NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards

Briefing paper

Quality standard topic: Winter deaths: preventing excess winter deaths

Output: Prioritised quality improvement areas for development.

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for winter deaths: preventing excess winter deaths. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Excess winter deaths and morbidity and the health risks associated with cold homes NICE guideline NG6 (2015).

2 Overview

2.1 Focus of quality standard

This quality standard will cover the prevention of excess winter deaths. The quality standard covers everyone, however some groups are more vulnerable to the effects of cold, including:

- people with cardiovascular conditions
- people with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma)
- people with mental health conditions
- people with disabilities
- older people (65 and older)
- households with young children (from newborn to age 5)
- pregnant women
- people on a low income
- people who are homeless

- people with addictions.

The prevention and management of influenza is not covered by this quality standard because an influenza quality standard will be produced.

2.2 Definition

Almost all causes of death show some variation with season. Overall, the death rate is higher during winter months and these deaths are referred to as 'excess winter deaths'. In the UK, these figures are based on death rates from the beginning of December to the end of March.

2.3 Incidence

Public Health England's 2014 Cold Weather Plan notes that winter weather has a direct effect on the incidence of heart attack, stroke, respiratory disease, flu, falls and injuries and hypothermia. Indirect effects include mental health problems such as depression, and the risk of carbon monoxide poisoning if boilers, cooking and heating appliances are poorly maintained or poorly ventilated.

Most excess winter deaths and illnesses are usually caused by respiratory and cardiovascular problems during normal winter temperatures, when the mean outdoor temperature drops below 5–8°C[1]. The risk of death and illness increases as the temperature falls further. However, because there are many more relatively 'warm' winter days than days of extreme cold, most cold-related ill-health and death occurs during these milder periods.

The number of excess winter deaths varies from year to year. The latest 5 year moving average for England and Wales (2009/10 to 2013/14) was 25,114[2].

Housing conditions

The death rate rises about 2.8% for every degree Celsius drop in the external temperature for those in the coldest 10% of homes. This compares with a 0.9% rise in deaths for every degree Celsius drop in the warmest 10% of homes[3]. It is estimated that excess winter deaths in the coldest 25% of homes are almost 3 times as high as in the warmest 25% of homes[4].

International comparisons show lower rates of excess winter deaths in countries where homes are more energy-efficient. Several factors also influence whether someone finds themselves living in a cold home. These include:

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[1] Making the case Department of Health
[2] Statistical bulletin: excess winter mortality in England and Wales, 2013/14 Office for National Statistics
[3] Cold comfort Joseph Rowntree Foundation
[4] The health impacts of cold homes and fuel poverty The Marmot review team

- heating system efficiency
- how well the home is insulated
- whether the person can afford to heat their home
- a person's vulnerability to the effects of cold.

Keeping homes warm: Standard Assessment Procedure ratings

The Standard Assessment Procedure (SAP) is the methodology used by the Government to assess and compare the energy and environmental performance of dwellings. The SAP rating of housing across England varies considerably. In 2012 the average was 59 (out of 100). The proportion of energy‑efficient housing (above 69) increased from 2% in 1996 to 18% in 2012. Around 2 million properties (9% of housing) had a SAP of less than 30.

SAP scores vary according to the type of construction, level of insulation and type of heating system and its associated costs. Housing with insulated cavity walls, insulation to walls and roofs and central heating tend to have higher scores. Properties reliant on traditional forms of electric heating may have a lower SAP score. Older properties tend to have lower SAP scores as they are generally less well insulated. The lowest rating is for pre‑1919 homes, which have a mean score of 41 and the highest is for post‑1980 homes which have a mean score of 63.

Average SAPs in the social sector are generally higher (around 60) but lower in the owner‑occupied sector (around 50) and the private rented sector (around 45).

Homes are given an energy efficiency rating based on the SAP score as detailed below[5]:

Band	Rating points
A	92-100 SAP points (most efficient)
B	81-91 SAP points
C	69-80 SAP points
D	55-68 SAP points
E	39-54 SAP points
F	21-38 SAP points
G	1-20 SAP points (least efficient)

[5] Energy Key

Vulnerable groups and affordability of heating

A 2010 study by the Centre for Sustainable Energy[6] identified groups that found it difficult to pay for adequate heating. On average households use only around two-thirds of the energy they actually need to stay warm enough at home; people on low incomes are more likely to use less heating. People who cannot afford to heat their home are likely to be under stress, for instance from being forced to live in the only heated room, or they may need to choose between heating and food or other commodities or risk falling into debt.

In England, spending a high proportion of income on fuel tends to be associated with a low income rather than high heating needs. This pattern of expenditure tends to be associated more closely with some groups, such as single parents.

A 2010 survey by the Centre for Sustainable Energy[7] found that people living on less than 60% of the national median income had difficulty paying their fuel bills. During the previous winter 46% had cut back on heating and 63% had lived in homes that were colder than they wanted them to be; 47% said the cold had made them feel anxious or depressed, and 30% said an existing health problem had worsened.

People who spend a larger part of their time at home are particularly vulnerable to cold homes, increasing both the likely cost of heating and their potential exposure to an inadequately heated home.

Excess winter deaths are more common among, but are not confined to, older people. In 2013/14[8]:

- 51% of cold-related deaths were among people aged 85 and older
- 27% were among those aged between 75 and 84

Fuel poverty

Fuel poverty relates to a household's ability to pay for adequate heating.[9] Fuel poverty is measured in England using the 'low income high cost' indicator – a household is said to be 'fuel poor' if its members are living below the official poverty line and have higher than average energy costs.

[6] Understanding fuel expenditure: fuel poverty and spending on fuel, Centre for Sustainable Energy
[7] You just have to get by, Centre for Sustainable Energy
[8] Statistical bulletin: excess winter mortality in England and Wales, 2013/14 Office for National Statistics
[9] Getting the measure of fuel poverty Department of Energy and Climate Change 2012

A previous definition, still in use in Wales, Scotland and Northern Ireland, is that someone is in fuel poverty if they need to spend more than 10% of their income on domestic energy bills to keep their home warm enough.

2.4 Initiatives to reduce winter deaths

Cold Weather Plan

Since 2011, Public Health England has published an annual Cold Weather Plan for England (see appendix 1). It aims to prevent the major avoidable effects on health during periods of cold weather in England by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately, emphasising the need for year round planning.

It recommends a series of steps to reduce the risks to health from cold weather for:

- the NHS, local authorities, social care, and other public agencies
- professionals working with people at risk
- individuals, local communities and voluntary groups

The Warm Homes, Healthy People[10] fund was announced by the Department of Health with the publication of the Cold Weather Plan to support the implementation of the plan in winter 2011/2012 by making £20 million available to local authorities and their partners.

In 2014 the Department of Energy and Climate Change set out draft regulations[11] to create a new fuel poverty target to ensure that as many fuel poor homes as possible achieve a minimum energy efficiency rating of band C by 2030.

Improving energy efficiency in the home

The Green Deal, introduced in 2012, allows a household to make energy efficiency improvements to their home, such as insulation, double glazing and heating upgrades. The scheme allows households to pay for some or all of the improvements over time through additional costs on their energy bill. Repayments are no more than the amount a typical household should save in energy costs.

The Energy Company Obligation, introduced at the beginning of 2013, operates alongside the Green Deal. It places a legal obligation on the main energy suppliers to deliver subsidised energy efficiency improvements to low income households to enable them to heat their homes to a comfortable thermal level.

[10] Warm Homes, Healthy People Fund 2011/12: a mixed methods evaluation V.Madden, C. Carmichael, C. Petrokofsky, V. Murray, 2013
[11] Cutting the cost of keeping warm Department of Energy and Climate Change 2014

Helping households with their energy costs

The Warm Home Discount Scheme was introduced in 2011, requiring energy companies with over 250,000 domestic customers to give a discount on electricity bills to low income and vulnerable customers. The scheme assists around two million households each year and the Government has extended the scheme to 2015/16.

The Big Energy Saving Network, launched in 2013, awards funding to eligible community and charitable organisations that help vulnerable consumers actively save money on their energy bills by switching suppliers and taking up offers of energy efficiency programmes.

Winter Fuel Payment

The Winter Fuel Payment is an annual tax-free, non-means-tested payment designed to help those over state pension age pay household heating costs. Payments are made during winter when fuel bills tend to be at their highest.

Local initiatives

Initiatives are in place in many local areas to improve energy efficiency in homes, support local residents to reduce the price of their fuel bills, support residents who are vulnerable to the cold and improve access to existing support.

2.5 National Outcome Frameworks

Table 1 shows the outcomes, overarching indicators and improvement areas from the public health outcomes framework that the quality standard could contribute to achieving.

Table 1 **Public health outcomes framework for England, 2013–2016**

<table>
<tr><th>Domain</th><th>Objectives and indicators</th></tr>
<tr><td>1 Improving the wider determinants of health</td><td>Objective
Improvements against wider factors which affect health and wellbeing and health inequalities
Indicators
1.17 Fuel poverty</td></tr>
<tr><td>4 Healthcare public health and preventing premature mortality</td><td>Objective
Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities
Indicators
4.1 Infant mortality* (NHSOF 1.6i)
4.3 Mortality rate from causes considered preventable ** (NHSOF 1a)
4.15 Excess winter deaths</td></tr>
<tr><td colspan="2">Alignment across the health and social care system
* Indicator shared with the NHS Outcomes Framework.
** Complimentary indicators in the NHS Outcomes Framework</td></tr>
</table>

3 Summary of suggestions

3.1 Responses

Twelve stakeholders responded to the 2-week engagement exercise, 1-17 April 2015.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have summarised in table 2 for further consideration by the Committee.

NHS England's patient safety division did not submit any data for this topic.

Full details of all the suggestions provided are given in appendix 2.

Table 2 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Local service coordination • Local coordination of services • Cold homes reflected in joint strategic needs assessment • Single point of contact	BC SCM LCC
Identification • Identification of those at risk • Identifying risk as part of holistic geriatric assessment • Identifying the effects of housing conditions	BC Foundations SCMs BGS/RCP RCPCH
Referral • Referral to single point of contact • GP records and referrals • Direct referrals from GPs to Home Improvement Agencies • Referral incentives	SCMs BC Foundations LCC
Interventions • Early intervention • Accessible advice and support • Discharge process • Heating grants	Foundations BGS/RCP HBH LCC SCM

Suggested area for improvement	Stakeholders
Additional areas • Respiratory conditions • Pneumococcal vaccinations • Flu vaccinations • Smoking cessation • Falls • Social isolation • Age-friendly housing designs • Prompt evidence based treatment • Training	BTS NHSE Pfizer BGS/RCP RDASH SCMs
Bolton Council (BC) British Geriatrics Society (BGS) British Thoracic Society (BTS) Foundations Healthwatch Brighton and Hove (HBH) Leeds City Council (LCC) NHS England (NHSE) Pfizer Ltd Rotherham Doncaster & South Humber NHS Trust (RDASH) Royal College of Nursing (RCN) Royal College of Paediatrics and Child Health (RCPCH) Royal College of Physicians (RCP) 4 SCMs	

4 Suggested improvement areas

4.1 Local service coordination

4.1.1 Summary of suggestions

Local coordination of key services

A stakeholder noted the need for partnership working by key local services including local authority public health and social services departments, the NHS, housing agencies, social care providers and the voluntary sector.

Cold homes reflected in joint strategic needs assessment

A stakeholder highlighted the need for the health consequences of cold homes to be reflected in joint strategic needs assessments and associated strategy, adding that describing how best to achieve improvements in heating and insulation should underpin such a strategy.

Single point of contact

A stakeholder suggested the importance of having a single point of referral for members of the public, front line staff and volunteers. They stated it would be unreasonable to expect workers to know all of the potential referral options for different affordable warmth related issues and to expect them to undertake complicated referral procedures. They felt that not having a simple referral mechanism would act as a barrier against directing people towards assistance.

A stakeholder suggested that there has been very limited commissioning to date by Health and Wellbeing Boards of the sorts of service which NICE recommends (recommendations 2 and 3 which relate to single point of contact referral services and tailored solutions). The stakeholder commented that providing a clear standard for that commissioning would help ensure that commissioning practice is well-informed and efficiencies are maximised.

4.1.2 Selected recommendations from development source

Table 3 below presents recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 3 to help inform the Committee’s discussion.

Table 3 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Local coordination of key services	**Excess winter deaths and morbidity and the health risks associated with cold homes** NICE NG6 recommendation 1
Cold homes reflected in joint strategic needs assessment	**Excess winter deaths and morbidity and the health risks associated with cold homes** NICE NG6 recommendation 1
Single point of contact	**Excess winter deaths and morbidity and the health risks associated with cold homes** NICE NG6 recommendation 2

Local coordination of key services

NICE NG6 relevant section of recommendation 1: Develop a strategy

Health and wellbeing boards should:

- Ensure planning includes identifying relevant local interventions and providers from all sectors (such as relevant local authority departments, the health sector, utilities, housing organisations and organisations in the voluntary sector).

Cold homes reflected in joint strategic needs assessment

NICE NG6 relevant section of recommendation 1: Develop a strategy

Health and wellbeing boards should:

- Include the health consequences of living in a cold home in the joint strategic needs assessment.

Single point of contact

NICE NG6 recommendation 2: Ensure there is a single-point-of-contact health and housing referral service for people living in cold homes

Health and wellbeing boards should:

- Ensure a local single-point-of-contact health and housing referral service is commissioned (see recommendation 3) to help vulnerable people who live in cold homes. A wide range of people are vulnerable to the cold. This is either because of: a medical condition, such as heart disease; a disability that, for instance, stops people moving around to keep warm, or makes them more likely to develop chest infections; or personal circumstances, such as being unable to afford to keep warm enough. In this guideline, the term vulnerable refers to a number of different groups including:

    - people with cardiovascular conditions
    - people with respiratory conditions (in particular, chronic obstructive pulmonary disease
    - and childhood asthma)
    - people with mental health conditions
    - people with disabilities
    - older people (65 and older)
    - households with young children (from new-born to school age)
    - pregnant women
    - people on a low income.

- Ensure anyone who comes into contact with vulnerable groups is able to refer people to the referral service. This includes: health and social care practitioners, fire prevention and safety services personnel and workers from charities and voluntary organisations, such as advice agencies.

- Ensure the referral service links with relevant national and local services that can provide a range of solutions. These are likely to include: health and social care providers, local housing providers, advice agencies (such as Citizens Advice Bureaux and money advice organisations), health and social care charities, voluntary organisations and home improvement agencies.

- Ensure the referral service:

    - Takes account of existing services.
    - Involves face-to-face contact, if necessary, with the person using the service, their families and their carers.

- Works with the person and their carers to identify problems caused by living in a cold home and the possible solutions.
- Makes it clear to the person and their carer what actions are planned (or taking place) and coordinates activities to minimise disruption in the home.
- Encourages self-referrals using a free phone number.
- Monitors and evaluates the impact of actions taken and gives feedback to the practitioner or agency that originally referred the person.

4.1.3 Current UK practice

Local coordination of key services

An independent survey[12] to evaluate the effectiveness of The Warm Homes, Healthy People Fund in 2011/12 found that, as a result of the fund, local authority leads felt that partnership working had improved very much (56%), moderately (19%) or very little (15%), with no responses to the 'not at all' category. Only 9% of the local authority leads who responded stated that partnership working had not improved because relationships were already strong.

There are many local initiatives to prevent winter deaths, however these vary by area and there is no specific model being used everywhere. One example is the Oxfordshire Warm Homes Healthy People Project[13] which began in 2011 and involves collaboration between a range of organisations, including a number of district councils, Age UK, Citizens Advice Oxford and NHS Buckinghamshire and Oxford.

Between December 2012 and April 2013, by partnership working, the project:

- engaged with approximately 770 people through the affordable warmth advice service.
- carried out 717 benefit checks resulting in increased income for 461, totalling approximately £922,000 per year and provided support for an estimated 580 people as 311emergency fuel bill payments were distributed.
- obtained grants for refurbishment work for 72 vulnerable households.

[12] Warm Homes, Healthy People Fund 2011/12: a mixed methods evaluation V.Madden, C. Carmichael, C. Petrokofsky, V. Murray, 2013
[13] Local action on health inequalities: Fuel poverty and cold home-related problems Public Health England 2014

Cold homes reflected in joint strategic needs assessment

No specific current practice identified.

Single point of contact

The Seasonal Health Intervention Network (SHINE)[14] is a single point of referral system offering advice and support to Islington residents, established in December 2010. Over 200 organisations refer clients into the team who then make contact and assess the client for around 30 possible interventions helping people with issues including health, energy efficiency, general housing quality, income and social isolation. The team also offers support with fuel debt, assisting residents with trust fund applications and negotiating payment plans with energy companies.

By April 2014[15] the SHINE Hub had handled over 6,250 referrals leading to 28,500 specific seasonal health interventions. Around 80% of referrals received are from the key priority groups: those aged over 65; people with respiratory or cardiovascular diseases; and low income families with children aged under 5. Client-reported outcomes are positive and an estimated £600,000 annually is saved by SHINE clients. This figure is based on energy efficiency improvements such as boiler replacements and smaller measures as well as energy bill discounts. SHINE has assisted council service delivery by providing a single point of referral for a wide range of interventions, and bringing together a wide range of previously disparate services across the statutory and voluntary sectors.

SHINE is nationally and internationally recognised and is known for innovative approaches to seasonal health issues[16].

[14] SHINE referral system Islington Borough Council
[15] SHINE project on fuel poverty and excess winter deaths case study Climate Just 2014
[16] Report on Islington's award winning Seasonal Health Interventions Network (SHINE) Project Right 2 Fuel UK 2014

4.2 Identification

4.2.1 Summary of suggestions

Identification of those at risk

Stakeholders highlighted the importance of early identification of those at risk of excess winter mortality and morbidity: identification in community settings, primary, secondary and tertiary care. A stakeholder suggested that in community settings, including homes, this could be done by frontline staff visiting homes or by pharmacists.

A stakeholder commented that in primary care GPs are ideally placed to identify at risk patients reducing mortality and morbidity. A stakeholder commented that in secondary and tertiary care elective, non-elective and A&E attendances may be due to an unhealthy home environment or behaviour in cold weather. A stakeholder felt there is a need to probe on 'cold impact' issues when a patient presents to primary, secondary or social care.

A stakeholder highlighted the need to effectively identify and target assistance to those most at risk from excess winter deaths as recent changes in the definition and research into fuel poverty leaves no clear method for targeting the fuel poor groups most affected by excess winter deaths.

A stakeholder highlighted the difficulty families of disabled children face in coping with winter fuel costs, food costs and other essential expenditure.

A stakeholder highlighted the need to incorporate a cold impact assessment into all first-line encounters in the home.

Identifying risk as part of holistic geriatric assessment

A stakeholder suggested that for older people identified through primary care risk stratification (or those supported by primary, community, secondary or social care services to live with long term conditions, or coming into contact with them) holistic comprehensive geriatric assessment should include opportunistically asking about heating, fuel poverty and housing.

Identifying the effects of housing conditions

A stakeholder highlighted the need to identify the effects of types of housing condition on excess winter deaths and methods for improvement. The stakeholder suggested a strong association between numbers of excess winter deaths and detrimental housing conditions.

A stakeholder suggested that morbidity caused by cold/damp homes should be addressed at a young age to reduce the probability of future mortality.

4.2.2 Selected recommendations from development source

Table 4 below presents recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 3 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Identification of those at risk	**Excess winter deaths and morbidity and the health risks associated with cold homes** NICE NG6 recommendations 4, 5, 6 and 7
Identifying risk as part of holistic geriatric assessment	**Excess winter deaths and morbidity and the health risks associated with cold homes** NICE NG6 recommendations 5 and 7
Identifying the effects of housing conditions	**Excess winter deaths and morbidity and the health risks associated with cold homes** NICE NG6 recommendation 12

Identification of those at risk

NICE NG6 recommendation 4: Identify people at risk of ill health from living in a cold home

Primary health and home care practitioners should:

- In collaboration with relevant local authority departments, use existing data, professional contacts and knowledge to identify people who live in cold or hard-to-heat homes. This includes people who are particularly vulnerable to the cold (see recommendation 5).
- Include this information in the person's records and use it (with their consent) to assess their risk and take action, if necessary (see recommendations 2 and 3).
- Ensure data sharing issues are addressed so that people at risk can be identified.

NICE NG6 recommendation 5: Make every contact count by assessing the heating needs of people who use primary health and home care services

Primary health and home care practitioners should:

- At least once a year, assess the heating needs of people who use their services, whether during a home visit or elsewhere, taking into account the needs of groups who are vulnerable to the cold.

- Use their time with people to assess whether they (or another member of the household) are experiencing (or are likely to experience) difficulties keeping their home warm enough.

- Be aware that living in a cold home may have a greater effect on people who have to spend longer than an average amount of time at home. This could include those with chronic health conditions (including terminal illnesses) or disabilities.

- Be aware that people may not want to admit they are having difficulties paying for heating and may try to hide this. (For instance, they might only put the heating on when expecting a scheduled home visit.)

- Give people at risk, and their carers, information about how living in a cold home can affect their health. They should also tell them about services that can help and refer them if necessary. Ensure recipients can understand and act on the information they are given.

- If a cold home is a risk to someone's health and wellbeing, assess the likely effect and identify how the situation could be improved. Make sure relevant services are aware who will take action and when. This could include:

    - referral to the local health and housing service

    - referral to a health service (for instance, to ensure the person is offered flu vaccinations at the start of the winter).

- Record assessments and actions in the person's notes or care plans. Make this information available to other practitioners, while respecting confidentiality.

NICE NG6 recommendation 6: Non-health and social care workers who visit people at home should assess their heating needs

People who do not work in health and social care services but who visit people at home should:

- Refer anyone who needs help with the problems of living in a cold home to the local single-point-of-contact health and housing referral service, if they give their consent (see recommendations 2 and 3).

- Give people who may be vulnerable to the cold information on the effect that living in a cold home can have on their health and what can be done to remedy this.

NICE NG6 relevant section of recommendation 7: Discharge vulnerable people from health or social care settings to a warm home

Those responsible for arranging and helping with someone's discharge from a health or social care setting should:

- Assess whether the person is likely to be vulnerable to the cold and if action is needed to make their home warm enough for them to return to. This assessment should take place at any time of the year, not just during colder weather, and well before they are due to be discharged to allow time for remedial action. For instance, it could take place soon after admission or when planning a booked admission.

Identifying risk as part of holistic geriatric assessment

NICE NG6 recommendation 5: Make every contact count by assessing the heating needs of people who use primary health and home care services

See above.

NICE NG6 recommendation 7: Discharge vulnerable people from health or social care settings to a warm home

See above.

Identifying the effects of housing conditions

NICE NG6 relevant section of recommendation 12: Ensure buildings meet the ventilation and other building and trading standards

- Use existing powers to identify housing (particularly in the private rented sector) that may expose vulnerable residents to the cold. Existing powers fall under both the housing health and safety rating system and trading standards legislation (in relation to energy performance certificates).

4.2.3 Current UK practice

Identification of those at risk

The Warm Homes, Healthy People Fund 2011/12 was implemented by the Department of Health to support the implementation of the Cold Weather Plan by making £20 million available to local authorities and their partners.

An independent survey[17] to evaluate the effectiveness of the fund in 2011/12 found that 80% of local projects identified a list of vulnerable people by working with the voluntary/community sector (62%), local authorities (61%) and GPs (25%). Reasons suggested for inadequate targeting included lack of engagement of healthcare professionals, difficulties in data sharing between partner agencies and short timescales. It was felt that with more time and more cooperation from healthcare professionals, particularly GPs, a more strategic approach could have been adopted.

The survey found examples of innovative methods to target vulnerable residents including using health risk stratification data, targeting patients being discharged from hospital and using local fuel poverty data.

A 2014 survey[18] found that of 3,500 families with disabled children 33% were going without heating at some time, with a third of those doing so more than once a month. This has doubled since the 2008 survey when 16% of families stated they were going without heating. In 2014, 36% of families with disabled children needed a loan to pay for their heating and 19% had been threatened with court action for non-payment of energy or utility bills.

Identifying risk as part of holistic geriatric assessment

No specific current practice identified.

Identifying the effects of housing conditions

An estimated 13% of children had spent the last year living in inadequately heated homes between 2001 and 2005. Children living in inadequately heated accommodation were twice as likely to suffer from chest and breathing problems as children living in warm homes[19].

[17] Warm Homes, Healthy People Fund 2011/12: a mixed methods evaluation V.Madden, C. Carmichael, C. Petrokofsky, V. Murray, 2013
[18] Counting the costs Contact a family 2014
[19] Local action on health inequalities: Fuel poverty and cold home-related problems Public Health England 2014

4.3 Referral

4.3.1 Summary of suggestions

Referral to single point of contact

A stakeholder highlighted that any patients identified as at risk of morbidity or mortality from excess cold should be provided with information and/or referred where a housing and health service is available. All patients need to be able to access the level of help they require.

GP records and referrals

A stakeholder suggested that it may be beneficial to include the risk of a patient living in a cold home within GP patient records and associated referral systems.

Direct referrals from GPs to Home Improvement Agencies

A stakeholder suggested direct referrals from GPs to a Home Improvement Agency as a quality improvement area. The stakeholder advised that HIAs are commissioned by approximately 85% of local authorities in England, and are a logical, community based resource that GPs should utilise more fully, and goes beyond the existing model of social prescribing.

Referral incentives

A stakeholder suggested the potential use of referral incentives for key health practitioners such as GPs to encourage referral of households for heating assistance. No source guidance has been found for referral incentives.

4.3.2 Selected recommendations from development source

Table 5 below presents recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Referral to single point of contact	**Excess winter deaths and morbidity and the health risks associated with cold homes** NICE NG6 recommendations 5, 6 and 7

GP records and referrals	**Excess winter deaths and morbidity and the health risks associated with cold homes** NG6 recommendation 4
Direct referrals from GPs to Home Improvement Agencies	No specific recommendations
Referral incentives	No specific recommendations

Referral to single point of contact

NICE NG6 relevant section of recommendation 5: Make every contact count by assessing the heating needs of people who use primary health and home care services

Primary health and home care practitioners should:

- If a cold home is a risk to someone's health and wellbeing, assess the likely effect and identify how the situation could be improved. Make sure relevant services are aware who will take action and when. This could include:
    - referral to the local health and housing service
    - referral to a health service (for instance, to ensure the person is offered flu vaccinations at the start of the winter).

NICE NG6 relevant section of recommendation 6: Non-health and social care workers who visit people at home should assess their heating needs

People who do not work in health and social care services but who visit people at home should:

- Refer anyone who needs help with the problems of living in a cold home to the local single-point-of-contact health and housing referral service, if they give their consent (see recommendations 2 and 3).

NICE NG6 relevant section of recommendation 7: Discharge vulnerable people from health or social care settings to a warm home

Those responsible for arranging and helping with someone's discharge from a health or social care setting should:

- If needed, refer the person to the local single-point-of-contact health and housing referral system (see recommendations 2 and 3). For example, refer them if the heating system needs replacing or the property needs insulating,

or to prevent or address fuel debt. (The latter may accrue during someone's stay in health or social care accommodation.)

GP records and referrals

NICE NG6 recommendation 4: Identify people at risk of ill health from living in a cold home

Primary health and home care practitioners should:

- In collaboration with relevant local authority departments, use existing data, professional contacts and knowledge to identify people who live in cold or hard-to-heat homes. This includes people who are particularly vulnerable to the cold (see recommendation 5).
- Include this information in the person's records and use it (with their consent) to assess their risk and take action, if necessary (see recommendations 2 and 3).
- Ensure data sharing issues are addressed so that people at risk can be identified.

4.3.3 Current UK practice

Referral to single point of contact

The Seasonal Health Intervention Network (SHINE)[20] is a single point of referral system offering advice and support to Islington residents, established in December 2010. Over 200 organisations refer clients into the team who then make contact and assess the client for around 30 possible interventions helping people with issues including health, energy efficiency, general housing quality, income and social isolation. The team also offers support with fuel debt, assisting residents with trust fund applications and negotiating payment plans with energy companies.

By April 2014[21] the SHINE Hub had handled over 6,250 referrals leading to 28,500 specific seasonal health interventions. Around 80% of referrals received are from the key priority groups of: those aged over 65; people with respiratory or cardiovascular diseases; and low income families with children aged under 5. Client-reported outcomes are positive and an estimated £600,000 annually is saved by SHINE clients. This figure is based on energy efficiency improvements such as boiler replacements and smaller measures as well as energy bill discounts. SHINE has assisted council service delivery by providing a single point of referral for a wide

[20] SHINE referral system Islington Borough Council
[21] SHINE project on fuel poverty and excess winter deaths case study Climate Just 2014

range of interventions, and bringing together a wide range of previously disparate services across the statutory and voluntary sectors.

SHINE is nationally and internationally recognised and is known for innovative approaches to seasonal health issues[22].

GP records and referrals

There are many local initiatives to prevent winter deaths, however these vary by area and there is no specific model being used everywhere. The Affordable Warmth Access Referral Mechanism (AWARM)[23] was implemented in Manchester between 2008 and 2010. From April 2008 AWARM activity resulted in over £600,000 of investment in new and replacement central heating systems and insulation. During the first year of the project over 1,000 referrals were made by frontline professionals from social services, voluntary, local government, housing and health sectors. The lessons learned from the pilot include:

- There are numerous opportunities to share data between local authorities, GPs and PCTs to improve how referrals are targeted.
- A pop-up system on GP patient electronic records would help to immediately direct referral to a one-stop-shop.

The Royal College of General Practitioners plans to pilot a new electronic referral system[24] for health and fuel poverty in conjunction with the Department of Energy and Climate Change (DECC).

Direct referrals from GPs to Home Improvement Agencies

In 2012 an independent evaluation[25] of the Department for Communities and Local Government handyperson programme did not identify any referrals to the programme from GPs. It found that sources of referrals to the programme were as follows:

- Self-referral: 45%
- Social care services: 34%
- Relative/ friend: 7%
- Acute hospital service: 6%

[22] Report on Islington's award winning Seasonal Health Interventions Network (SHINE) Project Right 2 Fuel UK 2014
[23] The Health Impacts of Cold Homes and Fuel Poverty Marmot review team 2011
[24] Cutting the cost of keeping warm - A fuel poverty strategy for England Department of energy and climate change 2015
[25] National evaluation of the handyperson programme Department for Communities and Local Government 2012

- Advocacy service: 5%
- Community health worker: 3%
- Local crime prevention initiative: 3%

Referral incentives

No specific current practice identified.

4.4 Interventions

4.4.1 Summary of suggestions

Early intervention

Stakeholders commented on the need for early intervention for people whose wellbeing will be negatively affected by the cold. The importance was emphasised of identifying vulnerable people to develop strategies and actions to find most appropriate solutions.

Accessible advice and support

Stakeholders highlighted the need for well-defined and easy to access interventions to combat the effect of excess cold, and support from community organisations to help support vulnerable people living in fuel poverty. A stakeholder commented that well-defined and easy to access support services should be contacted once it is identified that the person would benefit from a preventative intervention. The stakeholder suggested the person should be supported by a robust referral pathway, not simply signposted.

Stakeholders highlighted the need to raise awareness in affected individuals to provide advice to enable families to heat their homes better in the winter.

Discharge process

Stakeholders highlighted the need for hospital, mental health and social care discharge processes to consider how to ensure patients are discharged to a warm home.

A stakeholder commented that older people can be discharged from hospital too soon, without the right information or the right services in place to support them.

Heating grants

A stakeholder highlighted the need for grant availability for heating measures to reduce cold related ill health.

4.4.2 Selected recommendations from development source

Table 6 below presents recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Early intervention	No specific recommendations
Accessible advice and support	**Excess winter deaths and morbidity and the health risks associated with cold homes** NG6 recommendations 2, 3, 5 and 6
Discharge process	**Excess winter deaths and morbidity and the health risks associated with cold homes** NG6 recommendation 7
Heating grants	**Excess winter deaths and morbidity and the health risks associated with cold homes** NG6 recommendation 3

Accessible advice and support

NICE NG6 relevant sections of recommendation 2: Ensure there is a single-point-of-contact health and housing referral service for people living in cold homes

Health and wellbeing boards should:

- Ensure the referral service:
    - Involves face-to-face contact, if necessary, with the person using the service, their families and their carers.
    - Works with the person and their carers to identify problems caused by living in a cold home and the possible solutions.
    - Makes it clear to the person and their carer what actions are planned (or taking place) and coordinates activities to minimise disruption in the home.
    - Encourages self-referrals using a free phone number.

NICE NG6 recommendation 3: Provide tailored solutions via the single-point-of-contact health and housing referral service for people living in cold homes

Health and wellbeing boards and their partners should ensure the local single-point-of-contact health and housing referral service provides access to tailored solutions to address identified needs, rather than an off-the-shelf approach. Solutions should take into account the language and reading ability of recipients, including any vision or hearing problems. Solutions should include:

- Housing insulation and heating improvement programmes and grants. Programmes should be led, or endorsed, by the local authority and include those available from energy suppliers.
- Advice on managing energy effectively in the home and securing the most appropriate fuel tariff and billing system (including collective purchasing schemes, if available). Note: the most appropriate fuel tariff may not be the cheapest if, for example, someone does not have a bank account or needs to budget on a weekly basis.
- Help to ensure all due benefits are being claimed, as people receiving certain benefits may be entitled to additional help with home improvements – and may get help to manage their fuel bills and any debt.
- Registration on priority services registers (for energy supply and distribution companies) to ensure vulnerable households get tailored support from these companies.
- Advice on how to avoid the health risks of living in a cold home. This includes information about what these health risks are (see Public Health England's Cold weather plan for further information).
- Access to, and coordination of, services that address common barriers to tackling cold homes. For example, access to home improvement agencies that can fix a leaking roof, or to voluntary groups that can help clear a loft ready for insulation.
- Short-term emergency support in times of crisis (for instance, room heaters if the central heating breaks down or access to short-term credit).

NICE NG6 Relevant section of recommendation 5: Make every contact count by assessing the heating needs of people who use primary health and home care services

Primary health and home care practitioners should:

- Give people at risk, and their carers, information about how living in a cold home can affect their health. They should also tell them about services that can help and refer them if necessary. Ensure recipients can understand and act on the information they are given.

NICE NG6 relevant section of recommendation 6: Non-health and social care workers who visit people at home should assess their heating needs

People who do not work in health and social care services but who visit people at home (see who should take action?) should:

- Give people who may be vulnerable to the cold information on the effect that living in a cold home can have on their health and what can be done to remedy this.

Discharge process

NICE NG6 recommendation 7: Discharge vulnerable people from health or social care settings to a warm home

Those responsible for arranging and helping with someone's discharge from a health or social care setting should:

- Assess whether the person is likely to be vulnerable to the cold and if action is needed to make their home warm enough for them to return to. This assessment should take place at any time of the year, not just during colder weather, and well before they are due to be discharged to allow time for remedial action. For instance, it could take place soon after admission or when planning a booked admission.

- As part of the planned discharge, coordinate the efforts of all the practitioners involved to ensure the home is warm enough. This could include simple measures such as turning on the heating before discharge, providing advice on the ill effects of cold on health, or providing advice on how to use the heating system. (It could also involve more complex measures – see below.)

- If needed, refer the person to the local single-point-of-contact health and housing referral system (see recommendations 2 and 3). For example, refer them if the heating system needs replacing or the property needs insulating, or to prevent or address fuel debt. (The latter may accrue during someone's stay in health or social care accommodation.)

- Ensure any heating issues are resolved in a timely manner, so as not to delay discharge from hospital.

Heating grants

NICE NG6 relevant section of recommendation 3: Provide tailored solutions via the single- point-of-contact health and housing referral service for people living in cold homes

Health and wellbeing boards and their partners should ensure the local single-point-of-contact health and housing referral service provides access to tailored solutions to address identified needs, rather than an off-the-shelf approach. Solutions should take into account the language and reading ability of recipients, including any vision or hearing problems. Solutions should include:

- Housing insulation and heating improvement programmes and grants. Programmes should be led, or endorsed, by the local authority and include those available from energy suppliers.

4.4.3 Current UK practice

Early intervention

No specific current practice identified.

Accessible advice and support

There are many local initiatives to prevent winter deaths, however these vary by area and there is no specific model being used everywhere. In the winter of 2011/12 Essex County Council worked in partnership with NHS North East Essex and ten Essex Citizens Advice Bureaux on the 'Beat the cold this winter'[26] campaign to engage with disadvantaged, socially excluded and vulnerable people.

Qualified advisers knocked on doors to engage with residents of deprived communities, providing an information pack and explaining actions that could be taken to reduce fuel poverty and prevent ill-health during the winter months. Over a four week period in the winter of 2011/12, the project successfully engaged with 2,100 clients, providing free, independent, confidential and impartial advice. A number of outcomes were recorded which included 1,545 people reducing their fuel poverty, £318,601 of benefits being claimed, £210,100 of debt being managed and £95,000 of debt being written off.

Discharge process

In April 2014[27] a one year pilot project commissioned by The Pennine Acute Hospitals NHS Trust, in partnership with Manchester City Council and North Manchester Clinical Commissioning Group, began providing personalised hospital discharge support service for Manchester residents aged over 60 who had been treated at North Manchester General Hospital.

The Home from Hospital service provides vulnerable or isolated patients aged over 60 with personalised discharge support including assisting to warm the home, shopping for immediate essentials, preparing beds and making a meal. The service supported over 100 people within the first 4 weeks of the scheme.

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[26] Local action on health inequalities: Fuel poverty and cold home-related problems Public Health England 2014
[27] From hospital to home – we're here to help Manchester care and repair 2014

Heating grants

No current practice identified specific to heating grants.

4.5 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 29 May 2015.

Respiratory conditions

A stakeholder suggested that a care bundle should be provided on admission to hospital for chronic obstructive pulmonary disease (COPD)/community acquired pneumonia and asthma to ensure patients receive the best care.

A stakeholder commented it is unnecessary to emphasise COPD and childhood asthma in the quality standard as all patients with chronic respiratory disease will be vulnerable. The stakeholder suggested improvement in the self-management of adults with asthma and bronchiectasis.

This area of quality improvement is not within the remit of this quality standard as quality standards have been published for chronic obstructive pulmonary disease (QS10) and asthma (QS25) and a quality standard on pneumonia has been referred to the Quality Standards Topic Library.

Pneumococcal vaccinations

Stakeholders commented on the importance of the pneumococcal vaccination in older people (65+) and/or people with cardiovascular and respiratory conditions.

No source recommendations were identified to support this suggested improvement area. In addition, this area of quality improvement will in part be addressed by a specific quality standard on vaccinations (ages 0-18) which has been referred to the Quality Standards Topic Library.

Flu vaccinations

A stakeholder commented on the importance of the flu vaccination for people with respiratory conditions.

This area of quality improvement is not within the remit of this quality standard as it will be addressed by a specific quality standard on influenza which has been referred to the Quality Standards Topic Library.

Smoking cessation

A stakeholder felt that smoking is likely to exacerbate the effect of cold on lung and cardiovascular health and contributes to fuel poverty.

This area of quality improvement is not within the remit of this quality standard as quality standards have been published on smoking cessation: supporting people to stop smoking (QS45) and smoking: reducing tobacco use in the community (QS82). A quality standard on smoking: harm reduction is in development and is due to publish in July 2015. Equality considerations for this quality standard include the link between smoking and poverty.

Falls

Stakeholders commented that local strategies around care for an ageing population should include plans to reduce falls/harm from falls including winter falls and that falls prevention is important, particularly for older people with mental health problems (not specifically outdoor falls).

This area of quality improvement is not within the remit of this quality standard as it will be addressed by a specific quality standard on falls which has been referred to the Quality Standards Topic Library.

Social isolation

A stakeholder highlighted the need for interventions to reduce social isolation and loneliness to be embedded in health and wellbeing strategies and public health priorities in every local authority.

This area of quality improvement is not within the remit of this quality standard as it will be addressed by a specific quality standard on older people: promoting mental wellbeing and independence through primary, secondary and tertiary prevention which has been referred to the Quality Standards Topic Library. The source guideline is due to publish in November 2015.

Age-friendly housing designs

A stakeholder highlighted the need for housing strategies at local and national government level to incorporate plans for sufficient age-friendly housing designs built around principles such as those set out in the All Parliamentary Housing and Older People recommendations. The stakeholder commented that they should also incorporate plans to inspect heating and fuel economy for homes already occupied by older residents.

This area of quality improvement is not within the remit of this quality standard as it will be addressed by a specific quality standard on housing: planning to improve health and wellbeing which has been referred to the Quality Standards Topic Library.

Prompt evidence based treatment

A stakeholder commented that access to prompt evidence based treatment (as set out in other NICE guidance) when older people develop inter-current illness associated with cold weather, in particular respiratory tract infections, is needed.

This area of quality improvement is not within the remit of this quality standard as quality standards have been published for chronic obstructive pulmonary disease (QS10) and asthma (QS25) and a quality standard on pneumonia has been referred to the Quality Standards Topic Library.

Training

Stakeholders highlighted the need to raise awareness in practitioners about identifying those at risk. They commented that training on health risks associated with cold homes and the potential for and nature of beneficial interventions should be included in both initial training and CPD for all primary care professionals and service commissioners.

Stakeholders felt that ongoing training and support for front line workers is particularly important to ensure that they are kept abreast of changes to grant funding and that fuel poverty/adequate heating remain at the forefront of workers' minds. They commented that there is a need to embed training for front line workers and volunteers in their work programmes, and for it to be recognised as a high enough priority at a high level of management (eg inclusion of referrals as a CQUIN).

The quality standard should not contain any statements on training and competencies. Staff being trained and competent is an underpinning concept of all quality standards. An additional paragraph has been added to the overview for each quality standard which can make reference to specific examples of training and competency frameworks where the QSAC feel this is important.

Appendix 1 Cold Weather Plan Framework

Summary cold weather actions for health and social care organisations and professionals, communities and individuals

	Level 0	Level 1	Level 2	Level 3	Level 4
	Year-round planning *All Year*	**Winter preparedness and action** *1 November to 31March*	**Severe winter weather forecast – Alert and readiness** *Mean temperatures of 2°C and/or widespread ice and heavy snow predicted with 60% confidence*	**Severe weather action** *Mean temperatures of 2°C and/or widespread ice and heavy snow*	**Major incident – Emergency response**
Commissioners of health and social care	1) Take strategic approach to reduction of EWDs and fuel poverty. 2) Ensure winter plans reduce health inequalities. 3) Work with partners and staff on risk reduction awareness (eg flu vaccinations, signposting for winter warmth initiatives).	1) Communicate alerts and messages to staff/public/media. 2) Ensure partners are aware of alert system and actions. 3) Identify which organisations are most vulnerable to cold weather and agree winter surge plans.	1) Continue level 1 actions. 2) Ensure partners can access advice and make best use of available capacity. 3) Activate business continuity arrangements as required.	1) Continue level 2 actions. 2) Ensure key partners are taking appropriate action. 3) Work with partners to ensure access to critical services.	Level 4 alert issued at national level in light of cross-government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office. All level 3 responsibilities to be maintained unless advised to the contrary.
Provider organisations	1) Ensure organisation can identify and support most vulnerable. 2) Plan for joined up support with partner organisations. 3) Work with partners and staff on risk reduction awareness (eg flu vaccinations, signposting for winter warmth initiatives).	1) Ensure cold weather alerts are going to right staff and actions agreed and implemented. 2) Ensure staff in all settings are considering room temperature. 3) Ensure data sharing and referral arrangements in place.	1) Continue level 1 actions. 2) Ensure carers receiving support and advice. 3) Activate business continuity arrangements as required; plan for surge in demand.	1) Continue level 2. 2) Implement emergency and business continuity plans; expect surge in demand in near future. 3) Implement local plans to ensure vulnerable people contacted.	
Frontline staff – care facilities and community	1) Use patient contact to identify vulnerable people and advise of cold weather actions; be aware of referral mechanisms for winter warmth and data sharing procedures. 2) Ensure awareness of health effects of cold and how to spot symptoms. 3) Encourage colleagues/clients to have flu vaccinations.	1) Identify vulnerable clients on caseload; ensure care plans incorporate cold risk reduction. 2) Check room temperatures and ensure referral as appropriate. 3) Signpost clients to other services using 'Keep Warm Keep Well' booklet.	1) Continue level 1 actions. 2) Consider prioritising those most vulnerable and provide advice as appropriate. 3) Check room temperatures and ensure urgent referral as appropriate.	1) Continue level 2 actions. 2) Implement emergency and business continuity plans; expect surge in demand in near future. 3) Prioritise those most vulnerable.	
GPs and their staff	1) Be aware of emergency planning measures relevant to general practice. 2) Ensure staff aware of local services to improve warmth in the home including the identification of vulnerable individuals. 3) Signpost appropriate patients to other services when they present for other reasons.	1) Consider using a cold weather scenario as a table top exercise to test business continuity arrangements. 2) Be aware of systems to refer patients to appropriate services from other agencies. 3) When making home visits, be aware of the room temperature.	1) Continue level 1 actions. 2) Take advantage of clinical contacts to reinforce public health messages about cold weather and cold homes on health. 3) When prioritising visits, consider vulnerability to cold as a factor in decision making.	1) Continue level 2 actions. 2) Expect surge in demand near future. 3) Ensure staff aware of cold weather risks and can advise appropriately.	

	Level 0	Level 1	Level 2	Level 3	Level 4
Community and voluntary sector	1) Engage with local statutory partners to agree how VCS can contribute to local community resilience arrangements. 2) Develop a community emergency plan to identify and support vulnerable neighbours. 3) Agree arrangements with other community groups to maximise service for and contact with vulnerable people.	1) Test community emergency plans to ensure that roles, responsibilities and actions are clear. 2) Set up rotas of volunteers to keep the community safe in cold weather and check on vulnerable people. 3) Actively engage with vulnerable people and support them to seek help.	1) Activate the community emergency plan. 2) Activate the business continuity plan. 3) Continue to actively engage vulnerable people known to be at risk and check on welfare regularly.	1) Continue level 2 actions. 2) Ensure volunteers are appropriately supported. 3) Contact vulnerable people to ensure they are safe and well and support them to seek help if necessary.	Level 4 alert issued at national level in light of cross-government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office. All level 3 responsibilities to be maintained unless advised to the contrary.
National level	1) CO will lead on co-ordinating cross-government work; individual government departments will work with partners on winter preparations. 2) DH, PHE and NHS England will look to improve the CWP and the monitoring and analysis of winter-related illness and deaths. 3) PHE and NHS England will issue general advice to the public and professionals and work closely with other government departments and other national organisations that produce winter warmth advice.	1) Cold Weather Alerts will be sent by the Met Office to the agreed list of organisations and Category 1 responders. 2) PHE and NHS England will make advice available to the public and professionals. 3) NHS England will continue to hold health services to account for action and PHE will routinely monitor syndromic, influenza, norovirus and mortality surveillance data.	1) Continue level 1 actions. 2) DH will ensure that other government departments, particularly DCLG RED, are aware of the change in alert level and brief ministers as appropriate. 3) Government departments should cascade the information through their own partner networks and frontline communication systems.	1) Continue level 2 actions. 2) NHS England will muster mutual aid when requested by local services. 3) Met Office will continue to monitor and forecast temperatures in each area, including the probability of other regions exceeding the level 3 threshold.	
Individuals	1) Seek good advice about improving the energy efficiency of your home and staying warm in winter; have all gas, solid fuel and oil burning appliances serviced by an appropriately registered engineer. 2) Check your entitlements and benefits; seek income maximisation advice and other services. 3) Get a flu jab if you are in a risk group (September/October).	1) If you are receiving social care or health services ask your GP, key worker or other contact about staying healthy in winter and services available to you. 2) Check room temperatures – especially those rooms where disabled or vulnerable people spend most of their time. 3) Look out for vulnerable neighbours and help them prepare for winter.	1) Continue to have regular contact with vulnerable people and neighbours you know to be at risk in cold weather. 2) Stay tuned into the weather forecast ensure you are stocked with food and medications in advance. 3) Take the weather into account when planning your activity over the following days.	1) Continue level 2 actions. 2) Dress warmly; take warm food drinks regularly; keep active. If you have to go out, take appropriate precautions. 3) Check on those you know are at risk.	Follow key public health and weather alert messages as broadcast on the media.

Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
01	Bolton Council	Key area for quality improvement 2: Identifying those at risk of excess winter mortality and morbidity in community settings (including homes).	Frontline staff who work in community settings and in patients homes are ideally placed to identify home environments that may put patients at risk of morbidity and mortality. Pharmacists have access to information via prescriptions and can establish if someone is on a low income and receiving medication for a condition that may be exacerbated by living in a cold and/or damp home, this information should be utilised for the targeting of interventions	Home environments have a substantial effect on health. The UK's excess winter mortality rate is higher than other colder European countries is some part due to the state of the countries housing stock. Improving the housing stock for these patients will lead to a decrease in mortality and morbidity.	NICE Guidance Variable across staff groups and settings
02	Bolton Council	Key area for quality improvement 3: Identifying those at risk of excess winter mortality and morbidity in Primary care.	GPs have been difficult to engage in this area of work but are vital to the prevention of excess winter morbidity and mortality. GPs need recognise the importance of helping patients to develop and maintain a healthy living environment and cold weather behaviours, just as they would with areas such as smoking, alcohol etc.	GP's are seen as a trusted source of reliable information. GPs are ideally placed to identify at risk patients reducing mortality and morbidity. Patients may engage better with their GP as the trusted source, compared to other professionals.	NICE Guidance Variable across staff groups and settings
03	Bolton Council	Key area for quality improvement 4: Identifying those at risk of excess winter mortality and morbidity in Secondary and tertiary care.	Elective, non-elective and A&E attendances may have resulted due to an unhealthy home environment or behaviour in cold weather. Health professionals should asses that a patient is returning to an environment suitable to their recovery before discharge (ideally at admission or pre-admission where possible)	If a patient is admitted with a condition exacerbated by their home environment and/or behaviours, they should not return to this adverse environment until action has taken place to improve that environment (e.g. a referral to a home improvement service)	NICE Guidance Variable across staff groups and settings

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
04	Foundations	3. Probing on 'Cold Impact' issues when patient presents at primary / secondary / social care	When patient present to professionals in primary / secondary / social care, simple probing questions should be asked of the patient to determine the impact of cold on that individual, taking in consideration, health conditions, home conditions, personal situation and family/friends support network.	Although, not as comprehensively effective as an in-home assessment, simple probing questions concerning a patient's home environment can provide indicators to vulnerability to excess cold.	See above
05	SCM4	Key area for quality improvement 1 Population at risk	It is important to understand who is at risk and to identify these vulnerable people to be able to develop strategies and actions to find most appropriate solutions. NICE guideline on excess winter deaths recommends identifying people at risk of ill health from living in a cold home.	Only a small proportion of people at risk are currently identified and adequate support and advice provided.	
06	SCM1	How to effectively identify and target assistance to those most at risk from excess winter deaths	There is no standard and straightforward method to identify those in fuel poverty that are vulnerable to the cold and associated excess winter deaths.	Recent changes in the definition and research into fuel poverty leaves no clear method for targeting the fuel poor groups most affected by excess winter deaths. There is a need for methodology to determine those in the most identified vulnerable groups (that are themselves actually vulnerable).	See: Cutting the cost of keeping warm – a fuel poverty strategy for England: In conjunction with DECC Fuel Poverty Strategy in developing a standard list of questions for practitioners to identify those at risk of fuel poverty should have the ability to include those most at risk from excess winter deaths. See: Strategic Society (2013) Cold enough: excess winter deaths, winter fuel payments

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					and the UK's problem with the cold
07	SCM1	Identifying the effects of each housing condition in relation the to effect on excess winter deaths and the methodology to improve each one	There is a strong association between an increased number of deaths in relation to detrimental housing conditions (but there are a number of different conditions to consider).	This is therefore an area where intervention could have the larger positive consequences.	See: The Health Impacts of Cold Homes and Fuel Poverty Marmot Review Team
08	British Geriatrics Society	Key area for quality improvement 3	In older people identified through primary care risk stratification or already being supported by primary/community/secondary/social care services to live with long term conditions, or coming into contact with them, part of holistic comprehensive geriatric assessment should include opportunistically asking about heating, fuel poverty and housing. However, there is insufficient evidence to justify screening as opposed to opportunistic case finding and insufficient time in the day to suggest that GPs are the prime practitioners responsible for such screening		
09	Bolton Council	Key area for quality improvement 1: Morbidity across the life course caused/exacerbated by living in a cold and/or damp home.	Whilst the prevention of excess winter mortality itself is important, the linked morbidity issues far outweigh the deaths themselves.	If morbidity is addressed at a young age the cyclical effects of living in a fuel poor household can be prevented and therefore reduce the probability of future mortality. The majority of excess winter mortality has a tendency to affect the older age groups. The effects of living in a cold and/or damp home can	NWPHO paper 'Falls involving ice and snow, transport accidents and respiratory conditions: the impact of winter (2009/10) on emergency hospital admissions in the North West'

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				impact on a person across the whole of their life course and has considerable effect on their wellbeing, this often results in the use of high cost NHS and social care services, which could have potentially been prevented.	(http://www.nwph.net/nwpho/Publications/ice_snow_pub_Aug2010.pdf)
10	Royal College of Paediatrics and Child Health	Key area for quality improvement 1 As part of the topic background to this quality standard - to review the evidence of the difficulty families of disabled children face in coping with winter fuel costs, food costs and other essential expenditure.	The extent of this problem helps to put into context the amount of financial and other support required by families of disabled children to cope during the winter and reduced the risk of increasing ill-health and premature death.	Financial hardship is a crucial component contributing to increasing ill-health and, in some cases, premature death.	Various references to reports documenting the financial hardship experienced by people with disabilities, and their families, are already given in the list of key development sources for this quality standard, but important additional sources are: The 2014 Contact a Family survey of 3,500 families with a disabled person showing the financial pressures that are leading a significant proportion of these families to go without food and/or heating: http://www.cafamily.org.uk/media/805120/counting_the_costs_2014_uk_report.pdf The British Academy of Childhood Disability and British Association of Community Child Health's joint survey of Paediatricians members in 2014-15, seeking information about the impact of the austerity measures on the families of children with

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					disabilities and also the impact that financial restrictions have had on the services offered by these Paediatricians: http://bacdis.org.uk/policy/documents/ImpactofAusterityMeasuresonfamilieswithDisabledChildren16Jan2015.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
11	Bolton Council	Additional developmental areas of emergent practice- • Partnership working • Staff training • Health sector involvement in referral mechanisms	Health and housing groups focusing on excess winter mortality and morbidity must involve representatives of key services that can work together to tackle the issue: • Public Health • Housing • CCGs • Social Care • Financial Inclusion services • Foundation Trusts • Mental health trust • Environmental health • Social housing providers • Representative of the private rented sector (this would probably be through a Local Authority rep rather than landlords themselves) • Other local authority departments and health services (Social care) • Voluntary sector Front line staff in all sectors and services need to be suitably trained to spot the signs of excess winter mortality and morbidity and an unhealthy living environment/ unhealthy winter behaviours. Health services that are required to refer must be involved in the development of referral mechanisms to ensure that they are as easy to possible to use for staff ensuring that	These are key areas as they are essential to the success of any quality standard. It is essential that on identification of those at risk of excess winter mortality and morbidity the patient and their household can access the services required to improve their living environments and winter behaviour so to prevent future mortality and exacerbation of conditions. Without holistic services, comprehensive education and training packages, and simple, effect, easy to use referral mechanism developed by strategic partnership working the quality standards may not lead to the prevention of morbidity and mortality so it is essential these areas underpin all standards suggested.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			the referral itself takes up minimal staff time in appointments/visits. Services that develop these referral mechanisms may not always understand how clinician's work and will need advising on how to make mechanisms user friendly.		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
12	SCM2	Key area for quality improvement 5: How health consequences of cold homes can best be reflected in JSNA and associated strategy (NICE recommendation 1)	NICE recommendation 1 provides detail of what might be included in a strategy to address the health consequences of cold home but does not describe how best this might be done (e.g. assessing how heating and insulation needs to be improved)	There are robust ways to undertake this sort of assessment to underpin the strategy – and less robust ways. The quality standard would create the possibility of establishing a common approach across the country so that comparisons could usefully be made between different areas in terms of need, health burden etc.	Islington Council may have done this – and a few others – thus potentially providing a template for good practice. Will try to find out in advance of May 29th meeting.
13	Foundations	2. 'Cold Impact Assessment' incorporated within all first-line encounters in the home	When professionals visit a patient in their home, they should be mindful of the impact of cold on that individual, taking in consideration, health conditions, home conditions, personal situation and family/friends support network.	A cold impact assessment is most effectively delivered in the patient's home where the condition and thermal comfort of the dwelling can be experienced first-hand. Assessment methodologies employed in Home Improvement Agency sector are simple, quick and effective. An in-home assessment, also takes into account the area immediately outside the dwelling (paths / driveways etc), as it is in this area where the vast majority of falls occur, a number which increased dramatically when snow and ice is present. Maps Across to: NHS Outcome Framework • (Domain 3) Preventing lower respiratory tract infections in children from becoming serious (reducing emergency admissions) • Health related quality of life for older people • (Domain 2) Enhancing quality of life for people with long-term conditions Public Health Outcome Framework • (Domain 4) Health care, public health and preventing premature mortality • (Domain 4) Health related quality of life for older people • (Domain 4) Hip fractures in over 65s	• Decent Homes Better Health – Sheffield Decent Homes Health impact Assessment 2006 • Assessment & prevention of falls in older people – NICE 2014 • Revaluation of Home Accidents – ROSPA 2010

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14	SCM2	Key area for quality improvement 1: Inclusion of the risk of a patient living in a cold home within GP patient records and associated referral systems	NICE guideline highlights that living in a cold home is a key risk factor in a wide range of health conditions (including mental health). Yet patient record systems do not reflect this and referral systems do not provide an option to refer to the recommended 'single-point-of-contact' are (with a few notable exceptions) That means opportunities to secure interventions to improve patient health by making it easier for them to keep adequately warm at home are being lost.	Experience suggests that, without a prompt to consider whether the patient's ability to keep warm at home is effecting their health, it is unlikely that this will feature in a GP's (or other primary care professional's) consideration of how the patient's health can be improved. Thus cost-effective, health-improving opportunities to intervene identified in the NICE guideline will go begging. Data exists to enable the risk of someone living in a cold home to be assessed (based on their address and what is known about the housing stock and levels of deprivation in that area). So risk factor could be assessed based on address and 'added' to patient record as a flag. (See NICE guideline Recommendation 4)	NICE guideline on EWD plus associated evidence statements – plus 20 years of experience trying to engage the Some work is being done (eg Wiltshire CCG, Wigan Council, Liverpool Council, stuff we're trying to do in Bristol) to integrate this into record and referral systems, but very early stages. Some of this is being supported by Department of Energy and Climate Change (DECC) (see e.g. page 70 of https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408644/cutting_the_cost_of_keeping_warm.pdf) but in a pilot/piecemeal fashion without clear focus on consistent quality standards
15	SCM2	Key area for quality improvement 4: Commissioning practices to secure NICE guideline recommendations 2 and 3	There has been only very limited commissioning do date by Health and Wellbeing Boards of the sorts of service which NICE recommends. Providing a clear standard for that commissioning would help ensure that commissioning practice is well-informed and efficiencies are maximised.	Recommendations 2 and 3 are at the heart of the implementation of the NICE guideline so	There are some examples of good practice (Wigan, Liverpool, Stoke) which may provide decent procurement/commissioning 'templates' that could provide the basis of a quality standard. I'll try to get further contact information!

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16	Leeds City Council	Key area for quality improvement 4 Single point of referral for energy and fuel advice	We agree with the NICE guidance that it is important to have a single point of referral for members of the public and front line staff and volunteers. It would be unreasonable to expect workers to know all of the potential referral options for different affordable warmth related issues and to expect them to undertake complicated referral procedures, particularly if they are hard pressed for time. Therefore, not having a simple referral mechanism will act as a barrier against directing people towards assistance.	In the past, we have operated a local energy advice line on behalf of the Energy Saving Trust through which we have handled general energy efficiency enquiries about a range of issues such as energy efficiency grants, fuel bill advice and emergency heating provision. Since funding support for this service was withdrawn, we have been unable to support a single point of contact that can provide the necessary in depth assistance to households as well as information about local schemes and services. This means that although we operate a number of schemes that can assist people with different aspects of energy advice, we do not have the resources to support a single advice line that can be promoted universally to residents.	We know the value of having a single point of referral from experience of running energy efficiency and fuel poverty campaigns over many years.
17	Foundations	Additional developmental areas of emergent practice	Direct referral from GP to Home Improvement Agency	A direct referral from a GP, direct to a Home Improvement Agencies (HIA) can support all the above measures. HIAs are commissioned by approximately 85% of local authorities in England, and are a logical, community based resource that GPs should utilise more fully, and goes beyond the existing model of social prescribing	• Warrington HIA – GP referral project • York Handyperson Service GP referral project
18	Bolton Council	Key area for quality improvement 5: Any patients identified as at risk of morbidity or mortality from excess cold, to be provided with information and/or referred where a housing and health service is available (as recommended in the NICE	Different patients require different levels of engagement. Some patients may benefit from receiving a thermometer and a leaflet with general tips whereas others will need a full hand-holding service including home visits providing adaptations to their housing. All patients must be able to access the level of help they require.	In recent year's central government stopped providing the 'keep warm keep well' information in printed format leaving health professionals to print this for patients as and when they need it. For this reason many patients have not been able to access this vital information as those at risk of excess winter morbidity and mortality, do not have internet access and/or computer skills due to the makeup of the group. It is vital that all front line staff have access to	NICE Guidance Variable across staff groups and settings

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		guidance).		this information and room thermometers for patients and that they are aware how to access housing and health services (as recommended in the NICE guidance) where available so that identified patients receive the help they need to live a healthier life with a lower risk of winter related morbidity and mortality.	

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19	Foundations	1. Early Identification / intervention of people for whom cold will impact negatively on wellbeing.	Assisting and delivering housing support interventions should be undertaken before the onset of cold weather – ideally during summer months, because this allows the interventions to be delivered before the onset of cold weather.	Many health and care models assess the patient's physicality, but do not necessarily consider the patient's home environment, especially in the area of excess cold, as house condition, and thermal comfort are critical components in keeping a vulnerable person safe. Maps across to: NHS Outcome Framework • (Domain 1) Preventing people from dying prematurely Public Health Outcome Framework • (Domain 4) Mortality from preventable causes • (Domain 1) Improving the wider determinants of Health	The UK has some of the most thermally inefficient homes in Europe, and a significant number of vulnerable people living in fuel poverty • Hill's Report: Getting the measure of fuel poverty - CASE 2012 • Housing Health Cost Calculator - BRE/RHE 2014 • Marmot Review Team report on effects of fuel poverty – FOE 2011
20	Royal College of Paediatrics and Child Health	Key area for quality improvement 2 To provide advice to enable families to heat homes better in the winter	Lack of heating leads to ill-health and premature deaths (especially in those with disabilities and vulnerable health).	Families need advice on improving the heating in their homes (and how funding can be obtained for this purpose).	Contact a Family offers advice to help families meet their fuel bills: http://www.cafamily.org.uk/know-your-rights/help-with-fuel-bills/
21	SCM1	How to raise awareness in both practitioners and in affected individuals in identifying those at risk	There are misconceptions and the field of factors affecting excess winter deaths is complicated, numerous and varied.	The opportunity for identification of individuals at risk is vast amongst the various potential contacts through home visiting services or those that access services in the health care, voluntary and energy industry professionals.	See: Cold Weather Plan for England 2013
22	Foundations	4. Easy access to interventions to combat implications of excess cold	Well defined, and easy to access support services should be engaged with, once it is identified that the patient would benefit from a preventative intervention. Patient should be supported by a robust referral pathway, not simply	Simple and effective measures to help combat excess cold are available at low or no-cost from local authorities and organisations such as Home Improvement Agencies. These include practical interventions such as draft-proofing, insulation, but also, casework measures designed to encourage a patient to heat their	• Charitable Trust Reports - EAGA • Living Well At Home Inquiry – Housing LIN 2011

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			signposted.	home effectively without fear of extortionate fuel bills. This may include fuel supplier tariff switching, and income maximisation.	

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23	Foundations	5. Practical measures to tackle fuel Poverty	Well defined and easy to access support from community organisations to help support vulnerable people living in fuel poverty.	Tariff switching can deliver some savings to the client, especially if they are currently on dormant tariffs, but for vulnerable people the prospect of switching is often too daunting, as such support to assist such people would be a valuable factor in delivery	• Hill's Report: Getting the measure of fuel poverty - CASE 2012
24	Healthwatch Brighton and Hove	People with mental health conditions – Acute Mental Health Hospitals linking in with carers	Our local data and intelligence has revealed a pattern of poorer care where relatives and carers are not kept up to date with a service user's condition	In instances where discharge has not been correctly communicated to carers/ relatives, service users can go home to limited supplies, cold houses and can go missing. This has a risk involved for their mental and physical health having left hospital.	Healthwatch Brighton and Hove intelligence from the local trust's PALS data, our helpline, and the local Independent Complaints Advocacy Service (for raw data contact Kerry)
25	SCM2	Key area for quality improvement 3: Hospital and social care discharge processes need to consider how to ensure patient is discharged to a warm home	It isn't good practice to discharge a patient to a home that is unhealthily cold (and may well result in a deterioration of health and readmission). Yet the warmth of the home is not considered in standard discharge procedures. Other housing needs often are (such as access to toilet etc) but these may be less important to ongoing recovery of the patient that whether the home can be kept warm (and is so when they get back home).	Quality standard will help to ensure that this issue becomes a standard feature of discharge processes, thus creating the potential to avoid the risk that a patient will be discharged to a home that is dangerously cold.	Not sure if anyone is doing this well at the moment – we have yet to come across any hospital discharge process which includes the cold home risk in its assessment (even though many other home-related matters are considered)
26	Leeds City Council	Key area for quality improvement 1 Grant availability for heating improvements for vulnerable people from Central Government,	Grant availability for heating measures is vital if cold related ill health is to be reduced. There are a number of vulnerable households in the private sector who don't have adequate heating and it is vital that grants are available to assist these	The NICE guidance rightly emphasises the need for front line practitioners to refer vulnerable households at risk of cold related illness to further assistance. However, in order for this to be effective, practitioners need to be confident that help will be available to those people that need it when a referral is made, otherwise	The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011.

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		particularly for those households without a full heating system.	households when they are referred, otherwise front line referrers will become disillusioned with the referral process.	referrers will lose faith in the process and stop referring people. At present, the main source of funding available for large scale heating improvements for vulnerable private sector households is provided through the Home Heating Cost Reduction Obligation (HHCRO) which is paid for by the energy suppliers and managed by DECC. Eligibility is based on the receipt of an income related Government benefit, plus an additional factor, such as the household being a pensioner household, children in full time education being resident or the householder suffering from a disability. However, eligibility for particular heating improvements is also dependent on whether the heating measure is likely to save the household money. In practical terms, this means that for the most vulnerable households who don't already have a central heating system, there will not be anywhere near enough funding available through HHCRO to install a full heating system, even where the resident is vulnerable and in dire need, as this would not be calculated as representing a financial saving. DECC therefore needs to amend its grant system so that there is funding available to provide adequate heating for vulnerable households currently without it.	

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27	British Thoracic Society	Key area for quality improvement 1	Use of care bundle on admission to hospital for COPD/community acquired pneumonia and asthma. There is increasing evidence that the use of care bundles impact on the outcome and quality of care for patients admitted to hospital with COPD/pneumonia.	Variation in measures of COPD care occurs across the country, and we know that rates of hospital admission and mortality for community acquired pneumonia also vary widely. Care bundles are designed to ensure that every patient receives the best care, in a timely manner, every time.	https://www.brit-thoracic.org.uk/audit-and-quality-improvement/bts-care-bundles-for-cap-and-copd/ Hopkinson NS, Englebretsen C, Cooley N, Kennie K, Lim M, Woodcock T, et al. Designing and implementing a COPD discharge care bundle. Thorax. 2012;67(1):90-2. Robb E, Jarman B, Suntharalingam G, Higgens C, Tennant R, Elcock K. Using care bundles to reduce in-hospital mortality: quantitative survey. BMJ. 2010;340:c1234.
28	NHS England	Respiratory Scope	Possibly unnecessary to emphasise COPD and childhood asthma. All patients with chronic respiratory disease will be vulnerable	Improvement required in the area of self-management for adult patients with asthma and bronchiectasis in addition.	https://www.brit-thoracic.org.uk/document-library/clinical-information/bronchiectasis/bts-quality-standards-for-non-cf-bronchiectasis-in-adults/ https://www.brit-thoracic.org.uk/document-library/clinical-information/asthma/btssign-asthma-guideline-2014/
29	Pfizer Ltd	Uptake of effective pneumococcal vaccination in older people (aged 65 years and over)	Pneumococcal infection is a major cause of ill health and death in the UK. It can result in illnesses such as pneumonia, septicaemia and	Pneumococcal vaccination is offered to all children under two years, and at-risk children under five years, with high uptake (>95%). Pneumococcal vaccination is also offered to	For details on pneumococcal vaccination, please see the Department of Health's, Immunisation against

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			meningitis, all of which can lead to long-term ill health, permanent disability and death. Older people (over 65s) are particularly at risk of contracting pneumococcal disease, a risk that is heightened during the winter period. Pneumococcal disease is more common during winter when influenza and other respiratory viruses are circulating. There is a noticeable peak in the number of cases of infection in December and January each year. NICE guidance states that 0.5-1% of the UK population have community acquired pneumonia per year with significant mortality associated. Pneumococcal disease is estimated to make up 30% of this burden. Effective immunisation against pneumococcal infection therefore has an important role to play in preventing life threatening illnesses and excess deaths during the winter period.	those over 65, and to at-risk groups aged two and over. There is large regional variation in vaccine uptake in those over 65, with rates in some localities as low as 0.9% per annual cohort. A quality statement aimed at improving uptake of pneumococcal vaccination may help to prevent winter deaths.	infectious diseases – The Green Book, Chapter 25: Pneumococcal Infection, which highlights that pneumococcal disease peaks in winter months and sets out the serious conditions which can be caused by pneumococcal disease and the current recommendations for the use of the pneumococcal vaccine. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263318/Green-Book-Chapter-25-v5_2.pdf For evidence of the impact pneumococcal disease has on older people, please see Kastenbauer S and Pfister H.W, Pneumococcal meningitis in adults: Spectrum of complications and prognostic factors in a series of 87 cases. Journal of Neurology Volume 126, Issue 5 Pp. 1015-1025. http://brain.oxfordjournals.org/content/126/5/1015 For evidence on uptake of PPV in adults aged 65 years and over please see Public

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					Health England's, Health Protection Report, Pneumococcal Polysaccharide Vaccine (PPV) coverage report, England, April 2013 to March 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390119/hpr4814_ppv.pdf For evidence of the incidence of community acquired pneumonia, please refer to NICE's guideline on Diagnosis and management of community- and hospital-acquired pneumonia in adults. http://www.nice.org.uk/guidance/cg191/resources/guidance-pneumonia-pdf For evidence of the burden of community acquired pneumonia that is due to pneumococcal disease, please see Rodrigo et al, Impact of infant 13-valent pneumococcal conjugate vaccine on serotypes in adult pneumonia. European Respiratory Journal, March 18, 2015, doi: 10.1183/09031936.00183614

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					. http://www.ncbi.nlm.nih.gov/pubmed/25792633

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30	Pfizer Ltd	Pneumococcal vaccination coverage in people with cardiovascular and respiratory conditions	Pneumococcal infection is a major cause of ill health and death in the UK. It can result in illnesses such as pneumonia, septicaemia and meningitis all of which can lead to long-term ill health, permanent disability and death. People with certain long-term health conditions, including people with cardiovascular and respiratory conditions, are at increased risk of pneumococcal infection, a risk that is heightened during the winter period. Pneumococcal disease is more common during winter when influenza and other respiratory viruses are circulating. There is a noticeable peak in the number of cases of infection in December and January each year. There is evidence to suggest that there is increased risk of morbidity and mortality from pneumococcal disease in people with high risk conditions. Effective immunisation against pneumococcal infection therefore has an important role to play in preventing life threatening illnesses and excess deaths during the winter	Evidence suggests that the proportion of people with cardiovascular and respiratory conditions being vaccinated against pneumococcal disease is low. The latest data show that 50.9% of eligible 16 to 64 year olds and 23.5% of eligible 2 to 15 year olds with chronic respiratory disease have been vaccinated and 33.1% of eligible 16 to 64 year olds and 9.3% of eligible 2 to 15 year olds with chronic heart disease have been vaccinated. Given the considerable burden of pneumococcal disease and low levels of uptake of immunisation in clinically at risk groups, more should be done to improve vaccination coverage for these groups. A quality statement aimed at improving uptake of pneumococcal vaccination in high risk populations would help to prevent winter deaths. NB: clinical risk groups are defined in the Department of Health Green Book on immunisation against infectious disease.	For details on pneumococcal vaccination, please see the Department of Health's, Immunisation against infectious diseases – The Green Book, Chapter 25: Pneumococcal Infection, which highlights that pneumococcal disease peaks in winter months, and sets out the serious conditions which can be caused by pneumococcal disease and the current recommendations for the use of the pneumococcal vaccine including for those with chronic respiratory disease and chronic heart disease. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263318/Green-Book-Chapter-25-v5_2.pdf Please refer to the 2009 PPV Uptake Survey for the most recent available data on pneumococcal vaccination coverage levels for people in at risk groups. http://webarchive.nationalarchives.gov.uk/20130107105354/http://immunisation.dh.gov.uk/ppv-uptake-report-29-feb-

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			period.		2012/ For details on the increased risk of morbidity and mortality from pneumococcal disease in people with high risk conditions please see van Hoek et al, The effect of underlying clinical conditions on the risk of developing invasive pneumococcal disease in England. The Journal of Infection Volume 65, Issue 1 Pp. 17-24. *http://www.ncbi.nlm.nih.gov/pubmed/22394683* Please refer to Public Health England's Pneumococcal disease: guidance, data and analysis for information on the characteristics and epidemiology of pneumococcal disease. https://www.gov.uk/government/collections/pneumococcal-disease-guidance-data-and-analysis

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31	British Geriatrics Society	• Winter deaths – preventing excess winter deaths	In 2012/13 there were an estimated 30,000 excess (potentially preventable) winter deaths – most affecting older people. With rapid population ageing and a big rise in the "oldest old" and with older people often being isolated, living in older housing stock and sometimes with fuel poverty or fearful of spending on a fully heated house, this issue will continue to be important. Some of the excess is not due to hypothermia but due to preventable (influenza) or treatable (pneumonia) respiratory infections and to fractures resulting from falls in ice and snow.	Preventable mortality. Also several European countries with far colder winters (Germany, Austria, Sweden, Finland, Norway) have far lower rates of excess winter mortality. This is partly due to vaccination, partly due to building and heating standards that equip the housing stock for the weather, partly though schemes to make communities age friendly, reduce isolation and keep an eye on vulnerable, frail or demented older people, partly due to public information campaigns and partly due to better pensions entitlements leaving older people less fearful of the costs of properly heating houses, partly due to streets, public transport etc more attuned to cold weather. As we know that influenza vaccination will be the subject of future NICE quality standards we have not dwelt on it here.	WHO Europe 2012 strategy and action plan for an ageing population in Europe Melzer et al 2012 Better Healthcare for Healthy Active Ageing Birmingham Commission on Healthy Ageing Report 2014 Scottish Collaboration for Public Health Research and Policy 2010 promoting health and wellbeing in later life DH Cold Weather Plan for England 2014 Eurowinter Group Guidance 1997 Public Health England Vaccination Guidance 2013 NICE guidance on influenza vaccination All Parliamentary Group on Housing and Older People Learning and Improvement Network Report 2012 NICE 2015 Excess Winter Deaths and Morbidity and the Health Risks associated with Cold Homes Excess Winter Mortality in England and Wales 2013 ONS Public Health England 2014 Local action on health inequalities Fuel Poverty and

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					Cold Homes UK Health Forum 2014 Fuel Poverty and Cold Homes and Ill Health a guide for primary care Local Government Association Ageing Well Legacy 2012 (especially action on social isolation)

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32	British Thoracic Society	Key area for quality improvement 2 Influenza vaccination in eligible groups	There is NICE guidance for the vaccination in at-risk groups. Vaccination usually occurs in the autumn and covers the same at risk people.	People with respiratory conditions are one of the key groups at risk from the cold.	https://www.nice.org.uk/guidance/ta158 https://www.nice.org.uk/guidance/ng6
33	British Thoracic Society	Key area for quality improvement 3 Smoking cessation	There is NICE guidance on smoking cessation. Smoking is likely to exacerbate the effect of cold on lung and cardiovascular health and contributes to (fuel) poverty.		https://www.nice.org.uk/guidance/qs43
34	British Geriatrics Society	Key area for quality improvement 4	Local strategies around care for an ageing population should include plans to reduce falls and harms resulting from falls – especially fractures. They should include attention to excess winter falls and injuries associated with underfoot conditions.		
35	Rotherham Doncaster & South Humber NHS Trust	Key area for quality improvement 1 Falls Prevention, particularly for older people with mental health problems	There is strong evidence that interventions to prevent falls and harm from falls lead to improved health, independence and quality of life. Morbidity/ mortality rates linked to harmful falls in older people are significant, they are even higher for older people with mental health problems (such as depression and dementia)	Provision for falls assessment/ prevention and rehabilitation programmes for older people with mental health problems is variable across services. (Royal College of Physicians Falls and Bone Health audit results have shown that provision and service delivery -in line with guidelines- for all vulnerable groups is variable) There is a need to offer adapted programmes and increased options in terms of service delivery for older people with mental health problems and their families, this need appears to be widely overlooked (various reports from	NICE Falls guideline C.OT Occupational Therapy in the prevention and management of Falls guidance http://www.cot.co.uk/sites/default/files/publications/public/Falls-guideline.pdf Royal College of Physicians Falls and Bone Health workstreams

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			NICE fails guideline (2013) recommends assessment and interventions for falls prevention however accessing appropriate falls assessment and prevention programmes is problematic for older people with mental health problems – mainstream services can exclude them on the basis of cognitive ability or due to their difficulties with engagement/ motivation. They are also harder to reach due to their levels of dependence and isolation	Alzheimer's society and other patient/ carer bodies have identified lack of equity/ provision) Parity of esteem – NHS England current focus and workstreams National Dementia strategy/ prime ministers dementia challenge workstreams AHP and Public health workstreams: the hidden contribution of allied health professionals http://www.theguardian.com/healthcare-network/2015/feb/25/overlooked-workforce-rescuing-nhs-allied-health-professionals	AHP and Public health workstreams, the contribution of allied health professionals http://www.theguardian.com/healthcare-network/2015/feb/25/overlooked-workforce-rescuing-nhs-allied-health-professionals
36	British Geriatrics Society	Key area for quality improvement 1	Interventions to reduce social isolation and loneliness should be embedded in health and wellbeing strategies and public health priorities in every local authority		
37	British Geriatrics Society	Key area for quality improvement 2	Housing strategies at both local and national government level should incorporate plans for sufficient age-friendly housing designs built around principles such as those set out in the All Parliamentary Housing and Older People recommendations to ensure housing stock older people want to move to and live in. They should also incorporate plans to inspect heating , fuel economy for homes already occupied by older residents - especially those living with frailty, disability, dementia or social isolation		
38	Leeds City	Additional developmental	There is the possibility that some	Traditionally, some front line workers such as	

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	Council	areas of emergent practice Referral incentives for key health workers such as GP's.	form of incentive may be required to encourage some front line workers such as GP's to refer households for heating assistance, as is the case with other health priorities.	GP's haven't considered the state of heating in patient's homes to be part of their remit. Additionally, home visits by doctors are becoming rarer, therefore they are less likely to be aware of whether a patient is struggling to keep warm without asking them. It is therefore worth considering whether incentivising them to refer patients for heating assistance might be appropriate as this has been successful for other public health programmes. There is also a likelihood that some front line workers do not have the time to refer households for heating assistance, therefore a greater incentive might be desirable.	

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39	British Geriatrics Society	Key area for quality improvement 5	When older people do develop intercurrent illness associated with cold weather – in particular respiratory tract infections, including pneumonia, flu, COPD exacerbations, they need access to prompt evidence based treatment (as set out in other NICE guidance) in hospital where necessary – to reduce mortality from those infections.		
40	SCM1	How to raise awareness in both practitioners and in affected individuals in identifying those at risk	There are misconceptions and the field of factors affecting excess winter deaths is complicated, numerous and varied.	The opportunity for identification of individuals at risk is vast amongst the various potential contacts through home visiting services or those that access services in the health care, voluntary and energy industry professionals.	See: Cold Weather Plan for England 2013
41	SCM2	Key area for quality improvement 2: Training on health risks associated with cold homes (and potential for – and nature of - beneficial interventions) to be included in both initial training and CPD for all primary care professionals and service commissioners	Levels of knowledge on the health risks associated with cold homes and how they can be addressed are very low. The NICE guideline makes clear (particularly recommendations 5 and 8) that this knowledge is essential to addressing these risks with preventative interventions	Without decent training, health care professionals can't be expected to understand the health risks associated with cold home and the opportunities available to address them. A quality standard will ensure that training covers key issues, presents evidence legitimately, and ties in effectively with the NICE guideline.	See NICE guideline supporting documents
42	Leeds City Council	Key area for quality improvement 2 Ongoing training and support for front line workers and volunteers.	Ongoing training and support for front line workers is particularly important to ensure that they are kept abreast of changes to grant funding and that fuel poverty/adequate heating remain at the forefront of workers minds.	The NICE guidance rightly emphasises the need for training, particularly of front line workers. Such training is currently given on an ad-hoc basis by one or two members of council staff as and when requested by teams. However, for a more systematic approach, it is likely that a dedicated member of staff will need to provide	Leeds City Council has several years of experience of operating referral networks and fuel poverty training for front line workers and volunteers. This has taught us the importance of keeping

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				fuel poverty/cold weather training on a full time basis, particularly as our experience shows that training for teams needs to be kept up to date and refreshed.	training fresh and up to date in the fuel poverty/affordable warmth field.
43	Leeds City Council	Key area for quality improvement 3 Need to embed training for front line workers and volunteers in their work programmes, and for it to be recognised as a high enough priority at a high level of management	In order for this information to be disseminated in a comprehensive way so that affordable warmth issues are recognised where necessary, fuel poverty training needs to be embedded in front line training programmes and recognised as a priority at a high level of management	Leeds City Council and Leeds Public Health (both as part of the Primary Care Trust, and more recently as part of the Council) have had some success in training front line workers and volunteers. However, this has sometimes been on an ad-hoc basis and sometimes in response to a request from individual teams and organisations. We have found that teams and organisations have been more receptive to training, and that referrals have increased where there has been high level support.	We found that referrals for affordable warmth assistance from the primary care sector increased significantly when we were able to include them as a priority under the NHS CQUIN commissioning process for a year.
44	Royal College of Nursing	Royal College of Nursing had no comments to submit to inform on the above topic engagement at this time			
45	SCM3	I've read through both and don't have any comments or suggestions to make			
46	NHS England	Related NICE quality standards		Please add the one on influenza which is referenced at the beginning of the document where flu is excluded as a cause of winter deaths because it is apparently covered by a separate Quality Standard.	
47	Royal College of Physicians	Please take this email as confirmation that the RCP wishes to endorse the response submitted by the BGS to the above consultation			