Health and Wellbeing SUFFOLK

Agenda Item 8

Suffolk Health and Wellbeing Board

A committee of Suffolk County Council

Report Title:	Warm Homes Healthy People update
Meeting Date:	17 November 2016
Chairman:	Councillor Tony Goldson
Board Member Lead(s):	Ian Gallin
Author:	Teresa Howarth - Principal Environmental Health Officer, East Suffolk and Suffolk Warm Homes Healthy People Manager

What is the role of the Health and Wellbeing Board in relation to this paper?

1. Warm Homes Healthy People (WHHP) is a trans-Suffolk service assisting vulnerable households living in fuel poverty, whose health could be adversely affected by living in a cold home. The service is hosted by Suffolk Coastal District Council and works in partnership with statutory, health and voluntary organisations. The outcomes impact upon the refreshed Health and Wellbeing Strategy.

Key questions for discussion:

2. The key questions for discussion are:

   a) How can the partners better integrate Warm Homes Healthy People into their programmes and embed the service within the refreshed Health and Wellbeing Strategy?

   b) How can Suffolk better meet the NICE recommended quality standards relating to vulnerable residents in cold homes?

What actions or decisions is the Board being asked to take?

3. To recognise WHHP as part of the Community Resilience cross-cutting theme within the Health and Wellbeing Strategy and encourage community teams to work with local areas to develop plans to identify and support vulnerable residents during winter.
4. Partners to commit to coming together to develop a more co-ordinated approach to winter planning involving WHHP in the development of escalation plans of clinical commissioning groups (CCGs), hospitals, social care and district and borough councils.
5. Public Health to commit to support WHHP to develop a needs assessment and evidence base to ensure effective targeting of resources.

6.	That all parts of the Suffolk system investigate how they can better identify and assess those most at risk of fuel poverty and increase the level of referrals to WHHP.

Brief summary of report

7. To review the annual report 2015/2016 and to consider how to further integrate the WHHP service to better deliver against the outcomes of the Health and Wellbeing Strategy and meet the National Institute for Clinical Excellence (NICE) guidelines on cold homes. A recent review shows Suffolk is rated Red against three of the six quality standards, Amber on two and Green on one (Public Health Review September 2016).

Main body of report

Background

8. The Warm Homes Healthy People Service was established in 2012 to deliver home based interventions to alleviate fuel poverty. The opportunity to develop this new service, to tackle fuel poverty, came about following two consecutive years' bids to the Department of Health (DoH); funds having been made available following the highlighting of the UK's excess winter death problem and the impact of cold homes on health services and people. The Excess Winter Mortality (EWM) Index for the East of England is higher than the national average for the UK.

9. WHHP was built upon an existing consortium agreement, (Suffolk Energy Action Link (SEAL) established by the District and Borough Councils in 1999), and developed into a more extensive partnership involving the statutory, voluntary and community sectors. DoH as a source of funding ceased in 2013 but the service has been able to continue to date with a combination of local authority funding, public health support and ambitious bids to other funding sources.

10. WHHP provides free home energy surveys to vulnerable households suffering fuel poverty. The survey identifies required improvements such as insulation, heating and draught proofing. The funding secured to date has enabled most measures to be installed free of charge for residents. The scheme also offers winter crisis help in the form of loaning portable heaters, arranging emergency payments to suppliers and signposting to voluntary and statutory services as appropriate. Clients are referred in by partners or households self refer, and for specific schemes targeted mail-outs are conducted. Trials have also been undertaken working in a more concentrated way with communities to identify those at risk.

Annual report 2015/16

11. The annual report is attached at Appendix 1 and gives an overview of the projects in 2015/16.

Increasing the reach of the WHHP

12. One of the biggest challenges facing the WHHP is how to identify those who would benefit from the service with those needing help often being socially and/or physically isolated, sometimes in rural areas with little or no support networks. Partners on the Health and Wellbeing Board, particularly health and social care professionals have been identified as being key to helping the WHHP reach more vulnerable people. However, the experience of the WHHP is that many professionals fail to see the link between cold homes and ill health. The challenge is how to ensure the links are made and acted upon when they are faced with a patient who would benefit from assistance.

Self-Assessment

13. The WHHP with support from Public Health has been encouraged to undertake a self-assessment against the NICE recommended quality standards relating to vulnerable residents in cold homes.

14. There are six key quality standards recommended by NICE in relation to vulnerable households who could be affected by health problems associated with cold homes. These are summarised below with their current red/amber/green (RAG) rating following the recent self-assessment.

15. The self-assessment was conducted by the WHHP project officer and approved by the Partnership which includes representation from District and Borough Councils, Suffolk County Council (Public Health and Adult and Community Services), CCG and voluntary and community sector partners such as Citizens Advice Bureaux.

    Self-Assessment Summary

    QS1 =Vulnerable local populations are identified through year-round planning by local health and social care commissioners and providers - rated AMBER. The Cold Winter plan held in Adult and Community Services co-ordinates activity with its providers and runs from November to March and a Suffolk wide Winter Escalation plan is under development. However, a multi-agency forum which involves a wider range of stakeholders including the WHHP does not currently meet year round.

    QS2 =Local health and social care commissioners and providers share data – rated RED. There is currently very limited data sharing to inform the preventative programme of works delivered by the WHHP.

    QS3 = Tailored support available with help from a local single-point-of-contact –rated Green. The WHHP provide this service.

    QS4 = Vulnerable people are asked at least once a year whether they have difficulty keeping warm at home by their primary or community healthcare or home care practitioners – rated RED. There are currently no local protocols to define and identify proactively people who are vulnerable to the health problems associated with a cold home. Similarly there are limited protocols which request front line practitioners to ask whether individuals have difficulty in keeping warm, the exception being with those partners who form part of the Homeshield programme.

QS5 = Hospitals, mental health services and social care services identify vulnerable people as part of the admission process – rated Red. WHHP do not have any evidence that any referrals are made as part of an admission process despite requests for this to be considered.

QS6= Vulnerable people have a discharge plan that includes ensuring that their home is warm enough when discharged from hospital, or a mental health or social care setting – rated AMBER. There is evidence that the HomeFirst Team and Discharge social care team, based at the hospital do ask friends/relatives/social care to ensure that heating is put on at home for when someone is discharged, however there are very low incidences of referrals to Warm Homes initiative from discharge teams/plans.

Actions/decisions recommended

16. To recognise WHHP as part of the Community Resilience cross cutting theme within the Health and Wellbeing Strategy and encourage community teams to work with local areas to develop plans to identify and support vulnerable residents during winter.
17. Partners to commit to coming together to develop a more co-ordinated approach to winter planning involving WHHP in the development of escalation plans of CCGs, hospitals, social care and district and borough councils.
18. That Public Health commits to support WHHP to develop a needs assessment and evidence base to ensure effective targeting of resources.
19. That all parts of the Suffolk system investigate how they can better identify and assess those most at risk of fuel poverty and increase the level of referrals to WHHP.

Why this action/decision is recommended

20. Whilst there is a great deal of good work undertaken as part of the WHHP partnership and they have been successful in attracting significant sums of external funding to support Suffolk wide initiatives, the NICE framework has highlighted a number of areas for improvement.
21. The implementation of the recommendations will have a positive impact on vulnerable residents living in cold homes, will help to further reduce fuel poverty in Suffolk as a whole and have a positive impact on pressures on health services.
22. The work of the WHHP also supports and contributes to the Poverty Strategy which was approved by the Health and Wellbeing Board in 2015.

Sources of further information

a) Excess winter death and illness and the health risks associated with cold homes. National Institute for Clinical Excellence March 2015 https://www.nice.org.uk/guidance/ng6

b) Marmot Review “Fair Society, Healthy Lives” http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review