Public Health England

Protecting and improving the nation's health

Protecting health and reducing harm from cold weather – local partnerships survey report

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Abbreviations

CAB	Citizen's Advice Bureau
CCG	Clinical commissioning groups
CWP	Cold Weather Plan for England
DECC	Department of Energy and Climate Change
DH	Department of Health
DWP	Department of Work and Pensions
ECO	Energy Companies Obligation
GP	General Practitioner
HWB	Health and wellbeing board
JSNA	Joint strategic needs assessment
LA	Local authority
NHS	National Health Service
ONS	Office of National Statistics
PHE	Public Health England
SAP	Standard assessment procedure
WHHP	Warm Homes Healthy People Fund

Executive summary

Introduction

The Cold Weather Plan for England (CWP) provides a framework to protect the population from harm to health from cold weather. PHE received a number of requests from local areas for information on how others were providing services in line with the plan, and how activities were being funded and commissioned in the new health and social care structures.

Aim

The aim of this survey was to gain an overview of the provision of services aligned with the aims of the CWP, in light of new arrangements for the commissioning and funding of these types of projects.

Methods

An online questionnaire was sent to all upper tier local authorities.

Results

Activities to reduce the harm to health from cold weather continue at local level, however, many schemes have had to reduce scale and scope of services due to a reduction in funding or resources. Examples were given of different funding streams and approaches to commissioning services. Projects continue to use innovative and creative ways of providing services to communities and those most vulnerable to the negative health effects of cold weather. Partnerships remain key to effective working and local schemes continue to build on these relationships, although uncertainties around funding have, in some instances, had a detrimental effect on partnerships.

Conclusion

While many local authorities continue to provide programmes and interventions to protect health and reduce the harm from cold weather, it is apparent from this survey that the provision, funding and commissioning of services is not universal. Recommendations include:

- taking a system-wide approach to addressing the harm to health from cold weather, and nurturing and protecting existing partnerships

- reflecting the Cold Weather Plan and other strategic and operational plans in joint strategic needs assessments and health and wellbeing strategies
- ensuring that interventions are focused on addressing inequality locally, are proportionate to the level of need identified in the local population and are not inadvertently excluding those most at need
- placing greater emphasis on monitoring and evaluation of projects.

Introduction

Cold weather plan for England

The Cold Weather Plan for England [1] (CWP) provides a framework to protect the population from harm to health from cold weather. 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.

The CWP 2013 [1] recommends a series of steps for

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

It emphasises the importance of year round planning (action at level 0), of winter preparedness and action, (level 1) and of the importance of a long term strategic and year-round approach by health and wellbeing boards (HWBs) and commissioners to reducing winter morbidity and mortality.

The Warm Homes, Healthy People (WHHP) Fund was first announced with the publication of the Cold Weather Plan for England in November 2011. The fund aimed to support implementation of the Cold Weather Plan by making £20 million available in 2011 -12 and again in 2012-13, to support local authorities and their partners in reducing death and illness in England due to cold housing. The fund was part of a range of measures that the Department of Health (DH), NHS and other government departments took to protect individuals and communities from the effects of severe winter weather.

The Effects of Cold Weather on Health

The Office for National Statistics (ONS) calculate excess winter deaths by comparing the number that occurred during the winter period (December to March) with the average number of deaths occurring in the preceding August to November and the following April to July. For the winter of December 2012 to March 2013 provisional ONS figures show an estimated 31,100 excess winter deaths in England and Wales. This is an increase of 29% on the previous winter figure of 24,200. Likely explanatory factors for the higher than average number of excess winter deaths in 2012/13, are the prolonged influenza season and the unusually cold February and March. The majority of these deaths (25,600) occurred in people aged 75 and over.

Excess winter deaths and cold weather associated morbidity are mostly preventable. The CWP 20131 refers to strong evidence that excess winter deaths are related to cold temperatures and living in cold homes as well as infectious diseases such as influenza.

Direct effects of winter weather include an increase in the incidence of:

- heart attack and stroke
- respiratory disease
- influenza
- falls and injuries
- hypothermia.

Indirect effects of cold include mental health illnesses such as depression, and carbon monoxide poisoning from poorly maintained or poorly ventilated boilers, cooking and heating appliances and heating.[1] The effects of cold weather are most felt by vulnerable groups such as older people, the chronically ill, children, those with mental health problems and people with disabilities. Children living in cold homes are further disadvantaged as their ability to concentrate on homework is affected by the cold.[2]

Cold Homes and Fuel poverty

The Government has recently set out a new definition of fuel poverty following the review undertaken by Professor Sir John Hills.[3] Under this definition, a household is said to be in fuel poverty if:

- they have required fuel costs that are above average (the national median level); and
- were they to spend that amount they would be left with a residual income below the official poverty line [4]

Under the new indicator (the low income high cost indicator) the Department of Energy and Climate Change (DECC) 5, estimate that 2.28 million households were in fuel poverty in 2012, representing approximately 10.4% of the population. This represents a reduction of almost 5% of total households in fuel poverty, compared with 2.39 million households in 2011.

The DECC report refers to the ‘fuel poverty gap’ - a measure of the depth of fuel poverty calculated as the difference between a household’s modelled fuel bill and what their bill would be for them to be no longer fuel poor. The DECC report states that the aggregate fuel poverty gap fell by 5% from £1.06 billion in 2011 to £1.01 billion in 2012 as did the average fuel poverty gap over this period, from £445 to £443 (the average gap is the total gap divided by the number of households in fuel poverty). The DECC report suggests that this reduction results from changes in income, fuel costs and energy efficiency levels amongst fuel poor households that are broadly consistent with the

changes seen for the population as a whole. The overall change in the number of households in fuel poverty was relatively small – with the reduction happening mainly due to income increases for higher income fuel poor households.

DECC predicts that the number of households in fuel poverty is projected to increase from 2.28 million in 2012, to 2.33 million in 2014, with increases in energy costs a key factor.[5]

Lack of energy efficiency in the home is a key driver for fuel poverty and the DECC report shows that the depth and likelihood of fuel poverty increases with lower energy efficiency, measured using Standard Assessment Procedure (SAP) scores. Addressing energy inefficiency therefore continues to be an important step in reducing fuel poverty.

Although fuel poverty remains an issue, living in a cold home can be due to other behavioural and circumstantial factors and it is important to recognise that fuel poverty is not necessarily synonymous with living in a cold home, and vice versa. For instance, people can be fuel poor and not live in a cold home if they spend a sufficiently high proportion of their income on heating, although this may have consequences for other aspects of their health and wellbeing.[2] Others may not be fuel poor, but do not heat their homes adequately , sometimes by choice or embedded behaviours, or because of difficulties using heating systems.[6] People can of course be both fuel poor and live in a cold home.[2 6]

The amount households spend on heating may be influenced by the make-up of the household and the behaviours of individuals within. For example households may have increased heating needs if people spend more time at home because they are older, unemployed, have chronic illnesses or reduced mobility or if they are a family with young children. Many of these groups will also be less active at home and may be at increased risk from some of the harmful effects of living in cold temperatures for long periods.

Although we need more research to fully understand the links between prolonged exposed to cold and damp conditions at home and poor health outcomes, there is good evidence with regard to excess winter deaths and illness that cold housing plays a significant role in excess winter deaths and illnesses.[2 7]

Background and aims of the partnership survey

Evaluations of the WHHP funds in 2011-12 [8] and in 2012-13 [9] were undertaken by the former Health Protection Agency and Public Health England (PHE). The evaluations highlighted a number of themes including; the value of partnership working; the wider

benefits of interventions aimed at reducing harm from cold weather on health and wellbeing; and examples of good practice. In addition, the evaluations set out a series of recommendations for commissioners and service providers.

Local schemes continued over the winter of 2013-14; though the extent of provision and coverage across the country was unknown. PHE received a number of requests from local areas for information on how others were providing services and agreeing joint funding in the new health and social care structures through clinical commissioning groups (CCGs), local authority public health departments and other local authority or external funders.

The aim of this survey was to gain an overview of the provision of services aligned with the aims of the CWP in light of new arrangements for the commissioning and funding of these types of projects. We wanted to identify whether the range of interventions that were previously set up with funding from the WHHP fund were being continued. The survey also sought to ascertain whether actions were being undertaken in areas that did not receive WHHP funding and whether new interventions have been developed. This report aims to share information on what has worked well and the challenges experienced, and to establish a baseline of funding provision, resources and ideas.

Methods

An online survey was sent to all 152 upper-tier local authorities in England.
The survey was developed with input from Department of Energy and Climate Change (DECC), PHE and local authority colleagues working on winter warmth projects at London Borough of Islington Council and Dorset County Council. It was then piloted with a small sample of colleagues and further amendments made prior to the launch of the survey.

Results

Responses

The online survey recorded 252 views of the questionnaire with 113 responses. This was reduced to 73 completed questionnaires after the removal of duplicates and spoiled responses. This equates to a response rate of 48%.

Responses were received from local authorities across the country and included 10 London boroughs, 25 other metropolitan or unitary authorities, 19 upper tier (county) authorities and nine lower tier (district or borough) authorities. Of those completing the form, seven were employed as project officers responsible for affordable warmth or cold weather related projects. A further 12 had climate change, carbon reduction or sustainable development in their job title. Twenty-five were from a public health department (consultant or specialist posts), 22 had an environmental health/ private sector housing role and five had a job title suggesting a role in adult social care.

Of those who responded all but five had branded affordable warmth or cold weather related programmes with these five stating they had no specific branding for their programmes which were part of a wider strategic approach.

Cold weather interventions in 2013/14

Most respondents, 56/57 (98%) who answered the question, stated they were running a programme to address excess wither deaths and/or fuel poverty in the current year.

Few respondents (n=5) gave reasons for not offering specific programmes. Of these one referred to absence of funding opportunities from either national or local statutory bodies. The remainder stated that aspects of work on fuel poverty and reducing excess winter deaths are delivered through statutory services in private sector housing or through other programmes.

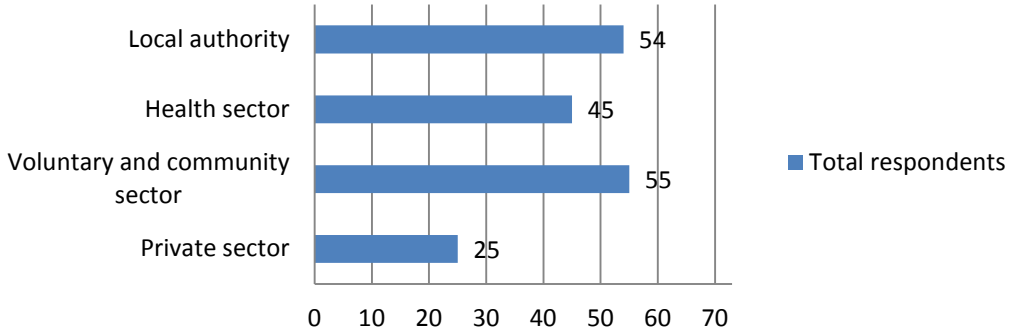
Partnerships

The 2012/13 Warm Homes Healthy People fund evaluation showed that collaborative working was key to the success of local programmes. Responses from this survey suggest that programmes continue to be delivered through partnership approaches with local authority, health sector and community and voluntary sector partnerships being the most prevalent (Figure 1). Twenty-five respondents reported they are also working with private sector partners, including energy companies and installers of energy efficiency measures. In addition, partnerships with ambulance, police and fire and rescue services, the Department of Work and Pensions (DWP) and faith based groups were reported. A number of respondents reported an increase in the number of stakeholders involved in their programmes. The advantage of public health being located within the local authority was highlighted by some.

"Public Health sitting within local authority, and the increased joint working across directorates, which, amongst other things, has enabled better sharing of resources and capacity"

"…the integration of Public Health into the Local Authority, meaning shared priorities/outcomes are more recognised."

Figure 1: Involvement of different sectors within partnerships to deliver interventions to address winter deaths and fuel poverty (*n=63*).



The wealth, health and wellbeing project in Tameside provides an illustration of how partners can work together to address the needs of the most vulnerable residents in the community.

Case study 1: Wealth, Health and Wellbeing in Tameside

The 'Wealth, Health & Wellbeing' project was delivered by a partnership involving the local authority environmental development services, the local Health Improvement provider and Housing associations in Tameside. It aims to deliver a range of services to the doorstep of some of the most vulnerable residents in the community and is provided as a more direct alternative to signposting families to services.

The housing association provide intelligence on the best areas to target the intervention based on levels of need of the residents - mostly focussed around the amount of rent arrears. A number of service providers are then able to deliver doorstep services with many of the assessments and interventions actually taking place in the resident's living room. A range of services are made available such as Citizens Advice Bureau, careers advice, health trainers, debt advice, benefits advice and also a fuel poverty assessments. The latter being provided by the local authority.

The fuel poverty assessment encompasses issues with gas, electricity and water bills and also on keeping warm and being energy efficient. The case studies below illustrate how the programme works and how multiple interventions that can be achieved in the home.

Personal case study 1: The client was a single person living in social housing who spoke no English and had no friend or family support network. The client, who was in contact with support services, was concerned over the amount being spent on gas and electricity and that the heating was not working. An interpreter attended the initial assessment to allow discussion with the resident.

Further investigation revealed that the resident did not fully understand how the pre-payment gas and electricity meters operated. We found that there was significant credit on the electricity meter (around £70) and the gas meter had a fault which the resident had not realised. Engineers from the gas supplier were contacted and came to the property within 3 hours and replaced the faulty gas meter. This had not been accumulating the credit being placed on it so the credit the resident had put on there was refunded (around £70) and it was explained how to operate these in the future.
The client also had an outstanding water bill. The water supplier was contacted to clarify amount owing and an affordable payment plan was set up for this. The resident was also signed up to have a water meter installed as they were single occupancy which will save in the region of £150 per annum.

The resident was also referred to local support services and now attends a coffee morning with other local residents speaking the same language as isolation was identified as a key issue.

Personal case study 2: The client was a single parent with two children living in social housing and in receipt of multiple benefits. She presented with a moderate amount of debt with gas and electricity supplier and a high amount of debt with water supplier. Contact was made with gas and electricity supplier to clarify the amount of debt and due to this being a moderate amount and accrued recently, an affordable repayment plan was arranged to clear off £140 gas and electricity arrears over an 18 month period. A tariff switch with the supplier was also arranged to gain lower prices going forward (total saving of £14 per month). An application to the Warm Home Discount was also submitted and confirmed successful over the phone gaining the resident an additional £135 support on the electricity account in the winter.

The resident also explained physical disabilities and was placed on the Priority Service Register with their gas and electricity supplier which provides a range of additional support for customers with disabilities. The housing association benefits advisor was also able to offer support.
The key feature of this programme is that it brings support to the home rather relying on signposting. One of the most striking findings to come out of this project is that over 70% of the participants stated that they had not accessed these services previously. These services were available and a large amount of signposting had already taken place via schools, community venues, newsletters and direct mailings. This shows that previous attempts to engage with these households in need have not been successful.

Furthermore, 50% of the households accessing services accessed more than one service (e.g. Fuel Poverty assistance and CAB advice etc).
In a further development a project run by one of the Housing Associations is training tenant volunteers to carry out home visit assessments to help people with energy related issues - energy efficiency and bills. This was funded through DECC Big Energy Saving Network Fund.

The local authority is contributing to the training of the tenant volunteers and has provided a flowchart and supporting information so the volunteers had a pathway to follow in assessing the needs of the residents.

The project evaluation is still pending but this project illustrates how up-skilling volunteers and creating tools to replicate good practice among other teams/projects/organisations can extend capacity.

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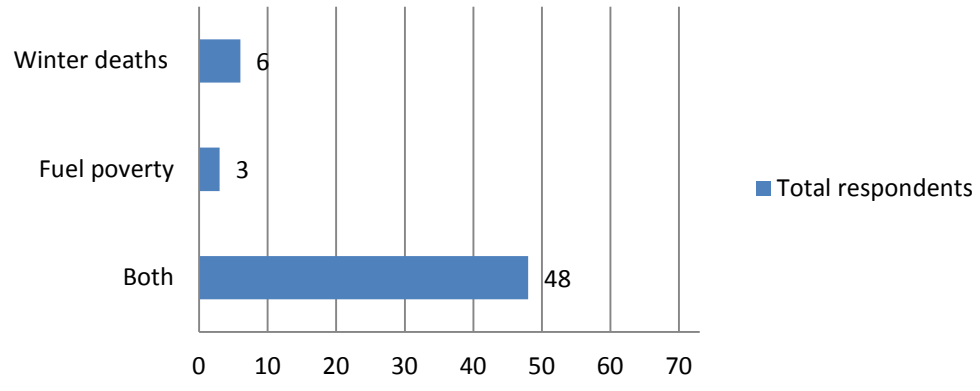
Strategic planning

Figure 2: Consideration of winter deaths and fuel poverty within Joint Strategic Needs Assessments (*n=67*)



The survey asked if fuel poverty and excess winter deaths were featured as a priority in local strategic plans.

Eighty-four per cent of respondents stated that both winter deaths and fuel poverty were identified as issues within the local strategic plans, including health and wellbeing strategies, with the remainder stating that either winter deaths (19%) or fuel poverty (8%) were featured. Four people chose not to respond to this question. Similarly, when

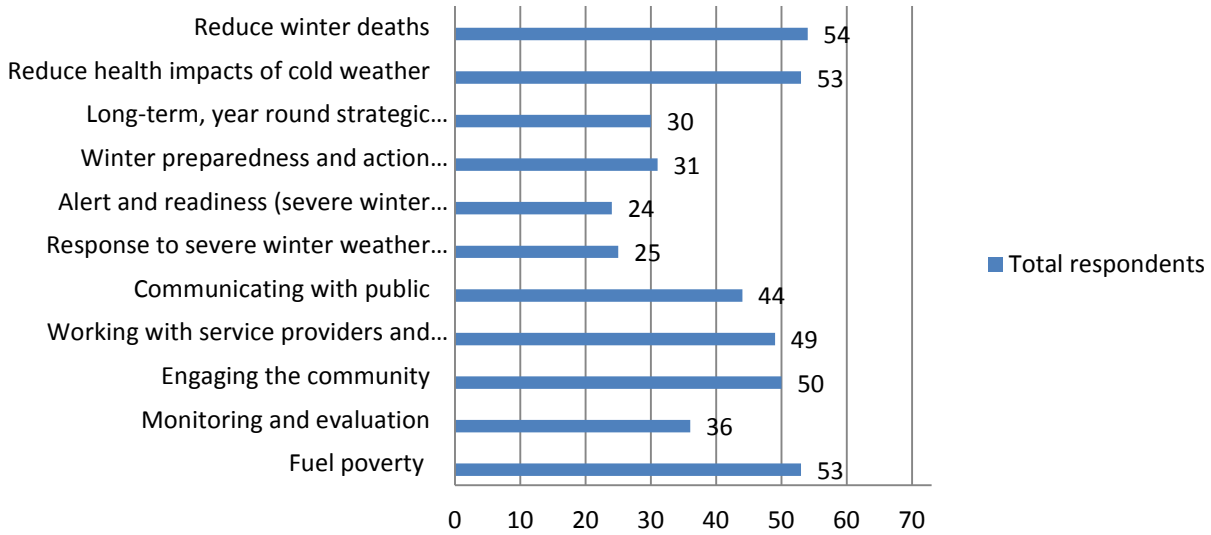
asked about specific actions on these issues; fuel poverty (22%), winter deaths (10%) or both of these (68%) were identified as commitments within each organisation's strategic plans.
Forty-six organisations provided web links to their strategic plans, joint strategic needs assessments or other policy documents. Others referred to documents currently in production or being revised.

As in the previous year, the proportion of respondents who stated they were engaged in long term planning was low (figure 3) which might be surprising given the high proportion of respondents who stated that action to prevent harm from cold weather was featured in strategic plans. It is possible that interventions related to fuel poverty for example, were not identified as 'long term planning'.

What services were provided?

Respondents were asked to identify which elements of the Cold Weather Plan for England their programme aimed to address.

Figure 3: Number of respondents that feature elements of the cold weather action plan for England in their intervention programme (*n=63*)



The proportion of respondents who stated they were delivering interventions to increase winter preparedness (level 1) was lower than in the previous year (66%). While home energy efficiency interventions such as insulation and heating modifications were the most often cited interventions; falls prevention programmes, schemes addressing social isolation, training of frontline staff and volunteers and community events were also given as specific examples.

There was also reduction in the rates of alert and readiness (level 2) programmes compared with previous years. While we cannot be certain of the reason for this reduction it may be due to a shift of emphasis towards CWP alert levels 0 and 1. It may also reflect that the period covered by the survey was a period of transition for public health teams.

Reactive services to severe cold weather, ice and snow were reported by 25 of the respondents. Seven schemes referred to a cold weather alert system for vulnerable residents including a text messaging services.

Communications and engagement

Of the 63 replies, 44 (70%) specifically referred to communicating with the public and 50 (79%) to engaging with communities. Awareness raising was a key aspect of communication strategies with the provision of advice and education for residents (62%) and staff and partner organisations (60%) featured in on-going work programmes.
A range of communications activity was reported including community energy efficiency events, distribution of promotional materials, benefits checks and debt advice. Respondents also referred to joining up with other campaigns such as the flu jab programme and an older people's festival.

Case study 2: Knowsley - Be prepared for winter.

The Be Prepared for Winter Steering Group aims to ensure that all relevant partners are working together to help vulnerable residents within the borough to stay safe and healthy during the cold weather. The group membership includes representatives from public health, local authority risk and resilience, neighbourhood services, NHS providers, social care, housing, care and repair services, voluntary organisations, CCG, environmental health, energy efficiency officers and financial inclusion.

The group has developed a shared understanding of the issues posed by winter and has shared work and communications. Outreach activities have taken place to promote health messages, energy efficiency and access to boiler repairs. Initial communications, including messages on health impacts of cold, flu vaccination, personal and household hygiene and fuel efficiency have been disseminated to a wide range of partners including social care, care homes and residential homes, voluntary sector organisations, schools and nurseries and housing associations.

Communications to cover Cold Weather Alert levels 2 & 3 have been pre-prepared, including media messages. A trial of the information cascade system for Cold Weather Alerts was undertaken in January, with emails sent to all relevant contacts including social services, residential homes and housing associations, as outlined in the Cold Weather Plan. A key issue was that contacts were missing or out of date, and this has

now been raised at Knowsley Resilience Action Group and added to the health protection risk log.

Addressing fuel poverty

Tackling fuel poverty was an aim of 84% of local authorities who responded. Schemes refer to a range of short and longer-term interventions to tackle the three key determinants of fuel poverty - improving the energy efficiency of the home, energy costs and increasing household income. Some of these are referred to in the case studies below.

Case study 3: Bradford Fuel Poverty Programmes

Bradford's fuel poverty programmes have traditionally included the role of the Warm Homes Officer. This post holder offers expert advice and help on the practical interventions which can mitigate fuel poverty issues. It also links directly into advice systems through funded quality marked services for those in acute fuel difficulties. This offers debt advice and higher level representation work through to tribunal level and under certain circumstances fuel 'top ups' to maintain heat, light and power to homes. There are also opportunities to tap into any government programmes on offer such as Green Deal to replace heating systems, appliances and install insulation.

Personal case studies

A gentleman was referred for a food parcel and gas/electricity top up via Bradford's Warm Homes Healthy People (WHHP) programme. He told us his circumstances and we felt he needed longer term provision of support as he was not in touch with any other services, to which he agreed. We contacted the Department of Work and Pensions and requested that the deductions from his benefit payment were reduced to a lower amount. We assisted him to attend a benefit tribunal which he won, we assisted him to obtain a concessionary bus pass and we assisted him to access debt advice at the Citizen's Advice Bureau (CAB). On one occasion he was very, very poorly and we liaised with his GP surgery for a home visit. He also had a spell in hospital; we visited him as he has no family in the area. With this intervention his circumstances have much improved and he knows he has support when he needs it which has greatly helped his mental health.

A woman we visited to give a food parcel and electricity top up to was in a desperate state. Her home, in a privately rented house, was so damp it ruined all her furniture. Her three children were forced to sleep in one room for warmth and beds and bedding were covered in mildew. This had obvious effects on their health and wellbeing. She was a single parent and was working part time. The landlord was not forthcoming in helping with the property so our support worker took her to view other places. With a small deposit from WHHP she now has a suitable property fit for her needs and no longer has to manage in inadequate housing.

Case Study 4: Cumbria Community Foundation winter Warmth Appeal.

Cumbria County Council has worked with third sector partners in the county to support vulnerable groups in the winter through the Warm Homes Healthy People Fund and last winter using the Local Welfare Assistance Fund. The county council has worked with Cumbria Community Foundation's Winter Warmth Appeal since 2011. It collects public donations and manages hardship grant distribution through a network of intermediaries including local Age UK branches. In 2013/14 over £100K was raised with over 700 households and more than 1000 older people on low incomes and in challenging circumstances benefiting from the fund. The Appeal has been integrated into the wider public health promotion work of the health and wellbeing board and the award winning 'Taking the Brrr out of Cumbria' programme.

The council has also worked with third sector run children's centres to help families at risk with financial support and help and advice on keeping warm.

Monitoring and evaluation

Thirty-six of the 63 schemes that responded (57%) were engaged in monitoring and evaluation. This low number may have been due to a lack of resources locally or to the absence of an evaluation framework or the requirement to report back to funding bodies as had been the case under the WHHP programme.

Specific interventions

Short term interventions: The survey asked for information about interventions that provided emergency assistance to people in need. Sixty schemes responded to this question. Responses ranged from the delivery of warm packs which were included in 32

(53%) programmes; the supply of emergency heating in 37 schemes (62%) and the provision of warm meals in 8 schemes (13%). A wide variety of other interventions were mentioned, in line with previous survey responses which had indicated that schemes were striving to find innovative means to address to fuel poverty and harm to health from cold weather. Examples cited included the following:

- snow wardens providing a snow clearance service, emergency shopping and ensuring access to medical services;
- hardship grants and other short term emergency payments;
- provision of blankets and warm clothing (winter coats, shoes etc.);
- handyman emergency repair service;
- targeted support for the homeless and street sleepers.
- interventions targeted at gypsies and travellers and others not in 'bricks and mortar' accommodation.

Case study 5: Bradford Warm Homes Healthy People programme

Practical support provided by the programme includes a range of immediate help for vulnerable people including hot food, food hampers, blankets, warm clothes etc. The programme has also been able to identify households at risk of fuel poverty and link them to further initiatives within WHHP that help with fuel debts, switching suppliers, accessing practical fuel poverty measures and expert advice from the warm homes officer in terms of managing heating systems/boilers etc.

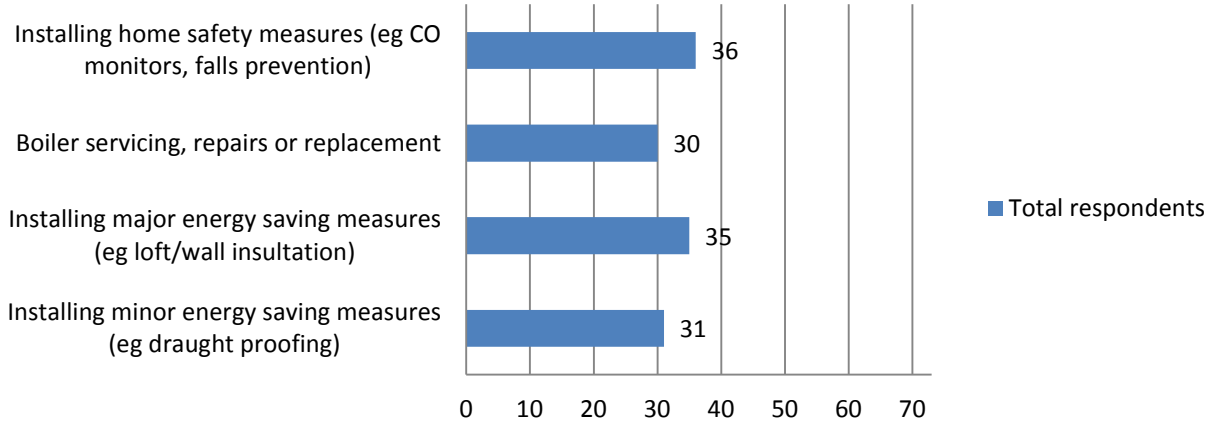
Specific support for homeless households has been offered through two routes. One has assisted with the upfront costs of accessing private sector housing options. The other has combined out of hours emergency accommodation, access to a hot meal and then the opportunity to engage with staff and volunteers around other issues impacting on lifestyles. This has been particularly successful in tackling wider health issues, as stabilising living arrangements can often lead to immediate health improvements.

An integrated service partnership between the statutory homeless/housing options service and a local voluntary group who manages an out of hours assessment centre used financial support for rent in advance and bonds in the private sector to resettle 31 homeless single people during this period. This included links into housing support and resettlement services to help individuals to maintain their accommodation.

One responder referred to a partnership with the British Red Cross who provided home visits and responded to requests for help including collecting shopping and medication. The respondent stated that this particular service was not however well used. The reasons for this were not given.

Sustainable home based interventions: Longer term interventions in the home were a key feature of the previous programmes, often being provided alongside energy efficiency grant schemes operated through or funded by energy suppliers. Figure 4 shows that these interventions have continued to be provided; but only in 50% to 60% of areas that responded to the survey.

Figure 4: Number of respondents indicating that their scheme is delivering sustainable home based interventions in the current year *(n=60).*



A number of respondents stated that energy saving insulation and other energy efficiency measures were now provided under the government's Energy Companies Obligation (ECO) and Green Deal programmes. It is not clear from the survey responses how many local authorities are engaged with providers of these schemes, which were available throughout the UK at the time of the survey.

Respondents reported specific interventions including appliance and boiler checks and one respondent highlighted how their scheme led to enforcement notices being issued to landlords under the Housing Act 2004, to require them to reduce or remove 'excess cold hazards'. Others refer to limited and basic interventions and to the provision of energy surveys, but without further intervention.

Case study 6: Derby City Healthy Housing Hub

The principle underpinning the Healthy Housing Hub is that delivering generally low cost preventative housing solutions to vulnerable residents leads to:

- improved health and wellbeing outcomes
- reduced longer-term demand on health and social care

The Hub targets those most vulnerable to housing-related poor health outcomes by harnessing the much wider 'virtual team' of staff and volunteers already working in the health, housing and social care professions, including occupational therapists, mental

health workers, GPs, community nurses, etc. This virtual team is able to refer vulnerable clients whose medical conditions or vulnerability may be affected by their housing conditions or whose housing conditions may be detrimental to their health and wellbeing.

Intelligent targeting through these referrals, and through public health intelligence and the involvement of local community groups significantly increases the likelihood that intervention will be instrumental in preventing, reducing, delaying or lessening the occurrence or severity of an undesirable health event and will therefore have the greatest impact on health, well-being and cost efficiencies.

The Hub utilises a range of interventions, including 'Prescribed Works', 'Healthy Housing Assistance', advice and support, partnership links and our 'handy-person service' to facilitate or directly deliver preventative housing solutions, such as: repair boilers, gas fires and install central heating in cold homes; remove trip hazards, fit grab rails; help with maintenance, relocation, fuel poverty, hoarding.

We recognise that safer, suitable housing can:

- reduce home accidents, falls and general health risks;
- reduce demand on GP, hospital and other health and emergency services;
- reduce reliance on social care;
- maintain independent living within own home;
- facilitate return home from hospital and
- increase client well-being.

Consequently, where the Hub can help prevent, delay, or lessen the seriousness of a health occurrence, its intervention has the potential to help significantly reduce rising costs to the health and social care sectors. Where the intervention's effects are on-going and as client numbers grow, the potential reduction in longer term growth in health and social care costs continues to increase.

Healthy Housing Hub Case study 1:

An elderly couple's boiler broke down in the autumn. They had a gas fire in the living room but no other form of heating, and no hot water. They had been using electric blankets to try to provide at least some warmth in the bedroom, but the electric blankets failed through over-use.

Unfortunately, the husband suffered serious winter illness and sadly passed away. It was sometime after this loss, that the lady was referred to the Healthy Housing Hub.

We were able to arrange promptly for temporary heating to be provided and ensure that a replacement boiler was quickly installed to provide effective heat and hot water again.

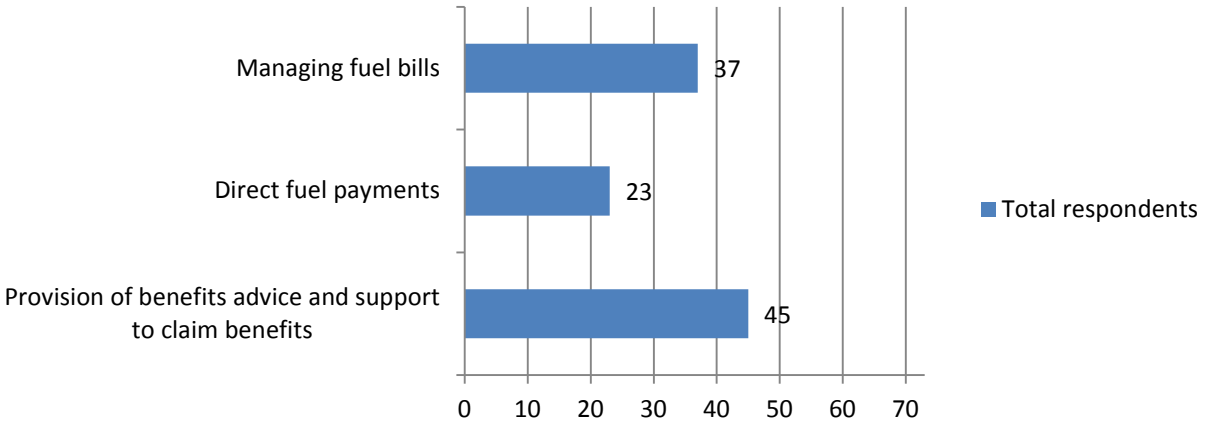
Healthy Housing Hub Case study 2:

A blind older gentleman, otherwise in reasonable health who wished to continue living independently. Due to fuel poverty, he was failing to keep warm. He had resorted to chopping wood to burn on an open fire in the living room. His gas cooker was in poor repair – so he was lighting the gas with a match.

Without intervention, there was a strong likelihood of cold-related ill health and personal injury. There were also risks associated with the faulty appliances.
We were able to line the open fire flue and install a gas fire. We accessed a Community Care Grant for a new cooker and established a best value energy tariff and maximised his benefits.

Income maximisation: The provision of benefits advice alongside direct fuel payments and advice on managing fuel bills continues to be a feature of intervention programmes.

Figure 5: Number of respondents indicating that their scheme is delivering income maximisation interventions in the current year *(n=60)*



Interventions include advice on switching fuel suppliers - provided through housing associations; referrals for debt advice and general support through awareness raising leaflets and the training of volunteers to provide advice within their community. One respondent reported limited access to direct fuel payments, indicating a reduction in provision on previous years.

Addressing social isolation: Addressing this issue was a priority previously identified as a means to tackle the harm caused by cold weather and continues to feature in a number of programmes. Examples of current activity include befriending/buddying

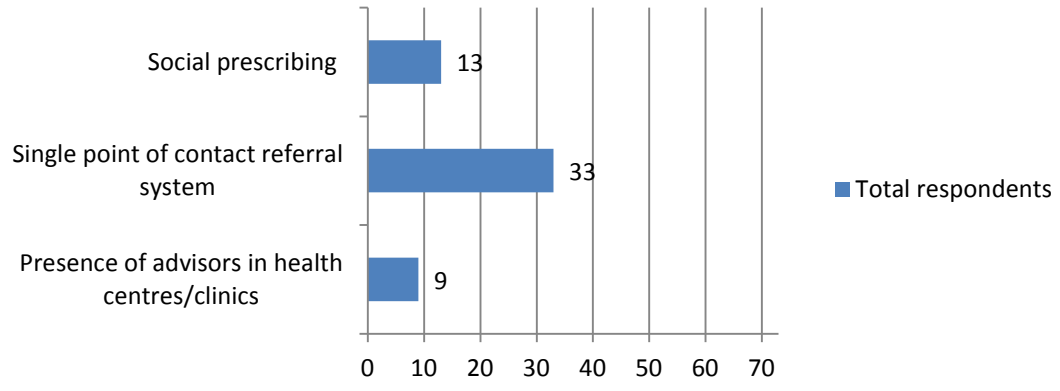
programmes (partnerships with Age UK), advice to look out for vulnerable neighbours and support for community cafés. One respondent referred to the production and distribution of basic keep warm information in six languages other than English. Twenty-seven (45%) of respondents stated they had been involved in community events and 35 (60%) had programmes targeting social isolation in vulnerable people.

Case study 7: Bradford Neighbourly support and sustainable funding programme

The neighbourly support and sustainable funding programme has offered small grants to fledgling groups and community activists to develop projects to benefit their immediate localities. This has been anything from regular group outings, coffee mornings and similar activities, through to taking more vulnerable people to necessary appointments and/or clearing heavy snow falls, befriending schemes etc. It has also meant engaging with local businesses to garner support for the programme, through direct financial support and donations in kind.

Working with health professionals: An aspiration of the previous evaluations was to build further working partnerships with health professionals outside the current partnerships with public health. Social prescribing schemes and partnerships with health centres/clinics remains limited. Having a single point of contact for referral into a scheme from health professionals was seen as a positive step and is present in 42% of the responses received.

Figure 6: Number of respondents indicating that their scheme is working with health professionals in the current year *(n=55).*



Signposting people to appropriate support, including health services, was also employed alongside or as an alternative to direct referrals. This was undertaken by health as well as other professionals. Awareness raising events on fuel poverty and the harm done by cold weather were provided for community healthcare staff and pharmacists. In one area, community respiratory and heart failure specialist nurse

teams were able to refer patients for financial inclusion check. In another, environmental health and housing officers gave presentations to local healthcare workers on reducing hazards in the home and the health importance of fuel poverty.

Case study 7: Bromley Winter Health Project

The Winter Health Project was a multi-agency collaborative project involving the local authority home improvement team, public health, community nurses, community pharmacists and voluntary/community groups.

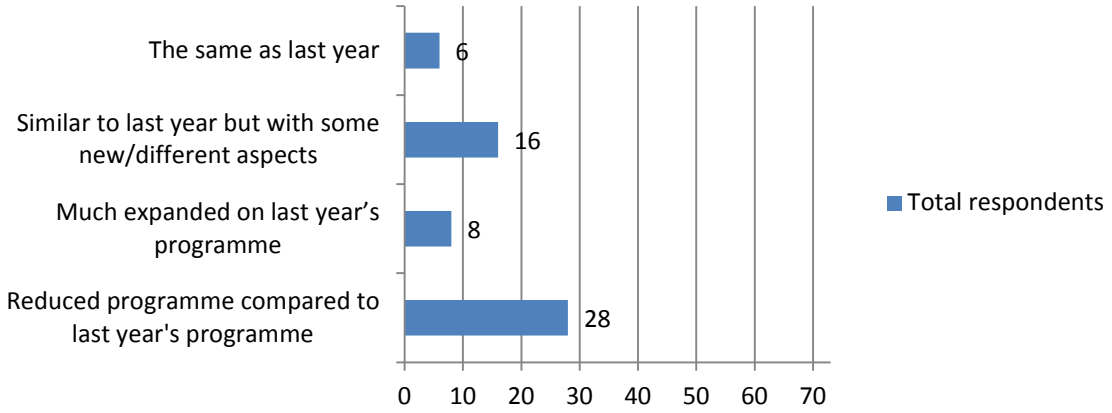
We developed a systematic and co-ordinated approach to identifying, caring and supporting vulnerable older people who are at risk of ill health due to the effects of cold weather, especially for those who live in cold homes. Front line healthcare professionals visit patients in their homes on a regular basis and easily gain an understanding of the home situation and its impact on their patients' health and wellbeing. Health professionals were provided with training to identify the risk factors, to provide the appropriate guidance and the referral process through which individuals would access support packages through the council's home improvement team; community pharmacists carried out this activity during their medicines use reviews and the nurses, during their home visits. We were also able to offer energy advice and assistance through the 'Re:New' scheme to the most vulnerable older people.

In the four month duration of the project, the number of people estimated to have received information on '*Keeping warm and well'* was approximately 8,000. In addition, approximately 260 people received direct home improvement advice and support through the Home Improvement Team, the Re:New scheme and through community support initiatives.

How does current service provision compare with previous years?

The survey sought to explore how programmes in the current year compared to previous years and the perceived reasons for any changes in provision.
Fifty-eight people responded to this question (Figure 7); with 47 providing additional details of how their scheme differs. While many stated their programme had reduced from previous years, others had been able to maintain or develop theirs.

Figure 7: How does this year's programme compare to programmes you have run in the past in terms of scale and scope (*n=58*)



A reduction in funding was cited as a principal reason for reduced or limited programmes being provided; with some respondents suggesting that plans for further expansion were suspended:

*"The previous two years with DoH funding enabled ********* to operate a comprehensive range of activities. However, for 2013/14 we have been severely limited by a lack of funding, there being no internal resources available to replicate the success of the previous two years."*

A number of respondents referred specifically to withdrawing media and communications plans to reduce demand and hence limit expenditure:

"Funding for this year's programme was dramatically reduced…We continue to run our Affordable Warmth Project with district councils…Media and communications campaign and substantial help with boiler repairs and maintenance has ceased"

Providing a more targeted and focused programme for less people with stricter eligibility criteria was one way of reducing spending; whilst ensuring the most vulnerable continued to be able to benefit from the interventions.

"We've tried to target the programme more effectively this year to identify those households most in need. Reductions in funding have also streamlined what's available."

One respondent described how the minimum age criterion was changed from 60 to 70 years. Limits on the amount of funding for boiler repairs were also put in place. Some respondents suggested that they had experienced a reluctance on behalf of public health departments to fund existing projects which had started with funding received by the Warm Homes Healthy People fund

"Public Health has decided not to fund sustainable home improvements such as emergency heating or insulation."

Others have been able to maintain or expand their programme. For some, this was made possible through local funding from public health and other budgets.

A number of respondents referred to the development and strengthening of partnerships which were established through previously funded programme activity.

*"We have stronger involvement and engagement with ********* Social Care teams and front line NHS services within community services. They are actively promoting warm and well messages to patients and service users. In addition ******** Healthwatch have facilitated us working with local GPs and Patient Participation Groups, through this joint to work we have been able to reach people who weren't reached last year."*

*"In 2013/14 local public health funding has been used to provide similar assistance, and in addition, a more partnership based approach to development of the programme and communication… For 2014/15 and 2015/16 ******* are currently developing a more comprehensive Healthy Homes programme which aims to visit over half of the homes in the borough and consider issues such as housing condition, fuel poverty/income maximisation and social isolation - making referrals into services for those most in need and not yet engaged."*

Funding

In line with the findings of previous evaluations, funding was the most frequently stated issue with 34 of 51 respondents highlighting this as a barrier to successful projects. Similarly, resource restrictions were stated by 15 respondents. Some respondents referred to the wider adverse impacts of restricted funding:

"Lack of financial resources which meant the programme for 2013/14 was greatly reduced from previous years, meaning we received much less publicity and political buy-in than before."

Funding available for local programmes

Respondents were asked to indicate the total amount of funding they have available in the current financial year for their programme. Of the 41 respondents who replied, 11 stated they had had no funding. Of those who responded to say they had received funding, respondents reported a budget range of £2,500 to £500,000. The interquartile range was £25,500 to £116,000, the mean £113,150 and the median £54,000.

Funding through public health departments

Of 48 respondents, 39 stated they had requested funding from their local public health department. Of these 13 had not received any funding from the public health department, two were awaiting a decision and the remainder had received partial funding. The range was similarly wide – from £5,000 to £495,000, interquartile range £20,000 to £66,000. The mean budget was £81,886 and the median £30,000.
When asked what proportion of funding came from public health departments, nine of the 31 people who responded (29%) stated that all the programme funding came from this source. A further four stated that more than three quarters of their total funding was provided by the public health department, one reported that half was from this source and three reported between 20% and 30% of total funding was from the local public health department.

There was little consistency in the availability of local public health funding across different areas, reflected by the lack of consistency in the amount allocated from public health budgets as described above. While this may also be a reflection of differences in the scope of schemes and the amount of funding requested it is difficult to distinguish if one was restricted by the other. One respondent referred to wider uncertainty around the departmental budgets in their first year of operation and the reluctance to commit funding beyond the essential budget requirements, a factor that may have been more widespread than this survey suggests.

"Public Health not funding this year as still unsure of budget under/overspend."

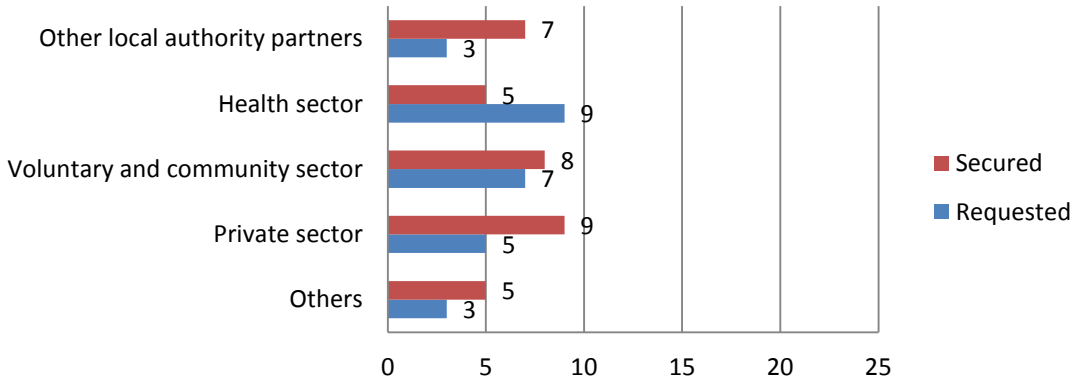
A number of respondents reported a requirement to enter into a competitive bidding process or to negotiate internally for a share of limited available funding.

"All the revenue funding for this project has been secured via a competitive bidding process to our upper tier public health department…"

For others, however, the process was more straightforward.

"Public health commissions the service annually."

Figure 8: Number of respondents who had requested and received funding from sectors other than the public health department (*n=25*)



Alternative sources of funding

Responses suggest that partnerships have sought funding from a range of sources with many securing resources for the programme from multiple funders, including other local authority departments, clinical commissioning groups, private sector providers - including energy companies - and other grant giving organisations. In addition, it is evident that in-kind contributions from public health and other local authority departments have contributed to the total resource available for supporting the programme and for interventions.

"The remainder of the scheme costs are the 'in kind' contributions of staff time to operate and project manage scheme delivery."

There was little to suggest that work to reduce excess winter deaths and the harm caused by cold weather has become embedded in the work of local authorities or their partners beyond what some describe as 'in-kind' contributions. Some referred to a bidding process indicative of a short term initiative approach; others suggested that no funds were available. While the strategic commitments to this work are evident in JSNAs and strategic plans this may not yet be translating into mainstream funding and approaches.

A number of respondents described how the success of the previous WHHP programme provided a lever to secure funding locally. One programme pointed to the benefit of having an existing partnership and established ways of working. It was suggested that this may have a persuasive impact on budget holders. This also illustrates the value of undertaking an evaluation and reporting the findings to showcase projects locally.

"…the Directorate of Adult, Community and Housing Services has agreed to allocate future funds to enable the programme to continue… This is as a result of the way in which the programme has been set up and managed with a lot of buy-in from partner agencies and the reach of the work carried out with relatively small amounts of money."

Many respondents describe how they were able to link with national initiatives through the Department of Energy and Climate Change (DECC) and the Energy Company Obligations (ECO) affordable warmth schemes via energy companies programmes for home energy efficiency measures. In most cases this was for insulation and other home improvements; with examples given of schemes supporting households to access ECO grants for home energy improvements. Other respondents provided examples of funding obtained through ECO and the energy companies for a wider range of interventions.

"Private sector funding was through the ECO Affordable Warmth funding stream through Osborne Energy."

"Whilst we haven't received any additional budget - we have worked to ensure we've been able to maximise opportunities available through the ECO scheme."

"ECO partners have been secured across Greater Manchester to provide heating/insulation."

Whilst funding was often secured internally, external sources of funding were available for specific elements of the programme. Examples were given of energy company sponsorship for specific posts and targeted programmes. Further examples reported how the public health department funded work with local third sector organisations to provide a series of targeted interventions where £15,000 was provided for the marketing of the warm homes programme.

Schemes have shown how they contribute to meeting the objectives of other departments and agencies in order to secure resources.

"Linking excess winter deaths targets into existing social prescribing projects funded by the CCG."

*"We have secured funds from ******** Council Benefits Team through the Local Support and Prevention Fund."*

Respondents described a number of innovative approaches to obtaining funding. One area reported contributions from a 'rogue landlord fund', accessing money obtained from penalties imposed on landlords and allocating this to home improvements. Others have turned to the community and voluntary sector to obtain funding.

"The Community Foundation raised approximately £50k for the Winter Warmth Campaign and the Council has matched this from the Welfare Assistance fund."

While it is apparent that a number of schemes have been able to secure funding from a number of sources, other respondents expressed difficulties in delivering services with lack of resources. However, this survey has shown that, whilst alternative funding streams may be limited in their size and applicability, there are other resources available. Key among these alternative funding streams is the ECO scheme. However, there is uncertainty about the long term security of this source of funding, the eligibility criteria and the type of interventions it can support. Respondents refer to the postponement or cancellation of referrals for replacement boilers and insulation, as installers have been unable to access funding.

Partnerships and collaborative working

The survey suggests that the continuation and further development of collaborative working continues to be a crucial factor, in line with recommendations in the 2012/13 WHHP evaluation report to continue to strengthen and foster partnership working. Responses illustrate a commitment to build upon the successes of previous years and to further the collaboration between agencies and across the public, private and community and voluntary sectors that were established over the previous winters.

*"The relationships built up during previous winter campaigns, alongside an existing programme being delivered in *******have made it much easier to establish a winter campaign this year*."

"Built on the partnerships established the last 2 years. [A] Recognised brand and an excellent reputation for delivery and reliability- tailored response to each enquiry using national ,regional and local intelligence and resources."

The extent to which programmes rely on local partnerships warrants further investigation and development.

Respondents recognised that developments in partnership working have been formal and strategic. This has occurred through new terms of reference, joint working arrangements, an alignment with health and wellbeing board priorities. Partnership working was also expressed as being more operational and pragmatic in nature for example in the recruitment of volunteers through community organisations. Respondents were however aware that such informal partnership arrangements remained precarious in places. While this is not wholly down to financial resource the continuation of funding to support partnership working and programme delivery was highlighted as a factor.

"Strong partnership networks exist at present, although future funding restrictions in the [funding] may not allow future delivery."

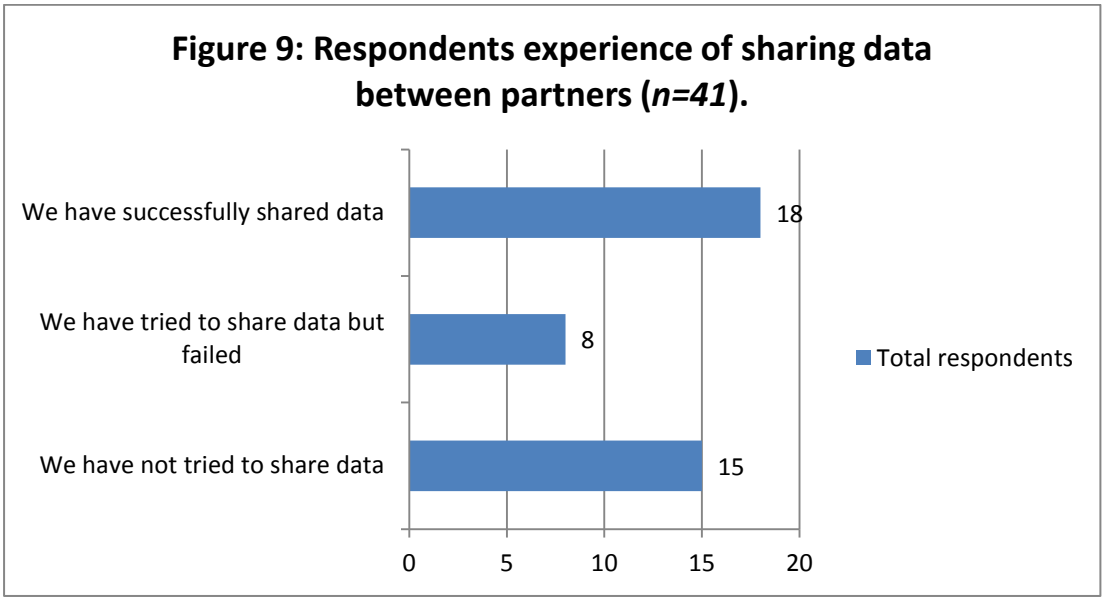
A number of respondents documented how they undertook to facilitate increased collaborative working and to strengthen partnerships. This included engaging and training health professionals and it was clear that many partners recognised the importance of collaboration across the health sector.

"Commitment from the Health and Wellbeing Board which identifies fuel poverty as one of the six locally determined priorities."

Data Sharing

While many respondents referred to good partnership working, others stated that joint working has yet to be developed. Examples of how this manifests in practice include difficulties in sharing data, with the health sector being particularly protective; concerns that referrals between sectors and providers could be improved and a wider lack of awareness of the programme and the potential benefits to health and social care.

Figure 9: Respondents experience of sharing data between partners (*n=41*).



Results suggest that some partnerships have given consideration to issues of data sharing and have put in place arrangements that allow client information to be passed between partners when in the client's best interest to do so. A number of partners reported data sharing protocols that were either being developed or were already in place. One respondent stated that the ability to share data was fundamental to the scheme.

"Data sharing is an implicit requirement for participation in the scheme. This year, the upper tier authority responsible for managing the overall fund have also produced standardised monitoring spreadsheets to collate data."

Further comments about developing protocols include:

"Data sharing protocols and agreements have been necessary and have taken time to set up. There is more scope for referrals to come into the scheme from partners and we are working on this."

"A referral form, completed by partner agencies was completed and contact details uploaded onto a web based database. The database was then accessed by the city council to write out to all vulnerable residents who had accessed WHHP services in 2012/2013. The database was being held by Revival Home Improvement Agency."

A number of respondents made reference to referral protocols including examples where a single point of contact was taking referrals, processing applications and arranging for interventions to be delivered, thus limiting the need to share personal information between partners.

In a number of cases, partnerships used consent forms to obtain the client's permission to pass their information to partners involved in providing services.

"We make referral to agencies- after seeking permission from the resident it is alright to do it."

"We have overcome data sharing issues with permissions forms supplied to people, asking if they want their data shared for specific purposes."

Respondents recognised the need to exercise care with personal data where client consent was granted.

"A referral network was set up between the voluntary agencies which enabled clients to be appropriately referred; this relied on clients giving permission which was relatively successful but also relied on agencies having robust systems" [of governance and data protection]

Despite the commitment to information governance there remains, in many areas, a concern around the sharing of data between health services, local authorities and other partners. One recurring theme is that there is a perception that the NHS is unwilling or unable to share data with other agencies. A number of examples of these difficulties were cited, with a degree of frustration evident in the responses.

"We have shared some data - personal data sharing proving problematic."

"NHS services are unable to refer individuals because of patient confidentiality and data protection."

"Data sharing is only an issue with the NHS, other partners are much more pragmatic."

In addition to issues around data sharing between partners, a number of respondents raised issues specifically related to emergency planning. The reluctance to share data was evident from two partnerships who were attempting to establish emergency response systems to safeguard vulnerable residents, and these responses suggest that this reluctance to share is not confined only to the health sector.

"We have shared data on our council tenants for emergency response purposes but have found it impossible to persuade GPs to share data, even with very strong safeguards."

"We wanted to implement a co-ordinated emergency contact system in the event of severe weather warnings; however we have been prevented from using the data to implement a warning service - as apparently the data can only be used in an actual emergency, rather than using it as a proactive, preventative measure"

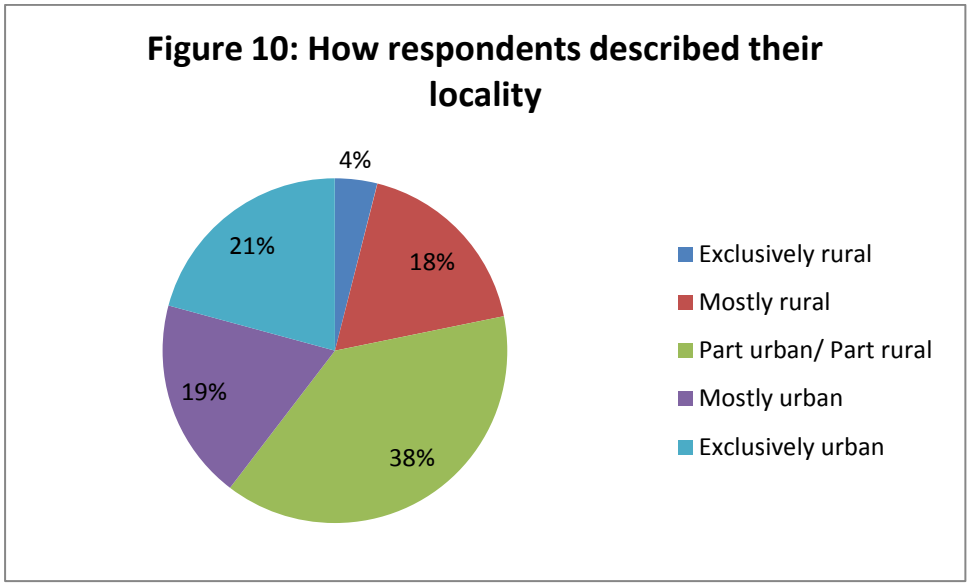
While some respondents referred to specific instances of data sharing issues, others commented on broader organisational governance issues that were presenting a barrier to the programme activity. Responses suggest that a number of partnerships had overcome these information governance issues with some good examples of innovative working given:

"Work on this last winter has allowed development of a Healthy Housing Vulnerable Household Index utilising housing, health and Experian data, analysed and held by Public Health Colleagues."

Regional variations

Previous evaluations have highlighted concerns that services provided through affordable warmth and other similar programmes have been largely focussed on urban areas, at the expense of those living in rural areas. Respondents were asked to describe the distribution of urban/rural populations and the distribution of interventions across the locality. These results appear to indicate that service provided in urban areas are over-represented at the expense of service in mostly rural areas. No interventions were delivered in exclusively rural areas despite two respondents being from exclusively rural areas as neither had programmes running the current year.

Whether this reflects a variation in need or in ease of access and delivery should be the subject of further research and investigation.



Discussion

Our survey has provided valuable insight into how local authorities and their partners are working to improve health and reduce the harm caused by cold homes at a strategic, organisational and operational level.

There is a strategic commitment to supporting the aims of the Cold Weather Plan for England demonstrated in many joint strategic needs assessments and health and wellbeing strategies which feature addressing fuel poverty and excess winter deaths as strategic priorities.

There is concern however that this strategic commitment has not necessarily led to long term commitments to health promoting interventions at the necessary scale and volume or for local areas to consider this as 'core business'. The short term nature of funding and programmes was highlighted as a concern in the evaluation of 2012/13 Warm Homes Healthy People programme and was indicated as a possible reason for lack of strategic planning locally. The 2012/13 evaluation recommended that consideration should be given to sustainable sources of funding which would allow local authorities, clinical commissioning groups and health and wellbeing boards to tackle excess winter deaths and illness year round. Despite the recognition given to this work in strategic plans this short termism appears to have continued amid uncertainties both around external funding arrangements and national commitments to home energy interventions.

With responsibility for public health now with local authorities and the wider adoption of measures recommended in the CWP for England featuring in health and wellbeing strategies, there may be further opportunities to facilitate longer term arrangements for

commissioning and prioritising of this work. It was encouraging to hear of a small number of authorities who had commissioned longer term programmes.

The advantages of public health departments being located in local authorities was highlighted by some respondents who cited improved partnership working between health and local authorities, heightened strategic awareness and systems wide approaches as key benefits.

A commitment to collaboration and partnership came across strongly in the survey and might be regarded as a key factor in the high number of local areas being able to roll forward a programme with reduced resources. The survey and the case studies have provided evidence of broad partnerships at a strategic and organisational level and at a more pragmatic operational level with a growing number of voluntary and private sector partners, including energy companies and more innovative partnership working such as those with uniformed services.

The resilience of partnerships and the resourcefulness that has been demonstrated has been a factor in local areas being able to develop and deliver programmes with reduced financial resources.

While the majority of local authorities responding to the survey continue to contribute to the delivery of programmes and interventions to protect health and reduce the harm from cold weather it is apparent that this is not universal. Many areas, though not all, are running a reduced programme of interventions this year and a reduced service overall. The availability of funding continues to be a key concern for many, though some schemes have secured alternative means. Tighter funding and different funding sources have led to some areas introducing altered eligibility criteria, addressing the needs of a narrower group of people. Whether this has resulted in more a more effective, targeted approach or created inequalities in access and unintended exclusions has yet to be determined.

At an operational level data sharing continues to be an issue in many areas preventing the NHS in particular from providing information on vulnerable patients to warm homes partnerships. The survey has highlighted schemes that appear to have successfully negotiated the issue through simple referral protocols and/or enhanced governance arrangements. This reflects the current recommendation from the Department of Health in their response to the Caldicott review on data protection in health “Information: To Share or not to Share” [10].

Concerns remain that only 57% of the respondents reported that schemes were engaged in monitoring and evaluation. The reason for the low proportion may have been due to a lack of resources locally or to the absence of a national evaluation framework or the because programmes were no longer required to report back to

funding bodies as had been the case under the WHHP programme. In the past programmes have provided an annual report of activity and outcomes and it is yet to be seen whether this formal reporting will continue.

While those responding to the survey cannot be regarded as a representative sample of all local authorities and partnerships it does provide evidence to suggest that protecting health and reducing harm from cold weather is an ongoing priority for many authorities.

Strengths

The current survey builds upon the evaluations of the Warm Homes Healthy People partnerships in 2011/12 and 2012/13 to provide an overview of the provision of services in England aligned with the aims of the CWP, in light of new arrangements for the commissioning and funding.

The survey went out to past recipients of Warm Homes, Healthy People partnership funding and to all other top-tier local authorities in England. Responses were received from partners across local government including district and borough councils and the health sector and included those responsible for managing local programmes as well as local authority public health officers and consultants. This ensured a broad range of responses from across partnerships.

The survey was initially piloted with a small number of local schemes and was reviewed by lead organisations before being distributed electronically.
The survey included a mix of open and closed questions and provided the opportunity to add a commentary to answers. Respondents were also approached to provide case studies which were included to illustrate and add depth to the findings.

Limitations

There are several limitations to this study. Firstly, the response rate was relatively low at 48%. The timing of the survey may have influenced the response rate with invitations to participate in the survey sent out during a mild but wet winter. Selection bias in the survey is likely to have occurred. Local authorities that did not respond may have differed in their experience of programme delivery following the announcement of a ring-fenced public health fund for local public health initiatives and while schemes were invited to share experiences and good practice there may have been a bias towards those struggling to continue their programmes. All responders were previous recipients of Warm Homes Healthy People funding from DH, although non-recipients were also invited to participate. Their experiences may differ from local authorities who had not received funding.

The questionnaire comprised a mix of closed and multi choice questions with free text responses. While the latter provided an opportunity to collect qualitative data this was not a robust qualitative method. It is intended that further research through semi-structured interviews will be undertaken to add further depth and insight to the data already collected.

The survey was distributed to upper tier local authorities and while these were the past recipients of grant funding it is recognised that, in two tier localities, the district and borough councils have a leading role in reducing harm from cold, largely through their environmental health private sector housing function.

Conclusion

The Cold Weather Plan for England recommends a series of steps to reduce risks to health from cold weather. Our survey aimed to understand better how local projects to protect health and reduce the harm from cold weather are working now that decisions for funding for public health initiatives are made at the local level; to share information on what works well and the challenges experienced; and to establish a baseline of funding provision, resources and ideas.

The results of the survey indicate that while work in this area is continuing across England there has been a reduction in activity, a tightening of eligibility and more targeted approaches to reach vulnerable groups. Recognition is given to the importance of reducing the harm from cold weather within strategic plans but this does not always translate in to local action at a scale equal to that delivered in recent years. Programmes do however continue to deliver a wide range of interventions in line with the key elements of the CWP for England, recognising the need to provide short-term help as well as long-term preventative strategies and energy efficiency measures. A growing number of community sector schemes are apparent together with a greater emphasis on holistic, system wide approaches.

Collaborative working, whether formal and strategic or informal and pragmatic, is a strong supporting factor, though examples of difficulties remain with data sharing.

While sustainable funding remains an issue, programmes that are supported through strategic direction, leadership and multi-sector collaborative partnerships, demonstrate innovative, practical ways of working to reduce cold related harm.

Recommendations

1. Efforts should continue to nurture and protect partnerships at all levels and to continue to explore collaborative approaches.
2. A systems wide approach is needed to implement a wide range of interventions to address the multiple problems of the most vulnerable
3. Local Joint Strategic Needs Assessment and Health and Wellbeing Strategies should reflect elements of the Cold Weather Plan and other strategic and operational plans.
4. Commitments within local strategic plans should translate into local action at the right scale and volume in order to achieve their stated objectives. Better understanding of the pathways required to achieve these objectives is needed.
5. Consideration should be given to ensure that interventions are focused on addressing inequality locally and are proportionate to the level of need.
6. Consideration should be given to provision of an equity audit function to ensure programmes do not exclude those most at need.
7. Examples of the successful use of data governance protocols, consent forms or referral schemes to increase uptake of schemes should be shared and adopted elsewhere.
8. Greater focus is required on the monitoring and evaluation of programmes. This is key to building the evidence base on the effect of interventions on health and wellbeing, and the wider determinants of health.

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