St Helens Council

Health Through Warmth
A Housing Lead Approach

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Background to St Helens

- St Helens in Merseyside
- Population: 177,188 Unitary
- Large health and well-being inequalities
  - 16 Wards
  - 10 years difference in life expectancy
- Rapidly growing ageing population
- Increase in frailty and dementia
- By 2025, the number of 85yr olds will increase by 69%
- St Helens CCG – 37 GP practices
- 3 main hospitals
  - Whiston Hospital
  - St Helens Hospital
  - Newton Hospital
About the Presentation

• The challenge
• What we have done
• Human stories
• Outcomes
• Future work
• Conclusion
Comfort, warmth, health, wealth
Heat or Eat? Fuel Poverty, Age Excess Winter Death and Morbidity
What is the challenge?

- Poor housing leading to poor health
- £1.4B pa cost to NHS (ref BRE research)
- Excess cold hazards in St Helens homes – £1.7M annual saving to NHS if all housing hazards mitigated
- Public Health identified high excess winter death and morbidity levels and wide variation across St Helens
- Cold related illness – circulatory & respiratory eg pneumonia
- Worse when external temperature 6°C & below
- Fuel poverty 10.3% (2014 LIHC) – over 8K - heat/eat
- Nationally, 34% of fuel poor households aged 55yrs+
- Challenge = tackle EWD, cold homes and FP locally + keep older/vulnerable residents warm & well in Winter
EWDs in numbers….

• 125 EWDs in St Helens in 2014/15
• EWMI 18.7 2010/11-2014/15 (% of average no. deaths compared with rest of the year)
• Inequality across the borough – highest wards Rainhill (35.9) and Billinge & Seneley Green (35.3), lowest Thatto Heath (2.5)
• Fuel poor, equity rich
• 1 in 5 EWDs due to cold homes (Marmot, 2011)
EWD in St Helens by Cause 2010/11 – 2014/15 (523 EWDs)

Excess Winter Mortality in St Helens by Cause 2010/11 - 2014/15

- Respiratory Disease: 48%
- Circulatory Disease: 21%
- Dementia and Alzheimers: 21%
- Other: 10%

Source: St Helens Public Health Intelligence Team derived from HSCIC Mortality Data
What we have done
Winter warmth initiative lead by Housing Services

Outreach Service
• Home assessment leading to interventions
• Integrated working – IASH, Proactive Care Liaison, Falls Prevention Service, Discharge Solutions, Handyperson/HIA

IASH
• Clear referral and assessment pathway, screening tool, single point of access for health and social care
• Cold and falls connected - assist people at risk of falls

Referrals
• Direct referrals and case finding
• Engaged with GPs – worst affected wards – hidden groups
• Top 2% – CCG risk stratification
• Appointment letters - cold homes message
• Feedback to GPs – what achieved for patients
What we have done

Winter Packs
• Winter survival packs with Age UK – cold homes health warning
  - Calendar with key contacts on keeping warm & healthy
  - Pack items to keep warm
  - Promotion/awareness raising
  - Cold weather advice line
• Linked to flu vaccination message

Making Every Contact Count
• Training health and social care staff to spot fuel poverty and cold homes and give energy efficiency advice
• Fuel poverty focus group
• Capture data on health & well-being impact
Human Stories – Mr & Mrs A

Contact from the client requesting assistance -
Boiler not working. No heating or hot water.

Mr A has Asthma and is a full time carer for his wife who has dementia. The lack of heating and hot water was detrimental to their health. Due to their health and uncertainty of their income the boiler was repaired funded via the housing emergency fund and a referral made for a benefit entitlement check.

Mr & Mrs A were also provided with:
• general energy efficiency advice
• carbon monoxide alarm
• cold alarm
• Draught proofing to single glazed windows
• Referred to priority services register
• Referred to Falls service
Human Stories – Mr B

Contact from Mr B’s family – Inefficient central heating system over 15 yrs old, expensive to run and requiring regular repairs.

Mr B had several health conditions exacerbated by living in a cold home - COPD, arthritis, a heart condition, and thyroid problems. Mr B didn’t qualify for full financial assistance due to a small increase in his state pension disqualifying his entitlement to Pension Credit.

The AWU assisted Mr B with external funding applications (FILT, SSE) totaling £1,000 towards the cost of a new central heating system. Mr B and his family were able to fund the shortfall for the works but would not have been able to fund the full amount.

Mr B’s home is now warmer and healthier following installation of the new energy efficient central heating system his home.
Achievements April 2015 – December 2016

- 916 home assessments resulting in
- Over 2200 interventions
- Measures provided include:
  - Main heating measures (boiler replacements/central heating systems)
  - Heating repairs / Upgrades to heating controls
  - Cavity Wall & Loft Insulation
  - Draught proofing & Reflective Radiator Panels
  - CO and Cold Alarms
  - Warm Home Discount, Priority Service Register & Energy Bill Advice
  - Onward Referrals to local partners i.e. Benefit Checks, Falls Prevention Service
- 12,000 Winter Warmer Packs will have been distributed to vulnerable households across the borough.
- Over £350K of external funding as a result of Housing & Health Partnership
- Over 120 main heating measures installed
- 67 Insulation measures installed
- 2680 homes assisted to apply for the Warm Home Discount scheme giving electric bill savings of over £375,000
- Collective energy switching scheme – 260+ tariff/energy company switches giving estimated annual savings on energy bills of approximately £80,000
Are We Hitting The Right Target Group?

• Of the 916 properties visited:
  - 87% had an occupant with a cold related health condition.
  - 64% had an occupant at risk of falls (including due to frailty)
  - 31% had an occupant who had an unexpected hospital admission in the previous 12 months
  - 61% had an occupant aged 75 or older

• Winter Warmer Pack recipients 2015/16 self reported:
  - Chronic medical condition – 2206
  - Elderly living alone – 1152
  - Frail – 622
  - Fuel Poor – 344
  - Poor mobility / Fall risk – 1567
  - Over 75 years old – 1800
  - >80% stated Pack had made a difference to their well-being
Future work

- Economic evaluation – GP and hospital attendance reductions using NHS no. (QALYs)
- NEA Warm & Healthy Homes evaluation
- Target EWD hotspots
- Reach hidden population groups
- Engage with Practice Managers re pack distribution
- Access funding for further measures – another customer redress initiative?
- Adapt and be flexible to maximise opportunity
Conclusion

• Good Housing, Good Health
• Following 2015 NICE guidance – EWDs & Morbidity and the health risks associated with cold homes
• Tackling cold homes and fuel poverty can positively impact health and reduce treatment costs
• Achieving PH, ASC & NHS outcomes
• Basic improvements to building fabric, energy efficiency and income maximisation make it less costly and more affordable for the householder to keep warm at home
• Requires a joined-up holistic approach between Housing, Health & Social Care to remedy ‘home’ issues
• Can make a big difference
Thank You
For Listening

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