Health and Wellbeing Board

Agenda

BRISTOL CITY COUNCIL

NHS
BRISTOL CCG

Date: Wednesday, 19 August 2020
Time: 2.30 pm
Venue: Remote Zoom Meeting

Distribution:

Board Members: Dr Alison Bolam, Helen Holland, Asher Craig, Christina Gray, Julia Ross, David Jarrett, Elaine Flint, Tim Poole, Vicky Marriott, Georgie Bigg, Dr Jacqui Jensen, Robert Woolley, Andrea Young, Eva Dietrich, Janet Rowse, Hugh Evans, Jean Smith and Sumita Hutchison

Copies to: Nancy Rollason (Head of Legal Service), Sarah Sharland (Legal Officer), Sally Hogg and Oliver Harrison (Democratic Services Officer)

Issued by: Oliver Harrison, Democratic Services
City Hall College Green Bristol BS1 5TR
Tel: 0117 35 26162
E-mail: democratic.services@bristol.gov.uk
Date: Tuesday, 11 August 2020

Agenda

1. Welcome, Introductions and Safety Information

2. Apologies for Absence and Substitutions

3. Declarations of Interest

To note any declarations of interest from the Councillors. They are asked to indicate the relevant agenda item, the nature of the interest and in particular whether it is a **disclosable pecuniary interest**.

Any declarations of interest made at the meeting which is not on the register of interests should be notified to the Monitoring Officer for inclusion.

4. Minutes of Previous Meeting - Thursday 25th June 2020

To agree the minutes of the previous meeting as a correct record. **(Pages 4 - 8)**

5. Public Forum

Up to 10 minutes is allowed for this item

Any member of the public or Councillor may participate in Public Forum. The detailed arrangements for so doing are set out in the Public Information Sheet at the back of this agenda. Public Forum items should be emailed to democratic.services@bristol.gov.uk and please note that the following deadlines will apply in relation to this meeting:-

Questions - Written questions must be received 3 clear working days prior to the meeting. For this meeting, this means that your question(s) must be received in this office at the latest **by 5pm on Thursday 13th August 2020.**

Petitions and Statements - Petitions and statements must be received on the working day prior to the meeting. For this meeting this means that your submission must be received in this office at the latest **by 12 Noon on Tuesday 18th August 2020.**

6. Work Programme

To note the work programme. **(Page 9)**

7. COVID-19 Local Outbreak Management Update - Christina Gray, Director of Public Health **2.30 pm**

This report will be not available until the day of the meeting as it contains daily updated data.

8. The Impact of COVID-19 Social Care Services at Home June 2020 - Vicky Marriott, Area Manager, Healthwatch Bristol, North Somerset and South Gloucestershire - **2.50 pm**

(Pages 10 - 47)

9. Healthier Together: Impact of COVID-19 and lockdown on health inequalities and steps that need to be taken to address this in Bristol, North Somerset and South Gloucestershire (BNSSG) - Adwoa Webber, Head of Clinical Effectiveness, BNSSG Clinical Commissioning Group (CCG) **3.10 pm**

(Pages 48 - 66)

10. Fuel Poverty Action Plan - Aisha Stewart and Hannah Spungin, Bristol City Council Energy Service **3.30 pm**

(Pages 67 - 106)

11. Going for Gold and food equality update - Elizabeth Le Breton, Bristol City Council and Joy Carey, Bristol Food Network **3.50 pm**

(Pages 107 - 109)

Bristol City Council
Minutes of the Health and Wellbeing Board

25 June 2020 at 2.30 pm

Board Members Present: Alison Bolam, Helen Holland, Asher Craig, Christina Gray, David Jarrett, Elaine Flint, Vicky Marriott, Jacqui Jensen, Hugh Evans, Jean Smith and Sumita Hutchison

Officers in Attendance:- Sally Hogg, Mark Allen, Oliver Harrison

1. Welcome, Introductions and Safety Information

The Chair welcomed everyone to the meeting and led introductions.

2. Apologies for Absence and Substitutions

Apologies received:

Tim Poole
Janet Rowse (Claire Chapman substitutes)
Andrea Young (Tim Keen substitutes)
Robert Wooley (Cathy Caple substitutes)

3. Declarations of Interest

None received.

4. Public Forum

None received.

5. Minutes of Previous Meeting

The minutes of the meeting held on 27 February 2020 were agreed as a correct record.

6. COVID-19 update

Christina Gray gave a slideshow presentation on Covid-19. This gave an overview of the position in terms of numbers and an overview of the plan. Looking at NHS lab results, there are 722 total cases since the beginning of records. The current rate of incidence is low at the moment.

- The negative effects of Covid related restrictions on public health are now significant. The virus is still a present risk.
- The LA needs to submit an outbreak plan by 30 June. This will be a method to identify and contain outbreaks.
- Remember that the virus will travel through multiple locality areas. We are working with the South West region authorities to align policy. This work is also taking place in the Resilience Forum and BNSSG. We are already doing a lot of joint work but now formalising this, especially in regard to care homes.
- There will be 2 new boards: the Covid Health Protection Committee and the Communication and Engagement board. The Engagement Board is Mayoral led, building on existing engagement work and equalities. The outbreak plan needs high levels of public trust to work. The Health Protection Committee contains a wide and diverse membership of health experts. This is to provide visible leadership and works through existing health networks such as the HWB.
- The Covid data is held in the joint bio security system, which is nationally held. However, local authorities are important contributors as they can get live feedback from the public. Our local intelligence then feeds into the data.
- Testing / tracing / isolating. Identify a case, identify ongoing transmission and stop the spread. Test tells us if someone is positive at the time. Testing needs to be agile and fast to deploy correctly and accessible for the public. An antibody test is being rolled out to key staff, which will tell if you have been exposed in the past. Note that we do not currently know whether this grants immunity.
- Health protection committee is expected to account and help vulnerable people e.g. homeless.
- There needs to be specific plans for care homes and schools. The BCC Education Director has regular meets with school heads, with lots of mutual communication, support and advice. There is a response plan in place for schools. Each school has its own needs.
- The outbreak plan has an appendix of high risk contexts, e.g. prisons, homeless, BAME community. This is a planning process not a fixed object. We need to help vulnerable people to isolate otherwise the outbreak plan cannot work. Some will have social, welfare or economic reasons that incline them to resist isolating.

Discussion Notes:

- Members gave their thanks to CG and the public health team for developing a comprehensive Outbreak Plan.
- The BCC Director of Policy will be leading on managing and supporting the Engagement Board. Engagement has been going well so far, but this will formalise the approach to take it into the next level.

- There have been some concerns from older people and BAME individuals about mixed messages. It is important there is unified messaging based on trusted data.
- VCSE will be expected to do a lot of support work. Community organisations are standing down their response work and moving back to business as usual, while being more aware of lessons learned from virus. They we will need to be informed ASAP if they need to go back to response work as they cannot turn on a pinhead. Engagement is critical to get into communities.
- There is a contact tracing app, which is simple to use, however we realise we are not in a one size fits all situation.
- Communications will need to identify a contact number clearly so people will actually pick up the phone.
- Acute colleagues were asked whether they would like to attend the Technical Board. This is an open opportunity for people who want to be engaged.

7. The impact of COVID-19 on BAME communities

Dr Tim Jones (University of Bristol) gave a presentation on the impact of Covid-19 on BAME Communities. There is a disproportionate death toll on BAME, so looked for evidence about this based on publicly available data. This report combines 5 studies. We need to understand factors to protect BAME individuals with future policies.

- Factors include deprivation, housing, employment, geography, discrimination, comorbidities, etc. The report itself goes into more detail.
- Risk of death increases with deprivation. Roughly double risk between most and least affluent.
- BAME are more likely to live in intergenerational and crowded housing, meaning it is harder to self-isolate and easier to infect the elderly.
- Low English proficiency means it is harder to understand medical advice.
- BAME are more likely to work in health, social care or other environments that put them at greater risk, e.g. taxi/bus driver, care homes. They are also more likely to work in areas that have shut during lockdown.
- BAME have higher rates of diabetes, heart disease, anaemia, etc. which increases risk. There are lower levels of physical activity and higher smoking in certain groups such as South Asians.
- BAME live primarily in urban areas, which have a bigger risk of infection.
- Experience of racism causes health issues, esp. mental health. Genetics is only a minor factor.
- Some measures to help include: ensuring adequate income support so self-isolation can happen, supplying cultural / language appropriate communications, suspending NHS charges during outbreak, collecting data by ethnicity, tailoring interventions that are understanding but not stereotypical, and ensuring a good representation of BAME in any Covid-19 response.

Discussion Notes:

- This is a good piece of work and has been developed quickly. Equalities group presentations have gone on and are helpful. We have also set up a Covid Race Equality Group. There are some additional actions that will need addressing coming out of the community. This will require

resourcing, many BAME are concerned about the situation but there are trust issues that need overcoming. The BAME Community wants to see action.

- Some acute practitioners have noticed BAME patients are more anxious about Covid risks. There is anxiety coming from BAME staff on the frontline, they feel they are not getting the information that they need. Clear communications is vital.
- Covid is an event that has exposed inequalities in the city and country. An action plan is currently being put together based on recommendations from equalities groups. All of the thematic boards need to be aware of this and take appropriate actions. HWB will lead on this work and it will get regular updates from the equalities board.

8. 2020-21 Plan on a Page

Mark Allen gave an update on the HWB "Plan on a Page", which links closely to the HWB strategy. The integrated care system section will be updated after the next development session. The recommendation is to approve the plan, pending the update of integrated care.

Discussion Notes:
There is currently no mention of Covid-19 activity on the plan. While health inequalities are on the plan, they will need updating to include Covid related actions.

ACTION MA to add Covid and BAME Covid activity into the Plan on a Page.

Any Other Business:
There has been a question from the Connectivity Board to the HWB: How can the public access NHS services via (public) transport and how do we promote active travel?

- There is a hospital bus is running from Bristol Temple Meads to the BRI now. Capacity is reduced to ensure social distancing.
- Southmead has a community service and regular First buses, but there has been a reduction. Running these services is up to First.
- Many standard NHS services are up and running, but some are now delivered virtually. Sarah Truelove at BNSSG silver group has detailed reopening plans.

ACTION Mark Allen to contact Sian Trew (CCG) re: healthcare reopening plans and related communication plans.

ACTION Sally Hogg to draft a response to the Connectivity Board addressing active travel schemes.

Meeting ended at 4.00 pm

CHAIR _____

DRAFT Forward Plan 2020 as of August 2020

24th September 2020, 2:30 – 4:30pm – Development Session

- One City Climate Strategy - joint session with Environmental Sustainability Board

TBC 29th September 2020, 10am – 1pm – BNSSG 'Creative conversation'

28th October 2020, 2:30-5pm – Formal Board

- Drugs and alcohol strategy
- Children and Families Board update
- Future Parks and health

26th November 2020, 2:30-4:30pm – Development Session

- TBC Food equality plan
- TBC Integrated Care System

TBC 16th December 2020, 2pm – 5pm – BNSSG 'Creative conversation'

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Bristol Health and Wellbeing Board

Title of Report:	The Impact of COVID–19 Social Care Services at Home
Author (including organisation):	Vicky Marriott, Healthwatch Bristol
Date of Board meeting:	19th August 2020
Purpose:	Information and Discussion

1. Executive Summary

Our pulse survey provides a brief a snapshot of life for Domiciliary care users, over the Covid 19 lockdown, and their carers. 46% of respondents said there was a change to their normal service, although almost a third said they experienced an improvement in the quality of care. Some said they wanted to keep themselves safe and therefore chose not to have people enter their home. Problems with professionals being unable to access PPE played a part in safety concerns. 83% benefitted from more family and friends support. Over 50% felt their health and wellbeing was affected by the isolation of lockdown. A third said they felt they were more anxious than before due to the insecurity of not knowing if they would have regular carers, being left without medication or other insecurity such as being short of food.

2. Purpose of the Paper

Evaluation of Domiciliary Care service and insight into experiences during Covid 19. Items for information and discussion.

3. Background and evidence base

Our recommendations are based on the voice and influence of Domiciliary Care clients. The complex issues faced by these often 'high risk 'category individuals include disruption of routine appointments with GPs and Hospitals and to the continuity of their social care support for care agencies. Half of those responding said service change had not been explained.

BCC vision for Adult Social Care Strategic Plan 2016/20 'ensure people get the right type of support, at the right time to prevent, reduce or delay the need for ongoing support and to stay independent. '

JSNA Health and Wellbeing Profile Older People 2019/20. Adult Social Care summary. 3,977 adults received a community-based social care support service during 2018/19. 1,985 of these were older people and 1,992 were people aged 18-64 years. Supported Living, Support to Access the Community, Day Services and Time For You. These clients were 18-64 years. The majority have a physical impairment (772), a learning disability (715), or a mental health issue (431), plus sensory impairment (63), Autism (53). Numbers in all client groups rose in 2018/19, except "Physical Impairment". In 2018/19, women accounted for 56% (2,222) of the take up of services, with 44% for men (1,755). For older people, women accounted for 66% of take up, with 34% men. Across the city, there are large differences in the rates (per 1,000 population, 65+) of older people receiving these services. The range is from under 11 per 1,000 in Clifton Down and Stoke Bishop to 89 per 1,000 in Lawrence Hill. At the end of 2018/19, BCC funded 38 fewer "domestic" care packages for older people (65+), and 23 fewer care packages for 18-64 age group, continuing a downward trend in funded packages since 2013/14. This at least in part

reflects supply of this provision, due to previous approaches to funding. There has been a substantial additional investment into home care provision, and work with the market is continuing to try and address shortfalls in supply that appear to arise due to workforce issues (recruitment).

Standards in Domiciliary Care 2000, set by the National Care Standards Commission states Standard 6 – Manager will ensure there is continuity of carers or support workers who provide the service to each service user
https://webarchive.nationalarchives.gov.uk/20130124065122/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4083671.pdf

4. Community engagement

This project was the first project in our 2020 workplan, informed by strategic priorities in Bristol and nationally. Our vision is ' to promote the experiences and involvement of local people to shape fair, accessible, and inclusive health and social care services for all.'
Two new Bristol staff engaged with community groups, but by necessity survey distribution was limited to an online survey. The VCSE, Health organisations, Carers Groups, Mutual Aids Groups and BCC helped distribute the survey to their contacts during lockdown.

5. Recommendations

The insights gained from hearing from this group of service users are multiple. However main recommendations are for clearer routes to access PPE and knowledge of how to use it. That clients are provided with continuity of carers to improve trust and reduce their isolation. There is improved communication about changes to services from agencies, especially for those without internet and there should be contingency planning support for users of direct payments. We propose with the help of the VCSE and BCC to widen this survey to hear from diverse communities about their care experiences as the impact of the pandemic continues.

6. City Benefits

Impacts for Equalities, Health and Sustainability.

7. Appendices

Healthwatch Bristol - The Impact of COVID–19 Social Care Services at Home June 2020

The Impact of COVID–19 Social Care Services at Home

June 2020

Healthwatch Bristol
3rd Floor, The Sion
Crown Glass Place
Nailsea
BS48 1RB
Tel: 01275 851 400
Email: contact@healthwatchbristol.co.uk
Website: www.healthwatchbristol.co.uk

bristolhealthwatch

@HWBristol

Registered Charity number 115848, company limited by guarantee 08187141
Registered office Healthwatch North Somerset, 3rd Floor, The Sion, Crown Glass Place, Nailsea BS48 1RB

Table of Contents

About Healthwatch Bristol

Healthwatch Bristol is the independent champion for people who use health and social care services in the Bristol area. We give people an opportunity to have a say about their care, including those who are not usually heard. We ensure that their views are taken to the people who make decisions about services. We have a representative on the Health and Wellbeing Board. We also share feedback with Healthwatch England and the Care Quality Commission (CQC) to ensure that your community's voice is heard at a national level too.

We are also here to provide information about services in the Bristol area, and signpost people to find specialist help. We work closely with other local community groups and organisations to make sure that we support people to make informed choices and decisions about their care and make public all reports of our work with patients, families and carers.

Our Survey

One of the priorities in our workplan for 2020, is to evaluate how social care services are meeting the needs of residents in Bristol, so that we give people the opportunity to inform services and improve care.

Covid-19 (Coronavirus) has caused major changes in health and social care service provision, and so it has become even more important now that we understand how the needs of those accessing domiciliary service have been met. Specifically, we wanted to identify what services work well or do not work well, and where improvements are needed.

Due to the outbreak of COVID-19 we chose to explore the impact on users of social care services at home. It contrasts the care at home compared to support during lockdown from state carers, families, and friends.

Who does this affect?

People receiving or providing domiciliary health and social care in Bristol. This include patients, care workers, family and friends, who might or might not have been categorised as being at high risk, shielding or self-isolating during COVID-19. With COVID-19, changes in the delivery of health and social care services at home had to be implemented for infection control. Care receivers are more likely to be in a high-risk category or shielding, resulting in their care being interrupted. Routine appointments with GP surgery and hospital services have cancelled or postponed procedures. Carers may also have been self-isolating due to higher rate of infection among them. The Covid 19 disruptions are set against a backdrop of social care services reported to have been chronically underfunded for many years (Nuffield Trust, et al., 2020).

The outbreak of COVID-19 has led to patients being discharged from hospitals to free hospital beds for patients affected by the disease. Discharge to assess (D2A) used 4 pathways for discharging patients. For patients to be supported and recover from home (Pathway 1), they had to be supported by their health and social care team. The community health services were responsible for providing patients with care, support, and follow-ups at their own homes.

On 1st April 2020 Sirona Care & Health began a contract in Bristol and with partners provided a front door for people needing community care. This Integrated Care Bureau works in tandem with secondary care to coordinate the needs of patients after hospital discharge.

The Better Care Fund is a national pooled funding arrangement for NHS and Local government to assist planning and delivering integrated care for older people with long term conditions. The Clinical Commissioning Group (CCG) for Bristol, North Somerset and South Gloucestershire (BNSSG) were due to launch a Better Care plan 2020 but Covid 19 has delayed this. The current arrangement with partners across the BNSSG is still in place meanwhile.

The vision for the Bristol City Council Adult Social Care Strategic Plan 2016/2020 is; *'care and support are undertaken in a timely and manner as agreed with the care receivers. The vision is to ensure people to get the right type of support, at the right time to prevent, reduce or delay the need for ongoing support and to stay independent.'*

Why we are carrying out this research?

- Adult social care, including residential care homes or care at home were among the five priorities for 2019 (Healthwatch England, 2019).
- Healthwatch Bristol priority in workplan for 2020 through feedback and sharing of experiences and opinions.
- Bristol City Council COVID-19 newsletters and briefings, March – June, 2020.
- Care system evidence of underlying weaknesses which included severe underfunding before the COVID-19 pandemic (The Nuffield Trust, May 2020).
- COVID-19 death rates in social care workers (The Nursing times, May 2020)
- COVID-19 death rates in people with Dementia (ONS May 2020).
- Domiciliary care services, families and carers experience of waiting times, access or reduced services (Care Quality Commission, 2019:41).

Objectives

To investigate issues of domiciliary care provision due to Covid-19 using a pulse survey open for two weeks which targeted both care givers and receivers.

To use an online tool to rapidly develop the survey, to manage the processes of sending it to the target group and promoters and to collect and collate the results.

To rapidly produce a report containing quantitative and qualitative data with recommendations and disseminate it through multiple channels to various agencies, stakeholders and the general public.

Methods

An online survey was developed using Survey Monkey. The survey comprised 34 questions, some closed and some open-ended, which covered consent, postcode area, the main survey questions, and demographics. The consent of a respondents was mandatory to enable collection of their responses. Respondents were asked if they wished to provide a method of contact for follow up questions or clarification. Our data protection measures are GDPR compliant and we have privacy and confidentiality policies in place and provided on request. Demographics were requested to seek understanding of the needs of communities in Bristol.

Survey Monkey provided links to post on FB and Twitter as well as a weblink and a QR code to be sent by email. The survey was widely promoted and distributed to community groups, care agencies, voluntary organisations, service providers, institutions, BCC councillors, newsletters, and word of mouth.

Survey Monkey managed the collecting and collating of the results, which were downloaded for analysis on Excel and Word documents.

Executive Summary

Our survey found 56% were satisfied with the level of care during lockdown for a variety of reasons. 46% experienced a change to their normal service provided, with over 20% seeing less carers or less frequency of visits. However almost a third said they experienced an improvement in the quality of their care.

Those dissatisfied cited either having '*no support since lockdown*' or less continuity of carers or missing seeing the people they knew and trusted. 50% said their care provider had not explained changes to their care. A third did not know what to do if a carer did not turn up. A third said their mental health had worsened '*feeling like I've been disregarded*' since their social and medical care changed.

The impact for those cared-for if no carer was able to provide the normal level of care was '*more work*' and '*more stress*'. Some said they had '*struggled on anyway*' or decided to '*manage without for now*'. One service user lived on '*bread and crisps for a week*'.

People made choices to keep themselves safe rather than have people in their home. Some chose to have less support and reduce the degree of contact from social care services. 83% of our respondents benefited from more help from friends and family during lockdown.

Carers were not supported and those being cared-for '*felt guilty asking family for more help*'. 88% of our respondents said their carers did not receive support during lockdown.

Carers, friends and family mentioned their concerns about the access to PPE (Personal Protection Equipment) and had queries about when it should be needed or used by friends and family and visiting carers.

Most of our respondents said they were aware of what they should do if they found they were infected with Covid 19.

57% looked for information from NHS websites. Social media and GP information was highly important also.

Recommendations

- Improve ways to help service users feel safe; advice on access to PPE & what the right PPE is, reassurance, and clear messages.
- Aim to provide continuity in carers, to maximise trust, security and support to individuals who are socially isolated. Make links to social prescribers.
- Address the challenge of communicating about changes to support and providing advice; include methods to reach people without internet.
- Ensure there is an adequate support to help users of direct payments create contingency plans where changes occur

The Survey

At the start of the survey we asked four introductory questions:

1. Consent and confidentiality
2. Consent to follow-up with contact details
3. Postcode area
4. Who they were responding on behalf of

Question 4 determined whether people were responding about their own care, or that they were carers, family or friends of someone receiving care.

The questions that followed these are referred to as the 'main questions'.

Breakdown of Responses

The survey which targeted Bristol, was sent out to various people, agencies and organisations.

In total we received 58 responses. All respondents answered the introductory questions. However, 40 did not answer any main questions and 34 of these were responding about their own care.

The survey targeted Bristol residents receiving care or those providing care services. However, some respondents were from adjacent areas or care workers who lived outside Bristol.

Of the 58 respondents

- 30 left no contact details and did not answer the main questions
  - 26 were responding about their own care
- 10 left their contact details for follow-up but no answers to main questions
  - 8 were responding for about their own care
  - 1 for some they care for
  - 1 did not specify.
- 18 respondents provided answers to at least some of questions
  - 9 were responding for about their own care
  - 6 were responding for someone they care for
  - 3 were responding for someone else
  - 8 left their contact details for follow up

Key Findings

This section includes respondents' answers. The summary shows the number of respondents who chose to answer each question. Where quotes are given, they are summarised for this report. Note: Questions 1-3 were for consent and follow up permission.

Respondent's Situation

Overview

Domiciliary care (also referred to as home care, social care, home help, or in-home care) involves the delivery of personal care and support services to people in their own homes so that they can maintain their independence and quality of life. The service delivery includes provision of personal care, help with washing and dressing, domestic chores, housekeeping and help with medication.

Provision of domiciliary care is for meeting needs that arise from illness, disability, or old age. Our interest is in the provision of state funded care and the care they may be receiving from family and friends also.

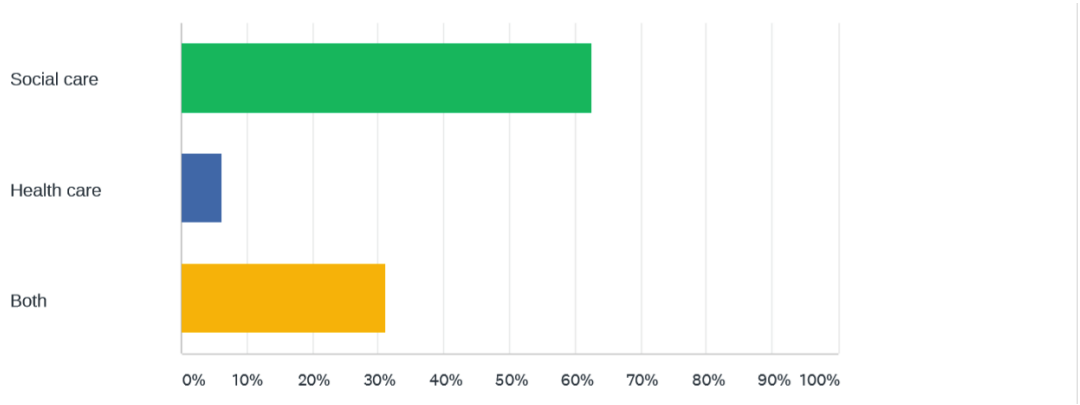
Who are you responding on behalf of?

54 answered

Out of the 54 people who answered this section, the majority, that is, 74% (40) were people who were answering the survey on their own behalf to ensure their voices are heard. 15% (8) responded on behalf of someone they care for and they are likely to be carers, family or friends. Only 11% (6) mentioned they were answering for someone else.

- 74% (40) On their own behalf
- 15% (8) For someone they care for
- 11% (6) For someone else.

What kind of care do you receive at home?



16 answered

- 63% (10) Social care (bathing/shower, housework, meals, personal care,
    - practical assistance)
- 6% (1) Health care (OT, chiropody, physiotherapy, nursing)
- 31% (5) Both

Who is your care provider?

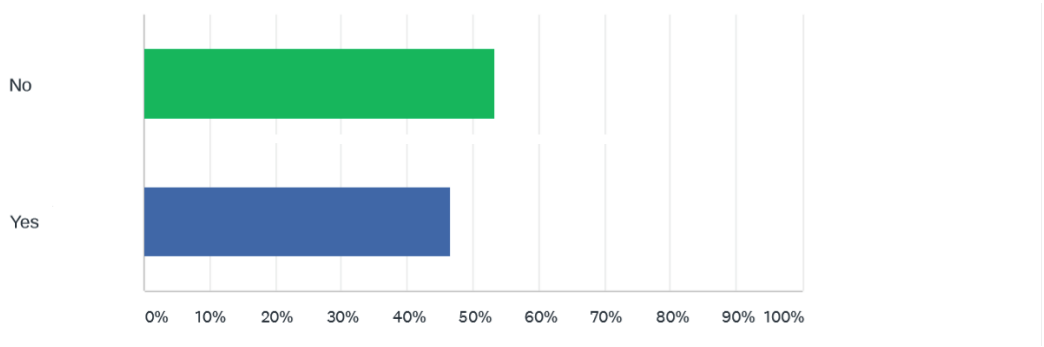
16 answered

- 6% (1) Brandon Trust
- 31% (5) Employ my own carer/s
- 63% (10) Other (3 specified family, 6 various care agencies, and 1 not known).

Names of eleven main care providers were given to respondents to choose from, but only Brandon Trust was mentioned. Given that 63% of the respondents mentioned 'Other', it suggests that there are various organisations providing domiciliary care, but their names were not included in the list.

This is supported by information on Bristol City Council stating that they have three tiers of home care providers e.g. main, secondary and framework providers. The main and secondary organisations deliver majority of care at home services, and the framework agencies provide services only when main and secondary are unable to.

I receive a personal budget and employ my own carer/s.



15 answered

- 53% (8) No
- 47% (7) Yes

Home care support can be arranged by the council or the care receiver. A personal budget is the overall cost of the care and support the local authority provides or arranges. Direct payment is a funding choice in personal budgets which gives the service user involvement in addressing their own care needs.

For those who have direct payments, they were asked to explain their experiences of using the services during the crisis:

- *PA* [personal care assistant] *unable to come due to no childcare (usually after school clubs/grandparents) Live with family members but one has been unwell, other trying to look after both of us.*
- *Been ok made sure PA had PPE* [personal protective equipment] *to keep my daughter safe.*
- *The Council has been supportive, acknowledging there may be additional costs etc, but the lack of PPE has been a big issue. Not only for me: I run a DPO* [disabled people's organisation] *and anxiety about the failure of various systems to actually supply the PPE requested has been one of the most common issues people have contacted us about.*
- *DP* [direct payments] *not personal budget. am only using 1 carer to cut down on contact as in the extremely vulnerable group.*
- *It has been difficult because carer does not have PPE and I have not been able to buy it. Both my husband and I are shielding and have therefore not been receiving personal care but I have been paying her to do shopping which is part of my care plan.*
- *It has all been well.*

The need for and difficulty acquiring PPE was raised 3 times, and one respondent who runs a DPO said it was the most common issue they were contacted about.

Social Care at Home

Overview

Respondents were asked the following questions in relation to their care experiences.

If you feel your health has been affected by the changes to your care?

8 answered

- 63% (5) What do you feel is worse?
- 63% (5) What do you feel is better?

The question allowed for answers to both what was worse and what was better regarding how health was affected by changes in care due to the COVID-19 situation.

What was worse:

- *Pushing my body to do too much. Not keeping clean. Some arguments with family members. Communication with PA challenging as they are preoccupied /exhausted with home-schooling etc.*
- *He* [person being cared for] *is somewhat bored by our company.*
- *I'd expect an impact on such an elderly person only eating bread and crisps for a week.*
- *Anxiety, loneliness.*
- *It means I have no help so I am ill and exhausted!*

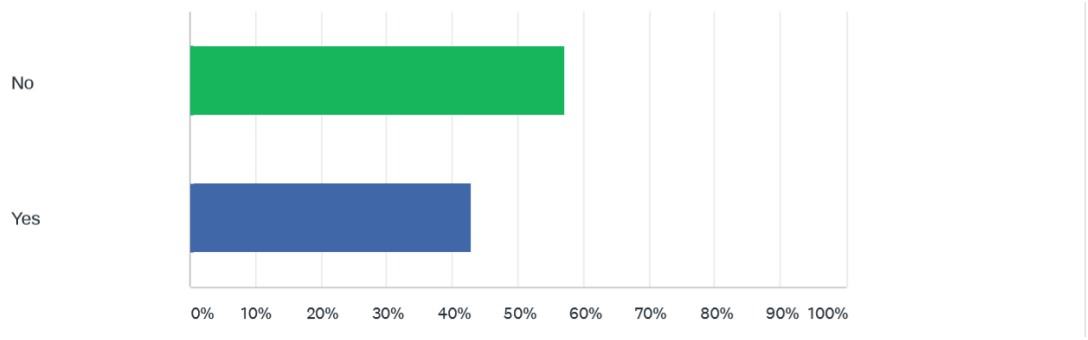
This indicated that experiences of individuals significantly varied from person to person during COVID-19 situation. Some people felt that there was so much going on leading to exhaustion and arguments. Others experienced mental health issues related to boredom, anxiety, loneliness.

What was better:

- *Not so many Carers coming in since got a PA.*
- *He has put on weight which is positive.*
- *I have an extra person in the house.*
- *Less carers keeps exposure less.*
- *nothing!*

This also showed a variety of experiences. Two people that were pleased that less carers visiting meant reduced risk, two others that found there nothing was better and one was glad to have an extra person around.

Have GP or Hospital appointments been cancelled, or medication missed?



14 answered

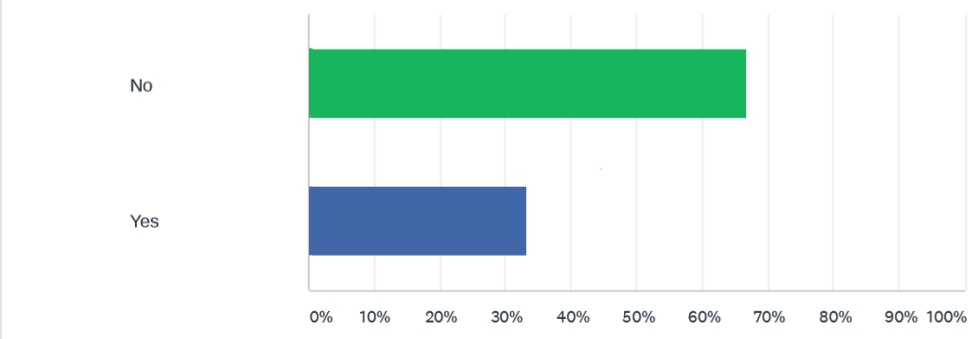
- 57% (8) No
- 43% (6) Yes - please give details.

Despite the interruptions during the COVID-19, majority of those who answered this question 57% (8) said that they had no missed health care appointments or medications.

The 43% (6) respondents who had their services interrupted gave details as follows:

- *Matron didn't come in and no calls from GP to see if we're ok.*
- *Appointments, an operation and a procedure were all cancelled.*
- *Doctors haven't been able to see me. I have a potential dislocation and they haven't seen me about it. My usual meds. have been stopped.*
- *Regular check-up cancelled.*
- *My husband was due a hospital appointment which was carried out over the phone, I have had 3 appointments cancelled and have been told to ask my GP to re-refer when they are able which has impacted on me. At present we have managed to get medication either from my carer or neighbours.*
- *Cancelled and held over the phone.*

Do you feel your mental health has been affected by the changes to your care?



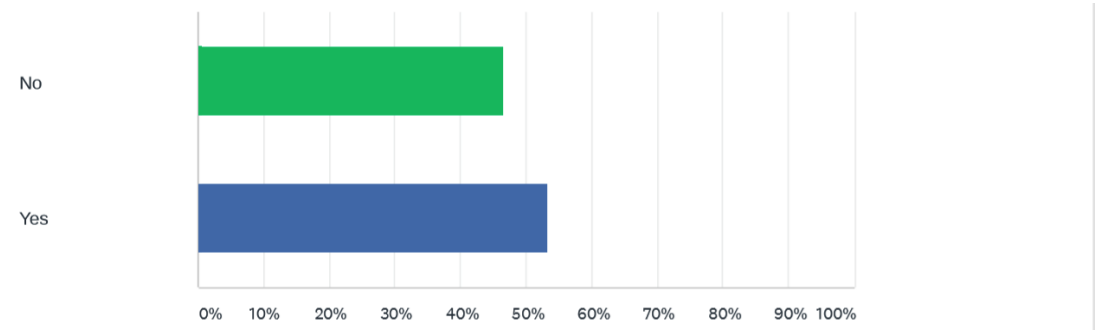
15 answered

- 67% (10) No
- 33% (5) Yes - in what way?

The response to our questions showed that 33% (5) of people felt their mental health was affected by changes to their care. Their responses depended on individual circumstances, which included insecurity from the inability to get carers or having regular carers, being left without medication and lack of food:

- *Not having any external help (though my weekly hours are low) not knowing when it will resume again. Feels awful with things piling up, and guilty asking family for more help when working from home and helping other unwell family member.*
- *Changes in my healthcare (as opposed to social care where there have been no changes) have caused me anxiety and distress.*
- *I'm not coping without meds and feeling like I've been disregarded as I'm not as important as Covid. Which I do understand but it means I've been left.*
- *I'd expect that only having bread and crisps to eat would have an impact on someone's mental health. In addition to the physical impact, of course.*
- *Increased anxiety as I don't know what carer I will get from day to day. Increased loneliness and isolation.*

Has isolation affected your health and wellbeing with loss of access to community activities?



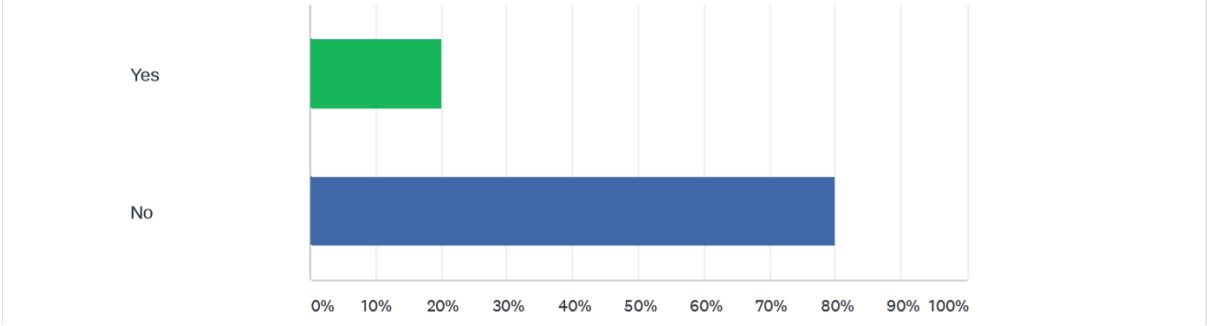
15 answered

- 47% (7) No
- 53% (8) Yes - would you like to tell us more about this?

The majority, 53% (8) of people gave various reasons why they felt isolation affected their health and wellbeing. The reasons given included issues related to stress, not going out and meeting friends, lack of community activities:

- *Whilst I've done better than I feared, I have really struggled with not being able to meet up with friends (I live alone), go to cafes (probably my no.1 hobby) get to green spaces that I need, the local train line to access, etc.*
- *Feel very stressed*
- *Bored, missing his friends, PAs, going out, the gym etc.*
- *There are no community activities I could attend even if I was medicated and able to.*
- *The person used to be assisted with transport to the shops but this had to stop, cutting off their ability to source food for a time.*
- *My carer would take me to the bank and to the shops. They don't do that anymore. I don't get to go out now.*
- *We have not been able to see Family and Friends who are our lifelines really. My 2 sons have moved in with friends to shield us and so that they are able to support their grandmother who is over 70 and lives alone and has no access to services. they also help* out when carer not available.

Do you live alone?

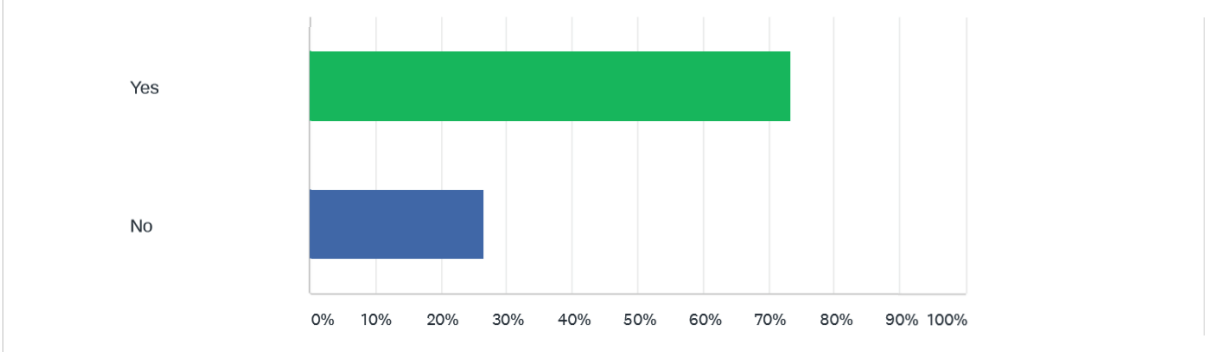


15 answered

- 20% (3) Yes
- 80% (12) No

The majority of respondents, 80% (12), had someone else living in the same home. Only 20% (3) lived alone.

Do you receive help from family or friends?

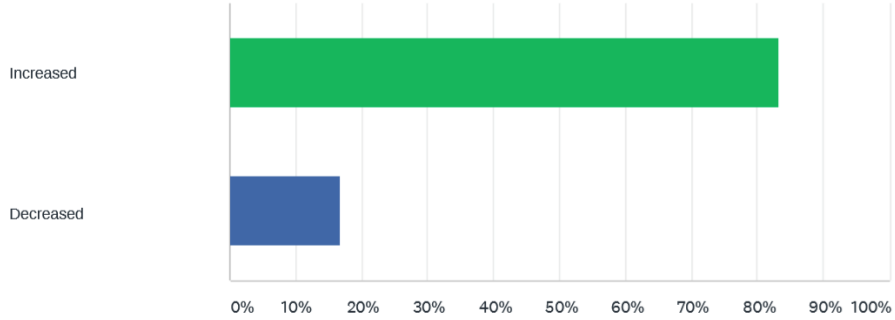


15 answered

- 73% (11) Yes
- 27% (4) No

Three quarters of respondents 73% (11) were receiving help from their family or friends, and a quarter 27% (4) were not.

Has the care you receive from family or friends changed since the virus outbreak?

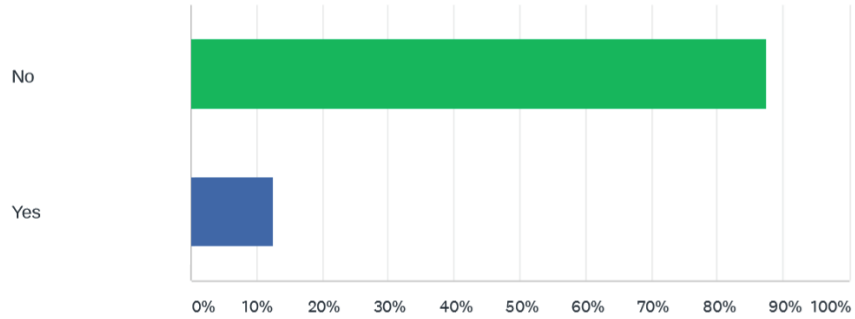


12 answered

- 83% (10) Increased
- 17% (2) Decreased

Most respondents, 83% (13) indicated that the support provided by their friends and families increased. The remaining 17% (2) stated that the support decreased.

If you have an unpaid carer, are they receiving support?



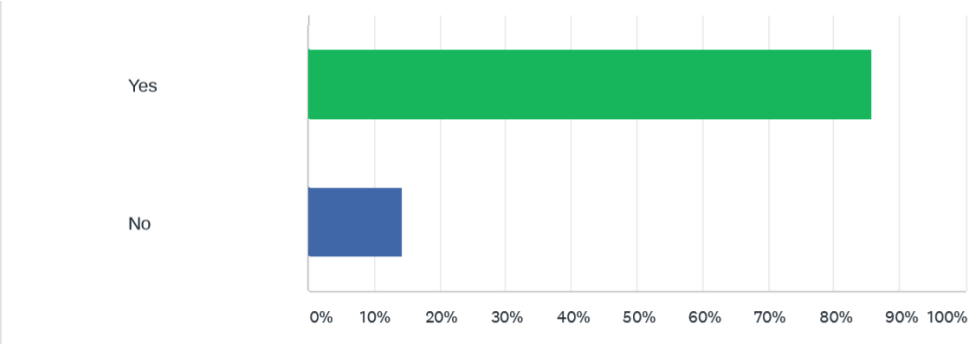
7 answered

- 88% (7) No
- 13% (1) Yes

Most people that responded said **No,** their carers were not receiving support.

The only one who answered 'Yes' later said they misunderstood the question.

Would you know what to do if you had symptoms of Covid -19?

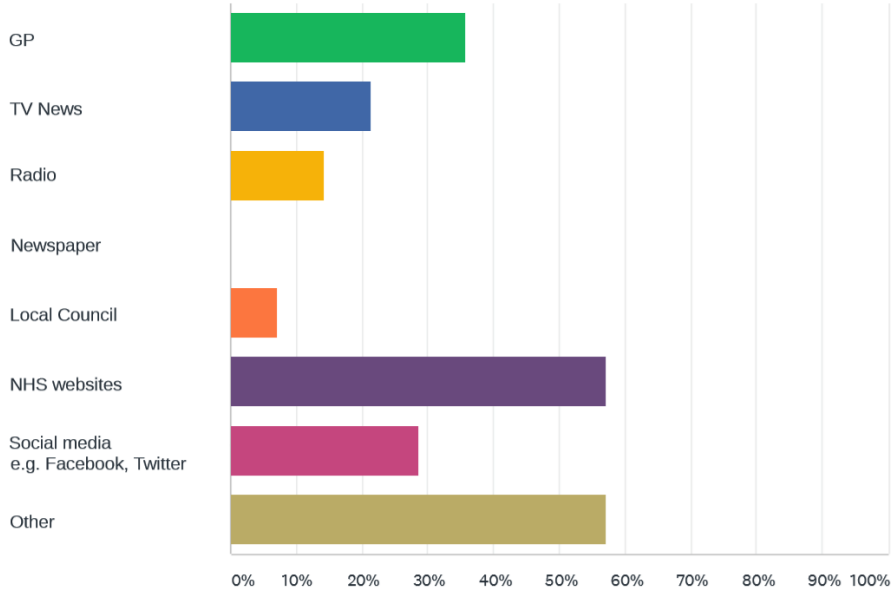


14 answered

- 86% (12) Yes
- 12% (2) No

As 86% (12) of respondents indicated that they knew what to do if they had symptoms of COVID-19, and only 12% (2) did not, this demonstrates that there was a high level of awareness and knowledge about the disease in the community.

Where do you look for information about COVID-19 (please tick all that apply?)



14 answered

- 36% (5) GP
- 21% (3) TV news
- 14% (2) Radio
- 7% (1) Local council
- 29% (4) Social media e.g. Facebook or Twitter
- 57% (8) NHS websites
- 57% (8) Other – please list sources here

The other sources listed by 8 of the respondents were:

- *BBC news summary (five things you should know..)*
- *Government website, WHO international*
- *Family, Mencap*
- *Family members who understand it and can explain it to me better. Although, no one knows if what we're being told is accurate and reliable - even that from the government.*
- *Carers*
- *BBC website*
- *111*
- *Family*

There were various channels where people were getting information about COVID-19. The NHS websites are most preferred by people, followed by information obtained from GPs. Social media and radio broadcast were also favoured by some people, and a few get the information from the council.

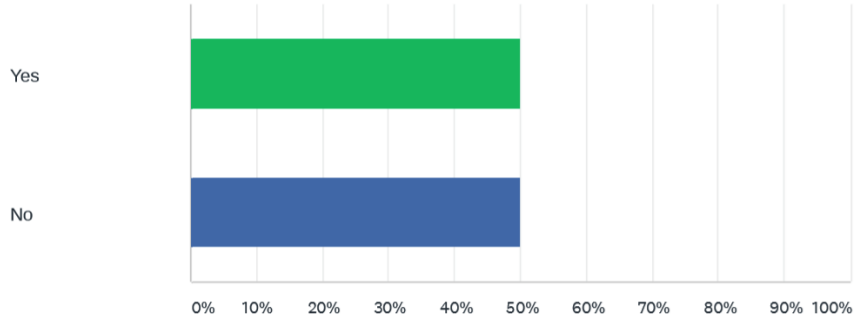
What information have you found helpful?

10 answered

For the 10 people who responded to this question, the sources of information they found helpful included:

- *NHS website*
- *Easy read document from Mencap.*
- *NHS telling us what to look for. Family members and trustworthy people on social media explaining the isolation and rules.*
- *I haven't.*
- *How to keep myself safe and the people I provide support.*
- *The local community have set up a great Social Media volunteer page but also keep it up to date with Gov information etc and takes requests for help with shopping, medication etc.*
- *All they have on the website.*
- *Stay at home, Protect Our NHS, Save lives.*
- *Hospital leaflets*

Had you heard of Healthwatch before this survey?



14 answered

- 50% (7) Yes
- 50% (7) No

If you have any further thoughts or comments about your care at home, please share them with us.

8 answered

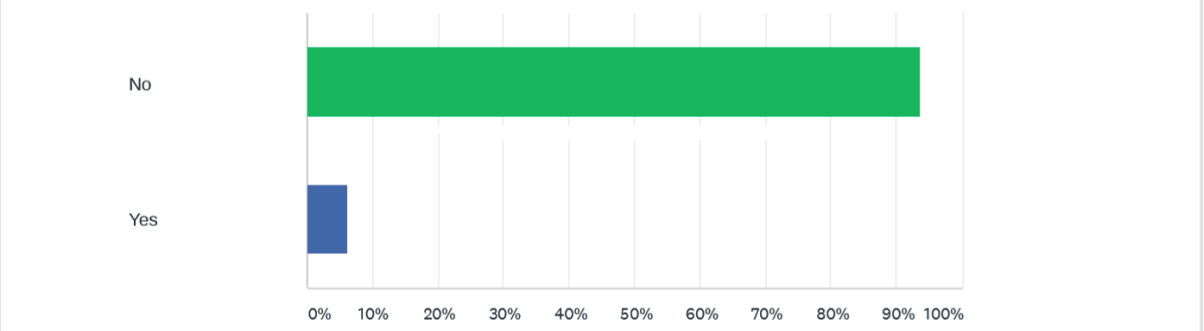
Respondents were given the opportunity to add their thoughts or comments about how they felt about the health and social care at home that they receive. There were mixed opinions with some indicating they the advice and information given to them about COVID-19 were inadequate. There were also issues about lack access to digital technology and fear of COVID-19 being brought home, presumably by carers. Despite these views, there was also positive feedback, where people said that they were very satisfied with their service delivery.

Responses included:

- *Feels like we were forgotten, and the advice unclear. Needs to be clear guidance including those who employ PA's.*
- *Feel worried since the COVID 19 in case brought into our home made feel very upset and worried.*
- *I'm just a disabled person at home with 2 registered young carers. I got the link from the young carers website.*
- *It is what it is.*
- *For this person who had no internet access, no mobility, no family or friends to help; everything stopped without systems in place to support this person adequately enough. It was very sad indeed.*
- *Excellent service and support.*
- *Perfect.*

How circumstances changed during COVID-19

Have you recently been discharged from hospital?



16 answered

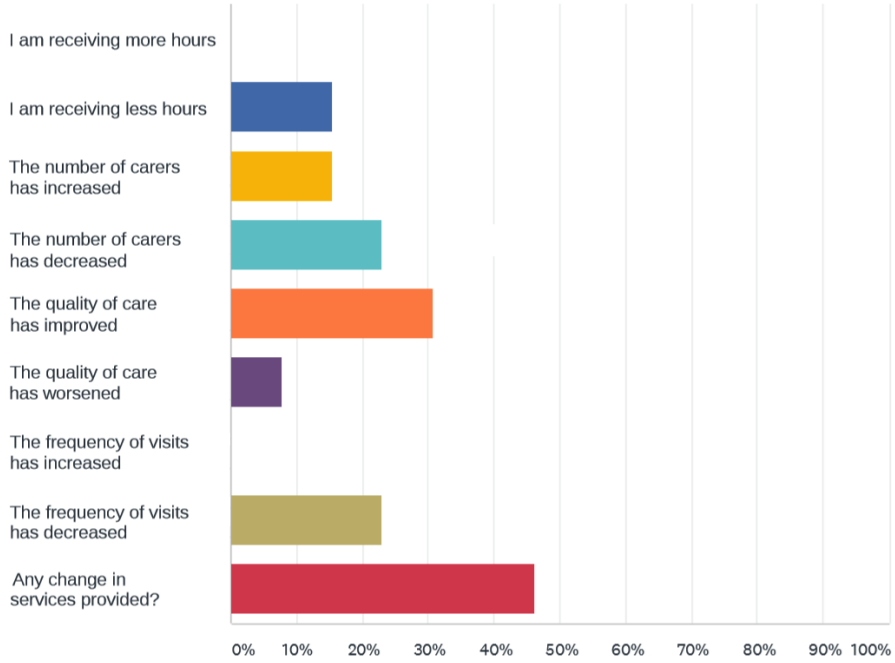
- 94% (15) No
- 6% (1) Yes – please tell us about it

Only 1 respondent had been recently discharged from hospital to the home team assessment and support. A Carer said they were '*Happy with level of care given*'.

They were '*able to use care link button if carer did not attend.*'

They said '*care received from family or friend increased during Covid*'

Has the care you receive at home changed due to COVID-19? (select all that apply).



13 answered

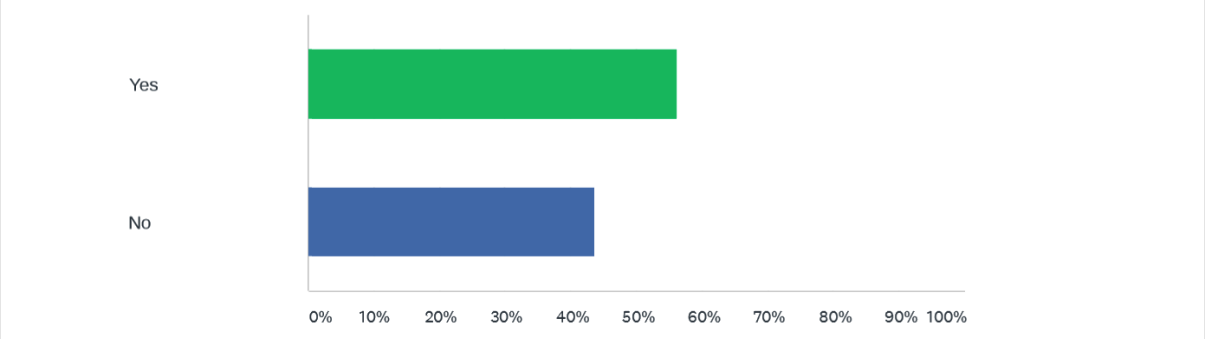
- 15% (2) Receiving less hours
- 15% (2) Numbers of carers has increased
- 23% (3) Number of carers has decreased
- 31% (4) Quality of care has improved
- 8% (1) Quality of care has worsened
- 23% (3) Frequency of visits has decreased
- 46% (6) Any change in services provided?

In answer to the question, any changes to services provided, only one said there was no change in care provision due to COVID-19.

The experiences of the 5 others were:

- *No change other than my having to change the time of day they work because of working from home.*
- *family member came to stay to help me/us.*
- *No care because of Covid.*
- *I have a different carer all the time now. I don't know any of them. The one I had before just left and nobody has told me if she's coming back. I feel a lot more isolated now I don't have her as I trusted her.*
- *have felt too afraid to have the carer come in because of my health vulnerability.*

Are you happy with the level of care?



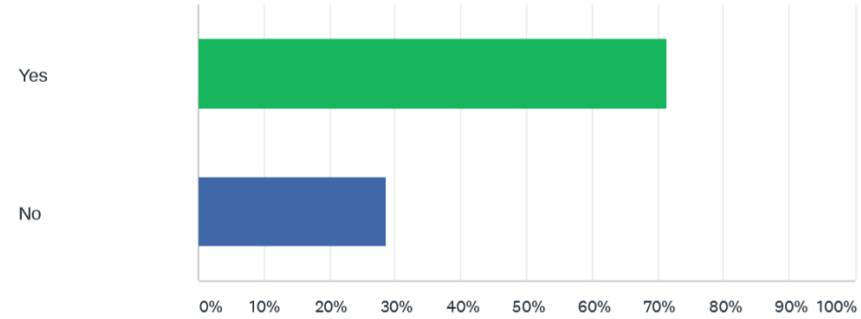
16 answered

- 56% (9) Yes
- 44% (7) No

Majority of the respondents were satisfied with their level of care. Those who were not happy with their care, gave us their views:

- *Haven't had any PA support since start of lockdown.*
- *My decision based on what I thought was in his best interest.*
- *My children have had to do more and my family member should be at home with her family.*
- *I miss the help*
- *I'm aware of a very elderly person living in supported accommodation with extreme mobility needs who has lived on bread and crisps for a week.*
- *I have a different carer all the time now. I don't know any of them. The one I had before just left and nobody has told me if she's coming back. I feel a lot more isolated now I don't have her as I trusted her*
- *As an employer I have to be responsible for my care workers health and safety. Plus be aware of mine and my husband health. He has a severe respiratory disease and I have an auto immune issue and as we have not been able to get suitable equipment to make the 3 of us safe. I have made the decision to manage without for now.*

Do you know what to do if your carer could not attend?



14 answered

- 71% (10) Yes
- 29% (4) No

Thirty percent of respondents did not know what to do if the carer did not come. Evidence shows that care receivers may not always have the same carer visiting their home.

Has anything happened because a carer did not attend? What was this like for you? What did you do?

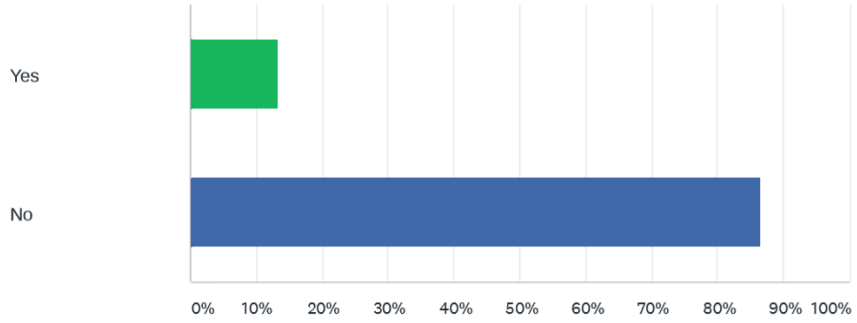
8 answered

Some people felt it was safer for the carers not to attend so as to reduce risk of transmission. One person stated that although they carried on doing the work themselves, they were concerned for the mental wellbeing of the person being cared for. For others, they knew where to get help if they needed it.

Here are some of the views given:

- *Look after my daughter myself felt safe thing to do has thought she had suspected COVID 19*
- *Just because you know what to do doesn't mean you get what you need - they are quite different questions.*
- *More stress and work for us as parents. person getting a bit bored.*
- *No*
- *No*
- *I have been struggling but it is my choice not to have the carer come in.*
- *I carry on regardless.*
- *Use care link (personal alarm) button.*

Have you had a care review and updated information on what to expect during COVID-19?

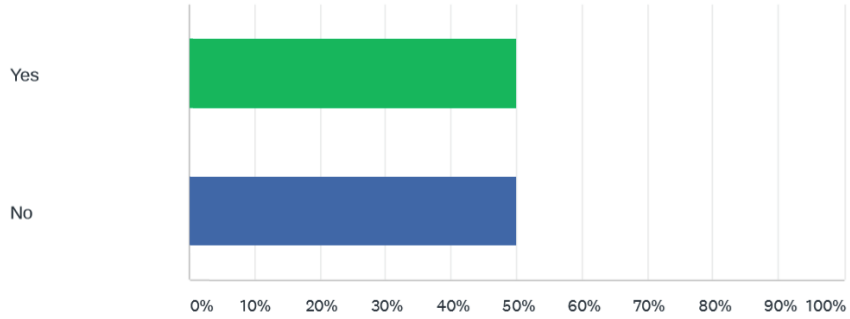


15 answered

- 13% (2) Yes
- 87% (13) No

No one who employed their own carer or who was responding about their own care answered **Yes** to having their care reviewed and updated with COVID-19 information. Five people who answered **No** to this question answered **Yes** to the following question that their care changes had been explained, this might suggest that this question did not fully elucidate the manner in-which their care changes were discussed.

Has your care provider explained the changes?

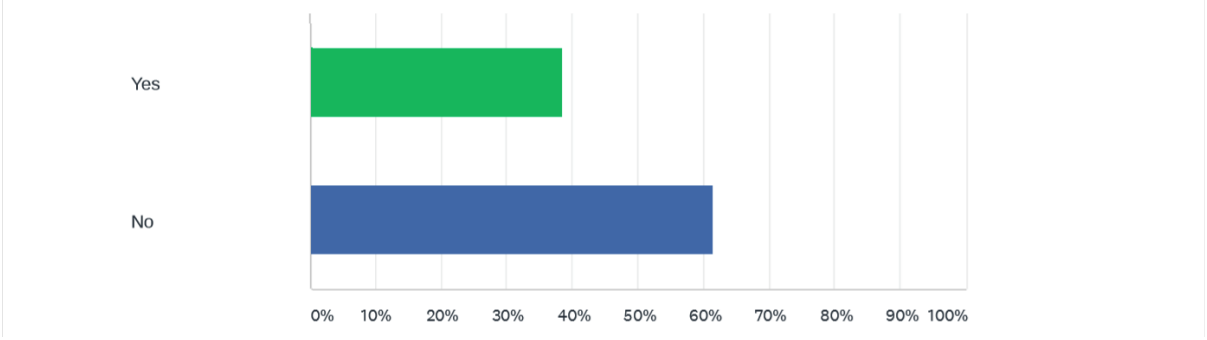


14 answered

- 50% (7) Yes
- 50% (7) No

Only two of **Yes** answers were from care receivers, the rest were family friends or carers. Of the 7 people who had earlier said they were not happy with their level of care, 6 of them said **No**, their provider had not explained the changes.

Have you been asked about how you feel about these changes to your care package during the crisis?



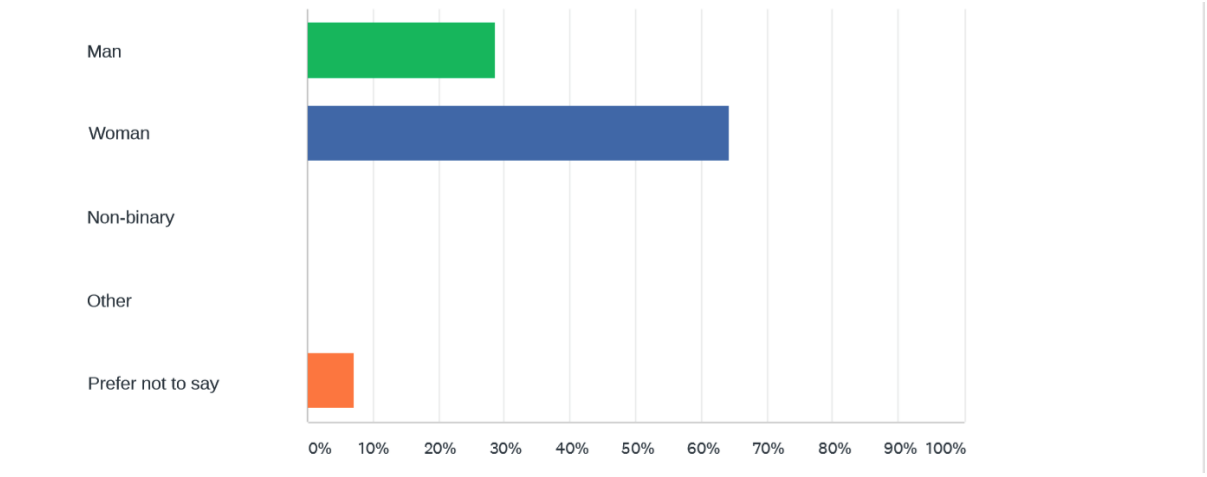
13 answered

- 39% (5) Yes
- 62% (8) No

Of the 7 people who said they had their care changes explained in the previous question, only one answered **No** here, stating they were not asked how they felt about it, and another did not answer this question.

Demographic information

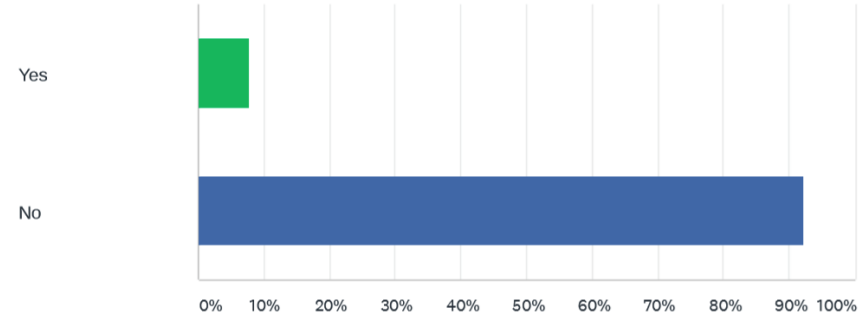
Please tell us which gender you identify with.



14 answered

- 29% (4) Man
- 64% (9) Woman
- 7% (1) Prefer not to say

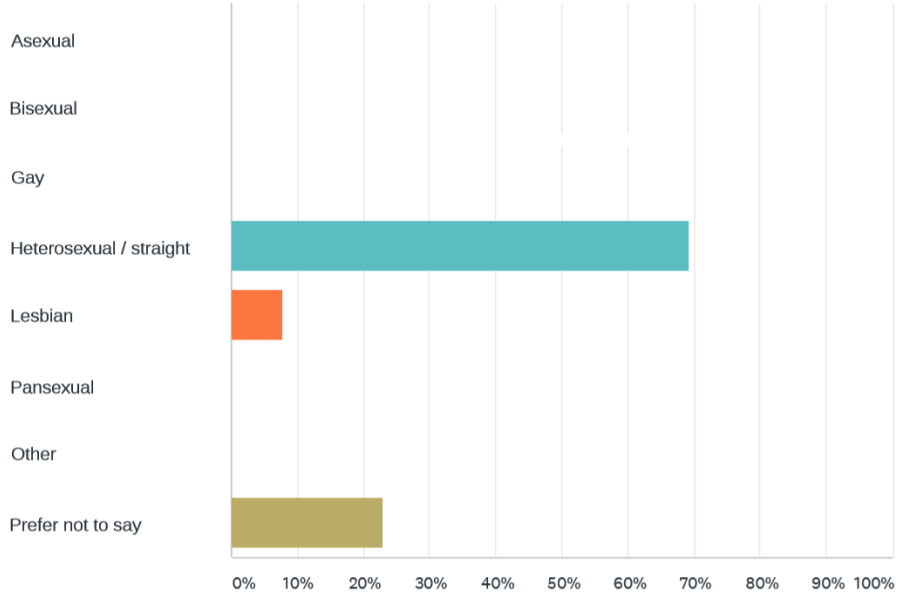
Is your gender different to the sex that you were assigned at birth?



13 answered

- 8% (1) Yes
- 92% (12) No

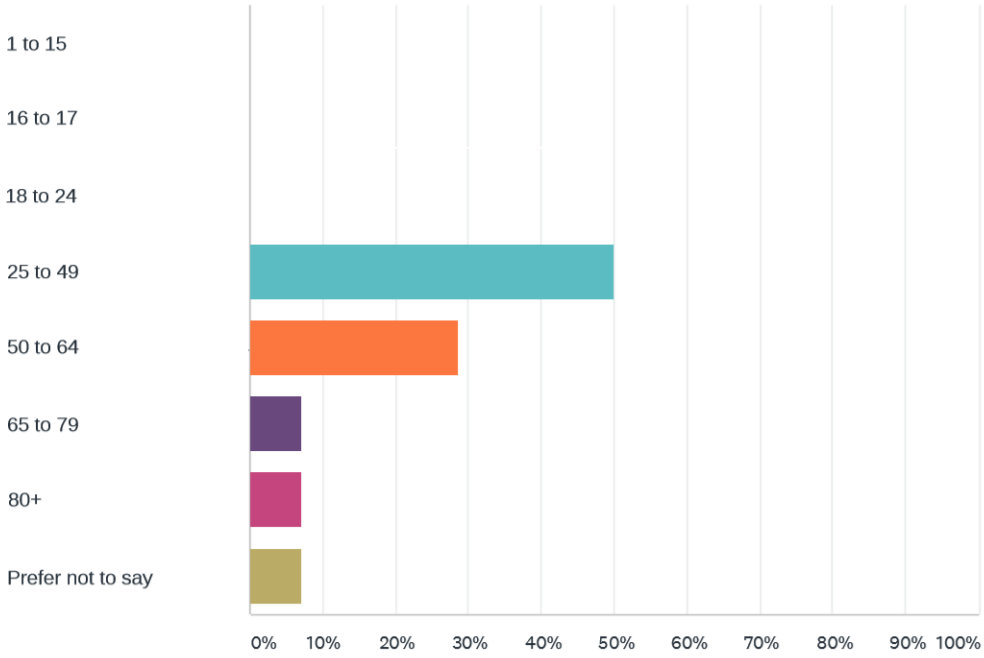
Please tell us which sexual orientation you identify with.



13 answered

- 69% (9) Heterosexual/straight
- 8% (1) Lesbian
- 23% (3) Prefer not to say

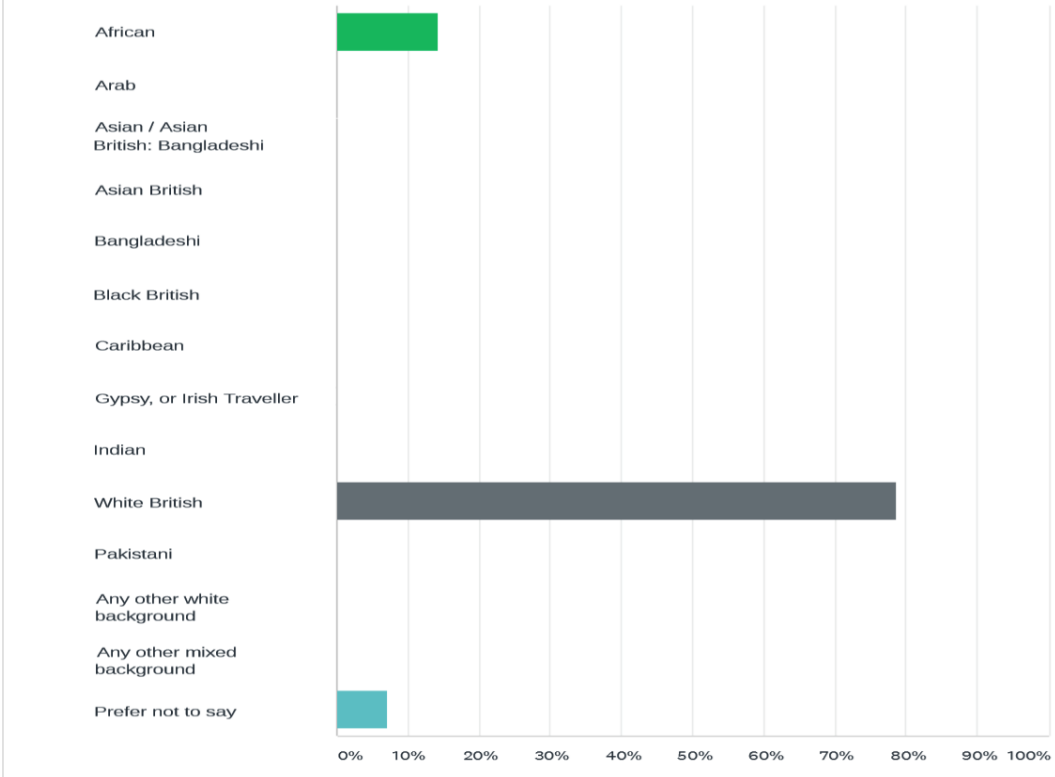
Please tell which age category you fall into.



14 answered

- 50% (7) 25 to 49
- 29% (4) 50 to 64
- 7% (1) 65 to 79
- 7% (1) 80+
- 7% (1) Prefer not to say.

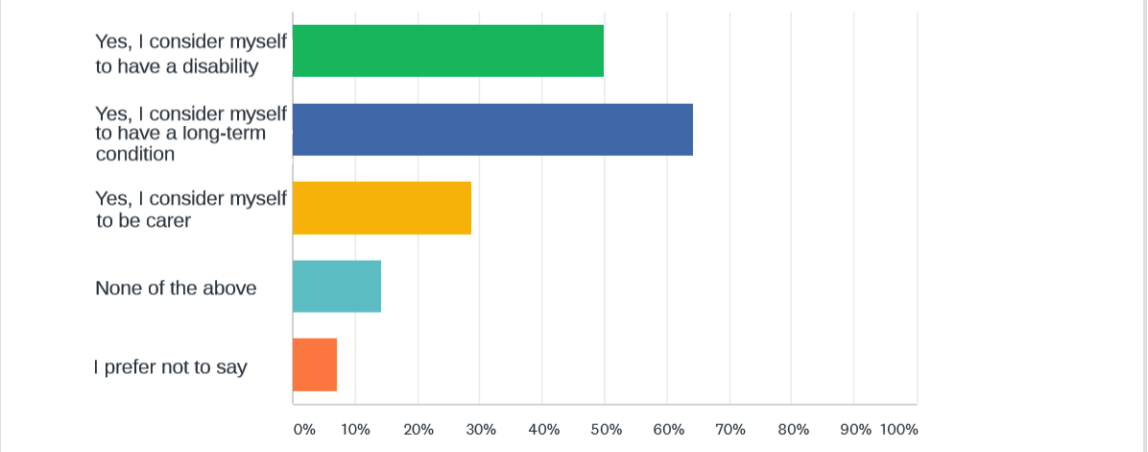
Please select your ethnicity from the list below.



14 answered

- 14% (2) African
- 79% (11) White British
- 7% (1) Prefer not to say

Do you consider yourself to be a carer, have a disability, or long-term health condition? (please tick all that apply).



14 answered

- 50% (7) Yes, I consider myself to have a disability
- 64% (9) Yes, I consider myself to have a long-term condition
- 29% (4) Yes, I consider myself to be carer
- 14% (2) None of the above
- 7% (1) Prefer not to say

Limitations

- This pulse survey was turned around quickly, using a software tool we were unfamiliar with.
- Some respondents only completed introductory questions.
- It represents three main demographic communities

References

Age UK (2020) Carer's support. Available: https://www.ageuk.org.uk/services/in-your-area/carers-support/#. 17/6/20.

Alzheimer's Society (2020) Office of National Statistics figures show dementia is main underlying condition for COVID-19 deaths, 15/5/2020. Available: https://www.alzheimers.org.uk/news/2020-05-15/ons-figures-show-dementia-main-underlying-condition-covid-19-deaths-alzheimers. 15/6/20.

BNSSG Clinical Commissioning Group (2020) Our localities, Bristol, North Somerset, South Gloucestershire. Available: https://bnssgccg.nhs.uk/about-us/our-localities/. 15/6/20.

Bristol City Council (2020) Information and advice newsletter and briefings, March to June.

Bristol City Council (2020) Home care services. Available: https://www.bristol.gov.uk/policies-plans-strategies/social-care-and-health/home-care-services. 15/6/20.

Bristol City Council (2016) adult social care strategic plan 2016 – 2020. Available: https://www.bristol.gov.uk/documents/20182/305531/Adult+Social+Care+Strategic+Plan+December+2016/2f87741f-a4eb-4a49-a70c-c24b77704380. 18/6/20.

Carers UK (2014) what is carer's allowance? Available: https://www.carersuk.org/help-and-advice/financial-support/help-with-benefits/carers-allowance. 17/6/20.

Care Quality Commission (2019) The state of health care and adult social care in England 2018/2019.

Gov.UK, PHE (2020) Stay at home: guidance for households with possible or confirmed coronavirus (VOVID_19) infection. Available: https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection. 17/6/20.

Healthcare at Home Ltd (2015) Building the case for clinical care in the home at scale: First report of the expert panel. Available: https://hah.co.uk/wp-content/uploads/Building_the_case_of_clinical_care_in_the_Home.pdf. 16/6/20.

Healthwatch Bristol (2019) Care at home: final agreed recommendations for the Bristol workplan for 2020, Prioritisation Panel Meeting 18/12/2019.

Healthwatch England (2019) Healthwatch network reveals top priorities for 2019, News – 31 December. Available: https://www.healthwatch.co.uk/news/2018-12-31/healthwatch-network-reveals-top-priorities-2019. 15/6/20.

Healthwatch (2020) How to start a research project June 2020. Available: file:///C:/Users/AcomoOloya/Documents/Acomo%20Folder/Survey%20&%20Research/How%20to%20start%20a%20research%20project.pdf. 15/6/20.

Healthwatch: Code of practice – public engagement: evaluation, audit and research governance. Available: file:///C:/Users/AcomoOloya/Documents/Acomo%20Folder/Survey%20&%20Research/HWE%20Code%20of%20practice%20-Research2018.pdf.

HM Government, NHS (2002) Leaflet: Your hospital discharge: going home. Available: https://www.england.nhs.uk/coronavirus/publication/covid-19-hospital-discharge-service-requirements/. 18/6/20.

HM Government, NHS (2002) Hospital discharge service requirement, 19/3/20. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880288/COVID-19_hospital_discharge_service_requirements.pdf. 18/6/20.

Holmes, E.A., O'Connor, R.C., et al. (2020) Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science, Lancet Psychiatry 2020; 7: 547–60.

Institute of Government (2019) Adult social care. Available: https://www.instituteforgovernment.org.uk/publication/performance-tracker-2019/adult-social-care?gclid=Cj0KCQjwuJz3BRDTARIsAMg-HxWYOOEEPAUpNciC7q_2IGwm-I1u64cUGANiDbDVCE6pMeSTEvFT3mUaAhqoEALw_wcB. 17/6/20.

NHS (2018) Help at home from a carer. Available: https://www.nhs.uk/conditions/social-care-and-support-guide/care-services-equipment-and-care-homes/homecare/. 16/6/20.

Nobles, J., Martin, F., et al. (2020) The potential impact of COVID-19 on mental health outcomes and the implications for service solutions, 15/5/20. Available: https://arc-w.nihr.ac.uk/research-and-implementation/covid-19-response/potential-impact-of-covid-19-on-mental-health-outcomes-and-the-implications-for-service-solutions/. 17/6/20.

Nuffield Trust, The Health Foundation, The Kings Fund (2020) Joint letter to the health and social care select committee, 15/5/2020. Available: https://www.nuffieldtrust.org.uk/news-item/letter-to-the-health-and-social-care-select-committee. 15/6/20.

Nursing Times (2020) COVID-19 death rate 'significantly higher' in social care workers, 11/5/2020. Available: https://www.nursingtimes.net/news/coronavirus/covid-19-death-rate-significantly-higher-in-social-care-workers-11-05-2020/. 15/6/20.

Sirona Care & Health (2020) Adult community health services: changes to your care, 3/3/2020. Available: https://www.sirona-cic.org.uk/blog/2020/03/03/adult-community-health-services-changes-to-your-care/. 7/7/20.

Socialcare.co.uk (2018) Role of a domiciliary care worker, 22/5/2018. Available: https://www.socialcare.co.uk/care/blog/role-of-a-domiciliary-care-worker/. 15/6/20.

The King's Fund (2020) Leading through and beyond Covid-19: what challenges are leaders facing? Available: https://www.kingsfund.org.uk/blog/2020/04/covid-19-challenges-facing-leaders, 7/4/20 by Murray, R. 16/6/20.

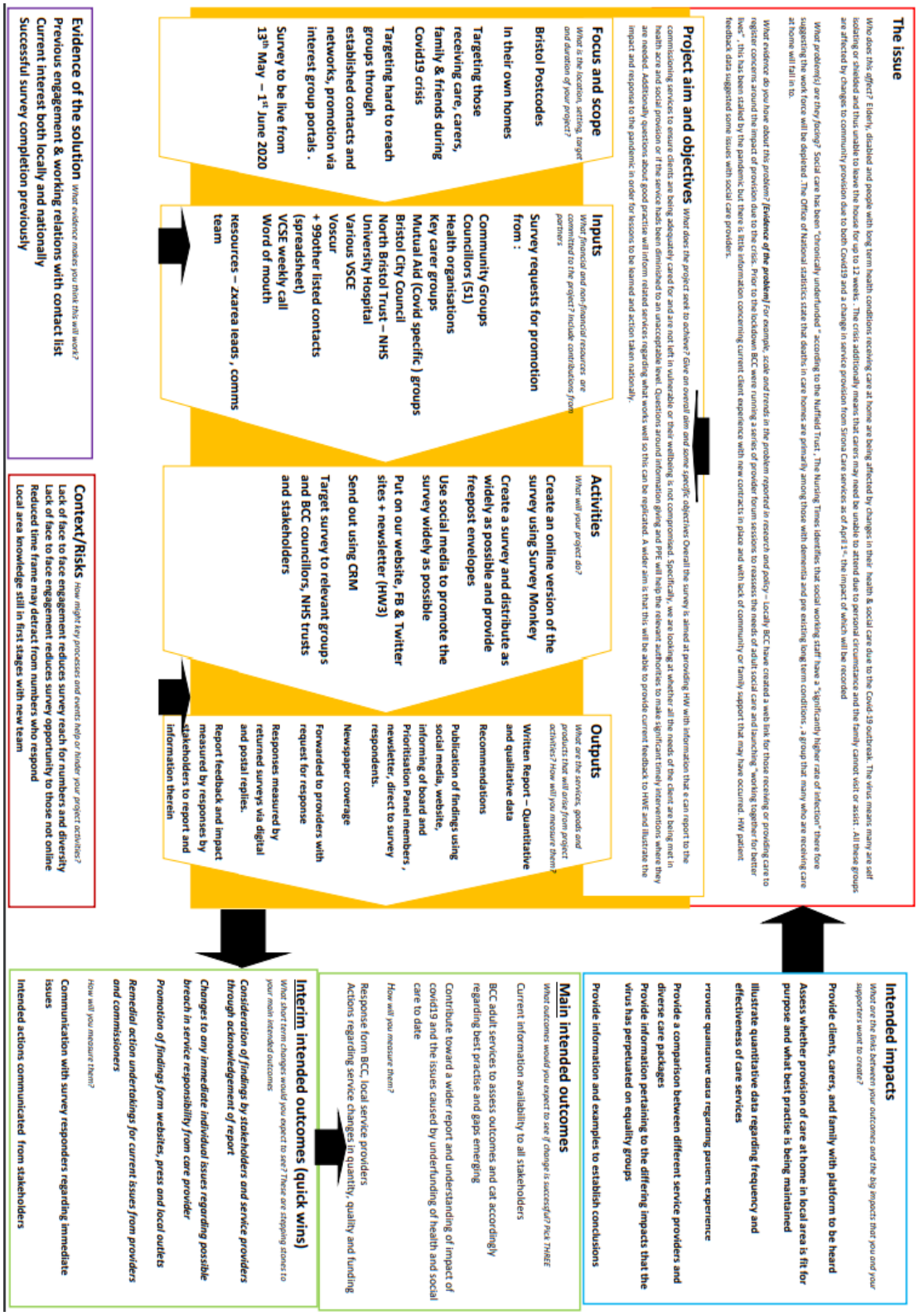
Appendix 1: Survey Consent and Confidentiality Page

About this survey – and your rights. **Find more about us at www.healthwatchbristol.co.uk.**

Consent and Confidentiality

- This survey is confidential and anonymous. We do not publish any personal information (e.g. names, address etc.). We will only use your email address (if included) for a follow-up question at a later date, should you consent.
- The information you give is collected by Healthwatch Bristol using either a paper survey or an online survey at SurveyMonkey.
- We collect and keep paper and digital records securely and lawfully only for as long as permitted.
- The surveys are only used for the purpose of this project.
- Comments you make may be used in a report (though any comments that could make it possible for someone else to identify you, will not be used).
- The information will be shared in order that we can carry out our authorised work to 'find out what matters to people and help make sure their views shape the support they need.'
- Your comments are passed on to people who commission, provide and plan health and social care services.

Appendix 2: Project Logic Model



Thank you

Thank you to everyone who took time to fill in the questionnaire to share their experiences and opinions.

Special thanks to colleagues and team members from Healthwatch North Somerset and South Gloucestershire who supported us throughout the investigation with their generous contributions.

Contact Us

Healthwatch Bristol
3rd Floor
The Sion
Crown Glass Place
Nailsea
BS48 1RB

Tel: 01275 851 400

Email: contact@healthwatchbristol.co.uk

Website: www.healthwatchbristol.co.uk

Find us on Facebook @bristolhealthwatch

follow us on twitter @HWBristol

Accessibility: If you require this document in another format, please let us know.

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Bristol Health and Wellbeing Board

Title of Report:	**Healthier Together – Impact of COVID-19 and lockdown on health inequalities and steps that need to be taken to address this in Bristol, North Somerset and South Gloucestershire (BNSSG) health system**
Author (including organisation):	**Adwoa Webber, Head of Clinical Effectiveness, BNSSG CCG**
Date of Board meeting:	
Purpose:	Information and discussion

- Paper to be no more than two pages long
- Draft papers are reviewed by the Public Health team
- Final papers will be published on the public website
- Board correspondence: HWB@bristol.gov.uk

1. Executive Summary

There is increasing evidence that COVID-19 and the action being taken to limit its spread has widened existing health inequalities. Healthier Together as a partnership has an initial set of actions to begin to understand and address this which are currently mainly, but not solely, healthcare focussed. As a partnership looking at 'place', healthcare partners and the local authorities will want to continue to join up efforts to achieve maximum impact on reducing health inequalities.

2. Purpose of the Paper

This paper is to:

- inform the Health and Wellbeing Board of Healthier Together's current understanding of the impact that COVID-19 has had on health inequalities
- inform the Health and Wellbeing Board of actions that are being considered to address these either at a partnership level or more specifically interventions in healthcare in Bristol, North Somerset and South Gloucestershire
- ask the Health and Wellbeing Board to consider it wants to develop an ongoing relationship with the BNSSG Population Health, Prevention and Inequalities Group
- ask the Health and Wellbeing Board to consider what would make a BNSSG-wide expert review/challenge/scrutiny group effective

3. Background and evidence base

There is increasing evidence that the impact of COVID-19 is different for different parts of our population and it is not the "great leveller" that some people previously described.

Work has been done at both a national (Public Health England amongst others) and at a local level, including the Bristol Race Equality COVID-19 Steering Group, to further understand the impact of COVID-19, both the disease itself and the actions taken to limit its spread. Appendix 1 describes the impact in more detail. Please note that these are focussed on health and the impact of someone's situation on their health. We understand that COVID-19 and lockdown has also had, and continues to have, an impact on the lives of children and young people in terms of disrupted education, child/family poverty, safeguarding issues and employment and training prospects which in turn will impact on their health and wellbeing.

There are a number of initial actions that:

a) Build on existing work, such as BNSSG Population Health, Prevention and Inequalities Group which has been set up to direct and move towards whole system tackling of socio-economic and health inequalities; engagement with our communities; equality and inequality impact assessments; using population health management and intelligence insights; and
b) Are new, such as comprehensive and quality ethnicity data collection and recording; and considering prioritising care and resources for people with poorer outcomes both for COVID-19 and non COVID-19; setting up an expert review/challenge/scrutiny group

4. Community engagement

Healthier Together partners have been working together to listen to communities, e.g. understanding that communication about COVID-19 has not been easily accessible to some parts of our communities. Some of the work on interventions is just being being considered and will need to be co-designed and potentially 'co-implemented' with and by the people that they affect, even in the scoping phase.

5. Recommendations

- Note Healthier Together's current understanding of the impact that COVID-19 has had on health inequalities
- Note the actions that are being considered to address these either at a partnership level or more specifically interventions in healthcare in Bristol, North Somerset and South Gloucestershire
- Consider how the Health and Wellbeing Board wants to develop an ongoing relationship with the BNSSG Population Health, Prevention and Inequalities Group
- Consider what would make a BNSSG-wide expert review/challenge/scrutiny group effective

6. City Benefits

Taking action on reducing or eliminating health inequalities will improve the lives of Bristol's citizens and help them and the city fulfil their potential.

7. Financial and Legal Implications

Healthier Together will need to consider how it can make the biggest difference it can to improving health outcomes with the money that it has.

8. Appendices

Appendix 1 - Impact of COVID-19 and lockdown on health inequalities and steps that need to be taken to address this in the Bristol, North Somerset and South Gloucestershire (BNSSG) health system

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Bristol Health and Wellbeing Board

Impact of COVID-19 and lockdown on health inequalities and steps that need to be taken to address this in the Bristol, North Somerset and South Gloucestershire (BNSSG) health system

1. Purpose

The purpose of this paper is to:

- inform the Health and Wellbeing Board of Healthier Together's current understanding of the impact that COVID-19 has had on health inequalities
- inform the Health and Wellbeing Board of actions that are being considered to address these either at a partnership level or more specifically interventions in healthcare in Bristol, North Somerset and South Gloucestershire
- ask the Health and Wellbeing Board to consider how it would like to have an ongoing relationship with the BNSSG Population Health, Prevention and Inequalities Group

2. Impact of COVID-19 and lockdown on health inequalities

2.1 The Healthier Together Executive Group has used the following documents to help to understand the impact of COVID-19 and lockdown on health inequalities:

- Disparities in the risk and outcomes of COVID-19, Public Health England June 2020
- Beyond the data: Understanding the impact of COVID-19 on BAME groups, Public Health England June 2020
- Local Action on Health Inequalities, Public Health England 2018
- Bristol City Council – Response to UK Parliament Call to Evidence Coronavirus (Covid-19) and the impact on people with protected characteristics
- South Gloucestershire Council Briefing
- Placed-based approaches for reducing health inequalities: foreword and executive summary, Public Health England, July 2019

This is In addition to the data included to describe health inequalities in the Healthier Together 5 Year Plan.

2.2 The following has been taken verbatim from slides presented at a recent South Gloucestershire Council Health and Wellbeing Board about the impact of COVID-19:

- "Whilst COVID-19 was initially seen as 'the great leveller' and a virus that "did not discriminate", it is now clear that the direct and indirect effects of the disease have not been felt equally across society.

- People who live in more deprived areas have higher diagnosis and death rates compared to less deprived areas.
- Hospitalisation and death disproportionally affect some groups including older people, men, low-paid workers, and people from Black, Asian, and Minority Ethnic groups.
- Risk factors for COVID-19 more prevalent amongst these groups may include: poor housing, occupations which do not provide opportunities to work from home, unstable work conditions and incomes, stress, comorbidities such as high blood pressure, diabetes, obesity, and existing heart/lung disease.
- Care Quality Commission and ONS report on COVID-19 and people with Learning Disability: mortality increase of 134% in recent months compared to baseline.
- In addition there will be considerable social and economic consequences, and effects on mental and physical health, arising from lockdown measures. Those "shielding" may be at especially high risk.
- Possible longer term impacts on children who were not able to attend school and/or who had limited access to home learning (inequalities in e.g. digital access, family capacity to support)."

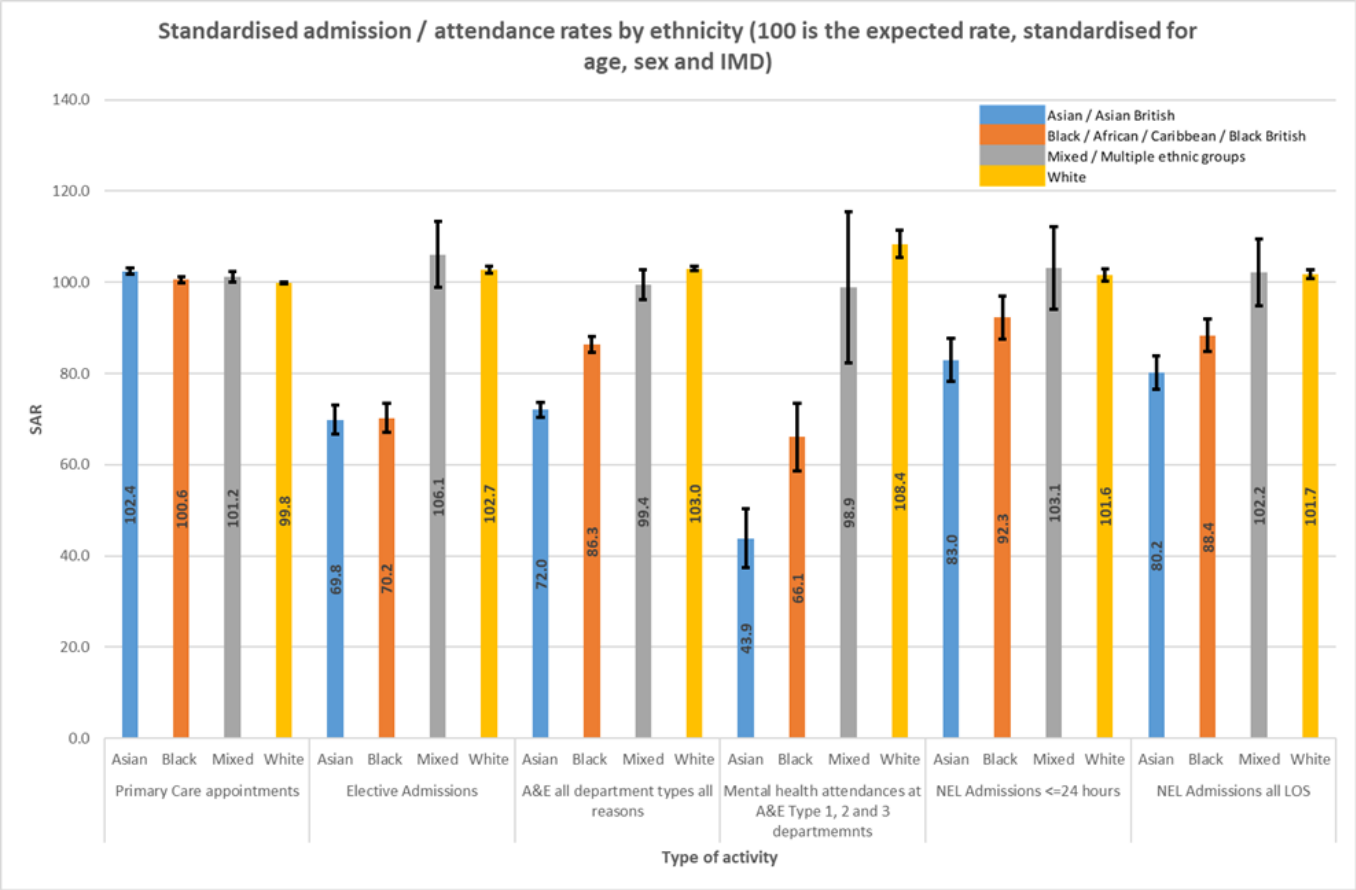
2.3 In terms of deprivation and poverty, in many instances lockdown will have made people's situation worse. Those whose income is low or precarious are more likely to have had their work reduced as they are more likely to be working in parts of the economy which had to shut down or which put them at greater risk of becoming infected with COVID-19 which would in turn affect their ability to work. The Kings Fund report, 'Tackling Poverty: Making More of the NHS in England' draws the following conclusions about the impact of poverty on access to and experience of health:

- Despite the presence of exemptions and grants, many people struggle to pay prescription charges, and travel and other costs can be prohibitive for those with, or with family members with, severe disabilities
- For some groups more likely to be in poverty – such as black and minority ethnic groups – access to primary care services is overall good, but access to other services such as dentistry, and acute care, is less so. Actual experience of care can be worse, even though access is greater
- For some core conditions we know that the NHS can do better, particularly in terms of its support for families at risk of or experiencing child poverty, those with mental health problems and those with long-term conditions – often the same people. This has implications for these people's presence in the workforce, where economic inactivity is a significant risk for poverty.

2.4 In BNSSG, 52% of registered patients do not have ethnicity recorded. The following therefore comes with a health warning to the validity of subsequent analysis.

In terms of understanding access to primary and secondary ("acute") care before COVID-19, Figure 1 shows activity for people who live in BNSSG by point of delivery in 2019/20 by different ethnic groups (95% confidence interval bars are shown).

Figure 1



Independent of age, sex and deprivation (IMD), which will account for some of the possible differences in underlying case-mix (comorbidities), Figure 1 shows significant and large differences in patterns of activity among different ethnic groups, dependent on the point of delivery. Apart from in primary care, where activity was very similar among the groups, Asian and Black populations experienced lower levels of activity across all points of acute sector delivery. In most cases there is a high level of statistical significance in the differences and therefore this is not a chance finding. This might be a result of bias, for example if the missing ethnicity data is predominantly from deprived White populations who don't use health services very often then the White group may appear to be higher users of healthcare. This wouldn't explain however, why primary care usage appears to be equitable where secondary care usage does not.

We have done some analysis on acute hospital activity levels comparing April and May last year to April and May this year. This helps to understand changes

in activity during lockdown. There has not yet been BNSSG specific analysis on community or primary care activity.

Figure 2 describes the percentage change in activity by broad ethnic category between April and May 2019 and April and May 2020. It shows a mixed picture, with the White group generally being the least affected but not always.

Figure 2 Ethnic category percentage change in acute hospital activity

A&E attendances, all types

Ethnicity	April and May 19/20	April and May 20/21	% change
Asian / Asian British	1,165	543	-53.4%
Black / African / Caribbean / Black British	1,588	681	-57.1%
Mixed / Multiple ethnic groups	561	251	-55.3%
White	25,183	11,665	-53.7%
Unknown	32,455	13,080	-59.7%
Total	60,952	26,220	-57.0%

Non elective admissions, all lengths of stay

Ethnicity	April and May 19/20	April and May 20/21	% change
Asian / Asian British	314	193	-38.5%
Black / African / Caribbean / Black British	392	243	-38.0%
Mixed / Multiple ethnic groups	137	69	-49.6%
White	7,266	4,972	-31.6%
Unknown	8,658	4,659	-46.2%
Total	16,767	10,136	-39.5%

Elective admissions, all lengths of stay

Ethnicity	April and May 19/20	April and May 20/21	% change
Asian / Asian British	313	108	-65.5%
Black / African / Caribbean / Black British	282	72	-74.5%
Mixed / Multiple ethnic groups	133	33	-75.2%
White	9,461	2,905	-69.3%
Unknown	7,027	2,062	-70.7%
Total	17,216	5,180	-69.9%

3. What do we need to do?

Note that:

- As a partnership looking at 'place', healthcare partners and the local authorities will want to continue to join up efforts to achieve maximum impact on reducing health inequalities. Currently, the proposals contained in this paper cover health in the main and not the totality of the work of the local authorities or local communities.
- Some of the specific health intervention actions listed may not have had the engagement of those communities affected and may not yet have been co-designed with our local population.
- Although the actions below are described within separate groups, it is obvious that intersectionality (how aspects of a person's social and political identities, e.g. gender, race, class, sexuality, ability, physical appearance, etc. might combine to create unique modes of discrimination and privilege) needs to be considered in our work.

3.1 As a partnership, consider and act on recommendations from existing reports

In terms of **BAME groups**, the Public Health England reports 'Beyond the data: Understanding the impact of COVID-19 on BAME groups' and 'Local Action on Health Inequalities' contain a number of recommendations that the Healthier Together will want to consider as a whole partnership. 'Beyond the data: Understanding the impact of COVID-19 on BAME groups' concludes,

"Throughout the stakeholder engagement exercise, it was both clearly and consistently expressed that without explicit consideration of ethnicity, racism and structural disadvantage in our responses to COVID-19 and tackling health inequalities there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention."

The recommendations in both reports have been extracted verbatim and are shown below.

2018 PHE report

"A number of important messages have been identified to support better focus on ethnicity within action on health inequalities:

Mainstreaming ethnicity: Without explicit consideration of ethnicity within health inequalities work there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention.

Influencing decision-makers and role of senior leadership: Progress on ethnic health inequalities has been slow and the need for senior leadership on this agenda has been repeatedly highlighted.

Data collection, analysis and reporting: Gaps in data collection must be filled and there must be more consistent analysis and reporting of data on ethnicity, health and healthcare so that there is adequate understanding of local needs and the extent to which they are being met by policies and services.

Action on the wider social and economic determinants of health may exacerbate ethnic health inequalities unless it adequately takes into account the ethnic patterning in residential, income, educational and occupational profiles.

Tackling racism and ethnic discrimination: The central role of racism must be acknowledged, understood and addressed. There is an urgent need to build the evidence base around effective action.

Commissioning of culturally sensitive health promotion interventions: Interventions need to work with cultural and religious understandings and values while recognising intra-group diversity and avoiding stereotyping.

Improving access, experiences and outcomes of health services: Actions at organisational level include: regular equity audits; use of Health Impact Assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff; sustained workforce development and employment practices; trust-building dialogue with service users

Engagement with minority ethnic groups: Across all areas of activity, the meaningful engagement and involvement of minority ethnic communities, patients, clinical staff and people is central to understanding needs and producing appropriate and effective responses or shaping services. A concerted effort is required by public and private sector employers and service providers.

Making use of evidence: The evidence base to inform policy and practice remains limited but more can be done to mobilise the available evidence and to document and evaluate promising local practice both locally and nationally."

2020 PHE report

"1. Mandate comprehensive and quality **ethnicity data collection and recording** as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

2. Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research

process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.

3. Improve **access, experiences and outcomes of NHS, local government and integrated care systems commissioned services** by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

4. Accelerate the development of **culturally competent occupational risk assessment tools** that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

5. Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns**, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to **target culturally competent health promotion and disease prevention programmes** for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

7. Ensure **that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants** of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

In terms of **learning disabilities**, in response to the recommendations of the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPOLD), the Learning Disabilities Mortality Review (LeDeR) programme has been established. Its aim is support improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities for people with learning disabilities (see health interventions below).

3.2 Third Phase of NHS Response to COVID

On 31 July 2020, NHS England issued a letter that describes the priorities and the requirements for the third phase of the NHS response to COVID-19. This covers the remainder of 2020/21. There is a focus on action on inequalities and prevention. The letter describes this further as,

"We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

• Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

• Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

• Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.

• Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.

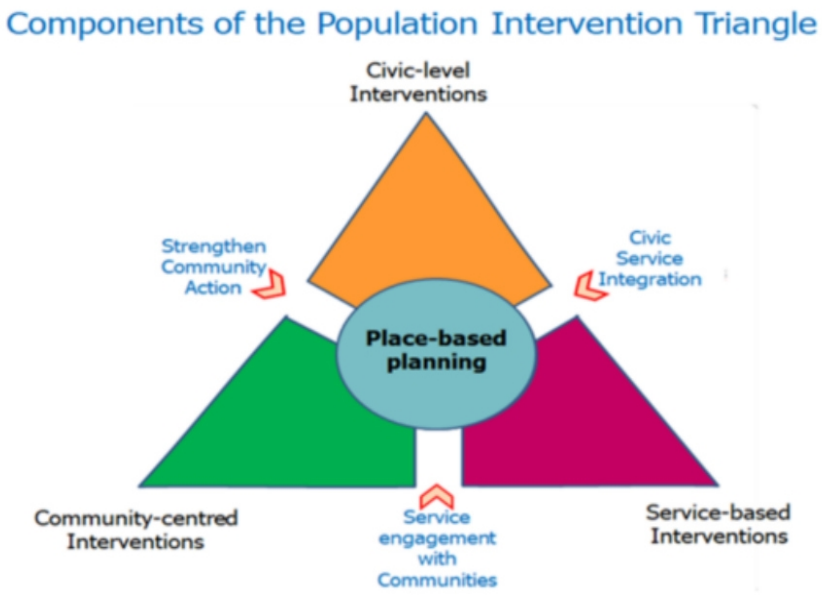
• Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September."

Final Phase 3 plans are due by 21 September 2020. All Healthier Together partners have been and continue to work on the writing the Bristol, North Somerset and South Gloucestershire Phase 3 plan and ensuring that the plan is carried out.

3.3 BNSSG Population Health, Prevention and Inequalities Group

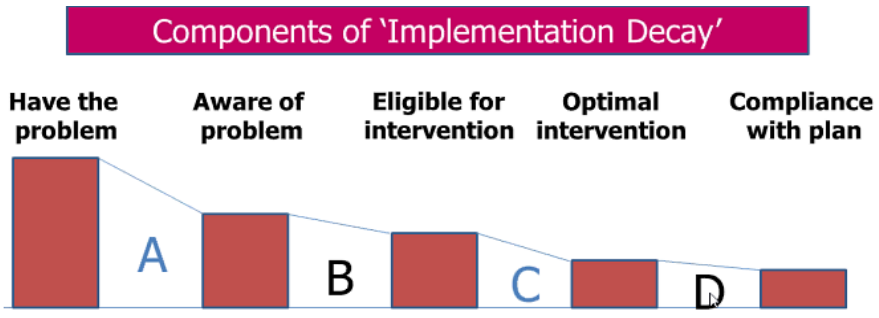
This has been set up to direct and move towards whole system tackling of socio-economic and health inequalities. Figure 4 below describes what is needed to improve population outcomes.

Figure 4 Components of the Population Intervention Triangle



Figures 5 and 6 demonstrate the health service and public health aspect of this.

Figure 5 Components of 'Implementation Decay'

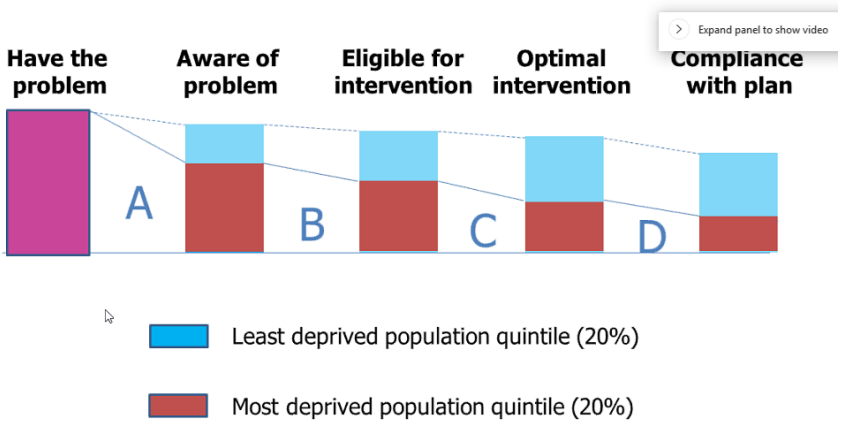


A. Awareness– under-recognition of risks/illness and sources of help by individuals and their peers
B. Navigation – risk or illness identified but barriers and access issues to support/advice or intervention
C. Unwarranted variation in quality of provision
D. Insufficient assets for recovery or ongoing support for self-management

Bentley, C 2016

Figure 5 shows that there is a difference (reduction) in the number of people who have a particular health issue, e.g. angina, renal disease, glaucoma, diabetic retinopathy, and the subsequent number who comply with a plan to manage that issue. Ideally, within people's autonomy about choices they make about their own health, the majority of people with a problem would be enacting the plan to help with that problem. However, of those who have actually have a problem, the under-recognition of risks/illness means that only some are aware that they have a problem. Once people are aware of the problem, barriers and access issues to get support/advice or an intervention mean that only some become "eligible" for that support/advice or intervention. Of those that do access help, unwarranted variation in the help that they do or do not receive means that only some get 'optimal' care. Of those who do receive optimal care only some have sufficient assets for recovery or support for self management.

Figure 6 Components of 'Implementation Decay' by deprivation



Bentley,C 2019

Figure 6 shows that this difference (reduction) in the number of people who have a particular health issue and the subsequent number who 'comply' with a plan to manage that issue is even greater for the most deprived population quintile. Fewer are aware that they have a problem. The barriers and access issues that they encounter mean that fewer become 'eligible' for support/advice or an intervention. A smaller proportion still receives optimal care and fewer have the sufficient assets for recovery or support for self management. Therefore, while the wider determinants of health have a significant impact on health inequalities, all healthcare services themselves also have a significant impact on health inequalities.

The Population Health, Prevention and Inequalities Group is currently made up of the Directors of Public Health, the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) Medical Director Clinical Effectiveness and the inequalities clinical lead at the CCG. It will also have a

representative from the provider organisations in the Healthier Together partnership. It will lead the work on:

1. Updating the BNSSG picture of population need in light of COVID-19 (with links to Population Health Management and Insights)
2. Producing a BNSSG Population Outcomes Framework
3. Identifying asks of the system to enable and influence a system-wide focus on population health, prevention and inequalities

The work will learn from approaches that have been taken elsewhere, such as NHS Scotland http://www.healthscotland.scot/, and adapt them for BNSSG use. The group will also want to consider how the recommendations in the Public Health England (and inevitably other) reports can be turned into interventions that will help to achieve population health outcomes in line with the framework being developed. This may involve directing a gap analysis.

How does the Health and Wellbeing Board want to develop an ongoing relationship with the BNSSG Population Health, Prevention and Inequalities Group?

3.4 Equality and inequality impact assessments

These have been completed for the group's involved in the response to COVID-19, i.e. the cells. Furthermore, an equality and inequality impact assessment will be done on the BNSSG NHS Phase 3 planning submission which will be made at end of July / beginning of August to understand the cumulative effect of the plan on health inequalities.

3.5 Expert review/challenge/scrutiny group

The chief executives of the Healthier Together partner organisations requested that an expert group, made up of people from the BNSSG community, be set up to provide scrutiny of the work and decisions of Healthier Together in relation to inequalities. The Healthier Together Partnership Board, whose members are the chief executives and chairs of the partners and the chairs of the three Health and Wellbeing Boards, will consider what is needed to make this effective before setting this group up.

What does the Health and Wellbeing Board think would make this BNSSG-wide expert review/challenge/scrutiny group effective?

3.6 Use population health management and intelligence insights

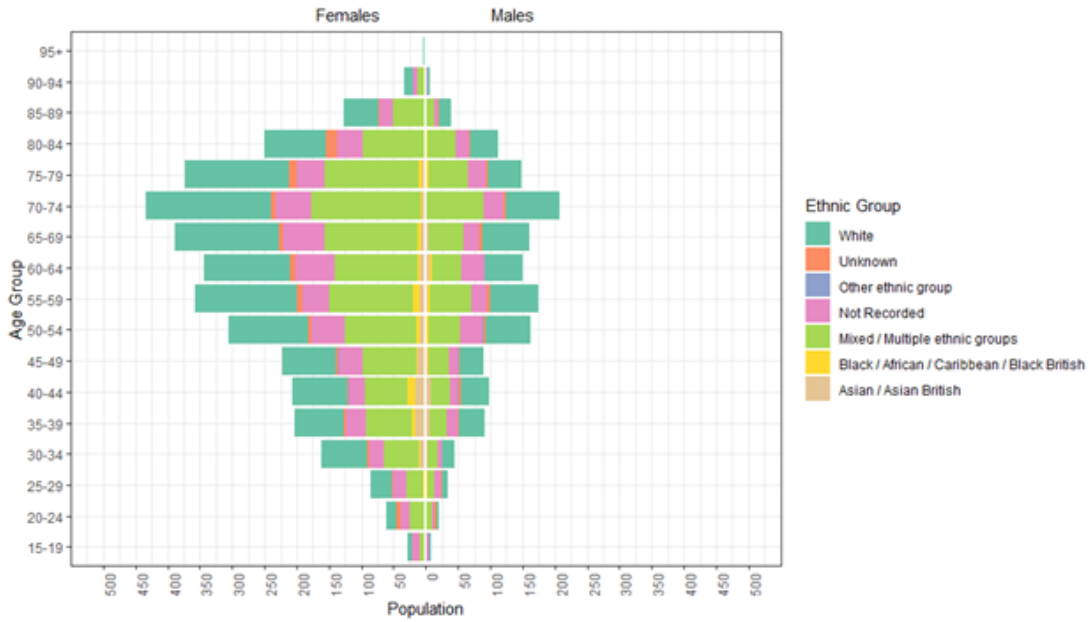
The manipulation and analyses of data and the information we get from our communities and other sources should be used to monitor health inequalities. It should be used to help understand where we need to target changes and also as a way to monitor what effect changes and interventions have had on health inequalities. Work has started on this "observatory" and below are examples of analysis that is being done.

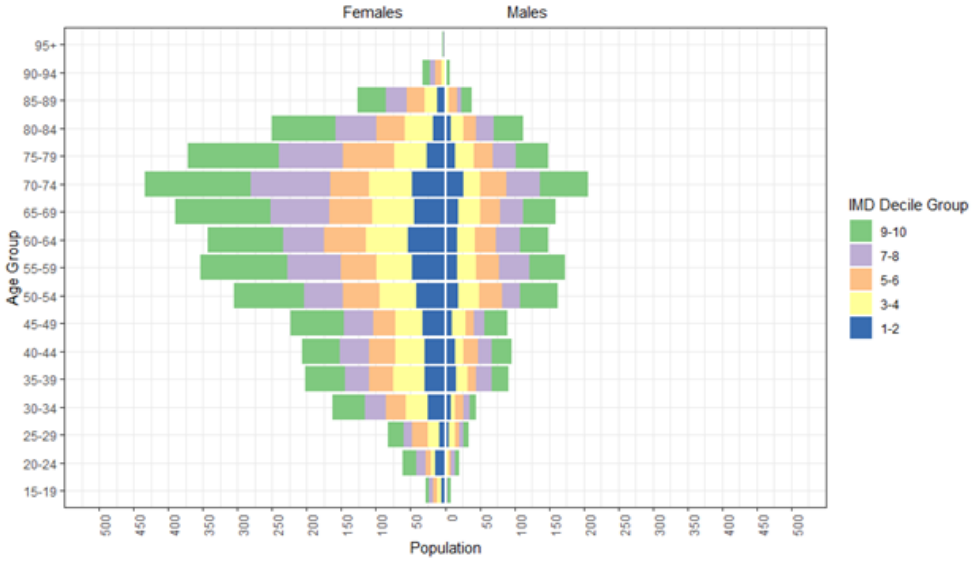
Example 1

We are developing a population view of the rheumatology outpatient lists using the system wide dataset. The aim of this is to help prioritise and manage the list in order to improve overall outcomes and reduce health inequalities. Together with the three hospital rheumatology leads we have identified the list of factors we believe are most important in understanding the population through equity and risk management lenses, such as ethnicity, deprivation (IMD 1 = most deprived), age, respiratory comorbidities, multimorbidity and polypharmacy.

The figures below show what two of the lists look like by deprivation and ethnicity. As a result, rheumatology lists might be managed differently such that groups at high risk from complications, e.g. people with respiratory complications might be followed up with a greater intensity than those at lower risk. While this might happen on a case by case basis currently, it is not planned for at a population level and there is no systematic mapping of outcomes to these groups.

It also appears that the lists might be less deprived that we might expect, given what we know about the association between deprivation and health. This means we need to explore further to see whether this might be an effect of less deprived populations not reaching secondary care. The intention is to combine this work with the electronic measurement of patient reported outcomes measures (PROMS).

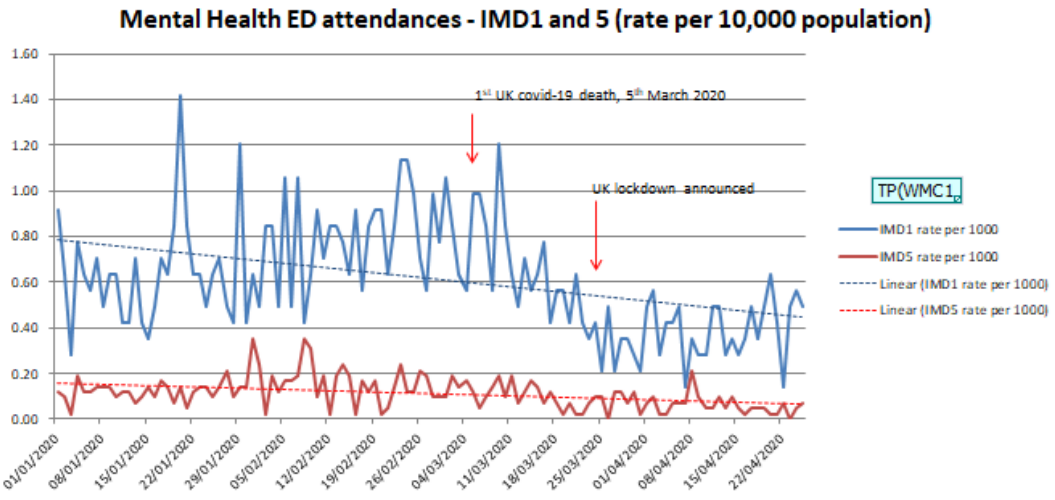




Example 2

The following graph suggests that access to Emergency Departments for those presenting with mental health issues has been most disrupted for the most deprived (discounting the point that Emergency Departments may not been the place that best meets the needs of this cohort of people). This information supplements the information the Mental Health Cell is getting from service users involved in its work.

More deprived = more likely to attend ED with a mental health problem; access most disrupted for most deprived



Index of multiple deprivation
IMD1 = Most deprived 20% of the county
IMD5 = Least deprived 20%

Who are the people in deprived populations who attend ED with MH problems? Do they interact with their GP? Would they benefit from targeted intervention?

3.7 Interventions in healthcare in BNSSG

It is important to recognise that there are areas of existing work in BNSSG to address health inequalities. For example, the Healthier Together Primary Care Strategy talks specifically about actions to be taken and the Cardiovascular Disease Programme's hypertension work is focussing only on those with poor outcomes. We also need to consider the opportunities to allocate resources in support of reducing inequalities.

We now have recommendations from national reviews/reports and the requirements set out in the Phase 3 planning letter which Healthier Together needs to respond to in a way the builds on the work that partners have already been doing. There are some local ideas that need to be scoped and tested further.

1. **Engagement with our communities** There have already been actions taken to respond to feedback and recommendations about how we are communicating COVID-19 related information to those parts of our communities who may have had poorer access to that information and with whom trust needs to be established. For example, the work with the Community Access Support Service (CASS) in Bristol on providing culturally and linguistically appropriate public health communications. Given the further work that will need to happen in terms of engaging people from our communities in the interventions being designed and proposed, the opportunities for doing this jointly across partners is being pursued.

   Providers of services, Healthwatch and other groups may have already gone out to particular population groups in order to understand the cultural appropriateness of services and improvements that are needed; some of the more practical aspects of service delivery, e.g. the format and language of appointment letters or service discharge summaries and; how the attitudes of staff impact on their experience of health and care. As the Healthier Together partnership we need to ensure that we don't repeat those exercises where they have already been done.

2. **Prioritising care and resources for people with poorer outcomes both for COVID-19 and non COVID-19**. For outcomes related to BAME groups and COVID-19, the Healthier Together Partnership will need to consider how taking this approach will help enact or respond the implementation of many of the recommendations in the Public Health England report 'Beyond the data: Understanding the impact of COVID-19 on BAME groups'. For example, accelerating efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective

management of chronic conditions including diabetes, hypertension and asthma may mean targeting allocating more of our resources to this and less to something else.

Given the emerging evidence around the combination of diabetes, obesity and ethnicity as a risk factor for COVID-19 severity, we expect the existing diabetes work to be specifically tasked with co-designing how to prioritise preventative and other care for people who have this combination.

In terms of non COVID-19 related care, for all people with poorer outcomes the cost of non-COVID delayed care is greater than for the average person. One way of beginning to prioritise planned care in such a way to reduce health inequalities and improve overall value for our system could be to think about those waiting for care who are at higher risk of having poorer outcomes **in addition to** considering the clinical urgency of everyone waiting for care when scheduling long term condition and other management. Prioritising these groups may have a limited overall impact on waiting times for most people but would improve the situation of some of our highest risk and most vulnerable people.

In all of this, proposals would be expected to have:

- been designed with or sense-checked by the people they affect
- undergone an equality and health inequalities impact assessment

a. **People with learning disabilities (LD)** (1.7% of the BNSSG population) **and autism** to improve their outcomes. The Learning Disabilities and Autism Cell have plans in place to improve the proportion of people who have an annual health check in order to reduce health inequalities and improve outcomes.

b. **People with mental illness.** Some of our worst outcomes are seen among those with serious mental illness (SMI). For people in BNSSG with a SMI diagnosis the change of dying prematurely (before 75 years of age) is 3.5 times that of the general population. The Healthier Together Mental Health Business Case clearly articulates how existing health inequalities will widen further as a result of COVID-19.
    i. Men from Black ethnic groups are nearly three times more likely to be diagnosed with COVID-19 than men from White ethnic groups and local communities report this leading to anxiety, fear, growing distrust of statutory services and worsening levels of mental health.
    ii. The poorest parts of England have experienced higher rates of mortality from COVID-19 than wealthier areas, and they are also likely to be hardest by the economic downturn. People in the lowest socio-economic groups already have worse mental health than those in middle and higher groups, which is likely to be compounded further.

The proposals in the mental health business case focus on proposals focus on those disproportionately affected including people from our Black communities; people affected by trauma and abuse, including refugees, and those living in our areas of greatest deprivation with the accompanying allocation of resources that is needed.

Proposals that are being developed for **initial consideration** at Clinical Cabinet are:

- Ensuring that LD and SMI patients are highlighted on referral letters
- Prioritising access to LD and SMI patients as long term condition management services are restored
- Flagging LD and SMI patients as a priority category when patients are added to waiting lists for clinics or procedures
- Working with primary care to ensure all correspondence and information is communicated in an accessible manner, which encourages and supports patients to continue to access services

c. **People living with higher levels of deprivation** could be another group that is prioritised. We do not currently have a clear understanding of how the full range of BNSSG services are accessed by socio-economic status.

Proposals on prioritising care will be discussed at Healthier Together Clinical Cabinet during the coming weeks. Decisions on any new approaches will be taken through the Healthier Together governance structure as appropriate.

4. Summary

Everyone deserves the same opportunities to lead a healthy life and to access the health and care services they need, no matter where they live or who they are. Closing the heath inequalities gap is one of the biggest challenges we face as a health and care system. There are clear actions we can take across our partnership tackle health inequalities. Our actions should:

- **Be data led.** It is essential that good data is collected and that we have a shared understanding of data sets and other information that are available across the partnership and any barriers to sharing. In addition, the data needs to be regularly reviewed.
- **Focus on partnership**. Reducing inequalities is everyone's business, so actions should be locally relevant and locally owned – and developed and delivered in partnership with agencies and the community.
- **Be measureable**. All actions should have some way of showing their impact. In some cases this may be quantitative with outcomes that can be counted, and others may be qualitative where impact is captured in a narrative way; or a combination of both. This action need to also ensure that we understand both

the impacts on the groups being targeted and on other groups so that we understand any potential unintended consequences as well as planned impact.

- **Be aspirational yet realistic.** We have the opportunity to make real change, and our actions should reflect that aspiration. However, it is important that they are grounded in evidence and within our combined capacity, so we do not set things up to fail. We will need to find a way to challenge ourselves on this.
- **Be open to challenge and evolve.** Actions should reflect our communities – what information tells us about their needs but more importantly what people tell us about what is important to them. All actions should be monitored to make sure they are fit for purpose, and evolve and develop as necessary.
- **Be appropriately resourced and sustainable.** Actions should refocus core budgets and services rather than short bursts of project funding.
- **Be systematically applied and scaled up appropriately.** We should not depend only on exceptional circumstances and exceptional champions, and must remember that "industrial scale" processes require different thinking to small "bench experiments"

5. Recommendations

5.1 Note Healthier Together's current understanding of the impact that COVID-19 has had on health inequalities

5.2 Note the actions that are being considered to address these either at a partnership level or more specifically interventions in healthcare in Bristol, North Somerset and South Gloucestershire

5.3 Consider how the Health and Wellbeing Board wants to develop an ongoing relationship with the BNSSG Population Health, Prevention and Inequalities Group

5.4 Consider what would make a BNSSG-wide expert review/challenge/scrutiny group effective

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Bristol Health and Wellbeing Board

Title of Report:	**Fuel Poverty Action Plan**
Author (including organisation):	**Aisha Stewart – BCC Energy Service**
Date of Board meeting:	**19/08/2020**
Purpose:	Information and Discussion

- Paper to be no more than two pages long
- Draft papers are reviewed by the Public Health team
- Final papers will be published on the public website
- Board correspondence: HWB@bristol.gov.uk

1. Executive Summary

The No Cold Homes Steering Group (a collective of organisations across Bristol that are committed to taking action to tackle fuel poverty in the city) has developed a Fuel Poverty Action Plan for the city. The aim is to provide a strategic roadmap for actions that support and lift households out of fuel poverty.

A revised draft of the full action plan is being shared to obtain input/feedback and discuss whether the current situation with COVID-19 has presented any opportunities to engage with those in fuel poverty and those with health conditions that could be worsened by living in a cold property.

2. Purpose of the Paper

We are presenting an up-to-date version of the draft Fuel Poverty Action Plan in hope of seeking final input/feedback prior to final signoff in October. Since last presenting to the Health and Wellbeing Board in August 2019, we have been engaging with the Bristol Homes & Community Board, Environmental Sustainability Board and various community organisations to ensure that the actions in the plan are represented of the current work and upcoming projects happening across the city that support people in fuel poverty. With COVID-19 having impacts on employment and household finances, we aim to discuss if there are any new opportunities to engage with the fuel poor households through health sector communication channels.

3. Background and evidence base

In December 2018, the JSNA chapter on Fuel Poverty was published which discussed the state of fuel poverty in the city, highlighted what services already exist to support those in fuel poverty, while mentioning what more can be done to tackle it. Recent data from the Department for Business, Energy & Industrial Strategy suggests that 9.8% of households in Bristol are fuel poor, which is an estimated 19,572 households across the city.

The JSNA chapter highlights how living in a cold home can worse the health of those with any existing health conditions and have an impact on children who are at greater risk of respiratory problems and lower educational attainment. Additionally, the chapter discusses the association between cold homes and mental health problems, as the physical discomfort of being in a cold home and financial worries can have an impact on one's mental wellbeing.

Additionally, the NICE guideline for excess winter deaths [NG6] provides recommendations for actions that can be taken to better support those living in cold homes. For each of the recommendations suggested, evidence and expert papers are linked to support the need for the suggested recommendation.

Furthermore, the One City Plan includes targets related to tackling fuel poverty and we aim to utilise the One City approach to bring together organisations across the city to work towards achieving the targets.

4. Community engagement

As part of the development of the Fuel Poverty Action Plan, we held an event in November 2019 to bring together various community organisations, service providers and council departments for a workshop that supported the development of the actions incorporated in the action plan. The No Cold Homes Group will continue to work with and alongside community groups to support those in fuel poverty.

5. Recommendations

Our recommendations to the Board are:

- Determine linkages with existing/upcoming services in your work to the objectives of the action plan
- Identify communication channels to engage with fuel poor households for energy efficiency measures or referrals for support/advice agencies
- Review action plan

6. City Benefits

The development of the Fuel Poverty Action Plan aims to provide a strategic approach for engaging with and supporting the residents of Bristol in fuel poverty. The various actions incorporated in the plan includes the improvement of the energy efficiency of homes across the city, ensuring affordable heating options and support/advice to tackle issues with debt and other financial difficulties.

The benefits to taking action as outlined in the action plan include:

- Projects for improving housing stock to a minimum energy performance certificate rating
- Seeking funding opportunities for advice/support agencies
- Strengthen relationships with frontline healthcare workers to identify fuel poverty triggers

7. Financial and Legal Implications

N/A

8. Appendices

Attached is the most up-to-date version of the Fuel Poverty Action Plan.

Bristol Fuel Poverty Action Plan 2020 –2030

A partnership approach to end cold homes in Bristol

Draft for review by One City Plan boards

Foreword

Bristol is committed to tackling fuel poverty and ensuring that the residents of this city have access to support services and the necessary energy efficiency measures to live in a warm and comfortable home. The impact of living in a cold home has a wide range of effects on physical and mental health that can have a lasting effect on individuals, families and our communities. With the impacts of COVID-19 affecting many household in the city, this time presents an opportunity to act collectively as a city to tackle this issue to prevent further hardship.

The Fuel Poverty Action Plan provides the city with direction and a strategic approach for supporting vulnerable households across the city. The plan includes actions we can take as a city to support households in fuel poverty and preventative measures to ensure more people do not fall into it. As the city moves towards its 2030 goal of being carbon neutral and climate resilient by 2030, we need to consider how we will support households through a just energy transition, where citizens are able to have access to affordable low carbon heating options and live in energy efficient homes. With involvement from the Health & Wellbeing Board, the Bristol Homes & Communities Board and the Environmental Sustainability Board, the Fuel Poverty Action Plan is an opportunity to utilise the One City Approach and bring together organisations to improve the lives of those living in cold homes and prevent further households from ending up in fuel poverty.

COVID-19 has presented a series of challenges and has resulted in financial hardship for many households, which could make managing finances and keeping homes warm could be more difficult than ever. We recognise that these are complex situations; however, we have an opportunity to galvanise action in the city and take collective action. The Health and Wellbeing Board sees this work as a chance to make progress on tackling issues on the wider determinants of health to improve the health and wellbeing of Bristol's residents.

Thank you to all the organisations that have supported the development of the Fuel Poverty Action and to those that are committed to taking this work further.

Bristol's Health and Wellbeing Board
August 2020

Table of Contents

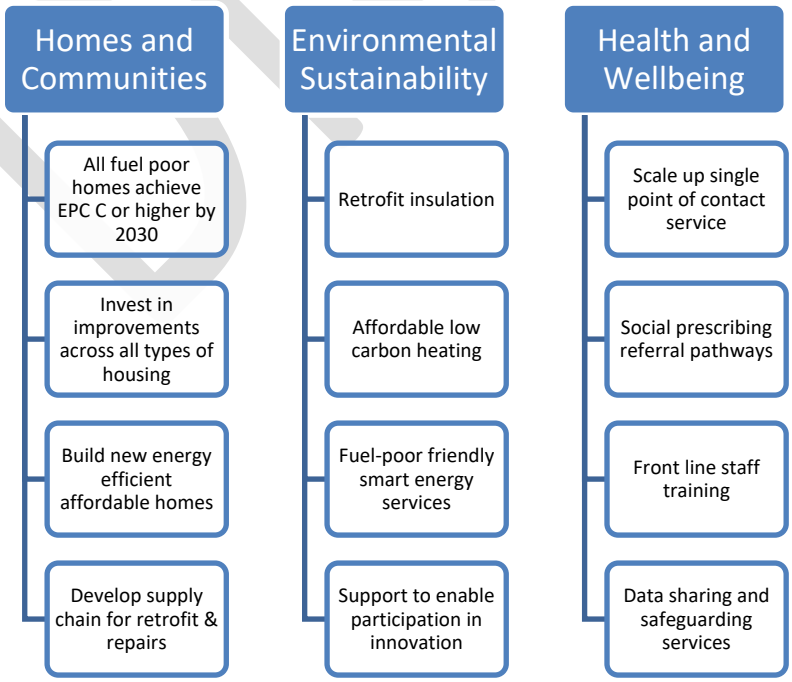
Executive Summary

Bristol is committed to tackling fuel poverty and improving the lives of those currently struggling to adequately heat their home. COVID-19 has resulted in more financial hardship for many households in the city and the Fuel Poverty Action Plan aims to galvanise action in Bristol to support vulnerable households. It will require investment of over £20 million to install insulation, improved efficiency and low carbon heating measures and renewable energy measures in fuel poor homes across Bristol. Specialist health and housing advice and referral pathways, integrated with income maximisation support, will also contribute to wider health and wellbeing benefits, in line with the One City ambitions to embed health and wellbeing in all key policy development. The Fuel Poverty Action Plan aim to work alongside the One City Climate Strategy , as it includes actions to tackle fuel poverty that will help achieve affordable warmth and improved health as well as carbon emission reductions.

The production of this action plan was led by the voluntary No Cold Homes steering group. An event hosted at City Hall in November 2019 brought together partners from across Bristol and surrounding regions to identify the actions needed to achieve this goal, with further stakeholders helping to clarify the scale of action required.

Leadership and co-ordinated action from across the city will be needed to deliver this plan. Bristol's One City Plan provided the appropriate model to ensure a collaborative approach with various organisations to tackle fuel poverty. The Fuel Poverty Action Plan and subsequent actions will involve engagement and action from multiple One City thematic boards. The Health and Wellbeing Board, the Homes and Communities Board and the Environmental Sustainability Board each have an oversight role for sections of the action plan.

Summary of activities overseen by One City boards



1 Introduction

In 2014, the government introduced in legislation a fuel poverty target for England to improve as many fuel poor homes as is reasonably practicable to a minimum energy efficiency rating of Band C, by the end of **2030**.

More than 20,000 homes in Bristol that are currently EPC band D or worse require improving to EPC band C or higher by 2030. The cost to make the necessary retrofit improvements is estimated at over £190 million. This would rise to £220 million if homes improved were retrofitted with low carbon heating measures are retrofitted instead of new gas boilers being installed.

The No Cold Homes steering group is a self-formed group that is committed to driving and co-ordinating action on tackling fuel poverty in Bristol, with active representatives from leading organisations, including Bristol City Council, private and voluntary sector energy organisations, local advice and support providers, clinical commissioning groups, health researchers and representatives from the community energy sector.

1.1 Fuel poverty and cold homes – definition

Fuel poverty is generally understood to refer to the situation where a low income household is struggling to afford their energy costs. Fuel poverty exists where a household lives in a property that is not energy efficient and therefore expensive to keep warm; lives in a home that is much larger than needed; or where they use a more expensive heating fuel. Whilst the official definition of fuel poverty (see below) is based on modelled fuel costs, for many households the high cost of their energy tariff makes it hard for them to afford to keep their home warm. Similarly, even in an energy efficient home, having a broken or outdated heating system will affect a household's ability to keep their home warm affordably. In the UK, space heating accounts for the majority of a household's energy usage. Fuel poor households are also likely to experience other forms of energy deprivation affecting a range of daily activities within the home, including cooking, bathing, cleaning, study, socialising and entertainment.

The official definition of fuel poverty used in England is the Low Income High Costs (LIHC) definition, which defines a household to be in fuel poverty if:

- They have required fuel costs that are above average (the national median level) and;
- Were they to spend that amount they would be left with a residual income below the official fuel poverty line.

The government is consulting on a revised definition, the Low Income Low Energy Efficiency (LILEE). Under this definition, households will be deemed fuel poor if their disposable income (after housing and energy costs) is below the poverty line and they live in a property with an energy efficiency rating of Band D or lower. The energy performance certificate (EPC) rating of a dwelling is used as an indicator of how affordable it is to heat a home. E, F & G rated homes are more difficult to heat and keep warm at an affordable cost, whilst homes that are rated C or above are more cost-effective to heat. However, EPC ratings can often be inaccurate due to issues with quality control in the

industry. Also, if a heating system in a property is broken, faulty or not being used, this will not be reflected in the EPC rating.

1.2 The harmful effects of living in a cold home

The experience of fuel poverty and living in a cold home can cause multiple forms of harm to physical health, mental and health and social impacts. The Bristol JSNA Chapter on Fuel Poverty provides a full analysis of the significance of fuel poverty as a public health issue affecting people living in Bristol.

Living in cold and damp housing increases incidence rates for heart attack, stroke, respiratory disease, influenza, falls and injuries and hypothermia, especially in the elderly. It can also cause mental health effects from depression amongst all age groups as well as indirect risks of carbon monoxide poisoning. The World Health Organisation estimates that up to 30% of winter deaths are caused by cold housing. In the 2017/18 winter period, there were an estimated 50,100 excess winter deaths (EWD) in England and Wales.[1]

Living in a cold home can also have indirect health effects on educational attainment, employment attainment.

Additionally, a cold home also has harmful economic and social impacts, including household debt, social isolation, loneliness and poor diet, due to people making trade-offs between whether they heat their home or eat well. Fuel poverty is also associated with harm to health from associated problems of damp and poor internal air quality.

The National Institute for Health and Care Excellence (NICE) guidelines identify the following groups as at greater risk of harm to health from living in a cold home:

- people with cardiovascular conditions
- people with respiratory conditions (in particular COPD and childhood asthma)
- people with mental health conditions
- people with disabilities
- older people (65 years +)
- young children (under 5)
- pregnant women
- people on a low income
- people who move in and out of homelessness
- people with addictions
- people who have attended hospital due to a fall
- recent immigrants and asylum seekers

1.3 The national context

The government recently consulted on its 2015 Fuel Poverty Strategy for England, which set a target for as many fuel poor homes as is reasonably practicable achieve a minimum energy efficiency rating of Band C, by 2030. The fuel poverty statistics and consultation responses by activists, including

[1] Julia Verne - Understanding and preventing excess winter deaths. Presentation

CSE's response, highlight that progress has stalled. The proportion of fuel-poor households rated D is projected to improve to 68% by 2019 – against an interim target for as many as reasonably possible to reach Band E by 2020.

The government's consultation asked whether existing national programmes are sufficient to meet the scale of the fuel poverty challenge and what should be included in a new strategy to meet that challenge. It asked respondents to comment on:

- Updating the current Low Income High Cost (LIHC) fuel poverty metric to Low Income Low Energy Efficiency (LILEE);
- Retaining the current target and interim milestones for the strategy;
- The current guiding principles of the fuel poverty strategy (Worst First, cost effectiveness, vulnerability and a proposed 4th principle on aligning a fuel poverty strategy with current and future Government priorities; and
- Policies and associated commitments to include in an updated strategy.

The Queen's speech in December 2019 confirmed the Conservative Manifesto pledge to invest £9.2 billion in improving energy efficiency within homes, schools and hospitals to help reduce energy bills. The manifesto committed to:

- Keep existing energy price cap legislation
- Invest £6.3bn to improve the energy efficiency of 2.2 million disadvantaged homes, reducing their energy bills by as much as £750 a year, with two schemes:
    - £3.8bn social housing decarbonisation scheme focused on improving insulation in 2 million social homes, reducing energy bills by an average of £160 / year
    - £2.5bn home upgrade grants (HUGs) to replace boilers, provide insulation and in some cases replace energy systems wholesale. 200,000 homes will be upgraded, providing an average annual saving of £750 a year. It will cover costs up to £12,000 and apply to fuel poor households, both private and social, with poor energy efficiency.

In July 2020, the Chancellor announced the new £2 billion Green Homes Grant to support the increase in energy efficiency improvements for households. £1.5 billion of the full £2 billion is allocated to the Green Homes Grant voucher scheme where households will receive funding for a range of low-carbon energy efficiency measures to be completed through Trustmark or Microgeneration Certification Scheme (MCS) accredited installers. The remaining £500 million is administered by local authorities through the Green Homes Grant Local Authority Delivery (LAD) scheme. Local authorities will be able to bid for funding to support low-income households in their area. Further announcements on planned action to tackle fuel poverty will form part of the Government's approach are understood to include: [2][3]

- an updated fuel poverty strategy for England and Energy White paper;
- £6.3 billion-worth of upgrade for those in fuel-poor homes;

[2] https://hansard.parliament.uk/Lords/2020-02-07/debates/45023680-92D1-4EF1-AC56-20B83289A51C/DomesticPremises(EnergyPerformance)Bill(HL).
[3] The above information was referenced in National Energy Action (NEA) Budget Submission 2020

- a consultation on raising minimum energy performance standards in private rented homes;
- action to improve the warm home discount and Energy Company Obligation.

Bristol City Council and other partners must work to ensure that fuel poor households in Bristol get their full share of this investment.

1.4 Bristol-specific challenges to addressing fuel poverty

Many of the challenges for tackling fuel poverty across Bristol are common to those in the rest of the country. The Bristol JSNA Chapter on Fuel Poverty compared the situation in Bristol with that in other core cities. Rates of fuel poverty and excess winter deaths in Bristol compare favourably to other core cities. A growing proportion of housing in the city is in the private rental sector, and within this, a significant share comprises houses of multiple occupation (HMOs), which are generally in poorer condition than non-HMOs.

Mapping of areas of Bristol with the highest proportions of fuel poor households tend to show up areas with large student populations and more affluent areas with older and larger Georgian homes, which are likely to have the highest total fuel bills, including Cotham, Bishopston and Clifton. However, mapping that overlays measures of poor health, low income and low energy efficiency tend to highlight other areas of the city, including Hartcliffe and Withywood, Lawrence Hill, Filwood, Ashley, Southmead and Easton. This demonstrates the importance of applying local understanding to development of action to tackle cold homes and associated harm to health in Bristol.

The JSNA highlights the inter-relationships between fuel poverty and poor quality housing, income poverty, debt, food, transport and health issues. Advice agencies report being at capacity and overwhelmed by demand. The need for more collaborative working and data sharing between support and health service providers is highlighted, as well as for research to inform the strategic direction of local efforts and resources within the health and social care sectors.

1.5 Rationale for action

The No Cold Homes steering group formed of representatives from various Bristol City Council departments, local charities, community groups and other organisations active in tackling fuel poverty and related social, economic and health challenges in the city came together to drive action to end cold homes in Bristol. The production in 2018 of a JSNA fuel poverty chapter for Bristol by the No Cold Homes steering group was an important first step in highlighting the importance of tackling this preventable cause of ill health. The first recommendation from the JSNA was that the Health and Wellbeing Board facilitate the development of a fuel poverty strategy in collaboration with relevant organisations across Bristol.

1.6 Opportunities - what enables us to confront challenges – include national enablers

A number of national enablers provide the basis to confront the challenges faced.

The general election provides the basis for a reset of national policy commitments on tackling fuel poverty, with improvements to the energy efficiency of our national housing stock appearing in manifesto commitments. An update of the fuel poverty strategy for England provides an opportunity to confirm and refresh commitments and associated action and investment.

In 2019, a BEIS select committee report on energy efficiency urged the UK government to follow the example of the devolved nations with respect to complementing ECO funds with publicly funded programmes. The report is generally considered very coherent with a thorough evidence base. The government will have to reply to all of the committee's recommendations, so this may result in further opportunities at national level towards which the action plan can contribute.

A Public Health England (PHE) e-learning module for front line health workers on recognising the health impact of cold homes has been developed, as a result of work by the BEIS fuel poverty and health working group. However a more tailored module is likely to yield increased referrals to Bristol's own single-point-of-contact service.

2 Our partnership approach

2.1 Fit with One City Plan

In January 2019 Bristol published its first ever One City Plan and in February 2020 the One City Environmental Sustainability Board published the One City Climate Strategy. The Fuel Poverty Action Plan is an essential additional to guide cross-sector, city-wide collaboration to tackle the challenge of cold homes. It will contribute towards the One City Plan goal of making Bristol a fair, healthy and sustainable city by 2050.

Bristol's declaration of a climate emergency and subsequent publication of the One City Climate Strategy provide an important regional context within which actions to end cold homes must be delivered. This will bring both challenges and opportunities, with the potential city-wide investment in new heating systems and insulation but also the prospect that fuel poor households - as well as others - will require financial and other help to participate in this transition.

The target to end cold homes by 2030 will require a holistic approach to tackling the complex problem of fuel poverty. It will require a collaborative approach, led and overseen by the Health and Wellbeing Board, the Environmental Sustainability Board and the Bristol Homes and Communities Board. Activities driven and overseen by the Economy Board will also be important to tackling fuel poverty.

The action plan will need people and organisations from across the city to take action. It will need to interact with other city-wide collaborative initiatives (see Box 1) towards the wider goal of making Bristol a fair, healthy and sustainable city by 2050.

Box 1: Related cross-city collaborations and delivery strategies

- One City Climate Strategy: Sets out scale of ambition and actions needed to achieve Net Zero by 2030.
- Bristol City Funds - £10 million investment funding for solutions that target the causes and effects of inequality in Bristol.
- Thrive Bristol - 10 year programme to improve the mental health and wellbeing of everyone in Bristol, with a focus on those with the greatest needs. Fuel poverty is an important underlying cause of poor mental health.
- Healthier Together - the Sustainability Transformation Partnership Long Term Plan 2020 – 2025 covering health care in Bristol and surrounding areas. The health sector needs to

engage fully in actions to end cold homes as a cause of ill-health and prevent discharge from hospital into cold homes.

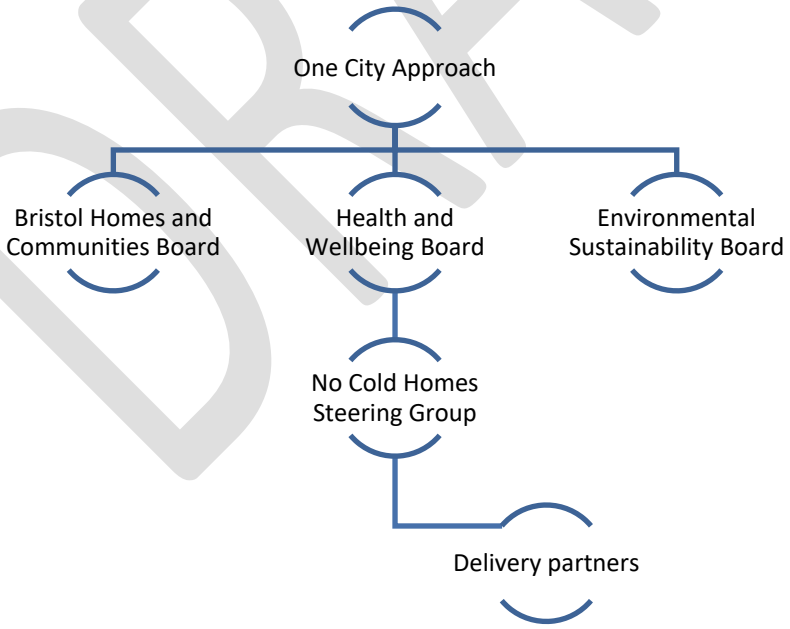
- Homelessness and Rough Sleeping Strategy 2019-24. Fuel indebtedness can push people towards homelessness. Equipping newly housed people to manage their bills can support them to regain independence in their own home.

2.2 Oversight and Delivery Responsibility

Oversight and governance of the Fuel Poverty Action Plan will be the responsibility of the Health and Wellbeing Board. However, due to the cross sector nature of implications and potential actions associated with fuel poverty, the Bristol Homes and Communities Board and the Environmental Sustainability Board will both play a critical role in improving the energy efficiency of housing and advocating for affordable, low carbon heating systems.

- The Health and Wellbeing Board
  - Specialist cold homes advice services and referral pathway
- Bristol Homes and Communities Board
  - Affordable, energy efficient housing
- Environmental Sustainability Board
  - Affordable, low carbon heating
  - An inclusive, affordable smart energy system

Figure 1: Delivery and reporting structure for Fuel Poverty Action Plan



The No Cold Homes steering group will support the oversight role of the boards, in the following ways:

- Co-ordinate the monitoring of activity by delivery bodies to the One City boards
- Compile data to enable reporting against key progress indicators
- Provide advice to boards and commission research on behalf of boards to underpin understanding of further action needed to accelerate progress and overcome barriers.

This will require dedicated funding, including additional budget to pay for any commissioned research. An executive team with representatives from Bristol City Council's Energy Service and the Centre for Sustainable Energy will provide administrative support to the steering group.

A wider network of No Cold Homes delivery bodies will plan and deliver activities. This includes Bristol City Council teams, health providers, businesses, non-profit organisations, Voluntary and Community Sector (VCS) organisations and academic bodies.

2.3 Outcomes focused action plan

The action plan focuses on achieving outcomes. The main outcome is that:

- By 2030, nobody in Bristol will suffer from a cold home due to fuel poverty and/or inability to have the necessary insulation and heating. This will be measured using the LILEE definition. As measured by: Number of households in Bristol with income 60% below median income living in a home with an energy efficiency rating of Band D or lower.

Intermediary outcomes are:

- Develop fuel poverty action plan for delivery from April 2020 onwards
- Health & Wellbeing Board reports regularly on progress towards completing all recommendations of the NICE guideline.
- Investment of £217 million to 2030 for retrofit of fuel poor homes in line with One City Climate Strategy to reduce energy demand and costs, using existing and new funding mechanisms, including City Leap.
- Additional £2.3million revenue funding secured for City-wide single Point of Contact (SPOC) health & housing referral service commissioned beyond 2021 to deliver advice and support services to 2,500 fuel poor hours annually.
- Health & social care practitioners, social housing professionals, voluntary & faith sector front line workers trained to identify people in need of support & make onward referrals
- All vulnerable people with cold-related health risk factors discharged from hospital to a warm home by 2025

3 Affordable, energy efficient housing

3.1 Oversight Board: Homes and Communities

3.2 Context

The One City Plan aims to ensure that every person in Bristol will be able to live in a home that they can afford and which is secure and warm. There is a shortage of affordable housing in Bristol, with a 74.8% increase in average house prices over the last ten years, a housing affordability ratio of 9.12, higher than the national average, and one of the highest rates of rent increases in the country.[4,5] The combination of high housing costs and low efficiency housing stock, particularly in the private sector, contribute to continuing high rates of fuel poverty.

Current statutory energy efficiency commitments require all fuel poor homes by 2030 in England to be levelled up to the energy efficiency standards of a current new-build home (EPC C). There is also a national policy target for all private rented sector homes to achieve a minimum EPC C by 2030.To tackle fuel poverty and carbon emissions, major improvements must be made to housing in Bristol across all sectors (owner occupied, private and social rented sectors). Bristol's existing housing stock contains large proportions of old, inefficient homes. A quarter of housing has solid walls.[6] An estimated 22,000 fuel poor homes need retrofitting to achieve at least an Energy Performance Certificate (EPC) rating of C by 2030.[7] These inefficient homes cost 2-3 times more to heat than more efficient homes. In response, people living below the poverty line under heat their homes to save money, exposing them to the harm associated with living in a cold home – a key driver of fuel poverty.

Bristol must deliver a large scale energy efficiency retrofit response. The scale of investment needed is estimated at £190 - £220 million over the next decade (see Appendix D). For this Bristol will need to claim a significant share of the Government's energy efficiency scheme and social housing decarbonisation schemes. Bristol has current funding for retrofit in the existing ECO scheme: Bristol City Council's Energy Company Obligation (ECO) Flex Statement of Intent is designed to ensure funding is targeted at fuel poor households.[8]

A significant amount of investment will need to be targeted at the private rented sector, making best use of the minimum energy efficiency standard (MEES) regulations. Tightened regulations are being developed to achieve the trajectory of minimum EPC C by 2030.

The April 2020 budget committed £12.2 billion to creating 200,000 new affordable homes in England. New housing in Bristol will be required to meet tightened energy efficiency standards. In Bristol stakeholders responded to a recent consultation on Future Homes Standards. Bristol City

[4] State of Bristol: Key factors 2019
[5] https://www.zoopla.co.uk/discover/renting/zoopla-rental-market-report/
[6] https://tools.smartsteep.eu/wiki/Bristol_-_Housing_Stock_Assessment
[7] See APPENDIX D for more information
[8] https://www.bristol.gov.uk/documents/20182/33407/ECO+Flexible+Eligibility+Statement+of+Intent+v1.0/76a98415-e38d-a031-21ce-a8188ab41478

Council is exploring the use of thermal imaging as a means to check that performance standards are met in new homes.

Temporary accommodation for homeless people and people at risk of homelessness needs to be improved to ensure that accommodation is safe, warm and appropriate for individuals and families to live in. This aspect of the plan needs to be more fully developed, planned and funded, interacting with delivery of the Homelessness and Rough Sleeping Strategy 2019-24.

3.3 Planned Actions

Action	Timeline	Status	Target / measure of progress	Delivery lead
Use selective licensing to drive improvements in energy efficiency of homes via EPC, MEES & Housing Act	2020 /2025 / 2030	Extend / tighten rqts. to D / C	PRS homes improved to EPC E by 2020/ D by 2025 /C by 2030	BCC Private Housing Team
Provide top-up grants to PRS landlords above £3500 (£250k in grant funding to 2022). Require improvements to EPC D by 2025 / to EPC C by 2030 – with supporting funding.	2019-2022	Extend beyond 2022 / Scale up	PRS homes improved to EPC E & higher by 2022	BCC Private Housing Team BCC Energy Service
Local authority-led mass retrofit investment in social housing to bring to C by 2030	2021 - 2030	Scale up	Social housing improved to EPC C or better by 2030	BCC Housing Team BCC Energy Service
Housing associations mass retrofit programme for fuel poor homes to bring to C by 2030	2021 - 2030	Scale up	Social housing improved to EPC C or better by 2030	Housing associations
Channel and support national government funding for low income private owner energy efficiency retrofit measures and heating	2020 - 2030	New	Fuel poor owner-occupier homes improved to EPC C or better by 2030	BCC Private Housing Team BCC Energy Service
BCC Energy Service to deliver ECO funding to focus on fuel poor households - private rented and owner occupied homes £750k	2020 - 2022	New	Private Rented Sector and owner occupiers & households improved to EPC E & higher by 2022	BCC Private Housing Team BCC Energy Service
Develop local supply chain on low cost repairs, retrofit, low carbon heating, new build	[Futureproof 2019-2021] 2021 onwards	NEW	Number of contractors trained	The Green Register/CSE

sustainable homes. Learn from Futureproof				
Build new affordable homes to C and above	2020 onwards	Scale up	# new affordable homes EPC C or higher in Bristol	BCC Housing Delivery
Prioritise investment in housing repairs to fuel poor households in social housing	??	Existing	??	BCC Housing Team BCC Accessible Homes
Financial support for private low income home owners to make repairs to heating and minimise heat loss	??	Existing / scale up		BCC Private Housing Team / WE Care
Use HHSRS powers to require improvements to PRS housing of FP households	??			BCC Housing and Private Housing Team

3.4 Other ongoing activities

Advice services also provide help fuel poor households identify their needs and help them access available funding for improvements to their homes. See section 5.4.

Futureproof is a market accelerator initiative facilitated by The Green Register and Centre for Sustainable Energy, currently working to build the skills for low carbon retrofit delivery in Bristol and the surrounding area. The initiative is mainly aimed at the 'able to pay' market. An adapted version with a different funding model is needed to enable widened access to high quality workmanship by lower income homeowners wanting to make improvements to their home.

Roof Over My Head is a multi-agency three day tenancy preparedness course for households who are homeless or in supporting housing moving to private rented accommodation. The course, delivered by WRAMAS (Bristol City Council Welfare Rights and Money Advice Service) and BCC Learning Communities' Team covers landlord and tenant responsibilities, budgeting, welfare rights, and other topics. It supports around 180 households per year.

4 Affordable low carbon heating

4.1 Oversight Board: Environmental sustainability

4.2 Context

Affordable heating options are key to tackling fuel poverty. Upgrading the energy performance of the city's buildings described above would have a significant impact on reducing fuel poverty as well as carbon emissions to heat inefficient homes. Nevertheless several factors influence a household's ability to keep affordably warm in winter e.g. income, building efficiency, and heating practices.

Gas central heating is now a higher carbon option than electric heating. Moving towards the decarbonisation of heat with the shift away from gas heating to heat pumps or district heating is likely to increase heating costs. This creates a tension between the dual challenges of attaining affordable warmth for every household and decarbonising heat. The anticipated 20-30% increase in fuel bills for heating costs may be balanced out by reductions in energy consumption due to energy efficiency improvements and the reduced standing charge on bills. It may, therefore, be possible to shift to low carbon heat without exacerbating fuel poverty.

The Energy Companies Obligation (ECO) is a government energy efficiency scheme in Great Britain to help reduce carbon emissions and tackle fuel poverty. Under ECO3, the current policy which runs to March 2022, the Home Heating Cost Reduction Obligation (HHCRO) requires obligated suppliers to promote eligible measures which improve the ability of low income, fuel poor and vulnerable households to heat their homes.[9]

The Budget (March 2020) announced a new £100m scheme to help households and small businesses invest in low carbon heating. It is also providing £270 million in funding for a Green Heat Networks scheme to encourage new and existing heat networks to adopt low carbon heat sources.

4.3 Heat networks

District heating provides a low carbon alternative to gas central heating to deliver affordable heat. Homes and businesses receive heat from energy centres through a network of pipes. Bristol already has a major city centre heat network, with over 1000 properties (700 of them council-owned homes) already connected to it. It has been awarded £10 million by the government's Heat Network Investment Project to expand this network to new areas of the city during 2020-2030.[10] The expansion is ongoing in the Temple Quay, City Centre and Old Market areas of the City, with new residential developments and existing social housing blocks being connected. Longer term activities to 2030 as part of the One City Climate Strategy will require heat networks across much of the city, particularly in areas with larger properties.

[9] https://www.ofgem.gov.uk/system/files/docs/2020/02/energy_company_obligation_2018-22_eco3_guidance_delivery_v1.4_1.pdf

[10] https://environmentjournal.online/articles/bristol-has-recieved-10m-to-expand-their-low-carbon-heat-network/ 6th March 2020

4.4 Heat pumps

Heat pumps will also play a major role in decarbonising heat in Bristol, as set out in the One City Climate Strategy. Homes need to be fully insulated before heat pump installation, and occupants given advice on how to use, maintain and repair them. The capital costs to install heat pumps are currently much higher than for gas boilers. Bristol City Council will need to join with other Core Cities to influence central government policy to redirect ECO funding from gas boilers to heat pumps to make heat pumps more affordable. Bristol City Council's Energy Service has yet to develop specific plans to roll out heat pump installation in areas of the city not served by the heat network. See Appendix D, Improving the dwelling of fuel poor households in Bristol to EPC band C (at minimum cost), for a detailed analysis of the cost of installing energy efficiency measures and a comparison of gas combination boilers and heat pumps as heating options.

4.5 Planned Actions

Recommended Actions	Timeline	Status	Target / measure of progress	Who has responsibility / who can influence
Develop 'affordable warmth' funded retrofit and subsidy package to pay for insulation and low carbon heating solutions for fuel poor households in Bristol from 2022/2023	2022 onwards	NEW	10,000 fuel poor homes retrofitted with low carbon heating by 2030 Approx. 17,000 insulation type measures (see Appendix D)	BCC Energy Service
Make best use of ECO3 funding for sold wall insulation in fuel poor homes to 2022 and gov funding to 2030	2020 – 2022 / 2022-2030	NEW	1100 external wall insulation by 2030	BCC Energy Service
Expand heat network connections to social housing blocks and fuel poor homes as part of One City climate strategy	Already started	Scale up	Social/affordable homes connected to low cost heat network by 2030	BCC Energy Service
Influence government policy and secure funding for heat pumps to be installed in fuel poor homes from 2022. Trial most suitable delivery model.	From 2022	NEW	Up to 10,000 fuel poor homes retrofitted with heat pumps by 2030 (see appendix D)	BCC Energy Service
Core Strategy BCS14: major developments in 'Heat Priority Areas' should connect to existing heat networks, where available. Where not yet available, developments should incorporate infrastructure to connect in the future.	Adopted in 2011	Scale up	New-build social / affordable homes connected to existing heat networks (includes existing post 2011 new homes not yet connected)	BCC Energy Service
Monitor roll out of low carbon heating to ensure BCC tenant	2020 - 2030	New	Static or reducing number of BCC tenant	BCC Housing Team

households are not pushed into fuel poverty			households in fuel poverty	
Test and adopt cost-effective techniques to monitor the actual heat loss performance of new build and retrofit homes	2022	NEW	Reduced performance gap of new and retrofit social & affordable homes	BCC Energy Service
Train community thermal imaging champions to deliver surveys for fuel poor households	Already Started	Scale Up	# fuel poor households surveyed/yr & install measures.	Bristol Energy Network / Futureproof
Help with hoarding, temporary rehousing and other support to enable installation of insulation and heating measures in fuel poor properties.	??	New	# fuel poor HH helped to overcome barriers to affordable heat measures installation	BCC Energy Service / WE Care / CSE
Under Bristol's Climate Change and Sustainability Practice Note, non-renewable electric heating remains excluded from the heat hierarchy for various reasons including that it is relatively inefficient compared to heat pumps and could end up with more residents in fuel poverty due to likely increase of running costs for users.	Updated in July 2020	New		BCC Planning

4.6 Other ongoing activities

Bristol City Council was awarded funding in 2019 to support the installation of central heating systems for fuel poor households. It is a collaborative project offered across Bristol, North Somerset and Bath & North East Somerset.

Bristol Energy Network provide ongoing activities that support people living in fuel poverty including educational events that promote energy efficiency retrofit.

The Making Space project facilitated by WE Care provides practical and emotional support to hoarders. Hoarding can contribute to fuel poverty as it may be impossible to service a boiler or fit a new heating system, resulting in a cold home and/or financial hardship due to reliance on expensive electric space and water heating.

WE Care provide support for home repairs vital to help vulnerable householder stay safe and warm in their homes, including fixing or replacing heating, improving energy efficiency or making adaptations.

5 An inclusive, affordable, smart energy system

5.1 Oversight Board: Environmental sustainability

5.2 Context

Bristol is an entrepreneurial city at the forefront of smart city initiatives: it ranks in the top 10 European cities for technology. Bristol's Smart City Strategy addresses how innovative solutions will change how people live in the city and address energy use challenges in the future. The council and The city also benefits from a thriving community energy sector who have supported the involvement of fuel poor households in innovation projects, such as Replicate (see below). The national smart meter rollout means that smart Time of Use tariffs will soon become more widely available: this brings with it a need to be attentive to the opportunities and risks for fuel poor households.

Bristol has leveraged EU innovation funding for the REPLICATE project that trials smart solutions to tackle fuel poverty, promote wellbeing and reduce carbon emissions. The project, led by Bristol City Council in partnership with the University of Bristol and the University of the West of England and other organisation runs from 2016-2021.[11] The project aims to deploy integrated energy, mobility and ICT solutions in cities. One of the project aims is to explore the role of smart technology in tackling fuel poverty. It is trialling smart technology in areas of the city with high rates of fuel poverty: Ashley, Easton and Lawrence Hill.

5.3 Planned Actions

Actions	Timeline	Status	Target / measure of progress	Who has responsibility / who can influence
Replicate smart connected homes trial tests how smart appliances, demand side response (DSR) & associated tariffs enable low income households to save energy & money on fuel bills.	2016-2021	Trial ends 2021	Lessons for engaging fuel poor households in DSR.	REPLICATE Team -BCC & partners
Replicate trial retrofit of loft insulation, new boilers and solar PV in fuel poor homes.	2016-2021	Trial Ends 2021	Bill savings & energy savings achieved	REPLICATE Team
Integrate lessons from Replicate into city-wide installations (see One City Climate Strategy Delivery Theme 4: Electricity)	2021-2030	NEW	Fuel poor HH engaged in smarter energy solutions	BCC City Innovation CSE
Community sector approaches & business models to enable fuel poor households to participate in smart tech e.g. solar PV or tariff	2021	NEW	Contribute to 9600 solar PV on fuel poor homes. Also batteries and new tariffs	Bristol Energy Network (BEN) CSE

[11] Replicate (Renaissance in Places with Innovative Citizenship and Technology) Bristol partners include Bristol City Council, University of Bristol; Knowle West Media Centre; Bristol Energy Network, UWE; NEC; Bristol is Open; Zeetta Networks & others.

pilots, building on e.g. Lockleaze Loves Solar.				

5.4 Other ongoing activities

The community energy sector in Bristol is engaged in a variety of initiatives to support people living in more deprived areas of Bristol to engage in innovative smart energy projects towards that help achieve reduced energy bills and make smart solutions work for fuel poor households. One such example is Lockleaze Loves Solar. This is an innovation trial which aims to install 1MW of solar PV across 300 roofs in the Lockleaze area at no costs to the householder. Target homes are social housing, lower income households and planned new housing in the area. The trial seeks to develop a viable business model for community groups to deliver rooftop solar projects in communities with fuel poor households.[12]

[12] https://www.lockleazehub.org.uk/lockleaze-loves-solar

6 Specialist cold homes advice services and referral pathway

6.1 Oversight Board: Health and Wellbeing

6.2 Context

Bristol has a strong economy and numerous cultural and natural assets, but the city faces a major challenge in the scale of inequalities that exist within it. 69,000 people in Bristol live in some of the 10% most deprived local communities in England. The city was ranked 55th in the country for the size of the inequality in employment between White British people and ethnic minorities.[13] One form in which these stark inequalities manifest is as fuel poverty, which can have lifelong adverse effects on health, learning and income.[14]

The National Institute for Health and Care Excellence (NICE) guidance (NG6) on excess winter death and the health risks associated with cold homes sets out a clear set of actions aimed at health bodies and professionals, including Health and Wellbeing Boards. The Bristol JSNA 2018 chapter on Fuel poverty adopted the full set of measures as recommendations to take forward. At the heart of this is having in place a Single Point of Contact (SPOC) specialist health and cold homes specialist advice service, with effective referral pathways from the health, voluntary and community sectors.

See Appendix E for a summary of Bristol's progress towards fulfilling the NICE guidance recommendations. Key outstanding challenges are to increase skills and capacity in the health and social care sectors to identify and refer onwards people with poor health who are most at risk from cold homes, as well as to extend and scale up the capacity and reach of specialist advice services.

Healthier Together is the Sustainability Transformation Partnership Long Term Plan 2020 – 2025 covering health care in Bristol and surrounding areas.[15] This plan provides a key opportunity for giving greater importance to and recognition of the responsibility of partners for reducing cold homes in line with the NICE guidance recommendations.

Warmer Homes, Advice and Money (WHAM) is a multi-agency partnership which provides a comprehensive service to people living in fuel poverty and financial hardship in Bristol.[16] It is funded by Bristol City Council and Bristol Energy's Fuel Good Fund. The project acts as a single point of contact for specialist energy advice.

CSE currently runs the Tenant Energy Advice (TEA) Service for Bristol City Council housing tenants. CSE's home energy advice line provides a free, local and impartial energy advice service – it is the first point of contact for a range of other CSE services delivered by trained advisors. New

[13] A Runneymede study, referenced in Bristol One City Plan
[14] Chance of a lifetime. The impact of bad housing on children's lives. Shelter 2006 pg 24
[15] Bristol, North Somerset, South Gloucestershire STPs; Avon and Wiltshire Mental Health Partnership NHS Trust; Bristol City Council; Bristol Community Health; Bristol, North Somerset, South Gloucestershire clinical Commissioning Group (CCG); North Bristol NHS Trust; North Somerset Community Partnership; North Somerset Council; One Care; Sirona care & health; South Gloucestershire Council; South Western Ambulance
[16] Centre for Sustainable Energy, Talking Money, Citizens Advice Bristol, Citizens Advice North Somerset, We Care Home Improvements, Bristol Energy Network, Bristol and North Somerset Council

partnerships enable delivery of tailored energy advice to particular interest groups. A recent new initiative is a specialist energy advice service for refugees and asylum seekers in Bristol.

These fit within an established network of advice and support agencies that provide independent, impartial advice and support across a range of areas that are vital for fuel poor households. Advisor knowledge and referral processes are crucial to make sure individuals' multiple advice needs are addressed. Robust data sharing and referral processes are also needed to make every contact count.

6.3 Planned Actions

Recommended Actions	Timeline	Status	Target / measure of progress	Who has responsibility / who can influence
Extend funding of WHAM hospital worker role to enable discharge of patients to warm home.	Funded post to 2020	Extend	Additional 1 FTE worker from 2020/2021 Reduction in 30 day re-admission rate for patients with relevant conditions [target number tbc].	BNSSG STP
Secure ring-fenced funding to prioritise investment in improving energy efficiency of homes of people with existing health conditions. This requires analysis to confirm target numbers.	2021	New	£ investment in improvements [target number tbc] homes improved of people with target conditions Reduction in 30 day re-admission [target number tbc]. Self-reported better mental health.	BNSSG STP BCC
Trial & scale-up smart safeguarding service for older people with cold-related health conditions	2022	New	Reduced number emergency admissions by safeguarding participants. [target number tbc]	Health trust / Bristol University (Sphere)/CSE / tech partner /
Public health awareness campaign tied into e.g. flu vaccination / cold weather plan / other Winter resilience planning – include WHAM/ other advice &	Input for winter 2020	Scale up	Key messages included in winter health campaigns. Increased awareness of harm to health from cold homes amongst general public & re awareness of available services. 25% increase in people referred to SPOC during/following campaign	BNSSG STP / CCGs / Trusts / WHAM/

support services in Plan				
Analysis of value of single point of contact (WHAM) and hospital discharge case worker to justify health funding & continued funding from government / ECO / other sources for expanded scheme.	Start 09/2020 Interim findings spring 2021 Final spring 2022	New	Funded evaluation of single point of contact /discharge service Qualitative evidence of benefits. Reduction in emergency admissions & GP events. £ value of savings to NHS	Bristol Health Partners CLAHRC West – funded as Applied Research Collaboration West (ARC West), CSE, WHAM, CCGs & Trusts
Development activity to secure funding for expanded service (BCC; government, ECO, redress, other existing funding sources)	09/2020	Scale up	£2.3 million secured for fuel poverty advice services in Bristol 2020 –2030 (£100/client, 23,000 clients)	CSE & partners BCC
Continue and expand delivery of year-round integrated advice services - by phone, home visit, outreach (income max, energy, repairs, measures, behaviours).	2021-2030	Scale up	23,000 fuel poor households reached by services: 2,500/yr Improved self-reported ability to keep warm / manage fuel bills / reduced worry.	CSE / ACFA / BCC / advice agencies
Joint PSR, via data sharing under Digital Economy Act 2017 between BCC, WPD, water companies to enable planning & targeting of measures & support	Already started	Scale up	Joint PSR between BCC, WPD & Wessex Water 15% increase PSR registered (against WPD PSR). All PSR customers in Bristol contacted & checked every 2 yrs Target to be defined for PSR customers in Bristol referred for & received support and/or funded measures.	WPD, Bristol & Wessex Water, BCC
Bristol social prescribing pathway mechanism to	Existing service ends	New	Target to be defined for referrals to SPOC (WHAM/ TEA) from health providers / from VCS.	CCGs / Trusts/Sirona / WHAM/The Care

generate referrals to specialist cold homes advice service.	March 2020			Forum /WRAMAS/VOSCUR
Develop Bristol-specific front line training on cold home awareness & how to make referrals to WHAM/TEA/CSE advice service – for health workers & for voluntary & community sector (VCS).	2021	New	Funding secured for development of bespoke training module, launch, promotion & support. Completion of training on rolling basis by [target number tbc] health workers/yr & [target number tbc] VCS FLWs/yr 2020 – 2030.	WRAMAS VOSCUR ACFA ?? BCC CSE / WHAM partners Thrive
Link cold homes awareness training to Thrive mental health awareness training	Set up in 2020		[target number tbc] health FLW / CVS FLWs completed both mental health awareness & cold homes awareness training.	Thrive CSE / WHAM partners BCC BNSSG STP
Build on city best practice to facilitate robust referral systems between advice services. Increase collaboration to 'Make every contact count'		Scale up	City-wide extension of referrals through adoption of common 'protocol'. Fuel poor households access holistic service provision and can access all relevant help	???

6.4 Other ongoing activities

Thrive Bristol, a ten year programme launched in 2018, aims to improve Bristolians mental health. The project covers all ages and considers mental health in its broadest sense. It focuses on prevention and early intervention and works by using public, private and third sector co-operation, leadership and resources across the city. Thrive offers collaborative training for workforces including housing officers and landlords on mental health awareness. The programme has a number of work streams that link with fuel poverty, and it supports social prescribing to Age Friendly Bristol.

Food insecurity is also a major challenge in Bristol. Where householders struggle to afford their outgoings they face the 'heat or eat' dilemma. A number of foodbanks across the city offer vital support, providing users with food, fuel vouchers and referrals to relevant advice agencies.

The Welfare Rights and Money Advice Service (WRAMAS) is a council service which takes referrals for assisted and specialist case work for individual clients to maximise their income from accessing welfare benefits, particularly disabled people and full-time carers. Talking Money and Citizens Advice provide a range of money advice services to help people struggling with debt, bills and money management. To scale up the support they provide will require further long tem funding. These and

other organisations maximise income for fuel poor households through a range of activities such as checking benefits entitlements, helping people appeal benefits decisions, helping with tariff switches, applying for discounts on utility bills, accessing essential goods/resources from charitable sources and clearing debt.

Bristol Water and Western Power Distribution (WPD) keep separate registers of their vulnerable customers in case of power or water outage but they now share Priority Service Register (PSR) data to improve services for vulnerable people and are starting to share information so that households are offered support when they need it.

First Contact Bristol was a referral service for use by frontline workers supporting older people to access different support services, including specialist energy advice. Funding for the service ends 31 March 2020. North Bristol NHS Trust have been promoting the scheme with referral postcards in A&E and on hospital wards. With the end of funding, this risks a gap in Bristol falling backwards in responding to the NICE recommendation for effective referrals.

7 Indicators and reporting

Actions within the plan and associated projects will be measured against a series of outcomes and indicators. Primary indicators will measure the overall delivery and impact of interventions being delivered by collaborating partners across Bristol. Secondary indicators will provide feedback on how effectively funded interventions are delivered.

Reporting on these indicators will be included as part of an annual progress review of this Fuel Poverty Action Plan. These are currently in draft. We would welcome suggestions on targets and how best to monitor them.

7.1 Primary indicators

Outcomes	Indicators	Baseline
Develop fuel poverty action plan in 2020	Action plan sign off by No Cold Homes steering group in 2020 Adoption / sign-off of action plan September/October 2020	No Cold Homes workshop to identify activities Nov 2019 Draft action plan produced.
Funding for fuel poverty activity	• Single point of contact service commissioned beyond 2021 and service expanded to meet needs • Funding secured from government, ECO3 or other existing grant funding schemes • Additional capital funding secured for installation of measures benefitting fuel poor homes (£20 million over lifetime of action plan) • Additional £2.3 million revenue funding secured for services supporting fuel poor households over lifetime of action plan	
Reduce the number of fuel poor homes in Bristol	Fuel poverty in Bristol (count/value/recent trend) Measured using: Annual fuel poverty statistics produced by BEIS. Mental health and wellbeing JSNA B17 - Fuel Poverty	Year: 2017 Count: 23,015 Value: 11.7 Trend:
Improve the energy efficiency of fuel poor homes in Bristol in line with national targets.	Number of measures installed against modelled target to meet EPC band C and above by 2030 (see Appendix D) to value £217 million, improving approx. 22,300 FP homes.	

	Number of fuel poor homes in • EPC bands F&G (2020) • EPC bands E to D (2025) • EPC band C and above (2030) Note: A home moved from EPC band G to EPC band C in 2020, for example, would contribute towards the 2030 target and interim milestones.	
Downward trend in the rate of excess winter death	Ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths – as single year / as 3-year aggregate Public Health Outcomes Framework E14 – Excess Winter Deaths Index	Year: 2017-2018 Number: 296 Value: 28.1%

7.2 Secondary indicators

Outcomes	Indicator(s)
Improved quality of life Quality of Life Survey Bristol	• % satisfied with the cost of heating their home (by tenure) • % satisfied with the state of repair of their home (by tenure) • % who find it difficult to manage financially
Improved health and wellbeing	• % below average mental wellbeing (Bristol Quality of Life survey) • Self-reported question (ONS Wellbeing Indicator or Warwick-Edinburgh Mental Well-Being Scale) • Symptom severity - people with existing cold-related conditions • Use of planned and emergency health services by people with existing cold-related conditions • Ability to pay bills (level of worry about paying heating bills; extent to which avoid switching on heating due to concerns about costs)
Data is shared to identify people who are vulnerable to the health problems associated with a cold home	• Energy and water utilities, suppliers, support organisations and health bodies share data to identify vulnerable people to plan city-wide services
Improved referrals by the health and social care sector and by the voluntary and community sector (VCS)	• Number of staff or volunteers completing training in awareness of cold homes (health/social care and VCS)

	• Number of trained staff reporting confidence to identify and make successful referrals to SPOC service (health/social care and VCS) • Numbers of successful referrals, broken down by referral route (health/social care and VCS)
Hospital admission rates and GP usage	Track the rates of service use for those who receive support, compared against control group and/or historical data.
Reduction in utility bills	• Reduction in energy bills, broken down by intervention (£/year) (TBC - estimated or reported). • Reduction in water bills, broken down by intervention (£/year). (TBC - estimated or reported).
Improved warmth in homes of fuel poor and vulnerable households	• Beneficiaries report improved warmth and comfort at home in winter
Income maximisation	• Number of successful referrals to income maximisation service • Amount of additional income secured per household • Reduction in fuel debt (£/hh)

7.3 Reporting progress

The No Cold Homes steering group will need to appoint responsibility for monitoring data collection and reporting by the different delivery bodies on a regular basis. Quarterly meetings will provide an opportunity to review progress.

The No Cold Homes steering group will be responsible for preparing an annual progress report to submit to the Health and Wellbeing Board. This will include collation of key indicators of progress, though it should be noted that national fuel poverty statistics are reported nationally a year in arrears. The Health and Wellbeing board will be responsible for providing overall oversight and scrutiny of progress against the target.

7.4 Supporting research

Further research will be required to support delivery of the action plan, including to understand the scale and feasibility of recommended actions, better understand the fit with One City Climate Strategy and to evaluate the impact of actions.

Appendix A List of useful documents and resources

BEIS (2016) Affordable warmth and health impact evaluation toolkit.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/512555/Affordable_Warmth___Health_Impact_Evaluation_Toolkit.pdf

Bristol City Council (2018) Bristol JSNA 2018 Fuel Poverty Chapter.
https://www.bristol.gov.uk/documents/20182/34772/Fuel+Poverty+JSNA+Chapter+%282018%29.pdf/46359d3e-74cd-524e-819f-d27c86a692ae

Bristol Open Data Quality of Life indicators
https://opendata.bristol.gov.uk/explore/dataset/quality-of-life-2018-19-citywide-trend/table/?disjunctive.ward_name

Citizens Advice and Cornwall Council (2018) Cold Homes toolkit. Local authority toolkit. Health professionals' toolkit.
https://www.citizensadvice.org.uk/about-us/how-we-provide-advice/advice-partnerships/cold-homes-toolkit/

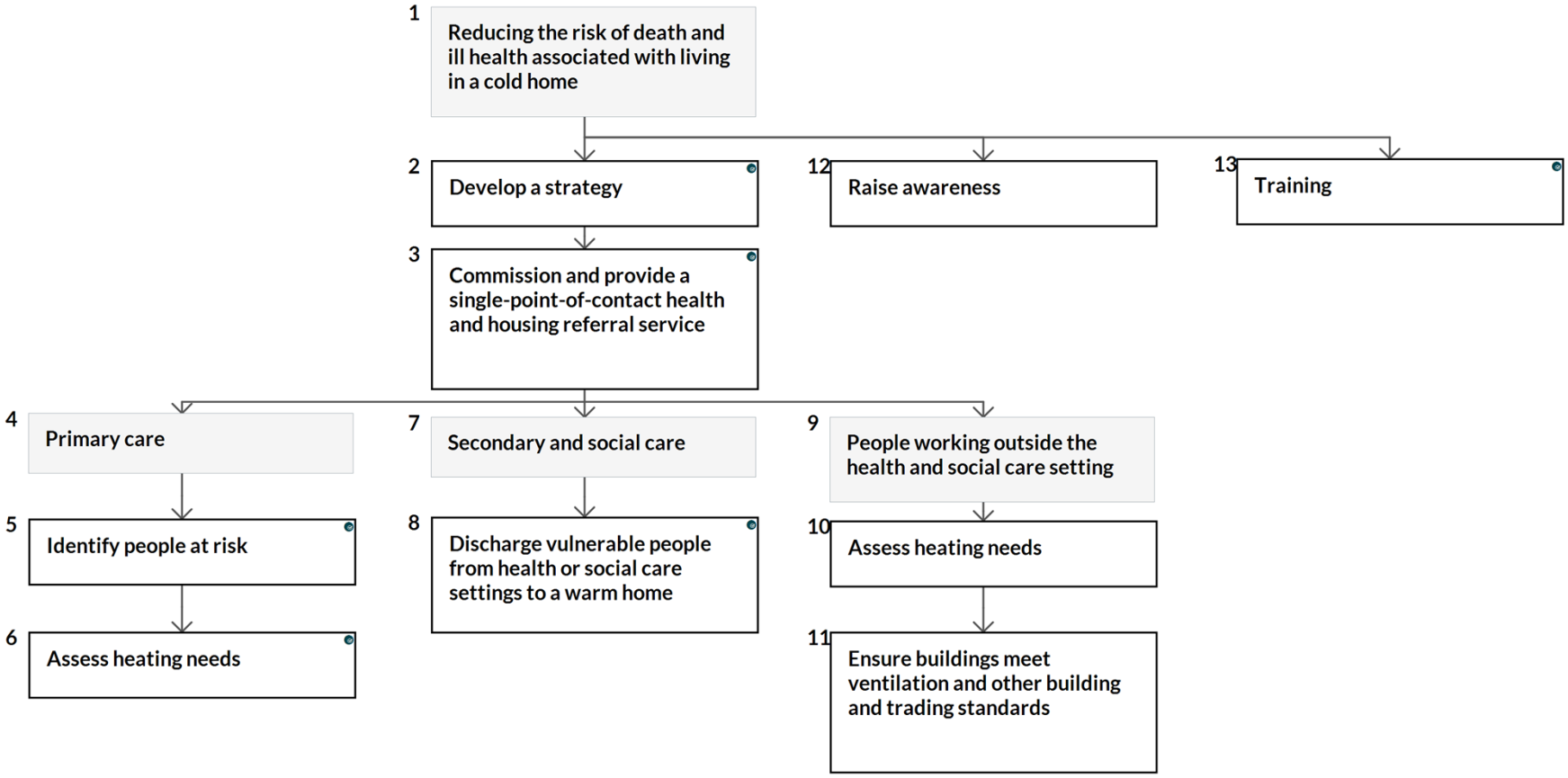
Nice Guidance (2015) NG6 'Excess winter deaths and illness and the health risks associated with cold homes'
https://www.nice.org.uk/guidance/ng6

Public Health England (2019) Helping People Living in Cold Homes. E-learning module.
https://www.e-lfh.org.uk/programmes/cold-homes/

Public Health England (PHE) (2019) Data sources to support local services tackling health risks of cold homes.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770963/data_sources_to_support_local_services_tackling_health_risks_of_cold_homes.pdf

Public Health Outcomes Framework
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Appendix B NICE Recommendations on Excess Winter Deaths and the Health Risks Associated With Cold Homes



Appendix C Glossary

Term	Definition
Bristol City Funds	*City Funds is a partnership of organisations committed to securing and directing £10 million investment funding towards solutions that target the causes and effects of inequality in Bristol.*
Bristol City Leap	*City Leap is a series of energy and infrastructure investment opportunities in Bristol to build a citywide energy system that will help decarbonise the city and improve the quality of life for people in Bristol.*
Centre for Sustainable Energy (CSE)	*Bristol based charity that deliver a range of energy advice services to residents of Bristol and England.*
Climate Emergency	*A climate emergency declaration is a statement that mandates a government or organisation to take urgent action to prevent climate change, often accompanied by emission reduction targets.*
Clinical Commissioning Group (CCG)	*Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.*
Committee on Fuel Poverty	*An advisory non-departmental public body that advises on the effectiveness of policies aimed at reducing fuel poverty in England.*
Energy Company Obligation (ECO)	*Government programme that requires energy suppliers to help lower-income households install heating and energy efficiency measures in their home to help reduce carbon emissions and tackle fuel poverty.*
Energy Performance Certificate (EPC) Energy Efficiency Rating	*When a home is built, sold or rented in the UK, it needs an Energy Performance Certificate (EPC). This includes a chart which displays the energy efficiency rating of the home. It shows how much a building will cost to heat and light, what its carbon dioxide emissions are likely to be and what improvements you can make to improve its energy efficiency. An EPC rates a property in bands from A (most efficient) to G (least efficient).*
Going for Gold	*Bristol's city wide effort to become a Gold Sustainable Food City. This is a national programme that celebrates and supports communities that are making positive changes to their food system.*
Health and Wellbeing Board	*A forum in which key leaders from the local health and care system work together to improve the health and wellbeing of their local population. Health and wellbeing boards have a statutory duty, with clinical commissioning groups (CCGs) to produce a Joint Strategic Needs Assessment.*
Healthier Together	*This is the name of the Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Partnership (STP). The Partnership has produced a Sustainability Transformation Partnership Long Term Plan 2020 – 2025 for health care in Bristol and surrounding areas. The plan covers all aspects of NHS spending in the area, covering three headline issues: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services.*

Houses of Multiple Occupation (HMOs)	*Properties rented to multiple households sharing kitchen, bathroom and toilet facilities. Multiple households refers to adults who are not related or a couple.*
Hybrid heat pump	*A combined heat pump and a gas condensing boiler create a domestic heating and hot water system. Hybrid heat pumps use a combination of gas and electricity. .*
Joint Strategic Needs Assessment (JSNA)	*The Joint Strategic Needs Assessment is used to assess the current and future healthcare and wellbeing needs of residents in a local authority. One chapter in the JSNA assesses needs relating to Fuel Poverty in Bristol.*
Local housing allowance	*The rates of housing benefit for tenants renting from private landlords who are eligible for support.*
Low Income High Cost (LIHC)	*An England-wide adopted measure of fuel poverty. It states that a household is in fuel poverty if they have above average modelled fuel costs and after spending that amount, they would have a residual income below the official poverty line.*
Low Income Low Energy Efficiency (LILEE)	*Proposed new fuel poverty definition for England. Under this definition, households will be deemed fuel poor if their disposable income (after housing and energy costs) is below the poverty line and they live in a property with an energy efficiency rating of Band D or lower. The LILEE measure would increase the number of households considered fuel poor by approximately 1 million, bringing the total number of fuel poor households in England up to over 3.6 million.*
Minimum Energy Efficiency Standards (MEES)	*Legislation that requires private rented (domestic and commercial) properties to have an EPC rating of E or higher. There is a cap of £3,500 on the amount of their own money that landlords are required to spend to improve the efficiency of a property. Enforcement of MEES is a local authority responsibility.*
National Institute for Health and Care Excellence (NICE) Guidance NG6	*This refers to guidance on 'Preventing excess winter deaths and illness associated with cold homes'. Clinical guidelines are recommendations on how healthcare and other professionals should care for people with specific conditions. NICE provides national guidance and advice to improve health and social care.*
Net Zero	*'Net zero' means that any greenhouse gas emissions are balanced by absorbing an equivalent amount from the atmosphere. Net Zero targets refer to policy targets to achieve net-zero greenhouse gases by a specific date. The UK has set a national target of Net Zero by 2050. Bristol has set itself a target of net zero by 2030.*
One City Climate Strategy	*Sets out scale of ambition and actions needed to achieve Net Zero by 2030.*
One City Plan	*A whole city plan and approach to reaching a shared vision of Bristol by focusing activity across sectors in the city.*
Single Point of Contact (SPOC)	*A person or organisation (with single contact phone number) that coordinates multiple services relating to health and housing for people at risk of living in a cold home. The creation and maintenance of a SPOC health and housing referral service is a key recommendation in NG6 to prevent harm to health from cold homes.*
Thermal imaging survey	*A survey that uses thermal imaging cameras to visually represent surface temperatures of an object.*

Thrive Bristol	*10 year programme to improve the mental health and wellbeing of everyone in Bristol, with a focus on those with the greatest needs.*
Universal Credit	*A means tested benefit replacing a number of other working age benefits in the UK. Migration to the new, online system started in 2019.*
Warmer Homes Advice and Money (WHAM)	*A multi-agency project led by CSE that provides a single point of contact (SPOC) service for cold homes support in Bristol.*
Welfare Rights And Money Advice Service (WRAMAS)	*Part of Bristol City Council, WRAMAS provides benefits and money advice, consultancy, information and training, to a range of clients, services and organisations throughout Bristol.*

Appendix D Improving the dwelling of Fuel Poor households in Bristol to EPC band C

Modelling conducted February 2020 by CSE in the National Housing Model (NHM) using a stock based on the English Housing Survey 2014. The results included here are estimates only, and should be considered indicative rather than definitive.

Table 1 shows estimates from modelling at minimum cost –with over 7000 new gas or oil combi boilers installed. **Table 2** shows estimated costs for installing air source heat pumps instead of these new boilers as part of retrofit improvements. This was done outside the NHM model. This does not include assessment of whether air source heat pumps are suitable for properties. It is only to give an indicative low-carbon cost estimate. **Table 3** shows the resulting improvements in EPC band for fuel poor dwellings.

- Modelling does not include heat networks or ground source heat pumps.
- Modelling does not include detailed assessment of suitability for solar (eg roofsize).
- Modelling does not exclude measures not suitable for properties in conversation areas.
- Modelling does not include replacement of all existing Gas Central heating in fuel poor homes.

Table 1: At minimum cost - includes install of new more efficient gas or oil combi boilers

Technology	*All urban south west fuel poor*		average.cost	Bristol scaled	
	number.of.installs	*total.cost*		bristol.number.of.installs	bristol.total.cost
Air Source Heat Pump (ASHP)	*13,907*	*86,843,000*	6,245	2,500	15,780,500
External wall insulation	*6,299*	*45,645,016*	7,246	1,100	8,294,300
Floor insulation	*31,473*	*24,896,419*	791	5,700	4,524,000
Hot Water Cylinder Insulation	*16,109*	*724,905*	45	2,900	131,700
Internal wall insulation	*30,066*	*173,454,132*	5,769	5,500	31,518,800
Loft insulation	*48,497*	*23,750,312*	490	8,800	4,315,700
Low energy lighting	*50,294*	*8,344,675*	166	9,100	1,516,300
MAINS_GAS Combi Boiler	*35,755*	*107,912,000*	3,018	6,500	19,609,000
OIL Combi Boiler	*4,898*	*20,111,700*	4,106	900	3,654,600
Secondary glazing	*447*	*577,423*	1,292	100	104,900
Solar DHW (solar thermal)	*32,194*	*144,873,000*	4,500	5,900	26,325,300
Solar Photovoltaic	*52,798*	*385,919,900*	7,309	9,600	70,126,500
Storage heater	*6,181*	*22,225,000*	3,596	1,100	4,038,600
Triple glazing	*981*	*2,679,307*	2,731	200	486,900
Wet Central Heating	*11,187*	*21,740,750*	1,943	2,000	3,950,600
All measures	***341,086***	***1,069,697,539***	**3,136**	**62,000**	**194,377,600**

(rounded to nearest million)	**£194,000,000**
Average cost/home improved	£8716

Table 2: Install Air Source Heat Pumps instead of new gas and oil combi boilers

Technology	*All urban south west fuel poor*		average.cost	Bristol scaled	
	number.of.installs	*total.cost*		bristol.number.of.installs	bristol.total.cost
Air Source Heat Pump (ASHP)	*13,907*	*86,843,000*	6,245	2,500	15,780,500
External wall insulation	*6,299*	*45,645,016*	7,246	1,100	8,294,300
Floor insulation	*31,473*	*24,896,419*	791	5,700	4,524,000
Hot Water Cylinder Insulation	*16,109*	*724,905*	45	2,900	131,700
Internal wall insulation	*30,066*	*173,454,132*	5,769	5,500	31,518,800
Loft insulation	*48,497*	*23,750,312*	490	8,800	4,315,700
Low energy lighting	*50,294*	*8,344,675*	166	9,100	1,516,300
ASHP instead of MAINS_GAS Combi Boiler	*35,755*	*107,912,000*	6,245	6,500	40,589,595
ASHP instead of OIL Combi Boiler	*4,898*	*20,111,700*	6,245	900	5,620,098
Secondary glazing	*447*	*577,423*	1,292	100	104,900
Solar DHW (solar thermal)	*32,194*	*144,873,000*	4,500	5,900	26,325,300
Solar Photovoltaic	*52,798*	*385,919,900*	7,309	9,600	70,126,500
Storage heater	*6,181*	*22,225,000*	3,596	1,100	4,038,600
Triple glazing	*981*	*2,679,307*	2,731	200	486,900
Wet Central Heating	*11,187*	*21,740,750*	1,943	2,000	3,950,600
All measures	***341,086***	***1,069,697,539***	**3,136**	**62,000**	**217,323,793**
				(rounded to nearest million)	**£217,000,000**
				Average cost/home improved	**£9745**

Table 3: Modelled resulting improvements in EPC (based on Table 1 modelling)

Bristol FP EPC profiles		
EPC band	before measures	after measures
C	720	17,860
D	12,550	3,250
E	5,330	1,340
F	3,300	570
G	1,120	0
All dwellings	23,020	23,020
Fuel Poor Dwellings improved		**22,300**

Appendix E: Summary of progress in Bristol against NICE Guidelines

*Achieved? symbols: ✓ = in delivery; ◐ = partially in delivery; X = not current being delivered. Timeframe of secured funding for activities in delivery is indicated where known.

Number	Recommendation	Achieved?	Actions
1	Develop a fuel poverty strategy	✓	This Action Plan has been produced in conjunction with the No Cold Homes Steering Group.
2	Ensure there is a single-point-of-contact (SPOC) health and housing referral service for people living in cold homes	✓	The Warm Homes and Money (WHAM) (funding to 2021) and the TEA (Tenant's Energy Advice) (funding to 2024) services enable many people to access support. WHAM will require further funding to continue beyond 2021 and to expand scope.
3	Provide tailored solutions via the single-point-of-contact health and housing referral service for people living in cold homes	✓	Six WHAM caseworkers work across multiple organisations to deliver the appropriate combination of money advice, energy, home repair and other advice and support needs, based on referrals from health, community and voluntary sector agencies.
4	Identify people at risk of ill health from living in a cold home	✓	Mapping analysis, as presented in the JSNA, to identify the scale and geography of the problem. First Contact Checklist being used for over 50s to identify people in need of support.
5	Make every contact count by assessing the heating needs of people who use primary health and home care services	◐	First Contact Bristol Checklist aims to ensure older people in access services they need, including energy advice and home improvements. This is currently only aimed at people over 50.
6	Non-health and social care workers who visit people at home should assess their heating needs	◐	First Contact Bristol is helping ensure older people are asked about relevant services they may need. This needs to be reviewed to generate more referrals and to be widened to other groups at risk of cold homes.
7	Discharge vulnerable people from health or social care settings to a warm home	◐	A WHAM caseworker rotates between discharge units at major hospitals to provide support to people being discharged to cold homes.
8	Train health and social care practitioners to help people whose homes may be too cold	✓	From 2020 WHAM to deliver training to frontline health workers in Bristol. For some workers it will be obligatory training.
9	Train housing professionals and faith and voluntary sector workers to help people whose homes may be	◐	Thrive programme to deliver joint training on mental health awareness and fuel poverty training.

	too cold for their health and wellbeing		
10	Train heating engineers, meter installers and those providing building insulation to help vulnerable people at home	X	This is not currently planned, but Bristol City Council Energy services and Futureproof could provide access to these groups. Priority activity for local action should be to: Train up heating engineers to explain how the system works in a way that occupants find easy to understand.
11	Raise awareness among practitioners and the public about how to keep warm at home	X	This is an action that should be delivered as part of cold weather planning. Advice agencies, including CSE, host and attend events throughout the year to raise awareness. This requires an online training module rolled out across the health service
12	Ensure buildings meet ventilation and other building and trading standards	X	Revised national Building Regulations are currently under review. These will increase the emphasis on ventilation.

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Bristol Health and Wellbeing Board

Title of Report:	Going for Gold / Food equality update
Author (including organisation):	Elizabeth Le Breton (BCC) Joy Carey (BFN)
Date of Board meeting:	19th August 2020
Purpose:	Oversight and assurance

1. Executive Summary

The Bristol Going for Gold programme has had to pause and adapt in light of the COVID-19 pandemic. The emergency food response and community resilience support shown during this time now demands we look at how we can adapt and develop the Going for Gold programme to ensure we 'build back better' for improved resilience and put in place key 'stepping stones' on which to develop a Bristol Good Food 2030 plan.

2. Purpose of the Paper

To update the Board on Bristol Going for Gold and to gain support to bring a Food Equality Plan to a Development Session and the Multi-Board to ensure a One City approach.

3. Background and evidence base

The Sustainable Food Places Network is a national programme that supports and celebrates communities that are making positive changes to their food system. Through this Bristol Going for Gold was launched in 2019, joining together individuals, organisations and policymakers behind a shared ambition of making Bristol a Gold Sustainable Food City by the end of 2020. There are six key '*Food Action Areas'* for collective action:

Unfortunately, COVID-19 has meant that we have had to review both our timelines and our two exemplar themes (Buying Better and Food Waste). This can be illustrated through three phases:

Phase 1: Pre-covid (the last delivery update captured by the Trello work with Marius);
Phase 2: A migration online and pause to some of the work from March 2020 followed by a review of the whole initiative to ensure it is fit for purpose going forward;
Phase 3: From September a new phase 3 to take us up to the submission deadline in Spring 2021

Since lockdown (Phase 2) a more sympathetic and COVID relevant approach was needed for the city. Rather than continue to promote taking action via the Going for Gold website, the public engagement focus became the #BristolFoodKind communications campaign. This has still been structured around the six food action areas, but focused on areas most relevant to people in lockdown spending more time at home: on urban growing, supporting a

sustainable local food economy by purchasing from local producers and reducing food waste.

This has been delivered through building awareness and providing online learning opportunities through blogs, film nights, webinars and films of our own production.

In addition, recovery in the eating-out food sector has been supported through an on-line webinar in June chaired by Cllr Craig, with a second one planned for late Summer/ Autumn.

Food equality has also been brought into clearer focus during lockdown. The collective emergency food response across the city has been immense, but has also highlighted the inequalities that communities in Bristol are experiencing in accessing good, healthy food. The shared knowledge and relationships between partners of Going for Gold greatly facilitated the emergency food response co-ordinated across the city.

To build on this work as we move into recovery, the Going for Gold 'Food Equality Action Area' it will be supporting the development of a Food Equality Action Plan. This will aim to further highlight where action is needed to address food insecurity and ensure that Bristol has a fit for purpose and diverse food future in relation to food access and affordability.

Moving into Phase 3 we hope to secure a new £5k Sustainable Food Places pilot grant for work this autumn that will enable us:

i) to maintain momentum gained over last few months and build a stronger, more connected and inclusive city-wide Bristol food movement post COVID-19;
ii) to further understand and define the characteristics and impacts of Bristol's good food movement; and
iii) to reflect on our learning from the Bristol Going for Gold approach

4. Community engagement

During lockdown, the community engagement role funded by through GfG worked closely with BCC, Feeding Bristol, FairShare and Family Action to help connect in new and existing community groups that were part of the emergency food response. There is now a need to support those groups as they plan the best way forward, and a webinar is being planned for the early Autumn.

It is anticipated that insights obtained from ongoing work in Knowle West and Inner City and East Bristol involving community consultation and engagement will inform the food equality action plan. This will be subject to practical considerations around Covid-19-secure measures for such engagement.

Findings from the BRIEF research study, led by University of Bristol, and involving key partners and community organisations involved in the Covid-19-related food response, will also inform the action plan.

Both the emergency food response and the Black Lives Matter events have again highlighted the need to ensure that Bristol's food movement is fully represented, with more

opportunities to hear from a diverse range of voices and initiatives. GfG has therefore reviewed and updated its community engagement role.

5. Recommendations

To champion a Food Equality Action Plan by having a Development Session and a Multi-Board to ensure One City approach. To see this as a key element of a wider Bristol Good Food 2030 plan which connects with the One City Plan.

6. City Benefits

Specifically in relation to food equality and diversity issues, the plan will help to identify what the issues are and how these can be tackled in partnership to help reduce food poverty in the city.

7. Financial and Legal Implications

n/a

8. Appendices

n/a