

Increasing fuel poverty awareness

among primary care health professionals and
exploring their role in signposting clients to
existing support to alleviate fuel poverty



Health
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Introduction

In May 2004 the Health Promotion Agency for Northern Ireland (HPA), in partnership with National Energy Action Northern Ireland (NEA(NI)), began an initiative to raise awareness among primary care health professionals of the links between fuel poverty and health. The pilot scheme also sought to develop and test a resource which would enable primary care health professionals to identify clients experiencing fuel poverty and signpost these clients to appropriate services.

Fuel poverty – definition and causal factors

A household suffers from fuel poverty if, in order to maintain an acceptable level of temperature throughout the home, the occupants would have to spend more than 10% of their income on all household fuel use.¹

Households have different requirements in terms of heat and energy, dependent on the age, lifestyle and number of occupants. It is acknowledged that the interaction of three independent but related factors impacts significantly on the prevalence of fuel poverty. These are:

- income;
- energy efficiency;
- energy costs.

Therefore, the prevalence and severity of fuel poverty is more than an affordability issue. It is influenced by a complex relationship between energy efficiency, energy related knowledge, access to fuel and fuel prices.²

Fuel poverty and health

Health professionals readily accept that there is a link between living in a cold, damp home and ill health. While fuel poverty affects everyone within a household, it is the old, young and those who are disabled or have long-term illness that are especially vulnerable.

Living in a cold, damp and mouldy home causes or exacerbates a number of medical conditions, including cardiovascular disease and respiratory illnesses such as bronchitis, chronic obstructive pulmonary disorder and asthma, as well as being a contributing factor in strokes. In addition, people living in cold and damp conditions tend to be at greater risk of falls and accidents in the home and suffer more from common illnesses such as colds and flu.

A range of issues related to fuel poverty may also indirectly impact upon individual health and quality of life, especially mental health. These include social isolation, debt to fuel companies, disconnection of fuel supply, deterioration of the condition of the house and spatial shrink (living predominantly in one or two heated rooms).

It is clear that living in fuel poverty not only damages health but adds to financial hardship, reduces quality of life and contributes to social disadvantage for many households.

Why were primary care health professionals identified as a key group to involve in the pilot?

“Engaging with local partnerships to tackle fuel poverty provides the health sector with a simple step to reduce an obvious health inequality. It can improve the quality of life for many and reduce immediately the burden on the NHS.”³

The proposal for the pilot scheme highlighted that “primary care health professionals are in an ideal situation to identify those individuals suffering the health and social consequences of fuel poverty. In order to do this they must have an awareness of the issue, an easy tool to identify those at risk and the information to signpost clients to appropriate services.”⁴ Additionally:

- primary care health professionals often see the effects of cold, damp housing on the health of their patients;

- primary care health professionals have the most contact with vulnerable people, and are often the most trusted confidants and advisers of isolated, older people;
- involving primary care health professionals provides the opportunity to target those most in need and most likely to benefit, but who are unlikely to apply on their own;
- tackling fuel poverty can help save lives, prevent ill health, reduce admissions (and readmissions) to hospital (as well as length of stay), thereby reducing suffering experienced by individuals and reducing costs to the health services for treatment.

Effectively tackling fuel poverty can:

- save lives and reduce illness;
- prevent conditions reoccurring when returning home from hospital;
- reduce GP visits;
- reduce the burden on other health care professionals and public health workers;
- reduce the need for in-patient care and the length of hospital stays;
- improve clients' sense of wellbeing and mental health;
- reduce falls at home.⁵

Fuel poverty in Northern Ireland

The 2001 Northern Ireland House Condition Survey estimated that approximately 203,300 (33%) of households in Northern Ireland experienced fuel poverty (the comparative figure for England at the time was 9%).⁶

The first opportunity to assess progress in alleviating fuel poverty in Northern Ireland was the 2004 Interim House Condition Survey (Interim HCS), the results of which were announced in 2006. The Interim HCS estimated that in 2004 there were 153,530 Northern Ireland households in fuel poverty (24%), representing a reduction of 49,800 fuel poor households since 2001.⁷

While the movement in reducing fuel poverty levels reported between 2001 and 2004 is positive, there is concern the reduction (from 33% in 2001 to 24% in 2004) may be undermined by fluctuating fuel prices.

There have been several significant movements in the cost of fuel since 2004. Phoenix Natural Gas announced an increase of 29.9% in the price of gas to consumers in September 2005 and a further increase of 17.3% in January 2006. Northern Ireland Electricity (NIE) announced a price rise of 10.8% from April 2006. These price rises, coupled with increases in the price of oil, led to the cost of heating rising.

Reflecting the dynamic nature of the energy market, there have been a number of recent reductions in the cost of fuel locally. Phoenix Natural Gas announced a price decrease of 14.6% effective from 31 March 2007. Firmus Energy, which currently supplies natural gas to approximately 1,000 consumers in the North West, announced they were capping their gas prices until 1 January 2009.

On 12 March 2007, NIE announced that its electricity tariffs would fall by 3% from 1 April 2007, equating to a reduction of approximately £11 off the average annual bill.

The Interim HCS does not take account of the recent changes in energy prices so the current net movement of households into or out of fuel poverty is undetermined.

In its 2006 Annual Report (published prior to the price reductions), the Northern Ireland Fuel Poverty Advisory Group (NIFPAG) noted that it would appear "that the increase in energy prices will have nullified any reductions achieved between 2001–2004 and that the figure given in that research of 153,530 households experiencing fuel poverty will have substantially increased."⁸

Despite the impact of recent fuel price changes on the numbers of households experiencing fuel poverty, the 2004 Interim HCS still provides a helpful guide in determining movement and trends based on the 2001 baseline data as well as helping to understand the factors that affect fuel poverty.

Key findings emerging from the survey are:

- fuel poverty remains highest in the owner occupied and private rented sectors (71% of homes in fuel poverty are in the owner occupied sector);
- households with solid fuel or electricity as their main heating source are more likely to be in fuel poverty than households with oil or mains gas;
- many pensioners experience fuel poverty – 54% of households headed by a person aged 60 or over experience fuel poverty;
- in 2001 fuel poverty was evenly split between urban and rural locations. The 2004 Interim HCS reported 20% of households in urban areas were in fuel poverty compared to 33% in isolated areas;
- the survey indicates that 76% of households in fuel poverty have annual incomes of £15,000 or less; 10% of households with an income between £15,000–£19,999 experience fuel poverty and this reduces to less than 1% for households with an income of over £30,000;
- significant numbers (28%) of households experiencing fuel poverty are in employment, and given that many support programmes are 'benefit driven', this means that existing provisions may not effectively target all the fuel poor.

Fuel poverty – policy/strategic context

Fuel poverty is receiving increased attention through the development of local strategies such as *Investing for Health* and *Ending Fuel Poverty – A Strategy for Northern Ireland*.^{9, 1} There are also a significant number of local and regional initiatives aimed at tackling the high incidence of fuel poverty across Northern Ireland.

Investing for Health, launched in 2002, recognised that tackling fuel poverty was a key element in improving the wider public health of the population. *Investing for Health's* Objective 4 – The Living and Working Environment, prioritises the need to tackle fuel poverty to

ensure everyone has the opportunity to “live and work in a healthy environment and to live in a decent affordable home.” Fuel poverty is also identified as a key priority within each of the four Investing for Health Partnerships. This has been important in increasing the engagement of wider sectors and stakeholders in working collectively to tackle fuel poverty at a local level.

The Department for Social Development (DSD) launched *Ending Fuel Poverty – A Strategy for Northern Ireland* in November 2004. The strategy highlighted the scale of fuel poverty in Northern Ireland and committed Government to meet the targets of eradicating fuel poverty in vulnerable households and those in the social rented sector by 2010 and in non-vulnerable households by 2016.

Acknowledging the essential role of other departments and agencies and the need for effective coordination, DSD have established the Inter-departmental Group on Fuel Poverty (IDGFP). The IDGFP, chaired by the Minister with responsibility for Social Development, was established as a means of ensuring effective coordination of policies and action. The group comprises senior officials from all the main departments with a role in addressing poverty, income, the energy market, energy efficiency and health.

Ending Fuel Poverty – A Strategy for Northern Ireland clearly identifies that the best way to tackle fuel poverty is through partnership with organisations that have an influence on the causes of fuel poverty as well as local communities. Recognising the role the private, community and voluntary sectors have to play in advising and supporting work to eliminate fuel poverty, DSD have established the Northern Ireland Fuel Poverty Action Group (NIFPAG).

NIFPAG creates a forum to allow the private, voluntary and community sectors to discuss issues related to fuel poverty, express views and opinions, and advise Government accordingly.

Collectively, one of the most important aims of the IDGFP and NIFPAG is to promote a partnership approach to tackle fuel poverty across government departments and with the public, private, voluntary and community sectors.

The pilot scheme

A pilot scheme was proposed to test an approach which would help primary care health professionals to identify clients at risk from fuel poverty and signpost them to appropriate services.

The objectives of the pilot scheme were:

- to raise awareness of the link between fuel poverty and health among primary care health professionals;
- to source a tool to permit easy identification of clients suffering the effects of fuel poverty;
- to develop a resource to enable primary care health professionals to signpost clients to appropriate sources of help and advice;
- to pilot the use of the identification tool and the signposting resource.

Target group

Within the original proposal the programme intended to engage with GPs, rolling the pilot out through a number of GP practices. On review the steering group felt that targeting people through a geographical area (ie Health and Social Services Trust area) represented a more appropriate way of testing the resources and training developed. Additionally, this provided an opportunity to evaluate the resources and training across a number of key primary care health professional groups.

Several primary care health professional groups were considered, but for the purposes of the pilot the following were selected:

- occupational therapists;
- health visitors;
- district nurses.

The approach

Step one: raising awareness among health professionals

It was decided that this would be done through a training course. The two hour training course was developed and delivered by NEA (NI) and eaga.

The training covered the following areas:

- what is meant by fuel poverty;
- the scale of fuel poverty in Northern Ireland;
- fuel poverty and its link to poor health;
- ways to address the health effects of fuel poverty;
- introduction to energy efficiency;
- introduction to the resources;
- questions, feedback and evaluation.

At the end of the training session each health professional received a fuel poverty pack, containing:

- a fuel poverty checklist;
- a leaflet for clients;
- presentations and information from training;
- a client consent form.

Step two: raising awareness of the link between fuel poverty and health among the public (particularly those most at risk)

At the training session the primary care health professionals were provided with a number of resources, including a leaflet and a fuel poverty checklist, which would help identify those at risk, provide a structure to raise the issue with the client and signpost them to appropriate sources of help and advice.

The checklist *Are your clients suffering from fuel poverty* (Appendix 1) was adapted from the fuel poverty and health toolkit, developed by the National Heart Forum.¹⁰ Participants were encouraged to carry the checklist on client visits to support them in raising issues linked to fuel poverty. The resource was designed to be hard-wearing and diary-sized to facilitate this.

This checklist provided guidance on potential signs and symptoms of fuel poverty, including a list of 'things a client might tell you' or 'things you may notice about your client's home'. The reverse side of the checklist detailed sources of help and advice, including a range of statutory, voluntary and advice agencies. A brief description of the support offered by each organisation was provided along with contact details.

The leaflet, *Is my home warm enough?* (Appendix 2), provided clients with information on how cold, damp housing can lead to poor health. It included information on energy efficiency and ideal room temperature, and ideas on how to keep the home warm. The leaflet also listed organisations that could provide advice and support. This leaflet was to be given to or read to clients by the primary care health professionals.

Evaluation

Aims of evaluation

The evaluation aimed to examine the effectiveness of training and resources in encouraging key primary care health professionals to raise the issue of fuel poverty with their clients.

Objectives

- To assess change in awareness, knowledge, attitude and motivation to address the issue of fuel poverty among primary health care staff.
- To assess the usability of the identification tool and resource pack, and make recommendations for improvement.
- To assess the potential impact the approach adopted by the pilot had on the fuel poverty status of clients.
- To assess sustainability and wider application of the project.

Methodology

Baseline survey of participating primary care health professionals

A baseline survey of primary care health professionals' awareness and current practice was carried out prior to training. The questionnaire assessed knowledge of and attitudes to the wider determinants of health, awareness of fuel poverty and its impact on health, and sought views on the potential role primary care health professionals may have in tackling these issues.

The baseline (pre-training) questionnaire was completed by 81 of the 97 health professionals trained (84%).

Follow-up survey of participating primary care health professionals

Three months after the training, group discussions were conducted with staff who attended the training in two Health and Social Services Trust areas. Findings from these were used to inform the development of a follow-up postal questionnaire. Six months after training this was sent to all primary care health professionals who had attended the fuel poverty training (n = 97). The questionnaire was designed to detect change in knowledge of and motivation to address fuel poverty, highlight barriers and make recommendations for further work.

Forty one primary care health professionals completed the follow-up questionnaire, a response rate of 42%.

The impact upon clients was to be assessed via a telephone survey of clients with whom primary care health professionals had raised the issue of fuel poverty. The aim was to examine if any of the advice or information offered had been acted on (and any subsequent actions). The primary care health professionals were given a consent form for clients to complete and instructed to gain consent from clients with whom they had discussed the issue of fuel poverty. The consent forms were to be collected over a four month period (January to April 2005) and returned to the HPA. However, only two client consent forms were returned, so potential reach and impact on clients was assessed via self report from the

primary care health professionals' follow-up questionnaire.

When feedback from the questionnaire was examined it was decided that it would be beneficial to include the views of the relevant professional managers. This was done by means of a semi-structured telephone interview. Seven managers were interviewed, three in Armagh and Dungannon Health and Social Services Trust, one in North and West Belfast Trust, one in Foyle Health and Social Services Trust and two in Homefirst Community Trust. These included a range of occupational therapy, health visiting and district nursing managers (see Table 1 below).

Table 1: Primary care health professional managers interviewed and area of responsibility

Managers' area of responsibility	No. of interviews
Occupational therapists managers	3
District nurses	1
District nurses and health visitors	1
District nurses, health visitors and community midwives	2

Presentation of results

The Chi-square statistical test was used to test for associations between groups within the data. Statistically significant findings are shown where appropriate and three levels of significance are present, ie $p \leq 0.05$, $p \leq 0.01$, $p \leq 0.001$. For instance, if a finding is significant at the $p \leq 0.05$ level it would be expected in a similar population 95 times out of 100. Where percentages are presented, each row or column may not total 100 because of rounding.

Findings

Ninety seven primary care health professionals from four Health and Social Services Trust

areas took part in the training. This included 23 occupational therapists, 27 health visitors, 30 district nurses and 17 'others' (social workers and other nurses). Six months after training, participants were sent a follow-up questionnaire to ask about the usefulness of the training and resources. The response rate to this questionnaire was 42% (n = 41).

Changes in awareness and knowledge

Training was viewed positively, with 88% of participants reporting that they learned something new from the training session. The main learned points were the extent of fuel poverty, how to increase energy efficiency in the home and the existence of organisations that work to deal with fuel poverty.

Ninety five percent reported that the training gave them all the information they needed to enable them to discuss fuel poverty with their clients.

Ninety five percent said they discussed what they had learned in training with colleagues and 88% said they shared the resources they received with colleagues who did not attend the training. Around 10% either made requests for further copies of the resource or made additional copies themselves.

To examine changes in awareness and knowledge as a result of the training, responses provided to the pre-training and the six month follow-up questionnaires were compared.

Primary care health professionals' knowledge of fuel poverty

Respondents were asked before and after they attended training how they would rate their knowledge of fuel poverty. There was a highly significant difference between responses to this question at the pre-training and the post-training stages ($p \leq 0.001$). More respondents rated themselves as knowledgeable at the post-training stage (60% compared to 15% pre-training). There was a decrease in the percentage of respondents rating themselves as knowing very little about the issue (36% pre training compared to only 3% post training).

Table 2: Knowledge of fuel poverty among primary care health professionals

	Pre training %	Post training %
Very knowledgeable	1	3
Knowledgeable	15	60
Know a little	48	35
Know very little about it	36	3
Base (n)	81	40
Significance	(p≤0.001)	

Prior understanding of fuel poverty

Prior to training, only 7% of respondents had had previous training on the issue of fuel poverty, while 8% had been involved in previous initiatives.

Participants were asked pre training and post training to describe what they currently understood by the term fuel poverty. The definition used in *Ending Fuel Poverty – A Strategy for Northern Ireland* is:

“The situation in which a household would have to spend more than 10% of its income on fuel to maintain an acceptable level of temperature throughout the home”.¹

A range of responses was given at the pre-training stage, some of which touched on the definition while others failed to. Answers included 'being unable to afford food and heating' (74%), 'older people not understanding heating benefits' (12%), 'solid fuel fires being more expensive', 'diet and health' (9%) and 'keeping the home at a comfortable and healthy temperature' (39%).

At the post-training stage respondents were more specific in their answer, with 94% saying 'people cannot afford to heat their home' and other responses highlighted 'poor energy efficiency', showing a clearer understanding and appreciation of fuel poverty issues of affordability, income and energy efficiency.

At the pre-training stage professionals were asked to select from a list those groups they felt were at most risk from fuel poverty. Post training they were asked to identify for each group whether they were low, medium or high risk in terms of experiencing fuel poverty.

Before the training, the group selected as being most at risk was older people – 98% of professionals selected this group as being at high risk. Other high risk groups identified pre training were people with disabilities and those with long-term illnesses. When asked post training, the same three groups were identified as being at highest risk from fuel poverty; see Table 3.

Table 3: Groups identified as most at risk from fuel poverty, pre and post training

Pre training	Yes %	Post training	High risk %	Medium risk %	Low risk %	Don't know %
Older people	98	Older people	90	7	0	2
People with disabilities	72	People with long-term illness	90	7	0	2
People with long-term illness	70	People with disabilities	85	12	0	2
Children	62	Children	61	32	0	7
Students	58	Students	41	39	5	15
Single households	44	Single households	34	44	2	20
Working people	8	Middle-aged people	0	54	30	17
Middle-aged people	5	Working people	0	34	51	15
I do not know	1					
Base (n) = 79		Base (n) = 41				

The percentage of respondents indicating that single households, middle-aged people and working people are at risk of fuel poverty increased post training, indicating a wider appreciation for the prevalence of fuel poverty across society.

The increase in recognition for the potential of working people to suffer from fuel poverty demonstrates a deeper understanding of the issues and is reflective of the 2004 Interim HCS, which showed that growing numbers (28%) of households experiencing fuel poverty are in employment.

Health effects

Professionals were asked to select from a list of health complaints those conditions that they would associate with someone living in a cold house. The top two answers prior to the initiative were chronic bronchitis or emphysema (90%) and asthma (72%). After the initiative the response to all conditions increased. The greatest increase occurred for falls and accidents (increased from 56% to 81%) and poor mental health (from 48% to 81%; $p \leq 0.001$). This demonstrates greater appreciation post training for the broader impact of fuel poverty on an individual and family in terms of wellbeing. There was also a highly significant increase for chronic heart disease ($p \leq 0.001$) and an increase in awareness for the association with stroke (from 15% to 29%), although this change was not statistically significant.

Table 4: Awareness of the health effects of fuel poverty

	Pre training %	Post training %	Sig.
Asthma	72	93	***
Chronic bronchitis or emphysema	90	100	*
Chronic heart disease	13	59	***
Stroke	15	29	N/S
Falls and accidents	56	81	**
Poor mental health	48	81	***
Gastroenteritis	8	12	N/S
Migraines	5	10	N/S
Base (n)	79	41	

*** = $p \leq 0.001$, ** = $p \leq 0.001$, * = $p \leq 0.05$,
N/S = not significant.

Alleviating fuel poverty

Participants were asked in what ways they thought fuel poverty could be alleviated. Table 5 demonstrates that the main answer given pre training and post training was increasing the energy efficiency of the home (95% pre training and 100% post training). The emphasis on increasing income declined from 68% prior to the initiative to 58% after the initiative and the suggestion of changing fuel type increased from 48% to 65%. None of these changes was significant.

Table 5: Ways that fuel poverty can be alleviated

	Pre training %	Post training %	Sig.
Increasing income	68	58	N/S
Changing fuel	48	65	N/S
Increasing energy efficiency in the home	95	100	N/S
Base (n)	79	40	

N/S = not significant

Ability to recognise fuel poverty

At both stages participants were asked what they might notice when visiting a home that would make them concerned that fuel poverty is an issue. The top answer given at both stages was coldness (84% pre training and 75% post training) followed by dampness (see Table 6). The responses given at the post-training stage were more detailed, suggesting that the professionals had learnt to recognise more signs, eg spatial shrink, use of blankets and clients spending a lot of time in bed.

Table 6: Signs indicating that fuel poverty might be an issue

	Pre training %	Post training %
Coldness	84	75
Dampness	31	55
Lack of heating	20	0
Many layers of clothing	16	35
Health/patient discomfort	13	17
Housing condition	9	15
Heating in one room only	0	15
No fire lit	0	13
Use of blankets	0	10
Mould growth	0	5
No smell of cooking	0	5
Spends lot of time in bed	0	5
Hot water bottle	0	3
Base (n)	77	40

The participants were also asked what a client might say that would suggest that fuel poverty is an issue. Prior to training, the answers focused mainly on issues of affordability in terms of low income and fuel costs, as well as poorer health and living in cold damp conditions. Answers provided post training were more varied, indicating that participants have been made more aware of a greater range of indicators to signal fuel poverty was an issue for their client.

Table 7: What a client might say to indicate that fuel poverty is an issue

	Pre training %	Post training %
Low income/price of heating	80	70
Ill-health/depression	17	20
Continued cold weather	8	0
Damp housing condition	3	0
Advice on schemes available	3	0
Diet	3	0
Unable to light fire/put heating on	1	18
Unable to sleep/poor sleep	1	3
Staying in bed to keep warm	0	18
Staying in one room	0	13
Poor mobility	0	3
No hot water	0	3
Base (n)	77	40

Awareness of agencies to refer people to for help

At both stages the participants were asked about their awareness of agencies they could refer people to for help in tackling fuel poverty. Awareness significantly increased after the training from 66% to 95% of respondents reporting that they were aware of agencies which could help clients to deal with fuel poverty. Participants were then asked to list any agencies that they were aware of. At the post-training stage participants were aware of a broader range of organisations that could provide advice.

Table 8: Awareness of agencies to which clients can be referred for help

	Pre training %	Post training %
DHSSPS/Social Services	49	18
Help the Aged/Age Concern/ Society of St Vincent de Paul	24	45
Warm Homes Scheme	11	45
NIHE	25	14
eaga	6	21
Heath Action Zone	4	0
Cosy Homes	2	0
Energy Efficiency Advice Centre	2	13
Citizens' Advice Bureau	0	26
Occupational therapists	0	3
NEA	0	6
Base (n)	55	38

How the training and resources have been applied – key findings

Use of resources

The primary care health professionals participating in the pilot were provided with two resources to enable them to identify clients experiencing fuel poverty and to signpost those clients to appropriate sources of help. These were the checklist *Are your clients suffering from fuel poverty?* (Appendix 1) and the clients' leaflet *Is my home warm enough?* (Appendix 2).

Use of checklist

During training the primary care health professionals were encouraged to carry the checklist with them for reference when on call. For this reason the checklist was designed to be hard-wearing and diary-sized. However, 15 out of 41 participants could not recall (9), or did not refer to the checklist (6) after the training course. Among the others, eight said they referred to it a few times, four said they learned it so they wouldn't have to refer to it and only one said they referred to it regularly.

Twenty six out of 33 said that the checklist had made them more confident in identifying a client living in fuel poverty (although only eight respondents had referred to it when out with clients). Twenty two out of 33 said the checklist made them more confident in broaching the subject of fuel poverty with a client.

Twelve said that the checklist had made them aware of people who they would not previously have thought of as suffering from fuel poverty (students, young families, working people) and more alert generally.

Nine said the pointers on the checklist had told them something they had not previously been aware of. Of these, four said they were more aware generally in relation to fuel poverty, one said they were more aware of the number of medical conditions affected and the others did not specify.

Thirty one out of 33 said the sources of help and advice on the reverse of the leaflet were useful. Only one thought that the checklist missed out on necessary information (but did not identify what this information was).

Use of leaflet

In terms of recall and use of the clients' leaflet *Is my home warm enough?* 37 out of 41 could recall the leaflet, 27 carried a copy of it with them when visiting clients' homes and 20 said they had left a copy with clients. Eleven out of these 20 left the client the leaflet to read by themselves, a further eight read through the leaflet with clients.

Sixteen out of the 20 said that clients appeared interested in the leaflet. Just over half (11 out of 20) said they checked if clients had followed up on the information provided in the leaflet, while nine were aware of clients actively following up on sources of advice or help.

Client consent

It was intended that clients should be involved in the evaluation process. Their details were to be captured by the primary care health professionals through completion of the consent form. However, only two client consent forms were returned from a total of 97 primary care health professionals that took part in the pilot,

although nine participants who responded to the follow-up questionnaire said they got clients to complete a client consent form. This made it difficult to evaluate the initiative from a client's perspective. Indeed it was impossible to establish how many clients may have benefited from their health visitor, district nurse or occupational therapist being trained and resourced in the area of fuel poverty.

In the follow-up survey questions were included to establish if the reason for the non-return of consent forms was due to a difficulty in obtaining consent from the clients or if primary care health professionals did not raise the issue of fuel poverty with them. From Table 9 it would appear that the consent process did not work in approximately a third of cases because clients did not want to give their details, but for a substantial portion the main reason appears to be that primary care health professionals did not bring the consent form to the attention of the client.

Table 9: Reasons why client consent forms were not completed

	n*
Clients did not want to pass on any of their details	9
Reluctant to broach the subject with clients	6
Forgot to broach the subject with clients	7
Extra burden and not part of workload	10
Other	8
No reason given	3
Base (n)	32

**Totals more than 32 as respondents could give more than one reason.*

Was fuel poverty an issue for your clients?

The primary care health professionals were asked if they felt fuel poverty was an issue for any of their clients. Thirty two (82%) felt that it was an issue while seven said it was not. Thirty out of 41 said they felt equipped by the training and resources to identify clients who could be suffering from fuel poverty. Twenty five said they

had identified clients for whom they thought fuel poverty was an issue and 23 said they had discussed the issue with their clients.

Of those who raised the issue with their clients (n=23), most felt confident in broaching the subject. Six said they felt a little apprehensive. However five (out of 23) said that they felt their clients were ill at ease discussing the issue.

Eighteen (out of 23) said they had enough information to deal with their clients' queries; only two said they did not. The additional information these participants said they needed was on benefits and the relevant telephone numbers for clients to contact, although these were included in the checklist.

The issue of raising fuel poverty with clients was examined further with the use of a list of statements that had been taken from comments made during qualitative discussions. Participants were presented with the statements and asked to what extent they agreed or disagreed with each (see Table 10).

Twenty three percent agreed with the statement 'I was reluctant to discuss fuel poverty with my client as I knew they would not want help'. Similarly, 23% agreed with the statement 'I did not discuss fuel poverty with my clients as I felt they were not eligible for help'.

Eighty four percent felt confident discussing fuel poverty with their client if they felt the client was eligible for help. This indicates that primary care health professionals take on a more in-depth role with clients, often making a value judgement on whether or not the person may be interested in the information. It also indicates that the focus is upon 'eligibility for help' in terms of support, ie in the form of grants. Although these are important in tackling fuel poverty, there are messages about fuel use and energy efficiency that could help households address fuel poverty.

A few additional points are apparent from the above responses; 26% of participants felt they did not have time to discuss fuel poverty with clients and 18% felt fuel poverty was a difficult subject to raise with their clients.

Table 10: Participants' reactions to statements regarding interaction with clients about fuel poverty

	Strongly agree %	Agree %	Disagree %	Strongly disagree %
I was confident in discussing fuel poverty with any of my clients if I felt they were eligible for help	16	68	13	3
I was reluctant to discuss fuel poverty with my clients as I knew they would not want help	0	23	49	28
I found it difficult to approach the subject of fuel poverty with my clients as I did not want to make them feel uncomfortable or embarrassed	5	13	56	26
I did not have the time to discuss fuel poverty with my clients	3	23	49	26
I felt it was not necessary to discuss fuel poverty with my clients as repairs had already been carried out	3	38	46	13
I did not remember to discuss fuel poverty with my clients	3	13	64	20
I felt I had sufficient information/knowledge to confidently discuss fuel poverty with my clients	10	77	13	0
I was reluctant to discuss fuel poverty with my clients as I felt they were not eligible for help	3	20	62	15
I did not discuss fuel poverty with my clients as I did not want to raise their expectations	0	10	67	23

Base (n) = 39

Some of the primary care health professionals involved in the qualitative work carried out to develop the questionnaire had raised an issue about the term 'fuel poverty', so this was placed as a question item on the follow up questionnaire. Respondents were asked 'do you feel that the term fuel poverty is an appropriate one to use when discussing this issue with clients?' Around a third (11 out of 34) who responded thought it was not, eight of them offered reasons saying that the use of the term poverty was offensive and made people feel 'belittled'.

Is it their role?

When asked if they felt their profession had an active role to play in identifying people living in fuel poverty, 42% replied yes and a further 46% said yes, but that the role is currently hard to fulfil. Only 10% felt they had no role to play.

Twenty three (out of 41) identified barriers making it difficult to incorporate the issue of fuel poverty into their work. These were 'other demands of their profession' (22), 'time burden associated with identifying clients and giving information' (14) and that fuel poverty is 'not a concern for my clients' (6).

Table 11: Barriers making it difficult for primary care health professionals to incorporate fuel poverty into their work

	Yes n
Other demands of my profession	22
Time burden associated with identifying clients and giving information	14
Fuel poverty is not a concern for my clients	6
Fuel poverty is not a priority target area for my primary care health professional grouping	5
Lack of training on how to communicate with clients on this issue	4
Lack of information on fuel poverty	3
Other <i>May be dealt with by other housing adaptations;</i> <i>Problems addressed by NIHE;</i> <i>Short of staff/heavy workload</i>	3
Base (n)	23

It is interesting to note that in the previous section 75% of respondents disagreed with the statement 'I did not have the time to discuss fuel poverty with my clients'. However when asked whether fuel poverty was an issue to be addressed within the context of their role 61% of respondents felt time burdens associated with identifying clients and providing information made it a difficult role to fulfil.

Respondents were asked for any recommendations to encourage the success of this pilot project if it were to be rolled out to other health professionals. Sixteen respondents offered some thoughts; these were 'more information resources' (8), 'training refresher courses' (6), 'information on eligibility criteria' (2) 'talking to more vulnerable groups' (1) and 'it's more relevant to district nursing' (1).

Primary care health professional managers

An additional element incorporated within the study was to involve the managers of the primary care health professionals trained in a review process. This provided an opportunity for further discussion in terms of the feedback received from participants as well as allowing managers an opportunity to contribute to the report's recommendations.

Findings from managers

Senior managers responsible for the primary care health professionals trained in each of the pilot areas were contacted to explain the rationale behind the research and invited to participate in a short telephone interview. Seven managers took part (see [Methodology](#) section).

All managers thought that fuel poverty was an issue for at least some of the clients that their staff came into contact with in their professional role. All but one manager agreed that their professional group had some role to play in addressing the issue.

Formal addressing of fuel poverty at local level

While some managers were aware that fuel poverty was addressed in the *Investing for Health* strategy, they were not aware if the issue was formally addressed in any of their own local strategies or action plans. One manager mentioned that fuel poverty would be addressed indirectly by staff when addressing health needs in general for their clients.

When asked about what role their staff might play in addressing fuel poverty, most managers commented on the roles that their professional group already play. Half of them mentioned that staff carry out assessments in the homes of their clients, which would incorporate the issue of fuel poverty. Referrals would then be made to appropriate agencies. Staff are also involved in directing clients to organisations that could provide help and also in providing information themselves. One manager of district nurses mentioned that staff would act as advocates for the client. One manager of district nurses and health visitors noted that in their area it is the occupational therapists that are involved in the referral process.

“Advocacy and signposting. Referral to Social Services and the Housing Executive. Assessment of homes.”

District nurse manager

“Assessing need, providing information and signposting. Occupational therapists are involved in referral.”

District nurse and health visitor manager

In particular, occupational therapy managers highlighted that their role is to make people independent and functional. They help address fuel poverty by making sure clients can manage their heating systems. Managers pointed out that staff are in clients' homes on a daily basis carrying out assessments which cover the issue of heating.

The responses suggest that primary care health professionals help to tackle fuel poverty by offering support to clients in terms of operation and management of their heating system. While this support is undoubtedly welcome and positive, it may be worth examining with clients whether, because of issues such as affordability, fuel prices and energy inefficiency, they cannot afford to heat their home adequately even though heating systems are installed.

Another manager pointed out that their staff should have a role in identifying clients in fuel poverty but would not address the issue if no resources were provided for them to do so. This manager suggested that it should be the job of those agencies who deal with the issue of poverty.

Barriers for staff in addressing fuel poverty

Managers were asked if they could give reasons as to why it might be difficult for their professional group to address fuel poverty in their area or identify those living in fuel poverty. A number of themes emerged: time and training, professional role and priorities, and the sensitivity of the issue.

Time and training

One of the main difficulties in providing training for fuel poverty is that staff have many training requirements as part of their job, including mandatory training for professional registration and other training as part of their professional

development. The general opinion was that fuel poverty as an issue in itself would not come high in the list of priorities for training.

“It is extremely difficult at present to release staff for awareness sessions as there is an increasing amount of mandatory training.”

Health visitor manager

Managers made suggestions for the inclusion of fuel poverty in other areas of training, eg where training currently exists on the issue of poverty in general. It was also noted that fuel poverty could be addressed in foundation training so that staff would only need refresher information at the post-registration stage.

Managers were asked about training currently offered to staff. Currently there is no training or support offered to staff that is directly related to fuel poverty. One manager noted that current training covers housing, health and poverty but is not explicit in addressing fuel poverty. There was a recommendation that it could be included in the Trust's induction programme for new staff.

“Training is currently offered in specialist practice, the curriculum currently includes issues of housing and health and poverty. Training could be more explicit in including fuel poverty. It could be included in induction for each professional group in the Trust induction programme.”

District nurse manager

There is a need to link the issues of health and fuel poverty more clearly. Managers suggested making the training part of a rolling programme so that it would not require all staff to be able to attend on one day.

“Any training would need to be more about the impact of the issue and connecting the issues with health. It would be useful for information to include case studies about identifying and addressing the issue as well as research about fuel poverty and health implications.”

Occupational therapy manager

"There are problems with freeing up a lot of staff to attend training on one day. A rolling programme of training would be better to allow staff to attend when they can."

Occupational therapy manager

Professional role and priorities

With regard to professional role and priorities, managers commented that addressing fuel poverty may not be a priority when dealing with clients. Some managers highlighted that the role of staff may limit how successful they can be in addressing fuel poverty. The comment was made that while staff may be able to assess clients and identify those in fuel poverty, that would be as far as it would go; staff may not be in a position to action their recommendations so they cannot ensure that they are carried out.

"Fuel poverty isn't specifically part of the core assessment of clients. It depends on the member staff who is performing the assessment. Some might focus on this as an issue and some may not."

District nurse and health visitor manager

"Staff are also not in a position to actually action anything so it is difficult to ensure that recommendations that they make are actually carried out."

Occupational therapy manager

Staff also may not think of themselves as a group that can be involved in tackling the issue. It was recommended by one occupational therapy manager that this could be improved by creating greater awareness of fuel poverty and how it relates to health.

Sensitivity of the issue

There were differences between occupational therapy managers as to whether staff felt any sensitivity about raising the issue with their clients. In one Trust area the manager commented that staff are used to dealing with confidential and sensitive issues and so bringing up the issue of fuel poverty would not be a problem. Another manager in a different Trust area commented that there are sensitivities with raising the issue as clients may not want to admit to any problem because of pride and unwillingness to complain.

"There are sensitivities for staff when asking people about the issue. People are very proud and don't want to complain if there is a problem with fuel poverty."

Occupational therapy manager

"There are no sensitivities about raising the issue because staff are used to dealing with confidential and sensitive issues."

Occupational therapy manager

Suggestions for improved action on fuel poverty

Managers were asked to identify anything that they thought would help or encourage their professional group to become more active in addressing fuel poverty. A number of themes emerged from the answers.

Training

At least one manager commented on the need for training in the issue of fuel poverty, however it would need to be more relevant to the staff and their work with clients and have more emphasis on the links between fuel poverty and health. It was mentioned again that the issue should be included in undergraduate training.

"There needs to be more emphasis on the impact of fuel poverty on health. Training about the issue should be included in undergraduate training so staff don't have to catch up with the issues in their post-registration training."

District nurse and health visitor manager

Written resources

All the managers stated that written resources would help their staff address the issue of fuel poverty. They suggested written materials that could be taken into the clients' homes.

"Leaflets, posters and quick reference guides would be helpful. Resources need to be quick and easy to use for staff for example how to spot if there is a problem, what to do next and where to signpost people to."

District nurse and health visitor manager

However this is what was provided by the pilot project and these findings suggest that resources alone, even with accompanying training, have a limited impact.

Other issues

Other issues mentioned included better IT infrastructure for referrals after assessment, a need to develop better partnerships to address the issue, and multi-agency planning. Two managers commented that it would probably take inclusion into Trust action plans for the issue to be addressed by their professional group.

"It may take the specific inclusion in action plans for this professional group to become more active in addressing this issue."

Occupational therapy manager

"There needs to be a more effective partnership approach with joined-up thinking. It needs to be taken to the next level where everyone is sharing information with each other."

District nurse manager

Conclusions and recommendations

This pilot goes some way to exploring the feasibility of a recommendation from the Institute of Public Health's 2004 report *Engaging Communities*, that links 'are developed in order to raise awareness and assist the health sector in identifying people in fuel poverty and providing householders with information'.¹¹

A primary aim of the pilot was to raise awareness among primary care health professionals of the link between fuel poverty and health problems, and to provide resources to enable them to signpost clients to appropriate sources of support. From the findings reported it is clear that knowledge and awareness of fuel poverty among participants has increased.

The participants developed a broader understanding of fuel poverty beyond affordability to include issues such as housing conditions, energy efficiency, energy-related knowledge and access to fuel.

Importantly, the training resulted in participants having a greater appreciation for the broad range of groups that may experience fuel poverty. Findings post training highlighted increased recognition that middle-aged people and working households can be at risk from fuel poverty. This reflects the 2004 Interim HCS which highlights that significant numbers of households (28%) experiencing fuel poverty are in employment.

Likewise, the training proved effective in helping primary care health professionals recognise households experiencing fuel poverty through signs within the home and things a client may say. When asked how fuel poverty could be identified, the responses provided after the training were again more detailed, illustrating that participants had learnt to recognise additional indicators, such as spatial shrink, use of blankets or spending time in bed.

Both before and after training participants could identify health conditions which may be

affected or aggravated by living in a cold home. Due to the focus of their work, training, skills and experience, this was to be expected. However it was interesting to note that the recognition that falls and accidents may increase and that fuel poverty may affect mental health increased post training, demonstrating a broader appreciation for potential impact on wellbeing.

As a result of the training the participants were more aware of and able to be more specific about the range of support available through other organisations and agencies to help address fuel poverty.

It appears the training (and resources) developed within the pilot were viewed as positive by participants and did lead to increased knowledge and understanding in terms of fuel poverty. However a key element of the pilot was examining whether this increased knowledge and information helped change behaviour and support primary care health professionals to raise fuel poverty with their clients and signpost them to appropriate sources of help.

Unfortunately, due to the very small number of client consent forms returned, the study is unable to determine directly the impact the programme has had among clients in terms of the information provided. It is also impossible to understand the opinion of clients in terms of the role of primary care health professionals in signposting to sources of support and information.

Post training, 83% of health professionals felt they had sufficient knowledge and information to discuss fuel poverty, but there were barriers which prevented them from raising the issue with clients, for example, an assumption that the client would not want help (23%).

There is a need to understand more fully the barriers which prevent (or make it difficult for) primary care health professionals to provide information on support to their clients. The

findings demonstrate that many primary care health professionals did not raise the issue with their clients, even though 88% agreed they have a role to play in addressing fuel poverty, 87% felt they had sufficient information and knowledge as a result of the training and only 16% forgot fuel poverty was an issue they could raise with their clients.

The majority of primary care health professional staff (88%) and managers (all but one) agree that their professional group have a role to play in addressing the issue of fuel poverty, but this role is hard to fulfil taking into account other priorities. Primary care health professionals recognise the value of addressing fuel poverty in terms of improving the quality of life for many vulnerable clients but feel it is competing with many other urgent priorities within their workload.

It appears therefore there is widespread agreement on the role of primary care health professionals in tackling fuel poverty, and recognition of the value of addressing fuel poverty, but the real issue is how primary care health professionals can be supported in overcoming the barriers preventing them from playing this role.

The rationale for the pilot was based on the position primary care health professionals have in engaging with households at risk from fuel poverty and their potential role in signposting to support. In order to do this "they must have an awareness of the issue, an easy tool to identify those at risk and the information to signpost clients to appropriate services." ⁴

The pilot delivered against all three of these issues yet the existence of several barriers restricted the issue of fuel poverty being raised with clients. Training, awareness and information are not sufficient to support changes in practice, and this is demonstrated by the feedback from participants detailing the difficulties they have in fulfilling a role to help alleviate fuel poverty (a role which they accept).

From the participants' perspective, the key barriers are the other demands of their profession and the time burden associated with identifying clients and providing information. The managers also cited time as a major issue for

their staff. The difficulty in accessing training (especially with increasing levels of mandatory training) was a key concern with fuel poverty not being viewed as a priority.

To ensure primary care health professionals are supported in contributing to tackling fuel poverty there is a need for greater collaboration to examine the barriers and identify potential solutions. A number of recommendations arising from the pilot are highlighted below:

- Tackling fuel poverty contributes to the core functions of the health service; it can reduce the burden on the health sector (and staff), prevent illness, and promote health. To tackle fuel poverty effectively staff need information, training and resources but in order to be sustainable staff need continuing commitment from management supporting them to focus upon fuel poverty as part of their work functions.
- The training and information provided should be extended beyond primary care health professionals 'on the ground' visiting clients in their home. Many managers appeared unaware of the resources provided within the pilot, recommending that the development of written material was a key priority. Involving management in the training programme would ensure they are aware of fuel poverty as an issue and how it relates to health, as well as demonstrating support (and encouragement) to staff to raise fuel poverty with clients.
- Primary care health professionals are in contact with vulnerable households and develop relationships and trust. It was recognised that front line professionals are well placed to provide a range of important information to people, but this does place demands upon them. It is important these demands are recognised and acknowledged.
- There is a need for further examination of the specific areas where support is required both at a practical and strategic (management) level to ensure primary care health professionals feel empowered and supported to raise fuel poverty as an issue with their clients.

- A theme emerging from the pilot was time pressure upon staff and an unwillingness to raise expectations among clients. This issue could be overcome with the primary care health professional being able to refer to a one stop shop or a single focal point to 'fuel poverty proof' the client and household. There is a need to recognise that fuel poverty is a broad issue and that to tackle it effectively requires a range of action which goes beyond physical measures alone, eg advice, information, benefit maximisation and advocacy.
- In the pilot comments were made on fuel poverty being addressed within current assessment processes, but this referred to the functional ability to manage heating systems (eg the ability to turn on/off or work the timer) rather than considering fuel poverty issues such as affordability and energy efficiency. Fuel poverty (taking into consideration the broad causes and effects) should be incorporated within the overall assessment process. This would mean that the issue should be embedded within foundation training and supported on an ongoing basis through continuous competency training.
- As witnessed in the pilot, training and resources (checklist/leaflet) are not enough on their own to sustain behavioural change. They are a first step to increase awareness, knowledge and to provide information but the barriers preventing primary care health professionals playing a role in eliminating fuel poverty (a role which they accept) need to be further understood.
- Primary care health professionals do not need to be experts in fuel poverty. They do need to be supported in order to recognise fuel poverty as one of the wider determinants of ill health and to work in partnership with key stakeholders and agencies to signpost and support households. It is important that links with the health sector are developed in order to raise awareness and assist the health sector in identifying people in fuel poverty and providing householders with appropriate support and information.
- To ensure continuing commitment and motivation there should be regular feedback, information and recognition of primary care health professionals for signposting clients to support, and recognition of successful outcomes.

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Appendix 1



Are your clients suffering from FUEL POVERTY?

Older people, children, people with a disability and those with long-term medical conditions are more vulnerable to cold.
Use this checklist to look for signs of fuel poverty among your clients.

Diseases and conditions related to cold homes:

- asthma
- chronic bronchitis or emphysema
- coronary heart disease
- stroke and TIAs
- worsening of long-term illnesses in the winter
- falls and accidents
- slow recovery from illness.

Your client may tell you they:

- can't afford fuel bills
- owe money for fuel

- use a prepaid meter to avoid running up debt
- lie or sit in bed to keep warm
- want to stay in hospital, as it's more comfortable
- feel the cold or draughts at home.

What you might notice about your client's home:

- it feels cold or draughty
- it smells of damp
- there is no visible form of heating
- the only heating is electric fires, fan heaters, oil filled radiators or bottled gas heaters

- only one room is heated
- there is home-made draught-proofing
- ventilators have been blocked or covered
- curtains are closed in the day to keep in the heat
- there are signs of damp, eg
 - pools on window sills
 - mouldy patches around windows or on walls, ceilings or upper corners of upstairs rooms
- the client wears lots of clothes indoors.

Adapted from the *Fuel Poverty and Health Toolkit*, National Heart Forum, 2003.

Sources of help and advice

Eaga Partnership
 Manages the Warm Homes Scheme, which provides insulation measures to owner occupied housing or privately rented homes. The householder must be in receipt of a qualifying benefit and either have a child under 16 or suffer an illness/disability. Applicants aged 60 or over in receipt of a specified benefit can also qualify for central heating. Eaga will provide advice on eligibility and accept referrals.
Freephone: 0800 181 667. Note: Clients will be asked for reference number MK662.
Website: www.eaga.co.uk

Northern Ireland Housing Executive (NIHE)
 Provides advice on grants and schemes for private sector and NIHE schemes for Housing Executive tenants, eg:
 • Heating Conversion Programme.
 • Disabled Adaptations Programme.
 • Ongoing maintenance and improvement schemes (loft/cavity wall insulation).
Tel: Phone your local Housing Executive office listed in the business section of the Phone Book.
Website: www.nihe.gov.uk

General Consumer Council
 Represents the interests of consumers and deals with complaints in relation to gas, electricity and coal matters where the consumer is unable to reach a satisfactory outcome directly with the supplier.
Tel: 0845 601 6022
Website: www.gccni.org.uk


Energy Efficiency Advice Centre
 Trained energy advisors provide:
 • advice on how to make homes more energy efficient, to reduce energy bills.
 • a free home energy check and a report on how to make the home more energy efficient, including any grants that are available.
 • a home visiting service, HEATSMART, to housing executive tenants who have or are about to have a new heating system installed, or are aged 60 or over.
Freephone: 0800 512 012
Local websites:
 Belfast: www.belfastenergyadvice.com
 Derry: www.foyleenergy.org
 Enniskillen: www.wrean.co.uk

Citizens' Advice Bureau (CAB)
 Gives advice on benefits available (eg Winter Fuel payments, Cold Weather payments) and on where to seek help with home repairs, insulation and energy efficiency.
Tel: Phone your local CAB listed in the business section of the Phone Book.
Website: www.adviceguide.org.uk/nireland

Age Concern Northern Ireland
 Offers telephone advice for older people on benefits, energy efficiency and saving money. Produces a number of useful factsheets, including *Help with Heating*.
Tel: 028 9032 5055 (Mon-Fri 9.30-1.00pm)
Website: www.ageconcernni.org

Help the Aged
 Offers telephone advice for older people on benefits, energy efficiency and saving money. Produces a number of useful factsheets.
Tel: 0808 808 7575 (Mon-Fri 9.30-1.00pm)
Website: www.helptheaged.org.uk


Advice NI
 Members of this organisation provide information and advocacy services on social security, housing, debt and consumer issues.
Tel: 028 9064 5919
Website: www.adviceni.net



Produced by the Health Promotion Agency for Northern Ireland, 18 Ormeau Avenue, Belfast BT2 8HS.
 Tel: 028 9031 1811 (Voice/Minicom). Fax: 028 9031 1711.

Appendix 2

- General Consumer Council**
 Represents your interests in gas, electricity and coal matters. Deals with complaints about gas, electricity and coal matters where you are unable to reach agreement with your supplier. Provides advice and information on fuel payment methods, gas and electricity safety and how to make your home warmer.
Tel: 0845 601 6022
Website: www.gccni.org.uk
- Age Concern Northern Ireland**
 Advice for older people on benefits and on how to help make your home warmer.
Tel: 028 9032 5055
 (Mon-Fri 9.30-1.00pm)
Website: www.ageconcernni.org
- Help the Aged**
 Advice for older people on benefits and how to make your home warmer.
Tel: 0808 808 7575 (Mon-Fri 9.00-4.00pm)
Website: www.helptheaged.org.uk




IS MY HOME WARM enough?

Cold, damp housing can lead to poor health – find out how to make sure your home is warm enough



Produced by the Health Promotion Agency for Northern Ireland,
 18 Ormeau Avenue, Belfast BT2 8HS.
 Tel: 028 9031 1611 (Voice/Microm), Fax: 028 9031 1711.

Am I at risk? 

Some people are more likely to have health problems as a result of cold, damp homes than others. Those who are most at risk are:

- older people;
- young children and babies;
- people with a long-term illness or disability;
- people who have difficulty getting around.

The temperature of your living room should be between 18°C and 21°C (65°F-70°F).


What can I do to ensure my home is warm enough?

There is a range of things you can do to help keep your home warmer.

- Check to see if you are entitled to a grant to help heat your home (call your local Energy Efficiency Advice Centre free on 0800 512 012).
- Insulate your walls (cavity wall insulation) and loft to reduce heat loss.
- Fit draught proofing to help seal gaps around windows or doors.
- Ensure your heating system is working properly.
- Insulate your hot water tank.

The following organisations can provide free advice. They can tell you about schemes or grants that may be available to help with the cost of making your home warmer and in some cases may be able to arrange for the work to be done.

- Eaga Partnership**
 Gives advice on schemes and grants to help you make your home warmer.
Freephone: 0800 181 667 (You will be asked for reference number: MK662)
Website: www.eaga.co.uk
- Energy Efficiency Advice Centre**
 Provides advice on how to make your home warmer and save money on your energy bills. For up-to-date information on all the various schemes, grants and cash backs available in your area to help heat your home call the freephone number.
Freephone: 0800 512 012
Local websites:
 Belfast: www.belfastenergyadvice.com
 Derry: www.foyleenergy.org
 Enniskillen: www.wrean.co.uk
- Northern Ireland Housing Executive (NIHE)**
 Advises on schemes for housing executive tenants to help make homes warmer. Provides advice on home improvement grants and schemes for private home owners.
Tel: Phone your local Housing Executive office listed in the business section of the Phone Book.
Website: www.nihe.gov.uk.
- Citizens' Advice Bureau (CAB)**
 Gives advice on benefits available to help you save money and information on where to seek help to make your home warmer.
Tel: Phone your local CAB listed in the business section of the Phone Book.
Website: www.adviceguide.org.uk/nireland
- Advice NI**
 Members of this organisation provide information and help with benefits, housing and debt.
Tel: 028 9064 5919
Website: www.adviceni.net





Health
Promotion
Agency



Campaigning for Warm Homes

Health Promotion Agency for Northern Ireland
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www.healthpromotionagency.org.uk