NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Preventing excess winter deaths and morbidity.

Date of Quality Standards Advisory Committee post-consultation meeting:
26 November 2015

2 Introduction

The draft quality standard for preventing excess winter deaths and morbidity was made available on the NICE website for a 4-week public consultation period between 7 October and 5 November 2015. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 17 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are

those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft quality statement 1: Should this statement focus on a specific action associated with collaborative strategic or year-round planning, and should the focus be on identifying at-risk populations or individuals?

5. For draft quality statements 3, 4 and 5: These statements include reference to the assessment of risk associated with cold homes. When such assessments are undertaken, where should data on the risk of health problems associated with cold homes be held? Who should own and be responsible for this information? For example, should this form part of the GP record?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Focus:
  - The quality standard was well received but a comment was made that it is too long.
  - The title of the QS should reflect the focus (the effects of cold on at-risk groups).
  - The focus is on home temperature but there are other considerations eg; damp homes, behaviour, safe staffing at times of higher demand and using weather patterns/ forecasting to predict spikes in illnesses.
  - More focus on morbidity is needed throughout the QS.
  - Prioritising the statements might guide local implementation – statements 1 and 2 are key.
- At-risk groups:
  - These are very broad. Suggestions to add asylum seekers/recent immigrants, older people with frailty, all people with asthma, people who smoke and children aged 5-19.
  - There is no evidence that cold increases the risk in under-5s so the QS should reflect the overall impact poverty has on child health.
- Implementation:
  - The QS needs real commitment at a high level within the NHS to be successful.
  - Is there a gain in setting up the structures to implement the QS when the additional resources could be directed in other areas to benefit at-risk groups?
  - A monitoring system of at-risk individuals is necessary eg a mobile phone app.

Consultation question 2: data collection

- Should form part of an existing mechanism, such as discharge planning or QOF.
- Should be a combination of performance measures and true health outcomes to fully demonstrate the effects of the quality standards
- The quality measure should be the existence of support services for people with cold homes and the number of people the service is helping.
- A major challenge is that there is no clear denominator of the “cold home vulnerable” population measured in the same way across the country.

- Accurate and current fuel poverty data at a local level is very difficult to obtain.
- Even if the systems and structures were in place this would be a very challenging and resource intensive activity

Consultation question 3: examples from practice of implementing the NICE guideline

- There are some good examples of home improvement agencies and housing advice services working closely with hospitals, and GPs, to support home assessments and housing options advice. Some examples of these are shown at http://careandrepair-england.org.uk/home-from-hospital-initiatives/
- The services operated by local authorities such as Camden and Islington were highlighted as good examples.
- For statement 1 Leeds City Council set up a Cold Weather Plan Group in 2014, re-named Adverse Weather Group, to reflect year-round planning and to support implementation of Cold Weather Plan and Heatwave Plan.
- For statement 2 Leeds City Council is jointly commissioning the Warmth for Wellbeing Service with Clinical Commissioning Groups in Leeds.
- For statements 4 and 5 in Leeds 'Winter Wellbeing Packs' are distributed to those eligible for Home Food Baskets and those supported via 'Hospital to Home' services run by the voluntary sector. The 'Hospital to Home' schemes are aware of, and refer into (where appropriate), the Warmth for Wellbeing Service as described above.
- Middlesbrough Environment City coordinates an Affordable Warmth Partnership, which works collaboratively to deliver a Winter Warmth programme throughout winter months.
- The Department for Energy and Climate Change has published a catalogue of health and fuel poverty schemes which can be found at https://www.gov.uk/government/publications/catalogue-of-health-related-fuel-poverty-schemes.

Summary of consultation feedback by draft statement

4.1 Draft statement 1

Local health and social care commissioners and providers collaborate on year-round planning and data sharing to identify populations who are at risk of health problems associated with a cold home.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Statement:
  - Year-round planning was welcomed.
  - Suggestion to split the statement; have one focusing on population-based strategic needs assessment and strategies to meet those needs, and one on the identification of vulnerable population groups and individuals and data sharing.
  - Identification of those at risk should be prioritised.
  - Better awareness of health issues related to cold homes and arrangements for health and social care services to respond to an individual's needs are key.
  - Should refer to specific populations, eg the over 75s.
  - Data needs to be shared safely and efficiently with each organisation having a responsible named person.
  - Good data sharing is already done but needs a formal data sharing agreement.
  - Data sharing presents a major barrier to delivering programmes.
  - The QS should recommend that local areas develop local versions of the Cold Weather Plan for England.
- Measures:
  - Should include evidence of collaboration with health, social care and housing agencies.
- Audience descriptors:
  - Add housing commissioners and practitioners to the audience descriptor.
  - Data sharing needs to include partners such as housing and the third sector.
  - Clarity of who the health and social care commissioners are is needed.
- Definitions:

  - Define how information would flow through the system when data sharing between health and social care.
  - Should refer to local data on house condition.

Consultation question 2: data collection

Stakeholders made the following comments in relation to data collection:

- Providing a measure of the success of identification of patients at risk is difficult without having a clear measure of the denominator.
- Easier to measure the percentage referred to a single point of contact service.
- Potential difficulties where health and housing services wish to access health data in order to target their interventions.

Consultation question 4: Should this statement focus on a specific action associated with collaborative strategic or year-round planning, and should the focus be on identifying at-risk populations or individuals?

Stakeholders made the following comments in relation to consultation question 4:

- Specific action associated with collaborative strategic or year-round planning :
  - On-going assessment and year round planning were identified as key areas.
  - Basic level of planning needed to provide a year round plan as detailed in the Cold Weather Plan.
  - Partners need to work collaboratively to take a proactive approach to interventions to ensure the most vulnerable receive support.
  - Response depends on resources so data collection and sharing are important in ensuring action is correctly targeted.
  - Specific action of providing advice and monitoring the activity of the advice service, possibly with at risk populations, but not monitoring individuals.
- Identifying at-risk populations or individuals
  - Focus on individuals and populations with target interventions for those at-risk.
  - Focus depends on the available data to determine whether populations or individuals are targeted.

4.2 Draft statement 2

People who are at risk of health problems associated with a cold home receive tailored support with help from a local single-point-of-contact health and housing referral service.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Statement:
  - Agreement this is a key area for quality improvement.
  - Statement 1 must be successfully in place if statement 2 is to be achieved.
  - This is a complex statement with several components to be achieved.
  - Suggestion to amend the statement 'People who are at direct, or indirect risk of health problems…'
- Rationale:
  - Add integrated care, housing and finance information and advice services to the rationale.
- Measures:
  - The measures are quite limited and could be developed to assist use of the standard eg the content and quality of the support provided, whether it fully met the individuals needs. Commissioning contracts could be used as evidence.
- Audience descriptors:
  - GPs should feed into the system and be told which of their patients are at risk.
- Definitions:
  - The service should be hosted by people who can ensure that the physical heating issues can be addressed and questioned the accuracy of self-reporting.

Consultation question 2: data collection

Stakeholders made the following comments in relation to data collection:

- Morbidity needs to be measured alongside mortality, the effect on quality of life and the financial cost are often higher than mortality.

- How best to evaluate the processes and outcomes of these interventions is the subject of on-going work. The Department of Energy and Climate Change has commissioned a toolkit to support local areas in evaluation, which is due to be published in 2016.

4.3 Draft statement 3

People who are at risk of health problems associated with a cold home are asked at least once a year if they have difficulty keeping warm at home by a primary health care or home care practitioner.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Statement:
  - General agreement with this statement.
  - Key community health workers such as district nurses, health visitors, midwives and allied health professionals are key staff to undertake this role, but are not primary or home care.
  - Suggestion that voluntary sector organisations, fire and rescue and community groups should be included.
  - Suggestion to change the statement to ‘Pregnant women and new parents should be asked about difficulties in keeping their home warm at booking appointments and first home visits’.
  - How will people who do not have regular contact with health or care practitioners at their home be assessed?
  - Asking about difficulties in keeping warm could be done in a care bundle, as part of an annual over 75 check (or similar).
  - For discharge planning, assessment and action are separate statements.
- Measures:
  - The numerators and denominators would not necessarily contribute to the aims of the QS and are open to local interpretation.
  - An alternative measure would be proportion of staff attending training/ completing e-learning on the subject.
- Audience descriptors:
  - Social care should ascertain the home heating status of vulnerable individuals.

  - The requirement for all practitioners to ask if people are having difficulty keeping warm at home would need to be built into existing assessment processes eg contracts/ CQUINs.
  - A designated key worker should be responsible for asking this question.
  - Discussing how a person uses their heating can be a complicated conversation that is more appropriate to an energy advisor.
  - Action to be taken once a vulnerable person has been identified is not clear.
  - The health professional should asses how the cold will affect health conditions rather than asking the patient to do this.
- Definitions:
  - Needs a definition of primary care (GP, pharmacist, optician, dentist) and home care practitioners (presumably social care).
  - No definition of “warm enough”; is this centrally heated, a certain energy rating, or temperature controlled?
  - Annual assessment should include causes of cold homes such as defective doors, rotten windows, damp and broken or inadequate heating systems.
  - Suggestion to link this to the annual flu vaccination programme, though the at-risk populations do not completely overlap.
  - Confirm this is on an opportunistic basis, not a formal screening programme.

Consultation question 2: data collection

Stakeholders made the following comments in relation to data collection:

- The denominator may be too broad and insufficiently targeted if it is to be based on the at-risk groups listed in NICE guidance.
- Data to evidence this would require new and additional data collection and a means to share this information across service providers.
- GPs should not assess patients’ homes, the data could be collected by post by the council.

Consultation question 5: For draft quality statements 3, 4 and 5: These statements include reference to the assessment of risk associated with cold homes. When such assessments are undertaken, where should data on the risk of health problems associated with cold

homes be held? Who should own and be responsible for this information? For example, should this form part of the GP record?

Stakeholders made the following comments in relation to consultation question 5:

- Who should collect/ store this data and how:
  - Location of the data is a matter for local resolution.
  - Clinical Commissioning Groups.
  - Single point of contact 'health and housing referral service' or local authority.
  - A central data base of people at risk.
  - Local Health and Well Being boards.
  - Social care agencies or others.
  - Any health service provider record.
  - The registered GP should own the information.
  - Not part of the GP record. GPs should not be responsible for collection.
  - Significant resource implications re: data recording, ownership, monitoring etc.
  - The health record could incorporate a question on keeping warm.
  - Annual asthma review could include assessment to prevent winter mortality.
  - The challenge would be whether systems are set up for these variables to be recorded and whether that information can be easily shared.
- Acting on data / data sharing:
  - GPs owning / holding the data must ensure action is taken on cases identified.
  - GPs should feed into a database and have access to the data.
  - Information regarding children with a child protection plan should be communicated between the named social worker and GP.
  - Data collection should not be duplicated and should be shared safely.
  - Discharge plans should include winter risks and be sent to the patient's GP.
  - An issue can arise at referral to a non-health provider but this can be overcome by partnership working so that health data does not need to be shared.

4.4 Draft statement 4

People who are being discharged to their own homes from hospital, a mental health or social care setting are assessed for the risk of health problems associated with a cold home.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Statement:
  - Agreement that this is an important area for quality improvement.
  - The statement does not include those moving in and out of homelessness.
  - Statements 4 and 5 could be combined so it is clear where the risk assessment (and referral for support, where required) is incorporated in the discharge plan (as these systems are already in place), rather than a stand-alone discharge plan to ensure the home is warm enough.
  - Statements 4 and 5 suggest the assessment and action is done on discharge, but it should be done earlier in the admission.
  - Assessing all people could have resource implications, prioritisation might be needed (age, underlying condition) to make this manageable.
  - Assessing everyone is inconsistent with statement 3 where only those who are at risk are asked about keeping warm at home.
  - Unclear if this statement applies to patients in the emergency department.
  - This could be incorporated into a pre-discharge assessment with referral to a single point of contact if needed.
  - This will lead to increased time in emergency department or unnecessary admission to hospital for some patients.
- Rationale:
  - Suggestion to add under 5s to the rationale.
- Measures:
  - Readmission rates should be monitored for those living in cold / damp homes.
  - The number of referrals and action must be monitored.
  - Readmission rates are proposed as outcome measures without information about which numerator or denominator are to be used.

- Audience descriptors:
  - People should be assessed on admission so that measures can be put in place in time for discharge to prevent possible readmissions.
  - Best practice is that discharge planning should commence within 24 hours of admission.
  - It is unclear who is responsible for undertaking the assessment.
  - Difficult for a health care practitioner to be responsible for ensuring a person's home is warm enough.
- Definitions:
  - Assessment should consider the risk of cold homes, covering heating, insulation and issues such as defective doors, rotten windows etc.
- Equality and diversity:
  - Add those at risk due to safeguarding considerations and prioritising the individual rights of the child within the family unit to the equality and diversity section.

Consultation question 2: data collection

Stakeholders made the following comments in relation to data collection:

- The proposed denominator is too broad to be insufficiently targeted if the number is to be based on the at-risk groups listed.
- Needs thought about how implementation can be monitored and data collected.
- Collecting data on the number of people assessed for health risks from cold homes from institutional settings would require new and additional data collection.

4.5 Draft statement 5

People who are at risk of health problems associated with a cold home who are being discharged to their own homes from hospital, a mental health or social care setting have a discharge plan to ensure their homes are warm enough.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Statement:
  - This statement was welcomed.
  - The statement does not include those moving in and out of homelessness.
  - A plan to address problems with a cold home should be completed on admission or at pre-op for elective admissions.
  - The practicalities make implementation difficult in emergency departments, especially as many patients are homeless.
  - This will lead to increased time in emergency department or unnecessary admission to hospital for some patients.
- Measures:
  - It could be beneficial to look at the subsequent costs of readmission rates.
  - The definition of the denominator needs to be defined and could be challenging if a setting serves different localities with different definitions/eligibility criteria.
- Audience descriptors:
  - How can healthcare providers ensure patients are going to a warm house?
  - How will the discharge plan be communicated to primary care and who will monitor it after discharge?
  - Query over the action to be taken – just give information about single point of access or ensure people are going back to a warm house.
  - If a patient is identified as vulnerable who is responsible for addressing this?
  - Are clinicians responsible to ensure the heating system has been serviced and CO alarms are fitted? Who would be liable if a CO death occurred?

Consultation question 2: data collection

Stakeholders made the following comment in relation to data collection:

- If the denominator is to be based on the at-risk groups listed in NICE guidance, this may be too broad and insufficiently targeted.

5 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Training and support for front-line professionals, and the general population, is needed as they need to be aware of the impact of cold housing on health and wellbeing, be alert to home temperatures, what they can and should do to address this and identify and refer people in need of help.
- People with chronic medical conditions should be urged to have their annual reviews with their GPs well before December.
- People on medication should be urged to comply with taking their prescribed medications regularly.
- Pharmacists have a role to play in cases where medications are not being renewed.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	*Stakeholder*	Comment on	Comments
1	Royal College of General Practitioners	General	The concern is about home temperature but also should consider hot water, hot food and travel outside the home in Winter. There may be necessary advice on clothing, keeping at least one room warm, behaviour (there is a potent myth that bedrooms should be cold and the window open in all weathers), the psychological effect of a glowing source of heat and the safety of appliances.
2	British Thoracic Society	General	This quality standard seems very much about cold homes and identifying the vulnerable…. whereas there are clearly a lot of other measures to reduce risk of winter deaths - flu jabs to susceptible people etc
3	Royal College of Physicians and Surgeons of Glasgow	General	We agree that preventing excess winter deaths related to cold housing is very important and we support the plan to have a quality standard in this area. We feel that this standard is overly long and that this will take away from its application in practice. In addition, we would, while agreeing with the statements in principle, question the gain of setting up the necessary structures for such a process. The additional resources required could be directed in other areas to the benefit of this at risk group of our population.
4	British Thoracic Society	General	The focus of this is exclusively on cold but there are other issues that impact on winter mortality e.g. vaccination rates, safe staffing at times of higher demand. Using weather patterns/forecasting to predict spikes in illnesses. 1) We should encourage an explicit reference to smoking in the list of risk groups i.e. people with addictions including tobacco smoking as this has a powerful synergistic effect on the cardiorespiratory causes of death that are increased by the cold. 2) There should be reference to damp as well. Cold damp homes aggravate respiratory disease and the interaction with fuel poverty is important. Well insulated homes become damp and mouldy if they are not heated adequately.
5	NHS England	General	Although the aim is to prevent excess winter deaths and morbidity, the whole focus of the QS is on the effects of cold on those who are at risk. Should the title reflect this more accurately?
6	Public Health England	General	Some information on prioritisation of the standards might be beneficial to guide local implementation. We would suggest standards 1 and 2 would be prioritised over 3, 4 and 5, since a population needs assessment, strategy

ID	*Stakeholder*	Comment on	Comments
			and service is needed prior to identifying and referring people in need of support.
7	Royal College of General Practitioners	General	I agree with the list given of at-risk groups. Another potentially vulnerable group that it may be useful to highlight are asylum seekers/recent immigrants. Many come from more temperate climates and are not used to extremely cold weather. They are also probably less aware of how to keep their homes warm and how to seek help if their homes are too cold.
8	British Thoracic Society	General	Respiratory “at risk” individuals would include those listed but also all asthmatics and patients with airflow obstruction e.g. bronchiectasis. Cold damp homes encourage the growth of fungi to which many respiratory patients are sensitised.
9	NHS England	General	Should ‘older people with frailty’ be stated as a specific group affected by the cold.
10	NHS England	General	Looking at the evidence review we were unable to find any evidence that cold itself increases the risk in the under-5 age group. We wonder whether this means that the standards should reflect the overall impact poverty (as a precursor for reduced heating) has on child health
11	Royal College of Emergency Medicine	General	The Royal College of Emergency Medicine would like to express that whilst the aims of this quality standard are worthy, we have significant concerns regarding the practicalities: • The ‘at risk’ groups are very broad. • It is unclear if these standards are planned to apply to the Emergency Department (ED). If they are, they should be considered aspirational. Implementation would lead to the ED becoming increasingly gridlocked due to the increased number of patients unable to be discharged “safely”. Or main concerns are with Quality statement 4 & 5, which are detailed below.
12	Asthma UK	General	Asthma UK is the UK’s leading asthma charity. We support people with asthma when they need us the most and fund world-leading research to find better treatments and ultimately a cure. Our goal is to prevent asthma attacks, especially those that result in death and emergency hospitalisation.
13	Asthma UK	General	It is not just those with childhood asthma that are at risk. Asthma affects people of all ages, with 80 per cent of asthma deaths in England and Wales in 2014 occurring in the over-65s . Three quarters of people with asthma tell us that cold air is a trigger for their symptoms, so the potential impact of changes in winter planning arrangements is of huge consequence for people with asthma.
14	Bolton Council	General	When discussing children reference is made to under 5’s, those aged 5-19 need also be included due to the effects of any health issues on educational attainment

ID	*Stakeholder*	Comment on	Comments
15	Middlesbrough Environment City, Middlesbrough council	General	We feel that this draft quality standard does reflect the key areas for improvement. However, to achieve these improvements the whole of the health sector needs to be more fully engaged. Groups and organisations working at a local level within the community feel that they have attempted to engage with the NHS regarding including these standards within their affordable warmth actions but with very limited success. In order to be more successful there needs to be real commitment at a higher level within the NHS. This will ensure that there is a practical level of engagement across all organisations, leading to across the board commitment to delivering a joined up approach to reducing excess winter deaths and ensure the wider determinants are also addressed. We would suggest that policy change is needed at a high level to ensure that practitioners work collaboratively to ensure delivery of the Quality Standards.
16	Royal College of General Practitioners	General	A monitoring system of at-risk individuals is necessary and could possibly include a mobile phone app or device triggered from the home when the ambient temperature falls below 18 degrees centigrade. It is easy with today's technology.
17	Royal College of General Practitioners	General	This a helpful document looking at a difficult area where responsibility is a shared task between the person/household at risk, their wider family/friends, the Local authority-Social Services and Housing and the Health Service. Voluntary organisations, NGO's and Housing Associations may also be involved.
18	Royal College of General Practitioners	General	In general the statements are very reasonable
19	Royal College of General Practitioners	General	Colder countries with severe winter weather, e.g. Russia, Canada, do not have this problem of excess winter deaths because homes were built properly insulated and community heating is sometimes supplied. Building regulations should reflect fuel efficiency: double glazing, loft insulation and warning of low/high temperatures.
20	Royal College of General Practitioners	General	The Local Authority levies a community charge on properties within its area of responsibility: the cheaper or more difficult housing is known to them including where the problem is aggravated by poverty.
21	Royal College of General Practitioners	General	There is a need to put emphasis on annual influenza vaccination and once (non-recurrent) pneumococcal vaccination.
22	Royal College of General Practitioners	General	GPs spend increasing amounts of time writing letters to social care and other agencies in support of all kinds of needs, mainly connected with the needs of families where children or adults have some form of disability as well as degrees of poverty. This report starts to address needs at source.
23	Royal College of Physicians	General	The RCP is grateful for the opportunity to respond to the above consultation. In doing so, we have liaised with

ID	*Stakeholder*	Comment on	Comments
			the British Thoracic Society and wish to fully endorse their submission. We have also liaised with experts in our Future Hospital Programme and would like to make the following comments. (comments included under each statement)
24	Public Health England	General	I am aware that you will review the QS after publication of PHE's Cold Weather Plan for England (CWP). To assist you with this we would point out some small changes that would need to be made if your current introduction to the QS consultation is used in the final version. We have: • removed the calendar year from the title of the CWP, so that it remains extant until further notice. • amended the outdoor temperature range at which health effects start to occur to 4-8°C (from 5-8°C) to be consistent with confirmed findings of the CWP evaluation undertaken by the Policy Innovation Research Unit. This is in both the CWP and Making the Case (which is incidentally a PHE, not DH publication)
	Question 1		
25	British Thoracic Society	Question 1	The standard is primarily about the identification of patients at risk and the referral to an appropriate service and this is well reflected in the quality standards.
26	Bolton Council	Question 1	Yes, the draft quality standard accurately reflects the key areas for quality improvement however we would recommend that there is more of a focus on morbidity throughout out the document than there currently is.
27	Public Health England	Question 1	Yes, but note specific comments below.
	QUESTION 2		
28	Royal College of General Practitioners	Question 2	Yes, but not sure effective systems and structures are in place.
29	NHS England	Question 2	Collection of data relating to the proposed quality standards would need the development of new systems – not aware that these indicators are routinely reported on currently?
30	Asthma UK	Question 2	Without providing the details of the design of the systems and structures required to collect the data, it is hard to provide substantive comment. Data collection for the quality standard should form part of an existing data collection mechanism, such as discharge planning or QOF. This would ensure collecting the data would not be too time-consuming to collect for healthcare professionals, or an inconvenience for patients. It would also minimise the time and effort spent designing the 'systems and structures'.
31	Leeds City Council	Question 2	Accurate and current Fuel Poverty data at a local level is very difficult to obtain. Currently the Council's Sustainable Energy and Climate Change Team receives figures from DECC which are based on small

ID	*Stakeholder*	**Comment on**	**Comments**
			numbers and extrapolated to provide a Leeds-wide figure. Also, the DECC data is usually more than 2 years' old therefore out of date. The new "low income, high cost" definition of fuel poverty has made it more difficult to calculate the need locally, and the use of proxy measures around "low income" (e.g. based on Council tax bands, income related benefits) and "high cost" (e.g. based on SAP ratings and type of heating in the property) are being used by the Council to inform targeted, area-based work. Even if the systems and structures were in place this would be a very challenging and resource intensive activity. It would be very helpful to have the ability to collect this information and analyse, but within the current system there is not the resources, structures and incentive to support locally. Maybe this could be considered on a regional level?
32	Bolton Council	Question 2	Not currently. Some of these measures would require data sharing across several organisations that cannot currently do this for various reasons i.e. Public Health departments do not currently have access to the same data that they previously had when they were within PCTs, this is an ongoing issue and would impact work like this. Also, as GP surgeries are private business with varying databases this would also make data collection difficult.GP surgeries often have differing databases and can make data collection difficult in any one local authority.
33	Bolton Council	Question 2	Data collection should be a combination of performance measures and true health outcomes to fully demonstrate the effects of the quality standards
34	Royal College of Physicians and Surgeons of Glasgow	Question 2	We are concerned that this is too ambitious a goal. There are many important issues being addressed by health and social care services and it is important not to overload any system: the quality measure should be the existence of support services for people with cold homes and the number of people this service is helping but we do not feel it will be possible to go down to the level of individual detail in this. We are also not clear why Q5 is needed given the detail expressed here.
35	Public Health England	Question 2	Quality standards in this area are clearly important, but measuring outcomes in this area, particularly in a way that can be compared between organisations, is very difficult. A major challenge is that there is no clear denominator of the "cold home vulnerable" population measured in the same way across the country. There are proxy measures (eg Excess Winter Deaths or households in fuel poverty), which could help an authority define the size of this population, but none are really adequate on their own. Local areas are bringing together multiple sources of housing, health and demographic/socioeconomic data available to them to make their own

ID	*Stakeholder*	**Comment on**	**Comments**
			assessments.
36	Public Health England	Question 2	See notes within individual statements
	QUESTION 3		
37	British Thoracic Society	Question 3	We have no real examples from practice that underpins this particular quality standard as it is so vague. Options could include the flu vaccination uptake which in reality, in the at risk group, is as important in preventing excess winter deaths. The focus on cold is important but is clearly much harder to assess and from a medical perspective/intervention.
38	Care and Repair England	Question 3	There are some good examples where home improvement agencies and housing advice services are working closely with hospitals, and indeed GPs, to support home assessments and housing options advice which also links to the need to ensure that the home is well adapted for the person being discharged. Some practical examples of these developing partnerships are shown on our website at http://careandrepair-england.org.uk/home-from-hospital-initiatives/
39	Carbon Action Network	Question 3	We are fully supportive of the development of single-point-of-contact health and housing referral services and would direct the committee to the services operated by local authorities such as Camden and Islington.
40	Leeds City Council	Question 3	Yes – we have several examples which demonstrate that Leeds is already working towards NICE guidelines: 1) Re: statement 2 “local single point of contact”. The Council’s Office of the Director of Public Health is jointly commissioning the Warmth for Wellbeing Service with Clinical Commissioning Groups in Leeds. It was procured in partnership with colleagues leading on the Council’s carbon saving and energy efficiency strategy (Sustainable Energy & Climate Change team). The Service Specification incorporates elements of the NICE guidance e.g. vulnerable groups, requirements around “person-centred, integrated” support, referrals to external agencies/groups. 2) Re: statement 1 “local … collaboration”. The Council’s Office of the Director of Public Health set up a Cold Weather Plan Group in 2014 which was re-named as the Adverse Weather Group, to reflect year-round planning and to support implementation of Cold Weather Plan *as well as* Heatwave Plan. The membership of the Adverse Weather Group spans different Council Directorates (Public Health, Environments & Housing, Adult Social Care, Children’s Services (ad hoc)) and NHS commissioners (CCGs incl System Resilience) and NHS Providers (Leeds Community Healthcare). The Group feeds into one plan where priorities and actions from all stakeholders are included and updated. The Group

ID	*Stakeholder*	**Comment on**	**Comments**
			reports directly up to the Leeds Health Protection Board. 3) Re: statement 4/5 – Winter Wellbeing Packs distributed to those eligible for Home Food Baskets and those supported via "Hospital to Home" services run by the voluntary sector (British Red Cross, Age UK, Horsforth Live at Home). Furthermore the Hospital to Home schemes are aware of, and refer into (where appropriate), the Warmth for Wellbeing Service as described above.
41	Middlesbrough Environment City, Middlesbrough council	Question 3	Middlesbrough Environment City (MEC) through funding provided by Middlesbrough Council Public Health Department, coordinates an Affordable Warmth Partnership, which works collaboratively to deliver a Winter Warmth programme of help and support throughout the winter months. The Affordable Warmth Partnership consists of the following delivery partners: Cleveland Fire Service Age UK Teesside Volunteering Matters Middlesbrough Council's Staying Put Agency Middlesbrough Food Bank A single point of contact referral process is operated by MEC which refers clients on to any partners who can offer help and support to vulnerable people where needed. The Affordable Warmth Partners offer support in the following areas: emergency heating; boiler repairs; referral to grant funding for boiler replacement and insulation measures; benefits advice; fuel debt advice; tariff switching and energy efficiency advice; befriending services; falls advice and healthy lifestyle advice. Householders contacting MEC for advice can be referred on to any of our partners for further help in any number of areas, ensuring emergency or crises support alongside longer-term support with the wider determinants of fuel poverty and health. The UNO housing database is being used by MEC and contains details of household energy efficiency of Middlesbrough households. This information has been overlaid with local public health data about excess winter deaths, hospital admissions for COPD, influenza, pneumonia, asthma and falls. Combining these two

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			data sets has enabled us to identify key wards for targeting our Winter Warmth programme. This data is shared with all Affordable Warmth Partners to allow them to focus key elements of their Winter Programmes. The UNO housing data held is currently being extended to include some health details of the householder. This will help highlight any links between housing standards and ill health. Collecting this kind of data will also help us begin to build up a database of vulnerable people who have previous sought help from the Winter Warmth project and allow us to offer year round support and advice.
42	Public Health England	Question 3	There are many local partnerships that were delivering interventions similar to the guideline before it was published and are now cross-referencing it. DECC has published a catalogue of health and fuel poverty schemes here https://www.gov.uk/government/publications/catalogue-of-health-related-fuel-poverty-schemes
	STATEMENT 1		
43	Care and Repair England	Statement 1	We welcome all year round planning.
44	Public Health England	Statement 1	The issues contained in this statement are key areas for QI, but the statement could be clearer to make it easier to use. This statement combines two separate but related functions (year-round planning, and identifying vulnerable people) with the means to do them both, but primarily the latter (data sharing). By trying to combine so many complex issues into one statement I find it lacks clarity. Identifying vulnerable people is important, but unless this is combined with an assessment of their needs and how to meet them, it is insufficient. There is not explicit enough attention to these aspects in this statement at present. I think the focus should be on assessing needs and establishing strategies and policies to meet those needs, with identification of vulnerable people as a component of that. One possibility is to separate statement 1 into two separate statements, one which focuses on population-based strategic needs assessment and strategies to meet those needs, and one on the identification of vulnerable population groups and individuals and data sharing.

ID	*Stakeholder*	**Comment on**	**Comments**
			For the former, NICE could set a standard around components of a population needs assessment around cold homes (epidemiological, corporate and comparative and local recommendations arising from this assessment) and strategic action taken at the level of a Health and Wellbeing Board to commission services to meet those population needs identified. Population data sharing is key to this, but not the only component of such an approach. Such strategies need to be mindful of environmental and demographic changes, so that interventions such as housing retrofit also take into account mitigation of overheating in summer. Evidence of year-round strategic approaches could be published joint strategic needs assessments and health and wellbeing strategies. For the latter, consideration needs to be given to mechanisms for data-sharing at population level in order to inform assessment and planning, but also at individual level so that when at-risk people are identified they can be referred for support to other services. This second element is incorporated in later statements, but is currently a barrier to supporting people that is sufficient to have its own statement, in my view. Data sharing agreements between organisations could be used as evidence.
45	NHS England	Statement 1	Identification of those at risk should be prioritised – this could be through existing methods such as risk stratification tools, frailty screening, multi-disciplinary team discussions.
46	Royal College of Physicians and Surgeons of Glasgow	Statement 1	In our view, the key issue is better awareness of health issues related to cold homes and the importance of ensuring that health and social care services have arrangements in place to respond to an individual's need for help and advice when they have a cold home.
47	Care and Repair England	Statement 1	Work should identify at risk populations and specifically the over 75s (almost two thirds of those who die from excess winter deaths are in this age group)
48	Asthma UK	Statement 1	Future data collections need to be able to be shared across primary care, secondary care and social care in a safe and efficient manner. This may require a named person being responsible for the sharing of data in each organisation, in order to ensure that the data sharing is appropriate. However, consideration should be given to the engagement with the people the data is being collected on. The benefits of a new data collection and a change in policy will need to be articulated to the public, and the third sector has a role in advising and engaging with the public to ensure the policy change is a success. Asthma UK

ID	*Stakeholder*	Comment on	Comments
			are happy to be included in the development implementation of this work.
49	Middlesbrough Environment City, Middlesbrough council	Statement 1	Successful delivery of targeted help for the most vulnerable residents relies on good data sharing and many organisations are already collecting and sharing data during the delivery of work covered by these Quality Standards. However, there needs to be a formalised data sharing agreement in place, plus agreement over what sort of data needs to be collected, stored and shared. Having a centralised data point, together with enough resource to ensure data is accurate and up to date, will be vital in ensuring this approach is successful. Having sufficient resources, including properly resourced staff time, to achieve this in the long term will be a challenge.
50	Public Health England	Statement 1	From my experience, the greater problem arises in relation to statement 1 where health and housing services wish to access health data in order to target their interventions to those with health vulnerabilities, or to assess the size of the population at risk when undertaking needs assessments, where they wish to match housing conditions with demographic data and health data. There are a number of areas around the country who have established mechanisms to manage this.
51	Carbon Action Network	Statement 1	The experience of our members suggests that data sharing presents a major barrier to delivering programmes, with areas operating very different data sharing regimes. It would be helpful if NICE could provide national guidance on data sharing for the single points of contact recommended.
52	Carbon Action Network	Statement 1	It may be useful, as a specific action, to recommend that local areas develop local versions of the Cold Weather Plan for England. The plan is very useful as a national tool; however, a local plan would encourage the identification of named local agencies and would assist in bringing together actors at local level where that may not already be happening.
53	Care and Repair England	Statement 1	Quality measures should include evidence of collaboration with health, social care *and housing* agencies
54	Care and Repair England	Statement 1	Health, public health, social care *and housing commissioners and practitioners* need to collaborate on year round planning
55	Bolton Council	Statement 1	• The standard would benefit from some clarity of who the health and social care commissioner are, so that the document can be used in areas where vital partners are not yet engaged. • Data sharing needs to go further than health and social care and include partners such as housing and the third sector

ID	*Stakeholder*	**Comment on**	**Comments**
56	Royal College of Emergency Medicine	Statement 1	Data sharing between health and social care regarding identification of patients vulnerable to the cold – is this anticipated to resemble the child protection register on the national spine? How information would flow into and out of the system seems unclear.
57	Care and Repair England	Statement 1	We would like the statement to refer to local data on house condition such as local councils stock condition surveys and housing, health and safety rating system data
58	British Thoracic Society	Statement 1	Providing a measure of the success of identification of patients at risk is difficult without having a clear measure of the denominator. It is much easier to measure some of the other quality measure such as the percentage referred to a single point of contact referral service. A primary care physician would give better information / response as the numerators and denominators are more clearly defined.
59	Leeds City Council	Statement 1	Yes – the statement recognises year-round action is required at a number of different levels, from strategic (Health & Wellbeing Boards) to operational (health- and social care workforce). More specific guidance, however, is welcomed as to ***how*** organisations can work together *and* share data in order to target the most vulnerable groups. Recognition is needed around data sharing requirements across health and social care to enable cohesive, system-wide, planning approaches to identification and pro-active interventions to protect vulnerable people. The quality statement would benefit from specifying CCG responsibilities to address Excess Winter Deaths and cold-related illness. We felt this was an omission in the NICE Guidance. This could be included as a mandatory requirement as part of System Resilience Planning, including identification of associated resources.
	QUESTION 4		
60	British Thoracic Society	Question 4	**Question 4** For draft quality statement 1: Should this statement focus on a specific action associated with collaborative strategic or year-round planning, and should the focus be on identifying at-risk populations or individuals? We welcome the fact that on-going assessment should take place and it is about all year planning and not just the “rush” when the Department of Health / Social Services release “winter monies”. All year activities would allow appropriate opportunities to assess and intervene before the winter issues arise.

ID	*Stakeholder*	**Comment on**	**Comments**
			Taking note that the NICE quality standard has a huge social component around the cold; aspects of vaccination with pneumococcal vaccine, flu vaccine, rescue antibiotics, advice for patients, pulmonary rehabilitation are all important aspects to consider. With regards to the focus being on individuals or populations it needs to be across all, with target interventions for at risk.
61	Asthma UK	Question 4	Preventing excess winter deaths should be a year-round concern, and forward planning and awareness of the issue could help spread the burden across the year. Our research indicates that nearly two-thirds of people with asthma do not have an asthma action plan, and improved year-round basic asthma care will help reduce excess winter deaths. Many of those identified as at risk of winter mortality will also be at risk of summer mortality, so commissioners and providers should work year-round to plan for seasonal changes. Our research also indicates that cold weather is a trigger for 75 per cent of the 5.4 million people in the UK with asthma. Although it is important to target the vulnerable groups already identified (including those with childhood asthma), the impact of cold weather on groups that may not be identified as at immediate risk needs to be accounted for. Whilst recognising the importance of seasonal planning, improvements in basic asthma care (such as having a written asthma action plan) will help reduce the risk of hospital admissions. Efforts should be made to ensure everyone with asthma has an asthma action plan, and that they use it before the winter.
62	Leeds City Council	Question 4	We were uncertain as to how to read/interpret this question, it is not very clear. In relation to 'focus' – we believe it should include both. There is merit in doing targeted area-based work (e.g. to target large scale capital works funded by ECO) as well as targeting vulnerable individuals (e.g. those with a cold-related long term condition) from a primary prevention point of view – to stop vulnerable individuals becoming unwell in the first place – or secondary prevention – to manage their condition(s) better. As mentioned in our response under Question 1, more specific guidance, however, is welcomed as to ***how*** organisations can work together *and* share data in order to target the most vulnerable groups.

ID	*Stakeholder*	**Comment on**	**Comments**
63	Bolton Council	Question 4	Quality statement 1 should focus on year round planning, this has been lacking in previous years. Year round planning is essential for any excess winter morbidity and mortality plan as many of the actions need to take place long before the cold weather has set in. It would depend on the available data to whether your target at risk populations or individuals. A population approach may be used in conjunction with either of the above approaches.
64	Middlesbrough Environment City, Middlesbrough council	Question 4	We feel that the successes of the Middlesbrough Affordable Warmth Partnership indicate that a strong partnership at a local level is needed to determine what the local priorities are. A basic level of planning needs to be in place to provide a year round plan as expressed in the Cold Weather Plan. Partners need to work collaboratively to ensure a proactive approach to interventions is taken to ensure the most vulnerable are receiving adequate support. However, response and action will be determined by the available resources therefore, data collection and data sharing will play an important role in ensuring action is targeted in the right areas.
65	Royal College of Physicians and Surgeons of Glasgow	Question 4	The focus should be a specific action of providing advice and monitoring the activity of the advice service, possibly with additional work with at risk populations, but not monitoring individuals.
66	Carbon Action Network	Question 4	We believe that there is merit in identifying both at-risk populations and individuals. Our experience suggests that vulnerable households do not always cluster.
67	Public Health England	Question 4	See comments with regard to statement 1
	STATEMENT 2		
68	Carbon Action Network	Statement 2	We are fully supportive of the development of single-point-of-contact health and housing referral services.
69	Bolton Council	Statement 2	It is essential that Quality standard 1 must be successfully in place if standard 2 is to be achieved
70	NHS England	Statement 2	People who are at *direct, or indirect* risk of health problems associated with a cold home receive tailored support with help from a local single-point-of-contact health and housing referral service
71	Care and Repair England	Statement 2	In relation to the agencies that the health and housing referral agency are expected to link to, we would add integrated care, housing and finance information and advice services (as required under the Care Act)
72	Royal College of Physicians and Surgeons of Glasgow	Statement 2	It would be better to measure expected against actual contacts with the service supporting those with cold homes and looking at outcomes for those who access the service including user feedback and the usefulness

ID	*Stakeholder*	**Comment on**	**Comments**
			of the service.
73	Public Health England	Statement 2	This is also a key area for QI as this is an area of need that is not met, given the evidence on numbers of people and depth of fuel poverty, housing statistics and cold-related morbidity and mortality. However it is again a complex statement with several components for the quality statement to be achieved, involving identification of those at risk, the existence of a service, the components of that service and the way that service is navigated. This is acknowledged in the supporting text, but the quality measures provided are quite limited and could be more developed to assist use of the standard eg the content and quality of the support provided, whether it fully met the individuals needs etc. Commissioning contracts could be used as evidence. Particular points regarding these measures: *Process – proportion of people at risk who receive help* (I have simplified your suggested indicator for brevity). *Denominator – the number of people who are at risk of health problems associated with a cold home.* I think this could be a valuable indicator, but would need to be interpreted with caution as at present there is no standardised definition for either numerator or denominator, and would be locally defined based on their assessment of needs, priorities and resources. Comparing between areas or over time could be problematic on that basis. *Outcome – mortality as a consequence of cold homes.* This is not currently measured at national or local level and would be technically difficult, if not impossible, at the level of a local programme. Attributing deaths to cold is not easy because this is rarely specified on a death certificate, there are many conditions that can be precipitated or worsened by cold exposure, and there are many other potential and related causes of death in the winter (especially influenza). Estimates are made at population level using time series analyses and adjusting for other factors. Assessing mortality specifically to exposure to cold homes is even more complex, let alone attributing any reduction in mortality to an intervention. How best to evaluate the processes and outcomes of these interventions is the subject of on-going work and DECC have commissioned a toolkit to support local areas in evaluation, which is due to be published in 2016. PHE is a member of the steering group for this work. Self-reported improvements in health and wellbeing

ID	*Stakeholder*	**Comment on**	**Comments**
			using standardised tools is the most easily applied measure, but with clear limitations. There is also interest in using measures of health service use such as consultations, emergency admissions and prescriptions, but this shares many of the challenges outlined for mortality.
74	Royal College of General Practitioners	Statement 2	This would seem to be the best idea with GPs feeding in to the system and being told which of their patients are at risk. Really must be hosted by people who can ensure that the physical heating issues can be addressed. How accurate is self reporting?
75	Bolton Council	Statement 2	Morbidity needs to be measured alongside mortality, the effect on quality of life and the financial cost are often higher than mortality.
	STATEMENT 3		
76	Royal College of General Practitioners	Statement 3	Agree. Include Voluntary Sector organisations.
77	Public Health England	Statement 3	The statement would benefit from a definition of primary care (GP, pharmacist, optician, dentist) and home care practitioners (presumably social care?), as to my mind other key community health workers such as district nurses, health visitors, midwives, allied health professionals are key staff to undertake this role, but neither primary care or home care. It might be worth emphasising that this is expected on an opportunistic basis (rather than establishing a formal screening programme, which would not be appropriate when considered against National Screening Committee criteria). I note that others in contact with vulnerable people such as Fire and Rescue, voluntary and community groups are not included in this quality statement, presumably because of further challenges collecting and sharing data and/or because the aim is to achieve better engagement of health and social care practitioners. I am aware that NICE does not include statements around training in QS, but an alternative proxy measure would be proportion of staff attending training/completing e-learning on the subject.

ID	*Stakeholder*	**Comment on**	**Comments**
			The action to be taken once a vulnerable person has been identified seems not to be explicit. It is part of statement 2, but without a clear measure around the proportion of people identified and referred for help. This will depend on the availability of a service, as well as eligibility criteria. For discharge planning, assessment and action are separated into two statements
78	NHS England	Statement 3	People who are at risk of health problems associated with a cold home are asked at least once a year if they have difficulty keeping warm at home by a primary healthcare or home care practitioner. *Pregnant women and new parents should be asked about difficulties in keeping their home warm at booking appointments and first home visits.*
79	Care and Repair England	Statement 3	We welcome the plan to assess, once a year, if people need support or are at risk of health problems due to a cold home. We would like the standard to consider how people, who do not have regular contact with health or care practitioners at their home, will be assessed. (It should be noted that only 6% of older people have any connection with social service, for example) Local areas would need to demonstrate that all those at risk were being assessed working with all local agencies that come into contact with people who might potentially be at risk living in cold homes. This should involve housing and third sector agencies as well as health and social care agencies.
80	Royal College of General Practitioners	Statement 3	The idea of asking about the difficulties in keeping warm in two cases: on discharged from hospital is good and could be incorporated in a care bundle such as is used in COPD, and as part of an annual over 75 check (or similar).
81	Royal College of General Practitioners	Statement 3	I feel that ascertaining vulnerable individuals' home heating status is useful but this relates primarily to social care since it is these agencies that are best placed to take action to mitigate the effects. I am concerned that proposals could put additional burdens on GP practices in reporting at a time where they are struggling to cope.
82	NHS England	Statement 3	The requirement for all practitioners to ask once each year if patients are having difficulty keeping warm at home would need to be built into existing assessment processes. How will this be incentivised, monitored? May be a need to build into contracts/CQUINs.
83	Bolton Council	Statement	• Individuals need to have a designated key work who is responsible for asking this question

ID	*Stakeholder*	**Comment on**	**Comments**
		3	• As pointed out in the text the group is 'likely' to be in regular contact with a primary health care service. Measures need to be put in place for those who aren't as they often can be the most vulnerable • The numerators and denominators used here don't really tell us much and would not necessarily contribute to the aims of the document and are open to local interpretation • Not all assessments have to be in the home and many won't be • How a person uses their heating can be a complicated and lengthy conversation that is more appropriate to an energy advisor. Signposting and referral mechanisms need to be in place • A health professional should asses how the cold will affect health conditions rather than asking the patient to do this
84	Royal College of Emergency Medicine	Statement 3	There is no definition of what is meant by "warm enough". Does this mean centrally heated, a certain energy rating, or temperature controlled?
85	Care and Repair England	Statement 3	We would also like to see, in the annual assessment, consideration of not just heating and insulation issues but also other areas that can lead to cold homes such as defective doors, rotten windows, damp and broken or inadequate heating systems. This means that those undertaking the annual assessment need to be trained to know what to look out for and/or are aware of local services that can help with such assessments such as local home improvement agencies.
86	Royal College of General Practitioners	Statement 3	One way of doing this may be to link this assessment to the annual flu jab programme, although one has to bear in mind that the at-risk populations for both do not completely overlap.
87	Royal College of General Practitioners	Statement 3	GPs should not be asked to assess patients' cold homes. They have neither such training nor equipment and time. Social Services do have a role to play here.
88	Royal College of General Practitioners	Statement 3	I am concerned that this may be interpreted as placing a responsibility on GPs to determine the information. This would be unduly burdensome. What if the person had no contact with health? And why is it the health professional responsibility to collect the data? Could be done by post by the council.
89	Leeds City Council	Statement 3	Re; Quality Statement 3. On page 19 the proposed denominator is "The number of people who are identified as at risk of health problems associated with a cold home". If this number is to be based on the at risk groups listed in NICE guidance, this may be too broad and insufficiently targeted.
90	Public Health England	Statement 3	Data to evidence this would require new and additional data collection and a means to share this information across service providers. An indicator that would be easier to obtain would be to measure the proportion of

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			referrals to the service from different professional groups/services and feed that back to them benchmarking them against others.
	QUESTION 5		
91	Royal College of Physicians and Surgeons of Glasgow	Question 5	Where assessments of risk are undertaken their location could be a matter for local resolution. We are not sure that the GP record would be the best place to keep these: they should be available in some kind of record which is easily accessible to health and social care practitioners who might be dealing with the individual. We note the comment that mortality as a consequence of cold homes was suggested as an outcome indicator but think it would be impossible to be certain of the extent to which a cold home contributed to mortality in individuals. There are also some comments about discharge planning for people with cold homes but these appear largely to be common sense: our experience is that in periods of the year when the weather is cold the question of ensuring that the patient's home is warm for them to return to is addressed as part of discharge planning from care settings including hospitals and we do not understand why so many settings are listed as these should usually be managed in the same way.
92	Leeds City Council	Question 5	We believe GP records (health record) are the most appropriate place to hold/own this data. Most clinical recording systems have existing codes that allow this type of data to be recorded e.g. "referral made to affordable warmth scheme". Furthermore most community-based healthcare professionals have access and can input into the same system. Access by social care professionals may be fragmented and problematic, unless they are working within existing data sharing agreements. Social care may need to make separate arrangements to record this data on their systems. Clinical Commissioning Groups would be best placed to be responsible for the collation and analysis of data. Data sharing agreements should be put in place to ensure Public Health Directorates and Social Care within Local Authorities have access to aggregated data. To echo an earlier comment in Question 2, from an implementation point of view, there will be significant resource implications as a result of requirements re: data recording, ownership, monitoring, sharing etc. Locally

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			we have found it challenging to progress incentives for health- and social care professionals to record this data. Much of historic referral activity was dependent on good will and commitment of individual staff members encouraging their teams (e.g. Champions approach). To improve consistency, particularly around the recording of "assessment of risk associated with cold homes", a "top down" approach (e.g. Public Health England? NHS England?) may be required. This may take shape as a KPI which is incorporated in contracts/service agreements/incentive schemes with healthcare providers. We assume that the term "local arrangements" in Quality Statement 3 on page 18 could be in the form of such incentive schemes.
93	Bolton Council	Question 5	As many different organisations will be involved in collecting this data, and will be required to access it, GP records may not be the best place to hold the data. The data would benefit from being held in one location, this may be with so either the single point of contact 'health and housing referral service' or with the local authority. Data sharing agreement will be vital to ensure that all relevant appropriate professionals can access the information that they need to when they need to.
94	Middlesbrough Environment City, Middlesbrough council	Question 5	As stated in the answer to question 2, a centralised database is vital to ensure that adequate data on the health risks associated with cold homes is accurate, up to date and shared amongst appropriate stakeholders. However, data sharing has always proved difficult between health sector and other partners. This means that the effectiveness of a centralised database would be severely undermined unless we have an agreed data sharing protocol in place.
95	Care and Repair England	Question 5	There will need to be a central data base of people at risk. It should be for local Health and Well Being boards to ensure that the data is collected and shared across the system. It is more likely that people will have a link with health systems (a local GP) than social care systems though this will not always be the case. The important issue is that there is lead agency and a process for collecting and accessing data.
96	Royal College of General Practitioners	Question 5	This information should be available to GPs but collecting the information is most appropriately done by social care agencies or others.
97	Royal College of General Practitioners	Question 5	It would be helpful if the question about the ability to keep warm could be incorporated into the health record.
98	Carbon Action Network	Question 5	Whilst the GP record may seem an obvious place to hold data on patients' risk of health problems associated with cold homes, we would be concerned about this being a data collection exercise. The experience of our members suggests that very, very few GPs in England are engaged in this agenda. If GPs are to own and hold

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			the data they must also ensure that action is taken on cases identified. All cases identified should be referred to the single points of contact as standard, and data sharing protocols put in place to facilitate feedback.
99	British Thoracic Society	Question 5	For draft quality statements 3, 4 and 5: These statements include reference to the assessment of risk associated with cold homes. When such assessments are undertaken, where should data on the risk of health problems associated with cold homes be held? Who should own and be responsible for this information? For example, should this form part of the GP record? The GP record would seem a sensible place for this information, however it would also need to be made available to secondary care providers to enable identification of those at risk at discharge
100	NHS England	Question 5	The information should be 'owned' and held by the registered GP. For those children with a child protection plan any change in the status of the information should be communicated between the named social worker and the GP.
101	Asthma UK	Question 5	The design of the future collection of data on those at risk of winter deaths should ensure that data collection is not duplicated across agencies, and that data is shared in a safe and appropriate manner between relevant parties. Primary care is placed at the heart of communities, and is thus well placed to lead on coordinating data collection and storage. People with asthma should see their GP at least once a year for an asthma review, so an assessment to help prevent winter mortality could take place at this contact. Discharge plans do also seem an opportune time to discuss winter risks, and providing that this data is supplied to the patient's GP, it is another opportunity to help prevent excess winter mortality. Coordination of the use of records must be central to the development of this work, and embedded in any systems and structures proposed. The status of vulnerable people will be of interest to many agencies, so it is important that the use of their data is coordinated and all relevant agencies are alerted of the risk.
102	Royal College of General Practitioners	General	I am concerned that proposals could put additional burdens on GP practices in reporting at a time where they are struggling to cope. GPs should, where relevant, feed into a database and have access to the data but they should not be made responsible for collecting any**.**
103	Public Health England	Question 5	refers to sharing of individual level health data for the purposes of identifying and recording that an individual has been assessed, whether or not they have been assessed as being at risk and then referring them to other

ID	*Stakeholder*	**Comment on**	**Comments**
			(usually non-health) organisations for support. This data could be held in any health service provider record, and would not only be relevant in the GP record. The only challenge I can see is whether systems are set up for these variables to be recorded and whether that information can be easily shared between health service providers, so that multiple providers are aware of assessment and action taken for an individual. That seems to be an issue for IT system commissioners and developers. The issue seems to arise at referral to a non-health provider such as a housing service. This is overcome by partnership working so that health data does not need to be shared. All partners are aware of eligibility criteria for the service and the fact that the health care provider makes the referral is sufficient for the referral to be accepted on health grounds that do not need to be revealed.
	STATEMENT 4		
104	Leeds City Council	Statement 4	In relation to **Statements 4 and 5**, we felt these could be amalgamated so it is clear where the risk assessment (and referral for support, where required) is incorporated in the discharge plan (as these systems are already in place), rather than a stand-alone discharge plan to ensure the home is warm enough.

ID	*Stakeholder*	Comment on	Comments
105	Public Health England	Statement 4	Another important area for QI, although I am less clear why aspects of discharge planning are in separate statements, whilst in other areas they are combined. The framing of the statements also might suggest the assessment and any action ensuing is done on discharge, when it should be done earlier in the admission to avoid delayed discharge, although that point is made later in the detail**.** Assessing <u>all</u> people to be discharged from hospital, mental health and social care settings to their own homes, could have resource implications, and a degree of prioritisation might be needed (age, underlying condition) to make this manageable. It is not entirely consistent with the proposed expectation in community settings that only those who might be at risk are asked about keeping warm at home. Collecting data on the number of people assessed for health risks from cold homes from institutional settings would require new and additional data collection, but might not be as challenging as the indicator for statement 3 as fewer services involved. Regarding outcome measures, readmission rates are proposed without information about which numerator or denominator are to be used. Given there are a number of factors that could influence readmission (including whether and when any action was taken after discharge), this needs further elaboration.
106	Royal College of Emergency Medicine	Statement 4	"An assessment at discharge (at any time of the year) of vulnerability to the cold at home can lead to their needs being addressed and prevent avoidable illness." Assessment before discharge – it is unclear if this also applies to patients in the ED. Given the range of people included in the at risk groups this is completely aspirational in any ED, and inability to take action would make the assessment redundant.
107	Royal College of Emergency Medicine	Statement 4	Does all the discharge planning only pertain to those admitted to an inpatient base (including an observation or clinical decision unit), or does it include sending home patients attending an ED? If a patient identified as at risk attends the ED when it is cold, does this mean they should be kept in the ED or admitted?
108	NHS England	Statement 4	Being at risk of cold at home, for example in people who are frail, [*under 5 years old*] or have long-term health conditions, can lead to existing conditions getting worse and cause new illnesses.

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109	Bolton Council	Statement 4	• Patients should be assessed on admission so that measures can be put in place in plenty of time for discharge to prevent possible readmissions • Readmission rates should be monitored for those living in cold and/or damp homes • Number of referrals and subsequent action must be monitored
110	Royal College of Physicians	Statement 4	Within the rationale for this quality statement it states: 'Risks are increased in people who spend significant amounts of their time at home. An assessment at discharge (at any time of the year) of vulnerability to the cold at home can lead to their needs being addressed and prevent avoidable illness.' Our experts have considered the above rationale with regard to patients on hospital admission pathways. We do not believe that 'assessment at discharge" is the correct focal point for these patients. The recommendation should be structured to encourage staff, patients, or carers to communicate any information about inadequate housing or heating to the responsible clinical team at the point of admission to hospital. Further to this, the hospital team should be seeking to build a complete picture of any housing or heating problems, identified on admission, within 24 hours. By doing this, the hospital team have an opportunity to address housing or heating problems early in admission and incorporate this into the patients discharge plan. Best practice is that discharge planning should commence within 24 hours of admission. As stands, the recommendation appears to imply that assessment might be postponed until day of discharge. We would recommend a re-wording as any such postponement could result in the patient spending an extended time in hospital – when their acute illness has been treated and they could otherwise have returned home. Our experts note that it is not clear who is responsible for undertaking the assessment. This is likely to be multi-disciplinary but it would be helpful to have a lead identified in the recommendation, perhaps a therapist. It is also unclear, once an assessment in hospital has identified a patient as being vulnerable to the cold at home, as to which team or staff are responsible for addressing this and whether they are community or hospital based. This should be made clarified with some pointers towards which staff should take the lead in different

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			situations and when social services should be involved. The responsible staff identified should be available 7 days a week More than one department or set of staff may be involved in addressing an inadequate or cold housing issue and we would strongly recommend that some illustrative case studies are included to show what best practice is with regard to minimum delay to discharge from hospital.
111	British Thoracic Society	Statement 4	It would be very difficult as part of a planned discharge for a health care practitioner to be responsible for ensuring a person's home is warm enough. I think asking a question about it, could be incorporated as part of an assessment prior to discharge and if necessary referral to a single point of contact could work.
112	Care and Repair England	Statement 4	We welcome the proposal for an assessment for discharge from hospital that considers the risk of cold homes and would want this assessment to cover heating, insulation and the state of the home including issues such as defective doors, rotten windows, damp homes etc... We also suggest that, given there may be some remedial action to take and some delay in putting this into place that the assessment should begin at admission.
113	NHS England	Statement 4	Equality and diversity considerations: *There also needs to be a comment about protecting those who are at risk due to safeguarding considerations (adults and children), and to prioritising the individual rights of the child within their family unit.*
114	Leeds City Council	Statement 4	Re: Quality Statement 4 (page 23). Proposed denominator is "the number of people being discharged to their own homes from hospital / mental health setting / social care setting". If this number is to be based on the at risk groups listed in NICE guidance, this may be too broad and insufficiently targeted.
115	NHS England	Statement 4	Important quality standard but again – needs some thought about implementation – how this can be monitored and data collected.
116	Royal College of General Practitioners	Statement 4	This is a year-round problem. There can be significant problems around high temperatures in summer for the same vulnerable groups.
	STATEMENT 5		
117	Royal College of Emergency Medicine	Statement 5	The quality standard states it covers all populations at risk of effects of the cold, including those who move in and out of homelessness, but then the document focuses on assessing patients being discharged to their own

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			home. The homeless do not seem to feature.
118	Bolton Council	Statement 5	• Again, any plan to address problems with a cold home is better to be completed on admission or at pre op for elective admissions • Could be beneficial to look at the subsequent costs of readmission rates
119	Royal College of Emergency Medicine	Statement 5	"Patients discharged from hospital have a discharge plan to ensure their homes are warm enough" As above the practicalities of this make implementation (if desired) highly difficult in the ED, especially due to many of our patients being homeless. The ED would be unable to discharge patients in the winter and would grind to a halt.
120	Royal College of Emergency Medicine		The standard is expected to contribute to improvements in timely discharge, however we have concerns that in reality implementation will lead to increased time in hospital for patients. If we do the suggested questions about the ability to keep warm at home, and find that a patient is at risk, is the recommendation to 1) simply give information about single point of access and tell them to keep warm, or 2) are clinicians obliged to ensure that they are going back to a warm house? If a patient has no relatives that can light or switch on the fire or central heating, please provide guidance on how healthcare providers can ensure patients leaving the dept are going back to a warm house, including expectations placed on social services. If clinicians are obliged to insist on patients having the central heating on, is there a responsibility placed on clinicians to also ensure the heating system has been recently serviced and CO alarms are fitted? Who would be liable if our insistence of the heating is on if a CO death occurs?
121	NHS England	Statement 5	As above, but how will the plan be communicated to primary care, who will monitor the plan after discharge?
122	Public Health England	Statement 5	Another important area for QI, although I am less clear why aspects of discharge planning are in separate statements, whilst in other areas they are combined. The framing of the statements also might suggest the assessment and any action ensuing is done on discharge, when it should be done earlier in the admission to avoid delayed discharge, although that point is made later in the detail**.** Assessing <u>all</u> people to be discharged from hospital, mental health and social care settings to their own homes,

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			could have resource implications, and a degree of prioritisation might be needed (age, underlying condition) to make this manageable. It is not entirely consistent with the proposed expectation in community settings that only those who might be at risk are asked about keeping warm at home. Collecting data on the number of people assessed for health risks from cold homes from institutional settings would require new and additional data collection, but might not be as challenging as the indicator for statement 3 as fewer services involved. Regarding outcome measures, readmission rates are proposed without information about which numerator or denominator are to be used. Given there are a number of factors that could influence readmission (including whether and when any action was taken after discharge), this needs further elaboration.
123	Leeds City Council	Statement 5	In relation to **Statements 4 and 5**, we felt these could be amalgamated so it is clear where the risk assessment (and referral for support, where required) is incorporated in the discharge plan (as these systems are already in place), rather than a stand-alone discharge plan to ensure the home is warm enough.
124	Public Health England	Statement 5	See points in statement 4. For the process measures, the definition of the denominator would need to be clearly defined and could be challenging if a hospital/mental health or social care setting serves different localities with different definitions/eligibility criteria (see point made in statement 2).
125	Leeds City Council	Statement 5	Re: Quality Statement 5 (page 28). If denominator is to be based on the at risk groups listed in NICE guidance, this may be too broad and insufficiently targeted.
126	Royal College of General Practitioners	Statement 5	The GP record is a useful place to store information but it needs to be shared, updated and regular audit of interventions made.
127	Care and Repair England	Statement 5	We also welcome the proposal that the discharge plan will also address whether a person's home is warm enough and would emphasise the points made in relation to Quality Statement 4 above that this should consider the state of the home in terms of repairs and improvements as well as heating systems and insulation.
	ADDITIONAL AREAS		
128	Care and Repair England	Additional areas	One area for consideration is the need for training and support to ensure that the annual assessments are both robust and helpful and meet the need to reduce the impact of cold homes and excess winter deaths. Local

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			collaboration will be needed to ensure that the process for undertaking assessments is fit for purpose.
129	Leeds City Council	Additional areas	Although we appreciate that training is not usually included in quality standards, the requirement for key staff groups (especially in health and social care where a 'call to action' is required) to understand the impact of cold housing on health and wellbeing, what staff can and should do to address this, underpins any quality improvement we seek on improved collaboration and data sharing.
130	Royal College of Physicians and Surgeons of Glasgow	Additional areas	One of the challenges with this is that there is a large number of people at potential risk of cold homes, and a large number of conditions which could be associated with cold homes - but all of these conditions have multiple other causes. This is our main reason for suggesting education of the general population, and specifically health and social care staff, about the risk associated with cold homes, and for monitoring services available to help, but not trying to go down to individual level monitoring of people at risk from a cold home.
131	Public Health England	Additional areas	I am aware that NICE does not include statements around training in QS, but an alternative proxy measure would be proportion of staff attending training/completing e-learning on the subject.
132	Royal College of General Practitioners	Additional areas	People with chronic medical conditions should be urged to have their annual reviews with their GPs well before December.
133	Royal College of General Practitioners	Additional areas	People on medication should be urged to comply with taking their prescribed medications regularly.
134	Royal College of General Practitioners	Additional areas	Pharmacists have a role to play in cases where medications are not being renewed.
	No substantive comments		
135	The Chartered Society of Physiotherapy		We have no capacity to respond to the specific questions. We are in agreement with this quality standard and will support our members in implementing the standards relevant to physiotherapy.
136	Royal College of Paediatrics and Child Health		Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the draft preventing excess winter deaths and morbidity consultation. We have not received any responses for this consultation.
137	Royal College of Nursing		This is just to inform you that the Royal College of Nursing has no comments to submit to inform on the above quality standard consultation at this time.
138	Department of Health		Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.

Registered stakeholders who submitted comments at consultation

- Asthma UK
- Bolton Council
- British Thoracic Society
- Carbon Action Network
- Care and Repair England
- Department of Health
- Leeds City Council
- Middlesbrough Environment City, Middlesbrough council
- NHS England
- Public Health England
- Royal College of Emergency Medicine
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Royal College of Physicians and Surgeons of Glasgow
- The Chartered Society of Physiotherapy