Excess winter deaths needs assessment

NHS Wandsworth

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Authors

Laura Asher, Public Health Specialty Registrar, NHS Wandsworth

Melissa Cottington, Public Health Information Analyst, NHS Wandsworth

Anupam Garrib, Public Health Principal, NHS Wandsworth

Amanda Cranston, Consultant in Public Health, NHS Wandsworth

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1 Executive summary

Aim

NHS Wandsworth has undertaken this needs assessment in order to describe the distribution and determinants of excess winter deaths (EWD) in Wandsworth compared to London and England, outline current provision and access to services to reduce EWD, understand the views of stakeholders on the causes and solutions to EWD, review the evidence for the effectiveness of interventions to reduce EWD and describe services developed elsewhere. The aim is to form recommendations on how best to reduce EWD in Wandsworth given local needs, current service provision, stakeholder views, national guidance and best evidence.

Background

EWD are defined as the number of deaths in the winter period (December to March) which occur over and above the expected number for that period. There are more EWD in England compared to other countries with colder climates, suggesting that some EWD are preventable. Variations in outdoor temperature and seasonal influenza help explain some but not all of the fluctuations in EWD over time. Circulatory and respiratory diseases contribute to most EWD nationally. Risk factors include increasing age, female gender, chronic conditions (particularly circulatory or respiratory), and living in fuel poverty. Isolation and homelessness may also be important, whilst there is an unclear relationship with deprivation. Fuel poverty, whereby greater than 10% of household income is spent of fuel, is the outcome of energy efficiency of the home, cost of fuel and household income. The number of households living in fuel poverty is increasing and government targets have not been met. The Marmot review (2011) found that cold homes cause and exacerbate serious health problems including cardiovascular and respiratory disease.

It is estimated that for every EWD, there are also around 8 admissions to hospital, 32 visits to outpatient care and 30 social services calls (Age UK, 2011). The annual cost to the NHS of treating disease due to cold private housing may be up to £859 million (Department of Health, 2009). Reducing EWD was highlighted as a priority in the Public Health White Paper and the Chief Medical Officer's Annual Report. The Cold Weather Plan for England was launched in November 2011.

Methods

Greater London Authority population projections, the Index of Multiple Deprivation database, the primary care database EMIS Web, the Building Research Establishment study, the West Midlands Public Health Observatory EWD tool and database, and the primary care mortality database were used to determine the patterns of EWD and risk factors. Current service provision and views of stakeholders were ascertained through meetings with individuals from primary care, community nursing and a community ward, housing and warden services, Age UK, the Public Health community development team, social services and the Wandsworth Older People's Network. A literature search was conducted for evidence of interventions to reduce EWD.

Results

Between 2004-2007 Wandsworth had substantially more EWD compared to London and England. However since then there has been a convergence of trends, with Wandsworth now only slightly worse than elsewhere. There are on average 109 EWD per year in Wandsworth.

The most important causes of EWD in Wandsworth are influenza and pneumonia (17% of all EWD), coronary heart disease (16%), chronic lower respiratory disease (10%) and stroke (9%). The greatest burden is in those aged 85 years and over, however the EWDI is substantially higher for those less than 65 years in Wandsworth (15.6%) compared to London (6.9%) and England (7.1%). Seasonal influenza vaccine uptake is lower in high risk groups under 65 years (average 38.9% between 2006-2011) compared to London (45.7%) and England (47.5%) which may explain some of this difference.

4-9% of households in Wandsworth live in fuel poverty. Wards with a higher proportion of the population living in fuel poverty appear to have higher levels of EWD. Yet there is no clear relationship between EWD and deprivation at a ward or lower super output area level. This may be because the most deprived areas tend to have a greater proportion of residents in social housing, which tends to be newer stock, better insulated and may protect against EWD. With the available data it was not possible to prove or disprove a relationship between deprivation and EWD at the individual level.

Between 36- 48% of private households do not meet the Decent Housing Standard. This is not atypical of an inner city borough with a high proportion of houses built before 1919. These tend to be susceptible to damp and coldness. It is not known how many older people or those in high risk groups are resident in these houses. Some older people in Wandsworth reported having to prioritise other needs above keeping warm.

The Department of Health recommends the following interventions are offered to all at risk individuals to reduce EWD: Assessment for affordable warmth interventions, benefits entitlement review, annual flu vaccination, medication review and support for adherence, falls risk assessment, assessment for assistive technologies and development of a personal crisis contingency plan. The impact of the recommended interventions on winter deaths has not been formally researched.

Boosting household income and energy efficiency improvements are important ways to reduce fuel poverty. Older people in Wandsworth recounted difficulties in obtaining information about grants for improving home energy efficiency and about accessing benefits. Older people also reported that they were more likely to trust energy efficiency schemes if these were signposted to them by health or social care staff. However, staff reported a lack of knowledge about referral pathways for affordable warmth interventions, grants and schemes available. Currently there is no systematic assessment in health or social care for fuel poverty. There is no single access point to affordable warmth interventions or the other key interventions to reduce EWD. Age UK Wandsworth delivers or signposts to several interventions relating to preventing EWD, including carrying out benefits entitlement checks, providing help in accessing Winter Fuel Payments and providing a Handyperson scheme. Some community nursing and social care providers contact vulnerable patients and clients in severe weather, but there is no similar process using GP patient lists.

Actions taken elsewhere to reduce excess winter deaths include (i) Training frontline workers to identify risk of cold and fuel poverty, (ii) Improving referral pathways to existing services, (iii) Developing a new service focussed on access to affordable warmth interventions (iv) Developing a one-stop service integrating affordable warmth and health interventions and (v) Developing a new service targeting a specific health condition.

Recommendations

1. Public health as per the current arrangements (and in line with transitional arrangements) will continue to take a lead in commissioning local initiatives to reduce EWD.

2. General Practice, community matrons, community wards, community nursing, adult social care, community mental health teams, intermediate care teams, inpatient geriatric teams, sheltered housing, tenancy support teams, WATCH, Telecare, Age UK Wandsworth, day centres, the community development team, the fire service, Neighbourhood Watch and community safety teams should all be considered contact points for actions to reduce EWD.

3. Increase the awareness of EWD within all key organisations across health, social care and voluntary organisations through partnership working.

4. Improve the identification of individuals at risk of EWD through targeted outreach work with greater priority to the following:
    - The under 65s in high risk groups amongst whom the EWDI is substantially higher in Wandsworth (15.6%) compared to London (6.9%) and England (7.1%).
    - Wards with the greatest EWDI: Tooting (38.7%) and Graveney (34.7%)
    - Wards with a higher proportion of households living in fuel poverty such as Graveney, Furzedown and Tooting.

5. Address knowledge gaps amongst staff on the identification of fuel poverty and the affordable warmth intervention referral process.

6. Consider ways to improve referral pathways and consider developing a single point of access for the identification, assessment and signposting to key interventions to reduce EWD to ensure equity in care provision and optimising uptake of grants and schemes such as RE:NEW, Warm Front and Cold Busters.

7. Work with community groups, GP practices, Primary Care Cluster Teams, Local Enhanced Service (LES) and the Direct Enhanced service (DES) seasonal flu vaccination leads to gain insight and address barriers to receiving the seasonal flu vaccination particularly in the under 65 high risk groups. Between 2006-2011 seasonal flu vaccination uptake in this group was notably lower in Wandsworth (38%) compared to London (46%) and England (47%). Consider innovative ways to increase uptake, such as clinics in sheltered housing.

8. Promote targeted work to improve the uptake of energy efficiency improvements in those households not meeting the thermal comfort standard (ranging from 12% in Northcote to 33% in West Hill) together with the vulnerable groups living in private households not meeting the Decent Housing Standard.

9. Maintain and develop joint working on winter deaths with voluntary sector organisations.

10. Set up an EWD Steering Group to ensure there are strong arrangements for joint working to drive the EWD action plan and monitor the impact of interventions.

11. Identify a lead individual to co-ordinate the EWD action plan and promote EWD projects to all key stakeholders.

2 Purpose of the report

The aims of this needs assessment are:

(i) Describe the patterns of EWD in Wandsworth and understand who is most at risk

(ii) Describe any differences between Wandsworth, London and England in terms of quantity and distribution of EWD

(iii) Describe current programmes and services which may address excess winter deaths, and the extent to which at-risk patients and clients are channelled into these services

(iv) Describe the views of older adults, clinicians and service providers as to the causes of EWD, gaps in current services and recommendations for future action

(v) Review the evidence for the effectiveness and cost-effectiveness of interventions to reduce excess winter deaths

(vi) Review services developed elsewhere to reduce excess winter deaths

(vii) Form recommendations on how best to reduce excess winter deaths in Wandsworth given local needs, current service provision, stakeholder views, national guidance and best evidence

3 Background

3.1 What are excess winter deaths?

There is seasonal variation in mortality in the UK and some other countries in Europe, with higher levels of mortality in winter than in summer. Measuring excess winter deaths (EWD) is a way to quantify this variation. EWD are defined as the number of deaths in the winter period (December to March) which occur over and above the expected number deaths for that period.

Excess winter deaths: The calculation of excess winter deaths (EWD) in this report uses the ONS definition which compares deaths in the winter months (December to March) with the expected number of deaths (average non-winter months). The calculation can be obtained from this formula:

EWD= (winter deaths (Dec-Mar)) – ½(Non-winter deaths (Aug-Nov, Apr- Jul)

The Excess Winter Deaths Index (EWDI) indicates whether there are higher than expected deaths in the winter compared to the rest of the year. The EWDI is the excess of deaths in winter (*December to March)* compared with non-winter months expressed as a percentage.

EWDI= (EWD/Average of non-winter deaths) x 100

Excess winter deaths are expressed as the EWDI, in order that comparisons can be made easily between different geographies and populations of different sizes.

Source: Excess Winter Deaths Atlas User Guide, West Midlands Public Health Observatory

3.2 Why a needs assessment on excess winter deaths?

- EWD were highlighted in the 2010 Wandsworth JSNA as an important public health problem and a key area for action.
- There are more EWD in England than other Northern European and Scandinavian countries with colder climates a phenomenon described as the 'excess winter deaths paradox'. Table 1 shows that the UK has a greater EWDI than Finland, Denmark and Germany. This suggests that some English EWD are preventable (Healy, 2003) (K Laake, 1996).

Table 1 Excess winter deaths index in 14 EU countries 1988-1997

Country	EWDI 1988-1997 (95% Confidence interval)
Finland	0.10 (0.07, 0.13)
Germany	0.11 (0.09, 0.13)
Netherlands	0.11 (0.09, 0.13)
Denmark	0.12 (0.10, 0.14)
Luxembourg	0.12 (0.08, 0.16)
Norway	0.12 *
Sweden	0.12 *
Belgium	0.13 (0.09, 0.17)
France	0.13 (0.11, 0.15)
Austria	0.14 (0.12, 0.16)
Italy	0.16 (0.14, 0.18)
UK	**0.18 (0.16, 0.20)**
Greece	0.18 (0.15, 0.21)
Spain	0.21 (0.19, 0.23)
Ireland	0.21 (0.18, 0.24)
Portugal	0.28 (0.25, 0.31)
Mean	**0.16 (0.14, 0.18)**

Source: Adapted from (Healy, 2003) ***95% Confidence intervals not provided**

- Department of Health guidance proposes that targeted preventative programmes for excess winter deaths could have a significant impact on mortality (Health Inequalities National Support Team, Department of Health, 2010).
- It is predicted that seasonal excess deaths will increase in Britain due to the increasing effects of climate change (Health Inequalities National Support Team, Department of Health, 2010).
- Work to reduce excess winter deaths, in partnership across sectors, is an important opportunity to address a number of agendas simultaneously, including
  - Achieving safer, warmer better insulated homes.
  - Supporting local carbon reduction targets
  - Addressing child poverty
  - Supporting long term conditions strategy
  - Supporting older people to live at home for longer
  - Joint working to address EWD could also support activity to prevent deaths associated with a heat wave.
- The process of addressing EWD may also be a valuable opportunity to develop practices of joint working.

3.3 Underlying causes of death

Circulatory and respiratory diseases contribute to most of the excess winter deaths. Circulatory disease accounted for 37% of EWD in England and Wales in 2009/10 (Office of National Statistics, 2011). The main circulatory diseases involved are coronary heart disease and stroke. This is thought to be because decreased indoor temperatures are associated with raised blood pressure (for every 1

degree decrease in temperature, systolic blood pressure increases by 1.3mmHg) (Woodhouse PR, 1993). Raised blood pressure increases the risk of coronary heart disease and stroke. This seasonal variation in blood pressure is heightened in older adults.

Respiratory disease was responsible for 32% of EWD in England and Wales in 2009/10 (Office of National Statistics, 2011). Respiratory disease has the largest seasonal variation in mortality (i.e. highest EWDI).The main respiratory diseases involved are chronic respiratory disease, influenza and pneumonia. Cold weather decreases lung function, and increases bronchoconstriction in asthma and chronic obstructive pulmonary disease (Department of Health, 2009). Cold can also lower the immune system's resistance to respiratory infections. The level of influenza circulating in the population increases in winter and in vulnerable groups, such as the elderly or those with pre-existing health problems, influenza can lead to life-threatening complications, such as bronchitis or pneumonia (Office of National Statistics, 2011).

Dementia and Alzheimer's disease accounted for 9% of EWD in 2009/10 and also displays marked seasonal effects. The reasons for the seasonal pattern in deaths from dementia and Alzheimer's disease are not clear. It may be related to the greater vulnerability of people with these conditions to respiratory diseases, difficulties with self-care, and falls, all of which may be more important in winter months (Office of National Statistics, 2011).

External causes of death include accidental falls, which can be affected by wintry conditions – for example, icy pavements. However, external causes usually only account for a small proportion of all excess winter deaths (2% in 2009/10) (Office of National Statistics, 2011). Hypothermia contributes a small proportion of EWD (Office of National Statistics, 2011).

3.4 Who is at risk of EWD?

A range of risk factors are likely to be important. Individual characteristics including age, gender and pre-existing medical conditions sit alongside social determinants, in particular fuel poverty, in determining those most at risk.

3.4.1 Age and sex

The elderly are far more susceptible to higher mortality in winter, though all age ranges are susceptible to some degree (see Figure 1). Women make up a greater proportion of EWD than men. Part of the reason for this may be differences in age structure between men and women; larger numbers of women survive to older ages, and this group is at greater risk of EWD.

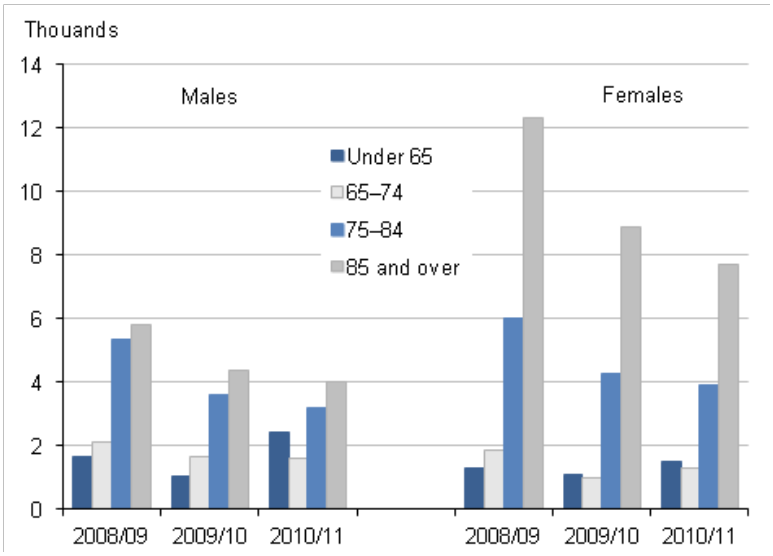

Figure 1 Excess winter deaths: by sex and age group in England and Wales 2008/09-2010/11 (Source: ONS 2011)

Older adults are more vulnerable for the following reasons:

- They are more likely to have an existing medical condition which is associated with EWD (see 3.4.4).
- They are more vulnerable to hypothermia due to having less subcutaneous fat and therefore weaker temperature control (Marmot Review Team, 2011).
- They spend longer at home so are more affected by indoor temperatures, and are more likely to be in fuel poverty due to needing to heat the home throughout the day (Marmot Review Team, 2011).
- When they go outside elderly people are less active and are less likely to wear sufficient clothing to counteract the effects of cold weather (Department of Health, 2001).

3.4.2 Deprivation

A New Zealand cohort study demonstrated that those in the lowest tertile of income were more likely to die in winter than those in the highest tertile (OR 1.13 (95% CI 1.08 to 1.19) (Hales S, 2010). However, most studies investigating risk factors for EWD have failed to find a direct association with deprivation (Wilkinson P, 2001) (Marmot Review Team, 2011). This is thought to be because the most deprived people tend to live in social housing, which is generally more energy efficient.

3.4.3 Type of residence

The New Zealand cohort found that those in rented housing were slightly more likely to die in winter compared to those who owned their home (OR 1.05 (95% CI 1.01 to 1.10) (Hales S, 2010). It is proposed that people living in social housing are typically protected from the ill-effects of cold as there are higher standards of thermal efficiency.

3.4.4 Medical conditions

People with chronic conditions, particularly if there are co-morbidities, have an increased risk of winter death. Chronic respiratory and circulatory disease is exacerbated by cold (see 3.3).

3.4.5 Cold housing and fuel poverty

3.4.5.1 Impact on winter deaths

Whilst excess winter deaths occur in both cold and warm housing, there is a greater risk in cold homes. The Marmot Review team estimate that 21.5% of all EWDs can be "attributed to the coldest quarter of housing, due to it being cold, over and above the amount of deaths which would have occurred had these houses had the same winter excess as the warmest housing" (Marmot Review Team, 2011).

Low indoor temperature increases the risk of cardiovascular diseases, which is one of the main underlying causes of excess winter deaths (Wilkinson P, 2001) (see 3.3). Living in fuel poverty is an important risk factor for low indoor temperature.

A household is in fuel poverty if it needs to spend greater than 10% of income on fuel to maintain satisfactory heating (Marmot Review Team 2011). Fuel poverty is the outcome of three factors:

a. The energy efficiency of the house
b. The cost of fuel for heating
c. Household income

The number of households in fuel poverty in England has been increasing steadily for last eight years to 4 million in 2009 (18.4% of all households) (see Figure 2). 3.2 million of these were vulnerable households (containing children, the elderly or someone who is disabled or who has a long term illness). Just over half of all fuel poor households have an occupant over 60 years, whilst a quarter have an occupant over 75 years. The majority of these individuals live alone (Department of Climate Change and Energy, 2011).

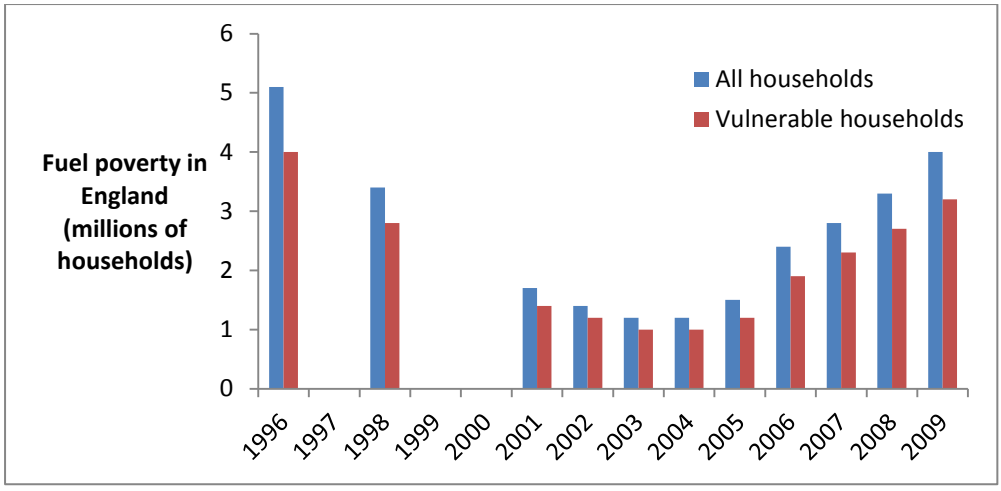

Figure 2 Number of households in fuel poverty in England, 1996-2009 (Source: ONS 2011)

The rising price of fuel is the most influential factor in the increasing fuel poverty levels. However, improvements in the energy efficiency of housing and rising incomes may have helped to partially offset the effect of price changes (Department of Climate Change and Energy, 2011).

One explanation for the excess winter deaths paradox is the variation in thermal efficiency of housing across Europe. Whilst a high proportion of Scandinavian housing has cavity wall, roof and

floor insulation and double glazing, this is less common in the UK. There is evidence of a correlation between some markers of thermal efficiency and EWD across European countries (Healy, 2003).

3.4.5.2 Broader health impacts of fuel poverty and cold homes

Direct health effects

- Respiratory problems are over twice as likely in children living in cold homes compared to those living in warm homes
- Cold housing has a negative impact on mental health in all age groups
- Minor illness such as colds and flu are more likely in cold homes
- Cold homes exacerbate existing conditions such as rheumatism and arthritis

Indirect health effects

- Children's emotional well-being, resilience and educational attainment may all be negatively affected by cold housing
- Dexterity is adversely affected by cold temperatures in the home, potentially leading to increased risk of accidents and falls
- Dietary opportunities and choices are limited by fuel poverty

3.4.6 Cold weather behaviour

Behaviour in cold weather has been raised as an important factor in excess winter deaths (Keatinge W, 2001). This includes wearing inappropriate clothes for cold weather and lack of awareness of the need to turn up the thermostat. Adults with learning disabilities, dementia or severe mental illness may be most vulnerable to this behaviour. The role of these factors has not been quantified, yet promoting avoidance of cold stress is proposed as a means to help reduce EWD (Department of Health, 2009).

3.4.7 Living alone

It is proposed that elderly people living alone are at increased risk of excess winter deaths. However the data are not available to prove or disprove this assumption.

3.4.8 Homelessness and sleeping rough

Homeless people are likely to be at greater risk due to their increased exposure to cold temperatures. However there are no data available to prove or disprove this assumption.

3.5 Environmental determinants of EWD

Outdoor temperature and flu epidemics may help in explaining trends over time, but do not give the full picture.

3.5.1 Outdoor temperature

There are clear patterns of seasonal mortality, with highest mortality in the coldest months (see Figure 3).

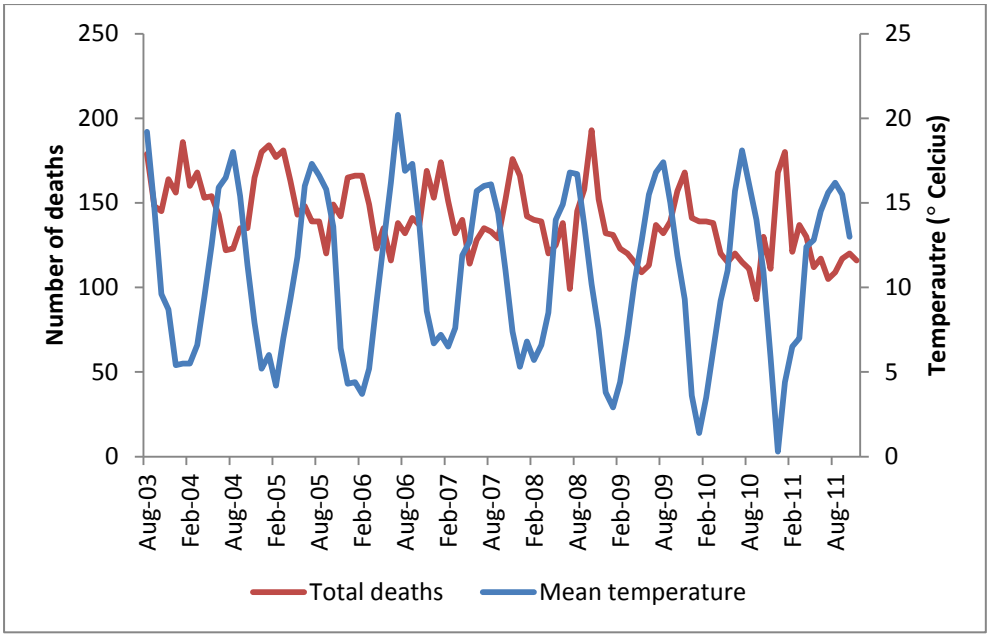

Figure 3: Seasonal variation in mortality, Wandsworth 2003-2010 (Sources: Primary Care Mortality Database and Met Office 2011)

Excess winter deaths are affected to some degree by outdoor temperatures however the relationship between temperature and excess winter deaths is not clear. For example an analysis by the ONS revealed that there was a period from 26 November 2010 to 8 January 2011 when deaths exceeded the five-year average by around 75 deaths per day. This increase in deaths coincided with a period of exceptionally cold weather and a rise in influenza-like illness (measured by GP consultation rates). However the winters of 2009/10 and 2010/11 were two of the coldest since 1995/96 yet the level of EWD in these years was similar to years with much milder temperatures (Office of National Statistics, 2011) (see Figure 4).

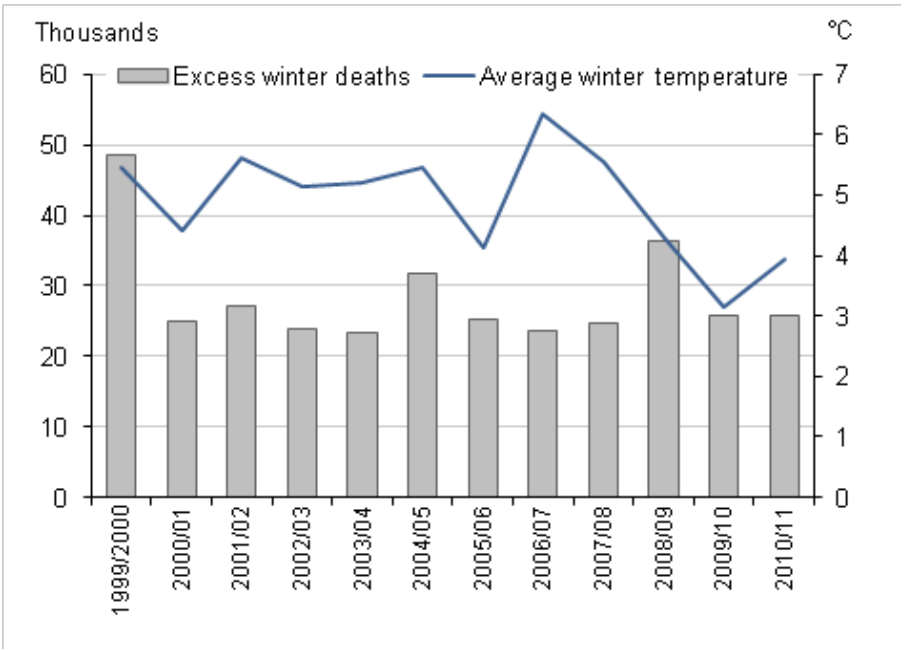

Figure 4: Trends in EWD and average temperature in England and Wales, 1999-2011 (Source: ONS 2011)

3.5.2 Influenza

A relationship between influenza incidence and peaks of winter mortality has been shown (Marmot Review Team, 2011). However this relationship does not always hold; although influenza-like illness activity in the winter of 2010/11 was higher than in many recent winters, there was no corresponding peak in EWD (Office of National Statistics, 2011).

3.6 EWD trends over time

The number of excess winter deaths has gradually decreased over the last 60 years, although the downward trend has levelled off since 1999/2000 (see Figure 5).

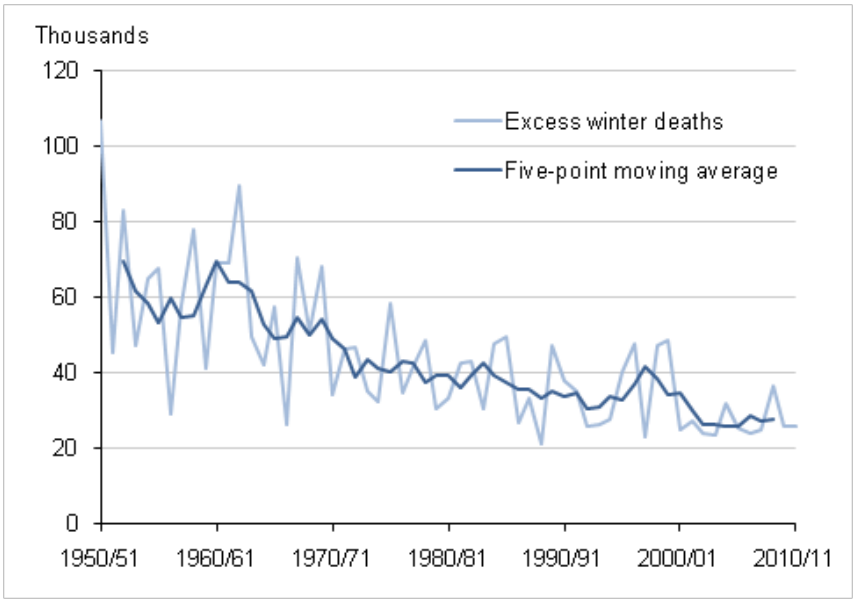

Figure 5 Excess winter deaths in England and Wales: by year and five-year moving average, 1950/51-2010/11 (Source: ONS 2011)

3.7 Regional differences in EWD

Little evidence has been found for consistent variation by geographical region within the UK (P Wilkinson, 2004) (see Figure 6).

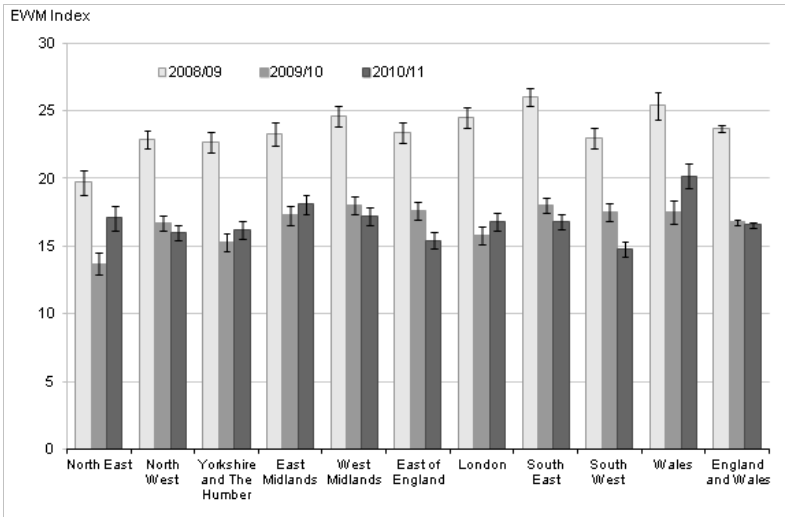

Figure 6 Excess winter deaths for regions of England and Wales, 2008/09-2010/11 (Source: ONS 2011)

3.8 Policy context

3.8.1 Health policy and strategy

Reducing excess winter mortality is one of the outcomes for the 'Healthy Life Expectancy and Preventable Mortality' domain in the most recent Public Health White Paper (HM Government, 2010). Excess winter deaths were also raised as an important issue and area for prevention in the Annual Report of the Chief Medical Officer (Department of Health, 2009). One outcome of this report was the Cold Weather Plan for England, launched in November 2011 (Department of Health, 2011). The aim of the plan is to reduce the health impact of severe winter weather and therefore minimise excess winter deaths (see 8.1). At its core is a cold weather alert system, initiated by the Met Office, which prompts health and social care services to take action when severe weather is occurring or forecast. This action includes contacting at risk individuals and ensuring rooms are adequately heated. Winter preparedness is another component of the plan, including ensuring at risk individuals are receiving all the benefits and services they are entitled to. The seasonal flu vaccination programme is another relevant strategy to reduce excess winter deaths (see 8.3.1).

In the recent restructuring of the NHS, Public Health has been given commissioning responsibility for local initiatives to reduce excess deaths as a result of seasonal mortality (Department of Health 2011).

3.8.2 Housing and energy policy and strategy

The Decent Homes Standard, which includes a measure of thermal efficiency, was set out by the government in 2000. All social housing and 70% of private households containing vulnerable individuals should meet the standard. However private landlords are only required to maintain homes to health and safety standards rather than thermal efficiency standards.

The government was required by the Warm Homes and Energy Conservation Act 2000 to publish a strategy to ensure that people do not live in fuel poverty. The Fuel Poverty Strategy was published in 2001 with objectives of eradicating fuel poverty in vulnerable households by 2010 and in all homes

by 2016. As these targets have not been met and fuel poverty is actually increasing (see 3.4.5), an independent review of the definition and issue of fuel poverty has been commissioned (Hills, 2011).

The previous Government's support for improvement of the energy efficiency of housing was mainly through the Warm Front scheme, which offers grants to eligible individuals to undertake improvements (see 8.3.4). The Carbon Emissions Reduction Target (CERT) placed an obligation on suppliers to install energy efficiency measures; though only 40% of this programme was aimed at priority groups (Marmot Review Team, 2011). The Energy Act 2011 signals a shift towards the Green Deal and the Energy Companies Obligation (ECO). Under ECO energy companies are obliged to improve energy efficiency of housing with a focus on vulnerable households. The Green Deal will allow individuals to undertake home energy efficiency improvements without paying up front costs. By 2018 private landlords will be required to meet specified levels of energy efficiency (HM Government, 2011).

Other policies related to reducing excess winter deaths include the winter fuel and cold weather payments (see 8.3.5).

3.9 Economic and social impact of EWD

Morbidity and mortality due to cold puts additional pressure on hospitals, general practices and other health services. Age UK have estimated that for every excess winter death, there are also around 8 admissions to hospital, 32 visits to outpatient care and 30 social services calls (Age UK, 2011). Furthermore, time off work due to illness puts strain on small businesses and the self-employed. It has been estimated that the annual cost to the NHS of treating disease due to cold private housing is £859 million (Department of Health, 2009). This figure does not take into account economic losses due to time off work, or additional spending by social services. It has been estimated that for every £1 invested in improving thermal efficiency of housing, the NHS is saved 42 pence (Department of Health, 2009).

4 Methods

4.1 Distribution of risk factors for EWD in Wandsworth

4.1.1 Demographic data sources

The Greater London Authority population projections for 2011 were used to estimate the current size of the Wandsworth population aged over 65 years and to predict how these numbers are likely to change in the future. Proportion of vulnerable homes by ward was determined using the Buildings Research Establishment study (see Table 2). Index of Multiple Deprivation data was obtained from the IMD 2010 database (Communities and Local Government, 2011).

4.1.2 Housing and fuel poverty data sources

There are three main data sources on fuel poverty and energy efficiency of private housing in Wandsworth (see Table 2).

Table 2 Housing and fuel poverty data sources

Source/s		What does it tell us?	Limitations
Building and Research Establishment (BRE) study	Originally modelled data from the 2001 English House Condition Survey and the Census. Model improved to include annual updates from the National House Condition Survey with the latest results provided for 2008	Proportion of private dwellings with inadequate thermal comfort, SAP rating <35[1] and proportion of households living in fuel poverty or classed as vulnerable	Modelled data may not reflect actual figures; fuel prices increased so probably underestimates fuel poverty
Annual fuel poverty survey 2009/2010	Based on National Indicator 187 (now redundant). Postal survey with 449 respondents.	Estimates proportion of households of all tenures which are in fuel poverty (defined as household containing an occupant in receipt of means tested benefits **and** with a SAP rating of less than 35[1])	Data unreliable as 6% response rate and disproportionate response by social housing tenants. Inaccurate way of determining fuel poverty.
Registered Social Landlord (RSL) questionnaire	Two questionnaires completed by RSLs with large housing stock	SAP ratings[1] and compliance with decent homes standard in RSL housing stock	Only two responses received- may not be representative

4.1.3 Long term conditions and influenza vaccination

Data on frequency and prevalence of long term conditions was gathered from the NHS Information Centre, which collates Quality and Outcomes Framework data (NHS Information Centre, 2011). Influenza vaccination uptake was gathered from EMIS Web (derived from draft Seasonal Influenza Vaccination needs assessment).

[1] Standard Assessment Procedure. SAP ≤35 indicates insufficient energy efficiency

4.2 Analysis of EWD in Wandsworth and comparison to London and England

4.2.1 EWD data sources

Wandsworth data on excess winter deaths were derived from the primary care mortality database. Most data were pooled for the period August 2003 to July 2010 in order to gain sufficient numbers to make comparisons between categories of age, cause of death and ward. London and England data were extracted from the West Midlands Public Health Observatory excess winter deaths tool and database (WMPHO, 2011). For the purposes of comparing Wandsworth data to London and England 2002-2009 pooled data were used. Comparative trend data are presented as three year rolling averages in order to smooth out trends.

4.2.2 Limitations of the EWDI

The EWD index is calculated based on the Office for National Statistics (ONS) Method (see 3.1). This defines the winter period as December to March, and the non-winter period as August to November of that year and April to July of the following year. However, if cold-related deaths start to increase prior to this, for example in November, the number of deaths in the non-winter period will increase, which in turn will decrease the estimate of excess winter deaths. Furthermore, if there is an excess of summer deaths, for example due to a heat wave, this will make the excess winter deaths figure lower.

The EWDI is not age standardized, meaning that differences in EWDI between different areas may be due to different age structures. Breaking down EWDI into age bands helps to reduce this problem.

4.3 Stakeholder views

The views of a number of stakeholders were sought on causes of EWD, potential solutions and gaps in current services. Clinical opinions on factors contributing to EWD and potential solutions were sought from Dr Judith Coles (Consultant Geriatrician, St George's Hospital) and Dr Shakeel Mughal (GP, lead for Central Wandsworth Community Ward). Interviews and meetings were conducted with a number of Health and Social Care staff (see Appendix).

A discussion on the causes of excess winter deaths was conducted with approximately 25 members of the Wandsworth Older People's Forum. A focus group with five older adults on excess winter deaths was also facilitated as part of the Joint Strategic Needs Assessment consultation at the Older People's Network Conference. Opinions of older adults gathered by community development workers at 'Reminiscence Sessions' were also considered (see Appendix). The comments gathered from these three sources were analysed for recurring themes. Issues raised twice or more (either by more than one individual in one setting, or in more than one setting) were distinguished from those which received a single mention. It is possible that older adults attending the Older People's Network/ Forum events are not representative of the general population of older adults in Wandsworth.

A meeting attended by 25 stakeholders was held to present provisional findings of the needs assessment and gather input into potential recommendations.

4.4 Evidence of effectiveness and cost-effectiveness

The Cochrane Library was searched for systematic reviews of the relevant interventions. A literature search on the effectiveness of interventions was also completed using Medline and PubMed databases. Key search terms included 'Excess winter deaths', 'Excess winter mortality' and 'Seasonal mortality'. There was no restriction by date of publication.

4.5 Service models for EWD reduction elsewhere

Examples of initiatives to reduce EWD which have been employed in other boroughs were collated from two recent collections of case studies (S Ahmed, 2011) (Local Government Group, 2011) and four main models were described.

5 Prevalence of risk factors for EWD in Wandsworth

5.1 Socio-demographic factors

5.1.1 Overall

Wandsworth has around 132,000 dwellings which are home to a population of over 290,000 residents. Wandsworth experiences particularly high levels of population turnover each year. However this movement is mainly restricted to younger and middle-aged residents.

5.1.2 Age

The age structure of Wandsworth is uniquely skewed towards the young, with the 20-39 years old age group representing 48% of the population compared to 27% nationally and 36% in Greater London (see Figure 7). GLA projections show the 2011 Wandsworth population in the 75+ age range being around 11,800 (4%). This is below the proportion in the Greater London population (6%). However, Wandsworth does have the second highest proportion of women aged 75+ living alone in London at 69% (London - 60%, and England - 60%). Over the next five years, there is expected to be an increase in the over 75's in England and a slight increase across Greater London. However in Wandsworth it is expected to fall slightly to 11,000 (see Table 3).

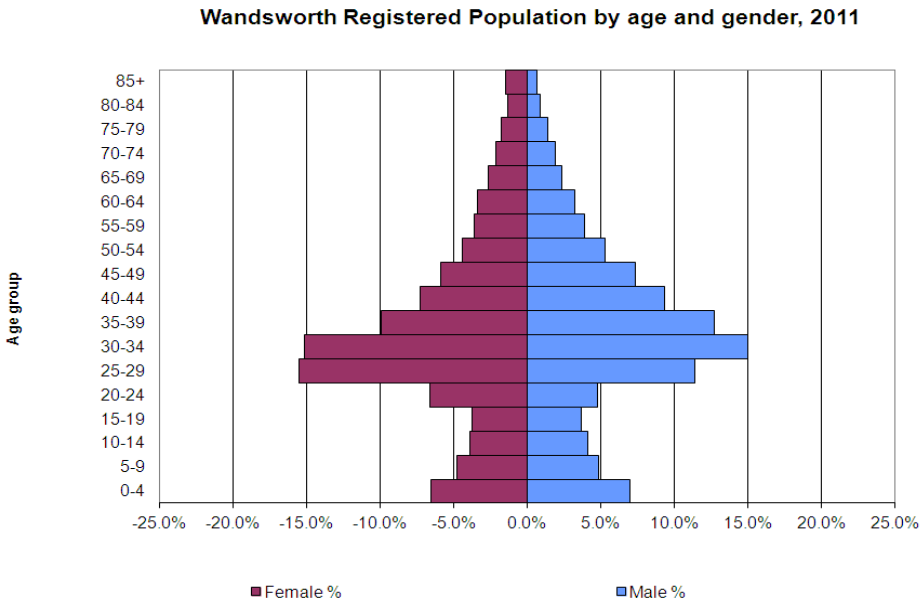

Figure 7 Population pyramid Wandsworth 2011 (Source: GLA population projections)

Table 3 Estimated change in the resident population above 65 years of age between 2011 and 2021, Wandsworth (Source: GLA population projections)

Age (years)	2011	2021	% change 2011-2021
65 - 69	6923	7281	5.2%
70 - 74	5842	6247	6.9%
75 - 79	4546	4456	-2.0%
80 - 84	3418	3286	-3.9%
85 - 89	2138	1935	-9.5%
≥90	1143	1324	15.8%
≥65	24,010	24,528	2.2%

There is some ward-level variability in the proportion of population over 65 years, ranging from 5.5% in Northcote, to 12.8% in Roehampton (see Figure 8).

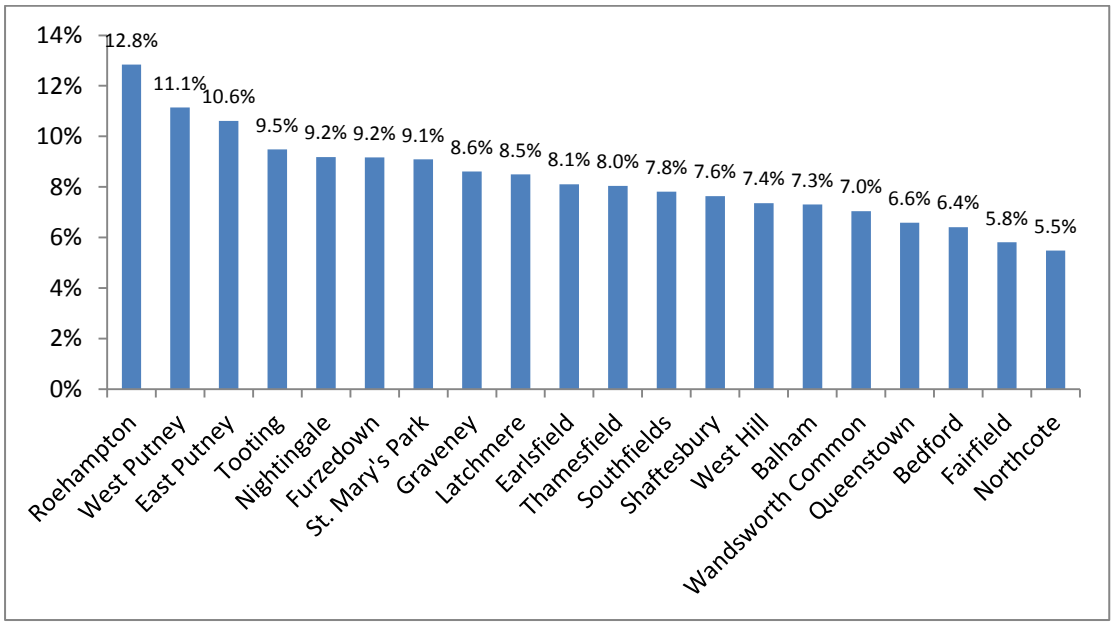

Figure 8 Proportion of resident population age 65 years and over by ward, Wandsworth 2011 (Source: GLA 2010 Round Demographic Projections)

5.1.3 Ethnicity

Wandsworth is home to a diverse range of communities and 20% of the borough's population is non-white, compared with 31% in Greater London and 12% nationally. In 2010 there was a higher proportion of white people in the 75+ population (83%) than in the overall borough population (77.9%), but this is expected to fall by 2015 to 78.2%, broadly in line with the all age proportion. Conversely, the proportion of people from Black ethnic groups is expected to rise from 9.3% to 11.9% and the proportion from South Asian ethnic groups will rise from 4.8% to 6.3% (Source: GLA 2007 Round Ethnic Group Population Projection).

5.1.4 Vulnerable households

It is estimated that 13% of households in Wandsworth are vulnerable (defined as containing a resident who is elderly, disabled or under 5 years). There is considerable variation between wards ranging from 7% in Thamesfield and Northcote to 27% in Roehampton (see Figure 9).

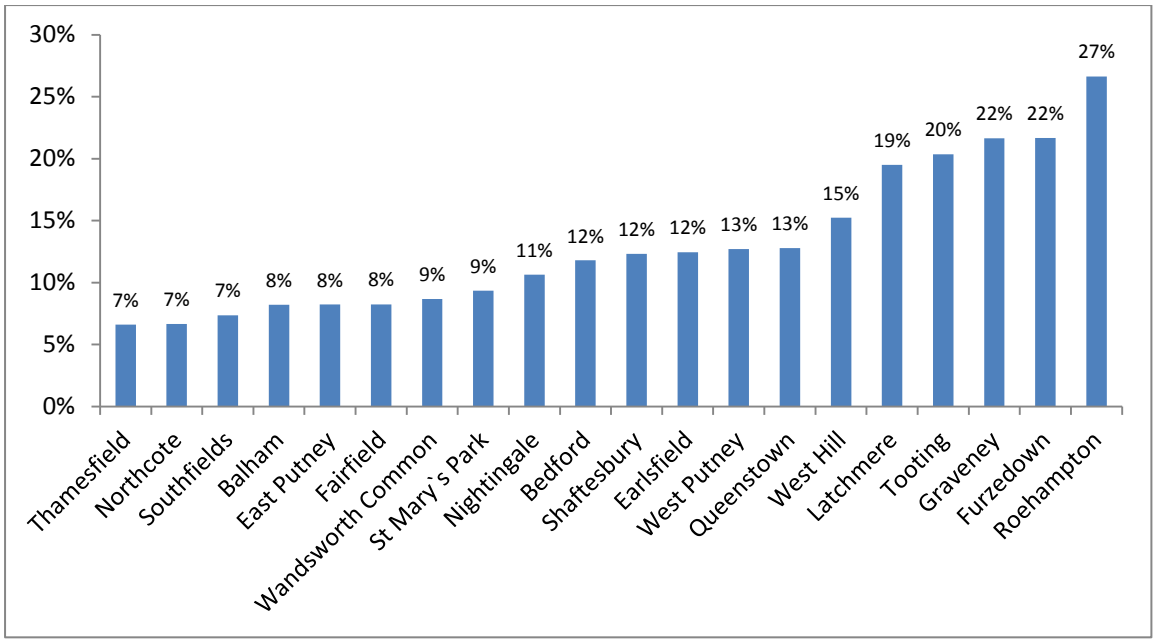

Figure 9 Proportion of vulnerable households by ward, Wandsworth 2008 (Source: Building Research Establishment study 2008)

5.1.5 Deprivation

There is considerable geographical variation in deprivation within Wandsworth (see Figure 10).

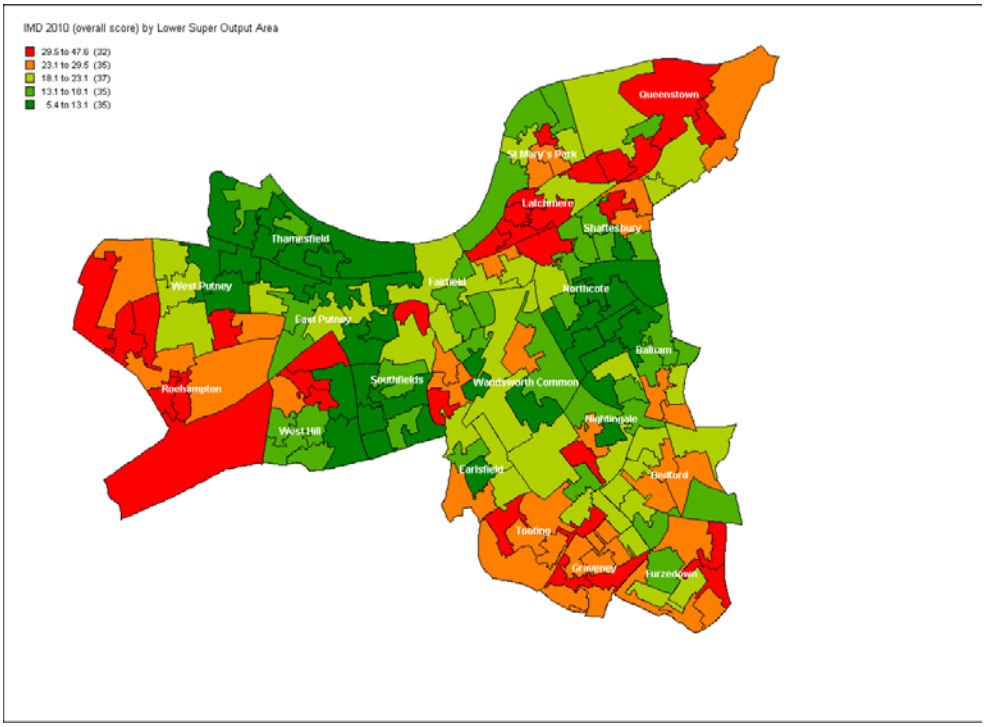

Figure 10 Index of Multiple Deprivation 2010 by Lower Super Output Area (Source: IMD Database 2011)

The number of people of pensionable age in Wandsworth is approximately 31,000. Of these 19,000 (60%) rely on the state pension only (Source: DWP, Pension age client Group caseload). The Income Deprivation Affecting Older People Index indicates that Tooting, Bedford, Latchmere and Queenstown all have high numbers of deprived older people (see Figure 11). This index measures the proportion of residents who are aged 60 and over who claim income support or income based job-seekers allowance.

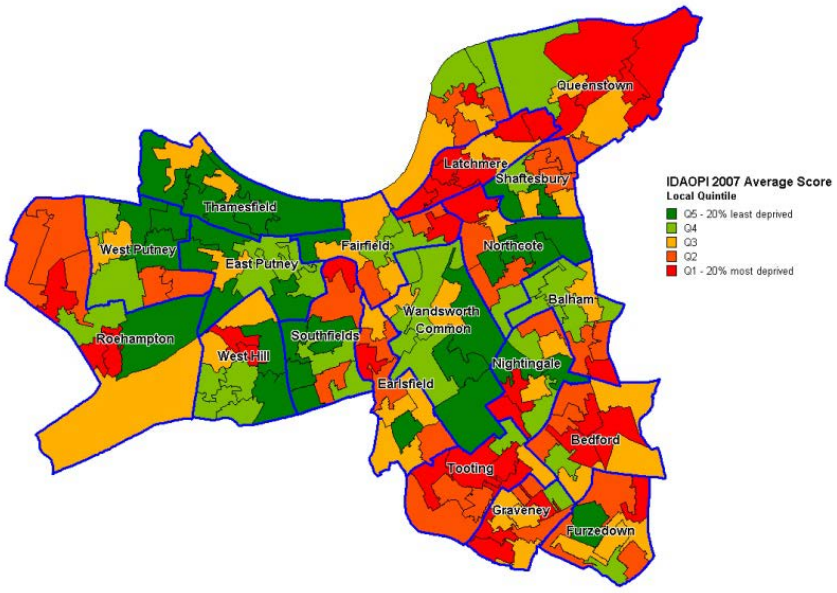

Figure 11 Income deprivation affecting older people index in Wandsworth by lower super output area 2007 (Source: IDAOPI database)

5.1.6 Homelessness

The average annual number of households officially recognised as newly homeless in Wandsworth is 708 (average of 2006 to 2008). In 2007 this represented 0.6% of all households in the Borough. Wandsworth ranks 72nd out of 354 local authorities in England (Crisis, 2007).

5.1.7 Asylum seekers and refugees

In September 2011 the Wandsworth Health Team for Refugees, Asylum Seekers and Homeless People had files on 100 refugee individuals and families, 70 asylum seekers and 9 failed asylum seekers. After receiving leave to remain, refugees may face a delay accessing a national insurance number. They may be ineligible for local authority housing and insufficient funds for privately rented accommodation. They may therefore go through a period of street homelessness. Failed asylum seekers may also be destitute.

5.2 Energy efficiency of housing and fuel poverty

5.2.1 Decent homes standard

This is the technical standard, introduced by the Government in 2000, by which homes are rated. A decent home is measured in four areas:

1. It meets current statutory minimum standard for housing.
2. It is in a reasonable state of repair.
3. It has reasonably modern facilities and services.
4. It provides a reasonable degree of thermal comfort- both heating and insulation.

5.2.1.1 Private housing

Overall 41% of private households in Wandsworth do not meet the Decent Homes Standard, ranging from 36% in Tooting to 48% in Roehampton (see Figure 12). These figures are not atypical of an inner city borough with a high proportion of houses built before 1919. Dampness and cold are common. In privately rented homes Council enforcement action and advice results in around 300 dwellings newly achieving the Standard each year. Limited grant aid and equity release loans for housing improvements are available from the Council.

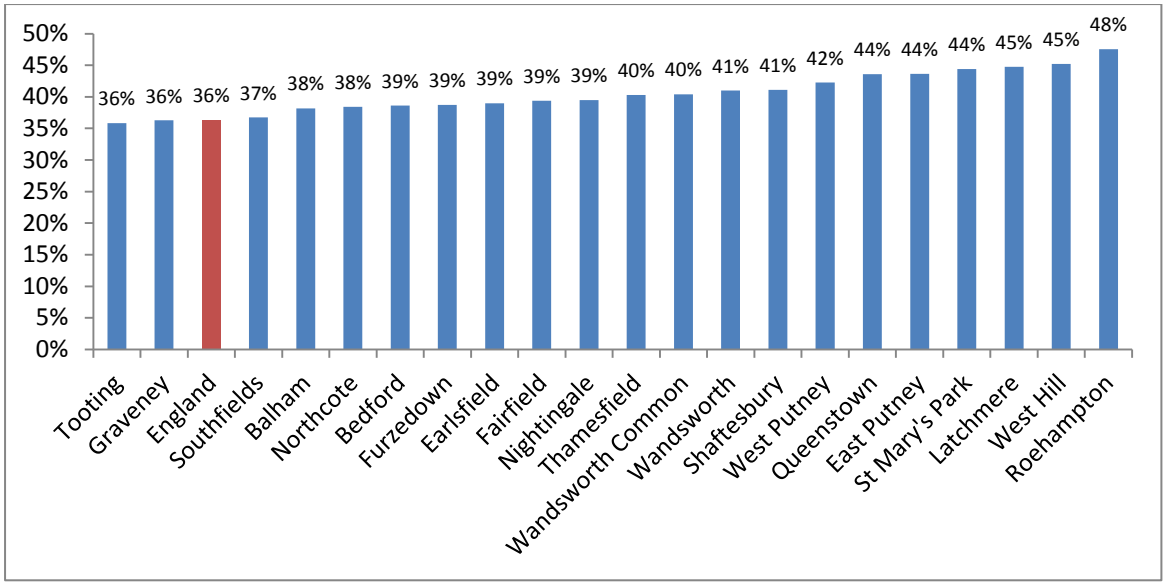

Figure 12 Proportion of private households not meeting decent homes standard by ward, Wandsworth 2008 (Source: BRE study 2008)

20% of private dwellings within the Borough failed the thermal comfort standard of the Decent Homes Standard. There was considerable variation between wards ranging from 12% in Northcote to 33% in West Hill (see Figure 13).

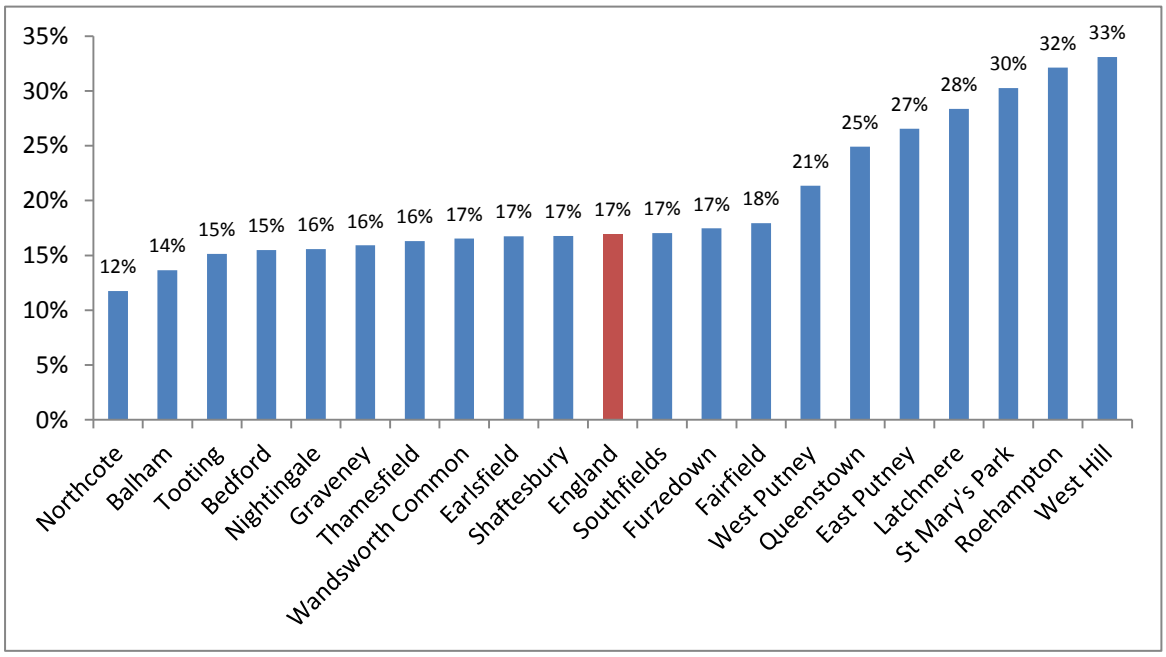

Figure 13 Proportion of private households not meeting thermal comfort standard by ward, Wandsworth 2008 (Source: BRE study 2008)

5.2.1.2 Social housing

There is no specific data on adequate thermal comfort of Council housing, but Council housing in Wandsworth achieves 100% compliance with the Decent Homes standard. The registered social landlords who responded to the questionnaire both estimated 100% compliance with the Decent Homes standard.

5.2.2 Standard assessment procedure (SAP) ratings

SAP is a form of modelling, which is an approved methodology for assessing the energy efficiency of dwellings. SAP makes data and recording assumptions based upon property age and type and location, space heating, water heating and lighting. It is expressed on a scale of 1 (very inefficient) to 100 (zero energy cost). A SAP rating of ≤35 is deemed to have insufficient energy efficiency (Chartered Institute of Environmental Health, 2011).

5.2.2.1 Private housing

According to the BRE study 8,591 dwellings in Wandsworth (9% of all private households) had a SAP rating of 35 or less. There was variation between wards ranging from 5% in Tooting to 15% in Queenstown (see Figure 14). The average across Wandsworth in private households is not available. The national average SAP rating is 51 (Wandsworth Borough Council, 2011).

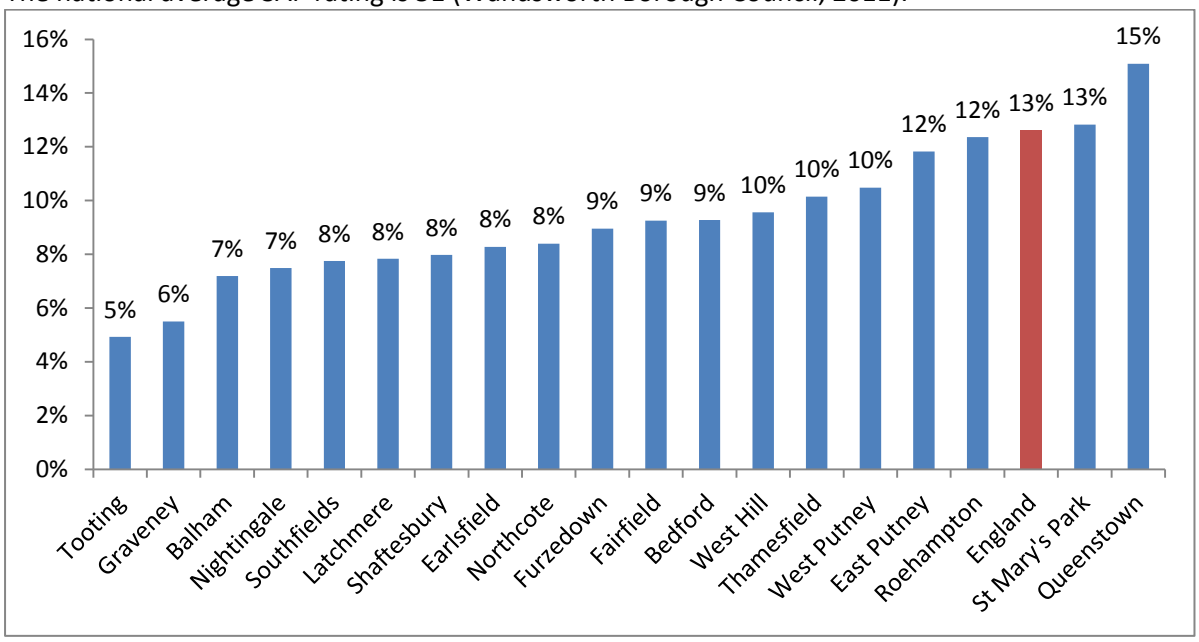

Figure 14 Proportion of households with SAP rating <35 by ward, Wandsworth 2008 (Source: BRE study 2008)

Figure 15 shows the proportion of households with SAP rating ≤35, by ward across South West London. Wandsworth appears to have generally lower proportions of such households compared to some other Boroughs such as Richmond.

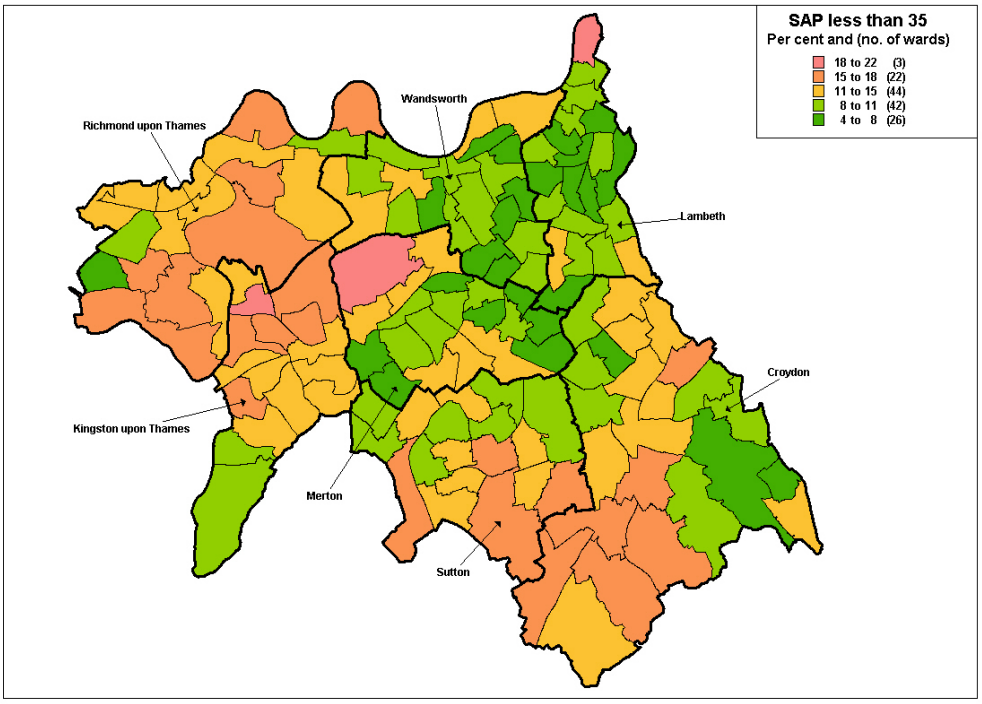

Figure 15 Proportion of households with SAP <35 by ward, South West London 2008 (Source: BRE Study 2008)

5.2.2.2 Social housing

SAP ratings are generally higher in Council housing than private housing, with no Council dwellings with a SAP rating of <35 in the borough. The average SAP rating of Council housing in Wandsworth is 71.3. SAP ratings of council housing by ward are not available. The Registered Social Landlord questionnaire estimated relatively high average SAP ratings between 62 and 69 across London.

5.2.3 Fuel Poverty

5.2.3.1 Private housing

The 2008 BRE study estimated that 5,050 private households in Wandsworth (6% of all private households) were living in fuel poverty (see Figure 16). Fuel poverty was estimated using both household income and features of the property including size, type of heating and insulation. Fuel poverty data may underestimate actual fuel poverty as the survey assumes a minimum income equivalent to income support. In reality some households may not be eligible for, or are accessing, these benefits. It is important to note that the figure will fluctuate with changes in household income and energy prices. There was variation between wards ranging from 4% in Thamesfield, Northcote and East Putney to 9% in Tooting.

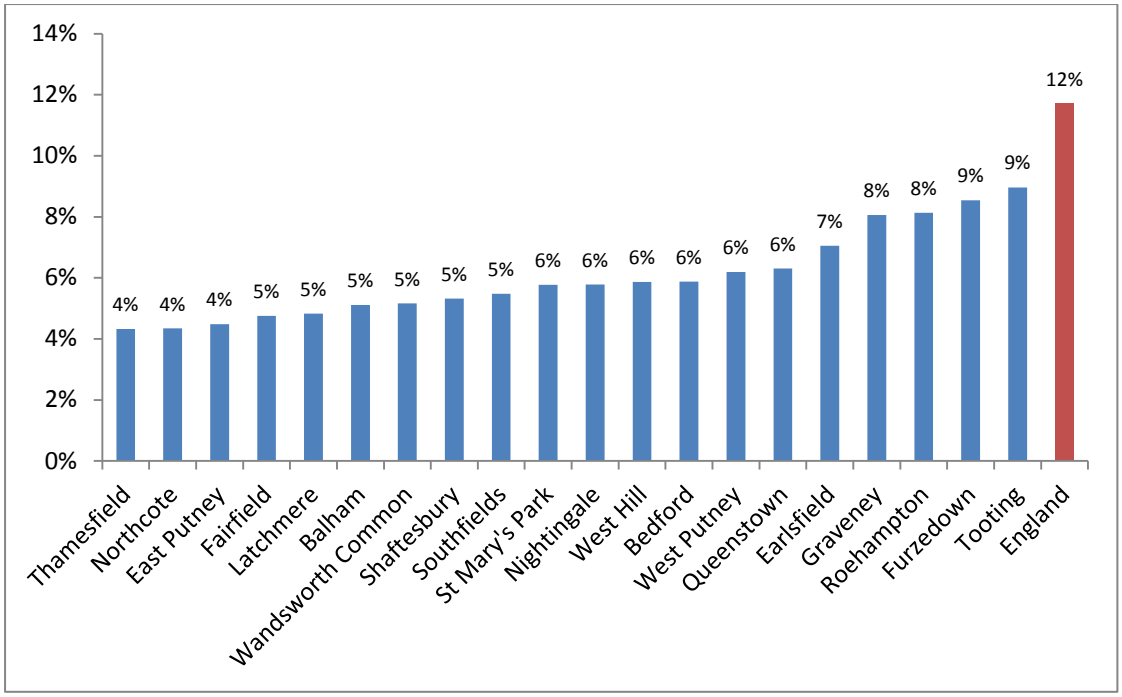

Figure 16 Proportion of private households in fuel poverty by ward, Wandsworth 2008 (Source: BRE study)

Figure 17 shows the proportion of households in fuel poverty, by ward across South West London. Wandsworth appears to have generally lower levels of fuel poverty compared to some other Boroughs such as Croydon.

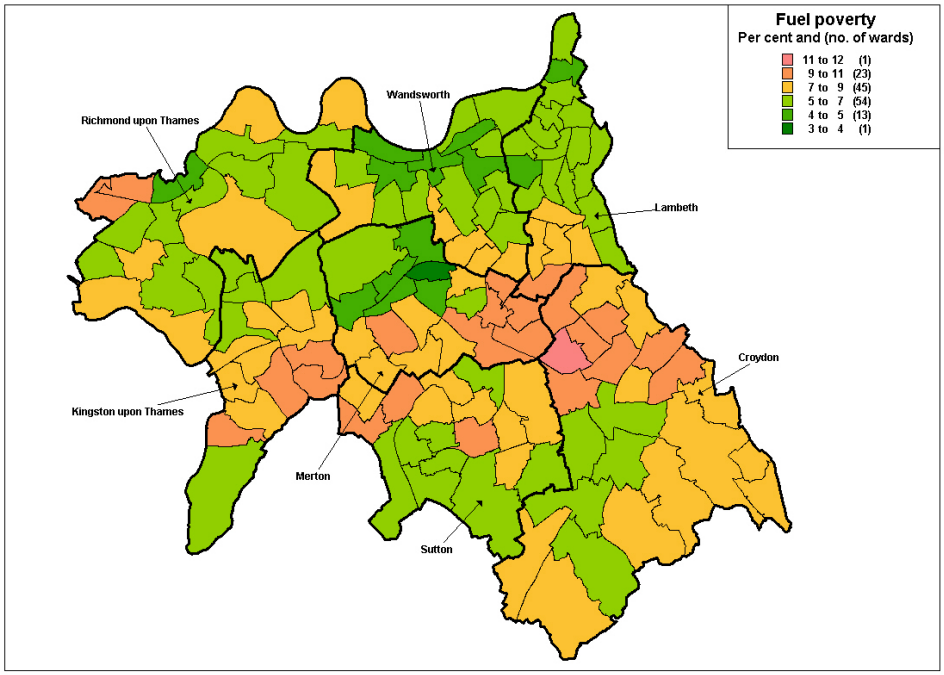

Figure 17 Proportion of households living in fuel poverty by ward, South West London 2008 (Source: BRE study 2008)

5.2.3.2 Social housing

There are approximately 4000 Council properties (both tenanted and let on long leases) on communally heated estates. This means the heating is supplied by the Council but charged to the residents including, for leaseholders, both fuel and maintenance costs. Fuel charges are reviewed annually based on actual costs on individual boiler houses and fuel consumed, however it is estimated that some residents may breach the fuel poverty cut-off.

5.3 Long term conditions

Table 4 shows the number of individuals and prevalence of the three long term conditions most important for excess winter deaths. Prevalence is lower in Wandsworth than London and England, which is probably due to the younger age structure.

Table 4 Frequency and prevalence of long term conditions in Wandsworth 2009/10 (Source: NHS Information Centre)

Condition	Frequency	Prevalence (%)		
	Wandsworth	Wandsworth	London	England
Chronic Obstructive Pulmonary Disease	2700	0.8	1	1.5
Stroke and Transient Ischaemic attack	2807	0.8	1	1.7
Coronary Heart Disease	5524	1.5	2.2	3.4

5.4 Seasonal influenza and pneumococcal vaccination uptake

Seasonal flu vaccination is targeted at individuals aged 65 and over, people with long term health conditions including heart disease, respiratory disease, stroke and diabetes, carers and pregnant women. The proportion of over 65 year olds in Wandsworth who received the flu vaccination in 2010/11 was 70.1%. Although this met the national 70% target, it was lower than that achieved in London (71.4%) and England (72.8%) (see Figure 18). The new 2011/2012 target of 75% coverage for over 65 year olds was not met (72.2% achieved), despite local campaigns aimed at raising awareness. There is some variation in uptake by age band within the over 65s, with 65-69 year olds having lowest uptake (see Table 5). Seasonal flu vaccination uptake amongst high risk groups under 65 years, for whom the target is 60% saw a significant drop in uptake in Wandsworth in 2007/09 (27%) and improved in the later years. Uptake in 2010/2011 was substantially lower in Wandsworth (43.4%) compared to London (48.9%) and England (50.4%) (see Figure 19). Pneumococcal vaccination is aimed at the same groups as the seasonal flu vaccination. Figure 20 shows pneumococcal vaccination uptake in over 65 year olds in Wandsworth.

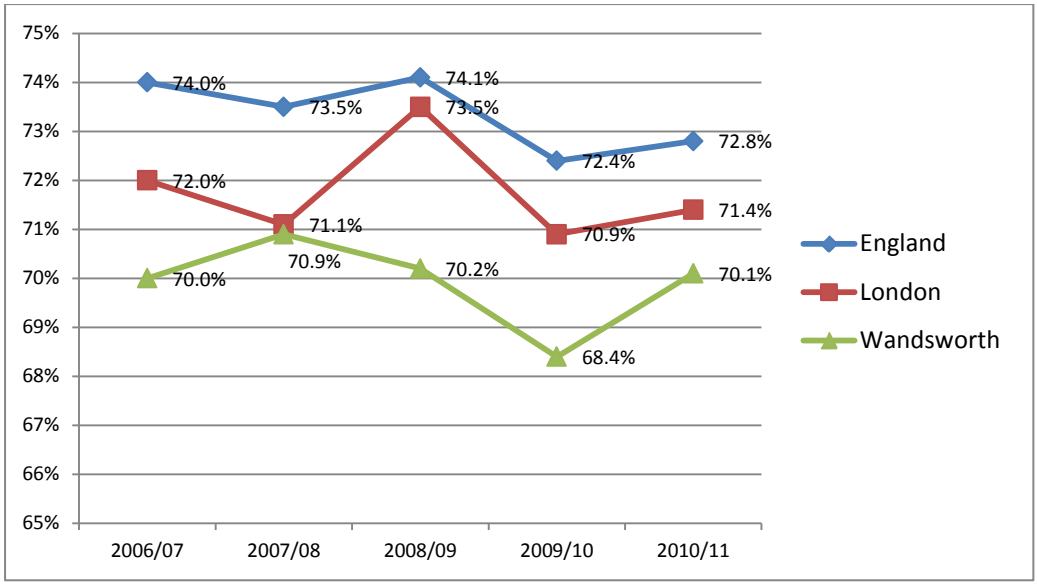

Figure 18 Seasonal flu vaccination uptake among people over 65 years of age in Wandsworth, London and England 2006-11 (Source: EMISWeb 2011)

Age (Years)	Influenza vaccine uptake (%)
65-69	61.6%
70-74	69.9%
75-79	75.5%
80-84	75.3%
85-89	75.4%
90+	70.3%
Total	**70.1%**

Table 5 Seasonal Flu Vaccination uptake among people 65+ years of age by age groups in Wandsworth, 2010-11 (Source EMIS Web 2010-11)

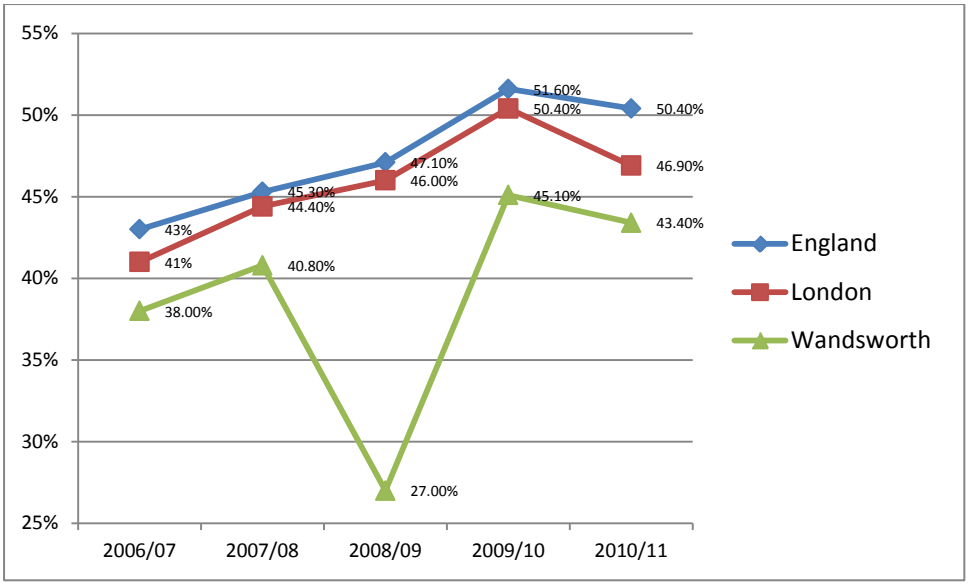

Figure 19 Seasonal flu vaccination uptake among people under 65 years of age in Wandsworth, London and England 2006-11 (Source: EMISWeb 2011)

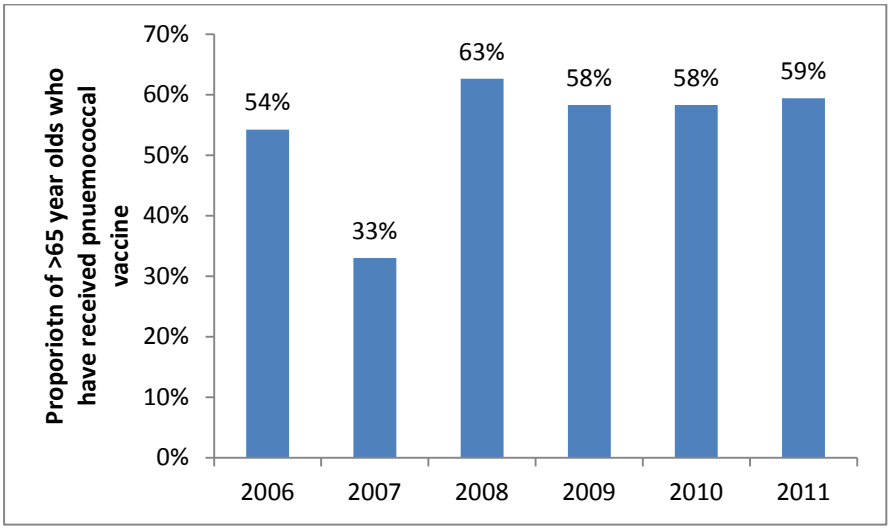

Figure 20 Pneumococcal vaccination uptake in over 65s, Wandsworth 2006-2011 (Source: ImmForm)

6 Hospital admissions

There is seasonal variation in hospital admissions due to chronic respiratory disease and flu and pneumonia (see Figure 21), with these conditions exerting a greater burden on health services during the winter months. We would expect these fluctuations as these conditions are exacerbated by cold weather.

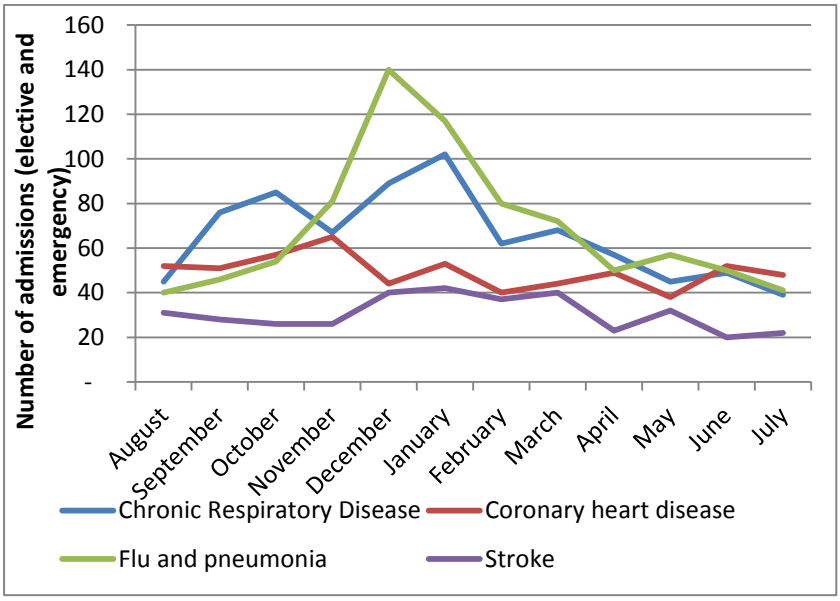

Figure 21 Number of admissions due to conditions related to excess winter deaths, Wandsworth August 2010- July 2011 (Source: Primary Care Mortality Database)

7 Excess winter deaths in Wandsworth

7.1.1 Overall EWD

There were 764 excess winter deaths in the period August 2003 to July 2010. This equates to an average of 109 excess deaths per year. The overall excess winter deaths index (EWDI)[2] for the period was 20.1%.

7.1.2 EWD by age and sex

Figure 23 shows the EWDI was lowest in the 65- 74 years age band (12.8%). This means there is least seasonal variation in mortality in this group. The highest EWDI was amongst those 85 years or over (28.4%) meaning seasonal variation in mortality is greatest in this group. There also appears to be greater seasonal variation in younger ages (e.g.19.2% in 16-54 age group and 22.0% in 55-64 age group) (see Table 6), which is not quite the pattern we would expect.

However, the number of EWD is highest in the over 85 age band and lowest in the under 75 age band. This shows that the burden of EWD is mainly on the older groups, which is the pattern we would expect. There are fewer deaths in winter compared to non-winter in under 16 year olds (EWDI -50% in 5-15 year olds- see Table 6).

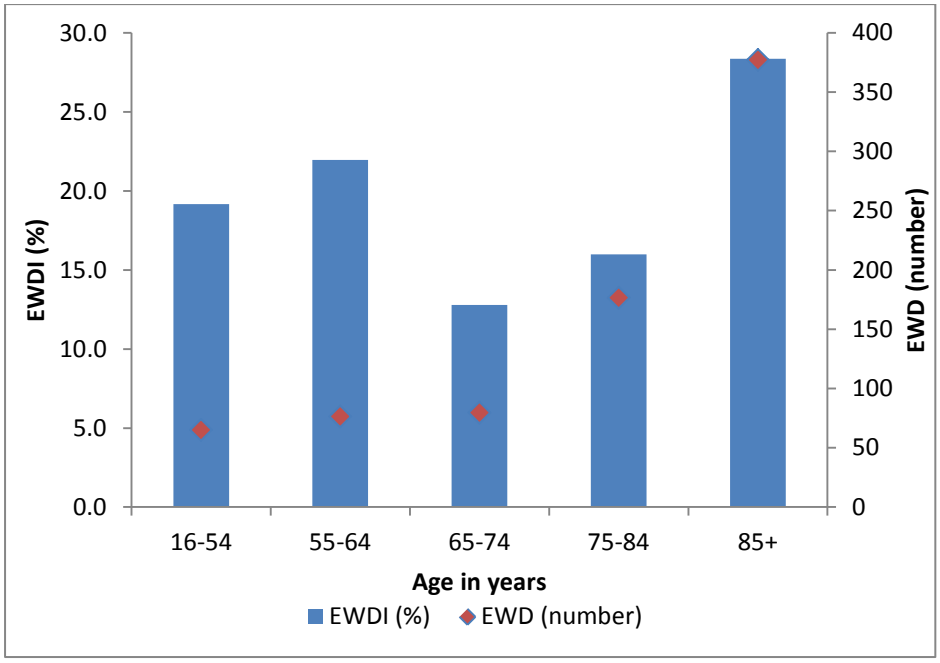

Figure 23 EWD and EWDI (%) by age band, Wandsworth 2003-10 (Source: Primary Care Mortality Database)

[2] **The Excess Winter Deaths Index** (EWDI) is the excess of deaths in winter (*December to March)* compared with non-winter months expressed as a percentage. *EWDI= (EWD/Average of non-winter deaths) x 100*

Table 6 EWD and EWDI (%) by age band and sex, Wandsworth 2003-10 (Source: Primary Care Mortality Database)

Age Band	Total EWD 2003-2010	Average EWD/ year	EWDI (%)
0-4	-4.5	-0.64	-9.47
Males	-5.5	-0.79	-20.00
Females	1	0.14	5.00
5-15	-6	-0.86	-50.00
Males	-3	-0.43	-75.00
Females	-3	-0.43	-37.50
16-54	65	9.29	19.17
Males	52.5	7.50	25.55
Females	12.5	1.79	9.36
55-59	16	2.29	10.26
Males	13	1.86	14.29
Females	3	0.43	4.62
60-64	60.5	8.64	31.43
Males	24.5	3.50	20.50
Females	36	5.14	49.32
65-74	79.5	11.36	12.79
Males	57	8.14	15.57
Females	22.5	3.21	8.81
75-84	176.5	25.2	15.98
Males	72.5	10.36	12.73
Females	104	14.86	19.4
85+	377	53.86	28.35
Males	138	19.71	31.58
Females	239	34.14	26.76

Including all age groups there was a similar EWDI in men (19.2%) and women (20.9%). However, there are some differences in the effects of age between men and women (see Figure 24). In the under 75s and over 85 year olds, EWD are greater amongst men, whilst in those aged 75-84 years EWD are greater amongst women. These differences may have occurred by chance or may reflect differing vulnerability to the effects of cold by age group and gender.

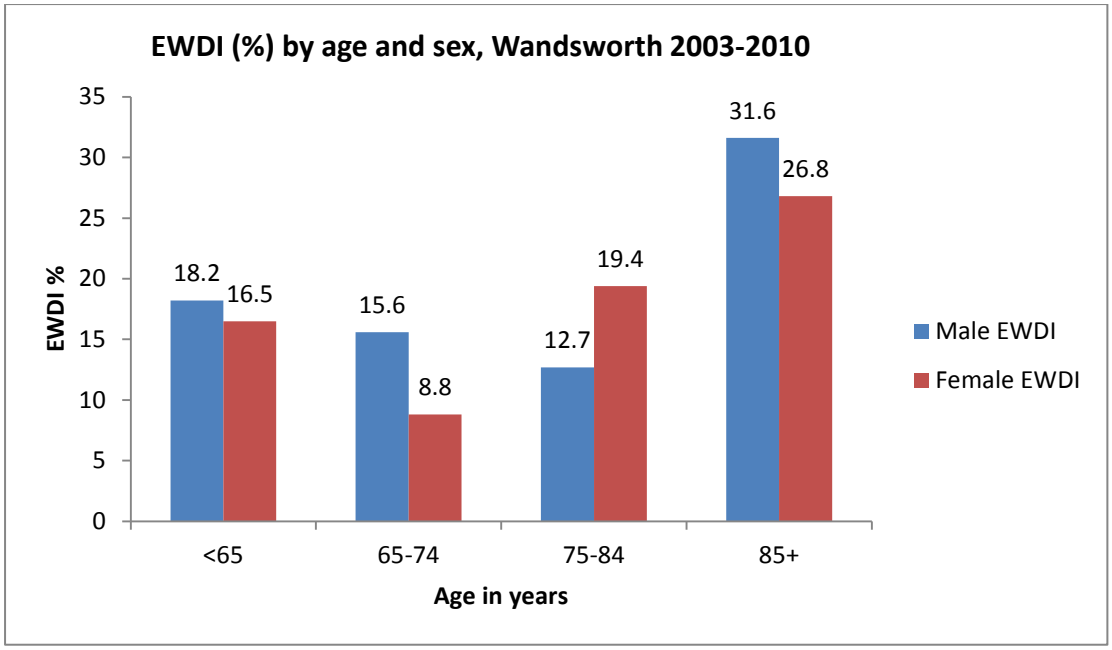

Figure 24 EWDI (%) by age and sex, Wandsworth 2003-10 (Source: Primary Care Mortality Database)

7.1.3 EWD by cause of death

Circulatory (38%) and respiratory (30%) disease categories contributed the greatest proportions of underlying causes of EWD (Table 7). The largest single cause of death category contributing towards EWD was influenza and pneumonia (17%), followed by coronary heart disease (16%) and chronic lower respiratory disease (10%). The greatest seasonal variation was seen in influenza and pneumonia (EWDI 56.7%) and chronic lower respiratory disease (EWDI 39.1%) (See Table 8). This corresponds with peaks in hospital admissions due to flu and pneumonia in the winter months (see Section 6).

Table 7 EWD, EWDI (%) and % total EWD by underlying cause of death category, Wandsworth 2003-10 (Source: Primary Care Mortality Database)

Underlying cause of death Category	Total EWD 2003-10	Average EWD/ year	EWDI (%)	% total EWD
All Circulatory Diseases	293	41.86	22.85	38%
All Respiratory Diseases	227.5	32.50	45.27	30%
Cancers	41	5.86	3.92	5%
External causes	49	7.00	34.51	6%
Infectious diseases	26	3.71	41.27	3%
Mental, behavioural and neurological	75	10.71	25.51	10%
Other	52.5	7.50	11.06	7%
Total	**764**	**109.14**	**20.09**	100%

Table 8 EWD, EWDI (%) and % total EWD by underlying cause of death sub-category, Wandsworth 2003-10 (Source: Primary Care Mortality Database)

Cause of Death Sub-category	Total EWD 2003-10	Average EWD/ year	EWDI (%)	% total EWD
Chronic lower respiratory disease	76.5	10.93	39.13	10%
Coronary Heart Disease	119.5	17.07	23.00	16%
Influenza & Pneumonia	131	18.71	56.71	17%
Stroke	71	10.14	35.32	9%
Dementia and Alzheimer's disease	13	1.86	10.00	2%
Injury and Poisoning	44	6.29	25.43	6%

7.1.4 EWD by ward

There was considerable variation in the EWDI by ward, with -2.9% in Thamesfield (meaning there were 2.9% fewer deaths in winter compared the average deaths in summer) and 38.7% in Tooting (see Figure 25 and Table 9).

Table 9 EWD and EWDI (%) by ward, Wandsworth 2003-10 (Source: Primary Care Mortality Database)

Ward	Total EWD 2003- 2010	Average EWD/ year	EDWI (%)
Thamesfield	-4	-0.57	-2.86
Latchmere	10.5	1.5	4.87
Southfields	15	2.14	9.49
Queenstown	16.5	2.36	10.54
Earlsfield	19	2.71	10.86
Balham	13	1.86	11.11
St Mary`s Park	37	5.29	11.64
East Putney	24	3.43	12.31
Furzedown	35	5	17.16
Shaftesbury	25.5	3.64	18.28
Roehampton	58.5	8.36	21.63
Fairfield	30	4.29	24
West Hill	55	7.86	24.66
Nightingale	81.5	11.64	26
West Putney	83	11.86	29.54
Northcote	36	5.14	30.51
Bedford	41.5	5.93	30.63
Wandsworth Common	66.5	9.5	33.33
Graveney	51	7.29	34.69
Tooting	64.5	9.21	38.74
Ward Not Known	5	0.71	100
Wandsworth	764	109.14	20.09

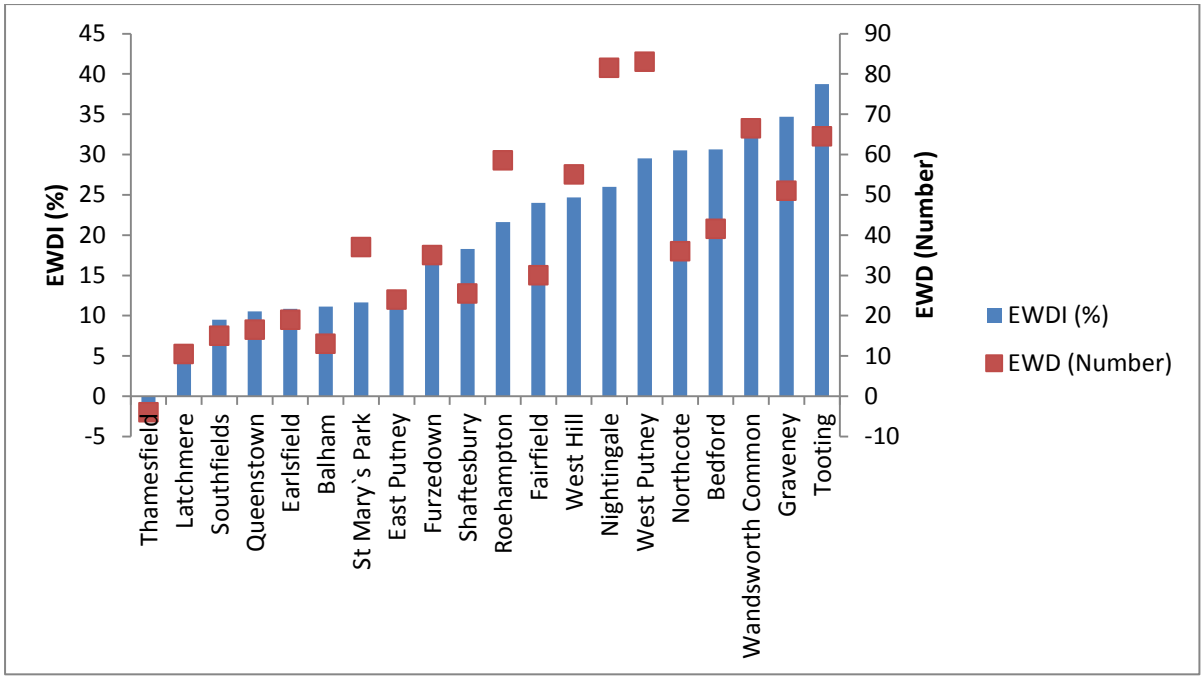

Figure 25 EWD and EWDI (%) by ward, Wandsworth 2003-10 (Source: Primary Care Mortality Database)

As the EWDI is not age-standardised it is possible that the observed differences between wards are due to the differences in age structure. However, there is no correlation between the ward level EWDI and the proportion of residents over the age of 65 years (see Figure 26).

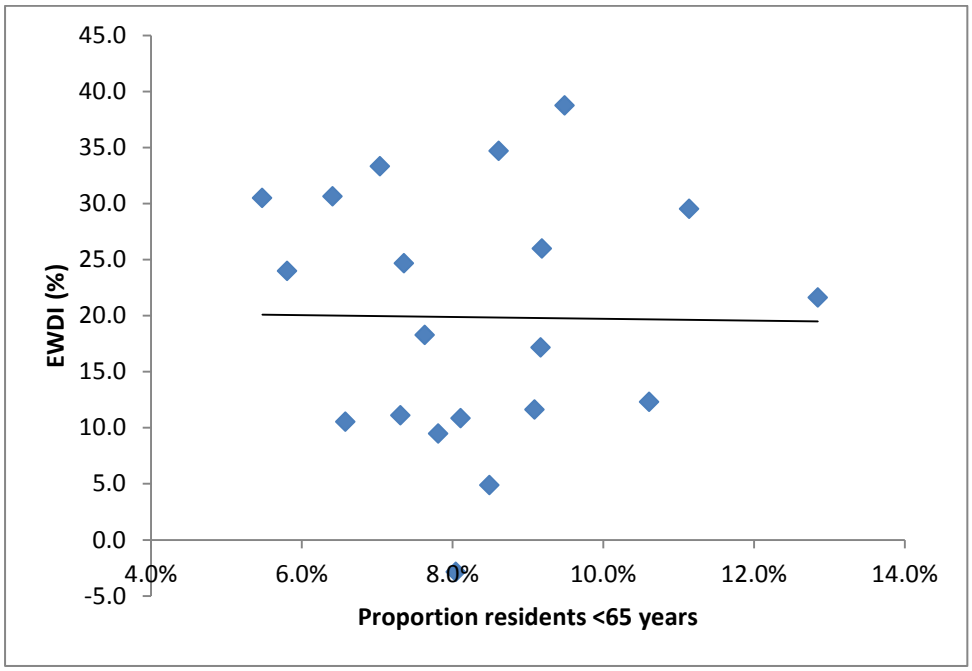

Figure 26 Correlation between EWDI (%) and proportion of residents >65 years at ward level, Wandsworth (Source: Primary Care Mortality Database and GLA round population projections 2010)

7.1.5 EWD by deprivation

There was no evidence of a linear relationship between EWDI and IMD 2010 at a ward level (Figure 27). However this result does not preclude a relationship between deprivation and EWD at an individual level, as there is known variation in deprivation levels within wards.

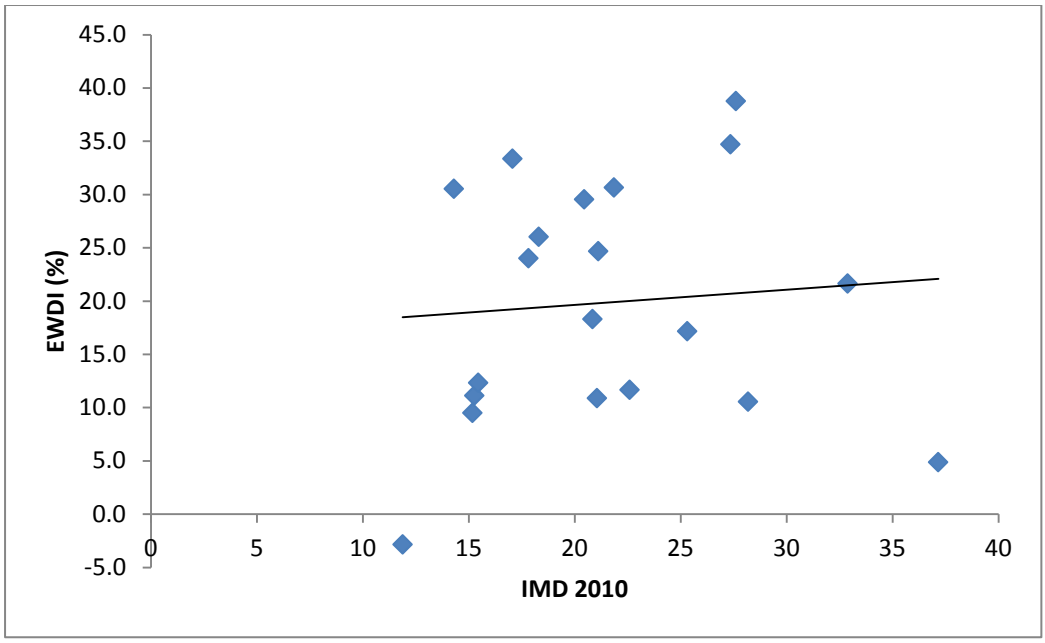

Figure 27 EWDI (%) and IMD 2010 by ward in Wandsworth (Source: Primary Care Mortality Database and IMD 2010 database)

EWD and EWDI for each quintile of IMD 2010 were calculated using both national and Wandsworth IMD quintiles (See Figures 28 and 29 and Table 10). In neither case was there a clear pattern between EWD I and deprivation. However, using the local quintiles there was a greater number of EWD in 3rd to 5th quintiles (more deprived), compared to 1st and 2nd quintiles (less deprived).

Table 10 EWD and EWDI (%) by local and national quintile of IMD 2010 (Source: Primary Care Mortality Database and IMD 2010 database)

Wandsworth IMD 2010 quintile	Total EWD 2003-2010	EWDI (%)	National IMD 2010 quintile	Total EWD 2003-2010	EWDI (%)
1st	94	28.0	1st	105	29.2
2nd	98	24.2	2nd	341	27.0
3rd	168	19.3	3rd	213	21.5
4th	224	30.7	4th	97	28.0
5th	177	24.9	5th	4	24.1

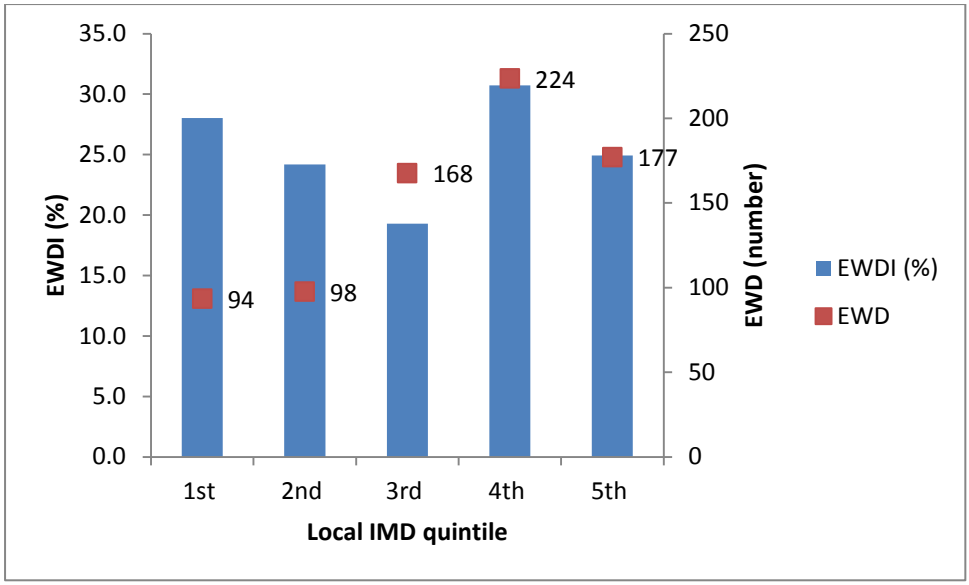

Figure 28 EWDI (%) and EWD by IMD 2010 local quintile, Wandsworth 2003-10 (Source: Primary Care Mortality Database and IMD 2010 database)

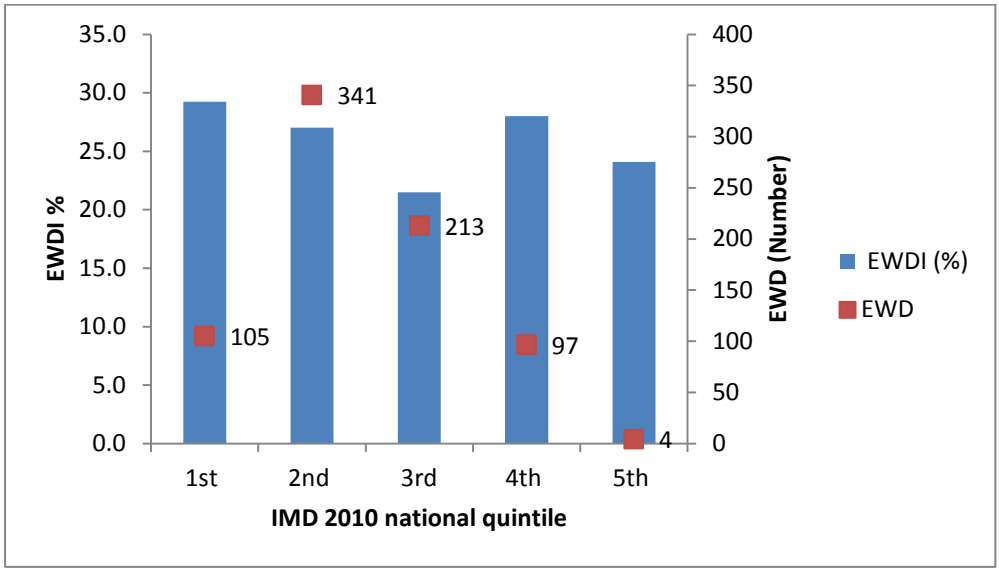

Figure 29 EWDI (%) and EWD by national quintile, Wandsworth 2003-10 (Source: Primary Care Mortality Database and IMD 2010 database)

There was also no clear pattern between EWDI and deprivation when the Income Deprivation affecting Older Adults Index was used (see Figure 30).

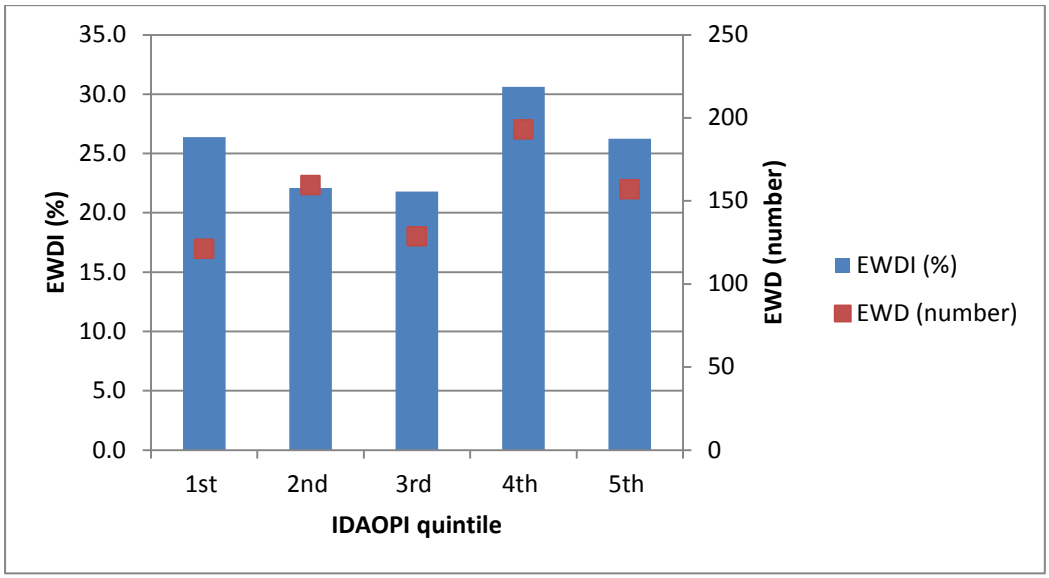

Figure 30 EWD and EWDI (%) by Income Deprivation Affecting Older People Index quintiles, Wandsworth 2003-10 (Source: Primary Care Mortality Database and IDAOPI database 2011)

7.1.6 Relationship between EWD and housing

At a ward level, there is no clear relationship between EWDI and the proportion of private households (i) not reaching the Decent Homes standard [p=0.18] (Figure 31), (ii) having inadequate thermal comfort [p=0.26] (Figure 32) or (iii) having a SAP rating <35 [p=0.13] (Figure 33).

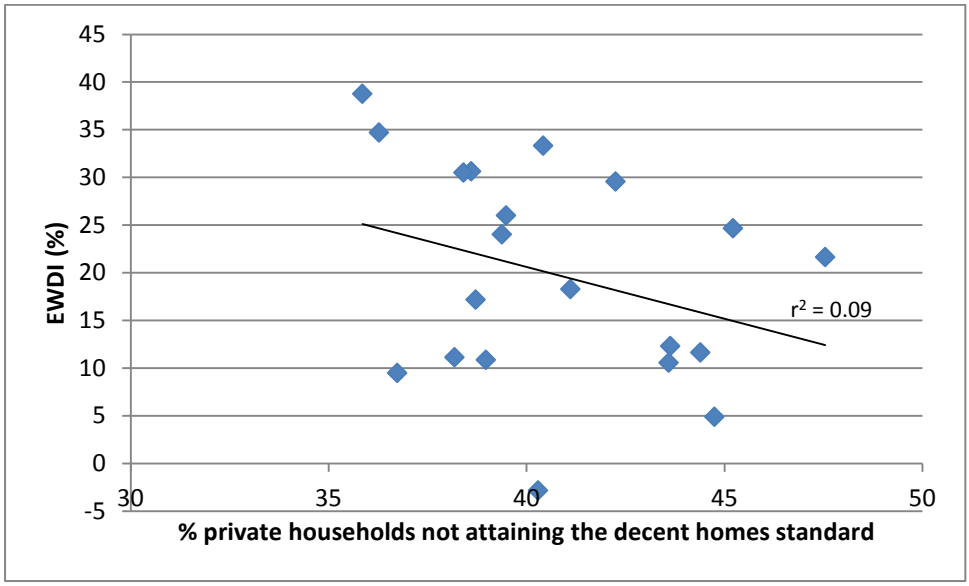

Figure 31 EWDI (%) and proportion of private households achieving Decent Homes Standard, by ward in Wandsworth (Source: Primary Care Mortality Database and BRE Study 2008)

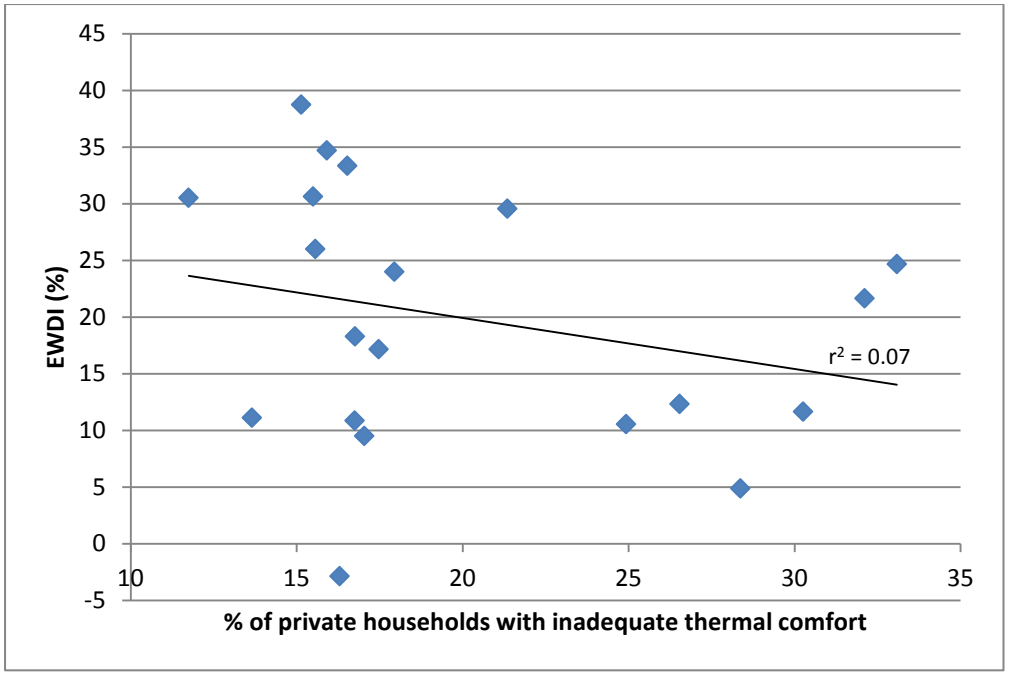

Figure 32 EWDI (%) and proportion households with inadequate thermal comfort by ward in Wandsworth (Source: Primary Care Mortality Database and BRE study 2008)

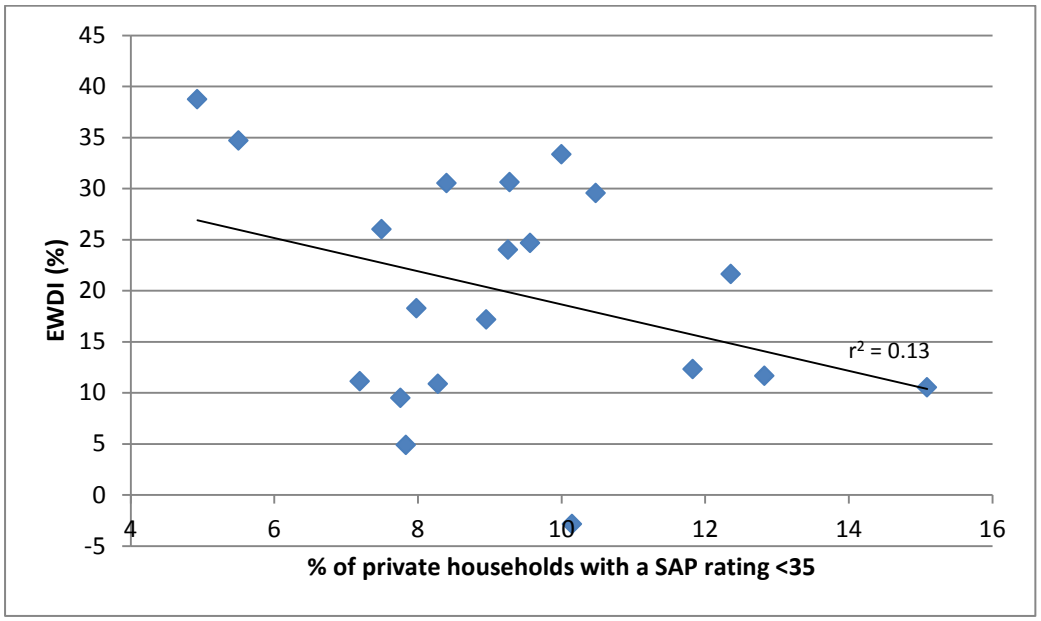

Figure 33 EWDI and % households with SAP rating <35 by ward in Wandsworth (Source: Primary Care Mortality Database and BRE Study 2008)

Although there was no significant relationship [p=0.09] between the proportion of households living in fuel poverty and the EWDI at the ward level, there was a borderline correlation (Figure 34). We were not able to analyse these data at the individual level; this may have shown a significant relationship.

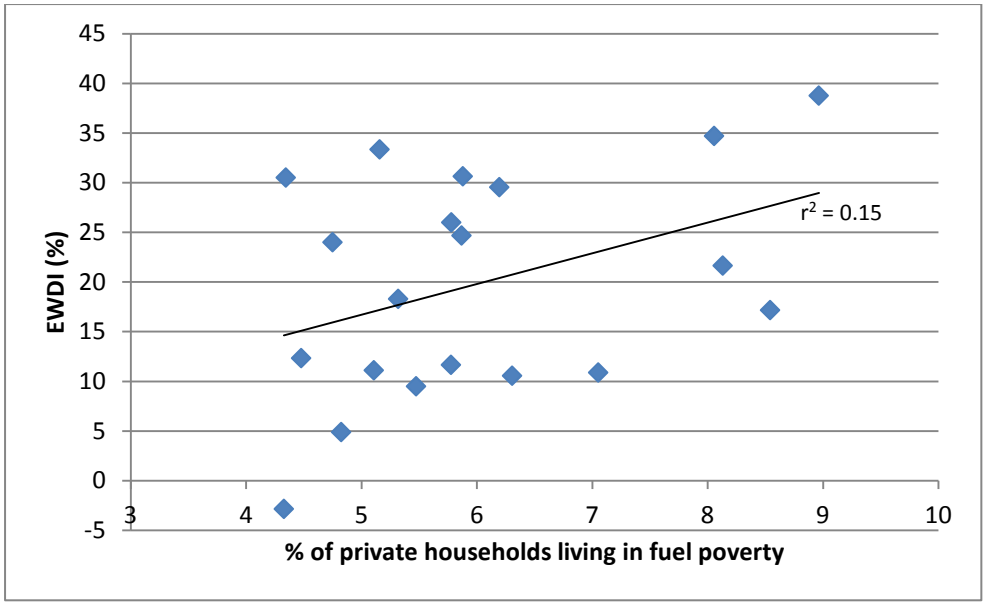

Figure 34 Correlation between EWDI and % private households in fuel poverty by ward, Wandsworth (Source: Primary Care Mortality Database and BRE Study 2008)

7.2 Comparisons between EWD in Wandsworth to London and England

7.2.1 Age

There are some differences in the impact of age on EWD in Wandsworth compared to London and England (Figure 35). Between 2002-2009 EWDI was substantially higher for those less than 65 years in Wandsworth (15.6%) compared to London (6.9%) and England (7.1%). This means there is greater seasonal variation in mortality in those under 65 years in Wandsworth compared to in the rest of London and England. In the age groups over 65 years the EWDI in Wandsworth is roughly similar to those in London and England.

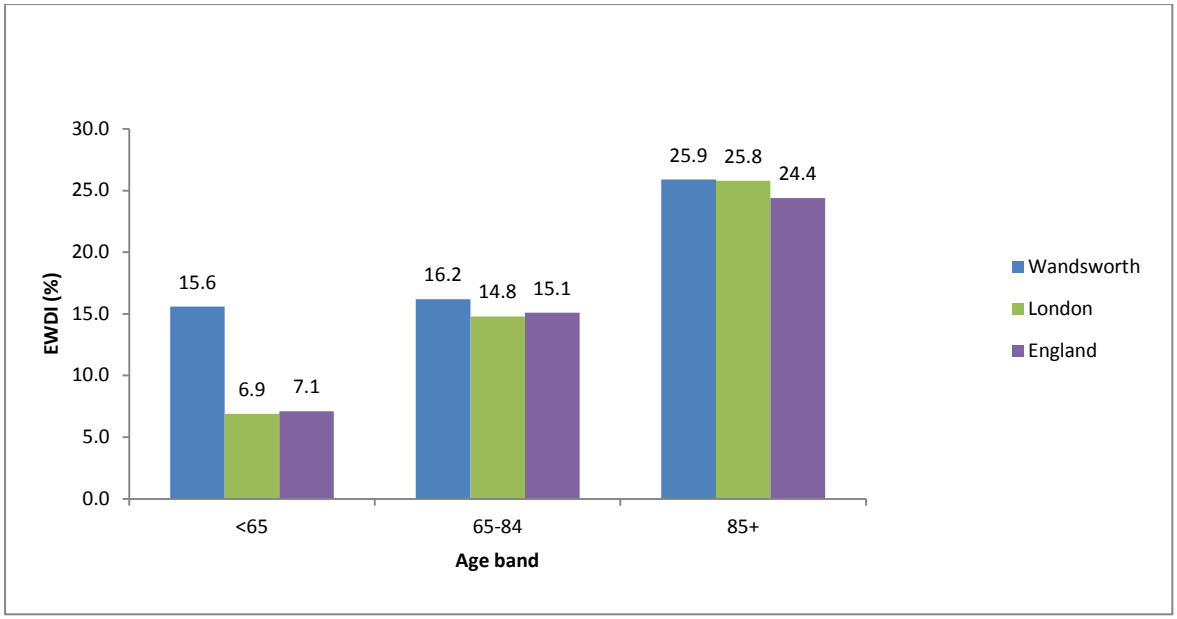

Figure 35 EWDI (%) by age band in Wandsworth, London and England 2002-2009 (Source: WMPHO 2011)

7.2.2 Cause of death

There are some differences in EWDI by cause of death in Wandsworth compared to London and England (see Table 11). Figure 36 shows that in Wandsworth, like London and England, there is greatest seasonal variation in mortality from flu and pneumonia, followed by chronic respiratory disease. Seasonal variation (EWDI) is lower for chronic respiratory disease in Wandsworth compared to London and England, but slightly higher for CHD and stroke. There is no obvious explanation why Wandsworth differs from the rest of London and England.

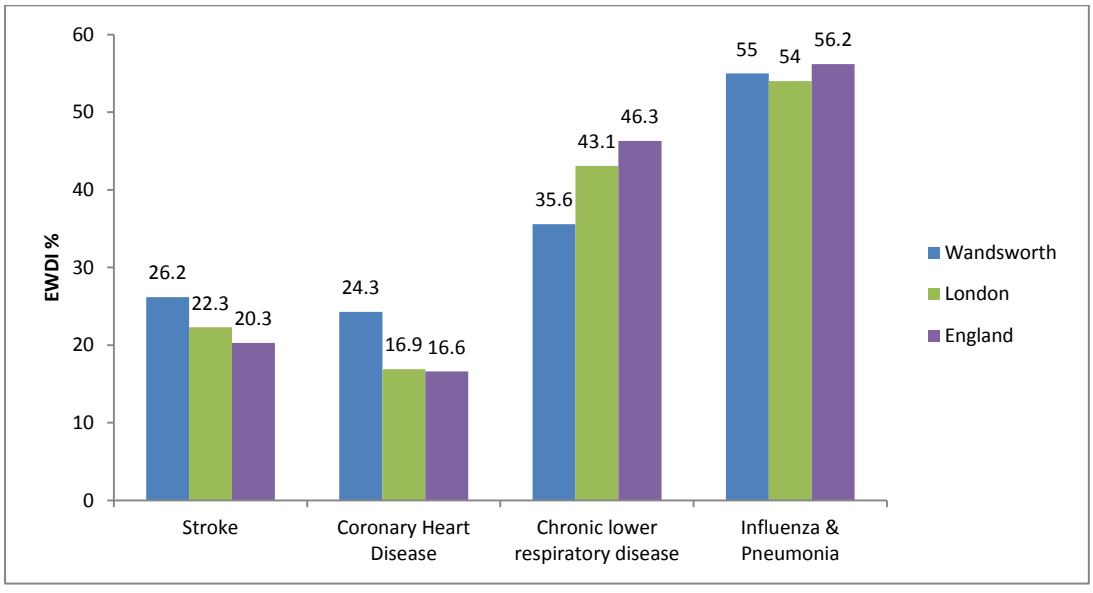

Figure 36 EWDI (%) by cause of death in Wandsworth, London and England 2002-09 (Source: WMPHO 2011)

7.3 Trends in EWD

The EWDI has fluctuated between 1990 and 2010 in Wandsworth, London and England (see Figure 37). EWDI was generally higher in all areas between approximately 1993 and 2000, and then saw a dip in all areas between approximately 2000 and 2004. From 2004 the trends in Wandsworth diverged from those in London and England overall. In 2004-2007 Wandsworth had a substantially higher EWDI (23.7%) compared to London (16.2%) and England (16.8%). Since then there appears to have been a convergence of trends; in 2006-2009 the EWDI in Wandsworth was 20.4% compared to 18.2% in London and 18.1% in England.

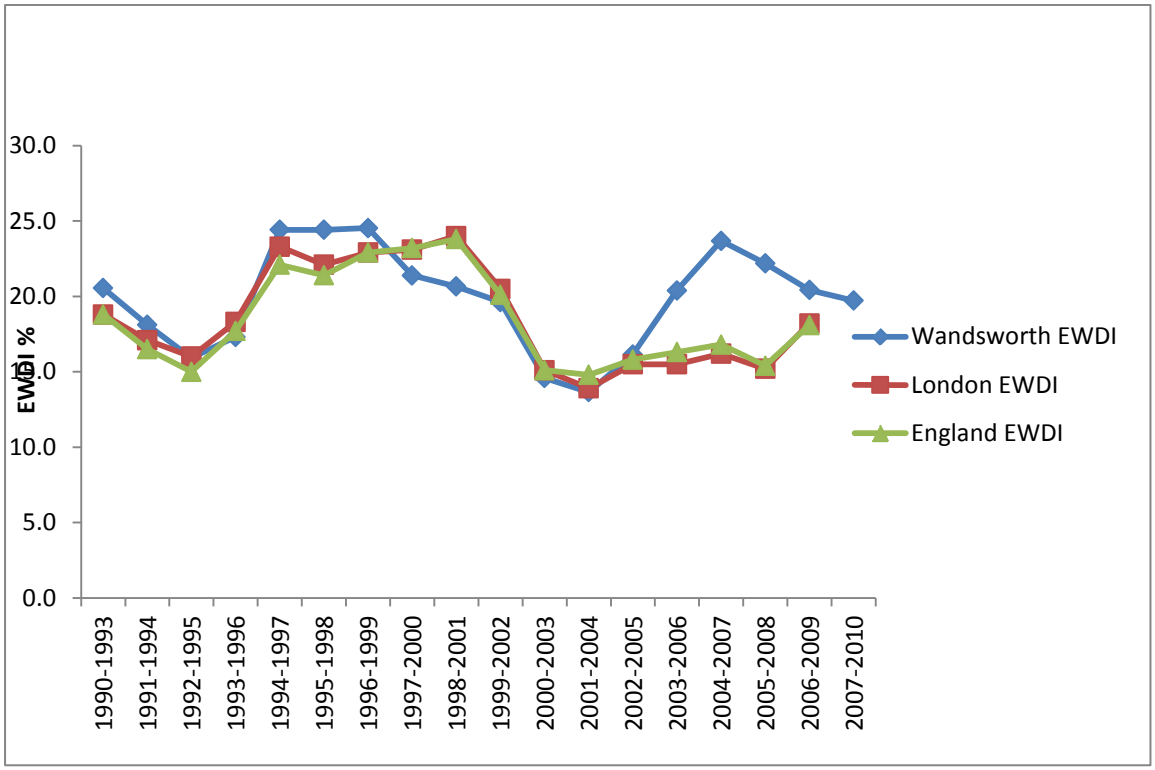

Figure 37 Time trends in EWDI (%) in Wandsworth, London and England 1990-2010 (Source: WMPHO 2011)

Using yearly figures for Wandsworth (Table 11) it is possible to see that the peak years for EWD were the winters of 2004/2005 (25.5%) and 2005/2006 (25.8%).

Table 11 EWDI (%) by year in Wandsworth 2003-10 (Source: Primary Care Mortality Database 2011)

Year	EWDI
2003/4	10.93
2004/5	25.46
2005/6	25.82
2006/7	20
2007/8	21.26
2008/9	20.75
2009/10	17.13
Total	**20.09**

7.3.1 Explanations for fluctuations in EWD in Wandsworth

Overall mortality data by cause of death shows that there was a peak in coronary heart disease deaths in Wandsworth during the winter of 2004/2005 (see Figure 38). This corresponds to the high EWDI this winter in Wandsworth.

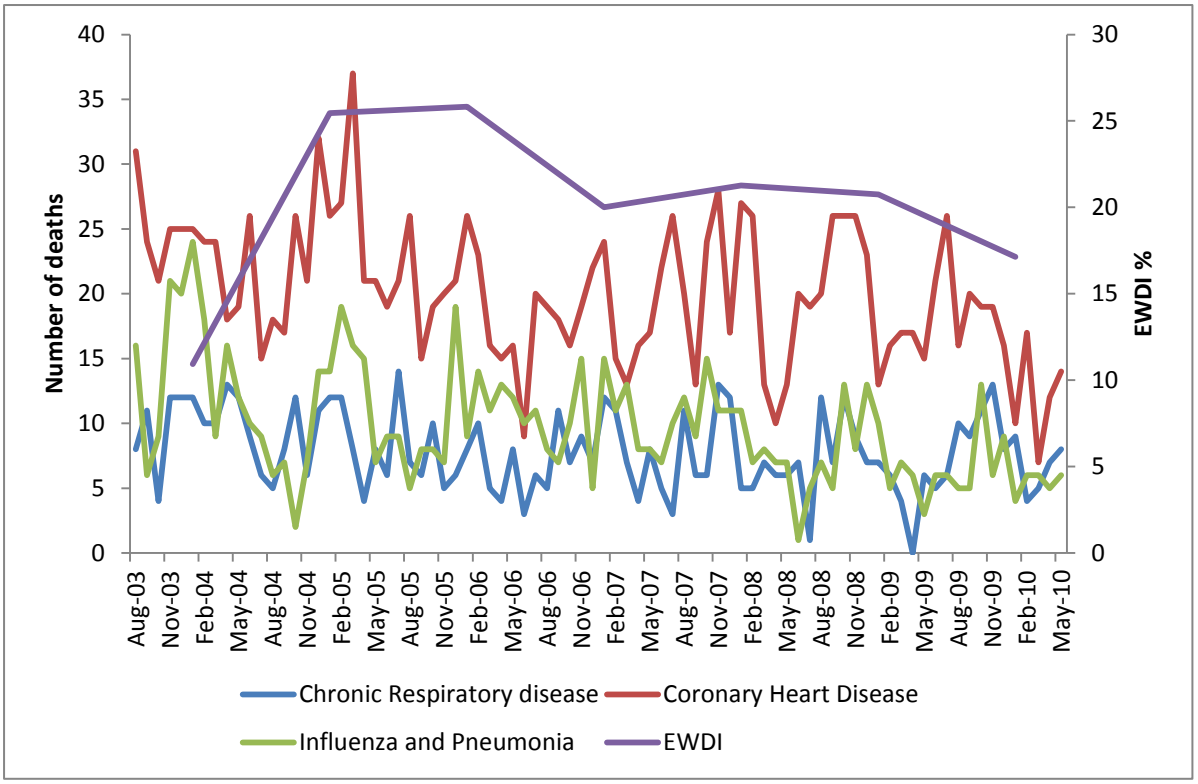

Figure 38 Time trends in mortality and EWDI, Wandsworth 2003-10 (Source: Primary Care Mortality Database)

Immunisation uptake data is only available from 2006, making it difficult to examine how trends in Influenza vaccine uptake may be related to trends in EWD. There is no obvious relationship between vaccine uptake and EWDI with the available data (Figure 39).

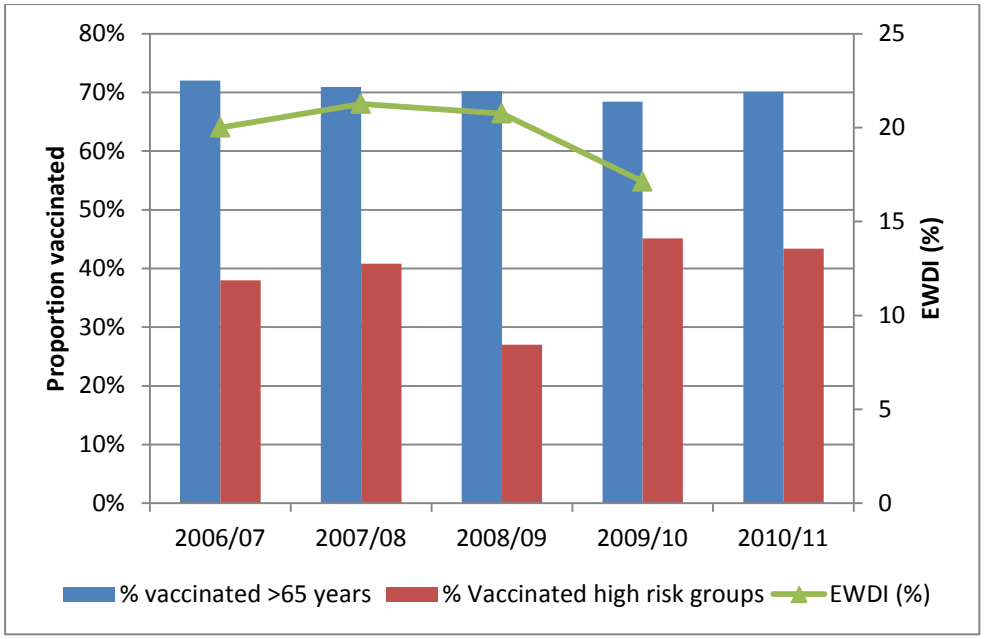

Figure 39 EWDI (%) and proportion >65 years and high risk groups receiving seasonal flu vaccine, Wandsworth 2006-11 (Source: ImmForm and primary care mortality database)

7.4 Factors contributing to excess winter deaths: views of older adults (see Appendix for full findings)

Views of older adults were sought from the Wandsworth Older People's Forum, Older People's Network Conference, JSNA Consultation and opinions of older people from the 'Reminiscence Sessions.

Some older adults reported difficulty in improving energy efficiency in their homes. The rising price of winter fuel and the proposed cuts to winter fuel allowance was raised. Energy efficiency schemes were reported as generally not well advertised and a difficulty in gauging which schemes were credible was mentioned. Older people were more likely to trust energy efficiency schemes if signposted by health or social care staff. Clarification was required on the eligibility criteria for grants and benefits allowance.

Whilst there was good awareness of the need to receive the seasonal flu vaccine, there were fears about developing flu-like symptoms after vaccination. Difficulty in accessing GP practices was also a running theme particularly for those with mobility problems or those living alone. Added to that, the risk of falls in the winter was seen as barrier to accessing GP practices. Older people were unclear as to who was eligible for a home visit and how to access this service. For those who do not attend for flu vaccination, it was felt that there was a lack of follow up by GP practices. Age UK was seen as a useful place to gain valuable advice and its Handyman service was seen as a worthwhile service.

7.5 Factors contributing to excess winter deaths: views of staff (see Appendix for full findings)

It was recognised by staff that those with co-morbidities were likely to at risk of EWD. Patterns of EWD by underlying cause of death may be difficult to determine. Whilst pneumonia may be recorded as the primary cause of death, chronic respiratory disease or falls may have been an important contributory factor.

The potential link between falls and EWD was raised. For example, if falls occur in cold weather older adults could be left on the floor for several hours in the cold and therefore be at risk of hypothermia, dehydration, skin and urinary infections and pressure sores. Whilst falls may be the primary cause of hospitalisation patients may subsequently die from a respiratory infection.

Hospitals were deemed to be under greater pressure in winter than other seasons meaning the quality of care may be reduced. This could account for some of the seasonal variation in mortality. Targeting flu vaccination at those with previous falls was suggested. Those at risk could be identified using Predictive Assessment of Risk data.

There was awareness that difficulties in accessing care are worsened in winter due to bad weather and lack of transport especially in the isolated elderly with mobility problems. Older adults from black and minority ethnic groups face even greater barriers to accessing services due to language difficulties or a lack of awareness about service provision.

The lack of a shared record of vulnerable adults between secondary care, primary care and social care was also mentioned. It was highlighted that clear pathways are needed for frontline health, social care, community workers and day centre managers if an individual is identified to be at risk from cold.

8 What is currently being done to address EWD in Wandsworth?

8.1 South West London Cold Weather Plan

The South West London Cold Weather Action Plan is a local public health plan, based on the Cold Weather Plan for England, which describes actions which should be undertaken before and during cold weather by individuals and organisations in order to reduce health risks. The Met Office operate a "Cold Weather Health Watch" service based on weather forecasts with one of four levels of alert. The Cold Weather action plan is triggered by these levels of alert with specific actions to be taken at the SWL Cluster and borough levels. Table 12 gives a summary of actions which are recommended at each alert level.

Table 12 Summary of South West London Cold Weather Action Plan 2011

ALERTS	CRITERIA	SUMMARY OF ACTIONS
Level 1: Winter preparedness program	1 November–31 March Healthcare and social services need to ensure that they are prepared for cold weather.	Public media messages Identify high risk individuals in consultation with partners Increase awareness in staff and people Encourage front line staff and vulnerable people to get flu jab Consider people are getting entitlements
Level 2: Severe winter weather is forecast – Alert and readiness	Met Office forecast 60% risk of severe cold weather lasting at least 48 hours - forecast to arrive within the next two or three days. Severe cold weather: a mean temperature of 2 deg C and/or widespread ice/snow	Check high risk people have visitor or phone call arrangements in place. Check room temperatures when visiting Ensure business continuity plans ready and sufficient staffing. Public media messages
Level 3: Response to severe winter weather	Severe weather conditions for Level 2 is now occurring, and is expected to impact on people's health and on health services	Activate surge capacity plans Where appropriate, daily visit or phone call to high risk people. Consider business continuity plans.
Level 4: Major incident – Emergency response	Exceptionally severe weather or threshold temperatures breached for more than six days affecting several parts of the country and is so severe that it creates widespread transport disruption and/or threatens the operation of health and social care services.	EMERGENCY Continue level 3 actions Risk appraisals Coordination at multi-agency Borough Resilience Forum, led by the PCT DPH.

8.2 Department of Health guidance on reducing excess winter deaths

In 2010 the Health Inequalities National Support Team (HINST) published the document '*How to reduce the risk of seasonal excess deaths systematically in vulnerable older people to impact at population level* (Health Inequalities National Support Team, Department of Health, 2010)'. This guidance was used as framework to understand current work in Wandsworth to reduce the risk of EWD and also the role of the needs assessment (see Table 13).

Table 13 HINST guidance and current progress on reducing excess winter deaths

Stage	Step	Current progress
1. Preparation	Gain insight into the local picture of EWD	Needs assessment
	Develop a shared understanding of the EWD agenda and role of partners	Needs assessment
	Develop joint working	Initiated by needs assessment
	Develop a data sharing agreement between health and social care and other relevant organisations	Not currently in place
	Co-ordinate a systematic approach across organisations	Not initiated
2. Identify vulnerable people	Establish a list of caring staff in the community who manage caseloads of the vulnerable elderly	As part of the needs assessment, the following organisations and teams were identified as working with vulnerable elderly in the community • Community matrons • District nurses • Community ward • Intermediate care team • Older adults community mental health team • COPD and heart failure specialist nurses • General practice • Social services • Sheltered housing wardens • Tenancy support team Inpatient geriatric teams and the Older people's therapy team were identified also identified as important contact points with vulnerable elderly
	Each key worker develop a list of clients/patients of vulnerable elderly at high risk from excess cold	Community matrons and district nurses maintain lists, no co-ordination between organisations

	Develop criteria for prioritisation, for example over 75 years, living alone, chronic and severe illness, energy efficient home	Community matrons and district nurses have prioritisation criteria, no co-ordination between organisations
	Manage the list. Augment the list with the help of community pharmacists and the voluntary community and faith sector.	As part of the needs assessment, the following organisations were identified as coming into contact with vulnerable elderly • Safer Neighbourhoods Team • Neighbourhood Watch • Age UK • Furzedown Project • HESTIA • Regenerate Rise • Community development workers
3. Systematically offer key interventions to reduce the risk of EWD	Assessment for affordable warmth interventions, including energy efficiency, household income and fuel cost	**The extent to which these interventions are currently offered by organisations and staff identified in Stage 2 (above) is described in Sections 8.3 and 10** **See Table 16 for a summary**.
	Review of benefits entitlement and uptake	
	Annual flu and pneumococcal vaccination	
	Annual medication review (every six months if 4+ medications)	
	Annual medicines utilisations review and support for adherence	
	Personal brief health interventions plan including smoking cessation advice, health eating	
	Assessment and support programme to prevent falls	
	Assessment for appropriate assistive technologies e.g. pendant alarms	
	Develop a personal crisis contingency plan (e.g. a buddy scheme where no friends or family)	

8.3 Relevant programmes and services available in Wandsworth

This section summarises the statutory programmes and services available in Wandsworth which are relevant to the key interventions to reduce excess winter deaths.

8.3.1 Seasonal influenza vaccination programme

All eligible patients receive a letter from the PCT inviting them to attend their GP for the seasonal flu vaccine. GP practices receive a financial incentive for achieving the 75% uptake target, via the Locally Enhanced Service agreement. However there is no additional incentive to achieve coverage above the 75% threshold, and it is likely that the most vulnerable isolated people are those missing out. A monthly Flu Update is distributed to all Wandsworth GP practices showing vaccine uptake by practice. Practices are encouraged to share methods for increasing uptake, facilitated by public health at local commissioning group meetings. In a new scheme, sixteen pharmacies have been trained to administer Flu vaccinations to eligible patients picking up prescriptions. Work has commenced to encourage flu vaccination in St George's Hospital.

There is no systematic scheme locally to ensure vulnerable older adults receive immunizations. Some GP practices offer weekend and evening clinics, but this is variable. There are no local schemes for collecting and supporting older adults to attend immunization clinics. There is currently no systematic home visiting service for patients with mobility problems, though home immunizations may be completed by district nurses and GPs for housebound patients on an ad hoc basis.

Leaflets and posters promoting flu vaccination are distributed at GP Practices, healthcare centres, libraries, pharmacies, dentists, council offices and targeted services. There is a bus advertising campaign. Articles and adverts have been published in the council magazine (Brightside) and the Carer's magazine. Community promotion events, such as the Asian Women's Meeting, have been held.

8.3.2 Falls services

A falls Locally Enhanced Service (LES) is currently in place to facilitate systematic identification of patients at risk of falls. Routine falls risk assessments are completed on inpatients and outpatients at St George's Hospital , Queen Mary's Hospital and St John's Therapy Centre, with care plans completed for those deemed to be at medium to high risk. For those who have fallen or at high risk of falls, interventions include: physiotherapy-led exercise classes, multidisciplinary assessment and one-to-one intervention. The Intermediate Care Service and Community Virtual Ward also routinely complete falls risk assessments (see 10.1.4 and 10.1.6).

Satellite falls and bone health clinics are run in non-clinical settings such as sheltered housing complexes and older people's centres, with the aim of case identification, assessing risk and making recommendations for referral to appropriate health and social services, voluntary and recreation services.

Wandsworth Borough Council provides the following services related to falls prevention:

- **START (Short Term Assessment and Reablement Team)** is a short-term homecare service for those who need help with personal care and domestic routines.
- **Telecare / Community Alarm (WATCH)** (see 9.3.7 and 9.3.8)

- **Wandsworth Home Improvement Service** helps older homeowners who need to repair, maintain, improve or adapt their home and any household with a disabled person who wants to remain living independently at home
- **Fit For Life is** a general exercise programme targeting older people.

A partnership between Wandsworth Housing Department, Vida Wellness and NHS Wandsworth PH has trained the majority of the Sheltered Housing Officers (SHOs) as instructors in the OTAGO exercise programme.

8.3.3 Energy efficiency improvements: sources of advice and referral

The Energy Saving Trust advice centre (ESTAC) is funded by government to provide free, impartial advice to all Londoners about saving energy. They help clients identify eligibility for energy efficiency schemes and grants, find out more about renewable energy and how to save money on fuel bills. ESTAC should be the first port of call for individuals, and health, social care and voluntary sector workers to determine the most appropriate affordable warmth measures.

The Home Heat helpline is a national helpline run by the Energy Retail Association. It provides advice for people having difficulty paying their fuel bills and advice on cheaper payment schemes from energy suppliers. It can also determine eligibility for assistance for energy efficiency improvements.

8.3.4 Energy efficiency improvements: services available

The Private Housing Team at Wandsworth Council undertakes and signposts to various energy efficiency improvements depending on tenure and eligibility (see Table 14). The team has annual targets on the number of houses in which energy efficiency improvements have been made. Warm Front and Coldbusters grants are available for residents who meet eligibility criteria based on receipt certain benefits. Improvements include loft and cavity wall insulation (not available to council tenants) and central heating installation. The RE:NEW scheme is available to any resident in Furzedown and Graveney wards and offers simple energy efficiency measures, referrals to Coldbusters or Warm Front, or direct installation of insulation and other measures. Falls risk assessments and benefits entitlement checks are also undertaken where appropriate. The scheme is promoted via mailings to all properties in the wards with energy advisors following up by door-knocking.

With the exception of approximately 100 dwellings, all Council properties have central heating fitted. The outstanding properties are mainly in Totterdown Fields and Roehampton, and are reported to be mainly occupied by older adults who have refused central heating fitting due to the disruption this would cause. All Council properties, where this is possible, are fitted with cavity wall insulation. There is a current programme to upgrade loft insulation in all properties where this is appropriate, and this has achieved nearly complete coverage.

There are challenges to improving energy efficiency of Council housing. Leaseholders are liable for costs of council housing renovations, for example double glazing. It is reported leaseholders are often not willing or able to pay costs. Age UK staff highlighted this as a particular challenge for older adults.

A mapping tool that uses key at risk indicators to identify those areas where severe fuel poverty is most likely to be found such as particular wall construction types, poor health and unemployment is

being tested by the Greater London Authority working with Energy Companies, Central Government and Local Authorities and should be completed by May 2012. This mapping can then be used to inform Local Authorities and other partners to more effectively direct their fuel poverty reduction programme (London Assembly, 2012).

Table 14 Assistance for energy efficiency improvements in Wandsworth

Scheme	Who is it funded and delivered by?	What does it do?	Who is eligible?	What are throughputs in Wandsworth?
Warm Front	Funded by Government	Provides improvements worth up to £3,500 including loft insulation, draught proofing, cavity wall insulation, hot water tank insulation and central heating installation	People on (i) Pension Credit **OR** (ii) Income-related Employment and Support Allowance **OR** (iii) Income support/ income-based Jobseeker's Allowance in some circumstances Council tenants only eligible for heating improvements, not insulation.	218 properties improved 2010/2011
Cold Busters	Sub-regional project money via Council's Private Housing Team	New and replacement central heating, insulation measures, double glazing and electrical works	Income Support, Council Tax Benefit, Pension Credit, Housing benefit, Income based job seekers allowance, working or child tax credit (if income less than £15600), Attendance Allowance, Disablility Living Allowance Council tenants only eligible for heating improvements, not insulation.	1100 properties received grant to date, 138 in 2010/2011
RE:NEW	Funded by London Development Agency	1. Easy measures e.g. draught proofing. 2. Referral to Warm Front/ Cold busters where eligible. 3. Loft and cavity wall insulation, boilers, solid wall insulation. 4. Benefits check	Any resident in Graveney and Furzedown wards.	Target of 1500 home visits by March 2012

Home visitor scheme	Housing Department, Wandsworth Council	1.General energy advice 2. Referral to Cold busters or Warm front where eligible 3. A benefits check	Any resident in Earlsfield, Graveney, Tooting and Furzedown wards	Now being scaled down as RE:NEW scheme being rolled out
Enforced council improvements	Housing Department, Wandsworth Council	Enforcement to make landlords improve insulation	Residents in private rented properties across Wandsworth where the landlord has not undertaken adequate measures to protect against excess cold as defined in the Housing health and safety reference system, which is a risk assessment procedure which forms the statutory element of the Decent Homes Standard. It measures the risk of hazards within a home including excessive cold temperature, along with indoor pollution and hygiene.	186 dwellings improved 2010/2011
London Warm Zones	Not-for-profit organisation	Residents would be offered a free home energy check and either discounted or free insulation	Residents in four wards around Putney and Southfields	Work to commence ?2011

8.3.5 Addressing ability to pay for fuel

The **warm home discount scheme** is a government scheme running from April 2011 to March 2015 to help low income and vulnerable households with energy costs. The scheme requires participating energy companies to give a discount on electricity bills to a specified group of older customers known as the Core Group. A rebate of £120 off electricity bills will be provided where older people pay their own bills and are in receipt of Pension Credit Guarantee. Low income families and those with long term illnesses and disabilities may also be eligible for a rebate. This scheme replaces the social tariffs which energy suppliers were previously obliged to offer vulnerable customers.

Winter Fuel Payments are generally £200 per household for occupants aged 60 or over but an additional £100 is paid to households that include someone aged 80 or over. Those receiving a state pension, income support and another of other benefits automatically receive the winter fuel

payment and do not have to make an application. Certain other groups, including those on housing benefit *and* over 60 years, are eligible but have to make an application. It has been estimated that only 19% of the recipients of winter fuel payments are fuel poor, and that only 50% of fuel poor individuals are eligible (Marmot Review Team, 2011).

A Cold Weather Payment of £25 is paid for each seven day period of very cold weather between 1 November and 31 March. Cold weather payments are made automatically and it is not necessary to apply. Those on pension credit, Income Support, income-based Jobseeker's Allowance and income-related Employment and Support Allowance (ESA) are eligible.

8.3.6 Benefits advice

8.3.6.1 Disability and Social Care Advice Service (DASCAS)

DASCAS provides independent advice to residents Wandsworth about benefits and services available to people with disabilities and the relatives and friends who care for them. DASCAS provides the following services:

- An independent telephone information service on any aspect of disability and social care
- Assistance with completing forms
- Advice and support for professionals working with disabled and frail people.
- Help with benefit claims
- Advocacy and support services up to tribunal level in disputed case
- Home visits with priority to those who are housebound.

8.3.6.2 Joint Home Visiting Team

The Wandsworth Joint Visiting Team involves the Council and the Pension Service working together to visit older people at home. The main purpose of the team is to provide a comprehensive visiting service to residents over 60 years old and vulnerable working age customers under 60 to help ensure they receive the benefits and services to which they are entitled.

8.3.6.3 Age UK

Age UK has a benefits advice service (10.3.1).

8.3.7 Assistive technologies

8.3.7.1 WATCH lifeline (pendant alarm) scheme

WATCH lifeline is a 24 hour emergency home response alarm service for older people and younger disabled residents provided by Wandsworth Council irrespective of housing tenure. There are currently 1100 users of this service in Wandsworth. The cost of the service depends on the level of benefits being received. There is no support planning assessment for users of the WATCH scheme. Clients are signposted to benefits advice and falls clinics where appropriate.

8.3.7.2 Telecare

Telecare is an assistive technology system consisting of various sensors around the home (including smoke, heat, cold and gas) which, when triggered, send an alert to the WATCH Lifeline Emergency

Control Centre. An Emergency Warden will call the client, visit the person's home, contact designated individuals or call the emergency services.

9 Evidence for interventions to reduce excess winter deaths

There have been no studies or evaluations which have directly measured the impact of interventions on excess winter deaths.

9.1 Energy efficiency improvements

There have been 19 studies which have considered the health impacts of improvements in home warmth and energy efficiency, two of which are RCTs. A cluster RCT of 1350 households in New Zealand found that insulating houses resulted in statistically significant improvements in self-reported health, wheezing in the last three months, and reductions in self-reported days off work and school and GP visits. Hospital admissions for respiratory illness were reduced but this was not statistically significant (Howden-Chapman, 2007).

Another New Zealand intervention study followed up recipients of a Healthy Housing programme (involving house modifications to reduce overcrowding, insulation and ventilation improvements, and health and social service assessments). They found a reduced rate of acute hospitalisation compared to the period before the improvements. All participants were under age 35 years (G Jackson, 2011).

A Health Impact Evaluation of the Warm Front Scheme was completed. The evaluation compared physical and mental health outcomes before and after receiving the Warm Front intervention. However this evaluation provides a low level of evidence as there was no comparison group. They were able to show that the average temperatures were increased by 1.6˚C in living rooms and 2.8˚C in bedrooms. The temperature in the majority of households was raised to above the 18˚C, which is proposed as the threshold over which a threat to health is avoided. The evaluation reports a 40% reduction in psychological distress following the Warm Front intervention, though precision of these estimates is not provided. A change in self-reported physical health was not detected (G Green, 2008). A qualitative study of recipients of Warm Front improvements found perceptions of improved physical health and mental health were common. The easing of symptoms of chronic illness was also reported (Gilbertson, 2006).

9.2 Falls prevention

The impact of falls prevention programmes on reducing excess winter deaths has not been formally assessed. However, a Cochrane Review of population based interventions for the prevention of fall-related injuries in older people has been completed. Six studies were included, none of which were randomised controlled trials (RCT). The relative reduction in fall-related injuries ranged from 6 to 33%. Mortality was not considered as an outcome. The review concluded that the population-based approach to the prevention of fall-related injury is effective and can form the basis of public health practice (Cochrane Collaboration, 2008).

9.3 Assistive technologies

The impact of assistive technologies on reducing excess winter deaths has not been formally assessed. A Cochrane Review of ‘smart home technologies’, including pendant alarms and Telecare,

found no studies had been completed which considered their impact on health, quality of life or economic outcomes.

9.4 Influenza and pneumococcal vaccination

The impact of influenza and pneumococcal vaccination on reducing excess winter deaths has not been formally assessed. A systematic review of 31 studies found that influenza vaccination is moderately effective in preventing influenza, but that there is a paucity of studies in over 65 year olds (M T Osterholm, 2011). Similarly, a Cochrane Review of vaccines for preventing influenza in the elderly found only one RCT, which did show evidence of effectiveness (Jefferson, 2010). A Cochrane Review of interventions to improve uptake of the flu vaccine in older adults found, from 11 RCTs, that personalised postcards or phone calls are effective. In addition home visits may be effective at improving uptake (Thomas, 2011).

9.5 Income maximisation

There has been little research which has directly evaluated the impact on health of increasing income through accessing means tested benefits, and none related specifically to excess winter deaths. However one randomised controlled trial examined the impact of delivering welfare advice and assistance to individuals over 60 years. They did not detect any effects on health but concluded this may have been due to the relatively short follow up time and other methodological limitations (J Mackintosh, 2006).

10 Role and input of frontline health, social care and housing staff in delivering key interventions to reduce excess winter deaths

10.1 Overview

Table 15 gives an overview of the interventions for reducing winter deaths which are signposted or delivered by statutory health, social care and housing staff, and Age UK staff.[3] A tick indicates the intervention is systematically offered to all patients or clients and a hyphen indicates the intervention is not usually offered or signposted by this service. This information was self-reported by the respective staff groups and was not analysed further.

Table 15 Summary of interventions offered or signposted by organisations and teams to reduce excess winter deaths

Service	Flu and pneumococcal immunisation	Energy efficiency grants	Benefits review	Falls prevention	Pendant alarm	Medication review
Health						
General Practice	✓	-	-	Where appropriate	Where appropriate	✓
Community matrons and nurses	✓	Where appropriate	Where appropriate	✓	✓	✓
Community ward	Where appropriate	-	Where appropriate	✓	Where appropriate	✓
Inpatient geriatrics	-	-	Where appropriate	✓	Where appropriate	✓
ICT	Where appropriate	Where appropriate	Where appropriate	✓	✓	Where appropriate
Falls and other clinics	-	-	Where appropriate	✓	Where appropriate	Where appropriate
CMHT	-	-	✓	Where appropriate	✓	✓
Social care						
Social workers	-	Where appropriate	✓	Where appropriate	✓	-
Housing						
Tenancy support team	-	Where appropriate	✓	✓	Where appropriate	-
Sheltered Housing	-	✓	✓	✓	✓	-
Voluntary sector						
Age UK	Where appropriate	Where appropriate	Where appropriate	Where appropriate	Where appropriate	-

[3] Information current in December 2011.

10.2 Statutory services

10.2.1 Community matrons

Community matrons are experienced, skilled nurses who use case management techniques with patients in the community who meet a criteria denoting very high intensity use of health care. The aim is to enable these patients to remain at home longer and prevent unnecessary hospital admissions.

Patients are routinely offered flu vaccination and these are delivered directly. A falls screen is completed on all patients as part of the initial assessment. A financial assessment, including benefits check, is carried out where there is a trigger, but this may not be a routine part of the initial assessment. A referral is made to the Telecare or WATCH schemes where appropriate. The community matrons also give leaflets and advice on keeping warm and distribute room thermometers. If there is an obvious problem with excess cold they will signpost or contact Social Services, the Housing Association or Warden to report heating problems. There is not a systematic check for eligibility for energy efficiency grants.

Where appropriate, patients with chronic medical conditions can have a rescue package at home (for example antibiotics and steroids) which they can start immediately if they are developing an exacerbation.

10.2.2 District nursing

District nurses provide care, monitoring and support at home. The aim is to decrease the need for hospitalisation and to allow patients to live independently.

Medications reviews are undertaken with GPs on a regular basis. Monitored dosage systems are arranged for some patients and in some circumstances daily visits are undertaken to ensure medication is taken. All new patients are assessed for falls risks and are referred if appropriate. Patients are referred for WATCH alarms where appropriate. Personal contingency plans may not always be done. General advice about keeping warm is sometimes given. Some nurses may undertake a financial assessment, be aware of benefits available for example the winter fuel allowance, and give benefits advice. Others may lack experience or knowledge in this area. There is not a systematic check for eligibility for energy efficiency grants and nurses are generally not aware of services available.

10.2.3 Community ward

There are four Community Wards within Wandsworth that aim to integrate and assist existing community health, social care and general practice systems. The Community Wards aim to reduce hospital admissions to St George's Hospital by identifying patients who are at high risk and managing them more effectively in the community.

The core team consists of a GP, Community Matron and Ward Clerk who do daily ward rounds and weekly MDT meetings, where community health professionals are invited, including the District Nurses, Specialist Nurses, Physiotherapist, Occupational Therapist, Social Workers, Intermediate Care Team, and Pharmacists. Information from these meetings is then communicated directly to the patient's registered GP by updating their EMIS notes.

Appropriate patients include the Community Matron's current case load; patients selected using computer generated predictive tools (Combined Model and PARR data); and GP referrals.

All patients 'admitted' to the community ward have a medication review and falls risk assessment. General housing issues and income issues are considered and the ward's social worker reviews the patient if any problems are raised. Suitability for assistive technologies including pendant alarms and Telecare are also considered. The initial assessment does not include specific questions about warmth of the home. However, if a social worker assessment was deemed appropriate, this would automatically include a risk assessment for excess cold.

There may be lack of knowledge amongst members of the community ward, including GPs, community nurses and social workers, as to appropriate referral pathways or sources of advice about affordable warmth measures.

10.2.4 Older people and neuro-rehabilitation therapies

This team covers the following services:

- Therapists working on Mary Seacole Ward (elderly inpatients) at Queen Mary's Hospital
- Brysson Whyte Rehab Unit (day hospital) at Queen Mary's Hospital
- Community Neurology Team based at St John's Therapy Centre
- Primary Care Therapy Team based at St John's Therapy Centre
- Day Hospital at St John's Therapy Centre
- Integrated Falls Service based at St John's Therapy Centre

These teams complete Falls Risk Profiles and provide a multi-therapy provision for patients within their homes and community settings for rehabilitation. If appropriate patients are signposted or given leaflets for the WATCH scheme or on general benefits advice.

10.2.5 Intermediate care team

The role of the intermediate care service is to facilitate avoidance of unneeded or extended hospital admissions, especially for older people, by provision of goal orientated, short term multi-disciplinary care and rehabilitation either at home or in an intermediate care bed.

Identification tools are routinely used at the initial assessment to assess falls risk and suitability for pendant alarm or Telecare. Affordable warmth measures, benefits entitlement and flu vaccination may be discussed but these interventions are not systematically covered in the initial assessment. The assessment includes risk of excess cold, but there may not be awareness amongst all ICS staff as to the appropriate referral pathways for affordable warmth measures such as energy efficiency grants.

10.2.6 Community Mental Health Team (CMHT) for older adults

CMHTs for older adults support people with mental health problems living in the community who require more specialist and in-depth support than a GP can provide.

Patients are routinely assessed for whether they would benefit from a pendant alarm. All patients have a personal crisis plan, but this does not include specific cold weather elements. Some patients are reviewed for benefits entitlements and signposted to the financial assessment team where appropriate. There is no routine assessment of falls risk or signposting for flu vaccination.

10.2.7 Primary care

GPs conduct medication reviews but this may not be undertaken with all patients. GPs encourage flu vaccine uptake but this may not be systematically covered during consultations. Patients are not routinely assessed for potential benefit from assistive technologies but GPs are generally aware of services available. With a LES now in place, GPs will be systematically screening patients for risk of falls. GPs would not routinely assess financial circumstances, risk of excess cold or fuel poverty. GPs may not be aware of appropriate referral pathways for energy efficiency improvements.

10.2.8 Inpatient geriatrics

A falls risk assessment and medicines review is completed on all patients admitted to geriatric wards. There is no systematic assessment of flu vaccination status. If there is concern about warmth at home or financial issues a social worker referral is made. The occupational therapist may refer to Age UK for the Handyperson service (see 10.3.1).

10.2.9 Social care

The significant harm that cold weather conditions can present to vulnerable older adults is integral to the work of all social care staff including social workers and care workers. At an individual casework level there is a specific trigger for social workers to identify the risk of cold and for assessing the severity of this risk. It is determined whether this risk is being adequately managed or whether remedial measures are required, including urgent or immediate action. In certain very high risk situations heaters have been purchased and provided to service users to offset any immediate risks due to excess cold.

All clients are assessed for whether a benefits entitlement check is required or a referral to the Joint Visiting Team is warranted. Social workers do not generally provide direct help to service users in making applications for energy efficiency grants, but will refer to appropriate information and advice agencies for this support.

Social care staff do not systematically establish whether an eligible or high risk service user has had the influenza vaccination. Social care service providers are not required to use the HOME FAST falls risk assessment tool. Prompts for Telecare/assistive technologies are incorporated into standard assessment documentation and resource allocation process, so the potential benefits of these interventions are routinely considered and would be acted upon if a likely benefit to an individual service user was identified.

10.2.10 Sheltered housing officers

Sheltered housing is designed to help residents maintain an independent and active lifestyle in a secure and friendly retirement community with the added security of an alarm service and sheltered housing officer for help and support. Anyone who is aged 55 years or over can apply for sheltered housing. A points scheme is used to prioritise allocations.

In Wandsworth there are 25 council run schemes covering 1078 individual flats. There approximately 1000 further flats provided by Registered Social Landlords, though these may have different eligibility criteria and support processes.

On moving in to council sheltered housing a support plan is developed for all residents. This includes benefits eligibility and maximisation of income check, falls assessment and provision of appropriate aids and adaptations, assessment for pendant alarm or other Telecare devices. The support planning

process also covers mobility inside and outside the home, social inclusion, Safeguarding and daily living skills. Referrals are also made to onsite falls clinics where appropriate. Sheltered housing officers make telephone or face to face contact on a weekly basis as minimum.

10.2.11 Tenancy support team

The Tenancy Support Service provides intensive support to Wandsworth Council Tenants identified as vulnerable and having problems maintaining their tenancy. Qualifying tenants will often have an underlying vulnerability including old age, a mental health problem, a physical disability or substance or alcohol abuse. The team of five Tenancy Support Officers has a caseload of approximately 100 clients at any one time.

A support plan is created for each client, covering areas of maximisation of income, tenancy issues, property condition, health and well-being. The tenancy support service adopts a holistic approach to individuals support needs dealing with issues as required by each service user and referring to appropriate services. A referral is made to the Telecare or WATCH schemes where appropriate.

10.3 Voluntary sector

10.3.1 Age UK

Age UK Wandsworth has an office base in Wandsworth Town, from which it delivers a wide range of services that aim to improve the quality of life for people aged 60-plus living in the borough. Older people and their carers can access independent information, advice and support through appointments and drop-in sessions at the office and over the telephone. Home visits are also available for clients with poor mobility. The future funding for the advice service is uncertain. Age UK receive referrals from social workers, occupational therapists, community nursing, carers and self-referrals. In 2010/2011 the Advice Service saw 800 people for detailed casework and handled 13,000 enquiries.

Age UK Wandsworth provide the following services relevant to preventing excess winter deaths:

- **General benefits advice**
  Carry out benefits entitlement checks – covering pensions, means-tested benefits and disability related benefits. Provide advice and support in claiming benefits, filling in claim forms, or helping the older person access other help. Challenge benefit authorities if decision is not in their favour (e.g. making appeals, representation at tribunal). Provide help accessing the Social Fund and Winter Fuel Payments where necessary. Age UK staff feel this is their most important role in reducing fuel poverty
- **Assistance paying energy bills**
  Checking for accuracy of meter readings, help accessing Warm Home discount scheme, and where necessary helping with applications to energy supplier charitable trusts for people in hardship.
- **Accessing energy efficiency grants**
  Staff use the ESTAC helpline as a first port of call and then assist with application to whichever scheme the client is eligible for, for example Coldbusters.

- **Emergency warmth measures**
  Age UK Wandsworth have a small supply of electric heaters and duvets which can be distributed at short notice as an interim measure whilst, for example, faulty central heating is being repaired during cold weather.
- **Handyperson scheme**
  Practical help with minor repairs and DIY, includes fitting grab rails. Energy efficiency advice is also given and installation of energy efficiency measures such as light bulbs, draught excluders and boiler jackets.
- **Cold weather behaviour**
  Verbal and written advice (leaflets) given on how to keep warm indoors and outdoors in cold weather, importance of keeping steps and paths free of ice, and checking the weather forecast.
- **Promotion of vaccinations**
  Verbal and written advice given on importance of seasonal flu and pneumococcal vaccinations. Articles included in Newsletter. Out and About scheme to assist people to attend appointments.
- **Falls prevention**
  Verbal and written advice on falls prevention, including an accessible 'Falls-free' plan which sign posts the client to various health and social services depending on needs. Grab rails fitted by handyperson. Referrals received from occupational therapists.
- **Assistive technologies**
  WATCH scheme and Telecare are promoted.
- **Reducing social isolation**
  Be-a-Friend and Out and About work to reduce social isolation all year round and this can be stepped up in colder weather, including telephone befriending.

10.3.2 Furzedown project

The Project offers a meeting place for older people, providing a wide range of classes and activities including two adult education classes. It is open 5 days a week, offering information and advice, also giving support to carers.

The project provides a home-visiting scheme to isolated older people in Tooting and Furzedown area. In bad weather when the minibus cannot run telephone contact is made with clients who normally attend activities at the centre.

10.3.3 Other projects

Other community projects working with older adults in Wandsworth include:

- Regenerate Rise
- Tooting Neighbourhood Centre
- Asian Elders Support Scheme
- Tooting Graveney Daycare Centre
- Hestia Age Activity Centre

10.4 Other points of contact with vulnerable people

10.4.1 Home Delivery Library Service

The Home Delivery Library Service delivers a library service to anyone who is housebound or has difficulty in reaching a static library.

10.4.2 Community safety

The Wandsworth Neighbourhood Watch scheme has over 470 coordinators. Each has responsibility for a part of a road, a whole road or a block of flats. The aim is to create a sense of community and to improve safety and security.

The Safer Neighbourhood Teams are made up of police officers. There is a team for each ward in the borough. They comprise of a sergeant, two police constables, and three police community support officers. All Safer Neighbourhood Teams should routinely identify vulnerable people who live on their wards. There is currently no specific work with this group during cold weather.

10.4.3 London fire brigade

Home fire safety visits by the London Fire Brigade include advice on how to make properties safe and free smoke alarm fittings. They are targeted at high risk individuals such as older people, especially those living alone, those with mobility, vision and hearing impairment, mental health services users and those liable to intoxication through alcohol/drug use.

10.5 Community development work

The community development team work with volunteers and paid workers particularly sheltered housing officers to raise awareness on the current guidance on keeping warm in winter. Since 2009, they have run Reminiscence Sessions for older adults, for example those at Regenerate Rise. The discussions range from exploring the main risk factors for EWD, practical ways of keeping warm during the cold weather, the importance of receiving the seasonal flu vaccination, establishing social networks, advice on benefits entitlements and home insulation. Home thermometers are distributed and participants are signposted to Cold Busters or the Citizen's Advice Bureau for benefits advice where appropriate.

10.6 Response to cold weather

The Cold Weather Action Plan describes how at Level 1 (throughout winter) high risk individuals should be identified, at Level 2 (severe weather forecast) systems for making contact with high risk individuals are in place; and Level 3 contact is made in person or by phone. Table 16 summarises the processes for making contact with vulnerable individuals by relevant organisations.

Table 16 Summary of contact made with vulnerable people during severe weather

Organisation/ team	Contact with vulnerable people during bad weather
Community nursing, including community matrons and district nurses	Yes- The community matron team has a list of vulnerable adults who they call every day during bad weather to ensure they are coping and have sufficient food. Community nurses are advised to keep a record of vulnerable adults to contact at Level 3
General practice	No- List of vulnerable people not routinely collated; no contact with these patients in severe weather
CMHT older adults	Not routinely- There is no specific contact with service-users during cold weather.
ICT	No- Patients are not routinely contacted in cold weather.
Social services	Yes- Contracted social care providers are required to have their own protocols in place for checking up on particularly vulnerable services users during periods of exceptionally cold weather.
Tenancy support team	Not routinely- There is no specific contact with clients during cold weather.
Sheltered housing	Yes- Sheltered housing officers make telephone and face to face contact on a weekly basis as minimum.
Community safety team	Not routinely- There is currently no specific work with vulnerable adults during cold weather.
Furzedown project	Yes- In bad weather when the minibus cannot run telephone contact is made with clients who normally attend activities at the centre.
Age UK Wandsworth	Yes- in bad weather contact is made with clients through the Handyperson and Out and About services

The Housing Department at Wandsworth Borough Council implements a Severe Weather Emergency Protocol. This aims to reduce deaths amongst rough sleepers and street homeless people by extended accommodation and support services during severe cold weather (Homeless Link, 2011).

11 Summary of evidence

11.1 EWD in Wandsworth: patterns and key issues

Age: As we would expect the risk of EWD increases considerably with age, and the greatest burden is in the over 85s. Although the under 65s make up a small proportion of the burden of EWD, comparisons with both London and England figures suggest there are greater EWD in this age group than we would expect.

Gender: Overall there is a similar EWDI in men and women.

Medical conditions: In Wandsworth the most important causes of EWD are influenza and pneumonia, chronic respiratory disease and circulatory disease. People with pre-existing chronic respiratory disease and circulatory disease are therefore most at risk. Those who are not vaccinated against flu are also at greater risk.

Ward: Some wards in Wandsworth are more affected by EWD than others, with Tooting and Graveney wards having the greatest seasonal variation in mortality.

Fuel poverty: EWD appear to be associated with fuel poverty at a ward level in Wandsworth. This fits with the background evidence that excess cold in homes increases the risk of EWD.

Deprivation: There is no clear relationship between deprivation and EWD at a ward or LSOA level. This may be because the most deprived areas tend to have a greater proportion of residents in social housing, which tends to be better insulated and may protect against EWD. With the available data it was not possible to prove or disprove a relationship between deprivation and EWD at the individual level.

Decent housing: Whilst more than half of private households do not meet the decent housing standard, due to the era they were built, it is not known how many older people or those in at risk groups reside in these houses.

Seasonal Influenza Vaccination Uptake: There was higher uptake of the seasonal flu vaccination among people over 65 years of age (70%) compared to people under 65 years in high risk groups (38%) locally. Between 2006 and 2011 the uptake of the seasonal flu vaccine in Wandsworth (38%) has consistently been below the London (46%) and England (47%) rates. This may help to explain the differences in EWDI for those under 65 years in Wandsworth (15.6%) compared to London (6.9%) and England (7.1%). Members of the Wandsworth Older People's Network reported mobility problems and isolation as key barriers to accessing the GP for a flu vaccination.

11.2 Key gaps in preventing EWD in Wandsworth

- There is no co-ordinator for preventing excess winter deaths across organisations, nor lead individuals within organisations.
- There is lack of awareness about fuel poverty and the health risks of cold amongst some frontline health workers

- There is no systematic identification of at-risk individuals at risk of EWD in primary care
- Not all interventions to reduce EWD are systematically offered or signposted by all frontline health, social care and housing workers
- In particular, there is a lack of knowledge amongst older people, health and social care workers about referral pathways for affordable warmth interventions i.e. ESTAC helpline, and assistance available e.g. Cold Buster grants.
- There is no systematic outreach or home visiting work for seasonal influenza vaccination for those with mobility problems

11.3 Challenges in reducing EWD

- Frontline workers may not have the capacity or capability to assess for risk of excess cold or fuel poverty and offer recommended interventions
- Winter deaths not perceived as priority in all services
- Rapid turnover of population
- Tighter eligibility criteria for Warm Front, but may be offset by local schemes with broader criteria i.e. Cold Busters and RE:NEW

12 What is being done elsewhere to reduce excess winter deaths

There are several examples of action taken in other boroughs to reduce excess winter deaths, which can be grouped into four main categories.

12.1 Improve referral pathways to existing services

The '**Hotspots' toolkit** was developed by National Energy Action to improve referral pathways to affordable warmth measures (National Energy Action, 2009). It requires an existing central referral agency, which may be ESTAC (see 8.3.3).

Frontline health and social care practitioners and fire safety officers are trained in identifying fuel poverty and given Hotspots referral cards. These are filled in when a vulnerable client at risk of fuel poverty is identified, and sent to ESTAC. ESTAC contacts the client and gives advice and assistance on energy efficiency improvements, income maximisation and fire safety services, making appropriate referrals for example to the pension service. Other aspects of preventing winter deaths are not incorporated into this model. The Hotspots process has been used in West Yorkshire, where positive testimonials have been collated but there is no evidence of effectiveness.

Pros

- Start up costs are potentially low

Cons

1. Relies on frontline worker to complete or refer to health interventions
2. No emergency funds held by ESTAC

12.2 Develop a new service focused on improving access to affordable warmth interventions

A new central point of contact for fuel poverty and other housing-related referrals is developed, for example '**The Affordable Warmth Access and Referral Mechanism' (AWARM)** in Greater Manchester (Housing Health and Fuel Poverty Forum, 2009). Vulnerable people are identified by health and social services and the voluntary sector and referred to the service. AWARM assists individuals in accessing affordable warmth interventions from the Government, council and energy suppliers.

Pros

3. Could hold emergency funds

Cons

- Start up costs may be higher

4. Relies on frontline worker to complete or refer for health and social interventions

12.3 Develop a new 'one-stop' service which integrates affordable warmth and health interventions

A 'one-stop' integrated service is developed by the PCT and local council to tackle fuel poverty and reduce hospital admissions. The **Seasonal Health Interventions Network (SHINE)** in Islington is one example of this model (Islington Council, 2011). Vulnerable residents are referred to the service by

health, social care and voluntary sector workers. They are assessed for 23 interventions including affordable warmth, benefits checks, falls assessments and medicine use reviews.

Pros

- Integrated and comprehensive service, providing systematic approach to reducing excess winter deaths
- Less reliance on frontline workers to complete all interventions

Cons

- Start up costs may be higher
- More complex to organise initially as covers health and social care as well as affordable warmth

12.4 Develop a new service targeting a specific health condition

'Healthy outlook COPD Forecast alert' service was developed in the West Midlands (Met Office, 2009). This service generates weather forecast triggered automatic alert calls for people with COPD when the outdoor environment increases their risk of illness. The automated calls are interactive, including questions about symptoms and medication. The patients' responses are followed up at practice's discretion. An evaluation found that 78% of users agreed the service helped them to manage their COPD better. However it was not possible to show any changes in hospital admissions due to the small numbers in the study.

13 Recommendations for action to reduce EWD in Wandsworth

These recommendations have been informed by DoH guidance (Health Inequalities National Support Team, Department of Health, 2010) but are also shaped by local needs, current service provision, stakeholder views, and available evidence.

Recommendations

1. Public health as per the current arrangements (and in line with transitional arrangements) will continue to take a lead in commissioning local initiatives to reduce EWD.

2. General Practice, community matrons, community wards, community nursing, adult social care, community mental health teams, intermediate care teams, inpatient geriatric teams, sheltered housing, tenancy support teams, WATCH, Telecare, Age UK Wandsworth, day centres, the community development team, the fire service, Neighbourhood Watch and community safety teams should all be considered contact points for actions to reduce EWD.

3. Increase the awareness of EWD within all key organisations across health, social care and voluntary organisations through partnership working.

4. Improve the identification of individuals at risk of EWD through targeted outreach work with greater priority to the following:
    - The under 65s in high risk groups amongst home the EWDI is substantially higher in Wandsworth (17.5%) compared to London (6.9%) and England (7.1%).
    - Wards with the greatest EWDI: Tooting (38.7%) and Graveney (34.7%)
    - Wards with a higher proportion of households living in fuel poverty such as Graveney, Furzedown and Tooting.

5. Address knowledge gaps amongst staff on the identification of fuel poverty and the affordable warmth intervention referral process.

6. Consider ways to improve referral pathways and consider developing a single point of access for the identification, assessment and signposting to key interventions to reduce EWD to ensure equity in care provision and optimising uptake of grants and schemes such as RE:NEW, Warm Front and Cold Busters.

7. Work with community groups, GP practices, Primary Care Cluster Teams, Local Enhanced Service (LES) and the Direct Enhanced service (DES) seasonal flu vaccination leads to gain insight and address barriers to receiving the seasonal flu vaccination particularly in the under 65 high risk groups. Between 2006-2011 seasonal flu vaccination uptake in this group was notably lower in Wandsworth (38%) compared to London (46%) and England (47%). Consider innovative ways to increase uptake, such as clinics in sheltered housing.

8. Promote targeted work to improve the uptake of energy efficiency improvements in those households not meeting the thermal comfort standard (ranging from 12% in Northcote to 33% in West Hill) together with the vulnerable groups living in private households not meeting the Decent Housing Standard.

9. Maintain and develop joint working on winter deaths with voluntary sector organisations.

5. Set up an EWD Steering Group to ensure there are strong arrangements for joint working to drive the EWD action plan and monitor the impact of interventions.

6. Identify a lead individual to co-ordinate the EWD action plan and promote EWD projects to all key stakeholders.

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15 Appendix A

Staff and service user views

Interviews and meetings were conducted with:

- Members of Central Wandsworth Community Ward (including social worker, community nurses, GP and ICT)
- Attendees at community matron meeting Tooting Health Clinic
- Dr Judith Coles (Consultant Geriatrician, St George's Hospital)
- Dr Shakeel Mughal (GP, lead for Central Wandsworth Community Ward)
- Alison Kirby (Lead Commissioner Older People, NHS Wandsworth)
- Ian McGee (Head of Warden Services, Housing Department, Wandsworth Borough Council (WBC))
- Ian Stewart (Chief Management Office, Housing Department, WBC)
- Andy Pike (Head of Technical and Programming Services, Housing Department, WBC)
- Frank Whittle and Fiona Sibson (Area Manager and Team Leader Private Housing, Housing Department, WBC)
- Simone Farr and Elaine Curley (Community Development Co-ordinators, NHS Wandsworth)
- Rachel Corry and Philippa Burns (Chief Executive and Advice and Support Services Co-ordinator, Age UK Wandsworth)
- Rob Persey (Assistant Director, Adult Social Services, WBC)
- Wendy Moreton (Policy and Performance Manager, Adult Social Services, WBC)
- Mick Morrell (Project Manager, Furzedown Project)

Email and telephone discussions with:

- Fleur Norwood (Head of Community Nursing, Community Services Wandsworth (CSW))
- Linda Venables (Clinical Team Leader Community Nursing, CSW)
- Monica Edwards (Clinical Team Leader ICT, CSW)
- Sally Hale (Head of Older People and Neurotherapies, CSW)
- Rhian Williams (Primary Care Nurse for Refugees, CSW)
- Jane Farrell (Interim Team Manager, East Wandsworth Community Mental Health Team for Older People)
- Andrew Crombie (Consultant Psychiatrist, East Wandsworth Community Mental Health Team for Older People)
- Sue Yoxall (Community Safety Manager, WBC)
- Dave Worth (Head of Housing Services, Housing Department, WBC)
- Patricia Comley (Service Standards & Leadership Improvement Manager, Wandsworth Adult Social Services)

NHS Wandsworth needs assessments consulted:

- Seasonal Flu Vaccination Needs Assessment (Draft), July 2011

- Joint Intermediate Care and Re-ablement Needs Assessment and Service Review, November 2011
- Falls Prevention, Management and Bone Health Strategy and Needs Assessment, June 2010

Factors contributing to excess winter deaths: views of older adults

Views of older adults were sought from the Wandsworth Older People's Forum, Older People's Network Conference JSNA Consultation and opinions of older from the 'Reminiscence Sessions' were considered.

Issues raised more than once (within or between settings) are in bold, issues receiving a single mention are in normal typeface as below. See Section 5.3 for how the data was gathered.

Housing and fuel

- **Not wanting to turn the central heating on due to cost. Prioritising other needs above keeping warm (including saving money for inheritance).**
- **Difficult to get information about or access grants for improving energy efficiency of homes. Many older adults do not have access to the internet, which seems to be the main source of information. Schemes are generally not well advertised. Lack of clarity over eligibility criteria for different grants. Difficult to know which schemes are official or trustworthy.**
- **Some council housing is poorly insulated and Warm Front grants are only available to home owners for some improvements.**
- **Difficulty clearing out the loft may be a barrier to some older people accepting free loft insulation.**
- Lack of functioning central heating systems in some homes.
- Rising price of fuel which is not offset sufficiently by winter fuel allowance. Concern about proposed cuts to winter fuel allowance.
- Difficulties improving energy efficiency of privately rented accommodation- lack of awareness of council enforcement practices.

Influenza and pneumococcal vaccine

- **Awareness of need for flu vaccine is generally high. Some individuals do not want to have the vaccine due to fears (and in some cases experiences) of developing flu-like symptoms after vaccination.**
- **Difficulty accessing GP for flu vaccine for those with mobility problems or living alone. Older people unclear as to who is eligible for a home visit and how to access this.**
- Those who do not attend for flu vaccination are not followed up by GP practice.
- Lack of awareness about need for pneumococcal vaccine.

Accessing GP

- **Getting to the GP surgery, dentist or hospital for outpatient visits is difficult for the less mobile who are unable to travel or who lack confidence on public transport because of fear of falling. Concern there is a gap for those not qualifying for home visits or Patient Transport to hospital. This is particularly important in winter when there is concern about going out in the cold or falling on wet or icy pavements.**

Falls

- **Increased falls outside during winter due to inadequate gritting of pavements and broken pavements less visible during snow.**

Potential solutions for reducing excess winter deaths

- **Age UK handyman service is useful for basic measures such as draught exclusion.**
- **Age UK benefits advice is a valuable service.**
- **Better advertising of grants to improve energy efficiency of homes is needed. More clarity needed over eligibility criteria. Need other sources of information apart from via internet.**
- **More likely to trust energy efficiency schemes if signposted by health or social care staff.**
- **Taking the flu vaccine to older adults, e.g. at sheltered housing or community centres, would be an effective way to get more people to get the vaccine. Organizing minibus pickups for a flu clinic at a GP practice was also a popular suggestion.**
- Perception that Neighbourhood Watch scheme has variable activity in Wandsworth and overall is not currently a useful way of identifying or supporting vulnerable elderly.
- Pendant alarms are a useful way for those living alone to feel secure.

Factors contributing to excess winter deaths: views of staff

Cause of death

- Those with co-morbidities likely to be most at risk.
- Exacerbations of COPD in cold weather likely to be an important factor.
- All chronic illnesses, particularly stroke, have the potential to reduce physical activity of individuals. This decreased activity leads to greater susceptibility to cold.
- Patterns of EWD by underlying cause of death may be difficult to determine. Pneumonia may be recorded as primary cause of death, even when chronic respiratory disease was an important contributory factor.

Falls

- Falls may be a factor for winter deaths, even if they are not a main cause of death. Falls cause bone fractures, which may lead to hospitalisation and complications including respiratory infections.
- If falls occur in cold weather outcomes are likely to be worse- older adults left on the floor for several hours in the cold are at risk of hypothermia, dehydration, skin and urinary infections and pressure sores.

Accessing care

- Difficulties accessing acute care and primary care may be increased in winter due to bad weather and difficulties accessing transport. These issues are likely to be greatest in the isolated elderly with mobility problems.
- Older adults from black and minority ethnic (BME) groups may face even greater barriers accessing services due to language difficulties or lack of awareness about services.

Quality of care

- Hospitals are under greater pressure in winter meaning quality of care may be reduced. This could account for some of the seasonal variation in long term conditions including stroke.

Identifying individuals at risk

- Lack of a shared record of vulnerable adults between secondary care, primary care and social care.

Potential solutions for reducing excess winter deaths

- Heart failure and COPD nurses good source of access to those at risk
- Give flu vaccination systematically in SGH
- A community geriatrician in Wandsworth would provide expertise on older adults with complex medical and social problems. These are likely to be the individuals most at risk of EWD.
- Clear pathways needed for frontline health, social care, community workers and day centre managers if an individual is identified to be at risk from cold.
- Increase uptake of flu vaccination by targeting those with previous falls. Could identify using Predictive Assessment of Risk (PARR) data.