

Working with the health sector to tackle fuel poverty

Healthy Homes
project final report

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1. SUMMARY AND RECOMMENDATIONS

Over thirty per cent of all Scottish households are living in fuel poverty today, despite a Scottish Government target to eradicate it by November 2016. These 748,000 households require help and support to tackle fuel poverty and this needs to be delivered in a timely, sustainable, and equitable manner.

Government-led efforts to tackle fuel poverty have largely focused on improving the energy efficiency of housing stock. Despite the successful output of many programmes and installation of energy efficiency measures, fuel poverty levels in Scotland have more than doubled since 2003, just after the Scottish Government set the target to eradicate fuel poverty by 2016. It is clear that tackling energy efficiency alone is not enough to lift families out of fuel poverty: a wider approach is needed which looks beyond the physical building and more holistically at all causes of fuel poverty and the individual experience.

The health implications of fuel poverty are well understood and widely accepted. There are examples of excellent partnership work between the health sector and energy advice sector. However, the health sector is currently underutilised in the provision and targeting of fuel poverty support.

The health and social care workforce needs to be adequately supported and resourced to help support people in or vulnerable to fuel poverty. It needs to be made as easy as possible for the health sector to engage in this agenda.

Recommendations

RECOMMENDATION 1: A new fuel poverty strategy must be developed as soon as possible, as well as new targets to tackle fuel poverty including interim targets to track progress.

RECOMMENDATION 2: A new fuel poverty strategy and Warm Homes Bill must take into consideration all drivers of and possible solutions to fuel poverty.

RECOMMENDATION 3: A cross-sectoral approach is needed to tackle the plight of fuel poverty and this should be built in to any future fuel poverty strategy.

RECOMMENDATION 4: Learning from existing pilots and projects should be analysed holistically to understand what works and what the barriers are, to encourage greater partnership work between the health sector and energy advice sector.

RECOMMENDATION 5: Fuel poverty issues should be included as part of core health inequalities training. This training should be made available at an early stage of practitioner professional development, and should be mainstreamed across departments.

RECOMMENDATION 6: Potential trigger points for fuel poverty identification and action should be investigated to embed this work into standard NHS practice.

2. FUEL POVERTY IN SCOTLAND

What is fuel poverty?

At Shelter Scotland, all our work is centred on ensuring there is a safe, secure and affordable home for everyone. This is where our work on fuel poverty comes in: for a home to be affordable and safe the fuel bills must be manageable.

In Scotland, 748,000 households live in fuel poverty – equivalent to over thirty per cent of the population¹. Officially, a household is in fuel poverty if it is required to spend over 10% of its income on energy bills, whilst maintaining a warm home.

There are two possible consequences for a household living in fuel poverty. Either, they spend over 10% of their household income on energy use, and have less money available for other uses, or they do not – and therefore do without the required energy to heat their home, power an electric shower, boil the kettle, or cook a hot meal. Fuel costs lead for many to a state of ‘fuel fear’ – individuals too afraid to use energy in the home because of the expense, or self-disconnecting.

Fuel poverty is caused by an interplay of four factors: low household income, high fuel costs, poor energy efficiency in the home, and how energy is used.

The interplay of these factors means that certain groups are more vulnerable to fuel poverty, including but not limited to:

- households with low income (around half of all fuel poor would be considered to be poor because of their income, and households in the lower income bands have the highest rates of fuel poverty: 92% for the bottom income decile and 56% for the 2nd bottom decile)
- people living in homes with a low energy efficiency rating (70% of those living in a home rated as having an Energy Performance Certificate (EPC) F or G, compared to 18% of those living in EPC B or C rated homes are in fuel poverty)
- older households² (45%), because they generally have lower income than working age households, generally live in larger properties, and have higher energy needs under the fuel poverty definition
- those who own their own property outright (45%), because of the large number of pensioners in this group.
- those living in rural areas (35%). The Scottish Rural Fuel Poverty Task Force³ identified 21 rural dimensions to fuel poverty including high energy bills that come with living in predominantly “off-gas” areas; higher than average consumption levels; exposure to adverse weather; higher unit costs for electricity, and other factors. In the 2014 Scottish House Condition Survey rural fuel poverty rates were much higher

A household is in fuel poverty if, in order to maintain a satisfactory heating regime, it would be required to spend more than 10% of its income (including Housing Benefit or Income Support for Mortgage Interest) on all household fuel use. If over 20% of income is required, then this is termed as being in extreme fuel poverty.

Source: The Scottish Fuel Poverty Statement, 2002

A satisfactory heating regime is defined as:

For “vulnerable” households, 23°C in the living room and 18°C in other rooms. For other households, this is 21°C in the living room and 18°C in other rooms. Income is defined by the Scottish Government as that of the householder and their partner not the whole household.

Source: Scottish House Condition Survey 2015

¹ Scottish Government (2016), Scottish House Condition Survey: 2015 Key Findings, <http://www.gov.scot/Publications/2016/12/1539>

² Older households are defined in the Scottish House Condition Survey 2015 as ‘Small households made up of one or two residents, at least one of which is aged 65 or older’

³ Scottish Rural Fuel Poverty Taskforce (2016) An Action Plan to Deliver Affordable Warmth in Rural Scotland, <http://www.gov.scot/Publications/2016/10/2017/downloads>

at 50%, and rising to 62% in Eilean Siar and 58% in Orkney. The decline shown in the latest statistics is partly attributed to the lower price of domestic liquid fuels.

The causes of fuel poverty are different for different groups and to effectively tackle fuel poverty an individualised approach is required which acknowledges all related factors.

How is fuel poverty being tackled?

Polices and strategies

In 2002 the Scottish Government made the ambitious target “to ensure that by November 2016, so far as is reasonably practicable, people are not living in fuel poverty in Scotland”⁴. In June 2016 the Scottish Government admitted their target to eradicate fuel poverty would not be met⁵, and the latest figures show 35% of households are living in fuel poverty⁶.

RECOMMENDATION 1: A new fuel poverty strategy must be developed as soon as possible, as well as new targets to tackle fuel poverty including interim targets to track progress.

To date, the Scottish Government have invested millions into tackling fuel poverty, focusing on raising the energy efficiency of homes. From an energy efficiency point of view, this has seen great success: there was a 74% increase in the share of the most energy efficient dwellings (rated C or better) between 2010 and 2015; and in 2015 37% of Scottish homes were assessed as EPC C or above⁷. The Scottish Government made energy efficiency a National Infrastructure Priority, with the Scottish Energy Efficiency Programme (SEEP) as its cornerstone to raise the energy efficiency rating of all buildings. Several local authorities have received money to fund pilot programmes to inform the development of SEEP which will be launched in 2017-18. Shelter Scotland believes that SEEP should aim for all homes to be brought up to at least an EPC rating C, in line with calls by the Existing Homes Alliance⁸ and the Commission on Housing and Wellbeing⁹ and the Scottish Fuel Poverty Strategic Working Group also recommended this for all properties of fuel poor households by 2025, with five-yearly targets set for progress towards EPC band B thereafter¹⁰.

In 2015, the Scottish Government set up two short life independent working groups, and both of these reported in October 2016¹¹. The Rural Fuel Poverty Task Force was set up in August 2015 in recognition of the serious and persistent nature of the rural fuel poverty problem, and their final report provided three guiding principles for the Scottish

⁴ As set out in the Scottish Fuel Poverty Statement 2002 and legislated for in the Housing (Scotland) Act 2001. Scottish Government The Scottish Fuel Poverty Statement 2002, <http://www.gov.scot/Resource/Doc/46951/0031675.pdf>

⁵ Scottish Government (June 2016), fuel poverty Strategic Working Group, <http://news.gov.scot/news/fuel-poverty-strategic-working-group#downloads>

⁶ Scottish Government (2016), Scottish House Condition Survey: 2015 Key Findings, <http://www.gov.scot/Publications/2016/12/1539>

⁷ Scottish Government (2016), Scottish House Condition Survey: 2015 Key Findings, <http://www.gov.scot/Publications/2016/12/1539>

⁸ Existing Homes Alliance (December 2016), Press release: Latest figures reveal too many Scottish homes still too cold, too damp, <http://existinghomesalliancescotland.co.uk/news/latest-figures-reveal-too-many-scottish-homes-still-too-cold-too-damp/>

⁹ Commission on Housing and Wellbeing (2016), One Year On, <http://housingandwellbeing.org/documents>

¹⁰ Scottish Fuel Poverty Strategic Working Group (2016), A Scotland without fuel poverty is a fairer Scotland: Four steps to achieving sustainable, affordable and attainable warmth and energy use for all, <http://www.gov.scot/Publications/2016/10/2273/downloads>

¹¹ Scottish Rural Fuel Poverty Taskforce (2016) An Action Plan to Deliver Affordable Warmth in Rural Scotland, <http://www.gov.scot/Publications/2016/10/2017/downloads>; Scottish Fuel Poverty Strategic Working Group (2016), A Scotland without fuel poverty is a fairer Scotland: Four steps to achieving sustainable, affordable and attainable warmth and energy use for all, <http://www.gov.scot/Publications/2016/10/2273/downloads>

Government to have in mind when developing their new fuel poverty strategy, as well as an action plan for affordable warmth which includes 53 proposed actions. They call for “a rural-proofed plan for effective delivery, which includes specifically rural fuel poverty targets and expected programme outcomes.”

The Rural Fuel Poverty Task Force’s guiding principles

- **Principle 1:** Fairness and social justice should be every household’s right, wherever in urban or rural Scotland they happen to live.
- **Principle 2:** All vulnerable households should receive the most effective practical help and support they need to keep their homes warm and at a cost they can afford.
- **Principle 3:** The progress made by Scottish Government in its strategic approaches to eliminating fuel poverty from peoples’ lives should be set within a statutory framework for delivery which is rigorously measured and held to annual account by the Scottish Parliament.

The Scottish Fuel Poverty Strategic Working Group was set up in November 2015 to “develop a vision for the eradication of fuel poverty in Scotland”, and specifically to outline a new fuel poverty strategy with recommendations for targets, scrutiny and delivery. They make 56 recommendations and four high level recommendations, highlighting that a new approach is required for tackling all causes of fuel poverty, as well as the need for collaboration across national and local government departments.

The Scottish Fuel Poverty Strategic Working Group’s four high-level recommendations

- The fuel poverty strategy should be firmly based on the principle of social justice and creating a fairer and more equal society.
- The fuel poverty strategy must address all four drivers of fuel poverty: income, energy costs, energy performance, and how energy is used in the home.
- Strong leadership and a joined up approach across several portfolios within national and local government are required to develop and implement the strategy.
- The Scottish Government should review the current definition of fuel poverty and establish a policy objective and monitoring programme that addresses all four causes of fuel poverty.

The Scottish Government has also committed to a Warm Homes Bill in the next parliamentary session, possibly as soon as 2017¹².

Current programmes

Currently, there are a variety of schemes and initiatives aimed at tackling fuel poverty from the Scottish and UK Government, energy companies and other organisations.

Scottish Government support is provided under the Home Energy Efficiency Programme umbrella, or HEEPS. The Energy Savings Trust, through Home Energy Scotland, manages the HEEPS schemes on behalf of the Scottish Government. Home Energy Scotland provides free, impartial, tailored advice and support to all Scottish households, including specific support for fuel poor households to help them reduce their fuel bills, make their homes warmer and more comfortable and increase their income.

Interest free loans are available for private owners and landlords to access energy efficiency measures, and home owners and private sector tenants may also be eligible for support under the Warmer Homes Scotland scheme if they meet certain qualifying

¹² Minister for Local Government and Housing, Kevin Stewart Scottish Labour fuel poverty debate 16/11/2016, <https://www.theyworkforyou.com/sp/?id=2016-11-16.17.0#g17.78>

criteria, such as being in receipt of a passport benefit. Grant funding has also been given to councils to provide support, again to private householders, through area-based schemes to tackle fuel poverty hotspots via energy efficiency improvements. There is also additional government support for renewable technology and district heating.

The Warm Home Discount is facilitated by the **UK Government** which requires large energy companies to provide a one-off, £140 discount on electricity bills in winter to their customers who meet certain qualifying criteria i.e. who are vulnerable in some way for example in receipt of a certain benefit. In addition, the UK Government provides winter fuel payments of £100-£300 to all people of state pension age, and Cold Weather Payments are made to people on qualifying benefits if the average temperature in your area is recorded as or forecast to be zero degrees celsius or lower for seven consecutive days. This payment is set at £25 for each seven day period between November and March.

There is also support available from **energy companies** in several forms. Companies must for example promote energy efficiency improvements to households through the Energy Company Obligation (ECO); keep a priority services register (PSR) for vulnerable customers which, amongst other things, prohibits disconnection of a registered customer during the winter months; provide discounted or free connection to the gas grid for low income and vulnerable households through Scottish Gas Network's Help to Heat initiative; and some companies also run charitable trusts which provide small grants that might be used to clear arrears, to replace a boiler, and in some circumstances for other expenses such as funeral costs or other household bills. Companies or their associated trusts also fund projects, for example for charities to run money and fuel debt advice services or provide energy efficiency measures in a certain community.

Many **local authorities** have fuel poverty advisers or income maximisers, who will link people into money advice, carry out benefit checks and energy surveys or provide energy advice. **Housing associations** often have a similar offering of money and energy advice and some offer access to district heating schemes, as well as investing in the energy efficiency of buildings.

There are also a large number of local **third sector organisations** providing a range of services such as:

- funding energy efficiency measures that complement the national provision,
- filling shortfall funding in national provision such as client contributions for some measures, or managing the practicalities such as clearing loft space before insulation can be installed,
- providing advice for the client on how to use energy in the home,
- advocating on the client's behalf with their energy company for example arranging affordable debt arrangement schemes,
- helping clients with the switching process, and
- maximising income through benefits checks or through applying to charitable trusts for grants or to clear debt.
- Some services, such as Shelter Scotland's money and fuel debt advice service, can also apply for emergency credit for clients in a crisis situation and some 'fuel banks' have now opened in Scotland providing vouchers for clients to top up their electricity and gas pre-payment meters.

A research project by Changeworks, commissioned by the Consumer Futures Unit at Citizens Advice Scotland, is looking into face to face fuel poverty advice services in

Scotland. This will identify the range of services currently available to help inform future policy development in Scotland¹³.

In conclusion, there is a huge range of support available for people in or vulnerable to fuel poverty. This support is provided by a range of agencies in different forms. A lot of the schemes are subject to short term funding and changes in names and eligibility criteria. How well a client is supported and linked in with all the different schemes and types of support available is dependent on the scheme first approached and the knowledge of the adviser providing support. However, it also reflects the nature of fuel poverty – there is no one size fits all solution and advice and support needs to be tailored to provide an effective service for the individual.

Government-led efforts to tackle fuel poverty have largely focused on improving the energy efficiency of housing stock. Despite the successful output of many programmes and installation of energy efficiency measures, fuel poverty levels in Scotland have doubled since 2003¹⁴, just after the Scottish Government set the target to eradicate fuel poverty by 2016. It is clear that tackling energy efficiency alone is not enough to lift families out of fuel poverty: a wider approach is needed which looks beyond the physical building and more holistically at all causes of fuel poverty and the individual experience.

RECOMMENDATION 2: A new fuel poverty strategy and Warm Homes Bill must take into consideration all drivers of and possible solutions to fuel poverty.

¹³ More information is available at the following web link: <http://www.changeworks.org.uk/projects/beyond-energy-efficiency-research-on-face-to-face-actions-to-help-consumers>

¹⁴ Scottish Government (2016), Scottish House Condition Survey: 2015 Key Findings, <http://www.gov.scot/Publications/2016/12/1539>

3. HEALTH, FUEL POVERTY AND COLD HOMES

How are fuel poverty and health linked and why should the health sector be involved?

“Addressing fuel poverty is one area where there is a genuine opportunity to start addressing health inequalities “up-stream” through changing a key determinant of health: cold and damp housing.”

ScotPHN (2016) Addressing Fuel Poverty¹⁵

Links between health and fuel poverty

Health, fuel poverty and cold homes are inextricably linked and the relationship is bi-directional: poor health increases susceptibility to fuel poverty, and fuel poverty can result in poor health.

Illnesses or pre-existing conditions can result in individuals feeling the cold more and having higher energy use, and there may also be wider impacts such as the individual being unable to work and having lower household income as a result: all these factors increase susceptibility to fuel poverty.

Parallel to this, being in fuel poverty can have two consequences, both of which can affect the health of the household. Either, households spend more money on their energy use, or they limit their energy use to what they can afford. Therefore, whilst fuel poverty does not always equate to cold homes, for example a household might compensate by simply spending more and more of their income, it is often related.

Certain aspects of medical care also exacerbate the consequences of not being able to afford fuel – for example if an individual requires medication to be kept refrigerated, or uses certain medical equipment.

The links between fuel poverty, cold and damp homes and ill-health has been a public health concern since the 19th century¹⁶, and the effects are evident across all age groups¹⁷. Cold homes are linked to cardiovascular, respiratory and mental health problems, can increase the incidence of common colds and flu, and can exacerbate conditions such as arthritis and rheumatism¹⁸. Children living in cold homes are more than twice as likely to suffer respiratory problems¹⁹. Living in a cold home is significantly linked to failure to thrive and poor weight gain in babies and young children, as well as

¹⁵ ScotPHN (2016), Addressing Fuel Poverty, Guidance for Directors of Public Health on taking action in support of: *A Scotland without fuel poverty is a fairer Scotland: Four steps to achieving sustainable, affordable and attainable warmth and energy use for all (Report of the Scottish Fuel Poverty Strategic Working Group to the Cabinet Secretary for Communities, Social Security and Equalities. October 2016*
<http://www.scotphn.net/projects/fuel-poverty/fuel-poverty-documents/>

¹⁶ ScotPHN (2016), Addressing Fuel Poverty, Guidance for Directors of Public Health on taking action in support of: *A Scotland without fuel poverty is a fairer Scotland: Four steps to achieving sustainable, affordable and attainable warmth and energy use for all (Report of the Scottish Fuel Poverty Strategic Working Group to the Cabinet Secretary for Communities, Social Security and Equalities. October 2016*
<http://www.scotphn.net/projects/fuel-poverty/fuel-poverty-documents/>

¹⁷ ScotPHN (2015), Fuel Poverty <http://www.scotphn.net/projects/fuel-poverty/fuel-poverty-documents/>

¹⁸ Marmot Review Team, 2011, The health impacts of cold homes and fuel poverty,
<http://www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty>

¹⁹ UK Health Prevention First Forum, 2014, Fuel Poverty: How to improve health and wellbeing through action on affordable warmth, <http://www.ukhealthforum.org.uk/prevention/fuel-poverty/?entryid43=34642>

delay with developmental milestones, more frequent and severe asthma symptoms, and higher rates of hospital admission²⁰.

In its most extreme form, cold homes are a contributory factor for excess winter deaths, of which there were 2,850 in winter 2015/16 in Scotland²¹. The World Health Organisation estimate that 30% of excess winter deaths are due to cold indoor temperatures²².

Whilst space heating accounts for over 55% of energy use, having a cold home is not the only link to health. Living in fuel poverty limits other fuel use too – affecting the ability to have a shower or use the oven to cook a hot, nutritious meal.

Fuel poverty can also lead to secondary health impacts. A household might be unable to afford to heat more than one room in their home, leading to overcrowding issues, and plug in heaters or other workarounds to using central heating can lead to trip hazards or burns and scalds. If a higher amount of household income is spent on fuel bills, this displaces other spending leaving less available to spend on other items such as fresh fruit and vegetables, or appropriate clothing. Finally, but perhaps most importantly, worrying about paying fuel bills can have an impact on mental health, too, particularly in the form of increased stress and anxiety and in all age groups^{23, 24}, which can be further compounded by issues of social isolation if people don't socialise for fear of the stigma surrounding poverty and not being able to afford to heat their cold home.

People who spend a high proportion of time in the home, including older people, children, people who are disabled or have long-term conditions, and people who are socially isolated, can be disproportionately affected by health issues related to cold, damp housing²⁵.

This all results in a cost to the NHS, whether that be GP visits, prescription charges, or longer stays in or repeat visits to hospital. Several attempts have been made to estimate how much fuel poverty costs the NHS, and the potential savings available. It has been estimated that tackling fuel poverty could result in savings of up to £80m every year for the NHS in Scotland²⁶. Another study found every £1 spent keeping homes warm can save the NHS 42 pence in health costs²⁷. There is, therefore, a significant economic argument for the health sector to prioritise helping to tackle fuel poverty.

The reach of the health sector

Aside from the arguments that fuel poverty is a public health issue, and the associated potential cost savings to the NHS, the health and social care sector has been targeted by the energy advice sector because of their huge reach and role as trusted professionals. For example, the only universal statutory involvement for under 5s in Scotland is the

²⁰ UK Health Prevention First Forum, 2014, Fuel Poverty: How to improve health and wellbeing through action on affordable warmth, <http://www.ukhealthforum.org.uk/prevention/fuel-poverty/?entryid43=34642>

²¹ National Records of Scotland (2016, Winter Mortality in Scotland 2015/16, <https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/winter-mortality>

²² World Health Organisation (2011), Environmental burden of disease associated with inadequate housing, <http://www.euro.who.int/en/publications/abstracts/environmental-burden-of-disease-associated-with-inadequate-housing.-summary-report>

²³ UK Health Prevention First Forum, 2014, Fuel Poverty: How to improve health and wellbeing through action on affordable warmth, <http://www.ukhealthforum.org.uk/prevention/fuel-poverty/?entryid43=34642>

²⁴ Marmot Review Team, 2011, The health impacts of cold homes and fuel poverty, <http://www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty>

²⁵ NHS Health Scotland November 2016 Health and Housing briefing http://www.healthscotland.scot/media/1250/housing-and-health_nov2016_english.pdf

²⁶ Calculated using population as the basis of working out Scotland's share. Archard, D., Washan, P., Stenning, J. and Summerton, P., 2012, Economic impact of improving the energy efficiency of fuel poor households in Scotland, Report for Consumer Futures Scotland – Final Report, <http://www.cas.org.uk/publications/economic-impact-improving-energy-efficiency-fuel-poor-households-scotland>

²⁷ Professor Christine Liddell, commissioned by Save the Children (2008), The Impact of Fuel Poverty on Children, <http://www.savethechildren.org.uk/resources/online-library/the-impact-of-fuel-poverty-on-children>

health visitor. This enables some fuel poor households or those vulnerable to fuel poverty who may not have identified themselves as requiring assistance, or who may not be aware of the advice and support available, to be reached.

Policies and strategies to support health sector involvement

Work on tackling fuel poverty relates with wider strategies of prevention; holistic, person-centred care; a shift to community based care; and better integrated public service provision²⁸.

In addition, both local and national strategies make specific reference to the need for the health service to tackle fuel poverty and specific ways in which this can be done. For example, many local single outcome agreements, under responsibility of Community Planning Partnerships of which NHS are statutory partners, include reference to fuel poverty as a means of meeting the national outcomes.

Two sets of guidance also point to the specific role of the NHS: that issued by the National Institute for Health and Care Excellence (NICE)²⁹, in March 2015 and guidance issued to directors of public health by the Scottish Public Health Network (ScotPHN) earlier this year.

The NICE guidance³⁰ focused on excess winter deaths and illnesses and the health risks associated with cold homes, including recommendations on assessing fuel poverty at different stages of interaction with patients, training for health and social care practitioners, and providing tailored solutions for individuals from a single point of contact.

Guidance to directors of public health made suggestions on how best to engage with the fuel poverty agenda, including checking that fuel poverty is on the agenda for community planning partnerships and integrated joint boards at all levels. It also suggested further investigation was required into ways in which the NHS can help identify those in or at risk of fuel poverty, and signpost them to support³¹.

There is increasing recognition of the importance of inter-agency working in tackling ill-health and health inequalities, and the report of the Scottish Fuel Poverty Strategic Working Group outlines four main government strategies which support this collaborative approach to eradicating fuel poverty³²:

1. Health and social care integration, including the creation of integrated joint boards bringing together NHS and local authority care services
2. Public service reform, and particularly how collaboration can allow for prevention and early intervention
3. Community planning, and

²⁸ For example, as outlined in the Commission on the future delivery of public services, 2011, chaired by Dr Campbell Christie CBE and in the Scottish Government's 2020 vision: Scottish Government, Strategic Narrative - Achieving sustainable quality in Scotland's healthcare, September 2011, <http://www.gov.scot/Topics/Health/Policy/2020-Vision/Strategic-Narrative>

²⁹ NICE guidance is officially for England only. The Scottish Intercollegiate Guidelines Network (SIGN) is their Scottish equivalent, who have not issued equivalent guidance.

³⁰ NICE (2015), NICE guideline [NG6], Excess winter deaths and illness and the health risks associated with cold homes <https://www.nice.org.uk/guidance/ng6>

³¹ ScotPHN, Addressing Fuel Poverty, Guidance for Directors of Public Health on taking action in support of: A Scotland without fuel poverty is a fairer Scotland: Four steps to achieving sustainable, affordable and attainable warmth and energy use for all (Report of the Scottish Fuel Poverty Strategic Working Group to the Cabinet Secretary for Communities, Social Security and Equalities, October 2016) http://www.scotphn.net/wp-content/uploads/2016/11/2016_11_02-Addressing-Fuel-Poverty-DPH-Guidance-Final-1.pdf

³² Scottish Fuel Poverty Strategic Working Group (2016), A Scotland without fuel poverty is a fairer Scotland: Four steps to achieving sustainable, affordable and attainable warmth and energy use for all, <http://www.gov.scot/Publications/2016/10/2273/downloads>

4. Community empowerment

The Scottish Fuel Poverty Strategic Work Group's report emphasised the importance of collaborative partnerships at a local level, recommending better linking of frontline services including health who are routinely in contact with households who are fuel poor or at risk of fuel poverty. They highlight the issues of working in isolation, and the benefits of equipping frontline services with basic skills in identifying anyone at risk of fuel poverty as part of a holistic needs assessment to make better use of existing resources. Furthermore, they recommend a more strategic and proactive engagement of the NHS by investigating the potential of sharing data to target those frequently using health services for conditions that could be aggravated by fuel poverty.

How involved are the health sector in tackling fuel poverty?

Despite the links, and although there are some excellent pilot and smaller scale schemes around the country, opportunities to involve the health sector have not yet been maximised, and the number of referrals by health practitioners into fuel poverty and energy efficiency advice schemes is, on the whole, low.

The involvement of the health sector in tackling fuel poverty fits into three broad themes:

1. Referrals of patients from health sector professionals into schemes tackling fuel poverty;
 - To enable staff to refer patients into schemes, staff must have the knowledge and confidence to identify a patient in or at risk of fuel poverty. They must understand their role in supporting their patient to get support on the issue, and know how to support them – which usually takes the form of referring patients on to other agencies. This might be done via training, staff briefings, intranet articles or advertising, encouraging word of mouth and building relationships between the two sectors. Staff also require the capacity to do this and the physical means – including time, assessment forms that include and prompt staff regarding fuel poverty issues, and easy-to-use referral forms that address data protection issues.
 - Particular challenges here include the heavy workloads of practitioners forcing them to prioritise aspects of care for their patients, as well as not having time to attend training or briefings which can help highlight the most relevant points for practitioners. This requires, therefore, efforts from energy advice providers to provide information and guidance to practitioners in a format they can engage with. It also points to an additional need for the message to be made clear at a managerial level to help staff make the case to prioritise this aspect of their work.
2. Using the health sector's reach to encourage patients who may be in or at risk of fuel poverty to self-refer to schemes tackling fuel poverty;
 - Health sector venues, such as GP surgeries and hospitals, can be used to target patients who may be at risk of fuel poverty for example running pop up stalls or providing leaflets. Information can also be provided in community health newsletters, or access can be given to health support groups for agencies to run advice sessions. Data sharing can also be used, for example writing out to all those with a specific diagnosis detailing support which is available. All of these methods generally require authority or approval by the health board or practice manager, and success rates can be improved when the relevant health authority provides backing or encouragement to patients to take up the opportunity.
3. Funding for fuel poverty support

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- Funding can also be provided by the health sector to support the work of advice agencies, particularly given the cost savings to the health sector of effective fuel poverty support.

There has to date not been a summary of fuel poverty schemes with a health focus or some form of health engagement. Shelter Scotland, in partnership with Energy Action Scotland, are currently carrying out a research project to produce a catalogue of health-related fuel poverty schemes which will bring together data on all the different schemes and ways the health sector has been involved in tackling fuel poverty. This research is due to be published in early 2017.

Conclusion

There are several compelling reasons for the health sector to engage in the issue of tackling fuel poverty. Firstly, there is a bi-directional link between health and fuel poverty: poor health increases vulnerability to fuel poverty; and living in fuel poverty has a negative impact on health. Second, fuel poverty costs the health sector money, and tackling fuel poverty can result in significant savings for the health sector. Finally, much of the health sector are uniquely placed in their roles in interacting with patients to identify households who may be vulnerable to fuel poverty.

There are examples of excellent partnership work between the health sector and energy advice sector. However, the health sector is currently underutilised in the provision and targeting of fuel poverty support.

RECOMMENDATION 3: A cross-sectoral approach is needed to tackle the plight of fuel poverty and this should be built in to any future fuel poverty strategy.

RECOMMENDATION 4: Learning from existing pilots and projects should be analysed holistically to understand what works and what the barriers are, to encourage greater partnership work between the health sector and energy advice sector.

4. PILOT: FUEL POVERTY TRAINING FOR HEALTH AND SOCIAL CARE PRACTITIONERS

As mentioned in chapter 3, training is one route used to increase and support engagement by the health sector in issues of fuel poverty.

There are several programmes offering face to face training targeted at health and social care professionals, including e.g. Energy Action Scotland's 'Stay Warm, Stay Well' training³³. Some online training has also been developed, for example by the Energy Savings Trust³⁴, and for the Healthy Homes for Highland partnership³⁵.

Adding to these schemes, in 2016 Shelter Scotland developed an online training course on fuel poverty specifically targeted at frontline health and social care professionals, with funding from British Gas Energy Trust. This chapter provides a summary and evaluation of the pilot with recommendations for the future.

The course had four learning objectives for frontline health and social care staff to:

1. Understand how to identify and assess people at risk of fuel poverty
2. Recognise the key links between fuel poverty and health
3. Recognise how to guide patients through some low level behaviour changes that will reduce fuel poverty and improve health outcomes
4. Identify how to refer patients to national and local energy advice programmes

Trainees

Between April 2016 and December 2016 the course was piloted, offering free places to 151 frontline health and social care practitioners across Scotland. There was considerable interest in the course and places were largely allocated on a first come first served basis, after checking for job role and ensuring reasonable geographical spread across Scotland. Ten of the fourteen territorial health boards were represented³⁶. Two thirds of staff were employed directly by the NHS (101) and a further 50 worked for local councils or for third sector organisations involved in support work in the community.

The majority of staff signed up for the training were nurses (50), including family nurses (37) and community disability nurses (2); allied health professionals including occupational therapists (32) and physiotherapists (6); and others involved in health improvement and support work.

Job titles ³⁷	Number of trainees
Occupational therapists	32

³³ Energy Action Scotland, Stay Warm Stay Well, http://www.eas.org.uk/en/stay-warm-stay-well_50648/

³⁴ Energy Savings Trust, Employee Engagement, <http://www.energysavingtrust.org.uk/scotland/businesses-organisations/employee-engagement>

³⁵ Changeworks, Healthy Homes for Highland, <http://www.changeworks.org.uk/projects/healthy-homes-for-highland>

³⁶ There were no trainees from NHS Borders, NHS Western Isles, NHS Orkney or NHS Shetland. A full breakdown of trainees by health board and organisation is provided in appendix 1.

³⁷ A full list of job titles as provided by trainees is provided in appendix 2.

Job titles ³⁷	Number of trainees
Physiotherapist	6
Support workers	37
Nurses	50
Health improvement	3
Other (including health visitor, midwife)	23
Total	151

Impact of training on staff

A transitional learning evaluation method was employed with trainees asked to complete a questionnaire before undertaking the training (120 responses), immediately after (136 responses), and three months following completion of the training (43 responses)³⁸.

Although nearly all trainees (96%) felt fuel poverty was an issue for their patients, only 23% felt they had good knowledge of fuel poverty³⁹. Similarly, only 11% said they had good knowledge on how to refer patients on for support. This demonstrates a clear learning need.

By December 2016, 136 trainees had completed the training, 5 had left their role (on long term sick, maternity leave, or having moved to a different post), leaving 10 unfinished. Trainees received monthly reminders regarding the training. In comparison to often high drop off levels for eLearning training, this is a high rate of completion, and particularly when the course is free and therefore monetary commitments aren't a motivation. However, it shows a challenge at getting even motivated staff through: trainees had either put themselves forward or had been put forward by their manager, and therefore were either self-motivated enough to sign up having identified a learning need or should have had the support of an enthusiastic manager. Anecdotally through conversation with some of these trainees and others who took longer to complete the training, workload pressures and other priorities were the main reasons for not completing the training. In order to ensure high take up and completion of the course, managers should be fully on board and provide motivation and encouragement to assist their staff in completion of the course. The course should be integrated into core learning and development and consideration should be given to making fuel poverty training mandatory.

After completing the training, 100% of trainees noted improved knowledge around issues of fuel poverty, how fuel poverty is interlinked with health, tips on behavioural changes that can be passed on to patients and referring patients on.

Almost all staff (92%) noted improved confidence in identifying and supporting patients at risk of fuel poverty.

133 of 134 trainees felt the training was worth doing, and 131 of 133 thought it was relevant to their role. Every trainee stated that they learnt something new. Qualitative information provided by trainees also identified how they planned to utilise this new

³⁸ Not all trainees responded to every question in the evaluations.

³⁹ When provided with ratings of poor, fair, good, very good, and excellent.

knowledge and confidence both for the benefit of their patients (current and future), and in their personal social circles too.

Several trainees also commented in support of rolling out the course more widely, and further benefits were also highlighted from undertaking the training, including improved working relationships with advice organisations.

Impact of training on staff – quotes from trainees

“I have very limited experience in this field and feel that, while I know a bit about the issues and the links between fuel poverty and poor health, I lack the knowledge about prevention and intervention strategies. I hope this training will help.”

“It was a really helpful reminder about the important link between poor health and fuel poverty. There were lots of little tips that can be passed on and great signposting to other agencies that can help. Thank you”

“I was not aware of all the assistance that is available. I was just aware of Home Energy Scotland but now I feel I will be able to access more resources to assist clients in need.”

“I learnt lots of information especially where to refer to”

“I am now more confident with being able to identify patients that are in fuel poverty and where I can refer to if need be”

“This is an excellent source of information and has given me confidence to offer advice to vulnerable clients”

“I am now thinking of patients I have seen in the past who would have benefited from this advice and will definitely use what I have learned to support patients to seek help in the future. Many Thanks to Shelter for running this training”

“I plan to use some of the information I received in this course to improve my own circumstances and to ensure that people I support are better advised on what fuel poverty is any how I can help them to get out of fuel poverty with both advice and practical help.”

“I feel that this has prepared me very well for the upcoming winter where I now feel more competent at recognising fuel poverty during my home visits. Although I have scored my current knowledge as 'very good' I feel that this will improve once I have applied my new knowledge in real life situations. I feel confident to bring up this topic with my patients and feel I have knowledge that can really benefit/support them.”

“This is an excellent resource and useful for ANY health worker based in the community.”

“Very useful course and I would strongly recommend this course to my colleagues.”

Patient benefits

Three months after staff had completed the training, further feedback was sought to identify whether knowledge from the course had been used. 98 staff had reached the three-month mark by the time this evaluation was concluded, and we secured a response rate of 44% (43 of 98 staff).

27 staff had identified an opportunity to put their knowledge into practice since completing the training. 26 members of staff also said their confidence had improved when identifying and discussing fuel poverty issues with their patients.

Specifically, 20 used their new knowledge sometimes or very often with their patients.

- 26 had provided patients low level behavioural advice 1-10 times (and 1 over 10 times)
- 15 had referred between 1 and 10 of their patients, to Home Energy Scotland (7 staff referred to this service), Shelter Scotland (4 staff), a local energy advice provider (4 staff), and an energy company (1 member of staff).

Almost all staff (23 out of 26) felt the advice they had provided had benefitted their patient's health in some way, with the 18 staff providing extra information on this all citing improvements in mental health, mostly through the professional's own observation and in some instances the patient's own admission.

Patient benefits – quotes from trainees

“Patients have made comment on how they feel more positive in knowing that they are facing winter with some support and guidance as well as knowing there is people just to speak to about their concerns.”

“[Patient is] less anxious about opening letters. Knows it is less likely to be a demand for unpaid bill.”

“[Patient’s] Self-stated improvement in decreased anxiety regarding these issues”

There was still however a number of staff (16) who had not used their knowledge. Those who hadn't cited reasons of a lack of relevance for the patients they work with (2), internal barriers (1) such as time constraints, and external barriers such as being off sick (2) or changing role (1) or not having seen any patients with fuel poverty issues (10). It is worth noting the relatively short time before practitioners were followed up on, plus winter did not fall in the three month period when heating issues and problems with energy bills are likely to be more apparent. Further qualitative information gathered from a focus group suggested that amendments to the course to encourage staff to reflect on fuel poverty in their day to day work may also be helpful.

Focus group

A focus group conducted with a group of 8 practitioners suggested staff were still struggling to identify issues related to fuel poverty. Staff felt that it wasn't necessarily their role to identify problems and therefore that they expected these to be picked up by a colleague or different department, despite sharing the experiences of some of the

patients they supported. This included one patient who had not been charged for her energy use in three years, another who was paying extremely high fuel bills, and many examples of patients who were struggling to afford the costs of their energy through their pre-payment meter. After discussion, staff highlighted that they needed to identify some possible trigger points to prompt them to consider issues for each patient, and that they required some reflection to understand how the materials in the course were relevant for them in their roles and how to apply their knowledge.

Practical points

Our eLearning format gives staff the flexibility to fit in training around work commitments and provides huge benefits for staff whose irregular hours and shifts make it difficult to undertake training. The course is designed to be completed in thirty minutes and can be completed in different sittings to again provide maximum flexibility for staff.

The training course was hosted on Shelter Scotland's own learning platform, moodle, for the pilot. The vast majority of trainees found the website easy to use (134/135).

Though only 1 person said they did not feel the training web site was easy to use, there were some comments provided that referred to issues around security of NHS servers, and computers not loading or displaying the course correctly. There were some access issues due to internal systems which created some barriers to access, but Shelter Scotland's training team were able to provide support to address these issues. For ease of access, familiarity for staff, and to overcome some technical barriers, online training should be hosted on the organisation's own learning and development site.

Practical points – quotes from trainees

"Very easy course to navigate round. Lots of information and well laid out"

"Very informative and helpful. Easy to navigate the training programme."

"Very useful learning tool"

Conclusion

As detailed in previous chapters, there are many reasons to involve the health sector more in tackling fuel poverty. It has the potential for huge patient benefits in terms of tackling ill health and health inequalities, as well as potential cost savings for the NHS. However, it needs to be made as easy as possible for the health sector to engage in this agenda, and the health and social care workforce needs to be adequately supported and resourced to help support people in or vulnerable to fuel poverty.

Training, and specifically the Shelter Scotland eLearning course on fuel poverty for health and social care practitioners, is one solution, and is supported by NHS Health Scotland's recent recommendation of the development of training or e-learning materials that enable

frontline staff to take opportunities to reduce health inequalities through action on housing⁴⁰.

Feedback from the pilot has identified that staff in health and social care require information and training on fuel poverty to adequately support their patients. Completion of the e-learning programme results in improved knowledge and confidence on this topic resulting in benefits for patients. However, to engage a wider range of practitioners and to encourage uptake of the training opportunity, the course should be embedded in core training provision and ideally hosted on the organisation's own learning and development site.

Initial evaluation also suggests further investigation would be helpful to identify possibly trigger points for fuel poverty identification and action to embed into standard NHS practice.

Both these points are supported by the Scottish Fuel Poverty Strategic Working Group who recommend local agencies *“put in place training and skills development that support front line staff to identify challenges people face in sustaining good health and wellbeing, including signs of fuel poverty...and make appropriate referrals to specialist advice and support services”* and that affordable warmth and energy issues become part of routine interventions⁴¹.

RECOMMENDATION 5: Fuel poverty issues should be included as part of core health inequalities training. This training should be made available at an early stage of practitioner professional development, and should be mainstreamed across departments.

RECOMMENDATION 6: Potential trigger points for fuel poverty identification and action should be investigated to embed this work into standard NHS practice.

⁴⁰ NHS Health Scotland (2016), Housing and health inequalities briefing, <http://www.healthscotland.scot/publications/housing-and-health-inequalities-briefing>

⁴¹ Scottish Fuel Poverty Strategic Working Group (2016), A Scotland without fuel poverty is a fairer Scotland: Four steps to achieving sustainable, affordable and attainable warmth and energy use for all, <http://www.gov.scot/Publications/2016/10/2273/downloads>

APPENDIX

Further details of trainees undertaking the training

Table 1: Health board area and organisation of all trainees

Health board	Organisation	
	NHS staff	Other
Ayrshire and Arran	2	-
Borders	-	-
Dumfries and Galloway	15	1 Council 10 Dumfries and Galloway Housing Partnership
Fife	11	1 Council 31 The Richmond Fellowship Scotland
Forth Valley	1	1 Link Group
Grampian	4	-
Greater Glasgow and Clyde	25	3 YPeople 1 LGBT Youth Scotland
Highland	2	-
Lanarkshire	3	1 Council
Lothian	38	-
Orkney	-	-
Shetland	-	-
Western Isles	-	-

Table 2: Trainee job title, as provided

JOB TITLES	
Occupational therapists	32
Specialist Occupational Therapist	1
Senior Occupational Therapist	2
Occupational Therapy Assistant	3
Occupational Therapy Support Worker	1
Occupational therapist, Community Respiratory Team	1
Occupational Therapist	20
Occupational Therapist Rapid Elderly Assessment and Care Team	1
Highly Specialist Occupational Therapist	1
Community Occupational Therapist (Adult Social Work Service)	1
Community OT	1
Physiotherapists	6
Physiotherapist	3
Physiotherapist - Learning Disabilities (& Project Officer - Making Every Opportunity Count (MEOC))	1
Senior Physiotherapist	1
Domiciliary Physiotherapy Team Lead (North Ayrshire)	1
Support workers	37
Senior Support Worker	3
Support Practitioner	28
Support Worker	1
Supporting People Officer	1
Healthcare Support Worker (Mental Health)	1
Housing Support Worker	2
Development Worker & Domestic Abuse Support Worker	1
Nurses	50
Staff Nurse	1
Staff Nurse - Community Nursing	2
Stroke CNS	1
Stroke Nurse Specialist	1
Nurse Specialist - Stop Smoking Service	1
Nurse, Health and Homeless Outreach Team	1
Community Staff Nurse	1
Family Nurse	37
Charge Nurse - Community Nursing	1
District nurse (student)	1
Community Learning Disability Nurse	2
Acting SCN (Senior Charge Nurse)	1
Health Improvement	3
Health Improvement Officer	1
Health Improvement Senior	1
Health Improvement Team Leader	1
Other	23
Clinical Specialist sonographer	1

AHP Support Worker	2
AHP Team Lead	1
Assistant Practitioner Falls	1
Community Food Worker	1
Community Link Worker	1
Development Worker	1
Health and Wellbeing Project Co-ordinator	1
Health Visitor	1
Income Maximiser	1
Local Area Co-ordinator, Health & Social Care	1
Palliative Care Children and Families Service	1
Sheltered Housing Co-Ordinator	8
Team Leader/Family Health Midwife	1
Visiting Officer - Sheltered Team	1
Total	151

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