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GMCA GREATER MANCHESTER COMBINED AUTHORITY

LOW CARBON HUB BOARD

Date: **22nd January 2016**

Subject: **Health, Food and Warm Homes**

Report of: **Mark Atherton, GM Director Environment**

PURPOSE OF REPORT

At the July 2015 Board meeting, officers were requested to initiate discussions with GM Health colleagues to identify opportunities for synergistic working. This report provides an update on the work underway to define and realise greater inter-linkages between the health, sustainable food and warm homes afforded as a result of increased devolution.

RECOMMENDATIONS

The Board are requested to:

- Note the current work being undertaken with GM Health colleagues on sustainable food and warm homes.
- Comment on the draft Terms of Reference for Good Food for Greater Manchester (Annex 1).

CONTACT OFFICERS:

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Darren Peagram, Sustainability Manager, Stockport MBC

BACKGROUND PAPERS:

Paper to July 2015 Board – Sustainable Food
ANNEX 1 – Draft Terms of Reference for Good Food Greater Manchester
ANNEX 2 - evidence at a national and local level on the impact of living in cold homes on the health of those residents

TRACKING/PROCESS	[All sections to be completed]
Does this report relate to a Key Decision, as set out in the GMCA Constitution or in the process agreed by the AGMA Executive Board	No
EXEMPTION FROM CALL IN	
Are there any aspects in this report which means it should be considered to be exempt from call in by the AGMA Scrutiny Pool on the grounds of urgency?	No

AGMA Commission	TfGMC	Scrutiny Pool
Low Carbon Hub 22/01/16		

1. BACKGROUND

Greater Manchester has a carbon reduction target of 48% (from 1990) by 2020. The UK has a long term goal of a minimum of 80% carbon reduction by 2050. To meet these targets, low carbon initiatives cannot take place in isolation but require being part of wider GM frameworks and programmes across a spectrum of areas, including health, transport, natural environment, housing and food. This paper reports progress on activities to better integrate the issues of sustainable food and warm homes with work on public sector reform in the health sector.

At its July 2015 meeting, the Board received a paper which explained that emissions from consumption of food and drink by individuals in Greater Manchester accounted for up to 20% of a residents carbon footprint. This includes both the purchase and consumption of food and drink from retail and restaurants. The report made preliminary recommendations to address this, which included promoting a healthy diet through public procurement as there has been a 30% fall in fruit and vegetable consumption in the lowest income groups in GM since 2006 and a significant proportion (over 25%) of children in the UK are overweight or obese. There is synergy between reducing the carbon footprint of GM residents and the healthy food and obesity agendas.

Buildings play a significant role in carbon reduction. Energy used in domestic buildings accounts for 35% of the direct CO_2 emissions across Greater Manchester; highlighting the importance of building-level actions.[1] More than 1 in 5 households in Greater Manchester are in fuel poverty.[2] The National Institute for Health and Care Excellence has produced guidelines (March 2015) on health risks associated with cold homes. The conclusions from this paper are summarised as:

- Cold temperatures are a significant cause of illness and death in winter.
- The risk increases with falling temperatures, but the risk starts to increase at relatively moderate cold outdoor temperatures, before emergency responses.
- Cold homes play a significant part of the problem; fuel poverty is important but also situational/attitudinal factors.
- NICE EWD recommendations offer a system-wide approach.

As the current DECC funded GM domestic energy efficiency schemes (Green Deal Communities) come to an end at the end of March, GM CEXs have asked that any future schemes are delivered in collaboration with GM health colleagues.

2. PROGRESS UPDATE

2.1 Sustainable Food

A task group led by Lucy Danger, and supported by Darren Peagram, is in the process of building a coalition of interested parties (public health, academia and third sector so

[1] Greater Manchester Climate Change and Low Emissions Strategies, Joint Implementation Plan, 2016-2020 Consultation Draft.
[2] http://www.agma.gov.uk/cms_media/files/7_annex_gm_fuel_poverty_paper.pdf?static=1

far). As noted at the last Board meeting, the Group is working towards setting up a sustainable food partnership for Greater Manchester called Good Food Greater Manchester. A draft Terms of Referenced for the eventual Partnership is provided at Annex 1 for comment.

A GM approach would strengthen collaboration and smarter working across GM, making progress on issues that cannot easily be done at an individual district level and keeping any new governance to a minimum. The Terms of Reference suggest that the Chair of the new Partnership will have a relationship with the Low Carbon Hub Board.

Following contact with the GLA about their experience on sustainable food, Rosie Boycott (Chair of the London Food Board) and two officers from the GLA are keen to visit Greater Manchester to speak about health devolution and food. This may be linked to a seminar to be held later in 2016. Mark Atherton is in discussion with GM health colleagues as to the best point of contact.

2.2 Warm Homes

Work has been undertaken to identify and evaluate the national and local evidence base for the impact on health of living on cold homes. Greater Manchester schemes assisting fuel poor residents, for example Warm Homes Oldham, have significant evidence to show the impact of cold homes on health and the health service (see Annex 2). This has been shared with GM Health colleagues.

The GM Housing Officers and GM Housing Provider Groups have commenced positive dialogue with Greater Manchester Health & Social Care Devolution (who are redesigning services to provide home and community based care and early interventions). A Health Housing and Public Service Reform paper, produced by Michelle Horrocks for GM Housing Officers Group, recommends a GM approach to developing a shared vision and set of priorities relating to Housing and Health across Greater Manchester.

3. NEXT STEPS

A meeting to discuss next steps on `warm homes' has been organised for 15th January, which may include discussion on the potential for LAs in Greater Manchester to develop and deliver a GM wide Single-point-of-contact health and housing referral service. Such a service could provide information on risks, on what help is available, access to tailored housing/energy efficiency interventions and grants and advice on benefits, fuel options and debt management. A verbal update can be provided to the Board.

ANNEX 1
GOOD FOOD GREATER MANCHESTER PARTNERSHIP – TERMS OF REFERENCE

Draft for comment

1. PURPOSE

From obesity and diet-related ill-health to food poverty and waste, climate change and biodiversity loss to declining prosperity and social dislocation, food is not only at the heart of some of our greatest problems but is also a vital part of the solution.

Developing a more sustainable[3] approach to food fits with the Greater Manchester (GM) vision for equality of opportunity and economic prosperity for all. Sustainable food impacts upon a number of socio-economic and environmental priorities for Greater Manchester.

The Good Food Greater Manchester Partnership would be established to:

- Demonstrate leadership and seek strategic agreement of the role sustainable food can have across GM
- Take a whole system approach to food across Greater Manchester ensuring links are made across the key issues, partners, and delivery of actions
- Develop a consistency of vision and approach with stakeholders
- Provide a hub for connections across all sector stakeholders
- Maintain links between food and wider GM priorities

The key issues that define the purpose of the Good Food Greater Manchester Partnership can be summarised as:

1. Promoting healthy and sustainable food to the public.
2. Tackling food poverty, diet-related ill health and access to healthy food.
3. Building community food knowledge, skills, resources and projects.
4. Promoting a vibrant and diverse sustainable food economy.
5. Transforming catering and food procurement.
6. Reducing waste and the ecological footprint of the food system.

2. RATIONALE

Evidence demonstrates:

- Greenhouse gas emissions from consumption of food and drink by individuals in Greater Manchester accounts for up to 20% of a residents carbon footprint

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[3] Sustainable Food in Greater Manchester is currently defined as: Fresh, seasonal and minimally processed; Farmed and produced with minimum impact to the environment; Reduce foods of animal origin & maximise welfare standards; Limits wasted food and reduces waste and packaging; Resilient and economically viable producers; Excludes fish species identified as at risk; Promotes health and well being; Incorporates food democracy and access for all. Where it does not run counter to the above considerations more locally sourced food should be prioritised.

- 40% of children in Manchester live in poverty
- There has been a 30% fall in fruit and vegetable consumption in the lowest income groups in Manchester since 2006
- Nationally 25.6% of 2-10 year olds and 35.9% of 11-15 year olds are overweight or obese[4]
- BAPEN estimates that around 30-40% of people admitted to hospitals or care homes in the UK are found to be malnourished/undernourished or at risk of malnourishment/undernutition.[5]
- Benefit delays and sanctions are the most significant reasons for referrals to food banks

3. TERMS OF REFERENCE

As part of their core purpose, the Good Food Greater Manchester Partnership would:

- Work with partners to ensure appropriate links are made to relevant Greater Manchester strategies
- Develop, agree and drive implementation of a strategy and action planto deliver against the six key food issues
- Identify resources and expertise for the delivery of the action plan
- Identify partner ownership of relevant activities to contribute towards the delivery of the action plan
- Support research to enable the development of relevant policy (e.g. food procurement)
- Attract funding for agreed actions and relevant projects
- Identify and support actions associated within areas of GM influence (procurement, waste)
- Provide oversight and challenge of delivery of actions
- Provide an information hub for all stakeholders
- Work with the other Low Carbon Hub Groups and Public Health teams to deliver joint aspirations
- Deliver projects as appropriate as part of the agreed strategy & action plan

4. OPERATING PRINCIPLES

4.1 Meeting frequency

The Group would meet quarterly, with meeting dates arranged for a full financial year. Where-ever practical papers would be issued five working days before meetings, and the meeting note will be issued within two weeks of the meeting date.

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[4] http://www.noo.org.uk/securefiles/160108_1307//Child_weight_factsheet_October_2015.pdf
[5] http://www.malnutritionselfscreening.org/about-malnutrition.html

4.2 Roles and responsibilities

Chair

- Agree agenda and papers
- Chair meetings
- Report back to the Low Carbon Hub Board and represent the views of the Group at LCH Board meetings

Members

- Regularly attend and contribute to meetings
- Ensure links are made to appropriate networks and groups across Greater Manchester
- Thoroughly review and inform the work of the Partnership
- Individually lead specific responsibilities and action plan activities
- Report progress against priorities they are responsible for

5. MEMBERSHIP

Membership would be drawn from:

- Elected politicians [councillors and/or MPs]
- Public Health
- National Health Service
- Academia
- NGOs
- Food producers, suppliers, retailers, industry, logistics
- Professional bodies
- Greater Manchester Combined Authority
- Professional bodies

ANNEX 2

SUMMARY EVIDENCE ON THE IMPACT ON HEALTH OF LIVING IN COLD HOMES

Background

Fuel poverty in England is measured by the Low Income High Costs definition, which considers a household to be in fuel poverty if:

- They have required fuel costs that are above average (the national median level).
- Were they to spend that amount they would be left with a residual income below the official poverty line.

Fuel Poverty is driven by:

- Household income
- Energy prices
- Thermal efficiency of dwellings

The increased likelihood of fuel poverty is where households:

- Have low income
- Live in older (pre-1945) and larger dwellings
- Are in the private rented sector
- Have inefficient boilers/ no heating/ non-gas heating

a) The national picture:

2.35M (10.4%) households in England were living in fuel poverty in 2013.[6] The calculated total fuel poverty gap per household in fuel poverty is £405 (based on the Hills definition of fuel poverty).[7] The National Institute for Health and Care Excellence in produced guidelines (March 2015) on health risks associated with cold homes. The conclusions from this paper are summarised as:

1. Cold temperatures are a significant cause of illness and death in winter.
2. The risk increases with falling temperatures, but the risk starts to increase at relatively moderate cold outdoor temperatures, before emergency responses.
3. Cold homes play a significant part of the problem; fuel poverty is important but also situational/attitudinal factors.
4. NICE EWD recommendations offer a system-wide approach.

b) The local picture:

More than 1 in 5 households in Greater Manchester are in fuel poverty.[8] Greater Manchester schemes assisting fuel poor residents, for example Warm Homes Oldham have significant evidence to show the impact of cold homes on health and health service. Oldham CCG has conducted their own analysis of the Warm Homes Oldham scheme: from a sample of nearly 800 people that were supported through the scheme. A&E attendances for the participants had gone down by 2% and emergency hospital admissions by 32%, with an estimated saving of nearly £40,000 to the CCG. Total GP

[6] Source: Annual fuel poverty statistics report 2015, DECC and National Statistics.
[7] 'Reducing the Health Impact of winter': Dr Angie Bone (Head of Extreme Events and Health Protection, Public Health England.)
[8] http://www.agma.gov.uk/cms_media/files/7_annex_gm_fuel_poverty_paper.pdf?static=1

appointments went down by 8% while the cost of drugs prescribed increased by 14%; this may be due to the patients better managing their conditions at home.[9]

c) National Evidence

NG6 Excess winter deaths and morbidity and the health risks associated with cold homes

The National Institute for Health and Care Excellence: NICE (upon the request of the Department of Health) have produced evidence-based guidance on interventions to reduce excess winter deaths and illness associated with cold homes, focusing particularly on:

- Those people and groups who are vulnerable
- An integrated approach to identifying people at risk and in taking action
- Complementary to Cold Weather Plan

The paper[10] identifies costs in illness and deaths:

- On average there are about 25,000 extra deaths in the winter months each year compared with non-winter months; so called excess winter deaths (EWD).
- Estimated that for every death there are an additional eight non-fatal hospital admissions.
- Temperature only has to drop below about 6C for death rates to rise.
- The effect lasts for weeks.
- The UK has more EWD than most other western European countries including colder European countries.

The monetary costs:

- Age UK have estimated that "the annual cost to the NHS in England of cold homes is £1.36 billion", this does not include the associated cost to social care services, which is likely to be substantial.
- This is made up of the costs of hospital admission, A&E attendance, additional GP and community nurse visits etc.
- Costs to families and carers also considerable.

Causes and vulnerable people:

- People with cardiovascular (40%) or respiratory diseases
- (33%)
- People with mental health conditions
- People with disabilities
- Older people (>65 and especially >75)
- Households with young children
- Pregnant women
- People on low income **and especially those in fuel poverty**
- And of course combinations of the above.

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[9] Oldham Council: Affordable Warmth Update, Quarter 22014-15.

[10] NICE prepared the paper as follows:

- Defined "scope" based on referral and consultation.
- Conducted reviews of evidence of effectiveness and economics (London School of Hygiene and UCL).
- Utilised best available evidence, including testimony.
- **Public Health Advisory Committee discussions.**
- 3 month public consultation on draft guidance.
- Open process; public meetings and stakeholders were able to comment at each stage.

The recommendations made by NICE

The recent NICE report makes thirteen quite detailed recommendations, here are the key points:

- Make cold homes part of planning by Health and Wellbeing Boards; Joint Strategic Needs Assessment.
- **Single-point-of-contact health and housing referral service providing information on risks, on what help is available, access to tailored housing/energy efficiency interventions and grants and advice on benefits, fuel options, debt management etc.**
- Identify people at risk of ill health from cold homes. Use existing data sources, record the risk and share information across agencies (with safeguards).
- Health and social care professionals (and others visiting vulnerable people) should "make every contact count". E.g. think about heating and housing needs when seeing patients/clients in vulnerable groups, provide information about the risks and the help available and be aware that needs may be hidden.
- Don't discharge people from hospital to cold homes. Assess need for immediate and longer term action in advance of discharge. Consider referral but don't delay discharge.
- Harness the non-health and social care work force (such as heating engineers and meter installers) going into homes to identify people at risk, advise them and refer appropriately.
- Training of health and social care staff, housing and voluntary sector workers and technical staff. In the health risks of cold homes, what can be done to mitigate them and how to help clients sensitively and effectively.
- Raise awareness among professionals and the public about how to keep warm at home. Publicity depends on central and local leadership and drive e.g. from DECC, DH, PHE, HWBs and Local Authorities.
- Make sure buildings meet ventilation and other building and trading standards. Through enforcement of existing powers; don't make things worse.

A case study[11]:

A community nurse visited an elderly gentleman with severe respiratory disease. He was on a continuous oxygen supply driven by an electric pump. She asked him about his electricity contract and learned that he was on a pre-payment meter and had to go out to top up his credit at least once a week.

The nurse had just been on a training course about cold homes and health so knew that the local health and housing service could help him and therefore referred him. An adviser worked with him to get him onto a better tariff, helped him claim unclaimed pension credit, get him onto his energy suppliers emergency list to ensure a continuous supply (of electricity and oxygen!) and saved him several hundred pounds a year.

Cost Benefit Evidence

Cold Homes and Health[12]:

Direct effects of cold homes include: Heart attacks, stroke, respiratory disease, flu, falls and injuries, hypothermia. The indirect effects include: Poor mental Health, Carbon monoxide. The impact of cold homes on health services include: increased demand on

[11] Source : Centre for Sustainable Energy
[12] Source: Dr Angie Bone, Head of Extreme Events and Health Protection, Public Health England (www.cse.org). extremeevents@phe.gov.uk

health and emergency services. The paper: 'DECC - Fuel Poverty: A Framework for Future Action' states: 'Policies that improve the thermal efficiency of dwellings tend to be more cost effective for addressing fuel poverty compared to policies that are focused on subsidising energy costs or increasing incomes.'

The Paper 'The Cost of Poor Housing to the NHS' (produced by Simon Nicol, Mike Roys, Helen Garrett, BRE) shows £848M savings to the NHS per annum if the hazard of excess cold is fixed:

Hazard	Number of Category 1 Hazards	Average repair cost per dwelling (£)	Total cost to rep (£)	Savings to the NHS per annum if hazard fixed (£)	Payback (years)
Excess cold	1,325,088	4,574	6,061,192,123	848,398,538	7.14
Falls on stairs	1,352,837	857	1,159,516,031	207,099,936	5.60

d) Local Evidence – Greater Manchester

Warm well families' research has looked at children with asthma:

Angela Todd from the University of Manchester has conducted significant studies showing the links between cold homes and children with asthma:
http://www.shu.ac.uk/research/hsc/ourexpertise/warm-well-families
She has also produced 'pen portraits' to give different demographics stories of being in fuel poverty. [13]

LA based schemes over the years:

GM has had a few energy efficient schemes delivered in collaboration with health. The GM Fuel Poverty Strategy details how some of the LAs have in recent years worked with health, however this has been sporadic across GM and not all schemes have been long term:
http://www.agma.gov.uk/cms_media/files/7_annex_gm_fuel_poverty_paper.pdf?static=1

Current GM Schemes

Warm Homes Oldham:
In August 2012 Oldham Council, the Oldham Clinical Commissioning Group (CCG) and Oldham Housing Investment Partnership (OHIP) signed the country's first 'Joint Investment Agreement' to help tackle fuel poverty in the Borough. This is the first in a series of projects that will come out of the Public Service Reform work that Oldham Council is leading on.

The fuel poverty project was commissioned out for delivery to Keepmoat (regeneration specialist) from April 2013. The project and contract was initially for 1 year, but has since been extended further and the project is entering into the 3rd year of delivery. In Year 2 of the project worked with 528 households, of these 412 households have been

[13] Also FILT evaluation:http://www.shu.ac.uk/research/cresr/ourexpertise/foundations-independent-living-trust-filt-warm-homes-evaluation

helped out of fuel poverty, accounting for 1247 people in total. The programme is evaluated by the Centre for Regional & Economic Studies at Sheffield Hallam University, which reviewed the realised health & wellbeing benefits to participants of the project.

For every individual lifted out of fuel poverty, Oldham CCG have allocated £250 and Oldham Council £50 into a fund for future investment.

Key findings include the following:

- 60% of respondents with a physical health problem felt that the initiative had a positive impact on their health
- Four-fifths reported that the project had a positive impact on their general health and wellbeing
- Almost all of those who self-reported as being at 'high risk' of mental illness on completion of the General Health Questionnaire moved to 'low risk' following the initiative
- 96% of respondents agreed that their home was easier to heat as a result of their involvement in the project; and 84% agreed that they now spend less on their heating.

The CCG have also done their own analysis from a sample of nearly 800 people that were supported through the scheme, A&E attendances for the participants had gone down by 2% and emergency hospital admissions by 32% – with an estimated saving of nearly £40,000 to the CCG. Five individuals had their GP and prescription use analysed and this showed that total GP appointments went down by 8% while the cost of drugs prescribed increased by 14% – this may be due to the patients better managing their conditions at home. Already this gives an initial indication that the project has been successful across financial, health and wellbeing, and comfort criteria. The health service calculates it will save £250 a year in reduced hospital admissions and social costs for every person lifted out of fuel poverty.

AWARM Wigan:

In 2015 Wigan Council received financial support from The National Institute for *Health* and Care Excellence (*NICE*) to continue and expand on delivery of their AWARM scheme to assist fuel poverty residents. The £200,000 project is funded by NICE, Wigan council and the Clinical Commissioning Group (CCG). 2,000 people in Wigan will be targeted over the next two years to alleviate them out of fuel poverty. Suitable residents are being identified through data from local GP clinics and surgeries. Referrals for the scheme also come from community health champions, the fire service, hospital discharge teams and wider primary care – in addition to referrals from health, housing and social care professionals visiting people in their homes.

Other health related fuel poverty schemes in GM include: Bolton Council's 'Safe, Warm and Dry' scheme, 'Healthy Heating' Scheme.

DECC catalogue of health related fuel poverty schemes across the country:

DECC commissioned National Energy Action in December 2014 to carry out an online survey to catalogue local schemes that are targeting individuals with health problems for energy efficiency measures and other fuel poverty interventions. The aim of the survey was to collate information on health-related fuel poverty schemes to better understand levels of activity in this area and highlight challenges to implementation, as well as

successful approaches. The catalogue has survey responses and interviews from around 75 schemes with details of any health referral systems used to identify and target households with health problems and their funding sources.

The catalogues includes for GM: Oldham (pg166), Bolton (pgs 33,188), Wigan (pgs 15, 186), and Manchester (AWARM pg 13, Citizens Advice Bureau pg 104). https://www.gov.uk/government/publications/catalogue-of-health-related-fuel-poverty-schemes)