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SHUSU
SUSTAINABLE HOUSING
& URBAN STUDIES UNIT

Reshaping health services and fuel poverty in the Outer Hebrides



Final report of the Gluasad Còmhla
(Moving Together) project



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About the authors

The Sustainable Housing & Urban Studies Unit (SHUSU) is a dedicated multi-disciplinary research and consultancy unit providing a range of services relating to housing and urban management to public and private sector clients. The Unit brings together researchers drawn from a range of disciplines including: social policy, housing management, urban geography, environmental management, psychology, social care and social work.

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The research team would like to extend their thanks to Tighean Innse Gall staff for their hospitality and help in reaching the furthest points of the Islands (not to mention a few scenic highlights).

Photos: Margaret Probin (page 5), TIG (pages 7, 12) and Graeme Sherriff (pages 19, 20 and 27)

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Executive Summary

Overview

Glusad Còmhla (Moving Together) started in March 2018, with a grant from the European Social Fund Aspiring Communities Fund. The project built on the existing practice of Tighean Innse Gall (TIG) and other partners in the Outer Hebrides, to develop an innovative approach to identifying and assisting people whose health is compromised by living in a cold or hard-to-heat home. Over the course of two years, 199 households were assisted through the project.

Tighean Innse Gall is a Community Benefit Society working across the Outer Hebrides and operating principally across the housing, community group and small business sectors to support people to access homes and to help to make them comfortable and affordable, promote independent living and encourage businesses and communities to be energy-efficient.

Context

The initiative reflected a recognition of housing as a social determinant of health, as well as an awareness of the distinct challenges faced by the population of the islands, not least the prevalence of fuel poverty and its impact on those with long-term health conditions.

Health policy over the past decade has been increasingly informed by an awareness of the 'social determinants of health', i.e. the broader factors underpinning people's health or the 'causes of the causes' of ill-health. A corresponding focus on fuel poverty, whereby householders cannot afford to maintain comfortable living conditions at home, recognises the detrimental effects of poor housing on physical and mental health.

Moving Together can be understood in the context of national (and international) initiatives that have emerged to tackle ill-health at this broader, social level. These include social prescribing, a process of making available non-medicalised support to improve health and wellbeing, which can include energy advice and assistance with improvements to the home.

The research

SHUSU led on the development of a collaborative evaluation methodology. The research was conducted in two phases corresponding to the periods of funding received for the project: from March 2018 until July 2019, followed by an extension until the end of March 2020. The study employed a predominantly qualitative methodology consisting of interviews with individual householders and stakeholders and supplemented by an online and postal survey in January 2020. An analysis of a dataset held by TIG covering the type and distribution of support measures was also conducted.

Findings

The impacts of fuel poverty Cold and damp conditions in homes limited the extent to which the home could be used, reducing the potential for visitors and socialising and stretching already constrained household finances, with implications for other parts of the household budget, including transport. Such conditions were taking their toll on physical health, particularly for those living with long-term conditions, and on mental health and overall wellbeing. Confidence, access to technology and awareness of available support, to some extent related to but not exclusively the result of age, were factors limiting the extent to which individuals sought help.

Assisting householders We were able to identify several fundamental ways through which Moving Together was able to help householders. Assistance provided included help with bills and switching tariffs, help with identifying and applying for relevant grants and benefits, insulation, surveys of housing condition and monitoring. Householders reported improvements in the physical performance of their houses such that they needed to use heating less. Help with debts and reducing energy costs helped to reduce financial anxieties and free up budget for other important parts of life. These improvements had impacts beyond home energy: giving people confidence that their guests were comfortable, alleviating exposure to noise during storms, enabling people to stay in a home

that they were previously considering leaving, reducing pain and discomfort associated with some chronic conditions and alleviating financial stress – in one case to the extent of being able to buy a car and therefore able to shop independently and have more options to visit friends.

A challenging context Our research adds to the evidence base relating to the distinct challenge of fuel poverty in rural and remote locations (and in particular island settings) and its impact on physical and mental health. Discussions with householders and project stakeholders emphasised the challenging nature of the Outer Hebrides and the ways in which living environments can have an impact on health. Some interviewees were living in cold conditions owing to financial concerns, and others were struggling to keep their home warm because of the poor, draughty condition of the dwelling.

The island context added to the challenge, and interviewees mentioned the cost of energy, the expense of having work carried out and the effect of remoteness on accessing contractors. As a project predicated on building up meaningful interactions with individuals and with an emphasis on home visits, the remoteness of households and settlements in relation to each other across the Outer Hebrides made the delivery of Moving Together particularly challenging. Whilst community spirit was something many interviewees looked back on, it was also something they still recognised in their contemporary lives. When seeking to identify vulnerability and

support those in most need, however, this closeness is not always positive: people can prefer to be private about any difficulties they are experiencing.

Supportive networks Moving Together built upon established collaborative practices across the islands, where partner organisations are strategically connected and adept at working together. A key driver for Moving Together was to explore how voluntary sector and statutory services could be integrated with primary and secondary healthcare to create meaningful and lasting changes in the health and wellbeing of some of the most vulnerable people in the Outer Hebrides. To these networks, the project brought additional expertise on housing and health, as well as skills and capacity in providing support to those with long-term health conditions.

Although the project initially worked through GPs and their surgeries, over the course of the project the referral pathway was widened to include a range of healthcare professionals including community and specialist nurses (e.g. the Parkinson's nurse), as well as a small number of self-referrals and referrals through community groups. Fittingly, for a project that had home improvement as a central pillar, conversations invariably happened in people's homes, where they were most at ease and likely to build trust. Home visits played a key role in the project in shining a light on vulnerable people's needs and revealing vulnerabilities that would not otherwise have been visible.

Project Partners

Tighean Innse Gall

Tighean Innse Gall is a Community Benefit Society working across the Western Isles and operating principally across the housing, community group and small business sectors to support people to access homes which are made comfortable and affordably warm, promote independent living and encourage businesses and communities to be energy-efficient. We have four principal sections: Insulation, Care & Repair, The Energy Advisory Service SCIO (TEAS SCIO) and Development. We provide a range of activities including insulation work, repairs, adaptations, home safety, energy efficiency advice, housing development, renovation and management. We work in close partnership with the local authority, Integrated Joint Board and Community Planning Partnership to help shape services throughout the Western Isles. We also work with and help inform national government and their agencies to find solutions to issues affecting our sphere of operation and impacting the remote rural communities which we serve.

Langabhat Medical Practice

Langabhat Medical Practice is a 6-site practice which covers most of rural Lewis. As a practice we are very aware of the impact that cold homes can have on the health of our patients. Participating in the Gluasad Còmhla Programme raised awareness of this issue with our patients and the wider community and resulted in many of our patients benefiting from the services offered through it. These benefits to the individuals' health will be ongoing re the home improvements carried out, the improvements in financial entitlements and the knowledge that there are programmes and organisations to approach for assistance.

The Shed

We provide a drop-in centre for any adults who struggle with drug or alcohol use or have been affected by those who do. There is a safe and social environment for anyone who would benefit from the extra level of support we offer. Our project has been working in partnership with the Moving Together team, and we referred 10 of our service users to the project, which benefited each one of them, both in their long-term health and financially.

Western Isles Association for Mental Health (WIAMH)

Although the first phase of the project had a relatively short working life, it has allowed the Western Isles Association for Mental Health to take a different approach when assessing the needs of our service user group. It has been established that fuel poverty and the financial implications associated with it have a notable impact on the health and wellbeing of a large percentage of our service users. Building up more robust networks with other agencies through the project has allowed us to better signpost to better-equipped external agencies who can assist and support people to make positive material changes to their living environments. Although the organisation's engagement with the project is now complete, it has left a lasting legacy. It is now organisational practice to continue to look at ways to promote and improve awareness around fuel poverty and seek interventions that can have positive outcomes for a person's ongoing recovery.

Western Isles Foyer

Western Isles Foyer was initially established in 2003 in response to an identified need for support to assist young people with tenancy management and sustainment. The project initially provided a supported accommodation service. We continue to provide this service but expanded our support remit in 2011 to provide a drop-in service, deliver independent living skills training and provide support and training to assist young people to move into/on to education, training or employment. We support service users via our current range of service provision with the overall objective of assisting young people to move on to successfully sustaining their own tenancies, living independent and fulfilled lives and participating as active members of their local community.

Western Isles Citizens Advice Service (WICAS)

WICAS is a local, independent charity which provides free, impartial and confidential advice and information to give you the tools you need to sort out any issues or problems. We're at the heart of the community and offer several services, including Income Maximisation to people referred through the project. We host staff employed by the Moving Together project who are embedded within WICAS to provide specialist fast-track advice to project participants.

1. Introduction

Glusad Còmhla (Moving Together) began in March 2018 with funding from the ESF Aspiring Communities fund. The project builds on the existing practice of Tighean Innse Gall (TIG) and other partners in the Outer Hebrides, to develop an innovative approach to identifying and assisting people whose health is compromised by living in a cold or hard to heat home.

The initiative reflects a recognition of housing as a social determinant of health as well as an awareness of the distinct challenges faced by the population of the Islands, not least the prevalence of fuel poverty and its impact on those with long term health conditions.

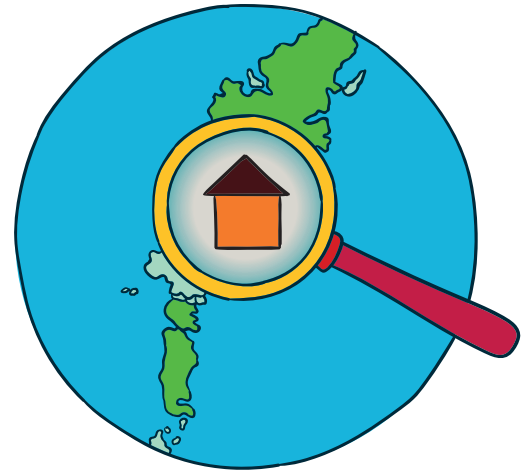
The premise behind the project was to work in partnership with GPs in rural Lewis, to enable them to identify people whose health was compromised by living in a cold or hard to heat home and offer them the option of referring such patients to the project for support. GPs had, for the first time, a route for referral that would recognise the expertise within TIG and to treat this in the same way that they make a referral directly to a hospital consultant. Over time, the referral pathway has been broadened to include a wide range of health professionals, including health visitors and specialists in dementia and Parkinson's disease. In July 2019, the project secured additional funding to allow the project to be extended to all communities across the Outer Hebrides.

The project has provided tailored support to people with long-term health conditions. This included assistance with switching to more affordable tariffs, access to grants and benefits, home energy advice, and access to insulation and technologies including white goods and renewable energy systems. At the point of project referral, the client and their home was assessed in a holistic manner to ensure that all routes to making the home warmer were addressed. This includes the behaviour of the client, the fabric of the house, health related needs and their household income.

Funding for the project also included paid members of staff for Lewis Citizens Advice Bureau. The project also enabled support for small charities locally and formal partners include the Western Isles Association for Mental Health (WIAMH); The Shed, a charity supporting people with addiction issues; and Western Isles Foyer, a charity supporting young people at risk of homelessness. These organisations have all been able to refer their clients into the project so that they could benefit from support.

In 2018, the Sustainable Housing and Urban Studies Unit (SHUSU) at the University of Salford was asked to undertake an evaluation of Moving Together. SHUSU worked alongside TIG to develop a collaborative approach, consisting of qualitative interviews, a survey of participating householders, and an analysis of an anonymised dataset detailing the distribution and nature of interventions.

This report starts by setting out the context of social determinants of health, fuel poverty, social prescribing, energy advice and the housing context of the Outer Hebrides. We then provide an overview of the reach and impact of Moving Together. This is divided into, firstly, the experiences of an impact upon householders and, secondly, the reflections of stakeholders involved in the process. Finally, we draw some conclusions about the project's impact and its contribution to the development of approaches to addressing homes and energy as social determinants of health.



2. Context

Housing and health and the Outer Hebrides

Health policy over the past decade has been increasingly informed by an awareness of the ‘social determinants of health’, i.e. the broader factors underpinning people’s health or the ‘causes of the causes’ of ill-health. A corresponding focus on fuel poverty, whereby householders cannot maintain comfortable and healthy conditions at home, recognises the detrimental effects of poor housing on physical and mental health. Initiatives have emerged to tackle health at this broader, social level, including ‘social prescribing’, a process of making available non-medicalised support to improve health and wellbeing, and energy advice and assistance with improvements to the home can be understood to be within its remit. Moving Together lay at the intersection of these initiatives to reshape health services and focused on the particularly challenging context of the Outer Hebrides, given the level of remoteness, the ageing population and the condition of the housing stock.

2.1 Social determinants of health

Our health is determined by a range of factors. Only a small percentage of our health and wellbeing – some studies estimate only 10–15% (Braveman & Gottlieb, 2014) – is treatable by a GP. Other factors, which include work, food, housing and finances, are referred to as the wider or ‘social’ determinants of health (Stansfeld, 2006). They underpin our physical, emotional and mental wellbeing.

Studies such as the seminal Marmot review (Marmot, 2010) and its update (Marmot et al., 2020) have set a sharp focus on the social determinants of health within national health policies, and this focus has exposed stark realities and disparities between individuals and communities across the country. In a particularly vivid example, one report found a 28-year difference in life expectancy between people living in the richest and poorest areas of Glasgow (CSDH, 2008).

As these studies conclude, it is insufficient to draw conclusions from the statistics on causes of death (such as heart disease and COPD). Rather we must probe deeper into the ‘causes of the causes’ (Marshall et al., 2019) and acknowledge and understand the realities that underpin people’s health. Thus, the ‘social determinants’ of health may also be referred to as the ‘causes of the causes’ (Marmot et al., 2020) of ill-health.

The life expectancy gap between richer and poorer areas also highlights the stark consequences of inequality and places socio-political inequalities firmly within the remit of health policy and therefore health services. The health inequalities agenda as put forward in the Marmot reviews exposes the uneven distribution of health and highlights

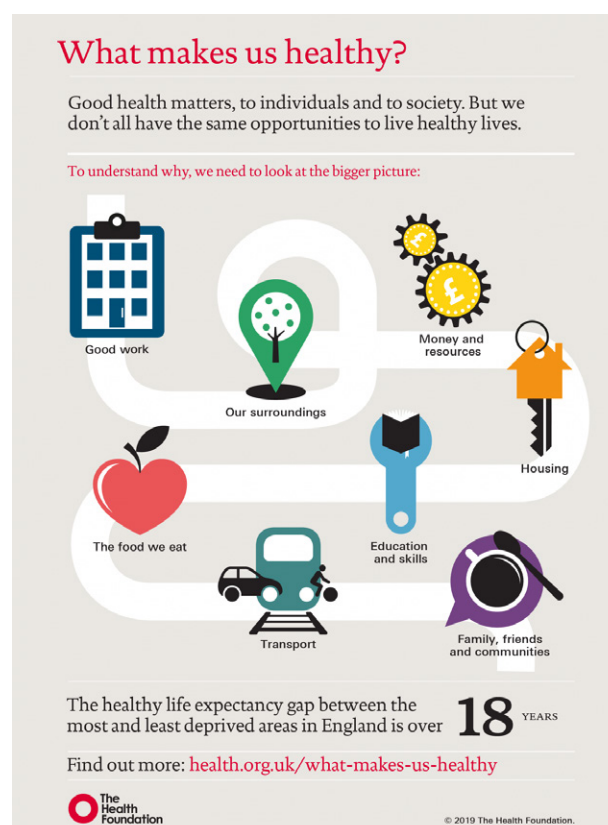


Figure 1 - Social determinants of health infographic, via Health Foundation: <https://www.health.org.uk/infographic/infographic-what-makes-us-healthy>

not only the moral, but also the economic and political, case for addressing health inequalities: that societies that are more economically equal are also happier and healthier (Wilkinson & Pickett, 2009).

2.2 Energy as a social determinant of health

One way to understand housing as a social determinant of health is through the lens of fuel poverty. Fuel poverty has been described as a social problem that affects those with limited financial means and is also intimately related to both the quality of the residential building stock and the cost of fuel (Boardman, 2012). It is widely recognised to be the consequence of three primary determinants: energy-inefficient housing, low incomes and high energy costs. The vulnerability of the household is also a factor, and people with long-term health conditions are more likely to be in their home more of the time and have increased sensitivity to cold conditions.

There is a well-established connection between cold homes and physical and mental health conditions. The Marmot Review Team (Marmot et al., 2011) collated evidence on the effect of fuel poverty on health, identifying a range of direct impacts including increased mortality rates during the winter months (as a result of respiratory, circulatory and cardiovascular diseases) and mental health conditions such as depression and anxiety. They also identified indirect impacts: an increased prevalence of psychological symptoms in children; an implied increase in malnutrition; and increased social isolation.

There is a growing body of evidence related to the impacts of cold and damp conditions associated with fuel poverty, as well as the stress resulting directly from poor housing conditions and indirectly from experiences of managing household budgets and dealing with suppliers (Butler & Sherriff, 2017). Research on lived experiences of fuel poverty has enhanced this understanding and drawn attention to less tangible but nevertheless important impacts upon wellbeing and quality of life connected to, for example, educational attainment and child development, stigma and self-worth, and family and social life. Understanding individual circumstances aids an understanding of the impacts of fuel poverty and the extent to which experiences of managing energy and the stress related to this themselves contribute to these impacts. For example, mental health issues can affect confidence and readiness to manage bills and negotiate with utility companies (Sherriff, 2016), and living in the private rented sector can severely limit a householder's level of control regarding the quality of the building fabric and heating system (Ambrose, 2015).

The geography of fuel poverty suggests particular challenges in rural and remote areas. Homes are more likely to be dispersed and off the gas grid, the latter reflecting a particularly challenging situation in relation to fuel poverty (Consumer Futures Unit, 2018). Works to retrofit for energy efficiency tend not to enjoy the economies

of scale that might be found in urban housing estates. Social disadvantage tends to be more spatially heterogeneous (Robinson et al., 2018, p.90) in rural populations, making the effective targeting of help more difficult.

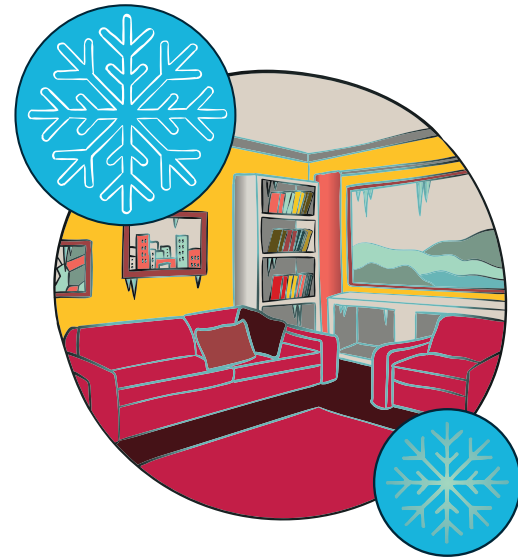
The alignment of the fuel poverty and health agendas in Moving Together echoed other work, such as the 'Warm Homes for Health' (Tudor Edwards et al., 2016) and 'Boilers on Prescription' (Burns & Coxon, 2016) projects. Tudor Edwards et al. (2016) assessed health benefits of making energy efficiency improvements to housing and found significant self-reported health benefits, as well as a 10% reduction in GP visits and a 67% reduction in hospital attendance over a 12-month period.

2.3 Social prescribing

Against this backdrop of aligning health policies and services around these social determinants is the rapid emergence, in the UK at least, of 'social prescribing'. Social prescribing is a loose term with no absolute definition and covers a variety of initiatives and perspectives. It broadly refers to identifying and providing access to non-medical support in order to improve an individual's health and wellbeing (Polley et al., 2017). A key practitioner role is the 'link worker' (or related job titles such as 'community connector' or 'community navigator'). They are tasked with identifying the individual's needs and appropriate support for those needs on the basis of a conversation with the person about 'what matters to them' rather than, as in a more medicalised model, 'what's the matter with them'.

At the heart of social prescribing is a recognition of the role and value of engaging in meaningful activity as a means of improving and maintaining wellbeing. The kinds of activities that social prescribing service users are referred to can vary widely: from community groups ('knit and natter' and 'Men's Sheds', for example) to statutory services (benefits advice, debt relief and management), giving rise to initiatives as diverse as books and boilers 'on prescription'.

Though the evidence base for social prescribing is still questioned (Bickerdike et al., 2017), social prescribing services have been proliferating at an increasing rate over the past five years. Perhaps a key driver for the recent success of the concept and term of 'social prescribing' has been its take-up by some GPs. It should be noted, however, that this passion has not been uniform throughout the profession, and a commonly reported pinch point



in social prescribing services has been the low numbers of referrals from GPs, whether arising from GPs' lack of awareness of these services, personal resistance or scepticism from individual GPs (Pescheny et al., 2018).

Social prescribing services look different in different places because they are commissioned and managed differently in different areas. Some are funded through Clinical Commissioning Groups (CCGs), which will often have a remit to reduce the demand for primary care services; indeed, some link workers within such services are co-located at GP surgeries. Some services are run by partnerships of voluntary sector organisations, for example in Rotherham (Dayson et al., 2016), where each organisation is micro-commissioned to run support activities. All social prescribing services or initiatives involve some degree of collaboration between health and voluntary sector organisations. A key question, however, is the degree to which voluntary sector organisations are funded and otherwise resourced to run activities and support health needs. With this in mind, Gibbons et al. (2019) have recommended that social prescribing services promote the development of an 'ecosystem' of organisations and groups that have the capacity to offer the relevant support.

Services also vary according to where they are placed on a scale of the level of support provided. Kimberlee (2015) suggested a scale from 'signposting' to 'holistic'. 'Signposting' may be done by GP receptionists, often with little follow-up, and 'holistic' services involve more personalised and time-intensive support from a link worker, sometimes including the link worker accompanying the person to an activity in order to facilitate their participation in the activity.

Given the variety of initiatives that are described under the banner of social prescribing, it is difficult to present a unified picture of the field or to say definitively what is or is not social prescribing. However, it is clear that Moving Together fitted somewhere into the picture, even if it was not totally contained within it. Moving Together had distinctive elements, processes and stakeholders that defined a referral pathway from GPs and other health professionals to a range of services that had improving home energy efficiency as a key component. The project focused on addressing the social determinants of patients' health, such as making improvements to their home environment and helping them manage their finances. In so doing, and through the combined strengths of its partner organisations, Moving Together can be seen as part of the widening, at a national level, of the lens through which the health system is viewed in order to focus on the most effective ways of tackling health and social issues at the local level.

2.4 Redefining and widening the health system

A legitimate response to the recent interest in social prescribing is that it is in fact nothing new: that the voluntary sector has been supporting people to manage the wider, non-medical determinants of health for as long as it has been in existence. While this may be true, it is nevertheless worth noting a palpable shift in not only the language of health and social care policy but also the ways in which these services are defined, designed and delivered.

With national policies such as the NHS (2019) Long Term Plan, NHS England's Universal Personalised Care (Sanderson et al., 2019) and the Scottish Government's (2019b) 'Realistic Medicine' framework, a greater emphasis is being placed on putting the person at the centre of the healthcare process, giving them a say through shared decision making.

There is also, as seen in social prescribing, a recognition of the need to coordinate healthcare between health sector and voluntary sector organisations. While there remain unanswered questions about the way in which voluntary sector organisations are funded to carry out this work or manage the shift in responsibility from the NHS to the Voluntary Community and Social Enterprise (VCSE) sector (and indeed the capacity of smaller organisations to take on this responsibility), opportunities for collaboration are being opened up. Furthermore, the range of professionals who can refer to such schemes is widening to include not only health professionals (such as GPs, Occupational Therapists, district nurses and ambulance staff) but also such frontline services as the fire service and police.

Taken together, what is emerging is a widened health and social care system involving a huge range of organisations, for many of which being considered as part of the health and social care system is a significant identity shift. As is to be expected in an emerging landscape, there are many details yet to be worked out and questions yet to be answered. Great potential exists to reshape health and social care through making sustainable changes in individuals' and communities' lives, and Moving Together was part of that reshaping and rethinking.

2.5 Advice and support around energy and health

Referrals to the Moving Together project could result in a range of beneficial energy-related changes for householders, such as a new heating system, insulation, a switch to a more affordable energy supplier or tariff, access to grants, energy debt management or a combination of these and other measures. Underscoring all this activity was a crucial element of the project and TIG's wider work: the provision of localised and trusted energy-related advice and support.

Households seek energy-related advice for a wide range of issues and from various sources, such as energy suppliers, housing providers and third-sector organisations like TIG. A review in 2015 of the energy advice landscape across the UK suggested that the demand for energy-related advice and support with energy complaints was on the rise, estimating that annually more than 800,000 households were seeking such support (Klein, 2015). However, in the absence of a central database and with data capture across organisations considered patchy and complex, this figure could significantly underestimate the scale of demand.

In a study examining energy advice among hard-to-reach and typically more vulnerable groups, Ambrose et al. (2019) suggested that provision broadly falls into one of two domains: (1) advice on energy efficiency and energy demand and (2) advice regarding switching and broader energy market issues (including affordability). Trends in recent years have shown a reduction in the provision of the former but an increase in the latter (mirroring, as Ambrose et al argue, an overall reduction in support for energy efficiency measures from the Government). The work of the Moving Together project encompassed both these areas.

Energy advice is deemed particularly critical where physical measures to improve the energy efficiency of the home have been installed and where, for instance, this could enable a household to understand and effectively control a new heating system. Fuel poverty charity National Energy Action (NEA) has argued against approaches that address only the energy efficiency of the home and not the capabilities and capacity of householders at the same time. Advice-giving in this context is often referred to as 'complimentary' or a 'softer' measure, but it '...should not be seen as secondary to capital measures but an essential part of the package' (Stockton et al., 2018, p.9). Within the Scottish context of energy advice, Energy Action Scotland echo these findings (Atterson et al., 2018, p.3).

The need for energy advice, tailored solutions and support with energy problems, as opposed to 'off-the-shelf approaches', has also been noted as key to reducing the negative consequences of cold homes for health. In 2015, NICE guidelines called for all health and wellbeing boards to appoint a single point of contact responsible for advising vulnerable groups on the risk of cold homes, accessing affordable warmth, energy efficiency, income maximisation and other related solutions. In the context of Government commitments to not only alleviate fuel poverty but also reduce carbon emissions, the Bonfield Review (2016) similarly made the case for the importance of impartial, trusted sources of energy-related advice. Despite this, the value of energy advice has been overlooked in UK policy to date (Boardman, 2016, p.2).

Energy advice is considered to be distinct from information provision, promotion or education and has been described as support that is '...specific to individuals

and their circumstances, with the aims of improving energy efficiency, comfort and the ability of a household to achieve affordable warmth' (Green et al., 1998, p.3). Darby (1999) expanded upon this to emphasise the importance of dialogue, with advice regarded as 'two-way communication between advisor and client (usually the householder) in order to make clear what the client's priorities and circumstances are' (Darby, 1999, p.1).

A number of studies have focused on what constitutes 'good' or 'effective' energy advice (see, for example, Green et al., 1998; Darby, 2003; Department of Energy and Climate Change, 2014), with general agreement that key characteristics include trustworthiness, accessibility, expertise, experience, good communication skills and knowledge of the local community and policy landscape. Klein's (2015) review outlined that when accessing energy advice households place importance on this being available in different styles and formats, comprehensive and accurate, proactive in terms of supporting those most in need, offering practical support, independent from energy suppliers and free.

2.6 Housing and health in the Outer Hebrides

In considering the social determinants of health and their relationships with housing and energy, it is important to take account of the housing and demographic contexts of the Outer Hebrides. The 2005 Western Isles Fuel Poverty Strategy (Comhairle nan Eilean Siar, 2005) recognised that the islands' housing faced several key challenges. The region recorded the highest percentage of households in fuel poverty and the third worst National Home Energy Rating (NHER) ratings, behind Orkney and Shetland. At the root of the problem, the strategy stated, were 'hard to heat homes due to the traditional mixed form of construction of properties and factors associated with the age of dwelling and lack of a full central heating system' (ibid., p.22). In an in-depth review of the links between poor housing, fuel poverty and poor health, Arnot (2016) still ranked the Outer Hebrides as having the second highest levels of fuel poverty in Scotland.

Rural Scotland

Over the past 25 years a number of studies have examined the interplay of housing and health in rural Scotland, and several have included data from the Outer Hebrides and other offshore communities. The link between housing, health and fuel poverty is recognised in the national islands plan, 'Plana Nàiseanta nan Eilean' (Scottish Government, 2019a, ch.6).

A review of the impact of fuel poverty and housing on Scotland's health concluded that the quality of the Scottish housing stock is poor. Reasons for this included higher ceilings in older dwellings, the poor thermal efficiency of pre-war, inter-war and immediate post-war housing and, in particular, the widespread use of precast concrete construction (Revie, 1998, p.16).

In a training resource on cold and damp housing, Davison (2004, p.18) directed training facilitators to the 2002 Scottish House Condition Survey, arguing that people were not aware of the poor condition of the housing stock. In a survey of local stakeholders for a study of fuel poverty in rural Fife, Delev (2012, p.40) noted that 'fuel poverty exists due to the fact that people live in small stone houses and [have] inefficient heating'.

Since that time a raft of policy measures and many local initiatives have been introduced across Scotland, such as Home Energy Efficiency Programmes for Scotland (HEEPS) and HEEPS ABS for the most deprived areas. Schemes have focused on renewables, energy advice, fuel poverty, retrofitting, community ownership/generation or a mix of these factors (e.g. Comhairle nan Eilean Siar, 2005; Baker et al., 2016; Lesley, 2019).

The Outer Hebrides

Data from recent strategic housing documents produced in the Outer Hebrides are useful for contextualising the housing situation.

The draft Outer Hebrides Local Housing Strategy 2017–2022 (Comhairle nan Eilean Siar, 2017) cited a resident population of 27,684 in the Outer Hebrides based on the 2011 census, made up of 12,576 households with an average occupancy of 2.17 people¹. Although it states that there are 280 settlements on the main and outer islands, approximately a quarter of residents live in the main urban centre, Stornoway. This population is not evenly spread: the largest island, Lewis, recorded 5,903 households in the 2011 census, whereas North Uist contained 587, Eriskay 73 and Vatersay only 37 households (National Records of Scotland).

It is an increasingly older population (although National Records of Scotland data indicate that it is ageing less rapidly than that of Scotland overall), with average household size projected to decrease markedly to well below 2 by 2039 and under-occupation being notable. The accompanying Housing Stock Profile Summary describes a property market primarily comprising private family dwellings, the ownership and location of which are rooted in the crofting system. There is, it notes, a 'long tradition of self-build on family owned croft land [that] meant houses could be of relatively poor construction, and that many were built over a long period of time'. The 2018 Scottish House Condition Survey (Scottish Government, 2020) found that Outer Hebrides households were eight times more likely to have oil heating than those across Scotland overall and that whereas three-quarters of Scottish households had access to gas, only 12% of those on the islands did.

The 2016 local Private Sector House Condition Survey found significant issues with disrepair, with one in five properties surveyed ranked as 'substandard' in terms of

the Housing (Scotland) Act 2006 definitions, and 75% of properties failed to attain the Scottish Housing Quality Standard (SHQS) (Comhairle nan Eilean Siar, 2016). Energy efficiency, health and safety and security were given as the primary reasons. The average SAP energy efficiency rating recorded was 49, against an average of 62 for Scotland as a whole.

Figures from the Scottish House Condition Survey on fuel poverty indicate that the percentages of Outer Hebrides households ranked as either fuel poor or in extreme fuel poverty were at least twice as high as those across Scotland overall and often even higher; this held regardless of property age, tenure and household composition.

For this study, it is worthwhile to note that the first Strategic Priority of the Western Isles' Local Housing Strategy is Housing Quality. The primary objective is to provide sustainability via 'Improvements To Housing Quality, Condition, And Energy Efficiency'. The document goes on to explain that 'good quality housing can potentially positively impact on other corporate ambitions to reverse population decline and the demographic imbalance, and the health and social care agenda to extend independent living and care at home for as long as possible' (p.31).



Mobile bank provides a service to remote customers

¹ Projections up to 2018 are available at statistics.gov.scot and indicate that the population has declined to 26,830.

3. The research

SHUSU were invited to be the research partner on the Moving Together project. We have led on the development of a collaborative evaluation methodology. The research was conducted in two phases, corresponding to the periods of funding received for the project: from March 2018 until July 2019 followed by an extension until end of March 2020.

The study comprised a predominately qualitative methodology consisting of interviews with individual householders and stakeholders and supplemented by an online and postal survey in January 2020. An analysis of the data set held by TIG on the type and distribution of support measures was also conducted.

Interviews

Qualitative interviews were carried out with householders who have received support through Moving Together and actors who had been involved in some way in project delivery. This latter group included members of TIG staff, both in and outside of the Moving Together project team, staff in the participating community groups, GPs, and associated NHS staff. Qualitative interviews create space for in-depth discussion of experiences and reflection on the challenges in the delivery of the project. Householders were interviewed in their homes, providing a comfortable and familiar environment for the interviewees, reducing the need for them to travel long distances to take part, and creating opportunities to refer to and

see elements of the home that may be relevant to their health. Other interviews were conducted in stakeholders' places of work, at the TIG central office, and in some cases by phone.

In the first phase, interviewees were selected in consultation with TIG to ensure a varied representation of different levels of experience of the project. In the second phase, survey respondents were asked to volunteer to take part in an interview and interviewees were selected from those opting in. Due to availability issues during the periods of fieldwork on the island, the interview set was supplemented with additional volunteers who were known to TIG but had not filled in the survey. All interviews were audio recorded and transcribed verbatim ready for analysis. The interviews were semi-structured, meaning that the interviewer prepared a question guide and used this flexibly to guide the narrative in response to the points raised by the interviewee.



Presenting our interim findings in Stornoway, September 2019.

In the first phase, 8 households were interviewed (5 single person households; 1 couple; 2 households of adults with dependents) as well as 15 project stakeholders (including GPs and NHS staff). In the second phase, 9 households were interviewed (6 single person, households; 2 couples; 1 household of adults with dependents), along with 8 stakeholders (including NHS staff).

Survey of householders

A survey of participating households was conducted in January 2020, timed to be near the end of the programme of work and therefore to maximise the number of households that had been supported and to give householders a chance to experience benefits (and any issues) arising from the assistance. Letters and paper surveys were sent to all participating households and participants were given the option to respond themselves online. Entry to a free prize draw was offered as an incentive to participate. In total, 27 responses were received, out of a possible 198 of households supported.

Project dataset

The researchers were also given access to a dataset held by TIG and recording details of the support given to householders during the course of the project. This

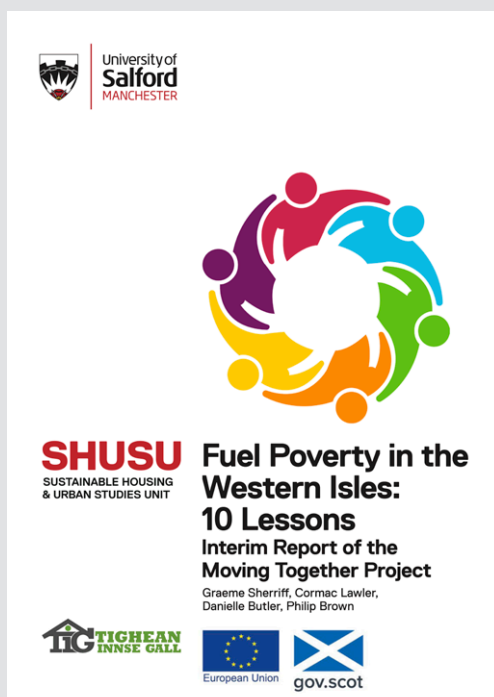
enabled the team to understand and document the reach of the project spatially and socially. This information is summarised in Chapter 4.

Workshops

Two workshops were held at the end of the first phase in September 2019, one in Stornoway and one in Benbecula. The interim results were presented and there was an opportunity for discussion with relevant stakeholders, some of whom had been involved in the project and some of whom would become part of the network during the second phase. At the end of the workshop, three facilitated discussions were held in subgroups.

Presenting the findings

In the following sections we use 'HH' when referring to householder interviewees, 'SH' to denote stakeholders, 'GP' for GPs, and 'TIG' for TIG staff. 'SC' denotes a comment received through the survey.



- 1 There is severe fuel poverty on the Islands, with distinctive features and drivers.
- 2 Tackling fuel poverty on the Islands requires a sensitive and distinct approach.
- 3 Home visits provide vital knowledge of patient context.
- 4 A person-centred approach builds trust and allows support to be tailored.
- 5 Trusted intermediaries play a vital role.
- 6 A multi-faceted approach to prescribing can offer holistic health support.
- 7 Widening referral pathways and inter-agency and cross sector collaboration broaden reach.
- 8 Inter-agency working is enabled by the connectivity of partner organisations and stability of networks.
- 9 'Messy' outcomes can be hidden by narrow metrics.
- 10 Time is required to build an approach that addresses complex conditions.

Box 1 - The ten lessons identified in our interim report

4. Project reach

Over two years, 219 households were assisted through the Moving Together project, with 198 of these receiving support over the course of the project. These figures provide an overview of the reach of the project, both spatially and in terms of the range of people who received support.

Figure 2 provides an approximation of the coverage of the project across the Outer Hebrides, showing firstly the two operational phases and secondly the house construction types. Figures 3 to 8 show the range of housing types, household incomes, benefit entitlements and health conditions amongst those supported.

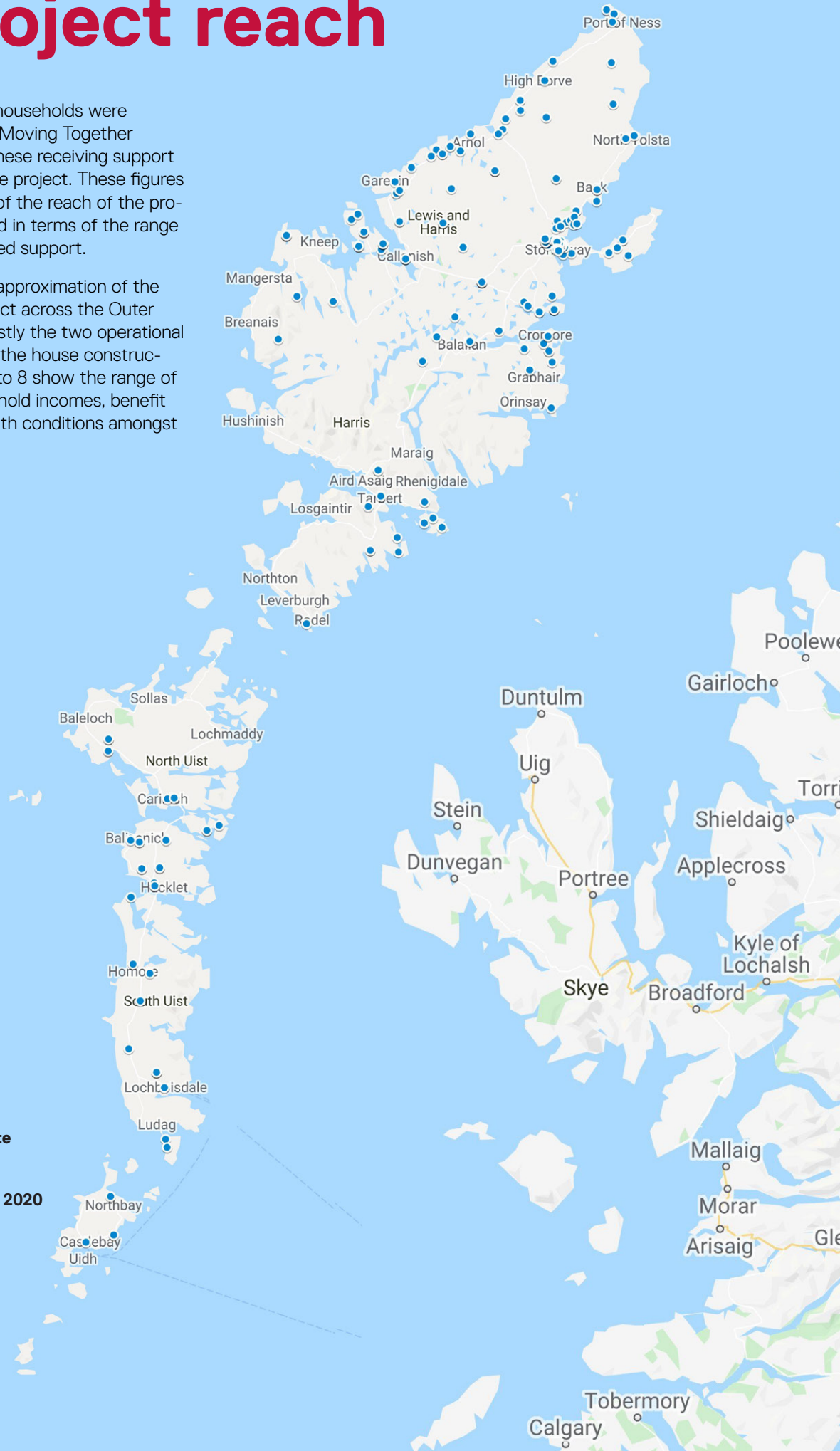


Figure 2 - Approximate location of supported households
Source: Google Maps 2020

Construction Type

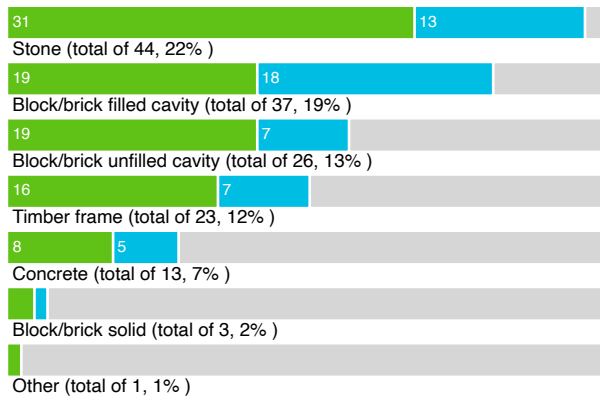


Figure 3 - Construction type of supported households (phase 1 and phase 2)

Household Income

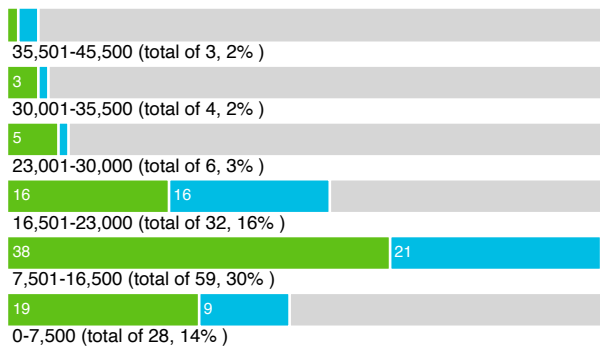


Figure 4 - Household income of supported households

Benefits

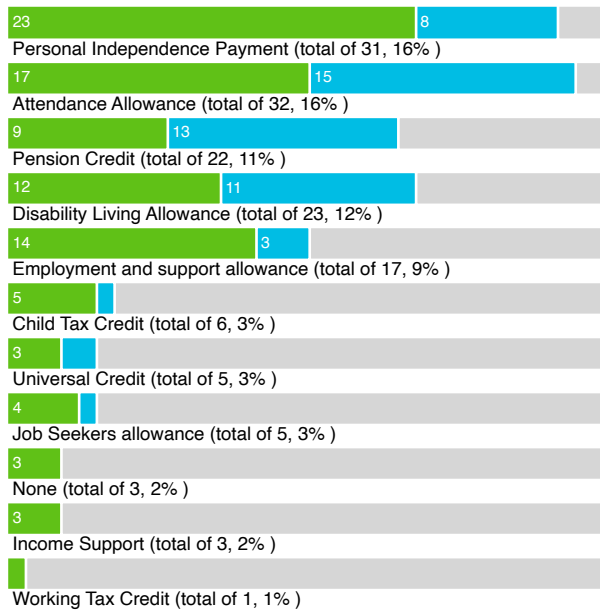


Figure 5 - Number of supported householders within which at least one person was receiving specific benefits (phase 1 and phase 2)

Health Condition

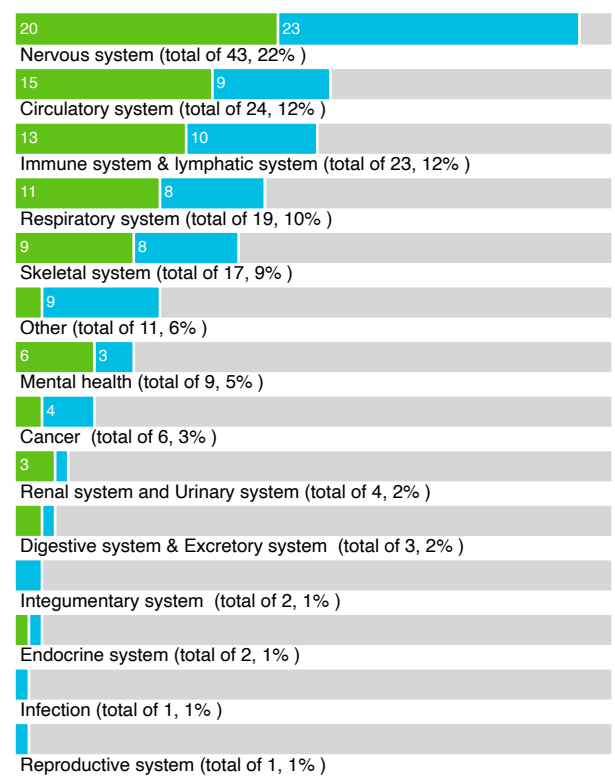


Figure 6 - Health conditions present in supported households (phase 1 and phase 2)

Council Tax

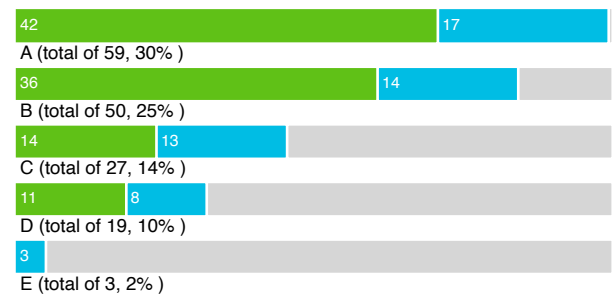


Figure 7 - Council tax bands of supported households (phase 1 and phase 2)

Tenancy

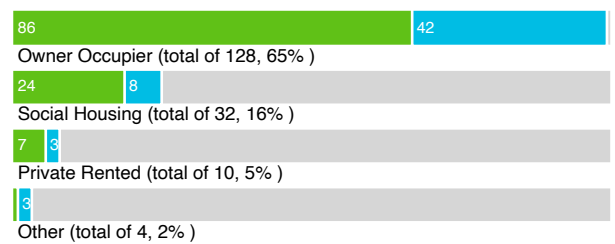
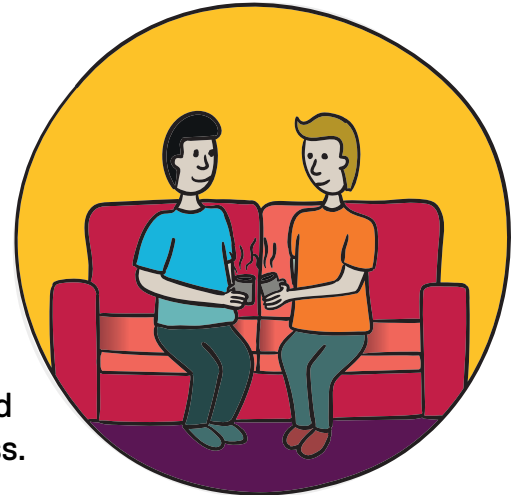


Figure 8 - Number of supported households in tenancy categories (phase 1 and phase 2)

Phase 1 Phase 2

5. Assisting householders

Our research adds to the evidence base relating to the distinct challenge of fuel poverty in rural and remote locations and its impact on physical and mental health. Climate, health, economy, demographics and building stock all play a role in heightening the vulnerability of the Outer Hebrides population and evidencing the need for support through programmes such as Moving Together. Our survey and interviews demonstrate positive impacts upon householders in relation to their health and associated aspects of their lives including social life and financial stress.



5.1 The need for support

Cold homes and health

Our discussions with householders and project stakeholders highlight the prevalence of poorly performing housing stock and the challenges householders face in keeping warm and avoiding conditions such as mould and damp. This reflects the nature of fuel poverty generally, as discussed in Section 3.2, whilst pointing to particular characteristics of island life that present distinct challenges.

This can have a profound effect on health and on those with chronic conditions and can become intertwined with poverty and isolation: *'people will always tell you they've not got the heating on because of affordability' (SH9)*. Even when heating costs can be afforded, this may be at the expense of other aspects of life, resulting in trade-offs that can have an impact upon wellbeing: *'I'd think I need that more than something else, so I won't get the something else' (HH11)*.

A stakeholder told us about a couple who had been hospitalised for hypothermia after disconnecting their heating. They had had storage heaters installed nine years previously but had stopped using them on seeing, through their electricity bill, what the operating costs would be. Interviewees mentioned the practice of turning off heating due to affordability concerns and the associated impact on wellbeing: *'people worry about paying for fuel, heating the house. You go into a house, and they've got the heater on just where they are, and sometimes even after a while they would turn that off, because they're worried' (SH12)*. Even when money is less of an issue, homes can be persistently difficult to heat: *'I can have the heaters on flat out all day, and it is going to cost an absolute fortune, but the house is still cold' (HHB15)*.

Cold and damp homes are known to have an impact upon a range of conditions, particularly pulmonary, respiratory and circulatory diseases, as well as affecting overall wellbeing and mental health. Interviewees recounted experiences of cold and damp environments making their conditions worse. One family spoke about the challenges relating to a child with juvenile arthritis. Another emphasised the importance of a warm home during their recovery from cancer, with a second describing their ongoing tendency to confine themselves to their bedroom as a *'bolthole'* in order to avoid the cold in the rest of the house: *'You just sort of snuggle up... [and] poke your nose out, and you think, it's cold out there!' (HH7)*.

A GP interviewee gave an example of the impact on householders of a combination of poor conditions and a sense of powerlessness. The GP spoke of a patient with *'long-standing problems with low mood and anxiety'*, who was *'finding it a struggle to keep the place warm, to keep the maintenance up, and that was obviously causing him concern and affecting his mood further' (SH11)*.

The effects on household life more generally were discussed. A family explained, for example, how they had to limit the use of rooms in their home: *'We used to have that room as a bedroom, but we can't have it any more because it's so damp. It's too dangerous. I slept there last winter as well, and it [affected] my chest... I was getting migraines and everything, and that's with the heater on pretty high up' (HHB15)*.

Social life can also be affected. One couple reflected upon visiting a friend who had the heating at what they felt was a low level. They recalled that *'you can feel the damp in the furniture'* and that it affected the husband's arthritis and the wife's hand. They commented that *'I love to see her, but is it really worth it? We get so cold' (HHB12)*.

The ageing population on the islands is also a consideration owing to the increasing prevalence of chronic conditions, fragility and vulnerability to the cold and is also related, although by no means always, to capabilities and confidence. As in other rural areas, shifting demographics have meant that fewer older people on the islands now receive care and support from their own families (Course, 2019). An example of a challenge is carrying wood pellets for stoves: *'I used to be able to bring in that bucket full. Now I can't. I use a smaller tub and fill it'* (HH11). Another is confidence in making phone calls, using the internet and writing letters: *'I'm not part of the computer generation, to sit there for what would take me hours on end to try and look for a cheaper tariff, you know, it's easier to stay with the one you're on even though you may well be paying the thing...'* (HHB18).

These capabilities can vary and can be related to mental health and the impact of chronic conditions, as illustrated by this interviewee with Parkinson's disease, who had been given assistance in writing a letter: *'when I'm in the right mood I can get that done in no time at all, but it's when you're in the mood to do it, and getting started is the hard thing'* (HHB18). The relationship is bidirectional: a cold house will have an impact on health, but health and physical and mental conditions can limit a person's ability to keep themselves warm and create healthy conditions for themselves, and even to realise they are in difficulty: *'...there comes a point with my mental illness, I've noticed that I don't even notice that I'm also cold... It's like anybody, if you're cold you're not comfortable*

and everything is harder' (HH5). Where householders have chronic conditions, such as dementia, these may limit their ability to make decisions about their health and their home. As an interviewee from TIG reflected, sometimes dealing with health conditions can limit the capacity to keep on top of managing the household: *'You think, well, is it because if they've got the health condition they've got enough to deal with?'* (SH14).

The island context

In understanding the condition of the housing stock and the experiences of the householders, the distinct situation of the islands must be taken into account. This includes the climate and overall standard of living. In discussions with householders and stakeholders, there were numerous references to heavy rain, cold and longer winters, wind chill, winds blowing through homes, storms that brought damage to houses, noise from wind and power cuts. The Outer Hebrides as a whole have the lowest average income in the UK and the highest rate of fuel poverty in Scotland (Course, 2019).

Our interviewees described further characteristics of island life including higher costs of energy, higher prices and longer waiting times for supplies such as fuel and materials for retrofit, predominantly detached and exposed homes and isolated individuals and small communities. Most relied on electricity, and gas connections were much more limited outside Stornoway itself. The scale of the islands added a particular challenge to the delivery of



projects centred around home visits: *'The geography is vast, and it's not just simple to get to the home visit and back up. One home visit might take you a whole day'* (SH4).

Experiences of fuel poverty and the challenges around energy use on the islands were to a large extent shaped by islanders' lived experiences and the distinctive history and culture of the islands, characterised by practices – albeit less common in modern times – that include crofting and the communal cutting of peat and its distribution to those in need: *'the community would do it and they would give free peat to the widows and people who couldn't do it for themselves. That's all died out now'* (SH14). Interviewees referred to historical practices as signs of a strong culture of interdependence – of working together and helping each other – most notably around the practice of peat cutting, which the interviewees repeatedly referred to as fading into the past: *'The folk now, they've stopped cutting peat together, so there's not the same community thing. People used to mix a lot there. Your neighbours used to come and help you with stuff. They don't do that now'* (HH4).

Our conversations with islanders suggested a strong culture of self-sufficiency and resilience, particularly in relation to the cold: *'My father... was a great believer in sticking on an extra jumper, that was his kind of mantra'* (HH2 & HH3). One householder reflected on historical change, feeling that islanders had previously been harder: *'...[the cold] would have been previously worst for them... You know, these people were – I don't know, they were from another sphere all together! Do you know what I mean?'* (HH1).

The social fabric of the islands was another important consideration. One aspect of this was the neighbourly and community-minded spirit of helping each other: *'I think, well maybe it's the benefits of living in small, rural areas, there's a lot more interaction with friends and neighbours, and there's usually always somebody who'll help somebody'* (SH5). This community connectedness, however, *'can work against you'* (SH13) in that people may have been reluctant to spread some messages – concerns about fuel poverty,

for example – far and wide *'because by doing that they have to admit that they actually had an issue themselves'* (SH13). One of the GPs reinforced this point, noting that *'I think there's a lot of pride stopping people from maybe taking advantage of things they might get benefit from'* (SH11) and how this pride may have prevented people from accessing support in public: *'people are a little bit private about difficulties they may be having, and they maybe don't really want people to know that they're accessing this type of service'* (SH11).

This pride in self-reliance and the potential 'stigma' of being in need – which perhaps echoed the culture of resilience – were key factors shaping how Moving Together stakeholders had to be both sensitive towards the needs of householders and creative about the ways in which referrals can work in a project of this nature.

5.2 Understanding impacts

Our understanding of the impact of Moving Together on participating households was gathered through our interviews with householders and their responses to our survey, as well as some reflections from stakeholders.

Figure 8 shows the range of forms of support afforded to householders as part of the programme. These included home visits to look at energy issues in the home and/or provide advice, and then in some cases to make referrals to other services. The initial conversations resulted in focused assistance, including help with bills and switching tariffs, identifying and applying for relevant grants and benefits, insulation, surveys of housing condition and monitoring. Other forms of assistance included installing renewables, and helping householders access LED lights and energy-efficient white goods. It is worth noting that this support is what TIG were able to give rather than necessarily the totality of the help required by the householders. TIG were limited by the size of contribution householders could make, the availability of funding, and the cycles of that funding. This latter issue illustrated, for example, in the five-year cycle of Warmer Homes Scotland (part of HEEPS) whereby a householder would not ordinarily be able to get support for both heating and insulation in the same period.

In our conversations with householders, references were made to increased comfort in the home, and this was recognised by the stakeholders who had been engaging with them: *'Yes, some people are delighted; they notice it's great, and you have to say, 'Oh yes, turn down the heating'. That's when you know'* (SH12).

As described in Section 6.1, householders evidenced a range of challenges relating to the quality of their homes and the impact on their health. This interviewee told us they had been close to moving away from their home but were now more confident that they could achieve a comfortable temperature in their current home: *'it was coming to the stage that I was nearly, I would be better moving into another house for my health, but*

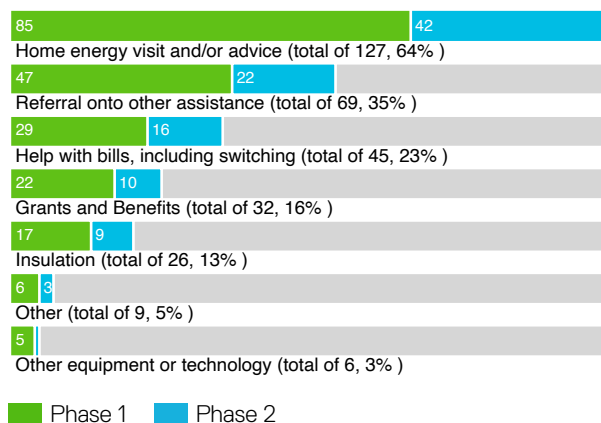


Figure 9 - Help given to participating householders. Note that some households received more than one form of help. (Moving Together project records)

it's warm now' (HHX). Another reported a large change in temperature in terms of the difference from the outside temperature: *'Before the external insulation was done, we reckoned on average the difference between outside and inside was about ten degrees... after the external insulation was done... we reckoned it had gone up to about 20 degrees' (HH11).*

Packages of measures, such as replacement boilers and tariff switching, could have a positive effect on lives: *'Within just over a month the survey had been done, the boiler was in, it had all been commissioned, [member of TIG staff] had sorted out the electric and was saving us £50 a month, £364 a year' (HH11).* These physical improvements were associated with broader wellbeing:

It's a physical improvement, but it's also a mental improvement, because they know the house is warmer and they know they don't have to have the heating on as long, therefore they won't be hopefully spending as much on cost of fuel, whether it be oil or coal or whatever. So you're helping them twofold... (SH12).

Helping to lower costs could result in people being more confident to use their heating – *'I can put the fire on again' (HH1)* – and could also have implications for other aspects of life, including diet, social life and mobility. A particular example was a householder with reduced financial stress as a result of home insulation, who lived on their own and had been able to buy a car after having more money available. This gave them greater flexibility, and they described easier access to shopping facilities and now being able to visit friends. It also helped with visits to the doctor, as they no longer needed to plan long bus trips:

It's made – you're more independent, you can go, it's just like if you've got an appointment with someone, even doctors. I was saying at the doctor's, she could hardly believe it all. I've got a car, because I had to get a bus, and if you had an appointment you had to arrange, 'When is my appointment?' Eleven o'clock, if my bus is at ten o'clock, I have a wait of nearly an hour sitting. I'll be falling asleep before the doctor appears (HHX).

In some cases, individuals were helped financially in other ways, including through advice on and help with switching to more affordable tariffs and help with addressing debt repayments. In some cases, substantial savings were to be found simply by switching tariffs. One stakeholder described their visit to a householder who had amassed hundreds of pounds of debts and was able, through a phone call to the agency, to arrange a revised payment schedule. They recalled the householder's reaction: *'For the first time in my adult life, I'm now debt free. Thank you very much' (SH6).*

Stakeholders observed that debt was a substantial problem on the islands and recalled dealing with households struggling to cope financially, as well as with personal bankruptcies: *'we're a small island, and I think last year we dealt with over £1 million of debt, which is quite phenomenal' (SH1).* Helping to alleviate debt could be a powerful way to help people: *'A £50 debt write-off can mean more to that individual than £15,000 worth of*

measures... the impact I've seen of people with what to you and I would be a relatively small debt has on their lives is enormous' (SH13).

One member of the TIG team described the impact on the life of this householder of having support with debt, as well as their awareness of and trust in the support networks available:

[It was] completely transformed. She went back to sleeping... she changed job in order to make it more affordable. It completely changed her outlook, but it also made her aware that the support network was there, so that if she saw that she was losing control of anything, all she had to do was pick up the phone (SH13).

Knowing that there were supportive organisations and programmes was reassuring for interviewees, with the potential to assuage anxiety: *'So, suddenly for [member of TIG staff] to come along, she was like a breath of fresh air for us, and we couldn't believe that people out there actually wanted to help us, if you know what I mean, because we've always been so independent' (HHB12).* It is important to remember that, whilst material changes to houses and financial savings were the measurable outcomes of the project, this feeling of support and guidance and the benefits of this for mental health and wellbeing should not be underestimated:

I think it was really conversations with [member of TIG staff] that spurred me on to get things better organised. I'm not sure if I said to you; I think I may have done, you were just so helpful. If you hadn't come into my life at that time I probably would have hit the depression, but it was just that you were coming up and you were asking questions that were small questions, but they were huge in my mind and something that I felt I've got to act on this or I'm going down the river. (HHB6).

This householder evidenced the potential for concern about the deterioration of the home to contribute to anxiety: *'I am now warm, and I am less anxious re deterioration of the house in the cold and damp' (SC).*

The responses to the online questionnaire provided an overview of householders' views of the assistance they were given as part of Moving Together and the ways in which this had affected them. Although the sample size was relatively small, Figure 9 to Figure 11 reveal some encouraging trends.

Figure 9 shows a slight trend towards using heating systems less. That some of the respondents used their heating system 'much more often' should not be seen as discouraging. Interviewees noted that one of the effects of benefits assistance and tariff switches was having more confidence to use the heating when they needed it: in terms both of having finances available and also understanding how to use their heating system efficiently.

This householder felt they no longer had to use as much heating to maintain a comfortable temperature: *'I only tend to put heating on when I feel the rooms getting cooler, and since the wall insulation has been installed I seem to be not doing it until later in the day, usually'*

(SC). Several householders mentioned having to use supplementary heating less often since changes had been made to their house or heating system. This example relates to a newly installed air source heat pump: *'it's on all the time on a low setting, but I don't now need to use the electric fire to supplement the heaters'* (SC). These benefits notwithstanding, one respondent noted that *'it is [still] very expensive to run all heaters in the house'* (SC).

With this in mind, it is encouraging that Figure 10 shows that the majority of respondents found that their homes were warmer on a cold day. One commented that their home was warmer *'but it's costing me a lot less'* (SC). These comments illustrate this:

The thermostats on my electric radiators are cutting in more often, indicating that the rooms are keeping the heat in better. I have not change[d] the settings on these either (SC).

The storage heaters were inefficient. Even in the summer months I would have the fire on quite often. Now the thermostat is set at 18°C, and it's warm all the time. The actual temp is around 21°C (SC).

Upstairs is noticeably warmer. We don't use it much, so the heating is always set low there. Even downstairs is warmer now (SC).

This householder described their positive reaction to the changes:

We were astonished by the difference in temperature even on the first day of the works. It is marvellous to have the whole house warm instead of a cold upper floor and a warm ground floor. If we get snow, we're looking forward to seeing it remain on the whole roof area instead of thawing on the upper roof while lying on the well-insulated [newer] lower roof (SC).

Figure 10 shows a slight trend towards lower heating costs. Some respondents were able to state this explicitly. It should be borne in mind that it can be difficult to estimate cost savings soon after retrofit, and one respondent noted this in their comments. It is also the case that older people living off savings may be less likely to observe savings on a monthly or annual basis: *'I live on independent means at this time with no regular income so do not see any change in available money'* (SC).

Use of Heating System

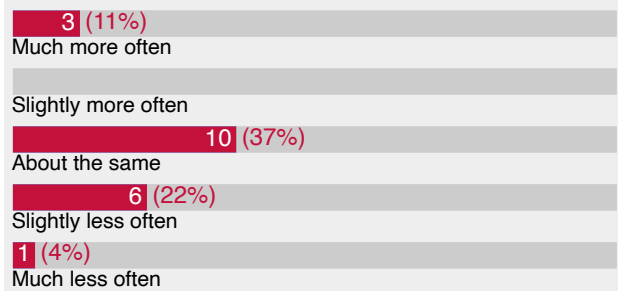


Figure 10 - Compared to before, do you now use your heating system...?

Temperature on A Cold Day

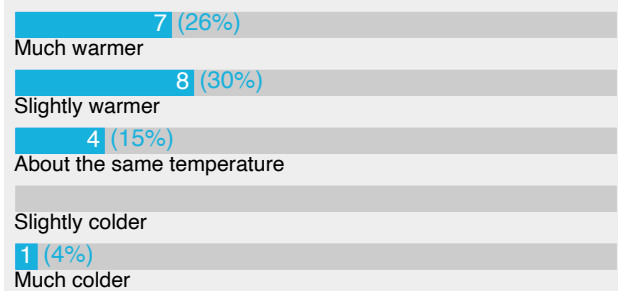


Figure 11 - Compared to before, on a cold day is your home now...?

Cost of Running the Heating System

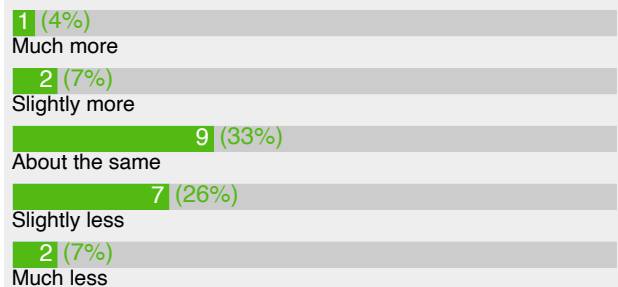


Figure 12 - Compared to before, how much does your heating system cost to run...?

Figures 13 to 20 provide further results from the householder survey. These should be interpreted with care. On the one hand, they suggest no clear relationships with overall health, ability to cope day to day, visiting GPs and seeking support from the NHS. On the other hand, this may reflect the nature of long-term conditions, which are not only unlikely to change significantly over the relatively short timescale of the project but are also subject to their own variances over time. One respondent illustrated this – *‘There has been no change to my health due to these improvements, nor was any expected’* (SC) – and another noted the role of new and evolving health issues: *‘I know I am better for the improvements, but I have had other health issues [that are] unrelated’* (SC). It is also the case that, however much energy-related impacts can be addressed, there may remain issues in the house that continue to affect wellbeing. One householder mentioned the accessibility of their stairs, for example. It is also worth noting that it may not always be possible for a householder to specify benefits precisely, particularly over a short period of time, as one respondent told us succinctly: *‘No change, just happier’* (SC).

Householder comments reflected additional, less tangible impacts on wellbeing. One householder described being better able to cope, reporting that *‘other events have challenged me and affected my coping overall in 2019’* but that *‘in respect of the work done, I cope better in the house, which is so important, as I rarely go out’* (SC). Another reflected that *‘although the work has only just been completed, I can already see that I’ll enjoy going upstairs much more’* and that this *‘should mean that I’ll be able to keep things organised much better’* (SC). Similarly, this householder referred to a more satisfying home life in general and related this to confidence when interacting with others: *‘Also confidence in active public life’* (SC).

It is worth remembering that improvements can help a house to remain habitable: *‘The improvements to my house in 2004 was very good. And without it nobody would be living in it now’* (SC). In one case, the householder found that the improvements helped with anxiety about house fires, carbon monoxide and other safety issues. One householder reported that storms were now not as noisy and that *‘I can now stay upstairs in my bed in a storm’*, whereas they were *‘always having to flee downstairs to the sofa before...’*

Whilst Figure 12 implies that there was little change in how householders lived in their homes and coped day to day, respondents provided some encouraging comments:

I expect to spend less time in bed during the day, trying to keep warm (SC).

I’m not aware of what I do being different, but whatever I do I have the comfort of being warm, which encourages me to be doing some activities [that] are challenging when I am cold. Being warm/comfy is motivating (SC).

No need to wear a cardigan as often when the heating is off, as the warmth no longer runs away through the roof (SC).

One respondent, who had said that guests visited about as often as before, commented that their experience was now different: *‘but I don’t have to worry about them being cold when they come’* (SC). Another added that they *‘expect to have guests at the same frequency as usual. However, they won’t need the heating on in the upstairs bedrooms next time’* (SC). Another observed a changing culture: *‘Due to the passing away of the older generation, younger people do not visit houses now, like the people that went before’* (SC).

Other comments acted as a reminder that challenging conditions persisted. One householder said that *‘because it’s cold I stay in bed longer and sit with a blanket on me at night’* (SC). Another reported that *‘being on one’s own in the house on cold days I have to be at fires, heat settings, constantly’* (SC).

Figure 19 indicates a high level of satisfaction with the service provided as part of Moving Together. In their comments on this question, householders reflected on the importance of the approach of allowing time to build relationships and support householders through the process, as well as the value of knowing that there are people and organisations there to support them:

The staff at TIG could not be more helpful. They dealt with the change of electricity tariff, fitted LED bulbs throughout the house and liaised with occupational therapy to fit hand and grab rails. They deserve a medal for the help and peace of mind they give! (SC).

It wasn’t easy for me to deal with the doing of it because of my difficulties, but the folk at TIG were so very patient. I was so grateful for all their kind help and encouragement (SC).

Just knowing that people care and are willing to help and make suggestions to make life easier is wonderful (SC).

The staff at TIG have dealt with other organisations on my behalf, taking the onus and burden off me, thereby giving me peace of mind, reducing stress levels and saved money on electric tariff as well (SC).

In this chapter we have established the relevance of Moving Together in the context of a challenging support environment and a climate, building stock and population that mean that the relationship between housing and health is particularly pertinent. We have provided evidence of the programme providing meaningful assistance to householders and, in turn, of health and wellbeing benefits in the context of their long-term health conditions. In the next chapter we consider the network of organisations providing that support.

Effect of Temperature on Indoor Activities

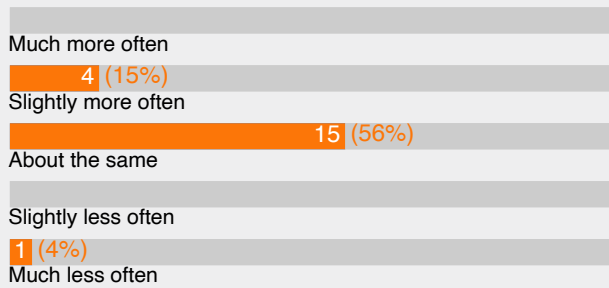


Figure 13 - Compared to before, does the temperature of your home affect what you do at home

Money Available after Bills

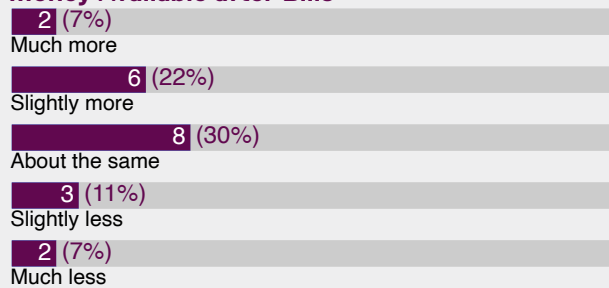


Figure 14 - Compared to before, how much money do you have available to spend once you have paid your bills?

Frequency of Social Visits to the House

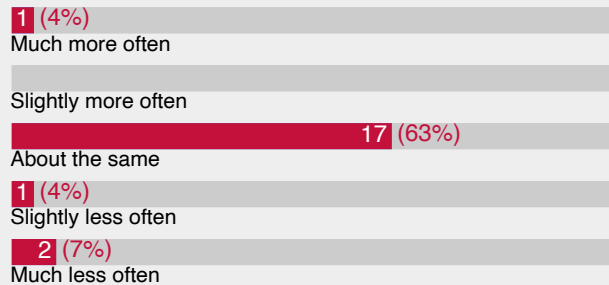


Figure 15 - Compared to before, do you have visitors in your house...

Overall Health

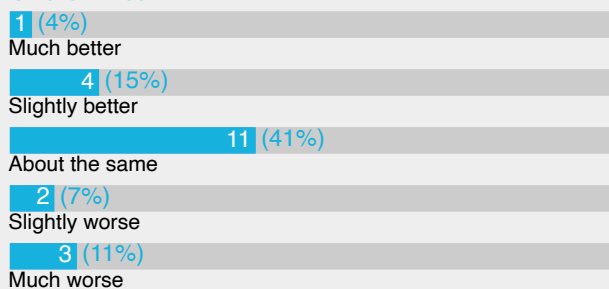


Figure 16 - Compared to before, is your overall health...?

Ability to Cope Day-to-Day

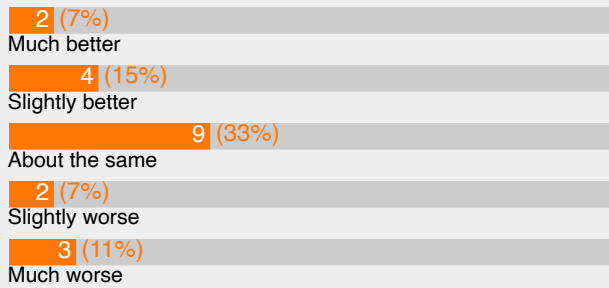


Figure 17 - Compared to before, is your overall ability to cope day to day...?

Frequency of Visits to GP

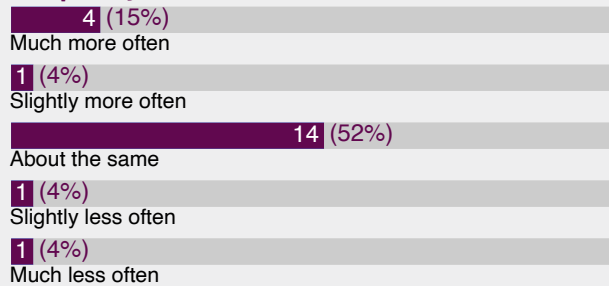


Figure 18 - Compared to before, are you visiting your GP...?

Other Support from NHS

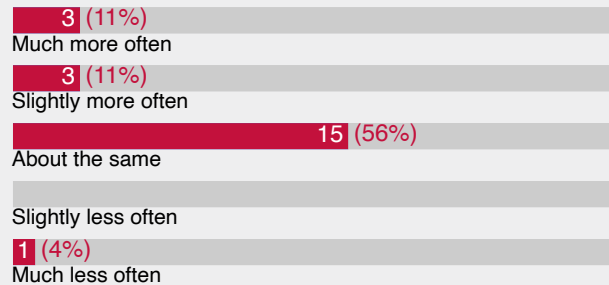


Figure 19 - Compared to before, are you getting any other support from the NHS

Help Provided by TIG

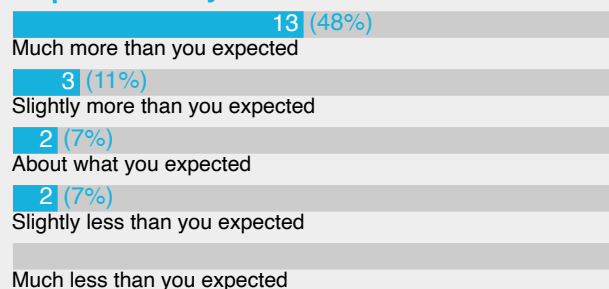


Figure 20 - Would you say that the help provided by TIG was...?

6. Supportive networks



Moving Together built upon established collaborative practices across the islands, bringing much needed expertise on housing and health, as well as skills and capacity in providing support to those with long-term health conditions. Over the course of the project, the widening of the referral pathway – encompassing not only GPs but also a diverse group of health professionals – was transformative in enabling a wide range of householders to benefit from the programme.

6.1 The network effect

Across the islands, there is a network of community and support organisations with ongoing collaborative relationships. TIG is an established part of this community, and the Moving Together bid grew out of discussions with other organisations and an awareness across those organisations of the importance of the condition of homes, the ability of households to maintain healthy indoor environments and the implications for those with chronic conditions of not being able to do this.

Moving Together was able to build upon and strengthen existing networks on the islands, reflecting to some extent the strong sense of community:

I actually met [member of TIG staff] she was, you meet all sorts of people when you're travelling around, so when we were travelling on the ferry together to Barra, and I just asked her who she was, I saw she had a badge on, and then we got talking, that was the first time I'd met her. Then she fully explained to me what she did and what referrals to give her. So a lot of it is word of mouth, but actual contact would be by email or phone (SH23).

Moving Together was welcomed by our stakeholder interviewees as a way to begin to embed knowledge relating to energy issues across these networks. Part of the recognised value of the project was in its potential to contribute towards the wider goal of reducing time spent receiving hospital treatment: *'...a big part of our job is keeping people at home and keeping them at home safely, rather than them having to go into hospital'* (SH11).

The project was also recognised to provide additional capacity to bring in advice and expertise on energy and housing quality issues, where stakeholders outside TIG may have struggled to allocate the time:

...it's lovely to be able to just hand that over to someone who, that's their job, it's much easier for them to sort out than for us (SH16).

Absolutely, and that's a good thing because they have time to spend explaining. I mean I haven't got the knowledge... The TIG staff, they've got the time to sit down and explain all that (SH14).

This stakeholder from a support organisation had previously been aware of TIG but not necessarily of the detail of what they could do for householders: *'So we know enough to say we're aware of the work that they're doing and that they'll be able to help you with this, but not necessarily how they'll do it'* (SH17). This provided an opportunity to refer on to them:

If throughout the course of that conversation they might mention something about the house is cold or they can't afford to pay their electricity or there's damp or anything at all like that, then I would say, 'Well, I'm not an expert in that, but I know somebody who is, so we'd like to refer you to TIG' (SH17).

Working together was also valuable in navigating the funding landscape. Joining forces meant being able to make the most of the array of different types of funding available and – when only certain organisations could access specific funding types – to maximise the chances of securing assistance for householders.

The sense of additional capacity was felt not only by the partner organisations but also by other teams within TIG working on the more operational side of support around energy and retrofit. The Moving Together team, they commented, provided capacity to engage with householders, as well as expertise on health conditions and experience of working with householders:

That's what the Glusad Còmhlà are great at... helping us to get more people, but also we'd be referring to them, and they would then be able to get people things like white goods and give them energy advice and how to improve things around the house, which is the stuff that we didn't really have time for, but that's what they were great for (SH12).

This implied that it was not necessarily the Moving Together project per se that enabled this but also the overall strength of relationships and communication and the increasing profile of TIG, and that Moving Together had played a role in building this:

Because things do take quite a long time to bed in, and there's so many different grants and pots of money and pots of resource it's quite difficult to find what they are. But now they know they can just phone TIG for, you know, it might not be Moving Together, it might be something else, just have a general talk around the person and their needs (SH13).

In dealing with vulnerable customers in particular, trust is vital, and this is often built through ongoing contact with householders. Interviewees referred to processes of earning the trust of islanders and getting past what one stakeholder described as a 'natural island reticence' (SH13). Stakeholders noted what could be referred to

as a network effect, whereby meaningful partnerships with trusted organisations were seen to help to spread trustworthiness across the network. Working together as a network can therefore benefit from the multiple relationships fostered across a range of organisations and a diverse group of householders. This helps to add authority to messaging around energy, which is something that benefits the network as a whole. One stakeholder who worked for an advice service noted:

'Well, we'll refer you to TIG', they take that as an endorsement. That TIG are endorsed by [the advice service], that we're not going to refer them on to some sort of scam company or a sham company or a cowboy, so because it's come from [the advice service] (SH10).

They added that the involvement of the NHS staff also gave authority to the message: *'maybe they feel like, well, if my nurse has said that I'm entitled to this then I probably am... I've found that to be a really good way of getting around that stigma and resistance'* (SH10).

As this stakeholder observed, word of mouth through existing and expanding networks was instrumental in building this level of trust.



A traditional sheiling, Lewis

Interviewer: Again, would it be fair to sum up then that word of mouth has been a key way that information has been communicated about the initiative and also that word of mouth relies on the fact that people are saying this is an initiative you can trust?

Yes, that's the – they'll phone [member of TIG staff] or they'll phone the team and they'll just seek advice, and they know it's confidential and they'll know that she'll have their best interests at heart. If she can't help them, she'll pass to another department or she'll speak to another department and then advise the person on their thoughts (SH12).

There were two aspects of this trust building. One was the network effect, whereby organisations afforded trust to each other by being associated across the project. The other was the extra time and capacity the Moving Together funding provided, so that more time could be spent with householders and by people with knowledge in health and skills in caring and support. A (non-TIG) stakeholder remarked:

That's a good way of describing it, trust building; it is all about trust because we can't – we don't have enough time, or we don't feel we've got enough time, to gain their trust. Sometimes it can take months: when we get a phone call, we arrange a survey, and people don't always want that. They're not always sure who's coming round with us. When someone gains their trust it makes a big, big difference (SH12).

The importance of trust was emphasised as a means of widening the engagement of the project: *'because they obviously trust her, and therefore by default that trust then is, albeit cautiously, transferred to you. And that's for me the most invaluable way of targeting the people most in need'* (SH13). This could be seen within TIG, as well as across the wider network:

Glusad Còmhla would work with someone until they felt they were comfortable for us to be approached... that sometimes takes several months to get the trust. I think that's the big thing with Glusad Còmhla; they get the person's trust. There's no aggressive, 'You can get free insulation, you should do it now...' (SH12).

An additional contribution of Moving Together was an ability to afford those with health challenges a degree of prioritisation:

Well, all these options: there's advertising, there's word of mouth, there's referrals from [member of TIG staff], etc. The ones when – like when [member of TIG staff] refers one they used to take priority because it's usually a health issue, so they would, not jump the queue, but we'd make sure that they were a priority when we went to that area next (SH12).

Time was an important resource, not only in terms of building relationships with individual householders but also in establishing the network and building its strength. One stakeholder interviewee indicated that they were only then at a point where they felt confident to refer to Moving Together, but they were concerned that the time-limited nature of the project would mean this momentum was lost: *'I think people are just beginning to feel confident about referring into the Moving Together project'* (SH13). These interviewees spoke about the longer-term implications of this and the challenges likely to be faced once the project closed:



Discussing Moving Together with project partners in Uist, September 2019

...it's a great asset, and, like all projects which have a timescale attached to them, that is, one of the issues is that people are used to things when they've been around for a couple of years, and it's the sustainability of the project and knowing if it's just going to be a short-term thing or if it's going to carry on (SH13).

...because it's building up momentum... They're just giving you honest advice that benefits them, benefits the customer. So yes, it's a shame that some of the momentum will be lost, because we really won't have anyone in – we won't have a link with the different community groups. We'll try to, but I'm not sure if we'll be able to, just because it's very time-consuming (SH12).

On the one hand, the network meant that many people were used to visitors offering a range of services to them. However, the multiplicity of support organisations available meant that some stakeholders indicated that Moving Together was only one of a number of agencies competing to secure referrals or access from their service (SH16). Where workers have limited time with a client, this may have an impact on their ability to raise such opportunities and pass on information, or they may prioritise one client over another.

6.2 Prescribing support

The GPs we spoke to were uniformly positive about the aims of the Moving Together project, whilst also being candid about limitations they had experienced in delivering on project outcomes through their prescribing. Recounting the ways in which they felt the Moving Together project had integrated, or disrupted, their ways of working, they reflected on the current transformation of the health service and the roles played by various organisations.

The GPs spoke about the limitations of the resources they had at their disposal when faced with complex health issues and other interrelated problems, and it is important to acknowledge the practical constraints placed on GPs in the form of short appointments and high patient volumes.

Despite these constraints, health professionals saw potential in the holistic nature of Moving Together and argued that it *'provides far more answers to people's needs and issues than we [GPs] can provide. It's nice to have that, because often we do feel like we're trying to battle complex issues with our simple solutions, which clearly is a losing battle'* (SH10). There was also a sense that Moving Together had increased their awareness of the impacts of cold homes and provided them with a mechanism through which to act. Prior to the project, one GP recounted, although there was an awareness amongst GPs of the impact of fuel poverty on patients' health, there was *'an ignorance of how to do anything about it'* (SH12), implying that this is something Moving Together had helped with.

There was a recognition that the conventional approach based around prescribing medicines has a limited ability to change the underlying issues that give rise to the

symptoms diagnosed within a medical consultation and that the work they had been part of in Moving Together broadly reflected the social prescribing agenda outlined in Section 3.3. Medicines can be presented as a *'simple cure for their complex issues, and, surprise, surprise, they often fall flat on their face'*, argued one GP, but through approaches such as Moving Together *'the real issues are dealt with that make a positive difference to people's lives, so clear we should be doing better'* (SH10).

Nevertheless, the type of prescribing that Moving Together aimed for was to some extent trying to *'chang[e] the mindset of clinicians'* (SH12). This was, they argued, a considerable challenge, considering the medicalised nature of doctors' training: *'[this] is the thing that I think is going to be quite difficult because we are medically trained, medically focused'* (SH12).

Each GP welcomed the opportunity to conceptualise their patients' ailments from a 'holistic' perspective. As the project progressed, however, it became evident that, despite the GPs being supportive of its aims, there were not as many referrals from GP practices as had initially been envisaged: *'I'm [a] really strong an advocate of it, and I'm a really poor referrer'* (SH12).

In large part this can be attributed to two factors, namely, the time constraints of a consultation that prevented a more holistic exploration of a person's symptoms and the causes of their ill-health and, less tangibly perhaps, an embeddedness within a traditional medical prescribing model. GPs spoke of how, despite the project being on their minds daily, the everyday pressure of the typical ten-minute consultation meant it was often neglected:

So, we're not necessarily very good at promoting it within the consultation, but... we are trying to achieve a lot in ten minutes, so sometimes that can mean it gets forgotten about or you remember it after the consultation (SH11).

This householder's account illustrates how the constraints of GP consultations could prevent account being taken of a broader range of issues:

There was a period around about the time that I told the doctor I'd got Parkinson's, because they never diagnosed me, or my GP didn't diagnose me. He said I'd got a bit of central tremor, or whatever they call it. Misdiagnosis. Eventually, I said, 'Look, you keep telling me that I can only come in here with one problem, but what if all the problems I'm trying to get you to listen to about are the same thing?' Basically, what they do is you can go in and talk about a headache, but you can't talk about the fact that your legs ache, your ears ache, or whatever goes with it, so they can't make a complete diagnosis on one facet of it. Doctors' consultation time is limited. I eventually got them to send me to a neurologist... (HHB18).

This householder, however, hinted that the situation was changing:

I remember when I was going back years and years. A doctor wouldn't really do anything apart from your medical, checking you out and all this carry-on, but they do more than that now, so that's quite good (HH1 follow up).

GPs recognised that the success of projects such as Moving Together, to the extent that they try to reduce the incidence of cold homes through prescribing, relies to some extent on changing their own behaviour. One example of this change is broadening the scope of questions on lifestyle to focus not only on habits such as smoking but also on factors relating to the home and home life: *'are you cold? how are you heating yourself?... what do you do with your life?'* (SH12). It's also about getting into the habit of doing things a little differently, and this related to getting used to using the IT platform through which referrals to Moving Together could be made: *'It's about understanding the system better. For me, if there's a new technological thing and I'm not using it every day, then I very quickly forget exactly what I ought to be doing with it'* (SH14).

Our discussions indicated that there is a need to be sensitive in proposing this transformation of GP practice and to consider the implications for GPs and their professional identity. One GP reflected on the potential impact of bringing organisations and professionals into an area that has to date been solely theirs and one that requires new skills and knowledge: *'We don't focus on all the psychosocial aspects in the same way, and it is quite an uncomfortable shift for us, I think, because we are straying into areas that we haven't got a clue what we're on about'* (SH12).

This had, the GP observed, led to colleagues feeling uncomfortable in clinical meetings when talking to TIG and project stakeholders, supposing that *'they feel a little bit vulnerable, I think, because their authority gets taken away'* (SH12). The GP positioned this, however, within the overall direction of travel in healthcare provision towards a more collaborative patient-centred approach: *'the way healthcare is going... we are all going to be much more multidisciplinary, and I'm not the boss any more, thankfully, it's a shared decision between me, the patient and the other healthcare professionals'* (SH12).

6.3 Referral pathways

Widening the pathway

Moving Together demonstrated that the responsibility does not, or need not, only lie with GPs. It can be broadened out to include the health service in a wider sense. This transformation has also been enabled by the introduction of social prescribing link workers or community navigators, who will have more time than the ten minutes

allotted to a GP consultation to enable a look at the wider issues: *'I think that's the thing that's going to make a huge difference to [primary care]'* (SH12).

Whilst it was intended that GPs would be the main referral channel through the project, this was not the case. GP contracts across Scotland were changed in April 2018, and a new emphasis was placed on multidisciplinary teams working within the GP practice with the GP as an expert generalist. The early recognition that the rate of referrals through GPs had been lower than expected, coupled with the new GP contract placing more emphasis on multidisciplinary working, encouraged the Moving Together team to develop an agile approach to seek other referral pathways and processes, whilst remaining true to the initial idea of the role that GP practices can play in identifying patients with health conditions exacerbated by living in a hard-to-heat home.

Many stakeholders talked of their surprise at the initially low rate of referrals, with one reflecting that *'limiting it to GPs is a mistake'* (SH14) in light of the new multidisciplinary approach and that the referral pathway needed to be defined broadly to reflect the contract changes. *'When it really started to build'*, reflected a stakeholder, *'was when we got in touch with other healthcare professionals, apart from GPs'* (SH4).

These included community nurses and specialist nurses, who *'took the time to sit down with individual people and told them about mPower'* (SH4). One-to-one approaches with householders were seen to be most effective:

I think when you talk to a group of professionals, it doesn't sow the seed as well as it does when you're one-to-one with someone, because there's an opportunity for them to ask questions and they start to think about different scenarios [that] would fit into it (SH4).

The role of health outreach via professionals who work in the home has to some extent transformed what might have been a GP's remit, and the Moving Together project had to respond to and recognise this.

One stakeholder noted how each client under the care of social services has a care manager (based in social work or nursing) and that social workers are often the first people into someone's house (SH16). Another, working in a health visiting and school nursing service, stated that the head of the local health improvement board had asked her team to become involved with Moving Together *'as they [Moving Together] had initially been working with the GPs to get referrals regarding this project, and they then decided to target a different cohort'* (SH15), because take-up had been low. This quote also demonstrates the input of strategic health officers.

When considering individuals with long-term and complex conditions, specialists play a vital role. As this householder explained, such individuals may not often be in contact with their GP and rely to a greater extent on specialists:

It would have been – okay, so you asked about the GP. I seldom see the GPs because all of this is so complicated that anything needs done, it's my cardiologist that's making the decisions, and I wouldn't take a change of medicine from GPs unless he okayed it, so that why I don't see the GPs very often, and you see a different one every time and you don't really get to know them anyway (HHB6).

But I think that's changing now, because, as I said, with the dementia nurses now engaging, once they find... that's Parkinson's now, that's dementia now... I don't know why the cardiac nurses haven't engaged, because people with heart problems, if they're sitting in cold houses that can have a huge impact on health. So I think, as I said, word of mouth is getting out there (SH14).

One of the ways in which this particular GP surgery adapted during the course of the project was giving more influence over referrals to an administrative staff member: *'so we now have somebody in the admin team that all we need to do is mention to them and they'll do the referral for us... [admin person] has been the main driver to make all this work really' (SH12).*

Over the course of the project, staff members of Moving Together partner organisations adapted by working more closely with each other, building on their existing collaborative relationships by having a physical presence or holding drop-ins in each other's organisations and in the GP surgeries, distributing leaflets and holding information events in community spaces. This practice was referred to by stakeholders as widening the referral pathway and creating different pathways. One stakeholder, for example, described a situation in which they recognised the need to develop a new referral pathway because the existing mechanisms seemed restrictive:

Yes, the challenges were at the very start, and the challenge was the GP practice, who, it didn't matter what we did, when I explained that I had spoken to [member of TIG staff] and would I be able to refer, I was given, 'No, you are not allowed to refer to the specialist nurse'. It didn't matter what I did or what angle I came from, that GP practice was not going to let me refer anybody to TIG. That's when myself and [member of TIG staff] developed a different pathway so I could refer directly to her, because that was a huge obstacle at the start (SH14).

This stakeholder continued to describe the ways in which NHS staff from different disciplines had become aware of the opportunity to refer to Moving Together, whilst acknowledging the need for further work and engagement across other parts of the service:

Entry points

In reality, experiences with the project referrals varied. The referral mechanisms across the 199 participating households are summarised in Figure 21. This shows that surgeries and medical practices were the largest single sources of referrals and, with nurses and health visitors included, that half the referrals were via the health service. Community organisations also contributed a substantial number.

Our interviews provided examples of a range of 'entry points' through which householders became aware of and/or were referred to the programme. It is important to note that stakeholders and householders did not necessarily recall one precise point of referral, because many of the householders had taken the opportunity to benefit from the programme as part of ongoing relationships with a community organisation or health visitor.

This stakeholder recalled the conversation he had had with their doctor and how it had led to communication from TIG and subsequent assistance through the project:

Yes, but I just mentioned the dampness in my room, and then my doctor, she all of a sudden stopped for a wee while, she says, 'Where's the dampness coming from?' I said, 'It's coming from outside', funnily enough. Then that's what started it all, she said, 'I can assure you that's very bad for you, you sleep there?' Yes, I sleep there, and I said, 'Oh it's damp, it's really quite damp', sometimes, in the bad weather. So that's how she, what do they call it, a referral?

Interviewer: Okay, and then you got a phone call from TIG, I assumed?

Yes, she phoned, I think, in here somewhere, someone here. Then she arranged, I got a letter to the house, it was Finlay, that he would be out at such a, and if I had any problems to phone if I wasn't available. So Finlay came along, that's how it... Finlay surveyed all the house, every room, he went through all the rooms, he went through the ones downstairs and everywhere (HH1 follow up).

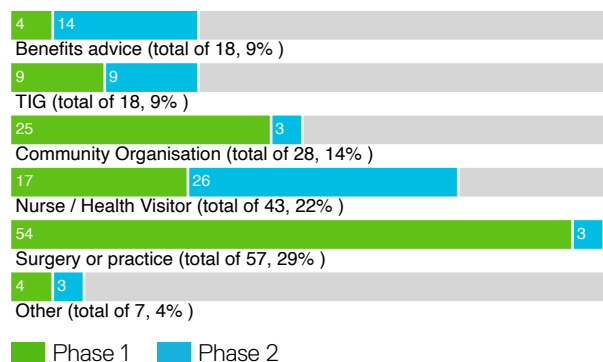


Figure 21 - Point of referral (Moving Together project records)

One householder had been speaking to TIG about having their outside steps improved. A Moving Together staff member advised them to phone their doctor to take advantage of the scheme: *'Contact your doctor's surgery, because there's a system at the moment where you might be able to get help with your heating system and other things' (HHB12).* Although the scheme could not help with the steps at this time, the householder was able to get help with their heating system and insulation.

Another struggled to remember the exact moment and source but recalled seeing information about the programme from an mPower representative or possibly a leaflet or newspaper advertisement about insulation (HHB6).

A householder interviewee had attended a community event for people with Parkinson's disease and had started to talk to TIG about opportunities to benefit from the project. Another had contacted TIG to follow up previous assistance through which they had received internal insulation. They'd noticed that their house could still be cold and that this was affecting the health of their child: *'We thought maybe there's a bit of extra support there' (HHB15).*

Self-referral

A self-referral route was introduced to increase participation and raise awareness. This was in response to someone taking a leaflet at a GP surgery and sending in an email expressing interest in the scheme:

I think that's when we realised that maybe self-referral is a good idea as well, because not only is it taking the pressure off GPs... it minimises GP time, but it also gave the person time to read over the leaflet, read over and think about some of the things they might have issues with (SH4).

GPs viewed self-referral positively and as a response to the constraints they perceived:

I think self-referral would be something that I would promote... It's just one less barrier for people who might be thinking about what is on offer, because they consciously have to come to us and ask us to refer them maybe, but if they can just bypass us then that will probably increase uptake (SH11).

This health professional also noted the potential for self-referrals to take pressure off staff: *'What happened from that was a lot of people self-referred to [name of MT worker], so they just bypassed me... that took a lot of pressure off me because people were able then to self-refer directly' (SH14).* This quote also implied that self-referrals were not necessarily entirely unprompted; they may have followed ongoing discussions with health professionals. This interviewee implied that to some extent this reflected a spectrum of severity within which there were different options, with those with less serious symptoms able to self-refer themselves, whereas with those who lacked capacity *'a family member would give their consent for me' (SH14).*

It is important, however, to note that an emphasis on self-referrals could have worked against the focus, within this particular project, on health and vulnerability. A reliance on self-referral, it was argued, could have excluded the most vulnerable, sometimes referred to as 'hard-to-reach' households, or provided insufficient support to ensure they were included. The following comment stresses that relying on self-referral can exclude or provide insufficient support to ensure that the most vulnerable are included. Stakeholder interviewees referred to concerns that *'the person who shouts the loudest can be the one*

that gets the most input', and one recalled a situation in which a high level of support was needed: *'Because there was the level of handholding and support and reassurance, she finally was able to have the insulation put in' (SH14).*

Home-centred and person-centred

A recurrent theme through our discussions was the importance of visiting people in their homes. One reason given for this observation by project stakeholders was that it's often not possible to understand the condition of a property and the living conditions of the householder, and therefore the level of energy vulnerability of the inhabitants, from the outside. Houses situated side by side can be completely different from one another, which means that people in severe fuel poverty can be living next door to people in more comfortable circumstances. This feature of housing on the islands called for a particular type of approach:

I suppose the other thing that we need to bear in mind for rural areas like this is that poverty is more hidden, because in a more urban area you know the postcodes and so the housing schemes and you go in and you blitz it. Here, you've got very wealthy people living next door to people who are living in very strait circumstances. That targeted approach that you might do in an urban area just doesn't work here. You need to be more creative (SH14).

From a GP's perspective, seeing a patient in the context of their home provided a more complete picture and reduced the likelihood of factors that could cause or exacerbate symptoms remaining 'hidden'. Such factors may simply not occur to the patient as being relevant to their condition or may be something that they are unwilling or embarrassed to bring up in the surgery, or there may not have been sufficient time during a short consultation to mention them:

I think being in the home is so, so important because I think someone going into a GP's surgery is hiding something that they might have at home, which may really be the main issue that they're there at the GP's surgery for, but they're just too embarrassed to discuss about it. It might be embarrassing for someone that they can't afford to heat their home (SH4).

Another interviewee, a GP, commented on the 'variable' state of repair of homes, whether rented or private, and admitted that they were sometimes shocked at how cold homes could be. Another GP spoke of visiting a patient in their home as the key to triggering a conversation about the impact of their home on their health.

Householders valued having the time to talk through their circumstances and health conditions and show staff and workers the issues they were facing in their homes. In this way home visits had an emotional role to play in helping build a relaxed and safe context for trusted relationships to be developed and for discussing issues that might otherwise be stigmatised.

To stakeholders visiting homes, this process enabled them to make their evaluations and support plans specific to the householder:

Every home visit is different, every issue is different. You come across a new issue every day with this job; it's something that you would never have thought of before... there's so much to take in. Your brain's full by the time you've left because you've taken in everything from how many family pictures are on the wall to is the person comfortable talking to somebody? (SH4).

As person-centred approaches occupy an increasingly central space in national health policies – for example, Scotland's Chief Medical Officer's 'Personalising Realistic Medicine' report (Scottish Government, 2019b) or NHS England's (2019) 'Universal Personalised Care' – the collaboration between TIG, mPower and other organisations and health services marks a significant shift in the transformation of healthcare in the Outer Hebrides. GPs made numerous references to the ways in which the health service is changing, and these include not only centring services on peoples' needs but also engaging people as active agents in their own healthcare. A GP, for example, felt that *'we should probably be looking to empower people more to take hold of their own life and wellbeing and destiny'* and noted that this *'put the locus of control back for the patient or the service recipient, if you want to call them that'* (SH11).

Whilst home visits are clearly important and particularly relevant to the rural context, it is important to bear in mind the practical challenges implicit in designing programmes around home visits, particularly in remote locations: *'The geography is vast, and it's not just simple to get to the home visit and back up. One home visit might take you a whole day'* (SH4).

Information flows

The collaborative engagement between partners came to characterise the way the project was delivered, with partners forming strong links in joint working and problem-solving. Regardless of how agile the team were in trying to recruit people to the project and network with other practitioners, however, one obstacle to more creative and flexible working was information sharing, particularly between health and other services.

The sensitivity of health-related information meant that some staff were, unsurprisingly, cautious. One health worker noted that the GP practice was unwilling for them to refer directly to Moving Together, which necessitated a less direct referral route:

So myself and [name of MT worker] found a different pathway, and, with the patient's consent, they would let me pass their details on to [name of MT worker] so we could bypass the GP over in [location supplied], because they had challenges with regards to data protection (SH14).

There are systemic challenges relating to information sharing. For example, the NHS uses a different data system than the local-authority-based social care services, and this presents problems with the development of a single assessment of a person's needs. Two stakeholders referred to this as a barrier. One felt that the intentions of the network around information, particularly the objective of a multi-agency approach, were too ambitious within the initial timescale of the project: *'we probably took on too much, like formalising mechanisms with the third sector around data sharing and sharing of people, sharing of information. It was probably too big an objective, or it should have been sorted before we started'* (SH3). Nevertheless, they indicated there had been missed opportunities to work more closely with the NHS in terms of data sharing and that these would have *'just needed a bit more thought and a bit more paperwork around it and a bit of protocols'* (SH3). On the other hand, another stakeholder (SH6) was sceptical about the likelihood of this approach being implemented, even though it would reduce the amount of duplication for clients. They had been advocating for better data sharing between the health board and the council for over a decade, including access to lower-level information about service users.

Managing data within organisations was also a significant challenge. TIG managed a large caseload and tracked progress across a large number of households. Data provided by TIG from Moving Together to other services could be extremely useful: as one stakeholder noted, the information sent to them from the project had been very valuable for demonstrating the impact of her referrals on the health of clients.

7. Conclusions

Moving Together is an ambitious programme, requiring the collaborative input of a range of professionals and organisations across multiple sectors. Its achievements and outcomes are testament to the creativity and generous spirit of the various stakeholders as much as to the unique blend of services that have joined forces in this project. It is also clear that the degree to which partner organisations are strategically interconnected on the islands - e.g. through key stakeholders sitting on partner organisations' boards - is a key enabler for this creativity, in addition to the growth of mutual trust.

A key driver for Moving Together was to explore how voluntary sector and statutory services could be integrated with primary and secondary health care to create meaningful and lasting changes in the health and wellbeing of some of the most vulnerable people in the Outer Hebrides. Moving Together is thus part of the wider picture of doing health differently, rethinking how health services can be delivered through the alignment of a diverse range of organisations and initiatives, and how and where these reconfigured services can be best delivered to make the most meaningful impact. There is a need to find a balance between having a comprehensive offer of services offering distinct and morally reinforcing support and, conversely, a landscape of projects 'competing' to access the limited time of professionals who work with and build trusting relationships with householders. This balance has to be carefully considered and monitored to prevent fatigue or ambiguity.

The role of TIG cannot be underestimated in driving the successes of Moving Together. From the point of referral - whether by GP, nurse, mPower, or other partner organisation - to the completion of support, TIG played a unique role in assessing householders' needs and meeting these needs holistically. Some of the support given was through quite significant home energy efficiency improvements; some of the support, such as securing access to benefits and providing energy advice was perhaps less visible but no less impactful.

Our findings provide evidence of the myriad of ways in which householders were helped and the ways in which this contributed to improvements in wellbeing. To give just a few examples that highlight the extent to which this support has affected lives beyond what might be narrowly conceptualised as home comfort: giving people confidence that their guests are comfortable, alleviating exposure to noise during storms, enabling people to stay in a home that they were previously considering leaving, reducing pain and discomfort associated with some chronic conditions, and alleviating financial stress - in one case to the extent of being able to buy a car and therefore able to shop independently and visit friends. TIG mobilised resources available to them to provide assistance

to households but were necessarily limited by availability of funding, the cycles of funding such as Warm Homes Scotland, and the ability of householders - particularly those with their own financial challenges - to make their own contributions.

A thread running throughout the support offered by all stakeholders is the way in which it was centred on the person and on what would be most beneficial and meaningful to them. Unsurprisingly, the person-centred support was grounded in careful conversations with each person to find out about their challenges, needs, wishes and aspirations - and fittingly, for a project that had home-improvement as a central pillar, this conversation invariably happened in people's homes, where they were most at ease and likely to build trust. Home visits played a key role in the project in shining a light on vulnerable people's needs and revealing vulnerabilities that wouldn't have been otherwise visible.

In this respect, enabling a network of health professionals across the islands to have these person-centred conversations about wellbeing was not only a pragmatic means of driving referrals into the project, but also a logical step in developing a project addressing the social determinants of health. It makes sense to include as wide a range of health and other professionals as possible, to widen the opportunity to have contact with vulnerable people, often in their own home, in order to make an assessment of their needs and mobilise the appropriate support around them.

It also made sense, as Moving Together partners recognised, to leverage the traditional community assets of the Outer Hebrides, such as strong social networks and trusted connections in widening the referral pathway. This included being present and visible at community events, but also included opening the project to self-referral, enabling and empowering people to have input in managing and improving their health and wellbeing. Whilst self-referral was valuable in creating access to the scheme for those who recognised the potential for them to benefit from the project and were able to be proactive, it is important to be mindful of the exclusionary potential of relying on this approach.

The recognition of the roles of health professionals is worth emphasising here: their expertise in assessing people's needs plays a vital role in maintaining a focus on health and vulnerability. The GPs who have been involved in Moving Together all acknowledge that this has been part of a learning process for them, and their willingness to participate and collaborate with the partnership bodes well for the ongoing development and innovation of health care on the islands. There is work to do to continue to

involve health professionals and find the most effective ways for them to make connections with energy advice and home improvements.

The current limitations of data sharing may also preclude further efficiencies but investigations into what low level information can be reasonably shared without significant risk should be undertaken, even if for the benefit of future projects. Part of this could involve having a clear data protocol, so all stakeholders are aware of what is and is not justifiable and beneficial to hold and pass on.

Moving Together clearly echoes some of the work labelled as 'social prescribing' around the UK: through tackling the social determinants of health, adopting a person-centred approach, and involving the collaboration of, and referral between, health and voluntary sector organisations. However, Moving Together is clearly a far more complex project than the majority of those that would fall under the social prescribing banner, and the scale of support offered within Moving Together is an order of magnitude greater than, for example, signposting a person to a community activity group.

In the latter phase of the project, after sharing the results of the interim report and engaging with networks of health and other professionals across the Outer Hebrides, the foundations of the work done in Lewis was built on and developed. This phase saw a continuity of the key themes outlined in the interim report (Sherriff et al 2019), such as the importance of person-centred approaches and the benefits of innovative collaboration between health professionals and voluntary sector support organisations. In the process, the evidence base created by the project was enriched and the learning was both deepened and distributed throughout the islands.

This research contributes to and reaffirms the evidence base relating to the distinct ways in which fuel poverty plays out in rural and remote settings. The climate of the islands, the vulnerability of the population, and the sometimes poor quality of the building stock combine to make cold and damp homes a significant public health issue. The higher cost of energy, particularly for off-grid customers, and the logistical and financial challenges of implementing energy efficient retrofit compound the situation. The sheer remoteness of many households means not only that providing support is time-intensive but also that economies of scale are rare. These challenges are felt across health care and social support, but it is this link with the home that is vitally important: support groups and hospital visits can be only so valuable if people then have to return to cold and damp homes, and when the poor condition of that home may itself be contributing to financial stress and social isolation.

Moving Together has added to the evidence that making homes more energy efficient, improving heat systems, and helping householders to reduce their bills and manage their debts pays dividends in terms of and can boost wellbeing for those with long-term health conditions. Its specific contribution is to demonstrate the value, if not necessity, of focused and sensitive support on the basis of relationships of trust developed over time, particularly in the case of this cohort. This support can be essential in getting people to the point of accepting assistance and of being comfortable with unfamiliar contractors coming into their homes, and can be a lifeline in overcoming the challenges that stem from long-term conditions such as dementia, social isolation, Parkinson's, and limited mobility. Given the prevalence of such conditions on the islands and amongst the older population, this makes initiatives like Moving Together an important part of the public health infrastructure.



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