Report to the Cabinet Member for Health and Wellbeing
Report submitted by: Executive Director Adult Services, Health and Wellbeing
Date: 12th November 2013

Part I

Electoral Division affected:
All

Affordable Warmth in Lancashire
(Appendices 'A' and 'B' refer)

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Executive Summary

The proposal is to provide funding to district authorities in Lancashire, to enable them to take action that will reduce the severe negative health consequences that cold and damp homes have on the most vulnerable Lancashire residents. These actions are expected to reduce demands on the Lancashire health and care system over the winter months, including the avoidance of emergency hospital admissions and winter deaths.

This is a deemed to be a Key Decision. Standing Order 25 has been complied with.

Recommendation

The Cabinet Member for Health and Wellbeing is recommended to approve that:

(i) £40,000 is made available as a grant, to each of the 12 Lancashire district local authorities, to enable them to deliver high impact affordable warmth interventions, over the coming winter 2013- 2014. This would be offered on a one off basis with no commitment to recurring funding. The funding would come from the public health grant within this financial year.

(ii) That these affordable warmth interventions are targeted at those most vulnerable to the harm that cold homes can have on health.

(iii) The specific format and content of the agreement with each district be delegated to the Executive Director for Adult Services, Health and Wellbeing, in consultation with the Director of Health Protection and Policy with support from the finance team.

Lancashire County Council

Background and Advice

Lancashire's Health and Wellbeing Strategy includes a delivery programme with affordable warmth as a priority. Addressing affordable warmth will make a direct impact on all four high level outcomes New and Expectant Families, Mental health, Long term conditions, and Promoting health and independence in older people. In addition it will support the healthy housing theme in the health and wellbeing Board's delivery plan and address priorities across the starting well, living well aging well work areas.

We know that emergency admissions to hospital place a significant burden on Lancashire's health and care services. Excess winter hospital admissions are rising. In 2010/11 there were 2548 excess respiratory admissions in the winter compared to the rest of the year. In 2011/12 there were 560 excess winter deaths in the County. Evidence indicates that 73% of excess deaths can be attributed to cold related illness and half of them to cold homes not just cold weather. There were 45,545 emergency admissions to hospital between December and March 2010/11by Lancashire citizens. The rate of excess winter admissions in Lancashire is significantly higher than the England average, provisional figures suggest this trend is rising.

Fuel poverty has been identified as a serious concern through the work this year with the Marmot team to addressing health inequalities in Lancashire. The Lancashire JSNA shows fuel poverty has more than doubled in the most deprived fifth of the population and has increased by more than 50% in the least deprived.

The health impacts of living in cold homes have been studied in detail and the results are well documented highlighting the impact of cold temperatures on higher winter mortality as well as a higher incidence of cold related illnesses. Amongst the most recent documents are the Marmot Review into the Health Impacts of Cold Homes and Fuel Poverty and the Hills Review into the Measurement of Fuel Poverty, please see Appendix 'B'.

District authorities and partners have a successful track record in delivering affordable warmth measures across Lancashire. The 'Affordable Warmth Interventions in North Lancashire (evaluation) Report' has highlighted personal stories of people who have benefited from the often small scale interventions and report significant health and wellbeing benefits, see Appendix 'A'.

Over the last two winters Warm Homes Healthy People (WHHP) funding was made available from the Department of Health to reduce deaths and illness due to cold housing. The Department of Health have now confirmed that this funding will not be available this year and instead point to the public health grant that is now held with councils since the implementation of the Health and Social Care Act. In 2012-13 all of the districts received WHHP funding, each district received on average £57,000, from WHHP funding.

Districts authorities in anticipation of WHHP funding being available have already identified needs within their community and have a delivery mechanisms already in place, should funding be made available. The ability of the district councils and other partners to deliver these services is very much dependent on funding they have

available. Without the WHHP funding many districts have indicated that they would not be able to offer the same level of intervention, particularly where emergency heating and heating repairs and replacements are concerned.

At this point in time a lack of committed resources not only significantly reduces the capacity to meet people's needs, but also makes it difficult for services to plan their response to the coming winter.

The winter impact of cold homes in Lancashire

If cold homes are attributed to 50% of excess winter respiratory admissions, (the Interim Hills report suggests that around half of EWD are caused by cold homes[1]), this would mean that in winter 2010 /11, 1274 emergency respiratory admissions alone could be related to cold homes, not just cold weather. In addition to the poor health experienced by individuals this has significant cost implications, please see appendix 1.

Lancashire EWD for 2010/ 2011 was 560, of which around half can be attributed to cold homes.

In addition to exacerbating respiratory conditions, cold homes are known to exacerbate circulatory disease. Cold homes also contribute to poor mental health outcomes particularly impacting on young and older people, please see appendix 2. Cold homes can increase arthritic symptoms, cause loss of mobility and increase falls and accidents; they can also increase social isolation. Older people who have a health condition exacerbated by the cold or have sustained injuries due to the cold, may need increased care or need to go into residential care.[2]

Options for Delivery

Option 1

It is proposed that funding is made available to each district authority, to target high impact, evidence based affordable warmth interventions at the most vulnerable people. Specifically districts will be asked to specify in the grant agreement how their work will benefit the following groups that evidence shows are particularly vulnerable to cold weather: older people; people with a disability or long term illness; children and young people; and people with mental health conditions.

The district authorities as the previous recipients of WHHP funding have their own established delivery mechanisms to deliver winter warmth programmes. In this option they would be responsible for delivering the work throughout the winter period. Distribution of the grant to district authorities will enable us to utilise these existing mechanisms and allow work to begin as soon as possible, making it possible to rapidly agree delivery actions, which is vital with the winter so near. These established mechanisms include working with the third sector and community organisations which are essential for the effective delivery of the programme. Districts will be expected to coordinate local action with partners including the third

[1] Fuel poverty- the problem and its measurement – interim report by the Fuel Poverty Review. John Hills 2011 (p74)
[2] The Health Impacts of Cold Homes and Fuel Poverty: the Marmot Review Team. 2011

sector to make the most effective use of the funding available, and can ensure it fits in with other local housing initiatives that the districts are responsible for and have expertise in.

The Public Health grant would be used to fund £40,000 for each district on a one off basis, committing this amount would allow planning of services to take place and increase our chance of identifying the most in need individuals, therefore it is important to commit the funding in a timely manner.

Advantages:

- District Councils were anticipating WHHP funding being made available for Winter 2013/14 and because of this many have local winter warmth partnerships (involving local third sector partners) on standby to bid for funding and deliver measures, reducing the risk of delivery being delayed until later in the winter.

- By leading delivery, District Councils are able to ensure that this programme is fully integrated into their existing housing programmes, such as private sector enforcement activity, energy efficiency programmes and home improvement agencies.

- It is suggested that, with their detailed local knowledge and housing responsibilities, district councils are the most suitable organisations to lead the delivery of winter warmth programmes.

Disadvantages:

- The successful delivery of this option assumes that District Councils have in place effective local partnerships that involve all of the key local organisations that can contribute to the delivery of winter warmth programmes. Experience from WHHP suggest that district councils are able to play this co-ordinating function, however third sector organisations may be equally able to fulfil this role.

Option 2

That an open application process is established though which local partnerships and third sector organisations could apply directly, for up to £40,000 in each area. Organisations within the third sector have an effective track record in delivering affordable warmth measures, often as part of local partnerships. If this option is agreed LCC will need to be assured that delivery of the programme is effectively coordinated between third sector providers, district councils and other local partner, and integrated with district council housing services in each area. A longer run in time would be required to identify all local potential partners, promote the scheme to them, and evaluate proposals and to ensure different proposals from within an area were complimentary. This would risk delaying delivery into the winter months.

Advantages

- This approach will be more inclusive and could allow a wider range of partners to bid for resources to deliver winter warmth, so that the most suitable are selected to lead the programme.
- Third sector providers may be better placed to lead and co-ordinate the delivery of winter warmth programmes.

Disadvantages

- The process of inviting and evaluating bids and ensuring co-ordination of bids from the same area will add further steps into the process of distributing resources for delivery which will inevitably create delays.
- There is a risk that non district council providers will be less able to integrate winter warmth measures into existing district council housing interventions that can add value to winter warmth measures.
- There is a risk that a range of local organisations from the same area will compete for funding rather than collaborating.
- There is a risk that a greater proportion of resource would be diverted from delivery of measures to fund co-ordination while District Councils have the capacity to undertake the co-ordination from within their existing services.

For the reason of securing rapid and coordinated actions that are integrated into existing housing services, it is recommended that the grant is distributed directly to district authorities as set out in option 1, districts will need to demonstrate how they are involving local partners.

It is anticipated that if resource is available to fund winter warmth measures in future years it be integrated into wider healthy homes services and a commissioning approach will be used.

Requirements of grant recipients

The funding will be made available to districts on a one off grant basis, in consultation with the district councils we will agree to spend the money on high impact affordable warmth measures this winter, and target the most vulnerable people.

If agreed, the work funded by LCC's public health grant will be promoted, in accordance with LCC communication procedure.

The national evidence and experience from within Lancashire will inform spending on interventions appropriate to the needs of the individual such as heating repairs, emergency heaters and advice about keeping warm; that can have a lasting impact and are not just a temporary fix. Advice and support to individuals can also make a real difference, giving people the financial confidence to use new heating systems. In North Lancashire last year approximately 185 people were assisted at clinics for utility bills. Overall they realised an average bill saving of £141.88 each. Private sector housing enforcement work has also been carried out to improve the conditions of privately rented housing, (see Appendix 'A' for more details on the types of intervention that could be delivered).

LCC will agree with each district the interventions and this agreement will be used to ensure value for money, to monitor the effectiveness of the work done and to capture the learning and outcomes of the work. The agreement will include a monitoring requirement and for each district to set out, how it intends to deliver the work. Only when LCC is satisfied that the proposed activity is value for money will LCC make the funding available.

LCC would expect the majority of the funding to be spent within winter before the end of March 2014. If this is not possible, district authorities will be required to report to LCC how much, if any, of the grant allocated will not be spent by the end of March. Requests to carry forward unspent grant to the next financial year by district authorities will be considered if the carried forward amount is committed to expenditure in line with the objectives set out in the original agreement.

LCC will ask health partners to help identify the most vulnerable people with health conditions that are exacerbated by cold homes, so that they can benefit from the support that is available.

As already highlighted, cold damp homes exacerbate health conditions and seriously restrict the lives of those affected, in some of the most serious cases they can cause hospital admissions and even death. The benefits to individuals and the cost savings to organisations make a shift to early intervention and prevention a key approach to dealing with winter pressures and managing long term health conditions.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

The risks of not implementing this work will mean a missed opportunity to mitigate the worse effects of winter on some of our most vulnerable residents. If this decision is implemented, securing effective action and value for money is vital, please see actions outlined in the main report.

Financial

The recommended option would see £40,000 being made available as a grant to each of the 12 Lancashire district local authorities on a non-recurrent basis. The total amount committed would therefore be £480,000, and this would be funded from the Public Health grant in 2013/14.

List of Background Papers

Paper	Date	Contact/Directorate/Tel
N/A		

Reason for inclusion in Part II, if appropriate

N/A

Appendix 'A'

What Works

Based on the experience of the last two winters in Lancashire the interventions that have had the largest impact are boiler servicing and repair/replacement and general heating system repairs. The outreach support WHHP has provided has been valuable in helping to identify people that are in need quickly, and supported fuel debt advice work, fuel switching clinics and advice on entitlements to benefits that can significantly increase income. Cold weather alerts are used to ensure vulnerable people are warm and have sufficient supply of food etc. preventing a crisis from occurring.

Emergency heating and prepaid fuel cards provide immediate alleviation of crisis situations, which analysis of actual case work suggests has prevented readmission to hospital, and gives temporary relief whilst more permanent measures can be put in place.

Projects working with people from the community can provide practical support and reduce social isolation, including neighbourhood befriending schemes, volunteer snow clearance and shopping support, for example. These initiatives work with the assets that communities have and can be supported by relatively low levels of financial support, for example last year £889 has paid for snow clearing equipment, DBS certificates and rock salt for ten 'snow angles'.

Boiler and heating repairs can cost as little as £200. Based on the average cost of emergency respiratory and CVD hospital admissions in Lancashire 2011/12 (£2,433) a saving would be made each time one in every 12 interventions prevents one hospital admission, in addition to the savings to other services and most importantly a better quality of life for the individual affected.

The average cost in Lancashire of a respiratory hospital admission is £1,829[3]

The estimated cost of emergency excess winter respiratory admissions attributed to cold homes:

1274 cold homes attributed respiratory admissions Lancashire 2010/11 x £1,829 = **£2,330,146**

The above is only an estimate of the cost of respiratory hospital admissions and doesn't account for other conditions, the personal costs to the individual or other services, such as increased social care costs and increased visits to the GP associated with cold homes. By targeting cold homes that house people with a

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[3] *Costs for non-elective hospital admissions in Lancashire 2011/12 are calculated for individual admissions (based on Secondary Users Services – Payment by Results) and added together for all admissions with a primary diagnosis of respiratory disease or circulatory disease. These costs are used for payments to acute trusts from Clinical Commissioning Groups*

health condition the numbers of EWD and emergency admissions prevented would increase

Monitoring of this work and feedback from residents suggests this has significantly improved their lives and kept people out of hospital. In Lancashire these interventions have been particularly effective when targeted at the most vulnerable groups, this includes people with a long term health condition, older people and children. The 'Affordable Warmth Interventions in North Lancashire report' highlights some examples of people who benefited from the often small scale interventions and reported significant health and wellbeing benefits, please see examples below:

***Client 1,* Angina, diabetes and depression; Wife has spondylitis, fibromyalgia, osteoarthritis and rheumatoid arthritis**
"We had no heating and hot water for 12 months. This has been a great deal of help. My wife has fibromyalgia and the cold weather bit into her; she had to have hot water bottles all around. We are now as snug as a bug. It has helped our health, it's helped my depression. I still have depression but I am not worried about keeping warm. The warmth has helped, we can wash properly; we only had cold water before. It has helped us physically and mentally. Without the funding we would not have been able to have the work done as we have no spare money. I don't know what we would have done"

Client 2, child aged 2 with Cerebral Palsy
"I had no money to pay for a new boiler when mine broke down. The new boiler keeps our house lovely and warm. My son suffers with Cerebral Palsy and being able to keep the house warm has made a big difference to him as he hasn't suffered so many chest infections. It's a more efficient boiler now and saves me money on my bills. It has also taken away the worry of the boiler breaking down"

Those clients receiving support had significant health conditions and were frequent visitors to their GP and/or have high levels of hospital admissions.

Appendix 'B'

Evidence case for action

Although there are various contributing factors to EWD diseases which are known to be affected by the cold account for almost three quarters (73%) of these deaths. These are diseases of the circulation (40%) and respiratory illnesses (33% of deaths)[4]. Cold weather and in particular cold homes is believed to be a main factor in causing the winter increase of respiratory and circulatory disease[5]. Deaths related to influenza and hypothermia represents only a small proportion of EWD.

The Hills report concludes that 'most of the changes in seasonal death risk seem to be related to the cold, with influenza and other risk factors bearing a smaller influence[6]. Hills also noted that the number of EWD is more than 10 times the number of deaths recorded from transport accidents.

Although there is more data on excess winter deaths than cold related illnesses, there is a considerable link with cold homes and ill health and subsequent pressure on the health service. The Department of Health reports approximately 8 hospital admissions for every excess winter death[7]

When cold weather occurs there is a sequence of events as people suffering from cold related illnesses are admitted to hospital, and there is a peak in deaths due to heart attacks after two days, strokes after 5 days and respiratory illnesses after 12 days.[8]

There is clear evidence of the link between living in low temperatures and poor mental health outcomes. Living in low temperatures has a significant relationship with common mental health disorders, and householders' reports of under use of heating and the prevalence of mould growth in the home also shows a relationship with poor mental health outcomes[9].

Cold Homes or Cold Weather?

There is a body of evidence which specifically considers the impact of cold homes on health, rather than simply cold weather. Studies reported in both the Marmot Review and the Hills Report look at the impact of the age and energy efficiency of homes. As there are other impacts such as behaviour, and the warmth of clothing when outside the house, expert opinion reported in the Hills report (Professor Paul Wilkinson and Professor Christine Liddell) suggest that internal and external temperatures each account for half of the temperature related excess winter deaths (Hills p 74).

The Marmot Review team estimates that 21.5% of all excess winter deaths can be attributed to the coldest 25% of housing, due to them being cold. This is over and

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[4] Chief Medical Officer report 2009
[5] The Health Impacts of Cold Homes and Fuel Poverty: the Marmot Review Team. 2011 (p24)
[6] Getting the measure of fuel poverty Final report of the fuel poverty review. John Hills 2012 (p73)
[7] Health and Winter Warmth. DOH Public Health Group (South East)Factsheet. 2009
[8] Chief Medical Officers annual report 2009
[9] Getting the measure of fuel poverty Final report of the fuel poverty review. John Hills 2012 (p81)

above the amount of deaths which would have occurred if these houses had the same winter excess deaths as the warmest 25%. These calculations took into account the number of deaths attributable to the house being cold rather than other factors (e.g. flu epidemics, air pollution, cold outside temperatures etc.).

This means that the coldest housing accounts for a disproportionate number of excess winter deaths. There is a statistically significant increase in excess winter deaths in older housing (28.8% in properties built before 1850 compared to 15% in properties built after 1980), and housing with poor thermal energy efficiency ratings[10].

Nationally there are studies which support the impact of intervention work, for example work to remove mould and provide comfortable level of heating in Glasgow had a major impact on health, including a reduction in the use of medication, a fall in hospital admissions, and reduced blood pressure for residents. Studies have also shown that improvements to homes with children who have asthma or a recurring respiratory condition can reduce the number of sick days off school by 80%.

[10] The Health Impacts of Cold Homes and Fuel Poverty: the Marmot Review Team. p24. 2011