

Fuel Poverty Statements

The specific statements made in the Local Plans can, as discussed above, be made in a number of policy areas. The form the statements take will probably fall within one of the following categories:

- * Statements of Recognition - mission type statements acknowledging the links between fuel poverty and poor health and the role of the PCT in addressing these. The statements can raise awareness, provide credibility and support action on the ground
- * Statements outlining current and planned partnerships to tackle fuel poverty. These should be with a wide range of organisations through a number of forums. Partners should include: local authorities (energy conservation officers, departments for housing, environmental health, Local Agenda 21, social services, health promotion staff etc), voluntary sector organisations (Age Concern, fuel poverty groups, Energy Efficiency Advice Centres, carer's groups etc) and energy service agencies (fuel suppliers, Warm Front Team)
- * Statements which report on current and planned action in the following areas:
 - a. to promote training and awareness raising for staff.
 - b. to facilitate systematic identification of vulnerable householders (for example via the use of core assessment tools)
 - c. to promote and establish referral mechanisms for health staff ensuring these householders are referred for appropriate services.
 - d. to promote or underpin the development of partnerships which promote affordable warmth
 - e. other promotional work to encourage the above - e.g. energy days, newsletters, etc.
 - f. project development and research.

Case Studies

1 Nottingham Health Authority HIMP 2001-2004

Under Health Promotion in the section on Older People the HIMP contains the following statements:

'Health is affected by a number of different factors, one of which is the state of housing that people live in. Substantial research has taken place already into the effects of cold damp housing on health and further national and local research is looking at the effect of energy efficiency improvements on people's health. (See Energy Efficiency, Health and Environment report produced by NEA on the seminar held by Nottingham Health Action Group in 1998 and 'Cutting the Cost of Cold - Affordable Warmth for Healthier Homes' edited by Janet Rudge and Fergus Nicol 2000)

● Research by Julia Green, Energy Inform, indicated that where energy efficiency improvements were made in low income households, 50% increased comfort levels were reported and carbon dioxide emissions were reduced through fuel savings

● The Independent Inquiry into Inequalities in Health (2000) recommends policies to improve insulation and heating systems in new and existing buildings to reduce the prevalence of fuel poverty'.

2 Sheffield Health Authority HIMP 2001-2004

Under 'Section 4: Root cause of ill health: A healthier Sheffield' the HIMP included a paragraph on housing and health which had a 'Statement of Recognition':

"Fuel poverty remains a problem across all tenures. Over one in ten households face difficulties heating their homes. One third of households in the City have no loft insulation, and the proportions are higher in the rented sector. The City has an Affordable Warmth Strategy, through which targeted investment, energy awareness and increased use of energy efficiency measures are being promoted"

In addition one of the planned action points under this section was the "development of 'housing link officers' for all PCTs with integrated housing and health access points"

3 Cambridge Health Authority HIMP 2002-2005

Within a section on Public Health and Health Inequalities, the HIMP has a key aim:

'to reduce the number of people living in fuel poverty in Peterborough and Cambridgeshire whose health is adversely affected by cold homes'.

With the following associated objectives:

1. Adopt a holistic approach to promoting the health of vulnerable people (especially older people)
2. Develop appropriate referral systems linking those living in fuel poverty with grant giving agencies, especially HEES
3. Ensure vulnerable people are receiving benefits advice
4. Establish target setting and monitoring mechanisms
5. Ensure local work is linked with, and supported by Cambs. Health Improvement/HFC Fuel Poverty Task Team
6. Influence standard of new housing
7. Lobbying

What next?

We hope this guidance note encourages you to begin the process of developing policy and practice to address fuel poverty and to include specific statements in your Local Plans for 2003 - 2006. This winter, the National Heart Forum in association with the Faculty of Public Health is producing a 'Fuel Poverty Toolkit' which will give you much more detailed information on fuel poverty and health issues. It is aimed at strategic planners, NSF coordinators and leads, primary care professionals, local strategic partnerships and patients. See www.heartforum.org.uk

References

1. Cold comfort: The social and environmental determinants of excess winter deaths in England, 1986-1996 by Paul Wilkinson, et al. The Policy Press (ISBN 1 86134 355 8)
2. Noel D L Olsen BMJ 2001;322:748-749 (31 March)
3. UK Fuel Poverty Strategy Nov 2001 <http://www.dti.gov.uk>
4. Warm Front Team Grants Helpline number: 0800 952 1555
5. To contact your local Energy Efficiency Advice Centre tel: 0800 512012
6. Based on 1999/2000 England and Wales
7. Housing Improvement and Health Gain: A summary and systematic review: Thompson et al MRC Social and Public Health Sciences Unit, Jan 2002
8. Minimising Winter Deaths - A Review of the Research Evidence: DoH 2002

NEA, the national energy efficiency charity, develops and promotes energy efficiency services to tackle the heating and insulation problems of low-income households. Working in partnership with central and local government: with fuel utilities, housing providers and health services, and with consumer organisations, NEA aims to eradicate fuel poverty and campaigns for greater investment in energy efficiency to help those who are poor or vulnerable.

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Guidance Note for Primary Care Trusts

PCT Local Plans and Fuel Poverty 2003-2006



Promoting Health
Through Affordable Warmth

Supported by the Energy Saving Trust



Introduction

Between 4-6 million households in England live in cold, damp homes they cannot afford to heat - they are in fuel poverty. Living in these homes contributes to a massive burden of preventable illness such as respiratory infections, premature heart disease, asthma and strokes, as well as exacerbating mental health problems. The most striking aspect of the impact of cold conditions and poor housing is the scale of excess winter mortality in the United Kingdom. Excess winter deaths in the UK are on average 40,000 per year¹, much higher than colder countries for example in Scandinavia, where fuel poverty is virtually unknown. **This should be viewed as a major health catastrophe.** Only a few hundred of these are due to hypothermia - nearly half are due to cardiovascular diseases and half from respiratory disease.¹ If only half these deaths are as a result of cold homes, this is equivalent to 5,000 easily preventable deaths for each winter month of the year. In a recent article published in the British Medical Journal, Noel Olsen, a leading public health specialist stated:

*"Cold damp houses are associated with premature mortality, physical and mental illness, and impaired quality of life. They aggravate a wide range of medical conditions, increase suffering, and make it harder to care for vulnerable people at home, thus adding to the burdens on the National Health Service....The effects on the NHS are seen in the annual winter crises, with their effect on hospitals and waiting lists...But it needs engagement from the health service....Local implementation should be reviewed by winter task forces and included in every health improvement plan and primary care trust plan."*²



In November 2001, the Government published its 'UK Fuel Poverty Strategy'.³ This commits it to a ten-year timescale to eradicate fuel poverty amongst vulnerable households and to a fifteen year programme to end fuel poverty altogether. Vulnerable households are considered to be those where household members are elderly, in poor health, with a disability or where there are young children. This emphasis on the health benefits of energy efficiency improvements presents the health sector with the challenge and opportunity to develop, in partnership with other agencies, policy and practice to address the health impact of fuel poverty.

Improving the energy efficiency of a home can:

- * save lives
- * prevent the return of a condition when returning from hospital
- * prevent illness from developing
- * reduce visits to the GP
- * 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 people's sense of well being and mental health



The Role of Health Professionals

The Government commented in the UK Fuel Poverty Strategy 2001:

"Health authorities, likewise, have in the past had an important part to play, particularly in identifying people who need help. Primary Care Trusts (PCTs) in the

future will be the focus of partnership working with local authorities as well as the main commissioners for services in the NHS within the framework of the HIMP, which will be a PCT lead.... clearly there is an important role for public health in developing localised and focused delivery of services in the fight against fuel poverty."

The health service cannot provide decent housing, but health professionals have day to day contact with ill and vulnerable people. These professionals are trusted and are in an ideal position to both identify someone at risk of ill health and to refer them to those who can improve their housing conditions.

It is essential that Local Plans contain the strategic framework to support this role. Local Plans will have the capacity to:

- * increase awareness within the PCTs of the links between housing and health eg. CHD and respiratory illness
- * underpin partnership development for affordable warmth
- * facilitate awareness training for health workers
- * promote the identification of households at risk
- * facilitate and promote referrals to fuel poverty programmes and good quality energy advice

There are numerous schemes which provide these services, but still too few vulnerable people being referred to them by health professionals.



These schemes include:

- * Warm Front - a Government scheme which provides 100% grants energy efficiency improvements for eligible households⁴
- * The network of Energy Efficiency Advice Centres, which can provide referrals to

appropriate services as well as energy advice and presentations⁵

PCT Local Plans: Priorities, Targets and Fuel Poverty

Including fuel poverty statements within your Local Plan 2003 - 2006 will both contribute to, and fall within, a number of health priority areas. These areas include:

The NHS Plan 2000

- * The NHS Plan has 10 priorities. Number 9 is '...to keep people healthy and work to reduce inequalities' and places emphasis on the wider determinants of health including factors such as housing. It also requires the NHS to work in partnership with other public services to intervene not just after, but before ill health occurs. Working in partnership with local authorities, voluntary sector groups, fuel companies and organisations such as the Warm Front Team to establish effective referral systems for energy efficiency services can help fulfil this priority
- * The plan also introduced the concept of intermediate care by health care teams to ensure people get active support. Ensuring homes are warm and dry can avoid unnecessary admissions and prevent bed blocking because a patient's home is not fit to return to

Tackling Health Inequalities - consultation paper 2001 and responses

- * Three of the six priorities - 'tackling heart disease', 'strengthening disadvantaged communities' and 'tackling wider determinants of health' - could benefit from affordable warmth work
- * The responses to the consultation emphasised the crucial importance of effective partnerships at all levels and the potentially pivotal role of PCTs in drawing the NHS into the health inequalities agenda. Tackling fuel poverty was an identified 'necessary action' made by respondents



Shifting the Balance of Power; Next Steps 2002

- * The establishment of Public Health Teams presents an opportunity to work in partnership on this issue to develop practices to promote affordable warmth

National Service Framework for Older People 2001

This is of crucial relevance to tackling fuel poverty, especially given the fact that 93% of the

excess winter deaths are amongst people aged over 65⁶. Of specific relevance are:

- * Standard 3 - Intermediate care to 'Provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living'. This is of particular relevance in addressing the 'revolving door' syndrome - people falling ill because of their cold, damp home, recovering in hospital, being discharged to their cold, damp home, falling ill again etc
- * Standard 6: Falls. Cold reduces physical dexterity, particularly for older people, making them more likely to suffer falls in the home
- * Standard 7 - Mental Health: A recent systematic review of housing and health studies found that 'housing improvements can improve residents' health, in particular their mental health'⁷
- * Standard 8: The 'promotion of health and active life in old age'. This section specifically advocates local initiatives to reduce fuel poverty to prevent ill health and accidents, and reduce the number of cold related deaths and illnesses in people aged 65+

National Service Framework for Coronary Heart Disease 2000

34% of excess winter deaths are caused by circulatory illness⁶

Standards 1,2,4,11,and 12 are relevant to fuel poverty action.

- * Standard 1: reducing prevalence of risk factors and reducing inequalities in risk
- * Standards 2 and 4: refer to providing information on modifiable risk factors
- * Standard 11: treatments to reduce risk of death
- * Standard 12: includes assessing individuals' risks and needs



Priorities and planning framework for 2003-2006

'Improvement, Expansion and Reform: The Next Three Years' This paper sent out by the Chief Executive of the NHS in October 2002, sets out the Department of Health priorities for the next three years for the NHS and social services. PCTs need to develop their 'Local Plans' (replacing HIMPs) which will be collated by the

Strategic Health Authorities to form the 'Local Delivery Plan' for the area. The Health and Social Care priorities include:

- * 'Improved access to all services through reduced waiting.' Again, tackling unnecessary admissions due to housing conditions that can be improved, and reducing 'bed blocking' by patients staying longer in hospitals because their homes are not suitable for them to be released to, are simple actions that can impact on this priority.
- * Coronary Heart Disease: 'reduce inequalities, through action to reduce the risk of heart disease'
- * Mental Health: 'reduce the suicide rate and deaths by undetermined causes by 20% by 2010'
- * Older People:

"The promotion of independent living and health and active life' Including specific targets to:

'Improve the quality of life and independence of older people so that they can live at home wherever possible...' and;

'Each year there will be less than a 1% growth in admissions and no growth in readmissions'

It is essential that the Single Assessment Process for Older People - (outlined in the NSF for Older People) - identifies homes which are cold or which suffer from damp or mould growth. The Process must also trigger referrals to all relevant energy efficiency services



- * Reducing Health Inequalities

'NHS improvement, expansion and reform should narrow the health gap by ... tackling the wider determinants of health - agreeing a single set of local priorities with local authorities and other partners, contributing to regeneration and

neighbourhood renewal programmes...' including a specific target to 'contribute to a national reduction in death rates from CHD of at least 25% in people under 75 by 2005 compared to 1995-97, targeting the 20% of areas with the highest rates of CHD.'