Equality Impact and Outcome Assessment (EIA) Template - 2015

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

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

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

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

1. Equality Impact and Outcomes Assessment (EIA) Template

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

Title of EIA[5]	Food Poverty Action Plan	**ID No.[6]**	
Team/Department[7]	Public Health		
Focus of EIA[8]	The Food Poverty Action Plan is one element of the food strategy for the city 'Brighton & Hove Food Strategy - Spade to Spoon: Digging Deeper - which was adopted by the Council 8th December 2012. This Strategy has nine aims, a series of key objectives and an action plan. Aim Two - *All residents have better access to nutritious, affordable, sustainable food*, includes an action to improve the understanding of food poverty in the city; establish baseline data and take forward an action plan. This Food Poverty Action Plan (FPAP) aims to; • focus the city's limited resources most effectively, • reduce the impact of food poverty on the health and wellbeing of local people, • mitigate against the likely impact of future health and social care budgets if food poverty is not addressed. It is both pragmatic and aspirational. It contains 80 actions; • Over half of these actions relate to Brighton and Hove City Council services or functions.		

	Delivery of these is achievable within current resources. • There are also other proposals where the work is being led by others, to which the Council is a partner. • Additionally, there are aspirational actions where external funding will need to be sought. This Committee is only being asked to agree to facilitate those Council actions within the plan that can be delivered within identified resources. • By its very nature it targets those population groups vulnerable to food poverty. The EIA will act as a prompt to ask for each protected characteristic group how will the FPAP work with the hardest to reach. Using research and evidence the FPAP identifies certain groups as at higher risk of food poverty; People who are most vulnerable to food poverty a. Disabled people (including people with learning disabilities) and people experiencing long term physical or mental ill health b. Large families, single parent families and families with disabled Children c. Working people on a low income, especially younger working age people d. Vulnerable adults - including some older people - who are isolated or digitally excluded – or who are experiencing transition e.g. bereavement/ becoming ill/ leaving hospital and people moving from homelessness, offending or addiction e. 16-25 year olds who are vulnerably housed and care leavers. f. BME people and migrants who have limited recourse to funds The FPAP recognises that; • Poor diet is associated with conditions such as obesity, coronary heart disease, diabetes, stroke and cancers. • Evidence demonstrates the contribution of food and nutrition to mental wellbeing and the development, prevention and management of some specific mental health problems. • Data related to premature deaths in England shows that Brighton and Hove ranks 98th worst out of 150 local authorities.

	• Cancer, liver disease and heart disease are key contributors to premature deaths (2,185 deaths under 75s). Poor diet and obesity are key factors in the causes of these deaths. [1]

[1] http://www.bhconnected.org.uk/sites/bhconnected/files/jsna/jsna-6.4.6-Good-nutrition-&-food-poverty1.pdf

2. Update on previous EIA and outcomes of previous actions

What actions did you plan last time? (List them from the previous EIA)	**What improved as a result?** What outcomes have these actions achieved?	**What <u>further</u> actions do you need to take?** (add these to the Action plan below)
No previous EIA		

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Age[13]	In 2014 in Brighton & Hove 16% of the population are aged 0-15 years, 70% aged 16-64 years and 13% aged 65 years or over. This compares to 19%, 62% and 19% in the South East and England figures of 19%, 64% and 17%. So whilst there are a lower proportion of children in the city, there are also a lower proportion of older people, giving the city a different age-structure compared to England and the South East. [1] Breastfeeding levels are the highest in the country and childhood obesity levels are below the national average (although again rates vary between more and less deprived households). Research by BHFP uncovered	The development of the FPAP included wide engagement and involvement of partners and of key stakeholders of relevance to age include; • community, voluntary and faith groups • shared meals /settings - via the survey and research project • organisations working with older people -via the research project • individual conversations were held with key stakeholders.	Whilst an affordable and nutritious diet is crucial for all ages it is especially the case for children and young people and vulnerable older population. The FPCP has identified people who are most vulnerable to food poverty which includes • Vulnerable adults - including some older people. • 16-25 year olds who are vulnerably housed & care leavers. • (Children in) large families, single parent families & families with disabled children.	The FPAP has as its second aim; Aim 2: As a bare minimum, ensure that every child, and every vulnerable adult, can eat one nutritious meal a day. This includes; • support to parents of under 5s including breastfeeding, food poverty advice and Healthy Start vouchers & vitamins • Promotion of free school meals & improving uptake. • 'holiday hunger' schemes. • Proactively considering food needs during care assessments with vulnerable older people.

[1] Office for National Statistics. Population Estimates for England and Wales, Mid-2002 to Mid-2010 Revised (Subnational). Released: 30 April 2013. Available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-280885
Office for National Statistics. Population Estimates for England and Wales, Mid-2014 (2011 Census-based). Released: 25 June 2015. Available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-368259

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	that almost half a million (462,334) shared meals take place each day, playing an important and largely uncelebrated role around food poverty. Universal Infant Free School Meals mean that at least 7,200 pupils across the city now have a healthy lunch. [1]			• Promotion of shared meals for older people especially those most isolated. • Exploring meal preparation as part of home care arrangements. • Consideration of food needs during transition times e.g. hospital discharge • Inclusion of malnutrition screening tool in care settings. • Nutrition training for residential homes • Healthy choice award in residential settings • Digital inclusion/skill s for online shopping.

[1] https://www.brighton-hove.gov.uk/content/press-release/brightonhove-best-breastfeeding http://www.hscic.gov.uk/ncmp; http://bhfood.org.uk/downloads/downloads-publications/99-eatingtogether-report-final/file

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Disability[14]	Based on national prevalence rates, there were an estimated 4,400 adults aged 18-64 years with a learning disability living in Brighton & Hove in 2011, with around 6% with a severe learning disability. In 2012/13, 768 people aged 18 to 64 with learning disabilities were known to the local authority in Brighton & Hove. In 2012/13, of the 768 people with a learning disability aged 18 to 64 living in Brighton & Hove who were known to the City Council, 600 (78%) were living in settled accommodation (where a person can reasonably be expected to stay as long as they want) and 168 (22%) were living in non-settled accommodation (where residents do not have security of tenure). [1]	The Countability research provided insight into the needs of local people with disabilities and whilst food issues were not highlighted per se delays in home adaptations which may be needed for cooking purposes were identified. Also identified were poor physical accessibility across the city and poor quality streets which may present as barriers to accessing food. [3]	Adults with learning disabilities have a higher prevalence of gastrointestinal cancer, early onset dementia, overweight, obesity and osteoporosis, as well as difficulty with eating, drinking and swallowing. One in three has unhealthy teeth and gums. Due to increasing life expectancy, people with learning disabilities are now more likely to develop long-term conditions such as diabetes. Supporting adults with learning disabilities with food choices is a key action identified in the Brighton & Hove Food Strategy. The Council's Financial	Disabled people (including Disabled people (including people with learning disabilities) and people experiencing long term physical or mental ill health are identified in the FPAP as most vulnerable to food poverty. The FPAP sets out a number of actions relevant to these groups; • 'Tackle the underlying causes of food poverty in the city' are doubly relevant for these groups for example integration of food poverty into money advice programmes. • Increasing use of free school meals for

[1] Institute of Public Care. Projecting Adults Needs and Service Information (PANSI). Available at: www.pansi.org.uk (password required) [Accessed 04/01/2012]
Health and Social Care Information Centre. ASC-CAR 2012-13 Guidance.
Emerson E, Baines S (2010). Health Inequalities and People with Learning Disabilities. Improving Health and Lives: Learning Disabilities Observatory. PPT presentation, available at: http://www.improvinghealthandlives.org.uk/uploads/doc/vid_7479_IHaL2010-3HealthInequality2010.pdf
[Accessed Jan 2011].

[3] Hastie J. Countability: Barriers and opportunities for disabled people in Brighton & Hove. The Fed. 2012.

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	Applying national figures to the local population, it is estimated that in Brighton & Hove in 2012 there were: • 13,173 people aged 18-64 with a moderate physical disability and 3,660 with a severe physical disability. Of these, 7,531 have a moderate or serious personal care disability • 122 people aged 18-64 with a serious visual impairment and 3,294 aged 65 or over with a moderate or severe visual impairment • 5,841 people aged 18-64, and 16,303 aged 65 or over, with a moderate or severe hearing impairment; and 48 people aged 18-64 and 455 aged 65 or over, with a profound hearing impairment In 2011, 980 Brighton & Hove residents were registered as Blind (630 were aged 75 or over). Of these, 145 people were recorded as having an		Inclusion Strategy also identifies disabled people (particularly those with mobility issues) as being at higher risk of financial exclusion. [1]	eligible families. Initiatives which help to alleviate food poverty including 'holiday hunger' schemes. • Vulnerable adults have their food needs automatically considered during assessments. • There is meal provision for those who need it with alternatives out of the home such as shared meals. • Explore if / how nutrition and hydration can be introduced to the checklist for Care Assessments • Develop specialised training courses and/or written 'Tip sheets' – for people in particular circumstances (and

[1] http://www.brighton-hove.gov.uk/content/council-and-democracy/equality/financial-inclusion-brighton-hove

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	additional disability (110 aged 65 or over), including 50 with physical disabilities, five with a learning disability and 35 recorded as deaf. Brighton & Hove City Council Adult Social Care provided services to 4,496 people in 2012/13, 62% of those were to people with Physical Disabilities.[1]			those who support and advise them e.g. support workers, paid carers and family/unpaid carers) • Adapting cooking to disabilities/sensory impairments (plus how to access adaptations / cooking equipment. • Include food ordering/ budgeting/ preparation in financial capability training sessions. • Also in 'getting online' training. e.g. How to set up a 'favourites list' for food shopping on-line. • Make information about shared meals more accessible via an easier search mechanism on the 'It's Local Actually' directory and by non-

[1] http://www.bhconnected.org.uk/sites/bhconnected/files/jsna/jsna-7.5.2-Adults-with-physical-&-sensory-impairments1.pdf

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				internet methods e.g. printed list /radio – promote in other settings (e.g. hospital discharge, care assessments, via GPs and other health professionals, e.g. Community Navigators).
Gender reassignment[15]	The needs assessment estimated that there are at least 2,760 trans adults living Brighton & Hove. The true figure is probably greater than this because a significant proportion of trans people do not disclose their gender identity in surveys. In addition, as Brighton & Hove is seen as inclusive, many trans people who live elsewhere visit Brighton & Hove to socialise, study and/or work. Data suggests that trans people in Brighton & Hove: • are represented in all age groups but have a younger age distribution than the overall population; • includes diverse gender	Community research conducted by the University of Brighton and Brighton & Hove LGBT Switchboard with 100+ community members identified many issues to do with accessing general services and aspects of city life. A number of recommendations are identified and one of relevance to this EIA is that all health improvement initiatives should ensure they address needs of trans people, incorporating	Trans people undergoing gender reassignment may be at higher risk of food poverty because of the need for time off work for appointments, treatment and - for those who chose – surgery. This may result in periods of unemployment and associated financial problems. The frequently reported experience of harassment may also deter people from shopping for more economical foods, in markets, for instance. Many trans people live in	The FPAP include actions for vulnerable adults as outlined above – these actions may well be relevant for some trans people undergoing gender reassignment too. For example; • Digital inclusion/skill s for online shopping. • Integration of food poverty into money advice programmes. • Adapting cooking to disabilities, plus how to access adaptations / cooking equipment. • Consideration of food needs during transition times e.g.

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	identities, including non-binary identities • are more likely to have a limiting long-term illness or disability than the overall population. • come from a diverse range of ethnic backgrounds • have diverse sexual orientations live throughout the city, with no concentration in any particular area • are more likely to live in private sector rented housing than the overall population. • Trans people are less likely to report that they are in good health and more likely to report that they have a limiting long-term illness or disability.	physical activity, smoking, mental health and wellbeing, and sexual health. Food diet and nutrition is a part of this.	the PRS housing and the range of cooking and kitchen equipment provided (e.g. access to a freezer) will also have an impact on how planned and economical shopping and cooking might be. Higher rates of limiting long term illnesses adds to this picture.	hospital discharge.
Pregnancy and maternity[16]	In Brighton & Hove, the number of live births was 3,291 in 2011, an increase of 8% from 2005 (3,035 births). In 2013 the number of births fell to below 3,000 (2,967).[1] Women in Brighton & Hove are	One of the key comments from the 2013 Big Parenting Debate was that parents feel responsible for teaching essential life skills as well as instilling good morals	Whilst an affordable and nutritious diet is crucial for all ages it is especially the case in pregnancy, during the post natal period and babies. The FPAP identifies large	The FPAP sets out a number of actions to address the needs of pregnant women and babies. Aim 2 – As a bare minimum, ensure that

[1] Office for National Statistics. Vital Statistics Tables

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	much more likely to have children at an older age than across the South East and England. There are the same number of births to mothers aged 45 + as those aged under 18 years in the city. 50% of live births in the city were within marriage, lower than in the SE or England. In 2013 the greatest proportion of babies born to mothers born outside the UK was to mothers born in Europe (18%), Middle East and Asia (6%) and Africa (5%). Ensuring women are as healthy as possible during their pregnancy is important to guarantee the best possible start in life for their child. A number of factors including deprivation and maternal health have been shown to be associated with an increase in low birth weight and infant mortality.[1]	and values via good communication and positive role-modelling. Life skills about food and cooking could be part of this and setting positive role models for food, eating and cooking starts with very young children. Food Banks have been working through Childrens Centres to support families in crisis needing 'emergency' food. The numbers of such families has been increasing.	families, single parent families and families with disabled children as at higher risk of and disproportionately impacted by food poverty. Being pregnant will be part of this picture compounded by other vulnerabilities such as unemployment, fuel poverty (needed for cooking) and housing.	every child, and every vulnerable adult, can eat one nutritious meal a day. This includes working with health Visitors, Childrens Centres, and community pharmacists to; • Breastfeeding support • food poverty advice • Healthy Start vouchers & vitamins.

[1] Department of Health: Tackling inequalities in maternal and infant health outcomes. Report of the Infant Mortality National Support Team; 2010. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122844.pdf

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Race[17]	The most recent population estimates (2011) show that 19.5% are from a BME group (compared to 12% in 2001). This is now a lower proportion than England (20.2%), but higher than the South East (14.8%). [1] Black and Minority Ethnic (BME) groups in the UK, including Gypsies and Travellers, share many of the same health and wellbeing risks and needs as the rest of the population. However, there are some key differences in risk and protective factors, incidence and prevalence of certain diseases, access to services and the resulting health and wellbeing outcomes.[2] Healthy weight: Nationally there is a correlation between obesity and ethnicity, with Black African and Black Caribbean	Local Health Counts data 2012 found that there was some difference in being a healthy weight for BME respondents (59%) and White British respondents (52%). Also in regard of fruit and veg consumption: Those of White British origin are more likely (54%) to consume five portions of fruit and veg a day than those of Black or Minority Ethnic (BME) (47%).	Access to healthy affordable foods will have an impact on dietary related conditions. Given the variations both within and between people caution needs to be used if considering ethnicity as the main explanation for these differences. Access to familiar foods and cooking equipment for migrants may also contribute to food poverty as these may also cost more.	The FPAP identifies as vulnerable to food poverty - BME people and migrants who have limited recourse to funds.

[1] ONS Neighbourhood statistics Ethnic Group (KS201EW) Census 2011 13th Jan 2013
[2] Diseases and different ethnic groups [Online].2011 Available from URL : http://www.patient.co.uk/doctor/Diseases-and-Different-Ethnic-Groups.htm. [Accessed April 2012

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	populations exhibiting the highest obesity rates amongst all ethnic minority populations, and Chinese and Bangladeshi populations the lowest. Women have a higher prevalence of obesity in every ethnic group; the gender difference is significant amongst Pakistani, Bangladeshi, and Black African populations. Similarly to the national picture, local data indicates that a higher proportion of Black or Black British (54%) or White Irish (57%) people are overweight or obese than other ethnic group. People of White Gypsy/Traveller or Other descent (32%) and of Mixed/Multiple ethnicity (33%) have lower levels of overweight or obese, but the latter has the highest level of underweight people (9%).[1] Type 2 Diabetes (NICE, 2012): In the UK, type 2 diabetes is more prevalent among people of			

[1] 53 National Obesity Observatory 2010. Demography and Health Inequalities of Obesity. http://www.noo.org.uk/NOO_about_obesity/adult_obesity/demography_inequalities [Accessed 20/08/2012].

54 NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

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	South Asian, Chinese, African–Caribbean and black African descent than among the white population. Good nutrition and food poverty: Nationally it has been identified that members of BME communities are amongst the groups most likely to experience food poverty. Local evidence suggests that White Irish people are the most likely ethnic group to eat five or more portions of fruit and vegetables a day and men of Mixed/Multiple ethnicity are least likely. [1]			
Religion or belief[18]	The city has a wide range of faiths and beliefs many of which work hard to positively engage and support their members and build their active participants. Faith organisations and groups are working better together in recognition of the similar roles they have in supporting the	The development of the FPAP included wide engagement and involvement of partners and of key stakeholders which include; • community, voluntary and faith groups • food banks - via the	Faith based organisations have a role to play in the community which is underutilised. Faith organisations may reach different groups of the public and those at risk of food poverty.	FPAP includes actions around; Holiday meal clubs for school aged children Community/shared meals for older people. Food Banks Expand the number of classes on offer in

[1] National Heart Forum. Nutrition and food poverty: a toolkit. 2004.
NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

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	wellbeing of their communities. Many welcome to those from other faiths. The interfaith event (2013) considered the role organisation have in relation to food poverty, food banks and financial inclusion amongst other topics. [1]	Food Banks network • shared meals /settings organisations working with older people • organisations working to alleviate poverty.	The use of community spaces at venues can help widen access to shared meals, or opportunities to learn cook places where people can cook and eat together. Food Banks are provided through a number of such venues.	cooking and shopping skills, for both general public and specific groups e.g. people with learning disabilities; single men; older/bereaved men ('Old Spice') and the groups identified above as at risk of food poverty including young working age people. Explore how budgeting, numeracy etc. can be embedded within cookery sessions. These may be based in faith venues. specific faith led initiatives can also be used to publicise food poverty e.g. Know my Neighbour Week' May 2016.

[1] Social Need in Brighton and Hove Inter-Faith Event. https://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Report%20of%20Inter-Faith%20Meeting%20on%20Social%20Need.%2025th%20July%202013.pdf

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Sex/Gender[19]	In 2014 there were 140,929 males and 140,147 females living in Brighton & Hove. Whilst there are more males (50.1%) than females (49.9%) in Brighton & Hove, the reverse is true of the South East (49.2% males and 50.8% females) and England (49.3% males and 50.7% females). This difference is partially attributable to the different age profile across Brighton & Hove; with fewer older people (females typically outnumber males in older age groups due to higher life expectancy) and large concentrations of younger adults where the gender breakdown is more balanced.[1] 90% of lone parent households are headed by women across the South East region and England as a whole. 88.3% in B&H. Brighton & Hove has a slightly higher proportion of male-headed lone parent	The Brighton & Hove City Tracker in 2014 asked about local people's level of concern in meeting basic living costs in the next 12 months. Almost one in four respondents (23%) agreed with the statement that they 'will have enough money in the next year to cover basic living costs including food, fuel and water'. The groups most likely to strongly disagree were women compared with men.	Lone parent households have a higher poverty rate, with approximately three-quarters of all children living in poverty in Brighton & Hove also in families headed by a lone parent. A higher proportion of women than men lead lone parent households with dependent children. This is true across England and the South East, though there are a slightly higher proportion of lone-parent male households in Brighton & Hove. This indicates that families headed by a single mother are disproportionate impacted by food poverty.	The FPAP contains actions for; • breastfeeding. • single parent families which in the 88.3% are headed by women. • It also recommends as part of Aim 3 – Brighton & Hove becomes the city that cooks and eats together' to expand the number of classes on offer in cooking and shopping skills, for both general public and specific groups e.g. single men; older/bereaved men ('Old Spice') amongst other groups. • It is the intention of the FPAP to reach those people who do not usually engage in food related work.

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[1] http://www.bhconnected.org.uk/sites/bhconnected/files/OCSI-BrightonEqualities-Report%202015-10-30%20FINAL.pdf

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	families than England and the South East, with close to 12% of families headed by a man.			
Sexual orientation[20]	Our best estimate of the number of lesbian, gay and bisexual residents is 11% to 15% of the population aged 16 years or more. This estimate draws on information collected via large scale surveys and audits conducted over the last ten years (including Count Me In Too). This is similar to two recent representative surveys conducted across Brighton & Hove (Health Counts and City Tracker), where 11% of respondents identified themselves as lesbian, gay, bi-sexual, unsure or other sexual orientation.	No information on this issue available.	There are a number of gaps in the availability of data on sexual orientation at Local Authority level in England, leading to limitations in our ability to highlight the full extent of inequalities experienced by people as a result of their sexual orientation in the local area. This will include both levels of deprivation and the risk or experience of food poverty. We can assume there is a significant ageing LGBT population some of whom will become vulnerable as they age.	The FPAP includes action for vulnerable older adults and the groups identified as at risk of food poverty. SEE ABOVE
Marriage and civil partnership[21]	In Brighton & Hove there were a total of 1,224 couples living in civil partnerships according to the Census 2011, 826 between men and 394 between women.	No information on this issue available.	Both wards also have areas with high levels of income deprivation which may increase the risk of food poverty.	The FPAP include actions for vulnerable adults and the groups identified as at risk of food poverty.

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	The LSOAs with the highest proportion of civil partnership couples are in East Brighton and Queen's Park (the wards covering the Kemptown area of Brighton). [1]			SEE ABOVE
Community Cohesion[22]	Food Banks tend to be located in areas of higher need as measured by the IMD.	Feedback from Food Bank workers indicates some people feel accepting help from Food Banks is stigmatising.		Work with the Food Banks network to raise this issue.
Other relevant groups[23]	Certain groups have more chaotic lives so planning and eating regular meals is more difficult. Eg. Homeless people and substance misusers.		Needs further consideration with targeted projects.	Fareshare provides food to charities and community groups in the city who work with some of these groups. They also encourage volunteering by the recipients of these groups/charities. Specific work with relevant services could be developed.

[1] http://www.bhconnected.org.uk/sites/bhconnected/files/OCSI-BrightonEqualities-Report%202015-10-30%20FINAL.pdf

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Cumulative impact[24]				
Assessment of overall impacts and any further recommendations[25]				
There are notable compounding effects on certain population groups of the welfare reforms and economic situation on their finances which increase the risk of food poverty.				

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

Title (of data, research or engagement)	**Date**	**Gaps in data**	**Actions to fill these gaps** (add these to the Action plan below)
BH Connected - see footnotes above for specifics.			
Priority groups identified from the following: City Tracker survey (see BHFP briefing Food poverty in Brighton and Hove Public Health's The impacts of welfare reform on residents in Brighton and Hove The Director of Public Health's report for 2015 BHFP's Report on identifying food poverty in Brighton & Hove (2013) Public Health/ BHFP's Healthy Ageing and Food (2015-pending) Feeding Britain – The report of the All-Party Parliamentary Inquiry into Hunger in the United Kingdom (2014); Walking the Breadline (2013) and follow up Below the Breadline: The relentless rise of food poverty in Britain (2014); Hungry for Change, The final report of Fabian Commission on Food and Poverty (2015)	2013-2015		
FPAP research ; **Research and evidence** A huge amount of research went into developing this plan – most importantly talking to local people and organisations. These are just some of the some key documents; **Research and evidence: Local (BHFP publications reports and research all downloadable at http://bhfood.org.uk/resources)** • BHFP overview briefing on **Food poverty in Brighton and Hove** includes data from the recent city tracker question on food and fuel poverty	**2013-2015**		

• **The Director of Public Health's report** for 2015 includes a specific chapter on food poverty • **The impacts of welfare reform on residents in Brighton and Hove** (2015) identifies the most vulnerable residents & also looks at food including coping strategies, importance of wider networks etc. • BHFP's **Eating Together: Exploring the role of lunch clubs and shared meals in Brighton & Hove** (2015) explores the 'hidden' role of shared meals in generating community resilience as well as access to nutritious food • BHFP's **Identifying Food Poverty in Brighton & Hove** looks at groups most at risk of food poverty using existing data. **Research and Evidence: National** • **Feeding Britain - The report of the All-Party Parliamentary Inquiry into Hunger in the United Kingdom** (2014) is a detailed analysis with recommendations. The development of this action plan is itself a 'Feeding Britain' pilot and will feature in the **'one year on'** report due December 2015 • **Sustainable Food Cities "Beyond the Food banks"** national campaign (NB ***Brighton and Hove is the country's only silver sustainable food city***) suggests actions to focus on with examples from **different cities;** also has a comprehensive list of **resources arranged by topic** • **Walking the Breadline** (2013) and follow up **Below the Breadline: The relentless rise of food poverty in Britain** (2014) • (Church Action on Poverty and Oxfam) provides a detailed analysis of food poverty issues • The **interim report from the Fabian Society's commission into Food and Poverty** has a range of evidence and is strong on 'trading down' and unhealthy food choices and the final report Hungry for Change is also strong on long term food poverty or 'household food insecurity' and recommends local authorities should create a food access plan (2015) • **Joseph Rowntree Foundation** has just announced new Minimum Income Standards defining 'acceptable' income for different groups in the UK			
Equalities in Brighton & Hove: Data snapshot for equalities groups across the city. Local Insight report for Brighton & Hove October 2015. Oxford Consultants for Social Inclusion (OCSI).			
ONS data - see footnotes above for specifics.			

4. Prioritised Action Plan[26]

Impact identified and group(s) affected	Action planned	Expected outcome	Measure of success	Timeframe
NB: These actions must now be transferred to service or business plans and monitored to ensure they achieve the outcomes identified.				
BME groups, especially migrants who have limited recourse to funds	BHFP to engage further with organisations working with these groups e.g. BVIE	Action Plan better reflects needs of BME people especially migrants	Addition/adaptation of the FPAP (Food Poverty Action Plan)	Focus for Year 1
Isolated/ digitally excluded Older People	BHFP to join the Citywide Connect steering group	Citywide Connect work tied in with FPAP aims	BHFP attend steering group meeting	Year 1
Disabled people & people with long term physical or mental ill health (identified as more vulnerable to food poverty)	BHFP to build on existing focus by continuing partnership working with organisations including the Fed, to ensure FPAP reflects changes to disability welfare benefits	Action Plan keeps up to date with the changing situation of disabled people	Addition/adaptation of the FPAP (Food Poverty Action Plan)	Year 2-3
Women (identified as more vulnerable to food poverty)	BHFP to engage better with Women's' Centre, in particular via food banks network	Women specific issues are better understood, and FPAP responds to the impact of new welfare benefits changes on larger families, single parent families and families with disabled children (already vulnerable)	Women's Centre engages with food banks network	Year 1-3
Young working age people (identified as more vulnerable to food poverty) Also 16-25 year olds who are vulnerably housed	BHFP and BHCC to continue to explore and gather data	Better data on these age groups and what interventions can support them	Via stakeholder meetings and ongoing BHFP development of plan. BHCC Childrens services. TBC	Year 1-3

and care leavers				

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

Lead Equality Impact Assessment officer: **Date:**

Directorate Management Team rep or Head of Service: **Date:**

Communities, Equality Team and Third Sector officer: **Date:**

Guidance end-notes

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

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

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

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

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

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

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

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

[3] EIAs are always proportionate to:

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

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

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

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

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

Do you need to complete an EIA? Consider:

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

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

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

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

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

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

This section should explain what you are assessing:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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