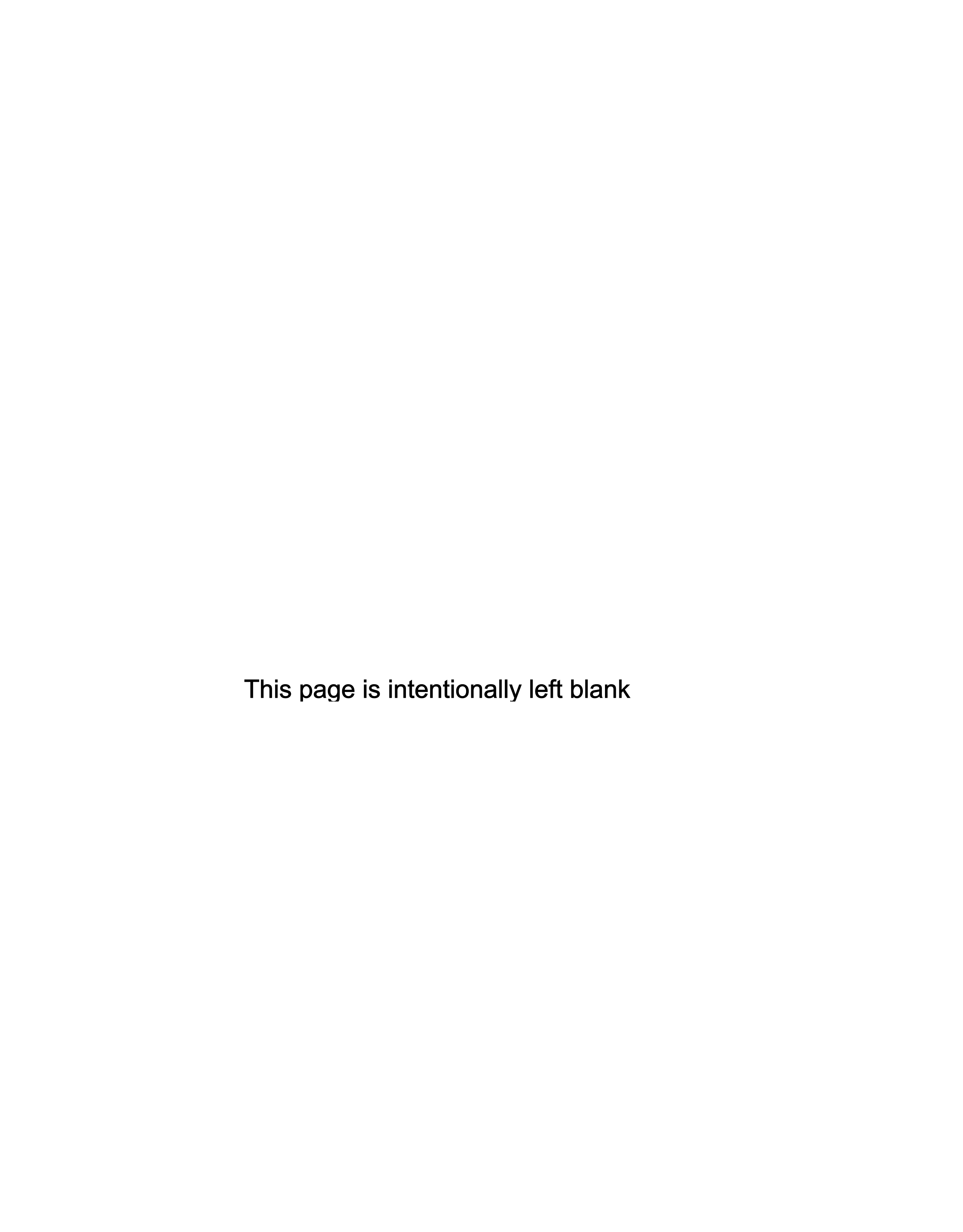
- Whitchurch is an identified project with funding from both NHS and local Council
- Acting as a catalyst for partnership working and other potential opportunities are being identified as a result
- Working with colleagues in Shropshire Council, we are planning a whole system approach to future mapping of service provision requirements
- Possible opportunities being discussed in Telford
- OPE and STP are driving partnership working and relationships are being built which can impact upon future decisions

Partnership working

- This has to be true partnership working
- Not one organisation leading another and asking them to help them deliver their priorities
- Understanding:
  - the need of the community,
  - the regulatory requirements and;
  - timelines of ALL partner organisations and working in partnership to deliver all priorities to deliver the community need
- This demands trust, honesty and compromise in order to deliver for the people

Thank you!

- Any questions?



This page is intentionally left blank

Health and Wellbeing Board

Meeting Date: 13th September 2018

Item Title: Tackling Food Poverty Together – Shropshire Food Poverty Alliance

Responsible Officer: Chris Westwood – Customer Services, Service Delivery and Improvement Manager, Shropshire Council

Email: chris.westwood@shropshire.gov.uk

A report is attached.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr Lee Chapman
Local Member All
Appendices • Brighton and Hove Food Poverty Action Plan 2015 – 2018 • Brighton and Hove Food Poverty Action Plan - Final

FOOD POVERTY IN SHROPSHIRE

Report For The Health And Wellbeing Board
August 2018

Shropshire Food Poverty Alliance

- 1 in 5 children in Shropshire are living in poverty (End Child Poverty 2017)[1]
- 27,000 Shropshire families, both in and out of work may have reduced food budgets due to Welfare reforms and changes to council tax support (Citizens Advice Shropshire)
- Shropshire households have lost an estimated £102 million per year from their budgets due to welfare reforms since 2015 (Beatty & Fothergill 2016)[2]
- 90% feel that food poverty levels are increasing (Shropshire Food Poverty Alliance Survey)

Volunteer run food banks across the county provide emergency food parcels, however this assistance is time-limited and is only available to households in extreme financial crisis. Food banks report that people who need emergency food parcels are coming from an increasingly wide range of situations, including families and those who are in work. Currently there is very little provision in Shropshire for households who find themselves in chronic long-term food poverty and the desired outcome of the Shropshire Food Poverty Alliance would be the introduction of initiatives across the county such as those implemented in Brighton, which go beyond emergency food provision towards a much wider and more preventative approach to food poverty whilst using existing infrastructure and expertise.

[1]Beatty, C & Fothergill, S (2016) The Uneven Impact of Welfare Reform: the financial loses to places and people, Centre for Regional Economic and Social Research Sheffield Hallam University.
[2] End Child Poverty (2017) http://www.endchildpoverty.org.uk/poverty-in-your-area-2018/

Some of the underlying causes of food poverty have their roots in much larger, national or strategic issues, beyond anything the Alliance can hope to change but we can pragmatically do is to look at what can be done to contain the outcomes for people. Therefore throughout 2018 the Shropshire Food Poverty alliance has been conducting participatory research to develop a Food Poverty Action Plan for Shropshire. We have identified a wide range of potential solutions, some of which are easy wins and some of which will require refocus of existing resources or new funding. The Action Plan will reduce the risk of families in Shropshire experiencing food poverty by connecting up support services and increasing the capacity of families to access low cost healthy food to ensure a healthy and nutritious diet.

2 Recommendations

The Health and Wellbeing Board are recommended to:

- note the purpose, work and aspirations of the Shropshire Food Poverty Alliance
- consider and contribute to the development and implementation of the Food Poverty Action Plan.

We would also like to extend an invitation for a representative from the Health and Wellbeing Board to attend future meetings of the Shropshire Food Poverty Alliance.

3 Background

The Shropshire Food Poverty Alliance was formed in January 2018 by a consortium of organisations who are committed to work together to tackle food poverty in Shropshire. Our membership includes public, faith and voluntary organisations including food banks from across the county. The Alliance is

currently being co-ordinated by Shrewsbury Food Hub, with a steering group of organisations including Citizens Advice Shropshire, Shropshire Council, Age UK and University Centre, Shrewsbury. Our aims are to:

- 1.1) Tackle food poverty and diet related ill health
- 1.2) Promote a healthy and sustainable diet
- 1.3) Build community food skills and knowledge
- 1.4) Increase access to affordable healthy food
- 1.5) Ensure there is crisis and emergency support so that people do not go hungry
- 1.6) Get food poverty (particularly rural) on the local and national policy agenda
- 1.7) Research and monitor food poverty so we know if we are being effective

Throughout 2018 we are working to develop a Food Poverty Action Plan for Shropshire. The Action Plan will make it clear what we need to do to tackle food poverty. A draft action plan will be issued for consultation in the autumn. As part of this process we have:

- Mapped levels of food poverty
- Interviewed people in food poverty (10+ interviews to date)
- Surveys (Organisations, schools and individiauls in food poverty) 100+ responses to date
- Visited food banks across the county
- Run three workshops to create connected solutions (58 attendees)
- Researched best practice from other counties to identify which approaches might work best in Shropshire

We are grateful for the financial support of the Food Power Program (run by national charity Sustain: the alliance for better food and farming), Shropshire Council and University Centre, Shrewsbury.

Snapshot of survey data

Citizen's Advice Shropshire have estimated that a possible 27,000 families in our county may have to cut their food budgets this year. Our survey shows that 81% of respondents feel that food poverty has increased in the last year and that working families as well as those on benefits are being affected.

Quotes from Shropshire Food Poverty Alliance Surveys

"I can't afford healthy food like fruit and vegetables, it breaks my heart because I want to be a good mother" (Survey response from Market Drayton)

"We have several children that come to school on a regular basis without breakfast. We also have children arrive after lunch late, having not had lunch. We also have children that eat a large amount of fruit in the mornings and have seconds at lunch time as hungry (sic)" (Primary school survey response)

Shropshire Food Poverty Alliance Case Study

Peter (not his real name) worked for a housing association for 17 years. Since taking redundancy he has been unable to find permanent employment and is claiming Universal Credit whilst taking on casual jobs via agencies. His food budget is £40 a month. Living in a house share, Peter keeps his food in his bedroom so that it isn't eaten by his 6 housemates. Unable to use the fridge or freezer, he relies on tinned and packaged foods, which he separates out into weekly piles. He tries to make the food last the month, but he says "sometimes you get to the stage where you are just really, really hungry and you've got to eat". As the month goes on he just eats less. This month he has been unable to find any work. "I've been trying to portion my food, but it got down to a tin of soup a day. It got to be a struggle". He came into the food bank on a Friday morning, but had not eaten since Tuesday.

Quotes from Citizens Advice Shropshire Survey[3]

"I haven't quite got as low as a foodbank, but I have had days sometimes where I've just had crackers but I also make sure my son has a decent meal, he gets free school means so he always has hot food but it has got close sometimes." **(Single parent, 35-49 Shrewsbury)**

"Its food or my Prescription, and I can't afford to have another stroke" **(Single person, 50 -64, rural village)**

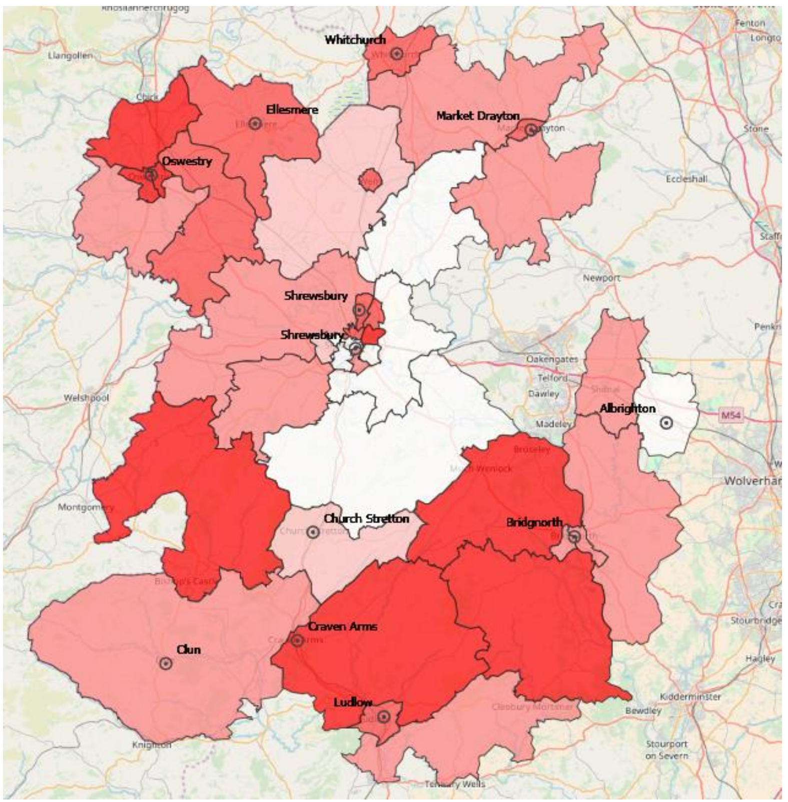
Shropshire Food Poverty Alliance Case Study

David and Emma (not their real names) live in Whitchurch. They have five children, and David stays at home to care for the children whilst his partner works. He has used the food bank in the school holidays in order to feed their children. David says "We are not poor, you know like Oliver Twist poor, please sir, you know, but some weeks you just can't make ends meet. It's like what do you do? The food bank makes that decision for you. If you have the food bank you can pay your bills and that's just how it is."

[3] Quotes are from research Citizens Advice Shropshire has carried out in response to the changes to the Council Tax Support scheme in Shropshire.

MAPPING FOOD POVERTY IN SHROPSHIRE

The UK doesn't routinely collect data on levels of food poverty. As an Alliance we want to understand which parts of the county are more likely to be affected by higher levels of food poverty. With the help of CREST at University Centre, Shrewsbury we have explored a number of indicators to examine how the county is affected. The map below combines five key food poverty indicators, with the darker red areas highlighting areas with higher levels of food poverty.



Indicators used:

Food retail businesses per square km, benefits claimants, adult obesity, households with slow internet access, households without access to a vehicle.

The location of food banks is also marked.

4 Opportunities

Based on our research we have identified a number of opportunities which we feel would positively impact on people in food poverty in Shropshire.

- Improve collaboration and communication between wider support agencies with appropriate consent
- Improve guidance, advice and signposting
- Awareness raising at both a local and national level on key food poverty issues
- A focus on prevention, rather than just emergency food provision
- Skills-based courses to improve confidence with cooking and budgeting
- New initiatives which improve access to affordable healthy food in rural areas
- New initiatives aimed to assist groups particularly hit by food poverty

Shropshire food banks provide highly valued support for people in food crisis across our county but provision may be fragmented as it is entirely run by volunteer organisations often with very little

funding or support. For some people, there is a stigma attached to using foodbanks and we are aware that people will often only come as a last resort. Our research suggests that there are opportunities that would allow us to tap into the existing to work of our food banks whilst enhancing their provision into new models, new community based packages that help to remove the stigma and to enhance their provision particularly in the advice they give to clients and how that is better integrated into the wider support available from other agencies.

These new models are an opportunity to expand the range of assistance offered by food banks and other community organisations so that they can support a wider range of people in food poverty. For example, Ludlow Food bank is experimenting with the provision of fresh fruit and vegetables via a voucher scheme. Oswestry Food bank is working with local primary schools to identify families who are struggling over the summer holidays when there are no free school meals. Whitchurch Food bank is working with the local hospital to provide food parcels to elderly people on release from hospital. Shrewsbury Food Hub is providing surplus food to support holiday clubs, Pay As You Feel Distribution tables at 2 churches and setting up Community Fridges.

These local pilots and our research indicate that there are a range of new initiatives which would assist people across the county in food poverty.

Community Pantries	• food membership schemes supplied with food via FareShare • members pay a small weekly fee in return for a selection of food
Community fridges	• located in community spaces • open access to surplus/donated food
Community cafes	• affordable volunteer operated community run cafe

Good Food Hubs	• based in village halls/community centres
	• communal meals prepared by volunteers
	    • help overcome social isolation
	    • Rockspring community centre offers a two-course meal for £2
	• Communal food ordering
	• Could also act as an information point/advice hub

Affordable food box schemes	• low cost food boxes delivered to people's doors • similar schemes operate in Derbyshire • work well to combat rural food poverty
Food co-ops run from community centres/ schools	• In Wales there are over 300 food co-ops, many of which are run from community halls and schools • communal buying means that communities can access food at lower cost
Promotion of the Healthy Start Voucher scheme	• £3.10 per week available to families on low incomes with young children • current take up rate in Shropshire is 62% of eligible families
Voucher schemes for fruit & veg	• Ludlow food bank is trialling a voucher scheme for fruit & veg • In London fruit & veg is prescribed via Alexandra Rose vouchers
Food for children	• Holiday projects which offer free food to those in receipt of free school meals • Free breakfast clubs
Food assistance on hospital discharge	• Food buying for elderly patients on discharge • Food banks like Whitchurch are already starting to offer

We have identified a number of key principles to take into account when designing new services:

- Services should be dignified, avoid stigma and be provided in an environment where people feel safe
- Skills building courses should enhance confidence and autonomy and be useful to the individual
- Services should be designed with multiple benefits in mind
- Services should be built from the grassroots, building on existing structures rather than undermine existing resources
- Services where food is available should have well publicised clear rules on eligibility and food should be offered without judgement
- All new services need sufficient funding and co-ordination and a long-term plan

5 Conclusions

There are things that can be done. The action plan, which will be published later this year, will clarify what we feel can be done to combat food poverty in Shropshire. It is a scoping study, designed to identify opportunities and the organisations who could implement them. Further work is needed to develop a detailed implementation plan which makes clear the costs, benefits and phasing of the work.

Being able to implement new initiatives identified in the Action Plan would particularly help to reduce the risk of families in Shropshire experiencing long term food poverty by providing connected support services and increasing the capacity of families to access low cost healthy food to ensure a healthy and nutritious diet. It will clearly benefit families and enable children to grow up healthily and increase concentration at school. However, it will also have wider benefits, including increasing community resilience, bringing people together over food to overcome social isolation, and reducing health related issues connected to poor diet and malnutrition.

The ability of communities to meet their own needs remains a high priority and the issue of food poverty for Shropshire's residents, its causes and potential solutions needs to be part of any planning so that pathways to and from this provision are cemented.

The Food Poverty Action Plan will prioritise opportunities for improving the current situation in Shropshire. Some actions will be "easy wins" such as connecting up existing support, embedding a clear focus on food into existing programmes which are already funded, or improving the knowledge and take-up of Healthy Start Vouchers and maximisation of family income. However, new resources would be needed to implement new concepts like community pantries and food co-ops, wherever possible building on the resources already available within each community such as schools, GP surgeries, existing shops or community halls. Funding will be needed for co-ordination, research work and development of funding bids for implementation.

The detailed implementation plan would identify how resources for work across the county can be secured by integrating actions into existing programmes, through grant funding from statutory bodies and trusts and foundations and through social enterprise.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **None to date**
Cabinet Member (Portfolio Holder)
Local Member **All**
Appendices **Appendix 1 – Brighton and Hove Food Poverty Action Plan** **Appendix 2 – Brighton and Hove Food Poverty Action Plan - Final Progress report**

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

Brighton & Hove
FOOD
Partnership

“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?

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'.

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

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.

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*

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.

Year 1	Year 2		Year 3		
Lead Partner Meeting: Year 1	Stakeholder Progress Event – Refocus Year 2	Report back to partners & Neighbourhood Communities and Equalities Committee	Lead Partner Meeting: Year 3	Reflection/ evaluation/ learning – plan next steps	Report back to partners & Neighbourhoods Communities and Equalities Committee

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.

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

– Participant at Young People's Centre

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 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

Brighton
and Sussex
University
Hospitals
NHS Trust

Department for
Work and Pensions

Brighton & Hove Food Poverty Action Plan 2015-18

Final progress report: June 2018

Find the Brighton & Hove Food Poverty Action plan 2015-2018 + 'One Year On' and final 'Food Power stakeholder event' reports at www.bhfood.org.uk/resources

Winner 2016 Community **Works Sector Star Award:** 'Most Innovative Commission or Public Sector Service'

Lottery funded **Food Power** Programme rolling out the approach nationally

www.foodpower.org.uk

Mayor of London using as a model for support to London Boroughs

Brighton & Hove
Food Poverty
Action Plan 2015-2018

Introduction

In 2015, partners from across the city pledged to take action on food poverty. After three years, lead partners reported back the progress that had been made. The Plan had 78 headline actions, but some were grouped so this report breaks them down further into 84 separate actions. There is more information and a case study on how the action plan was produced at http://bhfood.org.uk/policy/food-poverty-action-plan/.

Nationally it has been seen as best practice and has contributed to Brighton & Hove becoming the first silver sustainable food city in the UK.

Part 1 - Summary of Activity

Overall there was progress on 78 out of 84 actions (93%)

- **49 actions had made good progress (58%)**
- **29 had made some progress (34%)**
- **6 had made minimal or no progress (7%)**

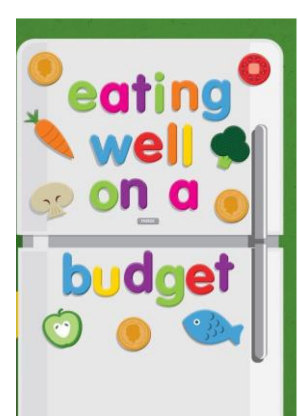
All partners were contacted via email or telephone, in Spring 2018, for final updates. Some progress updates were previously received via a 'halfway' event & emails in 2017. Some update responses have been summarised by BHFP who also decided the 'traffic light' status in the detailed report in part 2.

Highlights and challenges

Please see part 2 for full details – this is just a handful of the activities which took place!

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

Highlights



- ✓ BHFP's information and advice page & leaflets for people experiencing food poverty continue to be well used including a new directory and online map of food banks.
- ✓ Feedback from the 2018 stakeholder event indicates that BHFP training with frontline staff, plus awareness raising around this plan by BHFP and other partners, has raised the profile in the city and catapulted the issue into other plans and services & Fairness Commission findings.
- ✓ A strategic approach to welfare reform at the city council, plus DWP training for food banks and others in short term benefit advances, and other routes out of hardship, alongside hard work by money advice agencies has helped reduce the impact of welfare changes.
- ✓ Primary and Special School Meals Service became a Living Wage Employer as a beacon for other large catering employers.

- ✓ Organisations have collectively helped to 'measure' food poverty by including BHFP questions- most notably BHCC Housing who uncovered high levels of food poverty in their tenants.
- ✓ BHFP secured financial support from Food Power for next steps on food poverty agenda in 2018, and to undertake research with most at-risk groups including rough sleepers
- ✓ Learning has been shared with other cities nationally and evidence submitted to national consultations and parliamentary enquiries.

Challenges/Sticking Points

- ✗ Although the Living Wage Campaign has successfully increased sign-ups, many continue to experience insecure/low paid employment and in-work food poverty – ironically often those in food production/ retail / catering.
- ✗ Housing costs, and lack of housing, continue to be a huge issue in the city with food banks reporting housing as an increasing factor in demand.
- ✗ Likely rises in energy and food prices (compounded by Brexit) along with the continuing impact of welfare changes especially Universal Credit could be a tipping point for many people in the city who are just getting by.
- ✗ There has been less progress around the apprenticeships agenda although Plumpton College have some exciting food related apprenticeships going forward, and there is potential for related economic/apprenticeship actions to be picked up via the new Economic Strategy.
- ✗ The external climate has been difficult, with limited resources at BHCC, BHFP and other partners, plus health service restructures and high turnovers of staff in some organisations making partnership working difficult.

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

Highlights

- ✓ A joint citywide healthy start voucher campaign with a poster, social media, and changes to practices including an easy sign-up option via children's centres.
- ✓ Chomp, who address 'holiday hunger' with activity and lunch clubs targeted at families who get free school meals in term times, have expanded and now operate on 12 sites across the city with 700 meals served a year. A new partnership with the school meals service means that Chomp now taking place in three schools; and there are pilots in children's centres
- ✓ A joint exercise by BHFF welfare reform and the school meals service substantially Increased uptake of free school meals.
- ✓ Both the CCG and BHCC Adult social care have committed to better embedding the food poverty agenda and both malnutrition screening and a preventative focus on avoiding diet related ill health within their services.
- ✓ Digital Brighton & Hove have championed inclusion of food shopping in 'getting online' courses and digital access in food banks.
- ✓ Approx. 7000 copies distributed of a new 'Eating Well as you Age' booklet produced by BHFP in partnership and jointly funded by Age UK and the CCG to help prevent malnutrition in the community.

Challenges/Sticking Points

- Children – particularly in larger families & single parent families – have already been disproportionately affected by welfare/tax credit reforms continue to be hit hard e.g. the new "2 child limit". This makes actions aimed at families (such as Healthy Start vouchers, Schools & Chomp) particularly important.
- The climate in ASC, CCG, and BSUHT has been incredibly challenging which has made it difficult for food to be priority, though individual staff have been great champions.
- There was little progress in creatively combining care package to allow people to eat together (or other creative solutions to care packages not allowing enough time for good food preparation – not just 'take off the foil') however there is interest in a pilot going forward.
- The end of the community meals contract could have been an opportunity to divert funding to allow new social enterprise models to develop, as has happened in other areas and it was a shame this did not take place. Whilst there are private providers, there remains a gap/need for more affordable home delivery of meals to people who find it hard to get out and are at risk of malnutrition.
- BHFP facilitated a meeting on food and hospital discharge, which came up with recommendations. In response, Healthwatch are taking forward a project researching hospital discharge and older people, including food and hydration. The hospital is improving its short-term food parcel, the discharge pack. However, the CCG is not funding the longer-term bags which were a key recommendation and will cease funding the Red Cross 'settle at home' pilot which would have delivered the bags (and which plays an important role helpings very vulnerable people without family or friends support networks to access food).
- Whilst there has been some progress, schools could engage more over food poverty agenda. It is hoped that the findings from the 'Poverty Proofing the School Day' audit, which has built in questions on food and food poverty, will clarify the issues and the way forward.

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

Highlights:

- ✓ The uniquely positive vision of the 'City that cooks and eats together' has led to initiatives such as Casserole Club, where neighbours cook an extra portion for a local vulnerable person; and a higher profile for lunch clubs and shared meals. One of the less recognised effects of food poverty is social isolation, and these projects help to address loneliness alongside healthy food access
- ✓ BHFP and other partners have continued to promote run classes in cooking and shopping skills including Cooking on a Budget and BHFP set up the new community kitchen to act as a focal point for cooking together and for cooking skills.

- ✓ Possability People made the 'It's Local Actually' Directory easier to search for lunch clubs and Adult Social Care produced a paper directory which was sent out widely. Befriending organisations have played a key role in helping people to access them. New models have been tried e.g. 'Posh Club'. BHFP has been funded by BHCC to support shared meal settings.

- ✓ Sheltered Housing have championed the agenda, setting up shared meals and food growing and promoting casserole club. They have committed that all refurbishments will include a fridge/freezer rather than a fridge with icebox as this helps cooking on a budget for one or two.
- ✓ The role of surplus food has increased and become more coordinated via the new Surplus Food Network, and expansions to FareShare and Sussex Homeless Support operations.
- ✓ Real Junk Food Project have expanded and found rotating premises to offer a meal 5 day a week, and opened their food hub in Bevendean, with a shop and storage - though they are still seeking a permanent café site.
- ✓ The Local Transport Plan (March 2015) stresses both connecting people with shopping areas, and the importance of local shopping centres in allowing access to food, as well as creating healthier environments that encourage walking and cycling for food shopping journeys.
- ✓ There have been successful city-wide Sugar Smart and Veg Cities Campaigns.

Challenges/Sticking Points

- × Whilst there have been new shared meals set up, due to cuts there has also been losses including BHCC Tower House Day Centre (now reopened by St Vincent de Paul Society) Mad Hatters in East Brighton, Bluebird & the Bridge community centre & cafe in Moulsecoomb.
- × BHFP won the BHCC City Innovation Challenge, with the idea of offering free market stalls outside libraries but this ran into red tape and didn't happen. Market stalls are a great way to have easy access to fruit and veg, so it is hoped this can go forward.
- × Although Casserole Club has proved popular during the pilot, longer term funding to support the work is not secure.

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

Highlights

- ✓ Food Banks have continued to expand provision plus add-ons e.g. digital access and shared meals.
- ✓ Food banks are increasingly integrated with money, and other advice services (e.g. housing, mental health) and with BHCC welfare support and the DWP. Many food banks now have advisers visiting and both the DWP & BHCC run training for food banks.
- ✓ BHFP continue to support the Food Banks and Emergency Food network, bringing food banks together with other services and BHCC have funded this work.
- ✓ Although funding has been reduced, BHCC continued to support the Local Discretionary Social Fund meaning that people experiencing an emergency are not reliant purely on the voluntary/ community sector.

- ✓ FareShare and other surplus organisations (see also above) have increased their volunteer numbers and food supply, as well as their reach. They have encouraged healthier food donations. Supermarkets including Lidl, Tesco and Sainsbury's have been much more proactive at offering surplus. BHFP have set up an online food donations portal and do regular blogs about what food banks need donations-wise.

Challenges/Sticking Points

- ✗ Food Banks continue to report increasing demand.
- ✗ The LDSF funding is only secure year by year. Without it almost all crisis food solutions rely on voluntary sector provision.
- ✗ As identified in section 1, the city's housing crisis continues to be a huge issue in the city alongside low wages/insecure employment. Likely rises in energy and food prices (compounded by Brexit) could be a tipping point for many people in the city who are just getting by.

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

Progress

- ✓ BHFP's annual survey of food bank use continues to provide a useful insight (see intro for details).
- ✓ BHCC's city tracker question continues to provide extremely useful picture of household food insecurity or 'long term' food poverty. (see intro for details).
- ✓ Several organisations notably BHCC Housing have included BHFP's questions in their monitoring and then shared data. (see intro for details).
- ✓ Both universities have supported BHFP around tracking and measurement, and links are now much stronger.
- ✓ Many food banks now use 'Trussell Trust' categories to better track the reasons for food bank use locally and compare with national data.
- ✓ BHFP secured Food Power financial support (though this is short term) which allows them to keep up to data with national research on food poverty as well as carry out local research with groups identified as most vulnerable to food poverty.

Challenges/Sticking Points

- ✗ As the external climate changes, and because other areas don't measure it is hard to know what success looks like in terms of food poverty.
- ✗ There is data held by organisations e.g. the hospital collects data on malnutrition on arriving and leaving hospital, but this isn't shared with partners.
- ✗ The absence of a government measurement makes it hard to compare with other areas. BHFP continues to add a local voice to national campaigns for proper measurement of both emergency food poverty and longer-term household food insecurity in the UK.

What next?

Food Poverty Round Table, 2015

The next phase will continue the food poverty focus, but rather than having a separate Action Plan, food poverty will be absorbed back into 'Spade to Spoon' the city-wide food strategy for a 'healthy sustainable and fair food system' meaning that food poverty and food inequality will be at the heart of a new five-year action plan alongside health, the economy, community, and the environment.

Spade to Spoon: Digging Deeper sets the strategic direction for food work in the city from 2012 to 2032. The vision is a healthy sustainable fair food system for Brighton and Hove. Progress will be reported on by BHFP (subject to resources) supported by a cross-sector expert panel, which will meet approximately 3 times per year.

Brighton & Hove Food Partnership: Food Poverty Resources:

Advice for people experiencing food poverty: http://bhfood.org.uk/food-poverty-advice

How to refer to a food bank (includes infographic map of pathways produced with food banks in the city): http://bhfood.org.uk/referring-to-a-food-bank

Emergency Food Network: http://bhfood.org.uk/support-for-food-banks

Budget eating advice: http://bhfood.org.uk/eating-on-a-budget (also printed leaflets)

Free & low-cost meals: http://bhfood.org.uk/accessing-low-cost-meals

*Our **resources page** includes the **food poverty action plan**, **One Year On Report,** our annual **report into food bank use**, and other **publication**s e.g. research on shared meals http://bhfood.org.uk/resources*

With thanks to over 50 partners involved in the plan, and to our funders:

Food Poverty in Brighton & Hove – what we learned

In order to demonstrate progress on food poverty (and this plan) Aim 5 of the Food Poverty Action Plan focussed on how as a city we can track levels of food poverty. This involved a three-pronged approach – BHFP's annual survey of food bank use (for emergency/crisis food poverty), a question in BHCC's city tracker survey (for 'household food insecurity') and through a citywide approach, with various partners including questions in their monitoring and/or exploring this issue.

1. Emergency / Crisis Food Poverty: annual survey of food bank use

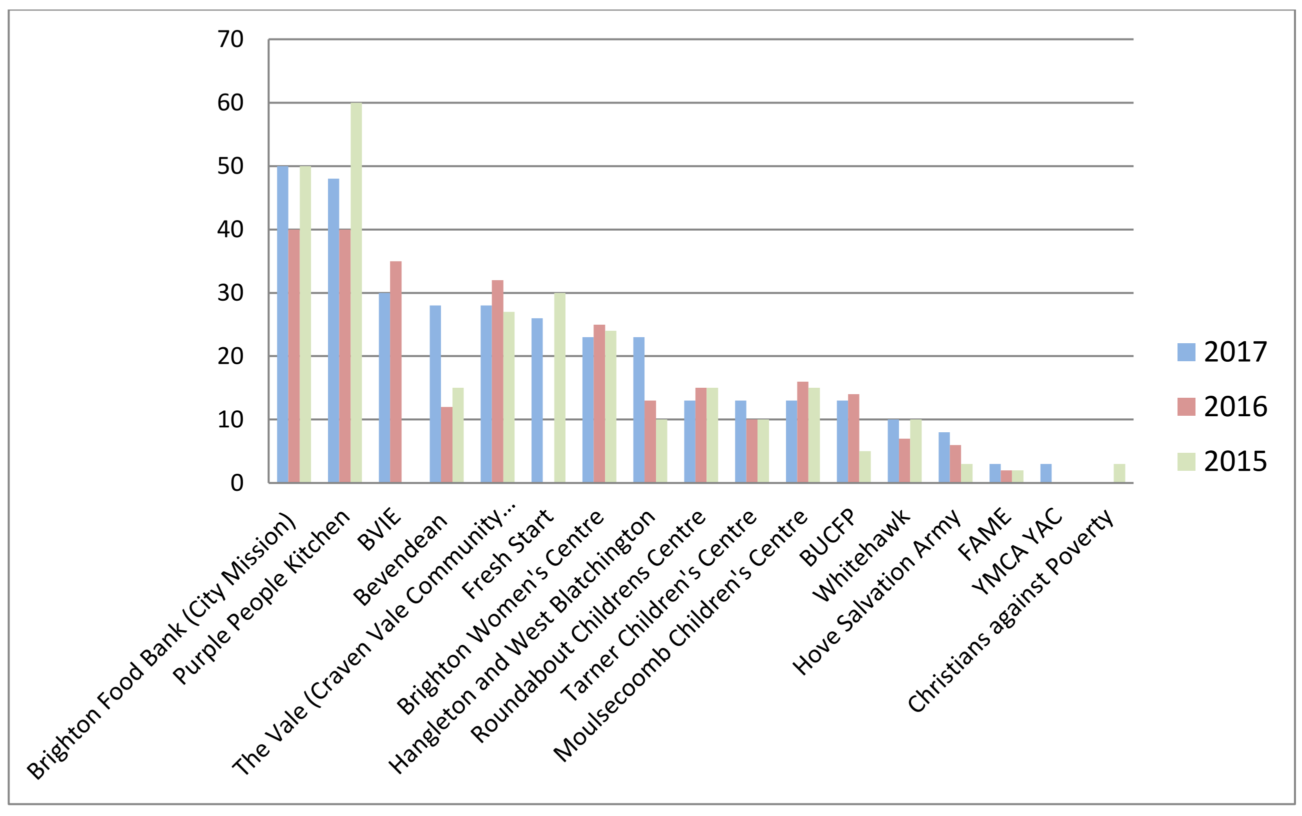
> *"Food poverty is going to get worse and foodbanks may be relied on for longer periods of time than 4-8 weeks. How, as a city, can we work together to support this?" - Food bank survey respondent, July 2017*

BHFP's annual survey of food bank use shows that food bank usage in Brighton and Hove continues to slowly but steadily increase[1]:

In 2017 **16** food banks gave out roughly **315** food parcels per week
In 2016 **15** food banks gave out roughly **298** food parcels per week
In 2015 **15** food banks gave out roughly **289** food parcels per week
In 2014 **13** food banks gave out roughly **266** food parcels per week

When asked about their perception of demand for their service, in 2017 no food banks reported a decrease in demand from last year. Three reported that they felt that demand was roughly the same and seven reported that there had been an overall increase in demand.

Food parcels distributed in Brighton & Hove snapshot of a typical week 2015-2017



[1] Brighton and Hove Food Partnership's annual 'Food Banks and Emergency Food Survey' www.bhfood.org.uk/resources . Note that parcel sizes / values vary between food banks plus distribution varies between weeks – this is not a 'league' table but a rough snapshot of overall distribution

Our survey showed that the **pattern of food bank use is changing**:

- Seven out of ten food banks reported an increase in demand over the last year from **vulnerably housed people** and **people in temporary accommodation**, and three out of ten from **street homeless people**
- Six out of ten food banks reported an increase in demand from people with **mental health issues**.
- Five out of ten food banks reported an increase in demand from both large **families and single parents**.
- Four out of ten food banks reported an increase in demand from **people in work**

"I have nothing but praise for the food bank and volunteers." A story from our blog

Debbie (nor her real name) is a mother of four children. When her husband became paralysed following complications during a routine back operation, he had to stop working. The part-time income from her own work was not enough to live on, but it put them over the threshold for ESA benefits. When we spoke to her, she had been waiting four months to hear whether she would be eligible for alternative PIP benefits, and before the food bank's support was having to choose between paying for food and bills. "I have nothing but praise for the food bank and volunteers. Even when they offer you a sauce or a vegetable that you wouldn't necessarily know about, they tell you ways to cook it … I will never forget them."

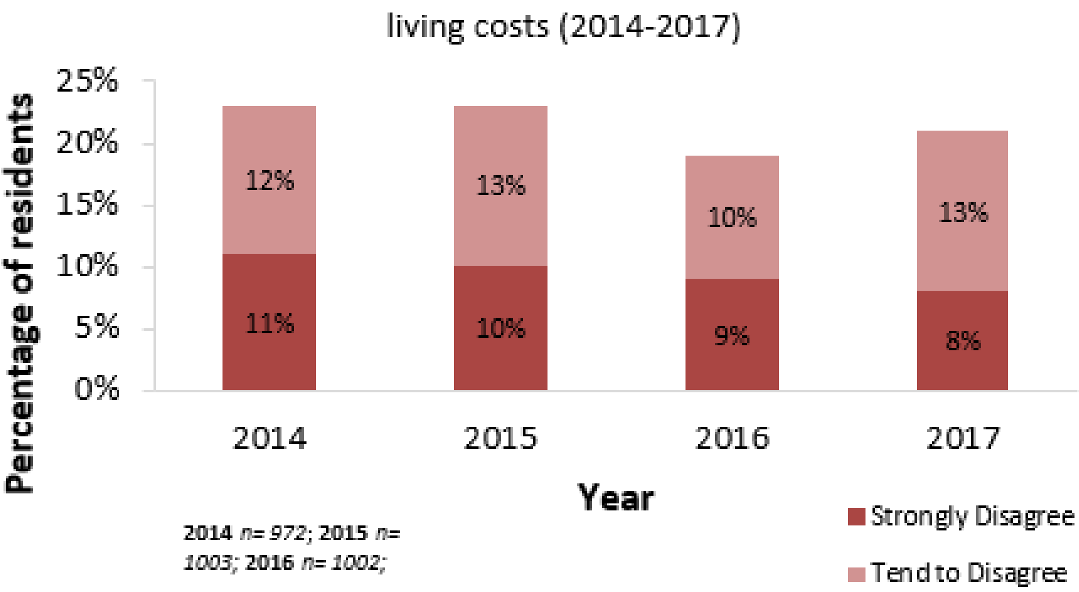
Why measuring food bank use isn't the same as measuring 'food poverty'

Although food bank use is often used as a 'measure' of food poverty, it isn't a good one. Food Bank use is only the tip of the iceberg. Food Banks are set up for short term emergency use and don't reflect longer term food poverty or household food insecurity experienced by many more people, and which was the focus of this plan. Even in an emergency, many don't access food banks because they can't get there (especially with health or mobility issues), don't know they exist or how to get a referral, or because of stigma.

2. Long Term Food Poverty/ Household Food Insecurity: City Tracker Survey

For four years, Brighton and Hove City Council has included a question which seeks to gather information on food and fuel poverty in their annual weighted survey of residents ('City Tracker'[2]): ***"Thinking about the next year, how much do you agree or disagree that you will have enough money, after housing costs, to meet basic living costs? By this I mean to pay for food, water and heating?"***

In 2017 **21% of people disagreed** – a slight increase (not considered statistically significant) from 19% in 2016 - indicating that **they don't feel they will have enough money to meet their basic living costs** and hence could be at risk of household food insecurity. This figure has remained fairly constant, at around 20% over the last four years, or **1 in 5 people in Brighton & Hove** (over 50,000 people)[3] Because of the difficult external climate, we think that 'holding steady' should be seen as success for the Food Poverty Action Plan. It is hard to compare our performance with other places, as others do not measure and there is little national data – this is a current 'ask' of Government.



Those most likely to struggle with meeting basic living costs continue to be concentrated in particular groups: - women, young working age people, Black and Minority Ethnic people and people with a disability or health condition. Where you live in the city is also a factor.

- Men (38%) are more likely to strongly agree that they will have enough money than **women (31%)**
- **The youngest age band (18-34)** are least likely to strongly agree **(27%)** compared with **36%** of 35-54s and **43%** of those aged 55+

[2] http://www.bhconnected.org.uk/sites/bhconnected/files/City%20Tracker%202017%20report%20-%20V2%2005%2012%2017%20vFinal.pdf

[3] Based on population estimate of 275,800 (2012) see http://www.bhconnected.org.uk/sites/bhconnected/files/City%20Snapshot%20Summary%20of%20Statistics%202014.pdf

- White British residents **(36%)** are more likely to strongly agree than those **from black and minority ethnic communities (15%)**
- **Disabled residents (18%)** are less likely to strongly agree than those without a disability **(38%)**
- The number of strongly agree ratings is highest in BN3 **(41%),** followed by **36%** in BN1, **31% in BN2** and **22% in BN41**

Age: Younger people

In 2017, only 3.5% of 55-65+ year olds, compared to 37.3% of 18-34 year olds, strongly disagreed that they will have enough money, after housing costs, to meet basic living costs in the next year.

Disability/long-term health condition

Those who **do not have a disability or health condition were consistently *more likely to agree* with the statement than those who do, especially those whose daily activities are limited 'a lot'.** This difference was consistent throughout four years, with around a **25-30% difference**.

3. Cost Savings from taking a city-wide preventative approach to long term food poverty/ household food insecurity

Evidence from Canada has shown that food-insecure people use health care services much more than those who are food-secure. People who were severely food-insecure had annual health care costs which were 121% higher (Tarasuk et al, 2015[4]). Given the future cost to health and social care services, plus the established effects on employment, education and social cohesion, even a small reduction in those figures represents a considerable saving in public money.

The 'One Year On' Food Poverty Action Plan Lead Partners' event in 2016

[4] https://www.sustainweb.org/resources/files/reports/MeasuringHouseholdFoodInsecurityintheUK.pdf

3. Gathering info through a city-wide approach

As part of the Food Poverty Action Plan, organisations have included BHFP's questions in their monitoring to help build a picture of food poverty in the city.

> "I am so glad we asked this set of new questions in this year's STAR survey, it has highlighted there is a need,"
>
> - BHCC Housing Department

Brighton & Hove City Council Housing Department added three questions to their bi-yearly STAR survey of tenants in 2016. They found similar overall levels to the city tracker, and again younger people and people with disabilities were more severely affected.

39% agree their household tends to eat less healthily because of affordability

However, the extra questions showed that food was impacting on health choices – with 39% of people saying their household eats less healthily because of affordability. Worryingly, 21% had skipped meals or reduced portion sizes in the previous two months because they couldn't afford enough food.

- Whilst more than half of those who responded (52%) agreed they would have enough money next year (after housing costs) to meet basic living costs, a **fifth disagreed (19%).**
- This figure rose to 29% for the **youngest age group** (16-34), more than half of whom 'strongly disagreed' (17%). In contrast, only one in ten of those aged 65 or over disagreed they will have enough money next year to meet basic living costs (11%).
- Households containing someone with a **disability** were more likely to disagree than nondisabled households (24% and 13% respectively).

21% skipped meals or reduced portion sizes in the last 2 months because they **couldn't afford enough food**

Brighton Unemployed Centre Families Project in their annual centre survey in December 2016 found:

- 42% of centre users said they have **reduced the size of their meals or skipped meals** because they couldn't afford food.
- 56% of centre users tended to agree or strongly agreed that they would not have enough money to **pay for food, water and heating** costs after paying housing costs.
- 62% of centre users tended **to eat less healthily at home** because they couldn't afford healthier options.

Warmth for Wellbeing programme (which includes advice services & BHESCo, a fuel poverty organisation) in 2016 found that **56% of their clients regularly missed meals or reduced portion sizes** because they couldn't afford enough food:

Options	Count	Percentage
Never	100	44%
Occasionally	21	9%
A few times a month	25	11%
Twice a week or more	33	15%
Daily	48	21%
Total	**227**	

CCG Research into Food with Equalities groups - 2017

The CCG commissioned research into Active Living & Healthy Eating in the city to inform local service commissioning, planning and delivery. Research was carried out in a variety of ways, including via surveys, focus groups & interviews. Note that some of the sample sizes are small, and the surveys not weighed so statistics should just be used as a guide. The following summaries are focused on food poverty, including the ability to eat, prepare and access healthy food.

Much of the research reported at least some participants who have struggled to afford food. Even when participants did not explicitly state that they struggled, many reported that they might not eat as healthily as they know they should due to cost.

- For participants with a **disability**, 29% stated that they did struggle to afford food in the last 12 months. 38% felt they tended to eat less healthily because of the cost of healthier options and 23% felt they sometimes did this. The majority of responses related to the cost of healthy food being a barrier, but also the ability and energy to cook a meal was a common barrier.
- Amongst participants with a **mental health condition**, 70% felt that food poverty was not an issue for them, although a few people identified specific challenges, such as with 'free from' foods being too expensive.
- For participants with a **learning disability**, support face-to-face was reported as integral to being able to budget and eat healthily. Lunch clubs were also highlighted as useful.
- Amongst participants who identify as **LGBTQ+** 24% said that food poverty is an issue for them and 27% strongly agreed or tended to agree with the statement that they tended to eat less healthily because they can't afford healthier options.
- For **young men**, 8% of respondents had skipped meals or reduced portion sizes in order to save money, however losing weight (19%) or saving time (17%) were much more common reasons for this behaviour.
- For women who identify as **BME**, participants said skipping or reducing meal size does not happen in their culture. However, they reported that they find it difficult to cook cultural food for their families, which are still healthy options.
- For participants who are part of **gypsy & traveller communities**, having the ability and access to cook healthy food was reported as an issue. There were also reports of struggling to afford healthy food and a lack of education into what is healthy.

Overall, the research suggests that there is a general perception of healthy food being more expensive, and therefore, inaccessible to groups who may not have disposable income. **Food poverty, in the sense of lack of access to healthy, nutritious food, therefore seems to be very prevalent.** Even if participants may not explicitly describe their situation as food poverty, or if it has not led them to the extent of skipping meals or reducing meal sizes, it may be because they will buy cheaper, unhealthier food instead. **Other practical implications** such as health conditions or disabilities that make it **hard to shop, prepare and cook healthy food**, as well as lack of appropriate cooking facilities, mean that often people find it easier to consume cheap ready meals instead.

Summarised by BHFP intern, March 2018

PART 2: DETAILED FOOD POVERTY ACTION PLAN PROGRESS REPORT

(updates in this section date from March 2018 unless otherwise stated)

The Big Roast 2018, sponsored by First Base

Abbreviations used in this report	
ASC	Adult Social Care
BHCC	Brighton & Hove City Council
BHESCo	Brighton & Hove Energy Services Co-op
BHFP	Brighton & Hove Food Partnership
BHT	Brighton Housing Trust
CCG	Clinical Commissioning Group
DWP	Department for Work and Pensions
NEA	National Energy Action
RSLS	Registered Social Landlords
TDC	Trust for Developing Communities

Key	
(red)	**Minimal/no progress**
(orange)	**Some progress**
(green)	**Good progress**
(Y.1)	Year 1 (2015-16)
(Y.2)	Year 2 (2016-17)
(Y.3)	Year 3 (2017-18)

Page 129

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

1A. Actions which address the broader or underlying causes of food poverty

	Action		Progress
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.		BHFP's information and advice page[5] for people experiencing food poverty continues to be well used. Food Bank referral page has developed into a directory and on-line map and is also well used. 'Eating well on a Budget' leaflets (with signposting info) produced and reprinted twice and widely distributed

[5] http://bhfood.org.uk/how-to-hub/food-poverty-advice/

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 4A.)* can become a site for money advice		There has been progress on integrating food with money advice, and including BHFP in the Moneyworks Partnership. Links between advisers and food banks are stronger (see Aim 5) Good progress in linking digital inclusion via Digital Inclusion partnership with food, especially with including food ordering in online training
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):*		
1A.3 (A)	Better/fairer paid staff e.g. good practice on tipping in restaurants; reduced use of zero hours contracts; supermarkets becoming living wage employers		There has been interest in this, but no real progress specific to a local level (though nationally this has moved up the agenda and some supermarkets have committed to paying the living wage).
1A.3 (B)	More apprenticeships with a food element		Plumpton College have extended their apprenticeships programme to include baking and processing and is offering apprenticeships at all levels from entry to degree and intend to work with 40+ apprentices each year from Sept 2018.
1A.3 (C)	Primary and Special School Meals Service becomes a Living Wage Employer as a beacon for other large catering employers		Fully achieved - paid to all staff from April 2018 and is included as a requirement in the new school meals contract.
1A.3 (D)	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 also 1B below for broader employment actions*)		There has been interest in this, but no real progress at a local level. **Challenges:** less private sector engagement in the plan. Potential for this & the related economic/apprenticeship actions to be picked up via Economic Strategy

1A.4	Reduce the impact of benefit issues, which currently contribute to a large proportion of food bank use[6]/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		**(Y.1&2)** DWP delivered awareness sessions on hardship routes to food banks and others at Brighton Job centre. It is hard to tell whether the situation with delays/refusals/sanctions has improved or not as a result, however local food bank use figures that year record this as less of an issue than nationally. The Fairness Commission recommendations include reducing delays in the benefit system for taking forward. **(Y.3)** Regarding Universal Credit, food banks have suggested good information provided on short term benefit advance may have helped to reduce the impact of universal credit in the area. **Challenges:** Although there has good progress against specific actions, this has been marked amber as more still needs to be done around benefits. The impact of Universal Credit is not likely to be felt until later in 2018
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		BHFP were commissioned to deliver food poverty awareness training to housing workers. Moneyworks helpline workers trained by BHFP. Several organisations have included 'food poverty' questions, notably BHCC housing *(see also 1A.6)*. BHFP online food poverty resources are well used. BHFP receive regular information on food poverty challenges and the two stakeholder events relating to this plan provided useful info.
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.		Workshop with senior BHCC housing staff and BHT took place led to changes in BHCC working practices, including inclusion of food poverty questions in STAR tenancy survey. This revealed high levels of food poverty in council tenants (see intro to this report). A pre-tenancy workshop with BHFP and BHT was piloted. Sheltered housing has championed food poverty initiatives.

Page 131

[6] 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

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		Whilst progress has been slower in some areas than in others, feedback from the 2018 stakeholder event indicated that food poverty has increased profile and moved up agendas, as reflected in this progress report. There was a suggestion at the One Year On event that BHFP should engage with the housing committee however there wasn't capacity to take this forward ***Challenges:*** *BHFP & BHCC resources. Additionally, BHCC staff turnover and health service restructures means engaging with different staff/partners*
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		New partners have engaged throughout the process and further partners have come on board for the next stage. Financial Support secured through Food Power to understand more about food poverty in the most vulnerable groups with the 'least heard' voices including rough sleepers. BHFP/Red Cross 2018 case study of leaving hospital showed importance of food support at hospital discharge. Migrant needs assessment 2017-18 looked at food need although the report only addressed food bank use not day to day food security – researchers have been asked to go back to (extensive) data to see if more info; and VIE who work with migrants without recourse to funds have also agreed to host a focus group CCG engagement research in 2017 looked at food and food access in 'less heard' groups – see intro for a summary by BHFP
1A.9	Share the learning from developing this plan locally and nationally, and respond to both national and local campaigns and consultations		Achieved via case study, webinars and hearing through the sustainable food cities network. BHFP input into design of national 'Food Power' programme to

Page 132

			tackle food poverty using a city-wide approach and are delivering mentoring support to other areas through that programme. Evidence has been submitted to national consultation and a parliamentary inquiry into food poverty. Plan and learning from it seen as influential nationally.
1A. 10	Submit the evidence which has informed this action plan to the Fairness Commission. Continue to liaise with Commissioners to ensure that food poverty is fully integrated as an issue		Evidence submitted. BHFP then met with BHCC to discuss how food poverty can be included in the 'Poverty Proofing the School Day' audit resulting from the Fairness Commission.

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; Encourage larger employers including national ones to sign up		The Brighton & Hove Living Wage Campaign continued to build and has now signed up 370 employers with 3064 salaries raised as a result of the campaign. Employers have pledged to pay their staff £8.75 per hour or more, which is the rate calculated by the Living Wage Foundation based on the true cost of living in the UK (2018).
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 as outlined in 1A.		Possability People have employment projects which are about getting people, who are the furthest away from the workplace into work. Some progress on apprenticeships & food agenda (see 1A) but nothing specifically in relation to disabled people. BHFP have been consulted on the new Economic Strategy and it is hoped some aspects will be taken forward through this.
1B.3	Via delivery of the key priorities of the Housing Strategy – improving supply, improving quality and improving support - deliver action to		This action was always ‘bigger picture’ although BHFP submitted to consultation on HMO (Houses in Multiple Occupation) standards in 2017.

	increase the affordability of housing, reduce failed tenancies and reduce fuel poverty (food vs fuel pay-off is a major cause of food poverty)- especially in the private rented sector.		***Challenges:*** *The lack of affordable housing and high levels of homelessness in the city is having a big impact on food poverty levels. Although there has been progress made against the actions the growing issues with homelessness in the city as reported by food banks and others mean this has been marked as red*
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 also 1B.5)*- 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 3A.3)* • 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.*		The financial inclusion agenda led to the creation of Moneyworks –to provide support to financially excluded and hard to reach groups by joining up the existing services throughout the area. Links between food and fuel poverty programmes have improved but could still go further. (See also elsewhere - Digital Brighton & Hove have championed inclusion of food shopping in digital inclusion courses.) ***Challenges:*** *Fuel poverty programmes tend to be funded year by year and change shape/staff, so it is difficult to embed food within them. The need for money advice (for example in food banks) is growing and funding opportunities for advice work not keeping up.*
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		**(Y.1&2)** BHCC Welfare Reform identified those most affected by benefit changes (the biggest impact being the benefit cap) and directly supported those

	benefit changes e.g. how the changes to working tax credit will affect eligibility for free school meals		households. They also produced a newsletter for people who work or volunteer with those who may be affected, to clarify the changes and signpost to support. **(Y.3)** Case working support for people identified as most impacted by welfare reform continues. In addition, a large-scale training programme has been undertaken by the Council's Welfare Rights team to provide front line workers and organisations including food banks with detailed knowledge about Universal Credit, which rolled out in the City at the end of 2017 and beginning of 2018. An up to date newsletter has also been produced to provide information about support for people on Universal Credit.
1B.6	Undertake research to better understand the poverty premium in terms of food shop ping (for example to include the price difference of healthy /unhealthy food) and the impact of local shops vs internet shopping / large retailers.		Food Matters have carried out research into the 'poverty premium' in relation to food in the city, and the cost of a healthy basket of food vs an unhealthy basket. This research is only available in draft format but expected to be expanded and repeated later in 2018.
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)		Moneyworks continue to coordinate money advice. Possability People have introduced a programme to better prepare people for retirement, involving financial advice & activities. *(See also 1B.4 & 1B.5)* ***Challenges**: This is a huge area, so although there has been progress, this will still need to go further.*

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

	Action		Progress
2A.1	Continue existing good practice in achieving high overall levels of breastfeeding with continued focus on deprived areas		**(Y.1)** In 2015/16, exclusive rate breastfeeding at 6-8 weeks was 57% – the highest rate in England. There were a range of initiatives in place focusing on areas and groups with lower rates in the city. In 2016/17, exclusive rate of breastfeeding at 6-8 weeks in B&H was 55.3%. This is a little lower than the previous year – but that figure was affected by an information system/data collecting change. The particular services that were in place in 2015/16 offering additional breastfeeding support in areas of the city that have lower breastfeeding rates (by definition more deprived areas) have ended. This is the result of financial challenge. However, Brighton & Hove continues to achieve overall high levels of breastfeeding. There is an aim to offer some additional support to areas of deprivation through the Healthy Child programme teams (HCP), and HCP Peer Support programme, including training to deliver early proactive contacts to mums. This work is also happening for groups with lower rates – such as young parents and travellers – through the Healthy Child Programme Healthy Futures team.

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		Children's centres have been proactive in bringing this agenda into their work including new cooking and eating opportunities for children and families. A new food poverty group led by the BHCC children's Centres and focussed on children, families and early years brings together public health, Welfare Reform, midwife services, health visitors, BHFP, Chomp and others has led on Healthy Start but also brought key people together over the wider agenda. A joint campaign was developed between Public Health, Children's Centres and BHFP to increase uptake of Healthy Start vouchers and vitamins, including local posters and work to improve knowledge amongst health professionals, with retailers and in community settings. *(Ongoing campaign see http://bhfood.org.uk/struggling-local-families-missing-out-on-thousands-of-pounds/).* The campaign has maintained (at 68%) the uptake of Healthy Start Vouchers, whilst take-up has fallen slightly elsewhere. Brighton and Hove now has the 3rd highest take up out of 68 regions in the South East (SE average is 60% and national average 65%) although other areas continue to do much better e.g. NE average is 74%.
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		Efforts have been focussed on healthy start vouchers rather than vitamins although there has been some progress and the BHCC food poverty group has meant the issue has stayed on the agenda. Data has shown that about 250 healthy start vitamins have been given out in the space of around 3 months from Children's Centres in Brighton & Hove (2018) *(See also 2A.2)* ***Challenges:*** *There has been a lack of data available from pharmacies regarding vitamin distribution. It has been suggested by local partners & in wider research*[7]

[7] McFadden, A., Green, J. M., McLeish, J., McCormick, F., Williams, V., & Renfrew, M. J. (2015). Healthy Start vitamins—a missed opportunity: findings of a multimethod study. BMJ open, 5(1), e006917.

	• Continue to work with Community Pharmacists and work towards distributing vitamins from them • Repeat update on vitamins (lunch-time seminar)	*that the current targeted system of providing free vitamin supplements for low-income childbearing women and young children via the Healthy Start programme is not fulfilling its potential to address vitamin deficiencies. There is wide professional and voluntary sector support for moving from the current targeted system to provision of free vitamin supplements for all pregnant and new mothers, and children up to their fifth birthday.*

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	1100 children attend a primary school breakfast club every school day in Brighton & Hove and 66% of the city's primary school breakfast clubs have been supported to improve the nutritional content of their breakfast provision through the Healthy Choice Award. BHFP produced a Primary School Breakfast Clubs in Brighton & Hove report and a good practice booklet for staff and volunteers working in breakfast clubs. Real Junk Food Project have improved links with schools and are developing a 'fuel for schools' project ***Challenges:*** *There seems to be a difference between free breakfast clubs and paid-for ones – potential to explore via the Poverty Proofing the School Day audit.*
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	The school meal service has continued to deliver universal infant free school meals at silver food for life and uptake remains high. The cost of meals was increased from September 2017 to cover the increased cost of the Living Wage Foundation living wage (higher than the government's living wage) from April 2018- this was the first increase since 2010.

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)		BHCC School Meals Service supported Moulsecoomb's BEST Week. During this week parents were invited to come and enjoy lunch with their child. It was very well received and there is hope that it will have a positive impact on overall take up of UIFSM and FSM. *(See also 2B.2)*
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		There were 75 families identified through the School Meals Service working in partnership with the Council Welfare Team and cross-checking records. This equated to around 90 children. There is a desire to be able to find a way that this identification process occurs on a more regular basis, to make it a less onerous task.
2B.5	Explore and share good practice on using pupil premium for healthy food related activity in schools		Public Health Schools Programme collates data (such as the Safe and Well at School Survey and IMD data on child poverty) to develop school profiles. Public Health also works with schools (and other partners) to develop priority initiatives such as healthy eating. Food and children continues to be a priority for Public Health, explored via the BHCC led food poverty group. Challenges: Schools are hard to engage with collectively and there has been less direct school involvement with this plan
2B.6	Raise awareness in primary schools of Chomp holiday lunch clubs for families, and improve referrals		**(Y.2)** There was a push on awareness about Chomp holiday lunch clubs. Leaflets were distributed in school bags in a partnership between BHCC & TDC, with information such as food poverty guidance and access to local resources including food banks, Chomp holiday lunch clubs and shared meals in local areas. TDC continue to promote Chomp and shared meals. Hangleton & Knoll Project have continued to promote CHOMP in the West via Facebook, leaflets at community buildings and targeted outreach to community groups.

			(Y.3) Chomp has continued to expand and referrals have greatly improved from some schools, although others are less engaged. Hangleton & Knoll Project co-delivered two Chomp sessions held in Knoll Park Pavilion during the summer holidays last year supported by their community development and youth workers, ensuring they were able to target those most in need through their existing work and relationships with local families and young people
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		**(Y.1)** A successful pilot partnership (combining Chomp with funding and staff from the School Meals Service) took place at West Blatchington Primary School. Hangleton & Knoll Project actively promoted CHOMP in the West via Facebook & leaflets at community buildings and targeted outreach to community groups. **(Y.2)** In 2017, 341 meals were served at West Blatchington primary school. The club also ran during October half term and Christmas. **(Y.3)** By 2018 3 successful school venues running Chomp - West Blatchington, Benfield, and St Marks in Whitehawk in partnership with the school meals team. Chomp is also piloting in Children and Family Centres in term times. Chomp served approx. 700 meals in total.
2B.8	Contact projects providing food for children during term time to see if they are interested in expanding holiday provision		Contact was made – however, there didn't prove to be a good way to find new venues, and meanwhile Chomp has expanded (see above) so this is unlikely to be repeated.

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 2E 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		As part of the CCG's current work, including The Caring Together programme – projects are currently being developed across the Central Sussex and East Surrey Commissioning Alliance, looking at a Community Aligned Short Term Services project. BHFP's input has led to one of the outcomes of projects being 'Increased access to good food and prevention of diet related ill health including under-nutrition and obesity, and the importance of hydration'. Once the Project Initiation Document is finalised (this is quite complex as involves 4 different CCG's), formal project groups will be set up to include partners across the community and voluntary sector.
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		***Challenges:*** *There has been good progress in promoting lunch clubs and other opportunities to eat/socialise together including via Access Point, the council's single point of contact and sending a list of lunch clubs to former meals on wheels recipients (see below) however the actual reconfiguration of care packages to allow combining is still a work in progress – there is interest from the Central Social work team in taking this forward in 2018/19*
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		When the RVS Community Meals (Meals on Wheels) contract ended, an independent review by ASC checked whether individuals had a new meals provision in place or had made alternative arrangements. The majority of people were happy with the outcome and some had found inventive, alternative ways of getting access to meals. ASC sent out a lunch club list, community transport pamphlet and casserole club leaflet for volunteers and diners to all former recipients There remains a gap left by the loss of the community meals service i.e. need for people to receive food help at home, and a pilot by Sussex homeless support will

			explore using the old RVS kitchen to deliver a limited number of meals to people who find it hard to get out and are at risk of malnutrition.
2C.4	Adult Social Care is currently re-commissioning the Home Care contract provision - meal preparation to be considered as part of this process		See 2C.7
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 a preventative approach)		Healthwatch are looking at this area in relation to hospital discharge 1018-19 (see above). The NHS standard contract (2017-19), which was updated in January 2018, sets out certain rules for food standards. This includes ensuring that NHS providers provide and promote healthy food and drink; also, from the 1st July 2018, the NHS service providers must not itself sell any sugar-sweetened drinks. In addition, one of the Sussex Community Foundation Trust CQUIN (commissioning for quality and innovation) measures in 17/18 was Staff Health and Wellbeing: Healthy Food for NHS staff, visitors and patient[8]
2C.6	Invite BHFP to give a presentation to the Home Care Provider Forum on nutrition and preparation of nutritional meals for vulnerable people		BHFP attended a Home Care Forum to give a presentation to the Council's contracted home care providers (who provide the majority of the home care within the city) however this area does need more exploration

[8] Some of the changes proposed for this measure include:

a.) The banning of price promotions and advertisements on sugary drinks and foods high in fat, sugar or salt (HFSS) on NHS premises
b.) The banning of sugary drinks and foods HFSS from checkouts on NHS premises
c.) Ensuring that healthy options are available at any point, including for staff working night shifts
d.) 70% of drinks stocked on the premises must be sugar free, 60% of confectionery and sweets do not exceed 250 kcal.

At least 60% of pre-packed sandwiches and other savoury pre-packed meals available contain 400kcal or less per serving & do not exceed 5.0g saturated fat per 100g

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		Learning was shared but the recommissioning process did not include any extra time for meals - the new provider was appointed in 2016 for 4 years. Some training for paid care workers also provided (see below) Challenges: This has been flagged as amber as although the action was completed the need remains current
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)		Paid care worker training on nutrition is provided on an annual basis via the BHCC training programme (1 course in 2017). Plus, BHFP have run sessions for private care providers in food and nutrition (3 courses in 2017) Challenges: This has been flagged as amber as although there has been some progress, the need remains current
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		**(Y.1)** BHFP prepared a briefing and facilitated a conversion on hospital discharge and food. Partners agreed to take the questions & recommendations to their hospital, CCG and Adult Social Care senior contacts. BHFP contacted Healthwatch. **(Y.3)** Healthwatch project on hospital discharge and the elderly planned for 2018-19, which will look at nutrition and hydration. (in progress)

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.[9]		*(See also 2C.9)* BHFP facilitated a meeting on hospital discharge and food with follow up with frontline workers (see above). Moneyworks provided some funding for food bags for the Red Cross - this pilot was very successful, but the CCG have not taken on funding the bags on an ongoing basis as hoped. Brighton & Sussex University Hospitals (BSUH) hospital discharge lounges currently supply vulnerable patients with a food bag at discharge however the contents of this varies between wards and has not been standardised. The Trust has set up a 'Food Improvement Group' (attended by Healthwatch) and one project under this group is to agree the exact content of a discharge food bag (items to cater for the first 24 hours post discharge) from both a nutritional and food safety standpoint; and to agree some criteria to ensure access to these discharge packs is fair and equitable.
	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		BHCC have suggested that there are limited settings where meals are provided by the council, and that the process developed when the RVS Community Meals contract ended will be adapted for other contracts ending as necessary.
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 (2016)*[10]			
2D.1	Explore how older people can best be supported, especially at key 'transition times' including hospital discharge *(see also 2C)* and bereavement to prevent long term food issues / entrenched isolation developing		'Eating Well as you Age' booklet produced by BHFP in partnership and jointly funded by Age UK and the CCG to help prevent malnutrition in the community. Widely distributed Citywide Connect have coordinated better support at bereavement e.g. work with funeral directors on signposting. Healthwatch project on hospital discharge

[9] https://www.freshthinking.uhmb.nhs.uk/2015/03/23/local-hospitals-offer-patients-food-to-go-bags-when-they-are-discharged/
[10] http://bhfood.org.uk/wp-content/uploads/2017/09/010916-Older-people-and-Food-final.pdf

			and the elderly planned for 2018-19, which will look at nutrition and hydration (see also above). Public Health are recommissioning their Ageing Well programme activities for older people during 2018 for a 2019 start. The new service will focus on reducing social isolation and loneliness, promoting good health and wellbeing, preventing ill health, and enabling people to remain independent for as long as possible. Identifying older people at risk of food poverty and/or malnutrition and taking positive action will be a key performance indicator for the service. Challenge: As this is a huge and growing issue, it is flagged as amber even though progress has been made
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		The CCG recognises that more work needs to be done to bring together information derived from the MUST tool and that a wider and more consistent use of the MUST tool needs to be explored. For example, Primary Care uses the tool routinely on older, frail patients and this information could be used to map out areas where there was a greater prevalence of community malnutrition. A review of the use of the MUST tool took place in March 2018, with the following feedback: Primary Care: A training need has been highlighted. The lead dietitian is working with the Primary Care Workforce Tutor and the SCFT Clinical Skills Hub to help develop nutrition and hydration training, which would include the use of this tool. There is no MUST tool automatically built into Systm1 and Emis, but some surgeries may have loaded a MUST template onto their system. A longer term strategy would be to develop a template that would include MUST and link with our local guidelines. The Lead Primary Care Dietitian has undertaken training with District Nurses and Integrated Primary Care Team nurses at Brighton General Hospital, Hove Polyclinic, Conway Court, Portslade Health Centre and Moulsecoomb Health Centre and care homes about MUST.

			<u>CCG Medicines Management Team:</u> Local Oral Nutrition Support (ONS) guidance on the CCG website includes information on MUST scoring tool and the requirement to have the score at hand when initiating prescribing and subsequently conducting monthly scores to monitor ongoing benefit of oral nutritional supplements. The CCG would like, healthy as part of its 'Caring Together', to develop the consistent utilisation of the MUST tool. Relevant programmes are: • Programme 1 - Preventative Services & Community Care • Programme 3 - Access to Primary Care & Urgent Care
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)* • 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 3A.3)*		Digital Brighton & Hove have championed inclusion of food shopping in digital inclusion courses. Possability People created an easier search function and a print button for the 'It's Local Actually' Directory, which made it easier to search for lunch clubs ASC organised the set up and control of 'My Life' portal. Casserole Club has been added to food section of My Life and Nutrition Course for Carers. There is also a link to the BHFP website. Non-digitally, Adult Social Care (ASC) has sent out a lunch club list, community transport pamphlet and Casserole Club leaflet for volunteers and diners to all food banks and lunch clubs as well in order for them to put up where people can see them and spread the information ASC ensured that the Carers Centre had information on the Food Nutrition Course for Carers & Casserole Club and provided leaflets and also shared within relevant adult social care teams.

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	**(Y.1)** The wording of this action was changed to "joint catering procurement" from "joint catering production unit". **(Y.2)** There was no progress on this at this point because there was no permanent Catering Manager employed within the Trust. A formal management restructure took place, potentially allowing for recruitment for this post. (Y3) The new catering managers are now in post and focusing on creating an allergen database and streamlining catering procurement and menus across the two main hospital sites (RSCH and PRH). Regular patient feedback on the hospital food comes from 'Patient Voice' questionnaires and through annual dietitian-led ward meal observation audits. The Trust 'Food Improvement Group' consists of members of the catering, dietetic and nursing teams as well as patient representatives. They meet quarterly to discuss patient comments on food and identify/implement/ monitor work streams to improve patient catering.
2E. 2	Adult Social Care and the Clinical Commissioning Group to work together to explore how nutrition and hydration can be improved in care homes	ASC and CCG carried out joint quality monitoring visits to nursing homes plus desk assessments, which take into account nutrition and hydration in relation both to individuals and the care home processes, and they have provided detailed info on these (see footnote for full update[11]).

[11] ASC and CCG have been carrying out joint quality monitoring visits to nursing homes. The care plans are checked and this can include a risk assessment about dehydration/malnutrition, if appropriate. If it is appropriate, the care plan should have a MUST assessment and weighing of the resident, as well as, monitoring sheets for food and fluids. At quality monitoring visits, there is a walk-around the property which includes observing if the residents have access to drinks in both their rooms and communal areas. The meal time can be observed and the chef can be asked about whose meals need fortifying.

			The CCG Lead Dietitian works with individual care homes, and they have provided detailed information about this role.[12] She has also been working with BHCC to improve the robustness of training offered to care home staff on the Food Safety, Nutrition and Hydration & make it more relevant to the attendees by targeting it towards the needs of the elderly at risk of malnutrition and dehydration. She is working with the Primary Care Workforce Tutor and the SCFT Clinical Skills Hub to help develop nutrition and hydration training.
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.		This training was successfully delivered (approx. once annually).
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.		This particular work has now ceased. Instead, the BHFP/Age UP publication 'Eating well as you age' was circulated across the city (~7000 copies). This is an information booklet aimed to raise awareness of malnutrition in the community.

We work closely with the Speech & Language team (SALT) about resident's swallowing difficulties and the correct food textures.
There is a three-monthly Nursing Home Professionals meeting which includes SALT and Community Dietitians to discuss the nursing homes in the city and any concerns.
ASC also undertake Desk Top Reviews (DTR) of care/nursing homes which would include looking at any concerns/complaints/incidents and safeguarding raised in the past year. This would see if any concerns about nutrition and hydration had been raised, which could lead to a focused visit.

[12] The CCG employs a Lead Dietitian Primary Care worker as part of the Medicines Management Team. The dietitian works with individual care homes –which either self-refer or are flagged up following intelligence, either visits or through meetings. Training offered can include MUST Screening, food fortification, adequate hydration, appropriate referral to Dietetic Services.
The Lead Dietitian for Primary Care has been in post since October 2017. She has been working with the council to improve the training offered to care home staff on the Food Safety, Nutrition and Hydration course to bring this in line with local guidelines and to make it more relevant to the attendees by targeting it towards the needs of the elderly at risk of malnutrition and dehydration. She spoke at the Sussex and Surrey Safeguarding conference to highlight the importance of nutrition and hydration, where she launched "Hydration Hints for Older People - https://www.gp.brightonandhoveccg.nhs.uk/files/hydration-hints-older-peoplepdf"
She is also working with the Primary Care Workforce Tutor and the SCFT Clinical Skills Hub to help develop nutrition and hydration training. The lead dietitian has been working directly with individual care homes to provide training in homes relating to MUST screening, food fortification, hydration, care planning and appropriate use of oral nutritional supplements. Care homes can contact the lead dietitian directly to arrange training, or she accepts referrals from the care quality team, the community dietitians at BSUH and GPs. She is also providing training sessions for community nurses (district nurses, responsive services)

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*

	Action		Progress
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[13] 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		BHFP and others such as Big Fig and community centres have continued to offer cookery courses, plus cooking has been built into other activities e.g. Chomp have run sessions. BHFP have secured funding for a purpose-built community training kitchen to open in 2018. ***Challenges:*** *funding can be sporadic, including for courses that are seen as priority such as Old Spice.*
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 3B.1*) • Lacking cooking equipment e.g. in temporary accommodation or bedsits		A leaflet was produced by BHFP in partnership with CCG and BSUHT on older people's nutritional needs and identifying malnutrition. There is still a desire to produce some that include other tip sheets - in particular, on cooking with limited equipment, which has become even more relevant with the increase in use of emergency accommodation which often has poor kitchen facilities. ***Challenges:*** *BHFP have not had the capacity to produce all desired tip sheets.*

[13] https://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

	• 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 online		Digital Brighton & Hove have championed inclusion of food shopping in digital inclusion courses.
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		Possability People hasn't had the capacity to progress on this front. The Independent Living Centre has since closed.
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		Sheltered Housing refurbishments will now include a fridge/freezer. In Sheltered Housing premises, shared meals have been set up and casserole club promoted, and other aspects of food such as food growing have also been encouraged.
3B.3	Encourage registered providers (social landlords) to ensure adequate kitchen provision in refurbishments/ developments i.e. • Appropriate kitchen space		BHFP submitted to HMO (Houses in Multiple Occupation) consultation in 2017 requesting this be incorporated in guidance (outcome unknown)

	• Appliances to enable budget cooking e.g. accommodation aimed at single people/couples, includes a fridge freezer (rather than a fridge with icebox)		BHCC have been proactive in promoting and have taken to private sector landlords' forum.

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 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.[14]

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 (2015)*[8]		BHCC have funded some BHFP development support and training for shared meal settings. BHFP have included shared meals in the 'good food grants' programme to provide some limited funding. Casserole Club set up (see 3C.9). 'Shared meals' have had a higher profile and partner engagement e.g. Possability People made sharing food a discussion theme at a Citywide Connect event, leading to action plans around promoting Casserole Club and new shared meal settings. New models /pilots include Posh Club - http://theposhclub.co.uk/clubs/brighton/ Although this has been flagged green because of progress, sustainability is an issue. Mad Hatters in East Brighton has closed, as has Bluebird.
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 Play bus; 'trusted' providers such as food banks *(see also Aim 4)*		Sheltered Housing have encouraged shared meals in Sheltered Housing premises. BHFP offer Good Food Grants and development support for shared meals settings (see above). Providers such as the Purple People Kitchen food bank have made a meal integral, and the Brighton Women's centre is looking at adding a meal to their food bank service.

[14] https://bhfood.org.uk/wp-content/uploads/2017/09/Eating-Together-Report-FINAL-1.pdf

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		Whilst this could be more coordinated, there has been some progress e.g. Chomp have expanded onto school premises (see above). BHCC were unable to find premises for The Real Junk Food Project but they have secured a storage hub (see below). Sussex Homeless Support are looking at taking on the former RVS meals on wheels kitchen. St Vincent De Paul Society have taken on the former BHCC Tower House Day Centre to act as a lunch club. Mayfield Manor private care home have also set up a lunch club accessible by the community. This continues to be a priority going forward given the loss of some provision e.g. Mad Hatters & Bluebird lunch clubs and community facilities such as The Bridge in Moulsecoomb.
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 particularly on evenings & weekends (identified as a gap)		RJFP found premises to offer lunch 5 days a week, in different community venues, and secured a storage hub in Bevendean which includes a pop-up shop. They are still seeking a permanent café site.
3C.5	Explore whether BHFP can support shared meal projects with recruiting volunteers and/or other development support e.g. around management/fundraising		BHFP's work has included provision of development support in these areas (funded by BHCC) to shared meal settings although capacity is limited.
3C.6	Provide 3x 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		BHFP coordinated several training sessions in food hygiene/safety for shared meal settings, and following further research into priorities for these groups, they also ran training sessions on mental health awareness and on boundaries
3C.7	Recognise the 'infrastructure' role of FareShare and grassroots surplus food distributors in supporting shared meal settings (plus food banks – *see 4A.2* – and other food services for vulnerable/ disadvantaged people) to keep their costs low and accessible –		BHCC have funded the Surplus Food Network and this has brought in additional funding through Sainsbury's and the People's Project. FareShare have also increased their infrastructure role through accessing national funding The wording was changed (see left) for this action in 2016.

	support via direct funding and/or in-kind support, especially storage facilities for surplus food *and/or strategic support [added 2016]*		
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, Community Navigators).		Possability People created a 'lunch club' category in the on-line 'It's Local Actually' Directory, which made it easier to search for them. ASC organised the set up and control of 'My Life' portal. Casserole Club has been added to food section of My Life and Nutrition Course for Carers- there is also a link to the BHFP website. Non-digitally, ASC has sent out lunch club lists, community transport pamphlets and Casserole Club leaflets for volunteers and diners to all food banks and lunch clubs in order for them to put up where people can see them and spread the information. ASC ensured that the Carers Centre had information on the Food Nutrition Course for Carers & Casserole Club and provided leaflets. [see above/below]
3C.9	Support initiatives which encourage neighbours to connect, with potential to share e.g. 'Know my Neighbour Week' May 2016; Neighbourhood Care Scheme.		KMN Week in May 2016 was a collaboration of organisations including One Church picnic, BHFP, Brighton University, and Hop 50+. Time to Talk Befriending held events to bring neighbours together, generally around food. One Church passed the project (KMN) on to Impetus in early 2017. BHFP, Impetus and Bright Dials Digital Marketing set up Casserole Club to reduce isolation by encouraging neighbours to share a meal. This has been advertised in a number of ways including coffee morning packs.

3D. It becomes easier to 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 3A.3 for digital inclusion – improving access to home food delivery)*		The Surplus Food Network, and the increase of FareShare's capacity with a new focus on fresh food, has increased supply. ***Challenges:*** *Less progress has been made on community run co-ops or bulk buying clubs.*
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		**(Y.2)** BHCC worked with restaurants and caterers on healthier options, as part of the Sugar Smart Campaign (which also ran much wider) and produced a guide to Healthy Choice catering. **(Y.3)** There are currently 103 Food Outlets who are part of the Healthy Choice (HC) scheme in Brighton & Hove. The scheme looks at preparation, purchasing cooking methods, choice, drinks and marketing of healthier options. The council offers HC training sessions, which usually take place quarterly. They also offer healthier frying catering training sessions.
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		**(Y.2)** BHFP submitted a far-reaching submission to City Plan 2. **(Y.3)** BHFP have explored the possibility of supplementary planning guidance with BHCC.

Page 154

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 Part 2)		**(Y.3)** A new policy had been drafted on 'Community Facilities' for City Plan Part 2, which protects against the loss of community facilities and sets out their importance in the city especially to vulnerable residents. Public consultation on the draft City Plan Part 2 is due summer 2018.
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		The Local Transport Plan (March 2015)[15] stresses both connecting people with shopping areas, and the importance of local shopping centres in allowing access to food, as well as creating healthier environments that encourage walking and cycling to be used for food shopping journeys.
3D.6	Shared meal settings refer to the Fed Centre for Independent Living's 'Out and About' guide[16] for information about informal shared transport options and other useful examples and guidance on ensuring effective (free) insurance provision for volunteer drivers		Shared meal settings were referred to this in the shared meals survey undertaken by BHFP. Transport remains a barrier to people accessing support such as lunch clubs.

Page 155

[15] https://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/BHCC%20Local%20Transport%20Plan%204%20Document%20v260515.pdf

[16] https://www.possabilitypeople.org.uk/wp-content/uploads/2017/08/Out-about-guide.pdf

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

	Action		Progress
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		(Y.2) Although funding was reduced, BHCC continued to support the LDSF meaning that people experiencing an emergency are not reliant purely on the voluntary/ community sector. (Y.3) BHCC will continue to provide support through the LDSF in 2018/19. Challenges: This is marked as amber as there is always a question over funding.
4A.2	FareShare and other food surplus organisations continue to redistribute surplus food effectively, underpinning the work of food banks 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 the Surplus Food Network and future city waste strategies *(NB affordable surplus food also supports 'shared meals' as well as food banks – see 3C.7)*		(Y.2) FareShare increased their volunteer number and their food supply, as well as their reach. They encouraged healthier food donations. Grassroots action to redistribute surplus food was enhanced with new peer to peer apps and platforms including Olio and Food Cloud (now called FareShare Go). Supermarkets including Lidl, Tesco and Sainsbury's were much more proactive at offering surplus. (Y.3) FareShare continues to recruit and support volunteers, including through provision of training: 17 have moved into employment so far in 2017/18. FareShare provision of surplus food to local charities continues to grow, with plans underway to significantly upscale operations. BHCC Public Health has committed funding for FareShare to continue to improve health outcomes until 2019. FareShare has worked closely with Surplus Food Network member Sussex Gleaning Network to

			rescue more fresh surplus produce from farms and get it to those in need. Two major supermarkets are coming on board with FareShare Go in 2018. The Surplus Food Network and a Food Waste Round table have explored issues including the 'value' of surplus food and the importance of quality donations.
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		In 2016, food banks identified housing advice as a particular need – resources were shared on housing advice via the Emergency Food Network (EFN). Also, an adviser from BHCC visited several foodbanks. Food banks have continued to expand provision, including access to advice services and a focus on prevention. Moneyworks partners have worked more closely with food banks, with more advisors attending food bank sessions. An annual BHFP survey continues to identify food bank needs in relation to training and other services.
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		There has been continued progress, including a pilot digital access project with Brighton & Hove Libraries/ Digital Brighton and Hove. Several Food banks meals offer meals or refreshments e.g. at Purple People food Bank. There have been pop up cookery sessions using food bank ingredients by BHFP but this was quite hard to coordinate and not seen as priority going forward. The Emergency Food Network has continued to help build links with other services and support as have individual food banks. There has been less progress on looking at food banks as a place for 'bought' food at low cost/ links with grocers
4A.5	BHFP secures funding to develop its work to support food banks & emergency food providers; and continue the EFN as a collective space for food banks to work together and meet with advice providers and the City Council		BHCC has funded BHFP to support the EFN for 3 years from 2017.

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

	Action		Progress
5A.1	BHFP to continue to measure crisis or emergency food poverty by providing an annual snapshot of food bank use in the city		BHFP's annual survey [17] [18] [19] of food bank use continues to provide a useful insight (see intro to report)
5A.2	Continue to gather information on longer term or chronic food poverty in the city; also on national good practice/ 'solutions'		BHCC continue to ask a question about food/fuel poverty in the annual city tracker. (see below) Although BHFP have less funding for coordination on food poverty issues, new financial support from Food Power has allowed them to keep on top of national issues and good practice
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		The CCG recognises that more work needs to be done to bring together information derived from the MUST tool to inform a wide overview of food poverty and has committed to doing so (for more detail see aim two)
5A.4	Use breastfeeding rate data to track rates of breastfeeding, taking note of trends in more deprived wards		This data is still tracked *(see also 2A.1)*.
5A.5	Use child measurement programme data to track rates of childhood obesity in different income groups		This data is still tracked and still shows disparity between different income groups in relation to child obesity.

[17] http://bhfood.org.uk/wp-content/uploads/2017/09/Food-Bank-Survey-Snapshot-July-2015-v2.pdf

5A.6	Food banks commit to measuring the reasons people are accessing them, using 'Trussell Trust' categories so that the data can be compared		Several food banks have introduced the use of Trussell Trust Categories which has been useful both for understanding reasons for food bank use and comparing with national figures. ***Challenges:*** *not all food banks are using this method, but it was anticipated this would happen.*
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		Several organisations have included BHFP's questions in their monitoring and responded with answers. BHCC's Housing department found food poverty to be a surprisingly big issue. Other organisations have also found high levels of need. (see intro to report) ***Challenges:*** *It can be hard to get data back from organisations for collation*
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 1A)*		Food Matters carried out research into the 'poverty premium' in relation to food in the city, and the cost of a healthy vs. an unhealthy basket of food. (see Aim 1) BHFP & Sussex University have strengthened joint working, with a joint event looking at tracking impact of food strategy, including the food poverty aspects, and Adrian Ely from Sussex University joining the expert panel for the food strategy refresh. BHFP and Brighton University have jointly applied for funding for a PhD student to track progress and impact.
5A.9	BHCC measures on-going levels of long term or chronic food and fuel poverty via a question in the annual weighted 'City Tracker' survey. CCG/BHCC explore whether contracts for health and social care services can help with measuring levels of food poverty (by requiring		BHCC continues to include the food and fuel poverty question in the annual 'City Tracker' survey. Although the sample is relatively small (1000 people) it has been consistent over four years so seems to provide a good picture.

[18] http://bhfood.org.uk/wp-content/uploads/2017/09/Food-banks-and-Emergency-Food-Network-report-2016-final.pdf
[19] http://bhfood.org.uk/wp-content/uploads/2017/09/Food-banks-and-Emergency-Food-Network-report-2017.pdf

	data collection); or whether they can share existing data e.g. from health visitor assessments		Although it is just one question (three or more would be much more effective) many cities are envious that we have anything. See intro for data. There has been less progress on bringing together other data sources and potential measurements e.g. Sharing health visitor assessment data not practical. BHFP have supported national campaigns around the need for a systematic Government-led means of tracking of food poverty.

Page 160

Shropshire Clinical Commissioning Group

Health and Wellbeing Board Meeting

Item Title: Technology Enabled Care Projects

Responsible Officer – Andy Begley
Email – andy.begley@shropshire.gov.uk

---

1. Summary

To ensure Shropshire Council continues to provide cost-effective and efficient services, the Housing Team are undertaking a series of Technology Enabled Care projects that aim to support Social Care and Housing services.

These projects explore different delivery models for existing telecare provision, as well as seeing how the latest consumer technology can be used or repurposed as Technology Enabled Care. Currently there are 3 such projects underway:

- Hospital Discharge Telecare Pilot
- The Broseley Project
- Beech Gardens Step-Down Beds

<u>Hospital Discharge Telecare Pilot</u>
This project sees Shropshire Council working with Welbeing, a telecare provider to support hospital discharge through the use of telecare equipment. The model of provision being tested here sees the Council fund the telecare provision and monitoring costs for the first 13 weeks post-discharge.

At the end of the 13 weeks the recipient has the choice of returning the equipment, with no further obligation, or keeping the equipment and paying the ongoing monitoring costs to Welbeing. Dependant on the range of equipment in place this can be as little as £3 a week.

For every person who goes on to become a private payer, Welbeing rebate Shropshire Council £1 per week per client for as long as they remain a paying customer. With sufficient numbers of referrals going through, this model can, over time pay for itself.

The trial will test;

- Any benefits to existing hospital discharge schemes (such as the Home from Hospital service)
- What effect it has on Delayed Transfer of Care rates
- What effect it has on reducing hospital re-admission rates
- What effect it has on any ongoing care and support costs

Run initially in the central Shropshire area, the trial is being rolled-out to the rest of the County with Whitchurch Community Hospital shortly being included. This will see referral rates reach in the region of 25 – 30 a month, with the roll-out programme continuing to the rest of the county over time.

A full evaluation report will be available towards the end of the year when all data has been properly analysed.

The Broseley Project

Whilst the Hospital Discharge Pilot makes use of existing, traditional Telecare equipment, the Broseley Project tests out the latest consumer technology and how it can be used as Technology Enabled Care.

Initially the project will test 3 pieces of existing consumer tech – an Amazon Echo Show, an Amazon Echo Dot, and a Samsung Gear-Fit Pro fitness tracker. The first phase of this project explores whether these 3 devices, working together can address 3 key issues:

- Social Isolation
- Falls Detection
- Fall Prevention

Using a shared community calendar, the Echo can remind and prompt people about events taking place in their community (the community bus is in town today, there's a coffee morning tomorrow etc), thereby helping tackle social isolation. It may also be used to "drop in" on friends and family who also have an Echo Show as well as seeing how this function can support the local GP surgery.

The fitness tracker currently records if you have ascended a staircase as well as measuring steps taken over a set distance. We will test if these functions can be repurposed to detect a fall (a sudden drop in height) or if someone is taking more steps to cover the same distance (a possible indicator of a falls risk).

We are working with the Lady Foresters Centre and Hitachi and have a pool of 20 volunteers to help test this equipment. The volunteers are all aged over 65 and live in the Broseley area. So far, the project has explored the practicalities of issuing the equipment to the volunteers and how the data it records can be accessed for analysis. The current stage is testing how our volunteers manage with the equipment, and if the data we hope to capture is actually being recorded. The learning from each stage helps inform future stages.

Beech Gardens Step-Down Beds

Beech Gardens is a supported living development in Ludlow built by housing provider Connexus. Within this development, Shropshire Council has commissioned 2 Step-Down beds in the form of 2 self-contained bungalows to support reablement following hospital discharge.

For this project, we are fitting out both bungalows with a range of both traditional assistive technology and consumer technology with the aim of supporting and encouraging reablement.

Whilst the traditional equipment will help with familiarisation as part of a long-term care package, the consumer technology is designed to support and encourage participation in reablement at an early stage. It is also hoped that the use of such equipment will provide a learning opportunity to better understand what technology best supports people post hospital discharge.

There is also an opportunity to use these bungalows as a demonstration and training site, supporting staff and individuals make better informed decisions about longer term care options.

2. Risk Assessment and Opportunities Appraisal

The Hospital Discharge Pilot uses well established telecare devices, the sort that are currently used by this and other councils. The Telecare provider complies with all Telecare Services Association standards in respect of equipment provision, installation and monitoring. Professional assessments are undertaken before a referral is made and the pilot has a fixed budget which is regularly monitored. A full evaluation of the pilot will be undertaken and recommendations will be made based on the findings from the evaluation.

For the other 2 projects, appropriate training and ongoing support is provide to the participants to ensure they understand how to use the devices. Prior to the trial being undertaken, we explain to each participant the purpose of the trial, the range of functions the devices have, and the information being recorded. In the case of the Broseley Project, it is made clear to the volunteers that the devices should not be used to replace their current method of summoning help in an emergency, or to replace any existing care or support they receive. An Agreement covering this and all data sharing issues has been drawn up which sign before starting the trial.

3. Financial Implications

The funding for these projects is coming from the Better Care Fund and is testing the scale of potential savings such interventions could bring.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr. Lee Chapman
Local Member All – Conference is relevant to whole county
Appendices None

This page is intentionally left blank