SHIELD: Social care Heat action Implementation to protect Everyone in Long-term care & Domiciliary services

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Outstanding Society Extreme Weather learning

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SHIELD: Social care Heat action Implementation to protect Everyone in Long-term care & Domiciliary services

- Dr Daniel Hind, University of Leeds

This project will co-design strategies for getting evidence-based heat safety policy better implemented in older adult social care (care homes and home care). Contributors include people with lived experience or care workers and managers from domiciliary care, extra care and the care home sector, as well as local government and the NHS.

UK Health Security Agency

CareQuality Commission

NCF THE NATIONAL CARE FORUM

INFORM, REPRESENT & CELEBRATE care and support west Promoting quality in Health, Social Care & Support Services

Westward Care

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West Yorkshire Health and Care Partnership

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HEALTHCARE IRELAND GROUP

directors of adass adult social services West Midlands

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LSE THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

UNIVERSITY OF LEEDS

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UNIVERSITY of York

QUEEN'S UNIVERSITY BELFAST

Heat is already killing people in English social care

- Excess deaths, five heat episodes, England, 2022: est. 2,985
- “older people aged 65 years and over are at risk of adverse effects of heat and more so for older people in care homes.”

UK Health Security Agency. AWHP Supporting Evidence (2024)

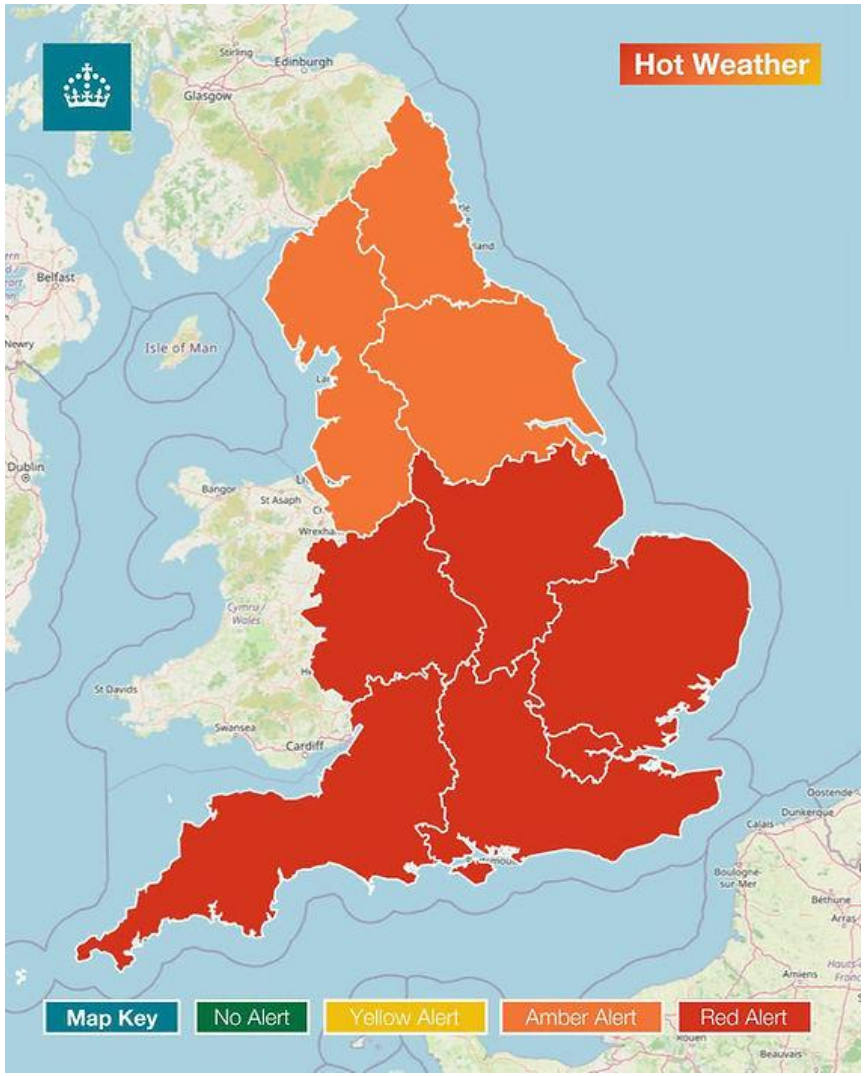
- Most heat attributable deaths happen at sub-alert temperatures

Howarth, 2023, Submission to the Environmental Audit Committee Call for Evidence on heat resilience

- 2026: 2,877 heat-associated deaths across the two early-season episodes (95% CI 2,476–3,278) - 753 in May, 2,124 in June

UK Health Security Agency. Interim heat mortality monitoring report, England: May and June 2026 (30 Jul 26)

UKHSA Heat Alerts (2022)…



… and summary action cards (2023)

UK Health Security Agency

Heat-Health Alert summary action card for care homes and other adult social care residential settings

This is a summary of the suggested actions for managers in this setting at each alert level. Check the Heat-Health Alert action card for health and social care providers for more detail, including what to do before summer, and adapt actions for your service as appropriate.

Summary actions for a yellow alert

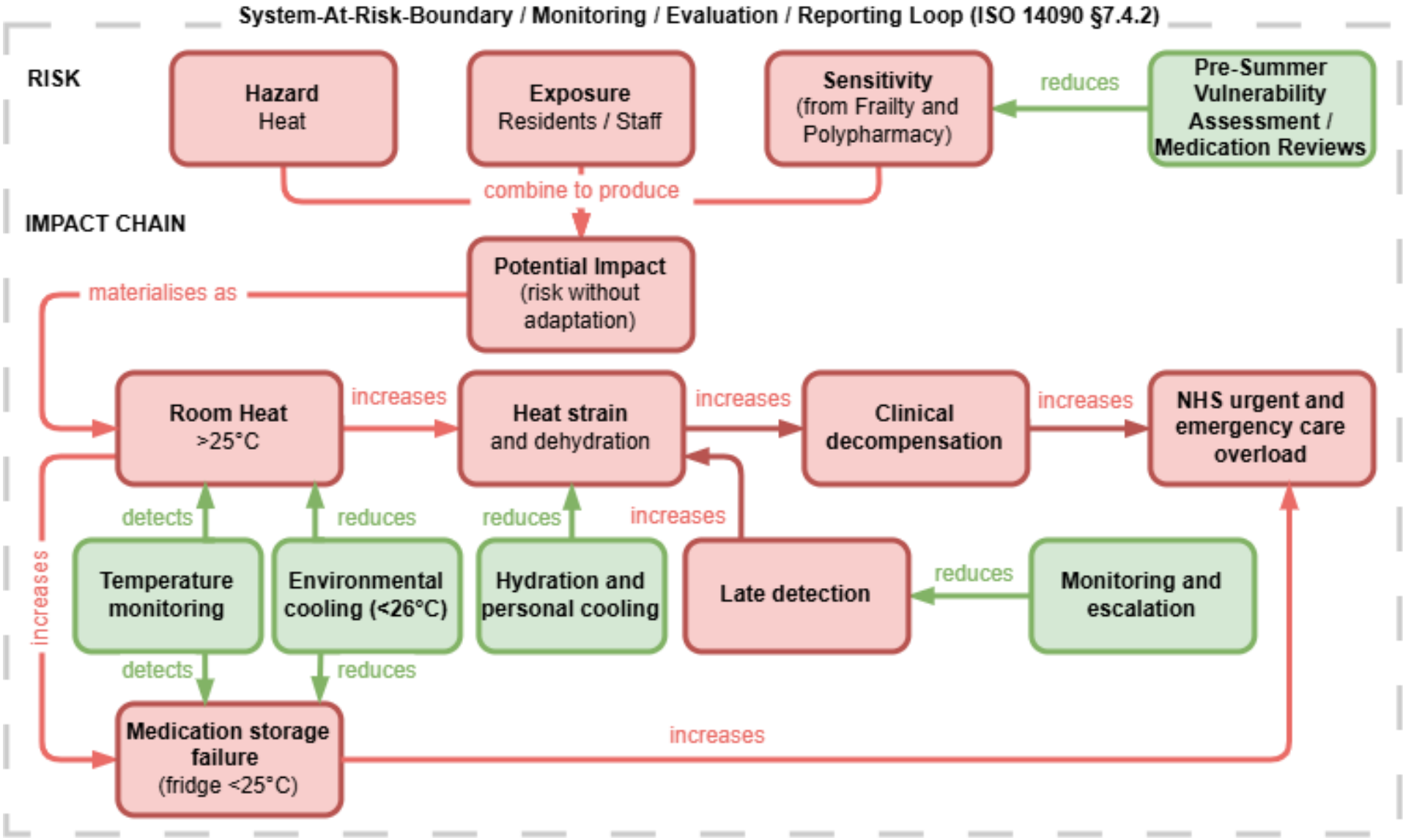
- ☐ Conduct a local risk assessment for hot weather in your area and your organisation's response, consulting the Heat-Health Alert, guidance and full action card
- ☐ Confirm that staff are aware of business continuity and hot weather plans and received the Heat-Health Alert. Share it with staff if they have not received it
- ☐ Share and explain the importance of Beat the heat messages to clients and staff, including raising awareness of heat illness signs and prevention
- ☐ Ensure staff check thermometers are installed and working, and monitor temperatures inside buildings especially where people spend most time
- ☐ Ensure staff keep certain rooms or areas below 26°C, giving people a place to cool down, and keep the building as cool as possible (for example, by closing windows when it's hottest and opening windows when it is cooler outside, such as at night)
- ☐ Review, prioritise and monitor individuals most vulnerable to heat-related illnesses
- ☐ Assess staffing levels, recognising possible increased care needs during hot weather
- ☐ Ensure staff promote client hydration, offering cold water and ice regularly
- ☐ Ensure medication is stored according to instructions
- ☐ Encourage and enable staff to carry water and stay hydrated, and report concerns about their own health promptly

Summary actions for an amber alert

- ☐ Continue yellow alert actions
- ☐ Follow your local business continuity and/or hot weather plans
- ☐ Ensure that staff monitor the temperature of at-risk individuals and their environment
- ☐ Advise staff and clients to raise concerns promptly, as heat illnesses can worsen fast

Summary actions for a red alert

- ☐ Continue amber alert actions
- ☐ Follow all local emergency response plans and continue to monitor the current situation by checking the weather alerts or local news
- ☐ Actively monitor all clients during hot weather episodes and monitor compliance with actions to keep living areas as cool as possible and cool rooms or areas below 26°C



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UK Health Security Agency

- Heat response was reactive, unplanned, and deprioritised below other pressures
- Guidance reached managers but rarely reached frontline and agency staff
- Hydration was done well; cooling infrastructure and staff welfare weren't

Research and analysis

Research exploring the experience of social care practitioners in relation to extreme temperatures

Published 22 January 2024

NIHR | Policy Research Unit
Policy innovation and evaluation

Adverse Weather and Health Plan: Process evaluation of local implementation in England

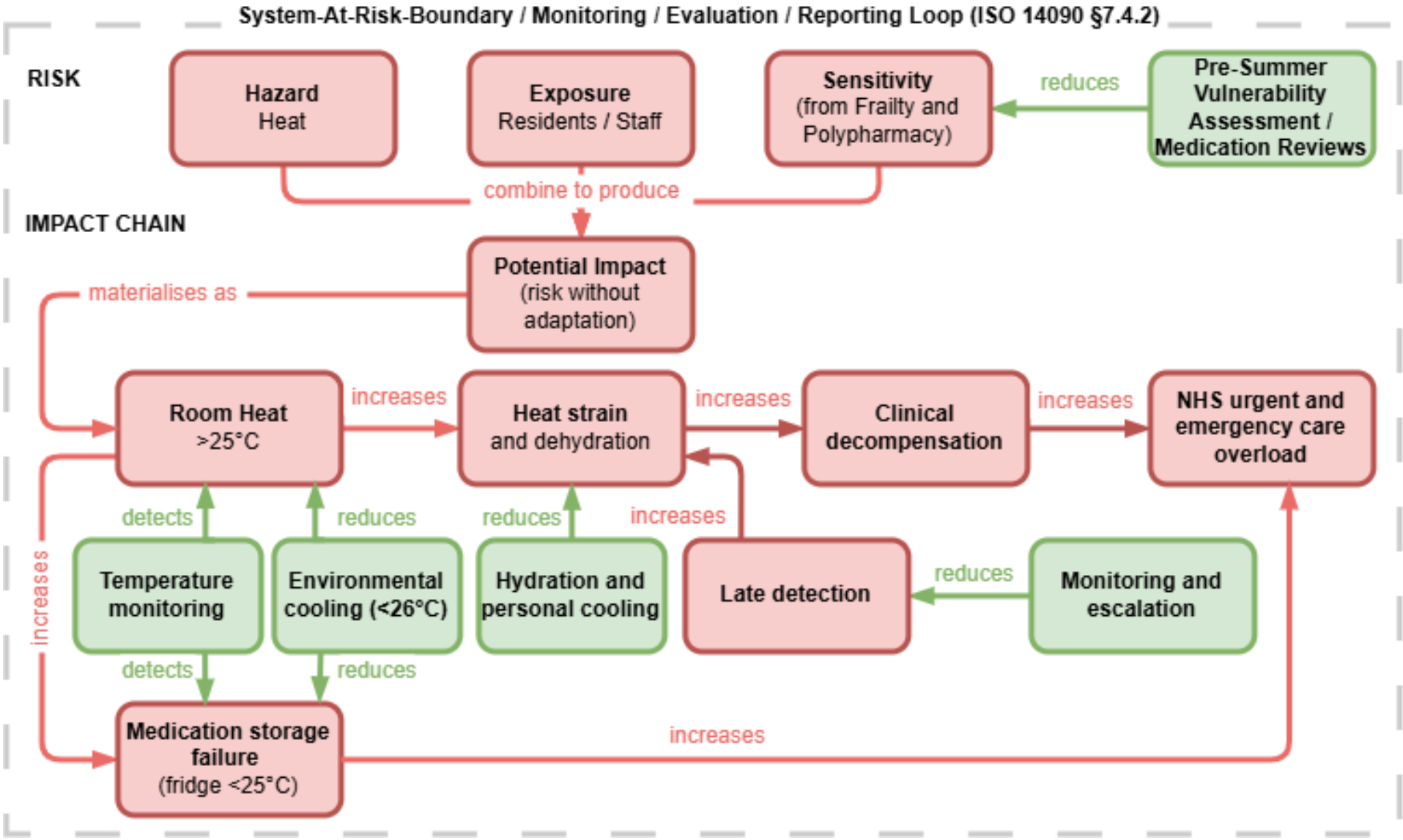
Principal investigator(s)

LSHTM
Dr Beth Jakubowski
Research Fellow

View profile →

LSHTM
Professor Cécile Knai
Deputy Director, Health Improvement

Results not out yet but will confirm the picture.



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‘Bad care’ problem, or absence of legislation / regulation?

- Homes rated ‘Good’ for safety: 1.75× risk of death at 25°C vs 16°C (outdoors)
- ‘Requires Improvement’: 2.14× risk of death at 25°C vs 16°C
- July 2022: nursing home deaths up 34% vs same calendar days in 23/24
- No ‘Inadequate’-rated inspection report mentioned heat preparedness/action

Hajat et al., *Age and Ageing*, 2026; Lochlainn, *Age and Ageing* 2026;55(5):afag114

- Post-2003 French reforms:
  - Plan National Canicule, ORSEC dispositions. Statutory municipal register of vulnerable people, statutory cool rooms in care homes.
- Heat wave of 2006: expected 6,450 deaths, observed 2,065 deaths

Fouillet A, et al. Int J Epidemiol 2008;37(2):309–17. doi:10.1093/ije/dym253

UK Care Quality Commission – *draft Adult Social Care assessment framework/ existing regulations*

- **Safe environments** flags environmental risks from adverse weather, including heatwaves.
- **Governance, management and sustainability** covers emergency preparedness including climate events.
  - *Good*: thorough business continuity plans incl. for adverse weather, with staff who know about them.
  - *Inadequate*: plans absent or not meeting people's needs, staff who don't understand them or know what to do.
- **Supporting people to live healthier lives** - identifying risk and preventing deterioration.
- **Three existing regulations**: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936), Part 3 - "fundamental standards" as a condition of registration: 12 (safe care and treatment), 15 (premises and equipment) and 17 (good governance).
- UK Health Security Agency's ***Adverse Weather and Health Plan****: protecting health from weather related harm, 2026 to 2027* confirms that CQC assesses adverse weather preparedness.
- **The audit trail**: risk assessment → plan → staff who know what to do → evidence in incidents and drills.

Heat is natural. Heat deaths are not. #NoNaturalDisasters

- Older people die in heat because of how:
  - Buildings are designed and adapted
  - Services are staffed
  - Care is commissioned, regulated and legislated upon.

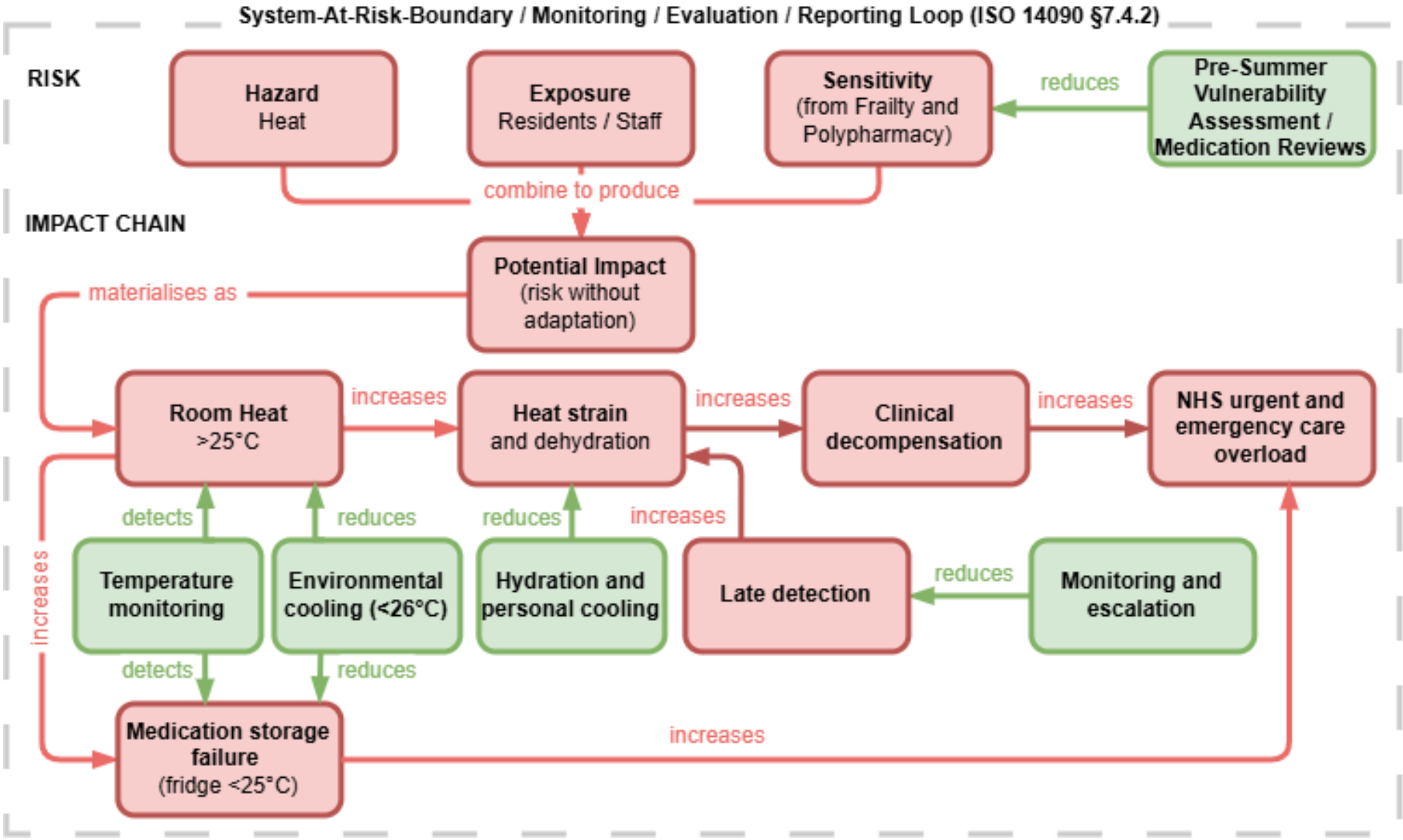
~~"Died of natural causes during the hot weather"~~	"Died in a building that could not be kept cool"
~~"Excess deaths"~~	"Preventable deaths"
~~"Vulnerable residents"~~	"Residents placed at risk by medication and building conditions"
~~"Unprecedented heat"~~	"Forecast heat"
~~"The heatwave killed 3,000 people"~~	"3,000 people died because services were not ready for forecast heat"
~~"Nothing more could have been done"~~	"Here is what can be done before next summer"

These are the incentives…

"My mum was **also in the attic in an old building… staff been in such distress that they forget to do key tasks… a lot of the staff are doing 12/12 hour shifts** and actually in that extreme heat… there was a thermometer in Mum's room, but it was to monitor the room temperature because she had a certain cream that… It could be explosive. I think if it got to a certain temperature. So **there was a thermometer to measure the temperature for the cream, but not for the people**."

…for our fragmented system leadership

"They were in… an **old house** that was converted into a care home and their rooms were unfortunately on the **top floor**. So you can imagine what that was like in heat. There were problems with opening and closing the windows… I was told to buy a fan… because **the care home couldn't cope with it**… the care home lift broke down and **my parents and other residents were actually trapped in their rooms on the top floor…And it was sweltering hot… there was no air con or anything.**"



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Long-term conditions
(Devices for Dignity)

Leveraging implementation science to solve the big problems: a scoping review of health system preparations for the effects of pandemics and climate change

*Georgia Fisher, Carolynn L Smith, Lisa Pagano, Samatha Spanos, Yvonne Zurynski, Jeffrey Braithwaite, for the Observatory on the Future of Healthcare**

"Implementation science offers proven tools to close the evidence–practice gap, yet has been almost entirely absent from climate adaptation in health and social care, particularly in planning and delivery"

Fisher G, et al. Leveraging implementation science to solve the big problems: a scoping review of health system preparations for the effects of pandemics and climate change. The Lancet Planetary Health 2025;9(4):e326-e336. doi:10.1016/S2542-5196(25)00056-7.

Lancet Planet Health 2025; 9: e326–36

*Collaborators listed at the end of the Review

Centre for Healthcare Resilience and Implementation Science (G Fisher PhD, C L Smith PhD, L Pagano PhD, S Spanos PhD, Prof Y Zurynski PhD, Prof J Braithwaite PhD) **and the Observatory on the Future of Healthcare** (G Fisher, C L Smith, L Pagano, S Spanos, Prof Y Zurynski, Prof J Braithwaite), **Australian Institute of Health Innovation, Macquarie University, Sydney, NSW, Australia**

Structured Pathway for Real-world Implementation (SPRINT)

WHAT CHANGES - four practice bundles

- **Objects and procedures**
  The things people use - tools, forms, kit, protocols
- **Interaction strategies**
  The new conversations and hand-offs the practice requires
- **Rules and resources**
  Time, money, workforce, IT, governance
- **Institutional logics**
  Whether the practice is legitimate and worth the effort

HOW IT'S LEAD

- Operational, relational, process and authorising Leadership

HOW IT CHANGES - six domains, 22 strategies

- **1. Mobilisation** *(#1–3)*
  Convert mandate into governable action: plan, roles and authority, champions
- **2. Fit-to-setting** *(#4–7)*
  Fixed vs adaptable; redesign pathways; secure resources; remove blockers
- **3. Buy-in** *(#8–11)*
  Why it beats current practice; what success is; what's in it for deliverers
- **4. Enable action** *(#12–14)*
  Deliver without destabilising the rest; trust and protection; skills and tools
- **5. Supporting appraisal** *(#15–18)*
  Track, interpret, hear informally, revise
- **6. Sustainment** *(#19–22)*
  Data skills, team structures, policy and governance, define normalisation

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May CR, Hillis A, May CM, Gilbert AW, Ayton D, Desveaux L, et al. SPRINT: a Structured Pathway for Real-world Implementation. *Implementation Science Communications*. Accepted for publication 15 July 2026.

Median absolute improvement in care

SPRINT domain	Strategy	Evidence	Effect
Mobilisation + Buy-in	**Local opinion leaders**	**18 RCTs**	**OR 12% (IQR 6.0–14.5%)**
Fit-to-Setting	Tailored strategies	32 RCTs; meta-regression (15)	OR 1.56 (95% CI 1.27–1.93)
Enable action	Printed educational materials	14 RCTs, 31 ITSs	OR 2.0% (range 0–11%)
	Educational meetings	81 RCTs	6.0% (IQR 1.8–15.3%)
	Educational outreach	69 RCTs	OR 4.8% prescribing (IQR 3.0–6.5%); 6.0% other (IQR 3.6–16.0%)
	Computerised reminders	28 RCTs	OR 4.2% (IQR 0.8–18.8%)
Support appraisal	Audit and feedback	140 RCTs	OR 4.3% (IQR 0.5–16%)

Empirical observations of professional behaviour change from Powell BJ, et al. Enhancing the impact of implementation strategies in healthcare: a research agenda. *Front Public Health*. 2019;7:3. doi:10.3389/fpubh.2019.00003

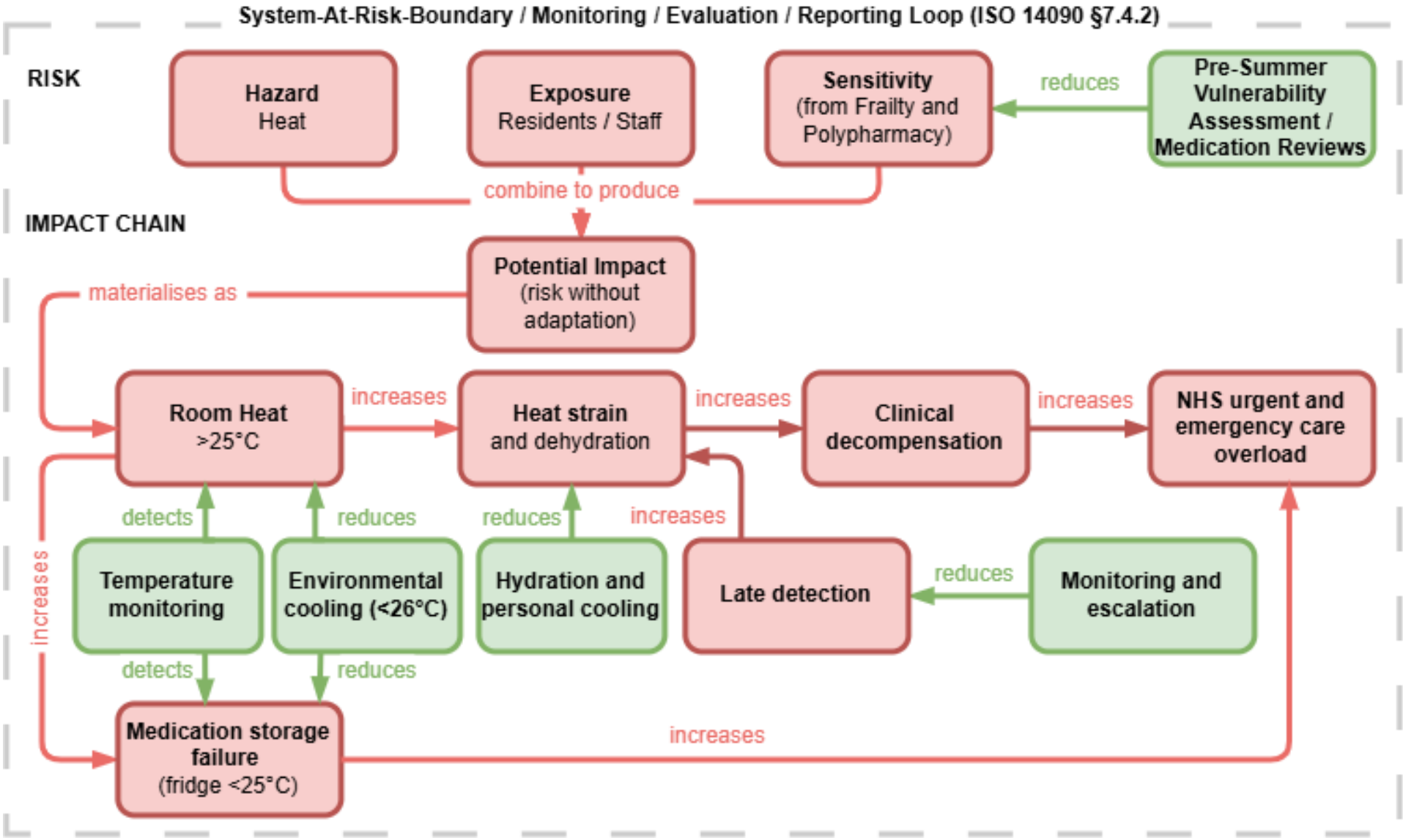
Tier	Health System	Government / local government	Representative bodies
Supranational	WHO Europe (HHAP guidance)	ISO 14090 / 22395 / 25557; United Nations Framework Convention on Climate Change obligations	-
National	Department of Health and Social Care; UK Health Security Agency; Care Quality Commission	Ministry of Housing, Communities and Local Government; Cabinet Office; Met Office; Care Quality Commission	National Care Forum, Care England, Skills for Care, Association of Directors of Adult Social Services, Association of Directors of Public Health; Local Government Association (LGA)
Region	NHS regional teams (7); UKHSA regional health protection/ EPRR	Government regional resilience structures; mayoral strategic authorities (West Midlands CA, West Yorkshire CA, North East CA)	Association of Directors of Social Care / Public Health regional bodies. Skills for Care Heads of Region/ Senior Regional Transformational Leads
Subregion/ 'System'	Local Health Resilience Partnership, Integrated Care Board (ICB)	Local Resilience Forum (police-force footprint); Integrated Care Partnership; Better Care Fund pooled budget	Skills for Care Locality managers (registered manager network)
'Place'	ICB Place Team	Upper Tier Local Authority, Directors of Public Health and Social Care	LGA local associations
Neighbourhood	Primary Care Networks; Enhanced Health in Care Homes GOP; district nursing; community pharmacy; neighbourhood health teams	District/borough functions (housing standards, environmental health); VCFSE, Age UK, Red Cross, faith networks	-

Co-produced implementation strategies

11 workshops

- Preparedness (staff readiness, safety, staffing levels, business continuity plans, organisational/ individual risk assessment)
- Response (environmental Controls (thermometers, cool spaces, meds, personal comfort, hydration, monitoring/escalation)

- Local government: 32
- Care home providers: 18
- Home care providers: 20
- Healthcare: 9
- UKHSA etc: 10
- Care sector representative bodies: 7
- Association of Directors of Adult Social Services: 5
- Public representatives / relatives / unpaid carers: 7
- Regulators: 2



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IF WE...

use these implementation strategies

Mobilisation:
Converting mandate into governable action

Fit-to-Setting
Making the work fit 15-minute visits / care home rounds

Get Buy-In
Making the work meaningful to those affected

Enable Action
Equip staff to do the work

Learning/ Reconfiguration
System self-improvement

Sustainment
Institutionalise the new practice

THEN WE CAN...

put the system in a state of readiness

Understand sensitivity to hazard

- isolation
- frailty
- housing overheating
- medication-related

Be ready to act

- Plans in place and staff alerted;
- Equipment ready - thermometers, fans, cool rooms;
- Staffing assessed;
- Beat the Heat messaging live
- Staff welfare enabled

SO THAT...

protective actions are delivered and monitored

Deliver

- Keep rooms below 26°C, shading, ventilation, fans;
- Hydration and personal cooling: cold water, ice, cool washes, cooler clothing;
- Store medicines safely

Monitor

- Monitor temperatures - room and at-risk residents;
- Spot and escalate deterioration early using SBARD

SO THAT...

residents and the system are protected

Fewer

- Helpline/emergency calls
- Ambulance dispatches and conveyances
- A&E attendances ·
- Unplanned admissions ·
- Deaths

What we're changing (4 practice bundles)

Interaction strategies - *the conversations and hand-offs*

Rules and resources - *time, money, workforce, IT*

Institutional logics - *whether it's legitimate and worth doing*

Objects and procedures - *the things people use*

Objects and procedures - *the things people use*

- **Write guidance for carers (not managers)** → one page per alert level: what to do this shift, what to watch for, when to escalate; easy-read and visual.
- **Instruments** → develop / validate risk assessment tools; develop a heat version of RESTORE2 and SBAR(D).
- **Kit** → pre-summer kit as a defined product — thermometers, fans, cooling aids, storage aids - card thermometers reprinted for summer as well as winter.

Common Heat Death/Illness Risk Factors

1. **Confined to bed** — OR 6.4–9.6 *(Bouchama 2007; Vandentorren 2006)*
2. **Psychiatric / mental disorder** — OR 3.6–5.9 *(Bouchama 2007; Vandentorren 2006)*
3. **Bedroom under the roof / top floor** — OR 2.3–5.4 *(Vandentorren 2006)*
4. **Unable to care for self / ADL disability** — OR 2.5–4.0 *(Bouchama; Vandentorren; Laverdière 2016)*
5. **Cardiovascular disease** — OR 2.5–4.7 *(Bouchama 2007; Vandentorren 2006; Laverdière 2016)*
6. **No social contact / activities** — OR 6.1 *(Bouchama 2007; Vandentorren 2006; Laverdière 2016)*
7. **Not leaving home daily** — OR 3.4 *(Bouchama 2007)*
8. **Psychotropic medications** — OR 1.9 *(Bouchama 2007)*
9. **Diuretic medications** — OR 2.4–2.9 *(Laverdière 2016)*
10. **Low household income** — AOR 2.8–3.2 *(Laverdière 2016)*

Sources: Bouchama (2007) meta-analysis, 1,065 heatwave deaths; Vandentorren (2006) case-control, France 2003; Laverdière (2016) 5-year prospective cohort, Québec

Risk assessment tools - unvalidated

#	Risk factor	HIST	CHILL'D OUT
1	Confined to bed	Partial - "dependence on carers"	Partial - "mobility limit ability to seek cooling"
2	Psychiatric / mental disorder	**Yes**	**No**
3	Bedroom under roof / top floor	**No**	**Yes** - "higher floor of multi-story building"
4	ADL disability / unable to self-care	Partial - "dependence on carers"	Partial — mobility question
5	Cardiovascular disease	**Yes**	**No** - only asks about medications generically
6	No social contact / activities	**Yes** - "social isolation"	**Yes** - "neighbour, friend, or family to check on them"
7	Not leaving home daily	**No**	**No**
8	Psychotropic medications	**Yes** - "psychiatric medications"	Partial - "medications that increase risk" (unspecified)
9	Diuretic medications	**Yes** - "diuretics" listed	Partial - same generic medication question
10	Low household income	**Yes** - "low-income populations"	**No**

Risk assessment tools - unvalidated

Framework	What it covers	What's missing for UK care homes
Australian ACQSC (regulatory guidance)	4 clinical domains: frailty, dementia, hydration difficulty, mobility. 4 environmental domains: uncoolable areas, solar gain, shade shifts, hidden outdoor areas	No medication list; no scoring; not validated
NuAge OAHVI (cumulative index)	9 categories scored 0–1: physical health, mental health, autonomy, CNS meds, cardiovascular meds, social isolation, low SES, heat island, absence of protective factors. ≥6/9 = 7–8× risk	Built for community-dwelling adults; social isolation and SES score differently in residential care; no room-level assessment; not validated

RESTORE2 mini · heat-specific · home care *Recognise early heat-related soft signs · take observations · respond · escalate*	**USE WHEN:** UKHSA Heat-Health Alert is Yellow, Amber or Red	Client name: DOB / NHS no.: Date / time:

Ask your client: how are you in this heat? *Then look — at the client and at the home.*

SOFT SIGNS IN THE CLIENT — any of these?

- Skin **very hot, flushed**, OR unusually **pale, clammy or sweaty**
- **New or worsening confusion**, agitation, drowsiness — not their usual self
- **Headache**, dizziness, or feeling **faint on standing**
- **Refusing fluids** or not finishing usual drinks; dry mouth; sunken eyes
- **Less urine than usual** — darker, stronger-smelling; drier pad
- **Muscle cramps**, weakness, unsteadiness, new falls
- **Extreme tiredness** or sleeping much more than usual
- **Nausea, vomiting or diarrhoea**
- **Reduced response** — quieter than usual, slower to answer, harder to rouse

SOFT SIGNS IN THE HOME — look around

Take out the kit thermometer. Place it on a surface away from direct sun for 2–3 minutes, then read it. Record the room temperature on the back of this card and in the SBARD if you escalate.

- Living room or bedroom feels **stifling** — or thermometer reads **26 °C or above**
- **Windows shut** in the heat of the day; curtains/blinds **open to direct sun**

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RESTORE2 mini · heat-specific · home care *Recognise early heat-related soft signs · take observations · respond · escalate*	**USE WHEN:** UKHSA Heat-Health Alert is Yellow, Amber or Red	Client name: DOB / NHS no.: Date / time:

COOL FIRST — what to do before you call

1. **Move** the client to the **coolest room**. Open windows on the **shaded** side; close curtains on the **sunny** side.
2. **Strip back layers** — light clothing only. Remove blankets and any duvet.
3. **Sips of cool fluid** — small amounts, often. Measure what's taken. Don't force, but offer repeatedly. Avoid very cold drinks if they bring on cramps.
4. **Damp flannel** to neck, wrists and face; a fine **water spray** to bare skin if tolerated.
5. **Fan if tolerated** — but if the room is **very hot (above about 35 °C)** switch to **wet cloths and skin spray** instead; in extreme heat fans can make things worse.
6. **Check medicines** — anything stored on a windowsill, in direct sun, or in a warm fridge? Move to the coolest cupboard and note it for the SBARD and the office.
7. **Wait and watch for 20–30 minutes** if you can. If you can't, **arrange the watch** before you leave (see Side 2, step 6).

THEN ESCALATE — use SBARD on the phone

Read down the column. Have the room temperature, what you've done, and your client's medication list to hand before you dial.

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Read down the column. Have the room temperature, what you've done, and your client's medication list to hand before you dial.

SBARD step	What you say	Heat-specific example (home care)
S — Situation	Who, where, what's wrong now	*"Mrs P, 84, lives alone. Visit at 11:00 — she's very confused, much more than usual. Living room 31 °C, windows shut, curtains open to direct sun."*
B — Background	Conditions, medications, baseline	*"Dementia, heart failure. On furosemide and amitriptyline. Normally chatty and orientated. Daughter saw her well last night."*
A — Assessment	What you see, room temperature, what you've done	*"Skin hot and dry. Refusing fluids. Room 31 °C measured with kit thermometer. Moved her to cooler bedroom (27 °C), light clothing, sips of water, damp cloth to neck. No improvement after 20 min."*
R — Recommendation	What you think is needed — say it plainly	*"I think she needs urgent assessment today — ambulance or GP visit, please advise."*
D — Decision	What's been agreed — and by whom	*"Agreed with 111 clinician at 11:35: ambulance dispatched, ETA 40 min. Daughter called, on her way. I'm staying until ambulance arrives."*

Interaction strategies - *the conversations and hand-offs*

- **'The cascade dies in the manager's inbox'** → worker acknowledgement so managers can see it reached the home care shift; alert level as a standing item at every care home shift handover.
- **Staff fear escalation will rebound on them** → heat-adapted SBARD agreed locally with crews, and the referral problem taken to the national ambulance body.
- **Cooling negotiated mid-heatwave with someone who refuses preventive care** → pre-summer cooling conversation with client/resident and family, recorded in the care plan. Top-rated home care item; activate a pre-agreed plan.
- **Temporary staff arrive 'cold', when continuity matters** → heat induction on staff arrival at care home; a heat-specific handover note on every agency-cover home care visit.

Rules and resources - *time, money, workforce, IT*

- **The NHS gets the benefit, social care pays the cost** → can we build a costed admissions-avoidance case so money can flow out of the NHS?
- **Emergency contract clauses only pay retrospectively, never for preparation** → pre-agreed amber/red flex at ring-fenced rates, and heat written into the 2028 contract renewal cycle now, while specifications are being scoped?
- **Contracts over-specified and under-monitored** → a small number of monitorable requirements sitting under existing duties to keep people safe, rather than a separate heat specification?
- **Small providers have no planning capacity and no IT** → a pre-populated plan template co-developed with the local authority, and heat status in the care record rather than on a separate form?

Institutional logics - *whether it's legitimate and worth doing*

- **"Old equals cold" — England doesn't get dangerously hot** → annual pre-summer briefing using England's mortality data ('even in cool summers').
- **The system convenes for winter pressures, not for summer** → a summer equivalent of the winter letter and seasonal cycle, framed as system pressure - beds, ambulances, discharge.
- **Escalating isn't provider failure** → recognise heat as a safeguarding concern and count a rise in appropriate heat alerts as improved recognition rather than declining quality.
- **Refusal of care doesn't mean non-compliance** → the accountable act is making the offer and recording the prompting, not compelling. And "vulnerable" becomes "priority".

How we change it (the six stages)

1: Mobilisation – *from mandate to governable action*

2: Fit-to-setting - *making it work in real buildings and real visits*

3: Buy-in - *making it matter to frontline staff*

4: Enable action - *equipping without destabilising*

5: Supporting appraisal - *making the system visible*

6: Sustainment – *normalise all of the above*

1: Mobilisation – *from mandate to governable action*

- **No one 'owns' heat; staff turnover affects know-how** → appoint care home heat leads on the Infection Prevention and Control-lead model, to cascade and review post-season; home care locality champions outreaching to agency and zero-hours staff.
- **The mandate is diffuse** → standardise and enforce local government care commissioning clause with quality-statement framing.
- **Reactive not proactive is the default / managers of SMEs already have multiple roles** → "ready by 1 May" play book; dated annual heat risk assessment signed by manager.
- **Business continuity plans cover snow, not heat; providers sit outside emergency planning** → insert heat into the existing Business Continuity Plan; include social care in Local Resilience Forum and alert-cascade arrangements.

2: Fit-to-setting - *making it work in real buildings and rounds*

- **Managers avoid assessment if it could indicate unaffordable capital works** → we need to offer cooling options as a hierarchy –low-cost operational actions, then capital - with documented, justified residual risk as a legitimate endpoint.
- **The care home estate is too varied for a one-size-fits-all approach; risk differs within a homes** → building-specific risk assessment flagging home's hot zones and constraints, with monitoring targeted at upper floors, south-facing rooms and conservatories.
- **No time to add anything to a home care visit; care home managers can't take on another role** → embed heat in existing processes: the spring care-plan review, the work management system, the shift handover.
- **Where the building can't be cooled** → cool the medicines instead: an air-conditioned, fridge-equipped medicines room in care homes. Home care to consider use of council-owned cool spaces opened from 1st May.

3: Buy-in - *making it matter to frontline staff*

- **The care home has fire drills, a named fire lead and window restrictors — but heat is deprioritised** → Hold a mortality briefing before the heat season
- **Social care providers think the cost of preventive heat action falls on them, but the benefits accrue to the NHS** → we have to make heat safety tractable in the sector's 'metrics that matter' – the CQC's safe environments, governance and emergency preparedness statements: this is care quality not an 'unfunded extra'.
- **The providers who engage are the ones already doing well** → reach the rest through registered manager networks, sector body newsletters and an April induction cycle.
- **Success defined by commissioners; client voice absent** → agree multi-perspective success criteria pre-summer; lived-experience members on commissioning panels.

4: Enable action - *equipping without destabilising*

- **Regulatory conflict:** Fire doors must stay shut; restrictors cap windows at 10cm, preventing ventilation; infection prevention and control sometimes translated into not leaving drinks at the bedside affecting hydration. No clear solution.
- **Pre-season training decay** → induction on arrival for temporary staff, late-spring refresher, new-starter induction, 3-5-minute daily briefings during alert weeks.
- **Staff need permission to personalise** → authority to adapt, plus a menu of alternatives - footbaths, wipes, preferred drinks, visual cueing - for when the default playbook fails.
- **Staff are concerned that escalation will rebound on them** → blame-free escalation, a one-page decision tree, pre-agreed routes to helplines, GP and community nursing to avoid so emergency service overload. Staff welfare permission structure: cool spaces on the round, water, buddy check-ins for lone workers.

5: Supporting appraisal - *making the system visible*

- **Temperature thresholds don't have corresponding actions.** 26°C for cool rooms, 8°C for the medicines fridge, 20°C for cold water → each threshold needs a named individual, a dedicated action, and a fallback action for when the breach cannot be fixed.
- **Incident logs minimise heat** falls, admissions, delirium episodes, UTI clusters → add a heat flag to incident reporting.
- **Debriefs are wanted – but there's no ownership.** → we need multi-agency debriefs within 72 hours of an amber or red episode, and an autumn lessons-learnt session across the area.
- **Implementation metrics to track :** a named person accountable for heat; a cool room and bedrooms held below 26°C; an up-to-date heat vulnerability assessment for higher-risk residents.

6: Sustainment – *normalise all of the above*

- **Nothing starts early enough** → autumn lessons-learnt, pre-summer briefings in April, ready for the May heatwave, activation triggered on the 6–15-day forecast, not the day
- **Home care workforce 25% p.a. staff turnover** → put heat into the Care Certificate , improve UKHSA domiciliary care guidance
- **Turnover depletes institutional memory, failures recur** → a post-season review must inform next year's plan, register and training — learning loop.
- **Regulated care doesn’t reach direct payment users, self-funders employing a personal assistant, and unpaid carers** → reach these groups by writing heat into Care Act assessments and reviews.

Next Steps

SHIELD-2

November 2026:	Full-stage grant application –cluster RCT of implementation bundle
February 2027:	Notification of outcome
May 2027:	Small tests of change in vanguard areas
	Refinement of playbook
	Research ethics application
November 2027:	Randomisation of 20-30 / 155 Local Authorities
January 2028:	Activation of systems leaders in experimental areas (Cluster RCT)
	Study powered to detect differences in A&E use / process indicators
April 2028:	Assertive outreach to social care providers in experimental areas
October 2028:	UK-wide Knowledge Mobilisation begins
April 2029:	Routine data available for analysis from summer 2028
	Statistical / health economic analysis and process evaluation
April 2030:	Project ends

Tier	Health System	Government / local government	Representative bodies
Supranational	WHO Europe (HHAP guidance)	ISO 14090 / 22395 / 25557; United Nations Framework Convention on Climate Change obligations	-
National	Department of Health and Social Care; UK Health Security Agency; Care Quality Commission	Ministry of Housing, Communities and Local Government; Cabinet Office; Met Office; Care Quality Commission	National Care Forum, Care England, Skills for Care, Association of Directors of Adult Social Services, Association of Directors of Public Health; Local Government Association (LGA)
Region	NHS regional teams (7); UKHSA regional health protection/ EPRR	Government regional resilience structures; mayoral strategic authorities (West Midlands CA, West Yorkshire CA, North East CA)	Association of Directors of Social Care / Public Health regional bodies. Skills for Care Heads of Region/ Senior Regional Transformational Leads
Subregion/ 'System'	Local Health Resilience Partnership, Integrated Care Board (ICB)	Local Resilience Forum (police-force footprint); Integrated Care Partnership; Better Care Fund pooled budget	Skills for Care Locality managers (registered manager network)
'Place'	ICB Place Team	Upper Tier Local Authority, Directors of Public Health and Social Care	LGA local associations
Neighbourhood	Primary Care Networks; Enhanced Health in Care Homes GOP; district nursing; community pharmacy; neighbourhood health teams	District/borough functions (housing standards, environmental health); VCFSE, Age UK, Red Cross, faith networks	-

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