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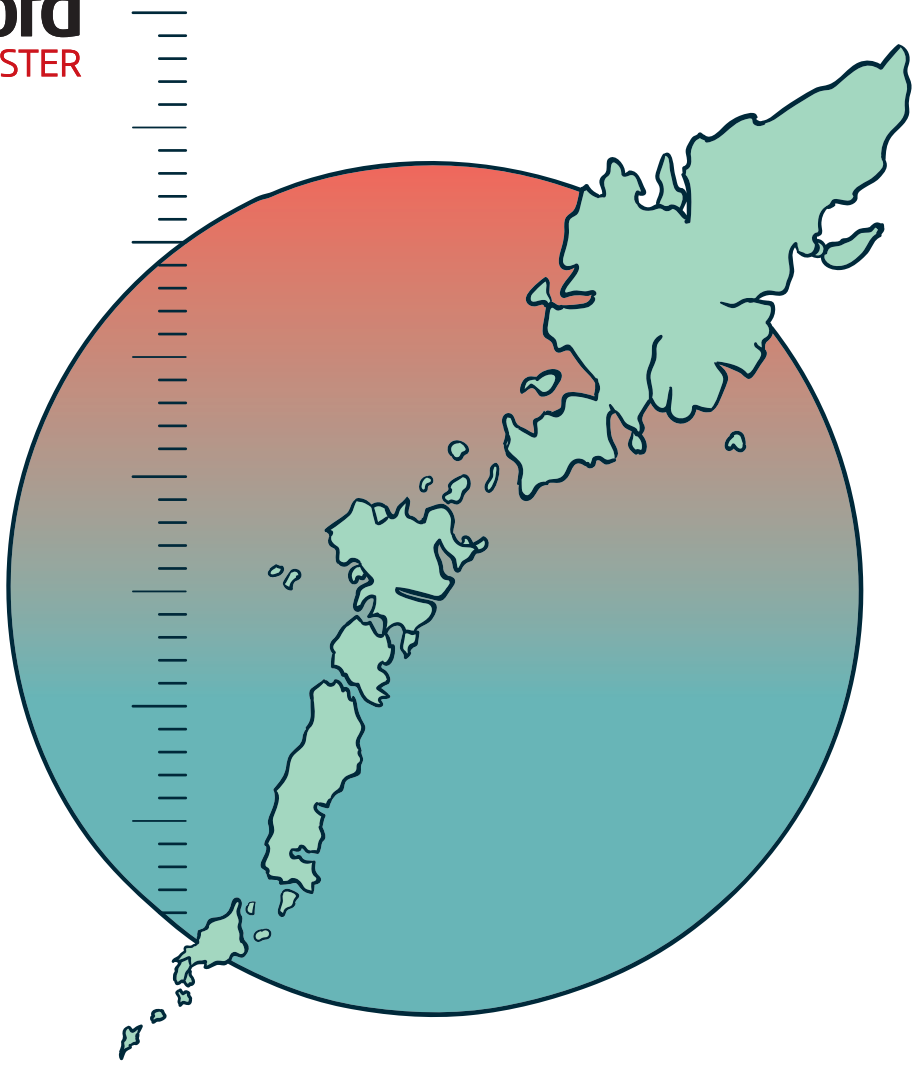

SHUSU
SUSTAINABLE HOUSING & URBAN STUDIES UNIT

Fuel Poverty in the Western Isles: 10 Lessons

Interim Report of the Moving Together Project

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The Sustainable Housing and Urban Studies Unit (SHUSU)

SHUSU, University of Salford, is a dedicated multidisciplinary 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. For more of our outputs, see www.salford.ac.uk/shusu

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Introduction

1.1 Gluasad Còmhla (Moving Together)

Gluasad Comhla began in March 2018 with funding from ESF Aspiring Communities fund. The premise behind the application was to work closely with GPs in the Langabhat Medical Practice, which covers rural Lewis, to enable them to identify people whose health was compromised by living in a cold or hard to heat home. GPs had, for the first time, a route for referral that would recognise the expertise within Tighean Innse Gall and to treat this in the same way that they make a referral directly from their computer to a hospital consultant. Funding for the project also includes paid members of staff for Lewis Citizens Advice Bureau. The project also wishes to support small charities locally and has as project partners 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.

At the point of project referral, the client and their home is assessed in a holistic manner to ensure that all routes to making the home warmer are addressed. This includes the behaviour of the client, the fabric of the house, health related needs and the income coming into their home.

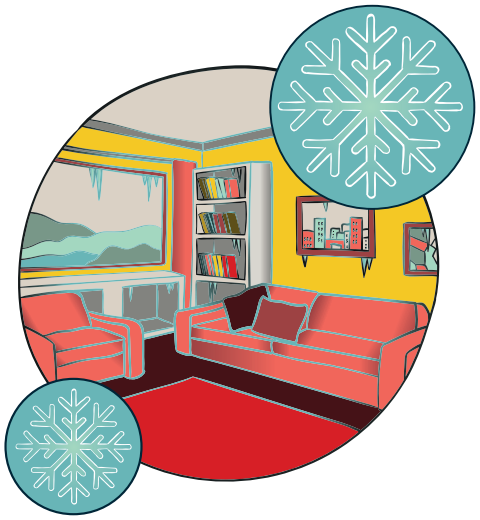
As of July, the project has secured additional funding to allow the project to be extended to all communities across the Western Isles. This phase will run until end of March 2020.

1.2 This research

SHUSU were invited to be the research partner on the project. They have led on the development of a collaborative evaluation methodology. At this halfway point in the project, this report provides an interim analysis in the form of ten key lessons. It is intended that these will inform the future development of the project and provide advice and inspiration to those developing initiatives with related aims. As part of this process, the findings were discussed in stakeholder workshops in Stornoway and Benbecula in September 2019.

Between November 2018 and May 2019, 19 qualitative interviews were carried out. These were with TIG staff (3), householders (5 individuals and 1 couple), GPs (3), a member of NHS staff, and stakeholders working in organisations involved in the Moving Together project (6). Householder interviews were conducted with residents in their homes. Other interviews were conducted in stakeholders' places of work, at the TIG central office, and in some cases by phone. 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. In the following sections we use 'HH' when referring to householder interviewees, 'SH' to denote stakeholders, 'GP' for GPs, and 'TIG' for TIG staff.

1. There is severe fuel poverty on the Islands, with distinctive features and drivers.



There are striking and concerning examples of householders facing severe challenges in keeping warm at home and evidence of considerable health impact. Stakeholder interviewees working alongside local and national partners have found ***'across the board, that the level of poverty, of hidden poverty is quite significant in the Western Isles' (SH2).***

In a particularly striking example, TIG staff recounted two residents who had developed hypothermia after disconnecting their heating, with one being hospitalised: ***'This wasn't somebody that had fallen out in the hills or something, this was somebody who had developed hypothermia in her own home, just because of the cost of the heating system' (TIG2)***. This couple had had storage heaters installed nine years previously but switched them off almost immediately on receipt of their first bill.

Our research adds to the weight of evidence that experiences of fuel poverty can impact upon quality of life and limit the ways in which the home can be used. One interviewee spoke of staying warm in bed - their bedroom a ***'bolthole'*** - in the knowledge that other rooms in the house were cold: ***'You just sort of snuggle up under the duvet and you think, oh God, it's lovely and warm in here, do I have to get out? You just sort of poke your nose out and you think, it's cold out there!' (HH7).*** *With help from the Moving Together project and other related support, householders told us they could afford to run their heating:* ***'I can put the fire on again' (HH1).***

An important characteristic of poverty on the island relates to the quality of the housing stock – as one stakeholder explained: ***'Partly it's because, people who built houses with board loans in the 40s and the 50s had to build the house to a particular design to access the loan, and that particular design just happens to be a typical hard to treat house now' (SH2).*** Islanders have childhood memories of growing up in very cold houses: ***'I remember the bathroom having a gale blowing through it, it was freezing' (HH3).***

Another aspect is the cost of heating on the island, which for a number of reasons is significantly higher than on the UK mainland: ***'A typical house that's all electric here will be paying minimum £35 to £40 on their electricity. If you're getting benefits of £73... That's a meagre existence' (TIG2***).

Islanders pay a premium for being remote – and remoteness also has an impact on their ability to have work done on their houses, with interviewees reflecting on the difficulty of finding tradespeople. Social isolation is recognised as an endemic issue on the island, certainly amongst those making use of the GP surgery and the beneficiaries of this project. Life on the island has an undoubted harshness: ***'...we have to cope with windchill and exposure and all the rest of it'*** (TIG2).

On top of – or often because of – the aforementioned issues, ill-health will interact with fuel poverty to produce a qualitatively distinct set of circumstances, or forms vulnerability. A cold house will have an impact on health, but health will also impact on the person's ability to keep themselves warm or do something about their circumstances:

> ...there comes a point with my mental illness, I've noticed that I don't even notice that I'm also cold. I've seen days where I've been so ill, I haven't even turned on the boiler and suddenly recognise late in the day I'm freezing cold. I've just been so - the illness just overtakes everything but obviously, generally speaking, yes, it's like anybody, if you're cold, you're not comfortable and everything is harder (HH5).

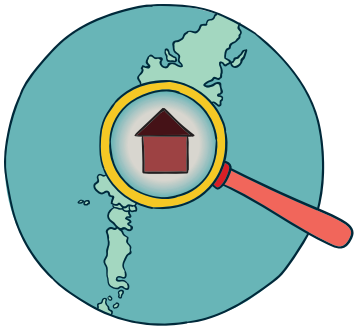
A GP interviewee spoke of a patient with ***'long-standing problems with low mood and anxiety'***, who was ***'finding it a struggle to keep the place warm, to keep the maintenance up and that was obviously causing him concern and affecting his mood further' (GP2).*** The GP felt that the householder was ***'perhaps feeling a little bit impotent in the situation, not really knowing what to do to make things better and not having the motivation to try and change' (GP2).***

Referring to the challenge of dealing with multiple problems at the same time, TIG staff considered whether the persistent struggle in dealing with health-related difficulties left little energy, time or capacity to deal with energy-related problems: ***'You think well, is it because if they've got the health condition they've got enough to deal with?' (TIG2)***. TIG staff will often, as part of their engagement with householders, support them by providing information about their energy use in order to change related behaviour:

> There's a massive thing to do with education as well. If somebody is finding storage heaters expensive, they're on a dual tariff meter and they think to themselves 'I can't afford to run the storage heaters so I'll switch them off. I'll just use a plug-in heater when I need a bit of warmth.'
>
> Actually, that plug-in heater is running on the more expensive tariff. They're actually making it worse. Alongside all the other stuff that we do about insulation and switching tariffs and benefit checks, is to educate about how to use energy to be most affordable. (TIG2)

The work of this project, therefore, has been challenging and has needed to tackle a complex cluster of needs. These needs are real and in some cases severe, and, though the experiences recounted to us through the course of our research resonate with those from other projects and places, there are unique aspects of energy vulnerability on the island that Moving Together partners have tackled in their distinctive way.

2. Tackling fuel poverty on the Islands requires a sensitive and distinct approach.



Tackling fuel poverty on the island requires an understanding of its often hidden nature – due to both the heterogenous nature of housing on the island, and cultural aspects of the community. These include their resilience toward cold conditions, and the stigma or shame that can be associated with being 'in need'.

A characteristic of the island observed by project stakeholders is that it's often not possible to understand the condition of the property, the living conditions of the householder, and therefore, the level of energy vulnerability of its inhabitants, from the outside. Houses situated side by side can be completely different from one another, meaning that people in severe fuel poverty can be living next door to people in much more comfortable circumstances. The complexity of this 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 (TIG2).

Experiences of fuel poverty and the challenges around energy use on the island are to a large extent shaped by islanders' lived experiences and the distinctive culture of the island, characterised by the Gaelic language and practices – albeit less common in modern times - that include crofting and communal peat-cutting and 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' (TIG2)***. Our conversations with Islanders suggest 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 were previously hardier:

> …(the cold) would have been previously worst for them. They would have come in to something - let's put it this way, they might have not been feeling the cold which we do now, which I do. I'm the one that feels it myself.
>
> They would absorb it more. You know, these people were - I don't know, they were from another sphere all together! Do you know what I mean? (HH1)

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, a practice 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.
>
> I remember when I was just growing up here, you used to just go out the gate there and I'd go down the road. I'd have to help this man with stuff. I would never think of that now because they would just say to you… They would be thinking, what's…? Folk have changed. (HH4)

The social fabric of the island arises as another key issue shaping the delivery of this project – one aspect of which is 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).***

Self-sufficiency comes through in this light-hearted aside from one of the GPs, who was pessimistic about the current political state of the UK: ***'we're all doomed – (but) at least we can cut peats up here, shoot deer, we'll be fine!' (GP1).***

This community connectedness, however, ***'can work against you'*** (TIG1) in that people may be 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' (TIG1)***. 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' (GP2)***:

> Here, I suppose the surgery can be a bit of a community hub, which in some ways is a good thing but in other ways 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. (GP2)

This pride in self-reliance and the potential 'stigma' of being in need – which echoes perhaps the culture of resilience – are key factors shaping how Moving Together stakeholders have 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.

3. Home visits provide vital knowledge of patient context.

Our interviews point to the importance of visiting individuals in their homes in forming an understanding of the ways in which their home life may affect their health and, as discussed further in item 4, in building an ongoing relationship of trust.

It was apparent that a large number of referrals had been made subsequent to someone visiting a dwelling. It was evident that after this time a stakeholder or a Moving Together team member could more fully understand how the householder was living in and using their accommodation. This knowledge helped them to develop bespoke pathways of support, whether through the Moving Together project, or by referring on. It also helped with targeting support where it was most needed: ***'...that way we can be sure we're seeing the people we need to see' (TIG1).***

From the GP's perspective, seeing a patient in the context of the home provided a more complete picture and reduced the likelihood of factors that could cause or exacerbate symptoms being 'hidden'. . Such factors may simply not occur to the patient as being relevant to their condition, 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)

Interviewees gave evidence of the ways in which visiting the home could bring these factors into sharp focus and to make clear the extent of poor conditions householders were living with and the complexity of the challenges, both social and technical.

After a home visit, one stakeholder felrt that it was ***'crazy'*** and ***'shocking'*** that ***'he had a funnel coming from the roof'*** commenting that ***'it was bizarre that people were living like that' (SH4)***. Importantly, as noted above, the stakeholder stressed that this observation depended on going inside the home: ***'looking from outside, you wouldn't have thought that it was like that' (SH4).***

Another interviewee, a GP, commented on the ***'variable'*** state of repair of homes, whether rented or private, and admitted that ***'you do go and visit somebody at home sometimes and think oh gosh, the place is really cold, or you can see that the windows are maybe not the best...' (GP2)***. Another GP spoke of visiting a patient in their home as the key for triggering a conversation about the impact of their home on their health: ***'So I've gone in and thought, bloody hell, that's cold. So, more thinking about myself, so I'm thinking I'm cold with my coat on, then they must be absolutely freezing. So, it's that's brought it back to mind' (GP3)***.

It was also apparent that an indirect but important outcome of home visits was the role that this played in building trust between stakeholders, TIG staff and the householder. Householders talked about having the time to talk through their circumstances and health conditions, and show staff and workers the issues they were facing in the home. In this way the home visits had an emotional role to play in helping build a relaxed and safe context for trusted relationships to be developed and to discuss issues that might otherwise be stigmatised.

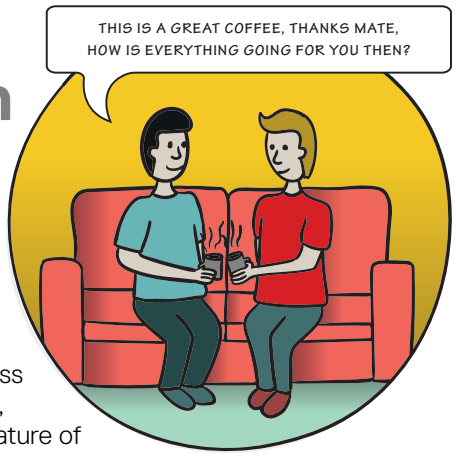
Whilst the research highlights the importance of working practices that enable a holistic understanding of the lived context of fuel poverty, it is also clear that this is a particularly challenging aspect of project delivery given the distinctive geography of the Outer Hebrides and that this necessarily adds to staffing and resourcing requirements.

> We all appreciate that the geography is huge and it doesn't just take you ten minutes to get to a home visit; it might take you an hour. To get to my home visit in Leverburgh that I've got at the moment, it's about an hour and a half, just to get down there. 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)

This challenge notwithstanding, there is a strong argument that an initial investment of time in making the visits can be an efficiency saving in the longer term as people, both worker and householder, gain a great deal from physical presence in a property and energy advice and retrofit solutions can be more sensitively deployed.

As an alternative, our interviewees gave examples of the increasing use of video conferencing for GP consultations, and whilst this clearly provide advantages in terms of efficiency and response time, there is a danger that these lead to a less complete understanding of both person and context. The importance of home visits is a key finding of our research as a central and irreplaceable mechanism of understanding and assessing the person in their environment.

4. A person-centred approach builds trust and allows support to be tailored.



Moving Together stakeholders make clear the importance they place on supporting each individual according to their unique circumstances and tailoring the support around these needs. Home visits are vital not only as a trigger for referrals, but also as a means of building trust with householders, and gaining deep insight into their particular situation, which shapes and informs the assessment of their individual needs.

Stakeholders spoke of the importance of sitting with householders, building up a relationship with them and sharing experiences: ***'because I'm a firm believer in that in order to get people to engage fully with you they have to see that the person that's sitting in front of them is somebody who does care, is a human being, and potentially has had similar experiences to what they've had' (TIG1).***

This relationship building can be aided by doing home-based assessments in Gaelic, where appropriate to the householder, as this can put the householder at greater ease and facilitate a more person-centred assessment. This means that each support package is necessarily bespoke, with a wide range of factors being taken into account and those providing support need to think and work creatively both to address these needs and to react to novel circumstances:

> 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? Is there personal hygiene issues? There's a huge variety of different things that you're looking at. (SH4)

Another key way that this work is centred on the person is the importance placed on emotional support throughout the process. A GP we spoke with recounted a situation with one of their patients who suffers with severe and longstanding mental health issues. This patient had found the home renovation process very stressful, leading to the person almost backing out from the process at the last minute: ***'they found that very stressful, somebody coming into the house when they're used to living quite isolated and the isolation in many ways suits them, because there'd be issues that they've got, so allowing somebody into the home is a big thing for them' (GP3).*** With the support and reassurance of TIG and mPower, however, this person was able to go through with the work.

A householder reflected on the process from their perspective, noting positively the nature of the support given and the extent to which the stakeholder made themselves available even during holidays by given the householder their mobile number:

> Well, he's got a very nice manner and seemed to accept I had these problems and he was ... patient with me and you can approach someone like that ... and said to me, 'Call if there's anything', and he wanted to make sure that I had had a visit from the project manager before the team came back but it was the Christmas holidays. He even said, 'Look, I'm on holiday but this is my mobile number...' (HH5)

Whilst it seems obvious, it should be acknowledged that such person-centred work relies on a connection to the role, a capacity for caring and a willingness to 'go the extra mile': ***'It's a privilege to do this job – every day of my life to be able to go down the road after work and know that ... I have helped at least one person' (TIG1).***

As person-centred approaches occupy an increasingly central space in national health policies – for example Scotland's Chief Medical Officer's 'Practising Realistic Medicine' report[1] or NHS England's 'Universal Personalised Care'[2] – the importance of involving organisations such as TIG and mPower, and other Moving Together partners, in developing a person-centred health service should not be underestimated. GPs made numerous references to the ways in which the health service is changing, and this includes not only centring services on peoples' needs but also on engaging people as active agents in their own health care. 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'***, noting this would ***'put the locus of control back for the patient or the service recipient, if you want to call them that' (GP2)***.

1 https://www.gov.scot/publications/practising-realistic-medicine/

2 https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

5. Trusted intermediaries play a vital role.

As discussed under item 4, trust is a fundamental component of Moving Together and of efforts to address social issues on the island: trust permeates every part of the assessment, referral and delivery process. We see this in the importance of establishing trust between project stakeholders and householders, and in the importance of project stakeholders building a trusted reputation on the island. It is also apparent in the way in which trust is disseminated or conferred through the social fabric of community life: through neighbourly conversations and trusted messengers.

Stakeholders described processes of earning the trust of islanders and getting past what one stakeholder described as a ***'natural island reticence' (TIG1)***. Though this reticence created an inherent inertia, it may also provide the catalyst for projects to progress, as islanders refer each other into the project by transferring their mutual trust to project delivery stakeholders. One woman who TIG supported subsequently made five referrals to her neighbours: ***'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' (TIG1).***

A GP described the ways community life can mediate the project's work, by stakeholders being a present and visible part of community life, including a presence in GP practices:

> I think another thing that has worked is when on occasion we'll get Moving Together to actually come to one of the surgery sites and be in the waiting room for a while. So the patients that come in may not be the right patients but by them talking to folk that come in, that triggers, particularly in our community, where communities are quite close, that will trigger people to go, 'Well, I don't need that but you know Mrs whoever down the road is, I know she's really struggling because I pop in and make her a cup of tea'. So I think the presence is making a big difference. (GP3)

This work requires building links within the community, and TIG have done this by talking to a range of people at, for example, community events and even through chance encounters – for example, ***'meeting an Occupational Therapist on a ferry'*** – ***'it's working hard on relationships',*** and often finding a ***'go-to person in a community' (TIG1)***.

Trust confers responsibility onto stakeholders: stakeholders may need to go beyond their organisational remit to help the person because they are seen as the trusted party. One stakeholder spoke of a man they had helped who had amassed £14,000 worth of debts and who was living in very poor conditions:

> He said, 'Would you make a phone call?' I said, 'Well, I'm not really the right person. It should be...' 'No, I trust you. Would you do it for me, please?' I said, 'Okay, well, give me the details,' and I phoned them. (...) In half an hour we'd bargained £14,000 down to £3,500 with a repayment schedule of £100 a month, which he agreed to pay there and then on the spot. He came in four months later and said, 'For the first time in my adult life, I'm now debt free. Thank you very much.' (SH6)

As a backdrop to the work of this project, there is concern about operators on the island who are less trustworthy. One householder describes the difficulty of identifying trusted contractors, implying not only that TIG is a trusted organisation but also that TIG is a part of his process of validation. Calling TIG was the first thing he did after a prospective contractor had visited his home:

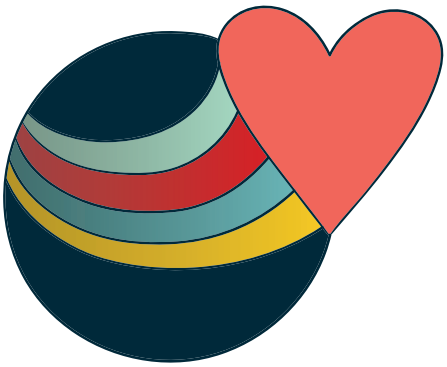
> I spoke to [TIG] and, believe it or not, I'd had a nasty experience just a few days before... It was a man came to the door and he said he was a representative for insulation for the island and I thought he was from TIG
>
> The first thing came into my head when that man went, I thought, I don't trust that fellow, there was something about him I didn't trust. 'Oh, we'll do this, we'll do that, that's no problem, yes, we'll do it, yes, yes', but there was something in him, I thought there's something not right here. ...
>
> The first thing I did, the minute he went out the door, I contacted TIG and I said, 'Is there a man called such-and-such from you?', and they said, 'No, there's nobody here of that name. I think you've got one of these cowboys that have invaded the island'. (HH5)

The same householder recounts their trepidation at the beginning of the process of having work carried out on their home – of being similarly 'invaded':

> 'I got too scared. The idea of being invaded by the workmen was terrifying for me for someone with my condition. ... But it was mostly my fault. I was frightened. I was frightened. I was frightened of the stuff they were going to put in, was it combustible? My fire phobia...' (HH5)

However, TIG were able to answer all their questions and reassure them of the work about to be done:

> 'He was really good. I told him I had problems and I told him all my anxieties about this happening and he arranged for the fire officer to come and visit with me. He did, and the safety officer from TIG... he was really nice. He was really good. He even did a job that really had to be done now rather than waiting till later. There was a huge gap in (the) electric cupboard and I was frightened of the rats getting in and eating the wires.' (HH5)



6. A multi-faceted approach to prescribing can offer holistic health support.

The GPs we spoke to were uniformly positive about the aims of the Moving Together project, whilst 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, indeed, disrupted their ways of working, they reflected on current transformation of the health service, and the role played by various organisations.

GPs spoke of the limitations of the resources they have at their disposal when faced with complex health issues and other interrelated problems, and saw potential in Moving Together since 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' (GP1).*** They also reflected on how, prior to the project, 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' (GP3).***

There is a recognition amongst the interviewed GPs 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. These are presented as a ***'simple cure for their complex issues, and surprise, surprise, they often fall flat on their face' (GP1)***. This GP felt that through approaches like Moving Together ***'the real issues are dealt with, that make a positive difference to people's live, so clear we should be doing better' (GP1).***

Each GP welcomed an opportunity to conceptualise their patients' ailments from a 'holistic' perspective. However, as the project progressed it was clear that, despite the GPs being supportive of its aims, there were not as many referrals coming from GP practices as was initially envisaged: ***'I'm [a] really strong an advocate of***

it, and I'm a really poor referrer' (GP3). In large part this can be attributed to two reasons, namely the time constraints of a consultation that prevented a more holistic exploration of a person's symptoms and cause of 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 means it was often neglected:

> 'From a clinical perspective I think we keep on thinking 'oh gosh, I didn't really think of that (referring the patient on), I should have done that; I'll have to try and remember the next time.' 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. (GP2)

Whilst there is clearly an element of questioning the medical model and reflecting personally that they had ***'26 years of bad habits to unravel' (GP1)***, one of the GPs emphasised that this is not necessarily a new concern. This GP had trained in the 1990s and ***'even then they were talking about practicing holistically and trying to think outside of that medical box as much as possible'*** and recognising that ***'we don't see hearts and lungs, we see people, with lives, and that we should be looking at the bigger picture' (GP1)***.

Despite this awareness amongst medical professionals, this GP argued, it is still the case that they often see patients coming back from specialists with treatment plans that they can see are unrealistic because they, as the GP, know more about ***'the person and their social circumstances and everything' (GP1)*** than the specialist. This knowledge and sensitivity, the GP argued, is part of being an ***'effective healthcare professional'***, adding that ***'I don't know if we're any better at doing that now than we used to be' (GP1)***. Nevertheless, the type of prescribing that Moving Together is aiming for is to some extent trying to ***'chang[e] the mindset of clinicians' (GP3)*** and, argues another GP, this ***'is the thing that I think is going to be quite difficult because we are medically trained, medically focused' (GP3)***.

The success of projects like Moving Together, to the extent that they try to reduce fuel poverty through prescribing, rely on some extent of behaviour change amongst GPs. One example of this change is broadening the scope of questions on lifestyle, focusing 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?' (GP3)***. It's also about getting into the habit of doing things a little differently: ***'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' (TIG2)***.

Moving Together has shown, however, that the responsibility does not, or need not, only lie with GPs, but can be broadened out to include the health service in a wider sense. This transformation will also be 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]' (GP3)***.

There is a need to be sensitive in proposing this transformation 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' (GP3)***.

This has, 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' (GP3)***. The GP positioned this, however, within the overall direction of travel in healthcare provision: ***'the way healthcare is going… we are all going to be much more multi-disciplinary and I'm not the boss anymore thankfully, it's a shared decision between me, the patient and the other healthcare professionals' (GP3)***.

7. Widening referral pathways and inter-agency and cross-sector collaboration to broaden reach.

Whilst it was intended that GP's would be the main referral channel through the project, this has not been the case. GP contracts across Scotland were changed in 1st April 2018 and a new emphasis was placed on multidisciplinary teams, working within the GP practice and working with the GP as an expert generalist. The early recognition that the referral rate through GP's had been slower 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 their patients with health conditions exacerbated by living in a hard to heat home.

Many stakeholders talk of their surprise at how slow the referral process was at first, and the consequent realisation that 'limiting it to GPs is a mistake' (TIG2), in light of the new multi-disciplinary approach, and that the referral pathway needed to be defined more 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 as they 'took the time to sit down with individual people and told them about mPower' (SH4). One-to-one approaches were 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).

One of the ways in which the GP surgery adapted during the course of the project was giving more referral responsibility 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' (GP3).

Staff members of Moving Together partner organisations adapted by working more closely with each other, having a physical presence or holding

drop-ins in each other's organisations and in the GP surgery, distributing leaflets, and holding information events in community spaces. Additionally, 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: 'we did take some though, and 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 of GPs... it minimises GP time; but it also give the person time to read over the leaflet, read over and think about some of the things they might have issues with' (SH4).

GPs see self-referral as a positive thing, and a response to themselves sometimes being to some extent a 'barrier': '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' (GP2).

Despite the widespread agreement that referral pathways should be widened, and that self-referral should be part of that, TIG emphasised the need to keep a focus on health and vulnerability within this work on addressing fuel poverty. A reliance on self-referral, they argued, could exclude the most vulnerable, sometimes referred to as 'hard-to-reach' households, or provide insufficient support to ensure they are included. The following comment stresses that relying on self-referral can exclude, or provide insufficient support to ensure that the most vulnerable are included:

> if it didn't have that health emphasis, if it was just a case of well, you self-refer, it's open to everybody, you risk then - the person who shouts the loudest can be the one that gets the most input. [Thinking of one beneficiary], she had tried twice previously to have her house insulated, but there wasn't the support there and she pulled out. She just felt she couldn't go through with it.
>
> xBecause there was the level of handholding and support and reassurance, she finally was able to have the insulation put in. That would have made a massive difference to her, not just to her physical health but actually to her mental health as well. (TIG2)

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 of the key barriers to this creative and flexible way of working was information sharing, particularly with health practitioners and services. As one stakeholder remarked:

> The key to this is information sharing, and I think there was always that desire to have some sort of database. I always had my reservations about whether that would actually work, because I've been advocating for over a decade for the health board and the council to share more information or give me access to certain very low-level information about certain clients. The one thing a client - when they first come to us, if they've come through the whole system, the last thing they want us to do is to start asking loads of questions again. (SH6)

However, the scale of the challenges relating to information sharing cannot be underestimated. One stakeholder felt that the intentions of the network around information were too ambitious within the timescales of the project: 'I think 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).

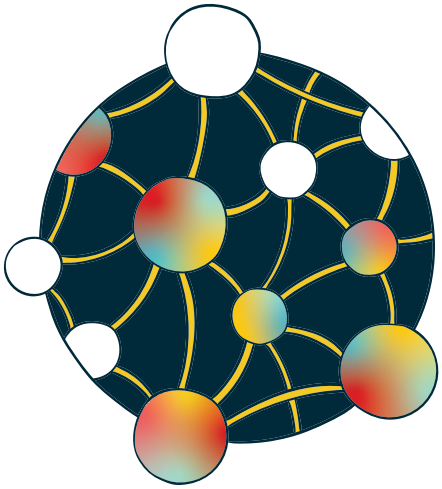
In particular, they aimed to, 'be able to know about how they share information about clients and what's reasonable to share with each other and how you pass on the client, and how we get that multi-agency approach towards people' (SH3). There were also, they felt, additional opportunities for working more closely with the NHS in terms of data sharing but this would have 'just needed a bit more thought and bit more paperwork around it and a bit of protocols' (SH3). They saw this, nevertheless, as a missed opportunity 'I think probably opportunities for sharing information about patients or clients, or for sharing services with patients and clients, were probably missed because of that' (SH3).

Managing data within organisations is also a significant challenge. TIG have to manage a bulky caseload, and track progress across a large number of households:

...the difficulty of juggling this quantity of information. You've got people that you're maybe following through for six to nine months, or maybe even a little bit longer in some cases. When you've got - we've now got 123, I think, on our caseload, we've had, you might say, 80 of those have still got some actions on them. Being able to keep a handle on where you are with everybody... It's a wee bit tricky! (TIG2)

As a direct response to this challenge, TIG are in the process of adopting an information management system to prevent people 'falling through cracks' (TIG2) and track their journey across services.

8. Inter-agency working is enabled by the connectivity of partner organisations and stability of networks.



One feature of the island that comes across very strongly, and is clearly related to the ways in which organisations were able to work together creatively, is the extent to which organisations are strategically interconnected. Many of the stakeholders sit on the boards of partner organisations, giving opportunities to learn about each other's work and identify ways of collaborating. This level of interconnectivity provides an inter-agency stability, which is itself a key enabler. Trust – a meta theme of this research – again plays a role here, in this stability arising out of existing mutual trust between organisations and key personnel, and in turn building trust between organisations.

The island context plays an undeniable role in this interconnectivity – one stakeholder reflected that ***'because we're quite small here, we get asked to be involved in a lot of networking events, but also strategic forums and committees' (SH6).*** This joint or parallel working provides the opportunity to learn about each other's services, and adapt to and link in with each other's work. There is a clear recognition that being joined up is not only beneficial to each organisation involved, it also weaves each organisation into a single fabric of shared work and shared responsibilities.

> So sometimes there will be things and if we just happen to be at the right meeting at the right time, but the more we're engaging with people then obviously the more that we know, that's where partnership is important. It's important to share what's going on. ...You could [work individually] but you won't be doing as good a job as you do if you're engaging with other people.' (SH5)

This has not always been the case, and a stakeholder reflected on ***'days gone past when funding was quite competitive, so groups were having to fight each other and compete against each other for funding' (SH2)***. This, they argued, ***'did lend itself to partnership work... if you share too much information, then another group might devise a similar scheme to yours and then go off with your funding' (SH2).*** Over their time working with TIG, however, they noted that ***'they've all come to the realisation that the way ahead is partnership working, and we're not particularly precious about who gets the credit for any particular work, as long as the householder is the winner in the end by being in receipt of some kind of assistance' (SH2)***.

There is also an awareness of the benefits of forming personal connections that enable peer learning networks to develop:

> We have a nurse on our committee ... who's on part of this project. She sits on our committee; likewise, I sit on hers. We co-supervise each other, so we do joint supervisions there because there isn't the facility within a small organisation to manage them. We have the same levels of angst and hassles, so she supervises me and I supervise her. We have regular supervision meetings, and that started recently.
>
> That's really good because it's good to have someone who knows what you're going through. Committees are great to a degree, but they only want so much involvement. Then, when it comes to that side of managing... Basically, we are the main hitter in the organisation. We're basically the drivers. We don't have anybody to turn to, so it's nice to talk with someone who's in the same boat. (SH6)

There is also a strong sense of learning about partners' work, often coming to the realisation that each organisation does more in terms of the various forms of support offered than people think they do. The local Job Centre does not, for example, only help people get jobs. ***This also applied to perceptions of the role of TIG: 'I think we all, I mean we knew about the house insulation and we probably knew about energy advice to a degree, but I don't think we realised just about switching tariffs and are you on the right thing? They do more than we realise that they did' (SH5).***

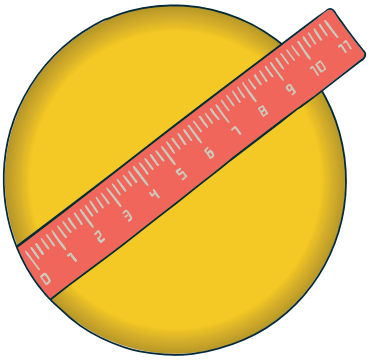
A growing awareness of what each organisation does, as well as an acknowledgement of what partners can and cannot do is a key driver for better outcomes:

> Certainly, from our work with [one of the nurses], she does great things to support her clients, but she doesn't have benefits on her radar. She doesn't have the house improvements on her radar at all. It's about building the relationships and the networks to allow people to say with confidence, I don't know about these things but I know a person that can help. (TIG2)

The overall result of this interlinked, joined-up nature of services and organisations is to ensure that the project is focused on identifying and supporting the most vulnerable householders:

> Just to make sure that - aside from the fuel poverty side of things, we're working with - we're doing drop-ins at the DWP as well, to try and find people who might be on ESA or other passport benefits. Still keeping that health focus in mind. There might be more to do with people on low incomes in general, from the extreme fuel poverty side but we need to work with not just the health services but third sector as well, I think, to make sure we're picking up on anybody that has that vulnerability there. (TIG2)

9. ‘Messy’ outcomes can be hidden by narrow metrics.



Moving Together stakeholders have needed to be open and flexible in order to put a predominant focus in their work on tackling needs and on the quality of support. This has reinforced the fact that project outcomes are often ‘messy’ in nature and in process. In this sense ‘messy’ is by no means a criticism. It reflects the diversity and sometimes unexpected nature of outcomes and the limitations of single metrics in describing them.

Furthermore, in the focus on targeting the most vulnerable and centring the work on them, it is apparent that impact, as seen by stakeholders, is not just a numbers game – even though the numbers themselves can be eye opening. Whilst large sums sound impressive and can help to win political and financial support, smaller amounts can also transform lives:

> We deal with a lot of multiple debt cases here, people that are just struggling financially to cope and we also deal with personal bankruptcies. I think last year - we're a small island and I think last year, we dealt with over £1 million of debt, which is quite phenomenal. (SH1)

> A £50 debt write-off can mean more to that individual than £15000 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. (TIG1)

One member of the TIG team described the impact on the life of this householder 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. (TIG1)

There is a recognition that little things count, and add up for the individual:

> It's little things like when someone comes in and fills the kettle for one cup of tea. Tiny little things, but I say, 'Do you realise?' 'Oh, it's not much.' I say, 'But add it up over a year.' We're constantly thinking, energy saving. It's just those little passive approaches that can't really be evidenced in the great scheme of things but can actually save people money. (SH6)

With the early realisation amongst partners that the number of referrals into the system weren’t as planned or anticipated through the GP pathway, project partners became anxious about the prospect of not meeting outcome targets. However, project stakeholders also recognised that seeing outputs in these terms may hide what has actually been done, and the extent to which lives have been changed.

It’s also clear that the project has made a palpable difference to the lives of the people it has supported, and these are more than the sum of the parts or the number of people supported, and relate not only to energy consumption, but also to quality of life in a more general and fundamental sense:

> Not just the house made warmer but his wallpaper was peeling and being pushed back up with drawing pins. Now you've got the insulation in, it's been taped and filled and it's painted, so it looks smart. It's warm, it looks acceptable and it's a place you can invite people in. ...he's tickled pink.
>
> As much as anything else, his income has increased, so he's now £85 a week better off. He's got free travel because he's got a bus pass. He's got money to make choices. (TIG2)

There is also, however, an acknowledgement that numbers do ‘speak’ to certain audiences – such as commissioners of services and projects:

> I think this project had a real opportunity to be able to go: If you put insulation in somebody's house and you reduce their fuel bills by X, you have now got another £400 a year to be able to spend on other things, and we've advised them about diet and blah, blah, blah. This has happened in their household, and the number of times that the child's come into the practice with asthma-related conditions has dropped from 42. Then we'll go, 'Got it', you know? (SH4)

TIG staff reflected that one implication of being driven by numbers and outputs is the risk that there may become a tendency to ***‘do the ones that are easiest to do. The ones that take that bit of extra time become difficult’ (TIG2).*** Instead, they stated that they aim to target the work to meet the genuine needs of the most vulnerable householders. A difficulty, as identified by one stakeholder, is that there will be individuals who could benefit from more assistance ***‘but who do not necessarily meet the immediate criteria of any particular scheme’ (SH2)***. They argued that there should be more resources for organisations like TIG to apply solutions when there is a need for a ***‘round peg to go into a square hole. I think there should be a degree of interpretation around – with certain individuals’ (SH2)***.

One of the householders supported this view, describing their own frustration at ‘falling through the cracks’:

> ...they're putting different, or trying to find different solutions and things because it is difficult because I fall in a different, in the wrong categories, if you see what I mean?
>
> I'm not, as I say, on benefits, and I'm not really eligible and I'm not old enough to be a pensioner so that that doesn't count. I'm not registered disabled, although my son has got autism so he's actually disabled, but yes, a little difficult in regards to finding where I fit... I've either earnt too much in the summer when I was working so that it doesn't allow me to do this, and then I've not got a benefit ... so I'm sort of in the middle trying to find an exit that suits. (HH7)

10. Time is required to build an approach that addresses complex conditions.

Time – the perennial constraint – unsurprisingly arises as a key factor shaping the delivery and impact of Moving Together. There are two main ways in which the constraint of time has been a challenge and revealed to partners the potential for innovation and transformation.

The first aspect is the constraint of GPs' time, which arose in every discussion of GPs' involvement with the project. The ten-minute consultation window available to GPs was contrasted with the longer time that TIG and other stakeholder organisations could spend: ***'we spend about an hour and a half with a person on a first home visit, and that's really in detail looking at their overall health and well-being, what the issues are.' (SH4)***

The second aspect is that endeavours of this complexity require significant time to set up, to build trust with and between beneficiaries and stakeholders, and to get partnerships and processes in place:

> With the mPower Project, we took a good six months to really get a sense of what the project was and where it fitted into - and we're learning every day with this project. ... We spent a lot of time actually getting to know the project ourselves, speaking with different people, stakeholders - not stakeholders as such, but partners that might be involved.
>
> I think a year's not long enough for a project, because you've got to set it up, you've got to engage with people, you've got to let them know that it's here, and a year's not long enough at all. (SH4)

The Moving Together project, having had a year (so far) to deliver against its intended outcomes, has experienced difficulties achieving the envisaged outcomes because of the way in which complex projects of this nature inevitably take time to get going: ***'because there was a delay in starting the project, there was quite a bit of umming and ahing before at the beginning, there hasn't been enough time to really get the momentum started' (SH6).***

Once the project had started, time has been needed for people to become familiar with and avail themselves of the services offered by project partners. An enormous amount of energy has been required to get the project 'out there', embedded in people's minds and lives, with the continual pressure to achieve outcomes within ambitious timescales:

> In terms of the communications around it, making it publicly known it's there. [TIG have] been good at it because they've done their drop-ins in the surgeries - the same as ourselves, we did drop-ins. Then the leaflets are there, they're on Facebook, they've got a promotional video. The promotion of it is there, and I think it's just they've not given themselves enough time to really get it up and running and let it be known to people that it's here - and before it's here it's gone. (SH4)

Time is therefore one of the main resources that partners wish they had had more of, or had approached differently in designing the project. The following observation, however, serves to shine a light on the opportunities created by the partnerships forged within this project:

> The third sector's often better (than public/health sector) because we tend to be in funded posts which have timescales, and if we see something, we'll try it, and if doesn't work, we'll bin it. We would quite openly say, 'If this isn't working, just bin it. It's not worth the hassle. It will take us away from our day job. It's not really worth it.'
>
> Health boards/councils/GPs, their contracts are a lot tighter, their remits are a lot tighter, so therefore to add something on to what they're already doing is a lot more difficult, so it does take them a lot more. (SH6)

As this quote elucidates, time constraints affect organisations in different ways according to their responsibilities and constitutions, and this, again, points to where voluntary sector organisations may be able to help their public sector partners. By widening the provision of health services to involve a greater range of professionals and organisations, exploratory initiatives and innovative practices can emerge and these can transform services, as well as people's lives.

Concluding points

It is evident that experiences of fuel poverty on the Island can be acute, are compounded by remoteness, and have significant impacts on health. Our overriding conclusion emerging from our evaluation of Moving Together so far, is that the project has addressed and continues to address a real need on the island. The evaluation has brought together the views from project workers, key stakeholders and residents to illustrate the significant level of poor health people are experiencing and the ways in which this has been driven by remoteness, poor housing conditions, sub-optimal heating systems and limited income. Our findings from our evaluation to date provide, what we have termed, key lessons, and these are as follows:

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.

Although the main body of this report focuses on each of these lessons individually there is an important message running throughout all of these: fuel poverty is difficult to identify, is not experienced uniformly, and can exacerbate ill-health which can cloud agencies' abilities to address its root causes.

The innovative work on the island has shown that by building inter-agency relationships with care and foresight, committing resources and time, and reaching out to individuals can make significant material impacts on lives. We have sought to elucidate the story behind this work and to understand how the impacts have been achieved. There is a great deal of learning arising from this work and this can help inform and shape the project as it goes forward. We hope this learning will also help commissioners understand how similar projects may be delivered in the future.

Gluasad Còmhla (Moving Together)

Project Partners

Tighean Innse Gall

Tighean Innse Gall is a Community Benefits 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 affordable; promote independent living and also encourage business 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 works; 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 Comhla Programme raised awareness of this issue with our patients and the wider community and resulted in many of our patients benefitting from the services offered through it. These benefits will be ongoing to the individuals health re the home improvements carried out, the improvements in financial entitlements, and the knowledge that there are programmes and organisations to approach for assistance"

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 has 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.

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 longterm health and financially.

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/onto 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 and living independent and fulfilled lives and participate as active members of their local community.

Western Isles Citizens Advice Service

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.

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