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RCGP Royal College of General Practitioners

Evaluation of Royal College of GPs: *Fuel Poverty Pilot*

May 2017

Evaluation of Royal College of GPs Fuel Poverty Pilot

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May 2017

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Executive Summary

This report is the final output of an evaluation study conducted by the Centre for Regional Economic and Social Research (CRESR) on behalf of the Royal College of GPs (RCGP). The evaluation sought to understand the effectiveness of a pilot project aiming to develop a referral route between primary care practices in Wiltshire and a warm homes service, Warm and Safe Wiltshire.

The aim of the project was to create a 'proof of concept' referral system that allowed primary health care practitioners to refer patients for energy support during a consultation as quickly and easily as possible. **The project objective was to improve the circumstances and health outcomes of up to 750 patients in fuel poverty in Wiltshire through piloting a primary care health and fuel poverty referral system to a local authority advice hub**.

The healthcare informatics firm Ardens, who supply IT systems to GP practices, developed a software tool that identified and flagged patients with one or more of a range of health conditions that can be exacerbated by cold homes.

The flag appears in the form of an !! sign on patients records. Practitioners click on the flag and they are then prompted to speak to the patient about heating their home. The practitioner then clicks to say whether or not the patient required support, which then leads to an automatic referral through to Warm and Safe Wiltshire (WSW). In theory the referral takes less than a minute to complete: just three clicks of a mouse.

WSW is a service provided by Dorset & Wiltshire Fire and Rescue Service and Wiltshire Council to reduce fuel poverty in the county and make its residents' homes warmer, healthier and safer places to live. Following on from a referral, WSW contact the patient and offer support with keeping the home warm.

The tool worked well and there is very little room for improvement to make it any quicker or easier to use. Referrals led to a range of outcomes for patients, but action within practices was variable and the overall number of referrals was relatively low. The project met its goal of recruiting 20 practices but fell a long way short of the goal to refer 750 people for support – just 71 people were referred in total over the course of the project.

Key points from the evaluation findings include:

- The delivery team worked hard to engage GP practices; and WSW were seen to have been exemplary in their approach to the project and dealing with referrals.
- There was some evidence of cultural change, with primary care practitioners beginning to understand that they had a role to play in addressing cold homes and fuel poverty.
- Even with small numbers coming through from GP practices, the referral mechanism added value to the WSW service. Staff felt that a high proportion of referrals through primary care would not have been made through other referral routes if the primary care pilot had not been operating.

- Practices successful in making referrals had a member of practice staff acting as a champion for the project, usually a practice manager.
- Where practices had sought to engage and convince them of the benefits, nurses and Care Coordinators were particularly effective sources of referrals.
- Successful practices combined use of the template in consultations with mailout to patients identified by the software and information in newsletters.
- Despite often being willing to engage with the pilot, GPs regularly felt unable to find the time to raise the issue of cold homes with patients.
- Some practitioners and stakeholders talked about the lack of incentive to engage with the pilot other than the potential that it might in the long-term lead to improved health outcomes for some of patients.
- Financially there is very little to stop many practices taking up the mechanism nationally and here is no reason in principle why the project should not be feasible as a nationally applied approach to fuel poverty in primary care.

These findings lead onto a number of recommendations for primary care practitioners, future project delivery teams and wider, systemic changes. These include:

1. Delivery partners should ensure that there is consistent, on-going engagement with practices over time with regular face to face meetings with lead contacts in each practice is important in order to help fully embed the template at a practice level.
2. There is a need to ensure that all primary care disciplines and teams, including those working in the community are engaged and participate in future schemes. This is the role of both delivery teams and individual primary care practices.
3. Delivery partners should seek to engage with social care and public health providers in order to help develop a joined-up approach to referrals.
4. Agreeing to include fuel poverty referrals as a local CQUIN target. This was previously trialled in Stockport with some success (see section two). There might also be opportunities in future if the Quality and Outcomes Framework becomes more locally determined.
5. A future project would also ideally be led by the CCG, but also embedded within the wider Joint Strategic Needs Assessment for the local area. More broadly greater alignment between public health, social care and primary care goals locally (in most local areas) would help to embed a culture of preventative as well as responsive treatment in primary care; and this would have specific benefits in relation to fuel poverty as it is included in the national public health outcomes framework.

1 Introduction

This report is the final output of an evaluation study conducted by the Centre for Regional Economic and Social Research (CRESR) on behalf of the Royal College of GPs (RCGP). The evaluation sought to understand the effectiveness of a pilot project aiming to develop a referral route between primary care practices in Wiltshire and a warm homes service, Warm and Safe Wiltshire.

The fuel poverty pilot was funded through the British Gas Energy Trust (BGET), one of a number of organisations that distribute Ofgem redress money (fines) accrued by energy companies. The aim of the project was to create a 'proof of concept' referral system that allowed primary health care practitioners to refer patients for energy support during a consultation as quickly and easily as possible. The project objective was to ***improve the circumstances and health outcomes of up to 750 patients in fuel poverty in Wiltshire through piloting a primary care health and fuel poverty referral system to a local authority advice hub***. The project aimed to meet the following outputs:

- Recruit one CCG area;
- Make up to 750 patient referrals;
- Recruit up to 20 GP practices.

1.1. The Ardens tool and referral route

The healthcare informatics firm Ardens, who supply IT systems to GP practices, developed a software tool that identified and flagged patients with one or more of a range of health conditions that can be exacerbated by cold homes. These include asthma, COPD, stroke or TIA, coronary heart disease, hypertension, at risk of falls, and depression. It also flagged people on an 'avoiding unplanned admissions' register.

The flag appears in the form of an !! sign on patients records. Practitioners click on the flag and they are then prompted to speak to the patient about heating their home. The practitioner then clicks to say whether or not the patient required support, which then leads to an automatic referral through to Warm and Safe Wiltshire (WSW). In theory the referral takes less than a minute to complete: just three clicks of a mouse.

WSW is a service provided by Dorset & Wiltshire Fire and Rescue Service and Wiltshire Council to reduce fuel poverty in the county and make its residents' homes warmer, healthier and safer places to live. Following on from a referral, WSW contact the patient and offer support with keeping the home warm. Support measures include:

- Physical improvement measures such as insulation or heating systems.
- Advice on how to reduce their energy bills through energy efficiency.
- Information about tariff switching and support switching suppliers.
- Signposting or referral to relevant additional services such as fire prevention, income maximisation and health protection.

The pilot was managed by a delivery team consisting of two GPs – one local to Wiltshire who led on engaging practices – a project manager at RCGP, a project lead from Warm and Safe Wiltshire and the CEO of Ardens.

2 Evaluation approach

The overarching research question for the evaluation is: **does the fuel poverty referral pilot merit national roll-out?** This is divided into five sub-questions, as follows:

- How effective is the identification process?
- Did primary care professionals engage wit h the referral pilot?
- What is the participant experience of this approach (including outputs/outcomes)?
- Is it an effective source of referrals for Warm and Safe Wiltshire?
- Is the referral mechanism viable and valuable for primary care health professionals to deliver (including a sense of value for money)?

In order to address the evaluation questions, a mixed methods approach was taken, using the following approaches:

- Analysis of project documentation (e.g. project plan)
- Assemblage and analysis of project output data (nos. of GPs engaged, referral organisations engaged)
- Analysis of anonymised Warm and Safe Wiltshire (WSW) participant monitoring data
- Analysis of output data
- Qualitative interviews and online consultation with 16 healthcare professionals
- Qualitative interviews with 11 project stakeholders and delivery organisations
- Qualitative interviews with 4 project participants (patients referred to WSW who then received support).

The evaluation initially aimed to conduct 15 interviews with project participants. However, recruitment proved very difficult as the only method of contacting participants within the data sharing arrangements agreed between CRESR, RCGP and WSW was to send an opt-in letter via WSW. This produced a very limited response despite reminder letters being sent out. In order to add further depth to the evaluation given the lack of participant data, an evidence and practice review was undertaken (see section 3, below).

3

Fuel poverty, health and primary care

There is a strong and growing evidence base on the potential impacts of cold homes on health. Cold homes negatively impact physical and mental health in adults and children. Between 10 and 25 per cent (Marmot Review 2011) of the 43,900 excess winter deaths (EWDs) in England and Wales in 2014/15 were attributable to fuel poverty and cold homes.

Cold fuel poor homes also affect the mental health of adults[1][2] and young people, on children's respiratory health, infant weight gain and susceptibility to illness.[3] For people with long term conditions and older people cold homes exacerbate existing medical conditions, increase hospital admissions and may slow down recovery following discharge from hospital. Roche (2010) estimates for every EWD there are eight hospital admissions and 100 GP consultations. The poor health outcomes associated with cold conditions and fuel poverty also impact on longer term health outcomes and contribute to wider social and health inequalities.

Cold homes cost the NHS. For instance Age UK estimated that costs of treating illness which are either caused or exacerbated by cold homes were around £1.36 billion per year. The Building Research Establishment (BRE)[4] calculated that reducing hazards in housing including cold could deliver £600 million of savings for the NHS every year. Lidell (2008)[5] estimated that for every £1 spent on fuel poverty prevention there is a 42 pence saving in NHS health costs.

The impact of cold homes on health is increasingly recognised in government and NHS policy. For instance the latest UK Fuel Poverty Strategy outlines the need for the NHS to be an important partner in action nationally and locally. NICE has developed guidelines on action to tackle cold homes[6] and the Department of Health's Cold Weather Plan includes emphasis on tackling fuel poverty.

[1] Green, G. and Gilbertson, J. (2008) *Warm Front: Better Health. The Health Impact Evaluation of the Warm Front Scheme.* Sheffield: CRESR, Sheffield Hallam University.
[2] Gilbertson, J. *et al* (2012) Psychosocial Routes from Housing Investment to Health: Evidence from England's Home Energy Efficiency Scheme. *Energy Policy*, 49, pp. 122-133.
[3] Liddell, C. and Morris, C. (2010) Fuel Poverty and Human Health: A Review of Recent Evidence. Energy Policy, 38, pp. 2987-2997.
[4] Nicol, S. *et al* (2010) *Quantifying the Cost of Poor Housing Information Paper. IP 16/10*. Bracknell: BRE Publications.
[5] Liddell, C. (2008) *The Impact of Fuel Poverty on Children, Policy Briefing*. Belfast: Save the Children.
[6] NICE (2015) *Excess Winter Deaths and Illness and the Health Risks Associated with Cold Homes.* https://www.nice.org.uk/guidance/ng

There is also a growing evidence base linking warmth interventions and energy efficiency improvements to health[7][8]. Energy efficiency improvements can reduce cold related illness and associated stress by making it easier for residents to heat their homes, although evidence on the effectiveness of different interventions for reducing cold home related ill health is requires further development.

3.1. The role of primary care professionals

Primary care professionals – GPs, nurses, community teams and non-clinical staff such as practice managers and receptionists – see vulnerable people as a matter of course. They are uniquely placed to understand the health needs of local residents and are trusted by their patients. As a result primary care can offer an important referral route for fuel poverty services. Indeed NICE guidelines recommend that fuel poverty referral pathways should be embedded within primary care, and that primary care staff should use their patient data to help identify people vulnerable to the effects of cold homes. The guidance says that this should be included in patients' records so that practitioners are able to include this in their assessment of patient risk.

3.2. Existing practice

Forging links between cold homes initiatives and primary care is increasingly prevalent in the UK. Across the country local authorities and voluntary sector organisations are working with CCGs and individual GP practices to generate referrals for support to reduce the impacts of cold homes. For example, in a survey of English local authorities for the Department for Energy and Climate Change (DECC[9]), 75 schemes focusing on cold homes and health were identified.[10] 44% of respondents said that GPs were involved in their scheme; 40% involved district nurses; and 33% involved practice nurses.

However, embedding fuel poverty referral processes within GP practices has proven challenging for many. A common theme across existing literature is that initial engagement with GP practices can be very difficult to achieve, partly owing to practical issues such as finding a common point of contact across practices and in more general terms, the links between primary health care services, local authorities and/or voluntary sector organisations are often not well established and "require considerable time and patience to develop and evolve"[11]. It can also be hard to sell the benefits of action on fuel poverty, and "getting [primary care professionals] to accept that concern about housing is an entirely appropriate task within healthcare seems to represent a major hurdle"[12]. Some have suggested that this might be part of a broader challenge to embed preventative measures within primary care services,

[7] Thomson H *et al* (2013) Housing improvements for Health and Associated Socio-Economic Outcomes, Cochrane Database of Systematic Reviews, Issue 2. Art. No.: CD008657. DOI: 10.1002/14651858.CD008657.pub2

[8] Maidment C *et al* (2014) The Impact of Household Energy Efficiency Measures on Health: A Meta-Analysis. *Energy Policy*, 65,pp. 583-593.

[9] DECC merged with the Department for Business Innovation and Skills to form the Department for Business Energy and Industrial Strategy (BEIS) in 2016.

[10] Burroughs, J (2015) *DECC and NEA survey to catalogue health-related fuel poverty schemes*. London: DECC

[11] Kimberlee, R. (2013) Developing a social prescribing approach for Bristol. Project Report. Bristol Health & Wellbeing Board, UK. Available from: http://eprints.uwe.ac.uk/23221

[12] Allen, T (2006) Improving housing, improving health: the need for collaborative working. *British Journal of Community Nursing, 11*, 4 http://www.magonlinelibrary.com/doi/pdf/10.12968/bjcn.2006.11.4.20836

while others point to the immense time and resource pressures that GPs in particular are faced with in the current policy and funding climate. [13]

Success factor in generating referrals from primary healthcare practitioners

Yet many projects have successfully developed referral routes from primary care providers. [14] In all cases devoting human resource to spend time engaging with practitioners has been critical; and the need to continue engagement throughout the period of a project, including persistence with those that do not initially sign-up. This reflects learning from emerging work on social prescribing schemes, whereby GPs refer patients for non-clinical services [15], as described in the Rotherham social prescribing scheme evaluation report:

> *At the beginning of the pilot [the lead organisation] had some difficulty getting some GPs … to engage with social prescribing. A significant amount of time has been spent raising awareness of what the pilot has to offer and the potential benefits for patients. In the year since the service has been receiving referrals there has been a steady increase in the number of GP practices engaging with the pilot and the number of patients being referred.[16]*

Importantly, meaningful health practitioner engagement must be seen as a long-term process, rather than something that can be achieved in a short space of time. The use of practitioner champions was seen as important to embed programmes within practices and ensure that enthusiasm for the project does not wane over time.

The Affordable Warm Referral Mechanism (AWARM) project in Wigan worked hard to establish referral links with GP practices. Here local 'community link workers' have been critical to generate referrals. Community link workers work in GP practices to provide a link between social, community and primary care – in Wiltshire care coordinators have a broadly similar role.[17] [18]

In Reading, the Winterwatch scheme had more success with practitioners who visited patients in their home, which was in part due to due to the health professional's 'lived experience' of their client's living situation. Similarly, the Kent *Keep Well, Keep Warm* scheme found that practitioners working across health and social care, such as Care Navigators

Engaging primary healthcare practitioners: 5 success factors

1. Time and persistence!

2. Practitioner Champions

3. Simple referrals systems

5. Engaging with community teams and social care - primary care link workers

5. Payments and/or adopting local targets for fuel poverty referrals

[13] DECC (2015) *Catalogue of health-related fuel poverty schemes*. London: DECC https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/451025/DECC_FINAL.pdf

[14] Unless stated, the source of evidence here is the DECC catalogue of health-related fuel poverty schemes

[15] For more information on social prescribing, see the Kings Fund explainer at https://www.kingsfund.org.uk/topics/primary-and-community-care/social-prescribing

[16] Dayson C, Bashir N and Pearson S (2016) *From dependence to independence: emerging lessons from the Rotherham social prescribing pilot.* Sheffield: Sheffield Hallam University. p16.

[17] Data from interview with Wigan AWARM representative and on-going evaluation of the scheme by CRESR, Sheffield Hallam University

[18] See also the Glasgow case study in Shelter (2017) *Health related fuel poverty schemes in Scotland*. Glasgow: Shelter Scotland. http://scotland.shelter.org.uk/__data/assets/pdf_file/0010/1325692/Health-related_fuel_poverty_schemes_in_Scotland_FINAL3.pdf/_nocache

who support patients discharged from hospital, were an important source of referrals. They felt that "their holistic approach to a client's wellbeing enables them to see the 'bigger picture'".[19]

Payment for referrals or other forms of support was seen as important by many schemes. In some instances - for instance in Stockport[20] - local providers adopted fuel poverty referrals as a CQUIN target, which was deemed to have been successful in driving engagement and referral numbers. Others had provided direct payments or felt that such payments would be necessary in order to improve engagement in future.

In more practical terms, it is univerally accepted that ensuring referral mechanisms are simple and quick to use is essential to ensure that health care practitioners effectively engage with fuel poverty referrals. In most instances this involved the use of a referral card that the GP or other practitioner filled in which was then sent on to the fuel poverty support provider. Wigan AWARM, another RCGP pilot, was also using an Ardens add-on to SystmOne to electronically flag patients with conditions that can be exacerbated by cold homes, with GPs able to refer directly through SystmOne.

[19] DECC (2015) *Catalogue of health-related fuel poverty schemes*. London: DECC https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/451025/DECC_FINAL.pdf

[20] http://www.nea.org.uk/wp-content/uploads/2015/08/North-West-January-2013.pdf

4 Research findings

This section outlines the key findings from the evaluation, under five central research questions:

- How effective is the identification process?
- Did primary care professionals engage with the referral pilot?
- What is the participant experience of this approach (including outputs/outcomes)?
- Is it an effective source of referrals for Warm and Safe Wiltshire?
- Is the referral mechanism viable and valuable for primary care health professionals to deliver (including a sense of value for money)?

The overarching finding is that the tool worked well and there is very little room for improvement to make it any quicker or easier to use. Referrals led to a range of outcomes for patients, but action within practices was variable and the overall number of referrals was relatively low. The project met its goal of recruiting 20 practices but fell a long way short of the goal to refer 750 people for support – just 71 people were referred in total over the course of the project.

4.1. How effective was the identification process?

At the heart of the pilot was the aim to attain 'proof of concept' that a fuel poverty software template could work effectively in primary care. The pilot successfully achieved this aim. The template was seen to be easy to use, and identified appropriate patients, even if few patients felt the need to take up the offer of support.

Was the template easy to use?

The template was straightforward for practitioners to use in most circumstances. All respondents were positive about the technology itself, praising its simplicity and that the algorithm identified appropriate patients, as one GP reflected: "*for me that was the beauty of the Wiltshire project, it was the lack of work, it was so simple, it didn't involve pages of assessment. A simple, simple process, click a button and it's done"* (GP 3). And in cases where patients were identified who had not been flagged by the system it was straightforward for practitioners to print off some information. Due to the demographics of the local population very few patients felt that they required help with keeping their homes warm, but this was not a failing of the software.

Practitioners working in the community did not always have the same ease of access to the template which meant that they needed to be aware of whether a patient was flagged by the system prior to heading out on home visits.

There were also some minor suggestions for improving the function of the template. These included:

- A suggestion that practitioners should not be able to close the template without giving a response (e.g. 'yes', 'no', 'did not ask'), which they felt might be a stronger prompt to act.
- A suggestion that the template could automatically add a bit more detail to the patient's notes for future reference.
- Although in one practice receptionists had acted as referrers, one respondent from a different practice felt that it would help if the alert was attached to a patient's appointment as well as the patient notes so that – for example – receptionists could be more easily made aware when a patient was checking-in.
- A request that practices could be alerted if patients then went on to receive support through WSW: *"the only thing that I would say is that I was never sure whether that referral had happened … A list of the patients that they've contacted would be really helpful. It would be a really good idea" (Care Coordinator).*

Overall, however, the template was seen to be easy to use and enabled quick referral of patients to WSW without onerous demands on time: "*It was really fast, it wasn't oppressive to use at all"* (GP2).

Did the identification software effectively identify suitable patients?

The software algorithm effectively identified patients with health conditions that are exacerbated by cold homes as well as those on the 'avoiding unplanned admissions' register. The template was not linked to other information sources such as social care databases, however, which meant that factors such as whether a patient was in receipt of means-tested benefits or house type could not be factored into the algorithm. As a result the template flagged a broad range of patients. In the areas of Wiltshire where the tool was being piloted there were low rates of fuel poverty and so as a result most patients did not find that they required support with keeping their homes warm. However, it is debatable whether introducing income-related proxies would actually improve the tool: a broad approach means that there is a lower likelihood of a patient missing out on something that they might benefit from, and it is also likely that introducing other datasets would create a large administrative burden.

In a small number of cases practitioners reported having referred people who were not identified by the software. This is not a failing of the template, it is inevitable that human interactions with patients will sometimes lead to practitioners finding other reasons why it might be appropriate to refer a patient. In fact, a strength of the tool was that it allowed practitioners to easily refer patients who had not been flagged with little more effort than if they had been.

4.2. Did primary healthcare professionals engage with the pilot?

While the software did effectively identify patients, **uptake by practitioners – particularly GPs – was relatively low**. 21 practices were recruited to the pilot, suggesting that the delivery team were successful in at least ensuring initial engagement but only 71 referrals to WSW were made over the course of the pilot. This in part can be attributed to the relatively wealthy nature of the local population, but many practitioners did not fully engage with the project and this has affected referral rates. **Where practices had sought to engage and convince them of the benefits, nurses and Care Coordinators were particularly effective sources of referrals.**

Did health professionals act when a patient is identified by the software?

The pilot monitoring data does not show whether practitioners chose to ignore the !! sign when it appeared on patients records, nor whether they always spoke to a patient before clicking the option 'referral not required'. As such there is no quantitative data to show whether practitioners did act when the software flagged a patient. However, fewer than half (nine out of 21) of the recruited practices referred any patients and only three practices referred 10 or more patients to WSW.

Consultation with practitioners suggests that action was also patchy within practices. Often referral in practices came from one or two engaged individuals with others not using the template. Some respondents talked about having forgotten about what the !! flag on patient records meant, and a small number of others said that they were completely unaware of the pilot. This suggests that the nominated leads within practices were not consistently effectively engaging other staff within practices, and that there was a need for more regular reminders and discussions about the pilot within practices to ensure that practitioners continued to participate over time. The project delivery team did make initial and some subsequent visits to practices but there is a case for future projects to devote more resources to continued in-depth engagement work with practices.

There was some variation in participation across professions. According to WSW monitoring data GPs and practice nurses were responsible for around two-thirds of referrals (47 out of 71), with Care Coordinators referring a further 15. Nine referrals came directly to WSW following a patient mailout by two participating practices. Consultation with practitioners suggested that this varied across practices, with some practices only targeting GPs with the pilot, and others focusing more on allied health professionals, including Care Coordinators. Although some GPs enthusiastically engaged with the pilot, most GPs did not routinely speak to flagged patients about referrals. In some instances in some practices practice nurses did engage very successfully with the project and were seen as potentially the best route to driving referrals in future. But in other instances the practice either did not attempt to embed the pilot among nursing staff or had found it difficult to do – for example district nurses attached to practices were not employed by the practices and so it was not felt appropriate to enrol them to the pilot in one instance. Care Coordinators who regularly see patients with complex chronic conditions were also seen as an important group to take forward the pilot but only some practices used Care Coordinators to generate referrals. The data does not show the extent to which community teams referred into WSW, but consultations with practitioners suggests that this group did not become very well embedded in the pilot on the whole, despite potentially being an important referral point.

When health professionals did make referrals to WSW they were usually appropriate. In the early months of the pilot WSW reported that some of the referrals coming through were not eligible for support or were not seeking support that WSW could provide, but this became less frequent as the project continued.

Did the pilot help to embed fuel poverty as an issue for primary health professionals to engage with?

There was evidence that the pilot had helped practitioners to start viewing fuel poverty as a responsibility for primary care practitioners. Many practitioners had limited prior knowledge of fuel poverty and its relation to health so the project was an important means to improve understanding. Those consulted as part of the evaluation all felt that, in theory, it was appropriate for primary healthcare professionals to be aware of and seek to help address fuel poverty and cold homes. The pilot results show that this did not always translate into practice but there was at

least willingness to engage with fuel poverty as an issue among practitioners, leading to some degree of cultural change in some practices:

> *I think in the areas where it's been taken up, absolutely, I really do think it has embedded awareness of fuel poverty. All the people I've spoken to they've taken it on board and believed it. I'm not sure I've managed to get that message past many of the people I've spoken to, and obviously not in every practice. You'd have sign up and buy in from one person in a practice but within going in and being in that practice every day it's hard to know how to make it everybody's business. (Delivery partner)*

However beyond the small number of practices that had actively engaged with the pilot and had produced most referrals, there was a sense that the pilot had not inculcated awareness of fuel poverty as something to focus on within primary care:

> *People see the benefit of asking the question and promoting it through newsletters for example, but I don' t think it makes people think hard about fuel poverty. It's an extra tool to help look after the patient. We have to realistic that within a ten minute appointment there's only so much you can do (practice manager).*

The above quote from a practice manager points to a wider set of barriers that prevented the template from being fully integrated into practice, many of which were beyond the scope of the pilot.

What were the drivers and barriers to referring patients?

Underpinning the delivery of the project was a range of different drivers and barriers to generating referrals.

The positive feedback about the software template itself shows that the ease of use practitioners experienced was an important driver of referrals. It should also be said that members of the delivery team put in a great deal of effort to visit practices and to persuade practitioners of the reasons to engage with the pilot. The fact that two members of the delivery team were also GPs in Wiltshire practices made a difference, and the professionalism of the project lead at Warm and Safe Wiltshire was also seen as critically important to any success the project did have:

> *I mean she was amazing and actually she was amazing at following up those practice visits and following up with the practices that needed a bit more support. I think what I helped her with was an introduction and the credibility. She was just amazing, and we found we had the most impact when we went together and when we told the story together. In the pockets where we were persuasive it really did take off (Delivery Partner)*

Where practices were successful in making referrals it was often because there was a member of practice staff acting as a champion for the project, usually a practice manager, as one member of the delivery team explained:

> *Practice managers were key – if you won them over they were the ones that could see the broader issues. Being a GP is an odd role, you're both the deliverer of healthcare and a director of the company but increasingly it's the practice managers who organise the practices – if you've got a manager who will say we can make this work then it can happen (Delivery Partner)*

Within practices, one or two practitioners then tended to act as the main source of referrals. In at least one of the four practices generating the majority of referrals, these were mostly generated by practice nurses. Two of the other practices were the

practices of members of the project delivery team which meant that there was a direct link into the project.

It is also clear that use of the template during consultations is only one way that primary healthcare practices can reach patients, and this targeted approach can be effectively combined with broader efforts to generate referrals. For instance two practices received funding from the pilot to send a mailout to patients identified by the algorithm, and others included information in patient newsletters. These were seen as successful additional measures, which picked up people who might not otherwise have made an appointment to see a GP or did not fall within the scope of the algorithm. The project team also produced posters for waiting rooms and practice staff rooms.

Consultation with practices also uncovered a number of barriers to referrals, which can be summarised under the following headings:

- Limited time during GP consultations;
- Insufficiently integrated into workflows;
- Lack of incentive;
- Lack of coordinated engagement across all healthcare professionals within each practice;
- Lack of eligible patients.

Despite often being willing to engage with the pilot, GPs regularly felt unable to find the time to raise the issue of cold homes with patients. As the quote in the preceding section notes, GPs felt that *"within a ten minute appointment there's only so much you can do"*. Not all respondents agreed that this was sufficient to prevent GPs from acting when the flag appeared on a patient's record but it was nonetheless a recurring theme. Even those GPs who were enthusiastic about the tool tended to actively refer sometimes and not others, as the following interview excerpt demonstrates:

> *If I was having a good week they would get asked, but other weeks when it's been flat out it's just been put to the side. It also depends what they present with, for instance when we were doing all the flu work and it's cold outside that's a much better trigger. I did a lot more asking in summer – about preparing for winter, can we sort out your antibiotics, have you had you flu jab and by the way there's this new scheme. (GP2)*

The pilot often felt like an add-on to the core work of healthcare provision for GPs, which meant it was also among the first things to be case aside when time was stretched: *"you can keep things as simple as possible but it's got to be part of their existing workflow for it happen" (Delivery Partner).* As with most professionals working in public services, pressures on GP time have increased significantly over the last decade which means that it is harder to fit in new additional tasks. It also can create a mental barrier to even attempt to do so especially if there is no obvious immediate benefit to the practice (such as a reduced workload).

Following on from this, some practitioners and stakeholders talked about the lack of incentive to engage with the pilot other than the potential that it might in the long-term lead to improved health outcomes for some of patients. Again, practitioners felt that this was a valid goal in itself but for GPs in particular this was often insufficient to change a culture that sees the GP's role as responsive to acute need rather than preventative. There was frequent mention of a culture of payment-by-task for GPs, suggesting that GPs would only effectively participate if paid to do so, as discussed

in the literature review above (section 2). Others talked about a lack of targets within local or national outcome frameworks.

For these reasons a small number of respondents felt that GPs were not the right group to be referring patients for support and that instead this should be focused on practice and community nurses, and Care Coordinators – who in some places had been the most enthusiastic and effective sources of referrals. However the more common view was that all primary healthcare professionals could have a role in generating referrals but that there was a need to work on alternative methods to incentivise GPs (see Section 6, below).

The variation in engagement across practices could not solely be attributed to cultural issues however, and it is clear that there was a lack of consistency in what different practices saw as the purpose of the pilot. For example some respondents thought that the pilot was focused purely on GPs and so did not seek to engage with nurses, care coordinators or other practice staff. This not only reduced the number of people able to potentially make referrals but also meant that there was not a shared objective across the practice to generate referrals in turn diluting the effect of the pilot. In other cases the issue was more a lack of consistent and on-going attempts engage staff by the practice lead for the pilot. This might have been hampered by changes in the pilot delivery team which meant that there was a reduction in capacity to ensure regular face-to-face meeting with practices through the winter of 2016-17.

Finally, respondents argued that for many practices there were simply not very many patients who felt that they required the service. Indeed a frustration for the delivery team was that the practice that most enthusiastically engaged with the pilot was also in one of the most affluent areas in Wiltshire:

> *The most successful practice I had was sadly the most affluent. And the reason that was successful is because one of the practice manager's was enthusiastic and shared that enthusiasm with her nurses, and I'm not convinced that the doctors ever did a referral but I think the practice nurses that were doing the chronic disease clinics were very good at least asking, sadly there wasn't a lot of uptake as they were a very affluent area. It's that chronic disease management that would have been the most useful way in (Delivery Partner)*

Again in this instance nurses were driving successful delivery of the pilot.

4.3. What was the participant experience of this approach?

Although there was a fairly small number of referrals made during the project, we can say a little bit about participant experiences and outcomes.[21]Participants received a wide range of measures through WSW, as detailed in Table 1, below. The most common action was to add the participant to their energy supplier's Priority Services Register (PSR). Those registered on the PSR receive advance notice of planned power cuts and are treated as a priority in emergencies.[22] However, over a third of participants received some physical home improvement, for instance measures to improve the energy efficiency of the building fabric (23%) or new or repaired heating equipment (11%). In addition participants received financial support, such as switching to a lower energy tariff (14%), applying for the Warm Homes Discount (14%) or for additional welfare benefits (16%).

[21] For information about who was referred through the pilot, see Appendix 1
[22] For more information about the Priority Services Register visit: https://www.ofgem.gov.uk/consumers/household-gas-and-electricity-guide/extra-help-energy-services/priority-services-register-people-need

Table 1: Actions undertaken

	Participants	%	Annual Amount
Energy supplier switch	10	14.1	£96.40†
Warm Homes Discount	10	14.1	£140
Surviving Winter grants	14	19.7	£200
Added to supplier's PSR	23	32.4	N/A
Water company Pension Credit discount	9	12.7	20%
Additional welfare benefits	11	15.5	N/A
Remedial measures in the home*	16	22.5	N/A
New or repaired heating equipment	8	11.3	N/A

NOTES: *Includes loft insulation top-up, cavity wall filling and draught proofing measures; †Average saving.

As well as practical measures to improve the warmth of people's homes and/or their financial situation, around two-thirds (65%) of participants received advice on how to save energy within the home. WSW returned to participants after measures had been completed to assess outcomes from their support. These are shown in Table 2, below. It shows that participants attributed a range of outcomes to the support received. However the monitoring data does not cover all cases and does not indicate whether a person has given a negative response to a question – as a result it is possible that the questions were asked only of a subset of participants and therefore the outcomes might be underreported below.

Table 2: Outcomes achieved

	Participants	%
Home is warmer/less draughty	7	9.9
Energy use is better managed	6	8.4
Heating and hot water controls better understood	11	15.5
Health improved	5	7.0
Budgeting/meter reading skills improved	5	7.0
Worry reduced	6	8.4
Switching supplier better understood	5	7.0

Interviews with participants (albeit limited in number) give some insight to the different experiences participants had in being referred to WSW. For instance, one participant received some quite transformational support to their home. Warm and Safe Wiltshire came to do an assessment and were able to get a central heating system installed. His home is now much warmer and this has had a really positive impact on his life.

> *"Before they helped me I just had little electric heaters that I moved from room to room. The house was very cold, extremely cold. There was no central heating. I think they were very kind to help me. It's made me a bit warmer. My house is more comfortable because it's warmer … Living in a cold home. All my health got worse. It changed my life when the house is warm, it's better for me when the house is warm." (Participant)*

Others had different experiences. One patient referred to WSW reported being ineligible for grant funding to pay for the works required. However, she was able to arrange for the works to be completed privately, supported by WSW. The referral was a catalyst to the works being carried out, even if WSW were unable to directly fund them. A third participant demonstrated an important barrier to implementing support: pride. This patient was referred to WSW but then refused the offer of a home visit to assess the participant's needs as he felt uncomfortable asking for help: *"…sounding as if I was begging, I just feel embarrassed about it"*.

These findings are comparable with other fuel poverty projects in that under existing funding regimes not all energy efficiency needs can be met through existing grant/funding streams, and there will always be a group people who will not accept help when offered it.

4.4. Was the referral mechanism an effective source of referrals for Warm and Safe Wiltshire?

Due to the small numbers of referrals during the pilot period, it could be argued that the mechanism did not prove an effective source of referrals for WSW. However, WSW staff felt that even with small numbers coming through from GP practices, the referral mechanism added value to the service. Staff felt that a high proportion of referrals through primary care would not have been made through other referral routes if the primary care pilot had not been operating:

> *it has allowed us to reach people we wouldn't have reached otherwise. People who aren't necessarily accessing other services, or having specific health conditions that meant our paths would have crossed. (WSW respondent)*

On the whole referrals were appropriate for WSW, particularly as the project progressed and practitioners became more familiar with the system, although there were a number of occasions where participants could not remember being referred, or did not fully understand what the service was about in advance. There might therefore be some additional work for primary care practitioners to ensure that patients are fully briefed about the service and what the referral will entail – although of course it is inevitable that some people will forget about this afterwards anyway. The task of reminding referred patients about the referral could also be made easier for WSW by providing the service with more information about the patient, as one respondent explained:

> *The information that we received was limited, which I understand was set up to make it easier for the GPs to just be able to refer with one click and not have to do anything more than that, but it did make it difficult from my end because I just get sent a name and address, telephone number, and an age. Often if I called somebody and they're an elderly person they don't necessarily remember a conversation they'd had with their GP. Even just a brief idea of why they'd sent the referral through would have been helpful. (WSW respondent)*

Overall, however, WSW were positive about the project and saw the pilot as a starting point to further developing relationships with primary care practices, which they would not have had the capacity to do without the RCGP pilot. The WSW lead on the pilot was keen to ensure that some form of engagement continued even if the referral system did not continue:

> *When the project ends in March I would hope that my relationship with practices can continue … I don't think I would have had the capacity engage with all those GP surgeries without the pilot so that has been good, it's got the subject onto*

their radar. And I do have contacts now, some surgeries are really engaged. A lot of that hard work has been done and I can just build on that this year.

This makes a wider point in that the pilot was starting from a low base with many practices: even to have made a group of practitioners aware of the WSW service was a positive outcome from which to build in future.

4.5. Was the referral mechanism viable and valuable for primary care health professionals to deliver?

Financially there is very little to stop many practices taking up the mechanism: the tool will be made freely available as an add-on for existing primary care practice software. And, despite the low numbers of referrals, the majority of practitioners consulted for this evaluation thought that the template was a valuable addition to their practice. Barriers relate to systemic and cultural issues within primary care more generally rather than the mechanism in itself.

At this stage it was difficult for GPs to point to any tangible outcomes such as reduced GP visits by referred patients. Health outcomes from non-direct health interventions can be difficult to assess and this might be a further long-term barrier to implementation. However recognition of the value of non-medical preventative interventions is growing across the healthcare sector, with the success of broader initiatives such as social prescribing[23] showing the possibilities for this type of project.

4.6. Is it feasible to roll-out the project nationally?

There is no reason in principle why the project should not be feasible as a nationally applied approach to fuel poverty in primary care. Successful roll-out as a national framework for fuel poverty action is, however, contingent on a wide range of factors, many of which are to do with the local context in different places across the country. These factors include:

- Existence of local domestic energy efficiency / fuel poverty initiatives. Such initiatives have become less prevalent in recent years as a result of funding pressures in local authorities and the voluntary sector alongside the reduction in size and scope of national funding programmes.
- Effective local champions (ideally GPs with a role in CCGs) to drive forward implementation locally. In order to begin the process of pushing the template towards mainstream practice it might be necessary for one or two large primary care chains to take on the template and roll it out among their practices. This would then demonstrate the value of the template at scale.
- Effective support from CCGs and local authorities as well as national support from key stakeholder organisations including RCGP, NHS Clinical Commissioners, CQC and potentially inclusion in NICE guidance.
- Broader engagement with fuel poverty as a healthcare priority across CCGs, public health and acute NHS Trusts at a local as well as national level.
- Extent to which organisations not using SystmOne can use the template.

The final section will take these considerations further by offering a set of recommendations for future iterations or rollout of the project.

[23] See for example: https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-annual-eval-report-2016_7.pdf

5 Conclusion

This evaluation sought to determine whether it was feasible to rollout the referral pilot nationally through analysis of its effectiveness from the perspective of primary care professionals, participants and Warm and Safe Wiltshire.

The viability of the referral tool nationally is not in question although this is dependent on the tool being transferrable to other operating systems as well as SystmOne. It is clear that the software add-on worked effectively, was quick and easy for practitioners to operate and carried virtually no cost for GP practices. Practitioner engagement was patchy both between and within practices but respondents to the evaluation were almost unanimously positive about the project in principle: the challenge was to take the next step to embed use of the tool in practice. This is the focus of most of the recommendations set out below.

Participants had varied experiences of the project as is normal for contemporary fuel poverty initiatives in a funding-constrained environment, but no complaints were made about the referral process itself (although few participants in the evaluation could actually remember the referral taking place). However, referrals did lead to outputs, such as new heating systems, insulation and improved finances, which theoretically should lead to improved health outcomes, as set out in the literature review (Section 2).

5.1. Recommendations for GP practices

- It is important that each practice allocates a project champion to drive engagement with the project. It is likely that the most appropriate person for this will be the practice manager. This champion should ensure that the project is discussed regularly at staff/partner meetings.
- Practices should aim to engage all practitioners in all disciplines (e.g. GPs, nurses, care coordinators) as well as non-clinical staff such as receptionists. This might include internal referral routes – for instance a GP asking a nurse / care coordinator to follow up a potential referral if they do not feel that they have time to do so in their own consultation.
- The template provides a flag to prompt referrals within consultations. However, the algorithm behind it also allows practices to pull off a list of all targeted patients. Practices could use this list to carry out mailouts to all identified patients, as well as include information in wider communications such as surgery newsletters.

5.2. Recommendations for project delivery teams

- Consistent, on-going engagement with practices over time with regular face to face meetings with lead contacts in each practice is important in order to help fully embed the template at a practice level
- Work to engage with primary care beyond individual practices by also focusing more on community teams, Intermediate Care Teams (where they exist) and – potentially – home care providers. Practitioners routinely working in patients' homes are perhaps best placed to identify problems with upkeep of the home, including keeping the home warm and also wider financial difficulties.
- Ensure that practices receive consistent messages about the project – for instance who is eligible (ideally all staff within practices) – and that practices are clear on all elements of project implementation.
- Work with the local referral partner (in this case WSW) to provide feedback to practices about outcomes of referrals; and likewise potentially increase the level of information supplied to the referral partner about the patient so that they are able to more quickly develop a rapport with the participant and more easily put in place a support plan.
- Seek to engage with social care and public health providers in order to help develop a joined-up approach to referrals.
- It is worth considering some nominal payment for appropriate referrals (£5 was suggested by one stakeholder). This may overcome some barriers to GPs referring although broader strategic measures as outlined belowe might be more effective.

5.3. Recommendations to address wider barriers to implementation

In order to overcome some of the barriers to implementation within practices it will be necessary for future projects to work in partnership with CCGs and other local healthcare stakeholders to produce a strategic framework for action on fuel poverty. Some of the options are outlined in the literature review (Section 2). It is beyond the scope of this evaluation to make any in-depth suggestions but examples might include:

- Agreeing to include fuel poverty referrals as a local CQUIN target. This was previously trialled in Stockport with some success (see section two). There might also be opportunities in future if the Quality and Outcomes Framework becomes more locally determined.
- A future project would also ideally be led by the CCG, but also embedded within the wider Joint Strategic Needs Assessment for the local area. More broadly greater alignment between public health, social care and primary care goals locally (in most local areas) would help to embed a culture of preventative as well as responsive treatment in primary care; and this would have specific benefits in relation to fuel poverty as it is included in the national public health outcomes framework.
- There is also a need to ensure that preventative approaches are embedded in practitioner training at all career stages – including initial medical or allied health training – and on-going professional development opportunities through organisations such as RCGP.

- Finally, it is difficult to suggest how wider issues relating to GP payment cultures and time pressure can be alleviated without systemic reform of the healthcare system – not something this evaluation can make recommendations about.

Appendix 1: participant data tables

A1

RCGP Warm and Safe Wiltshire Fuel Poverty Pilot Evaluation

Analysis of Monitoring Data

1. Referral Route

	Participants	%
GP	52	73.2
CC	15	21.1
Other	4	5.6
TOTAL	71	100.0

2. Participant Age

	Participants	%
Under 60	6	8.4
60 to 69	12	16.9
70 to 79	16	22.5
80 to 89	19	26.8
90 and over	6	8.4
Unknown	12	16.9
TOTAL	71	100.0

3. Household Tenure

	Participants	%
Social renting - LA	7	9.9
Social renting - HA	19	26.8
Owner occupation	37	52.1
Private renting	2	2.8
Unknown	6	8.4
TOTAL	71	100.0

4. Household Type

	Participants	%
Couple with no children	18	25.4
Couple with children	1	1.4
Lone parent	2	2.8
Single person	30	42.3
Multi-person	4	5.6
Unknown	16	22.5
TOTAL	71	100.0

5. Receipt of State Welfare Benefits

Number of benefits	Participants	%
None	27	38.0
One	21	29.6
Two	11	15.5
Three	9	12.7
Four	2	2.8
Unknown	1	1.4
TOTAL	71	100.0

NOTE: Includes State Retirement Pension

6. Health Conditions

	Participants	%
With a disability	14	19.7
With dementia	3	4.2
With restricted movement	12	16.9
With other medical condition	32	45.1

NOTE: Participants may be included in more than one category.

7. Energy Sources

	Participants	%
Electricity only	26	36.6
Gas/electricity	21	29.6
Oil/electricity	6	8.4
LPG/electricity	3	4.2
Coal/electricity	1	1.4
Unknown	14	19.7
TOTAL	71	100.0

8. Heating Systems

	Participants	%
Night storage heaters	24	33.8
Gas central heating	22	31.0
Oil central heating	4	5.6
Other	7	9.9
Unknown	14	19.7
TOTAL	71	100.0

NOTE: Six participants stated that their heating system was not working.

9. Insulation/Heating Issues

	Participants	%
Homes with filled cavity walls	20	28.2
Homes with loft insulation	28	39.4
Homes difficult to keep warm	16	22.5
Unable to afford comfortable warmth	8	11.3
Energy debt	2	2.8

NOTE: Participants may be included in more than one category.

10. Practical Actions

	Participants	%	Annual Amount
Energy supplier switch	10	14.1	£96.40†
Warm Homes Discount	10	14.1	£140
Surviving Winter grants	14	19.7	£200
Added to supplier's PSR	23	32.4	N/A
Water company Pension Credit discount	9	12.7	20%
Additional welfare benefits	11	15.5	N/A
Remedial measures in the home*	16	22.5	N/A
New or repaired heating equipment	8	11.3	N/A

NOTES:

*Includes loft insulation top-up, cavity wall filling and draught proofing measures.

†Average saving.

11. Advice Received

Number of topics	Participants	%
None	25	35.2
1 to 3	7	9.9
4 to 6	19	26.8
7 to 10	20	28.2
TOTAL	71	100.0

12. Pilot Outcomes

	Participants	%
Home is warmer/less draughty	7	9.9
Energy use is better managed	6	8.4
Heating and hot water controls better understood	11	15.5
Health improved	5	7.0
Budgeting/meter reading skills improved	5	7.0
Worry reduced	6	8.4
Switching supplier better understood	5	7.0