Discharging vulnerable people from health or social care settings to a warm home: Issues for older people.

Briefing paper from an Economic and Social Research Council (ESRC) funded seminar
27/6/16 Cast Theatre, Doncaster

Summary of key points

1. The number of people being discharged from health and social care provision who may be at risk of the negative health impacts of cold homes is increasing. People with dementia and frailty need to be recognized as vulnerable populations.

2. There needs to be a better way of talking about the link between cold homes and health e.g. How do we define who is at risk? There is no clear national, standardized definition and every local area warm homes service has a different definition of who is vulnerable.

3. Currently policy relies on money following the problem rather than fixing a problem upstream. This means the NHS spends a lot of money fixing a person (e.g. surgery and rehabilitation to mend a broken hip) rather than fixing the problem upstream (e.g. fixing the home and heating). Money follows the problem rather than fixing the cause of the problem and preventing the negative health consequences.

4. An integrated approach is required to ensure people are discharged from health and social care to a warm home: Integration is required at:
   a. a National level (across Government Departments and ministries) and
   b. locally (across NHS, Local Authorities, voluntary sector etc).

5. Home environment and housing should be integral to health and social care activity but concerns are currently not picked up on well by professionals, for example indoor temperature and fuel poverty are not routinely considered as health risks. How do we ensure home circumstances of people admitted to health and social care are routinely considered? For example discharge planners should be aware of the importance of addressing cold homes. How can we ensure temperature of the home environment is considered in addition to more traditional nursing and therapy interventions?

6. A single point of contact system, simple referral pathways and a mix of interventions (e.g. Warm Homes Schemes, advice workers in health care hospital settings, Making Every Contact Count, Hospital Discharge Schemes, Energy Doctor) delivered by a range of partner organizations are essential to make an impact.

7. Active support, referral and hand holding is needed for more vulnerable clients. It’s no good just handing over a phone number or making a referral. Case management is needed.

8. Data sharing remains a challenge although there are examples where this has been overcome e.g. Advice workers having an NHS Honorary Contract, being based in an acute Trust, or being Public Health honorary employees / contractors, establishing a shared database with a cold homes section.

9. There needs to be a better way of evidencing the link between cold homes
and health. There is clear evidence of the health impact of cold homes on health. However, there is a lack of evidence that establishes and explains the relationship / associations between being discharged from health and social care to a cold home and being admitted or readmitted. What is the impact of cold homes on re/admission to health and social care? Is there any evidence of seasonal differences in discharge delays?

10. Research has focused on the health burden of cold homes. There is an evidence gap regarding social outcomes of cold homes and the associated need for/use of social care services. This needs to include admission to residential care. Can addressing cold homes delay or prevent admission to residential care?

11. Some evidence of impact from evaluating ‘Warm Homes’ initiatives is being ignored because it doesn't employ a Randomized Controlled Trial (RCT) design. Some of this research is robust and still provides valuable evidence. Realist approaches to evaluation and evidence generation would be valuable and should be recognized by those involved in policy as well as commissioning and provider activity.

Background

This briefing paper summarizes the content of presentations and discussion at a seminar held in Doncaster on 27th June 2016. The seminar considered from the perspective of older people how to meet the recommendation to ensure people are discharged from health and social to a warm home. The recommendation was made in the National Institute for Health Care and Social Care Excellence (NICE) on ‘Excess winter deaths and illness associated with cold homes’ (NG6) (2015).

The seminar is the fourth in a series funded by the ESRC. The seminar series explores various aspects of understanding and responding to the health impact of cold homes and fuel poverty. More details of the other seminars can be found on the series website: http://www.healthyplaces.org.uk/esrc-seminar-series-fuel-poverty/

This briefing paper provides an outline of each of the speaker’s presentations. Presentation slides are also available on the seminar website. This is followed by a synopsis of the key issues raised and evidence gaps identified.

Introduction

Dr Rupert Suckling, Director of Public Health, Doncaster Metropolitan Borough Council.

Using Doncaster as an example, Dr Suckling outlined the challenge cold homes provides for public health in England. There has been little reduction in cold related deaths despite all the efforts that have been made. Enduring challenges include:

- a better way of talking about and evidencing the link between cold homes and health
- making energy more affordable
- translating the NICE guidance into practice
- generating evidence to inform policy as well as practice.
NICE NG6, ‘Excess winter deaths (EWD) and illness associated with cold homes’

Dr David Sloane, NICE Public Health Advisory Committee and Project team.

The context for the NICE guidance (NG6, 2015) was provided with reference to the evidence used and three points:

1. Poverty and inequity are health issues
2. Cold weather causes an increase in illness and death. The greatest impact and strongest evidence lies in circulatory and respiratory conditions
3. Fuel poverty causes double jeopardy.

Recommendation 7 in NG was linked to 3 key behaviours from services:

• Early assessment of vulnerability and risks
• Planned discharge to include consideration of heating
• Referral to single point of contact health and housing service if necessary

Briefings of the evidence the NG 6 is based on are available on the NICE website (https://www.nice.org.uk/guidance/ng6/evidence). Dr Sloan outlined a couple of challenges related to evidence and policy:

• Evidence:
  o Time series studies are a major source of evidence on prevalence of cold related harm, but these take a population approach looking at external temperatures and effect. They do not look at individual cases. Few studies are based on measures of internal temperatures or focus on individuals.
  o Very little attention paid to behaviours, for example self-disconnection

• Policy
  o Regarding fuel poverty and the cause of EWD – policy initiatives e.g. carbon saving, public health, housing and poverty do not always align at national or local level.
  o Some congruent policy initiatives could potentially be catalysts for coordinated action but this remains challenging. These include the Cold Weather Plan, environmental policies to reduce fuel use, energy efficiency and the reduction of fuel poverty.

NICE NG6 Public health perspective and gaps in evidence

Dr Angie Bone, Head of Extreme Events and Health Protection, Public Health England

The Quality Statements linked to NG6, can help guide services achieve Recommendation 7 regarding discharge to a warm home. Services include hospitals, other acute care settings, mental health, primary and residential care (NICE 2015). The Quality Statements are:

• **Statement 1.** Local populations who are vulnerable to the health problems associated with a cold home are identified through year-round planning by local health and social care commissioners and providers.
• **Statement 2.** Local health and social care commissioners and providers share data to identify people who are vulnerable to the health problems associated with a cold home.

• **Statement 3.** People who are vulnerable to the health problems associated with a cold home receive tailored support with help from a local single point of contact health and housing referral service.

• **Statement 4.** People who are vulnerable to the health problems associated with a cold home are asked at least once a year whether they have difficulty keeping warm at home by their primary or community healthcare or home care practitioners.

• **Statement 5.** Hospitals, mental health services and social care services identify people who are vulnerable to health problems associated with a cold home as part of the admission process.

• **Statement 6.** People who are vulnerable to the health problems associated with a cold home who will be discharged to their own home from hospital, or a mental health or social care setting have a discharge plan that includes ensuring that their home is warm enough.

The importance of the current policy agenda and related initiatives in achieving the quality standards was emphasized. E.g. The Care Act 2014, NHS 5 Year Forward View, Sustainability and Transformation Plans, Vanguard Clinical Commissioning Group’s, Local Authority Integration Pioneers.

Enduring challenges to achieving the quality statements include:

• **Policy and practice:**
  o How do we define who is at risk? There is no clear national, standardized definition and every local area warm homes service has a different definition of who is vulnerable.
  o The number of older people and those vulnerable to cold is increasing, as well as the number of people living with long term conditions.
  o An integrated approach needed to tackle this at a National level (across Government Departments and ministries) and locally (across NHS, Local Authorities, voluntary sector etc). The Department for Business and Energy and Industrial Strategy etc.
  o Home environment and housing needs to be integral to activity but are currently not picked up on well by health professionals, for example indoor temperature and fuel poverty are not routinely considered. How do we effectively consider the home circumstances of people admitted to health and social care?
  o Are discharge planners aware of the importance of addressing cold homes? Do they know to consider the temperature of the home environment in addition to more traditional nursing and therapy?
  o We need to make the case that the involvement of the NHS in housing is vital.

• **Evidence**
  o What are the seasonal differences in admissions? Are there seasonal differences in delayed discharge?
  o What is the impact on discharge planning/intermediate care of tackling cold homes?
The voluntary sector perspective.
Mervyn Kohler, Age UK, External Affairs Manager

Mervyn highlighted the service and financial pressure on the NHS to reduce delays in discharge. The National Audit Office estimate an £820m cost to NHS due to 2.7m older patients in hospital beds who are no longer in need of acute treatment. The number of bed days lost in acute hospitals in 2015 as a result of delayed transfers was 1.15m (up by 31% on 2013).

Whilst patients may be ‘medically fit for discharge’, social factors such as the home they are going back to may mean they are not ready to be discharged. There are some ‘safety nets’ but these are new or not available everywhere for example:

2. Discharge Programme.
3. Emergency Care Improvement Groups
4. Frailty Units. 55% of hospitals had one, and of those 68% said their facilities did not have enough capacity
5. The Better Care Fund Mechanism. This is not new money but transferred money linked to integration.

There are some promising examples for example in Northumbria there is ‘a ticket home’ planning discharge with family and relevant professionals. However, these are locally based and need scale and spread to be effective. Evidence from evaluation is also limited because of the size and nature of such interventions.

Points from discussion included:

- Integration of services is always going to be about the transfer of money. The expectation is that Local Authorities will deliver more in terms of outcomes but for less money.
- Evidence in essential to help tap into the funds such as Better Care Fund. We need to collect the right data to make the case for investment.
- There is a problem with the quality of some specific evidence. We should be more cautious – steer away from small samples and short-term studies.
- We have to view the evidence in the context in which researchers are having to work – we shouldn’t dismiss evidence because it doesn't meet certain standards. There is a lot of evidence that offers insight which is being ignored because it does not meet the Randomized Controlled Trial (RCT) standard, but RCTs are impossible to set up in this area in terms of time, intervention costs and trial costs.
- Even where evidence exists it is not always taken into account or applied because of limited resource e.g. where evidence on support networks surrounding discharge has been generated we couldn’t get people into that pathway because there is nobody there to take on that role.

Health and Wellbeing Boards (HWBs): progress on tackling fuel poverty and addressing the NICE guidance on cold homes
Juliette Burroughs, Senior Researcher and Policy Officer, National Energy Action.
This research examined the extent to which Local Authorities HWBs are implementing the 2015 NICE guidance. Detailed findings are available in the project report. (Burroughs and Ruse 2016) The study only accessed what the HWBs publically reported that they are doing to work towards tackling cold homes. It may be that work was being done on the ground but not being recognized by HWBs.

- 67% HWBs made no mention of the NICE guidance
- 31% prioritized fuel poverty in Health and Wellbeing Strategies
- 18% prioritized excess winter deaths
- 14% prioritized both of the above
- 5% mentioned hospital discharge, 19% a referral services, 9% training of frontline staff

The personal commitment of key figures in the local area to highlight and champion the cold homes agenda appeared to make a difference.

**Understanding vulnerability from the perspective of older people with dementia**

Dr Barbara Gray, University of Ulster

Dr Gray provided a strong case that people with dementia are at great risk of excess winter deaths and illness. This has only recently been given more attention. Previous lack of awareness may have been due to dementia not being given as a cause of death, fear and stigma regarding a dementia diagnosis, concealment of symptoms and a delay in diagnosis. This means a cold related death or illness may be linked to a co-morbidity rather than the dementia itself.

Barbara described a perfect storm where nobody joins the dots, “a combination of otherwise less innocuous circumstances which aggravate a situation drastically.”

Further detail is available in Gray et al (2015).

**Identifying people at risk of frailty**

Dr Sarah De-Biase, Improvement Programme Manager, Yorkshire and Humber Academic Health Science Network Academic Unit of Elderly Care and Rehabilitation, Bradford Institute for Health Research.

Using Research One data, the electronic Frailty Index (eFI) identifies from a General Practice population those at risk/ likely to have frailty. It can therefore potentially be used to identify people at risk of the negative impact of cold homes because of frailty. Frailty is an increasingly common condition with a prevalence rate of 16% people aged 80-84, and 26% in those over 85. The eFI is in the early stages of application in practice.

Points and questions from discussion:

- Research is required to generate evidence on how a frailty diagnoses impacts on cold related harm (deaths and illness)
- Can the eFI be used across primary, acute and social care to communicate frailty diagnoses and identify who may be vulnerable to cold related harm?
- Does the eFI have potential to identify people to be referred to a single point of contact?
An overview of local initiatives

A number of people from across England were invited to describe and discuss services they delivered at a local level that may help to achieve Recommendation 7 of the NICE Guidance (NG6). We present here a list of those who presented, followed by a summary of key points raised.

Presenters

- John Kolm Murray, Islington Council, Seasonable Health and Affordable Warmth Coordinator
- Elrian Mulloy Environmental Health Manager Preston City Council, Hospital in-reach scheme
- Vanessa Powell-Hoyland, Public Health Specialist, Doncaster Council Winter Warmth Project
- Roy McNally/Janette Linacre, Foundations/Manchester Care and Repair
- Jane Mears Senior Environmental Health Officer East Riding of Yorkshire Council.
- Phillip Morris Senior Development Manager Centre for Sustainable Energy, Wiltshire Warm and Safe

Key Points

- An integrated approach (working across health, local authority, voluntary sector, energy) and a mix of interventions (e.g. Warm Homes Schemes, Hospital Discharge Schemes, Energy Doctor) are essential to make an impact.
- Endorsement and having a champion at the top of organization is essential for success.
- A lot of time is spent by front line workers liaising with energy suppliers for vulnerable clients. This needs to be built into service plans.
- Data sharing remains a challenge although there are examples where this has been overcome e.g. Advice workers having an NHS Honorary Contract, being based in an acute Trust, or being Public Health honorary employees / contractors, establishing a shared database with a cold homes section.
- Variations in electronic systems e.g. System one and Carefirst, causes problems implementing and running schemes to identify, assess and refer vulnerable clients.
- Homelessness is an increasing pressure, so the priority becomes getting some kind of accommodation not the condition of it. This can take up a lot of hospital admissions team time.
- The greatest gains can come from targeting service developments at people with specific conditions e.g. respiratory and mental health. Working with those clinical teams and pathways is more profitable. These teams understand the great importance of cold homes in the lives of people receiving their care.
• Simple referral pathways are needed. Hospitals want one place to refer people regardless of tenure, location of residence, clinical condition, demographics e.g. whether they have children etc.
• Many interventions are funded on a short term basis. Single point of contact/service providers can lose a lot of credibility by not being able to guarantee interventions when funding ceases.
• NHS doesn’t always align with the geographies of LAs which makes it a challenge to get the NHS involved
• Mainstream warmth on prescription provision and Making Every Contact Count can be effective in identifying and reducing the risk of those who are vulnerable
• Active support, referral and hand holding is needed for vulnerable for clients. It’s no good just handing over a phone number or making a referral. Case management is needed.
• Evaluations of services/intervention are good at identifying who they see, are sometimes good at identifying the impact of their services, but are not good at scoping out who isn’t able to access the service/intervention.
• Advice workers in hospital settings have time health professionals don’t to ask about home heating and interventions. Do you know how to use your boiler? When was it last serviced? Worry about paying heating bills etc. They can refer to a single point of contact.
• Ambient monitor program has been developed with a local authority and hospital discharge team. If individuals meet certain criteria they are put on the ambient monitor program. An alert is sent if the temperature in the home becomes too low (below 14 degrees) A responder will then go and visit the person and check that they are okay.
• A Hospital from Home scheme has telephone support workers who phone everyone over 60 discharged from hospital to assess, provide advice, and refer on.
• Home Improvement Agencies deliver interventions in the home – often to older people living alone in privately rented homes. They are not just a handypersons service but also provide valuable protection against rogue traders
• An app can be used to assess and make a referral. (Contact Phillip Morris for more information)

Implications for research, policy and practice,
An open discussion was held to identify implications of the content of the day regarding discharging people from health and social care to a warm home. Implications were identified for research, policy, implementation and practice

Research
• There is clear evidence of the health impact of cold homes on health. However, there is a lack of evidence that establishes and explains the relationship / associations between being discharged from health and social care to a cold home and being admitted or readmitted. What is the impact of cold homes on re/admission to health and social care? Is there any evidence of seasonal differences in discharge delays?
• Research has focused on the health burden of cold homes. There is an evidence gap regarding social outcomes of cold homes and the associated
need for/use of social care services. This needs to include admission to residential care. Can addressing cold homes delay or prevent admission to residential care?

• More academic research is required that adds to underpinning relationships, associations and impacts of cold homes and the theoretical understanding of these – not just evaluations of fuel poverty or energy efficiency interventions.

• Time series studies are a major source of evidence on prevalence of cold related harm, but these take a population approach looking at external temperatures and effect. They do not look at individual cases. Very few studies are based on measuring internal temperatures or that focus on individuals.

• There is a need for enhanced evidence regarding the economic impact of cold homes on health and social care provision.

• There is potential to develop better, more creative ways of communicating evidence more effectively to different audiences to promote engagement regarding Recommendation 7 and discharge planning.

• Case studies and pen portraits are valuable tools to communicate messages about household behaviour and vulnerability related to cold homes, but there is potential to develop these methods and scale up dissemination.

• Many fuel poverty, energy efficiency, affordable warmth interventions have been delivered locally, in line with the localization agenda. However, this means that evaluations are small scale and lack power. Is there some way to collaborate on data collection methods and merge datasets of evaluations to create a more powerful message through meta-analysis?

• There was a consistent message that people running single point of contact schemes struggle to get referrals from health care professionals. There are assumptions to explain this but we do not have evidence to explain it. There is potential for some qualitative work to understand barriers and facilitators to the engagement of health professionals with this agenda.

• How do we get better at identifying people who are vulnerable to being in a cold home and having a negative health impact of being in a cold home, as part of discharge processes?

• How do we better integrate consideration of home circumstances into discharge planning?

• How do we achieve integrated system-wide approaches to realizing Recommendation 7?

Policy

• There is a policy disconnect at a national level. Each relevant government department will look at the cold homes and health from their own perspective and issue policy accordingly e.g. health – Cold Weather Plan, Department for Business, Energy and Industrial Strategy. However, there is no system to look across government departments and have a joined up response. Neither is there the structure or intention to examine cumulative impacts of policy from different departments e.g. welfare reforms, housing, health, health and social care.

• This lack of cross-department working can be mirrored at a local level, limiting joined up responses locally

• Those generating policy need to actively involve key organizations from health and social care and voluntary sector in the co-production of policy and
implementation plans e.g. Royal Colleges in medicine, nursing and midwifery, Age UK etc.

- More active employment of media and social media could be used more proactively to get policy message across.
- Ensure that the health and social impacts of housing and cold homes are integrated into the training of relevant professionals and staff.
- Currently policy relies on money following the problem rather than fixing a problem upstream. This means the NHS spends a lot of money fixing a person (e.g. surgery and rehabilitation to mend a broken hip) rather than fixing the problem upstream (e.g. fixing the home and heating). Money follows the problem rather than fixing the cause of the problem and preventing the negative health consequences.

**Implementation**

- There are problems in selling the importance of addressing cold homes from a practitioner and strategic level locally. There needs to be ‘buy in’ in both.
- We need new ways of communicating and sharing the health benefits of housing interventions to clinicians. This will involve getting Royal Colleges and professional organizations to buy in.
- There is a lot of time thinking of and talking about holistic care but it is difficult to generate cross sector working between housing and health. Health and social care don’t always see housing issues as their responsibility to do something about. This needs a cultural shift. There is also a need for systems that make it easy – such as the single point of contact or ‘one click’ options for referral.
- It is important to focus on the business case when developing discharge planning to meet Recommendation 7. It is necessary to show how it can work and improve health outcomes.
- Embedding referral schemes/single point of contact within the NHS may help engagement and joint working e.g. out-reach and in-reach schemes. Caseworker approaches seem to work, especially if they have honorary NHS contracts so are embedded in the NHS. This also helps overcome data-sharing obstacles.
- Keep processes and systems clear and simple e.g. single point of contact or one click referrals schemes.
- Having champions within health and social care organizations really help to get engagement. They can take time to develop this is worth the investment.

**Practice**

- Make it easier to do the right thing. Look for elegant and simple solutions to engage health and social care practitioners and organisations.
- There is a need for better cross sector communication and collaboration e.g. Regional Networks. Some people are having real difficulties in areas that others have solutions to so we need to share our experiences and learn from each other.
- Key enduring challenges are data sharing and getting referral systems to work. This seminar has showcased practical examples that overcome these obstacles. Ongoing collaboration will help such dissemination.
• Very often we concentrate on respiratory because of the clear evidence base but a case was successfully made to target two additional populations 1) frailty 2) dementia.

References


