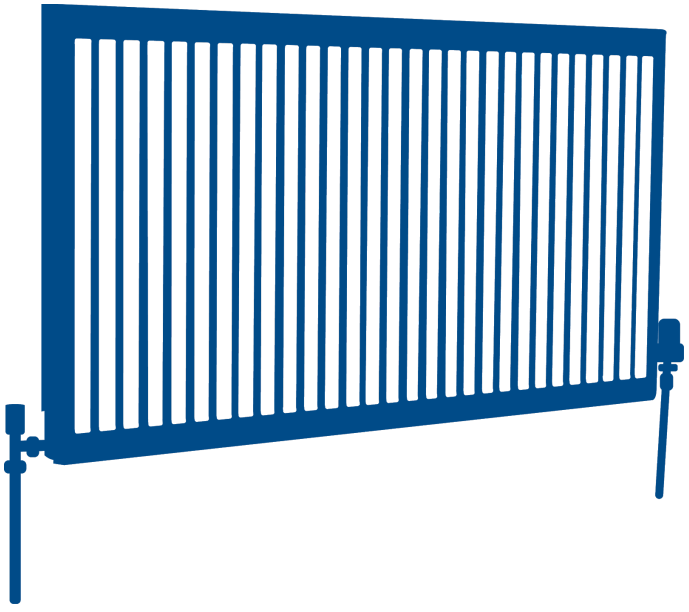
Warm homes, affordable fuel and healthy people

How local Citizens Advice can help



citizens advice

Contents

Executive summary

Cold homes and unaffordable fuel bills put your health and well-being at risk. The National Institute for Health and Care Excellence (NICE) wants to see a network of local housing and health referral services address the problem. Front-line health workers refer 'at risk' patients to a single point of contact that coordinates a package of support. This might include a cheaper energy tariff, installation of energy efficiency measures or a benefits check.

Citizens Advice supports the NICE guideline and has carried out some practical projects to help develop housing and health referral services, summarised below. However, we think more action is needed to make referral services commonplace throughout the country. We want:

1. All local authorities and health agencies to work with voluntary sector agencies, like Citizens Advice, to provide housing and health referral services in their area.
2. NHS trusts to recognise the vital role housing and health referral services can play in alleviating winter pressure on health services.
3. Public Health England, NHS England and relevant government departments, to oversee and review implementation of NG6 and promote good practice.
4. Local authorities and health agencies to consult the Cold Home Toolkits for practical guidance on setting up housing and health referral services.
5. Local authorities and local health agencies to make sure there are adequate and sustainable resources for housing and health referral services.

The winter resilience project

Seven local Citizens Advice took part in a pilot to trial and test different referral pathways with health partners. Internal and external evaluations[1] of the pilot provide rich material on our experience:

We reached the right people and learned a lot about their needs - 80% of clients found it difficult to afford their heating costs and all were either disabled or had a long term health condition.

Giving back a sense of control - the pilot's biggest impact was on clients' feelings of control of their energy use and ability to keep warm. There was a substantial improvement in clients' ability to manage their energy and pay their fuel bills.

Impact on health and well-being - most clients experienced little change in their physical health, with some clients' health continuing to decline. This was in

[1] The external evaluation, carried out by the Centre for Sustainable Energy, is available here.

the context that many clients had severe health problems. We were not able to establish whether we slowed down the rate of decline. However, we did find an overall modest improvement in clients' well-being.

Supporting clients - making sure clients got the right support package often required skilled advisers carrying out face-to-face case work on complex problems. Energy support included installation of energy efficiency measures, how to use heating controls, claiming the Warm Home Discount, sorting out energy arrears dispensation, changing suppliers and/or tariffs and registration on fuel companies' Priority Service Registers.

We also often helped clients claim benefits, manage debts or sort out care needs. Our ability to provide holistic advice is a particular benefit of involving local Citizens Advice in referral services.

Working with health practitioners - developing relationships with health partners took a long time and required sustained input from senior managers. Respiratory nurses, who often see at first hand the cold conditions their patients endure, were particularly willing to engage and were a good source of referrals. Whilst GPs often did not have time to participate in referral pathways, we found that other staff in GP surgeries such as care coordinators were enthusiastic participants. We received ringing endorsement of our service from referral partners, as illustrated by the following feedback:

"Since receiving help (from Citizens Advice), the quality of life for patients has greatly improved"

The Gloucester pilot office has now received funding from the Better Care Fund to take referrals from all health care professionals within the Gloucester and district area.

Other local Citizens Advice housing and health referral services

Warm and Well in North Yorkshire is coordinated by Citizens Advice Mid-North Yorkshire and funded by North Yorkshire Council. Citizens Advice Mid-North Yorkshire provides a comprehensive referral service, as recommended by NICE, and is widely promoted by local health service providers, local councils, Home Improvement Agencies and other local charities.

Warmth for wellbeing was a comprehensive referral service coordinated by Brighton and Hove Citizens Advice. The project included a shared online referral system which allowed a single step assessment and secure sharing of data between partners. An independent evaluation of the project found:

"*Clients regaining a sense of control over their domestic environment, finances and care that fundamentally improved their wellbeing*."

We developed two toolkits to help local authorities and health trusts tackle fuel poverty

We always wanted other local Citizens Advice to learn from the experiences of the winter resilience pilot, so we developed a toolkit to help do this. We subsequently collaborated with Cornwall Council to develop two further toolkits, commissioned by BEIS.

One toolkit helps local authorities, health and third-sector partners work together to support fuel poor and vulnerable households. The other toolkit provides guidance on developing cold home referral services, so that health professionals can identify and refer patients who are vulnerable to cold-related ill health.


The toolkits are available at:
www.citizensadvice.org.uk/cold-homes-toolkit/

Recommendations in full

We want all people vulnerable to cold-related ill health, and front-line workers who support them, to have access to a local housing and health referral service. For this to happen, we recommend:

1. **All local authorities and local health agencies should work with voluntary sector agencies, like Citizens Advice, to provide a housing and health referral services in accordance with NICE guideline NG6**. The voluntary sector is a vital resource in this service model and strong partnership working is key. Warm & Well in North Yorkshire is a good example of such an arrangement.
2. **Providing support to the most vulnerable population is key to alleviating winter pressure on health services.** NHS Trusts should work with CCG commissioners and local authorities to prioritise housing and health referral services for more vulnerable people by focussing on key health pathways.
3. **Public Health England should work with national partners, including NHS England and relevant government departments**, to establish a national oversight and review mechanism for monitoring implementation of NG6 and promote good practice.
4. **Local authorities and health agencies should consult the Cold Home Toolkits** for practical guidance on how to set up a housing and health

referral service and tackle fuel poverty in their area. This is available on the Citizens Advice website.

5. **Local authorities and health agencies should work together to provide adequate and sustainable resources** for housing and health referral services. Many people vulnerable to ill health from cold homes and unaffordable fuel bills have complex needs, requiring skilled case workers and often home visits.

For information on how Citizens Advice can help develop or participate in local housing and health referral services, contact:
WRproject@citizensadvice.org.uk

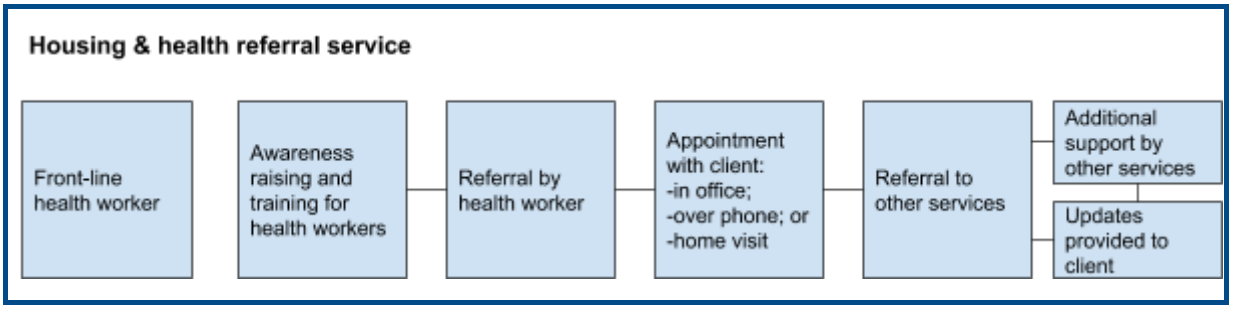
Introduction

Cold homes and unaffordable fuel bills lead to cumulative problems for the health and well-being of some of the most vulnerable people in the UK. Older people, young children and those with an existing respiratory or cardiovascular health condition are most at risk.

The World Health Organisation (WHO) estimates that **at least 30% of excess winter deaths are due to cold homes** - deaths that could be avoided if homes were adequately insulated and heated and people able to afford their fuel bills (Rudge, 2011).

In 2015, the National Institute for Health and Care Excellence (NICE) published far-reaching recommendations to encourage action against cold-related ill health (NICE, 2015).

NICE wants England's 152 Health and Wellbeing Boards to commission local 'single point of contact' housing and health referral services - see diagram below. The premise is simple; front-line health workers refer 'at risk' patients to a single point of access that coordinates a package of support to tackle the root causes of a cold home. That package could include help securing a cheaper energy tariff, installing practical energy efficiency measures or a benefits check.



The benefits of implementing a housing and health referral service are not only felt by the individual. **Integrated housing and health referral services have the potential to alleviate winter pressure on local hospitals and GP surgeries by tackling a known cause of Excess Winter Deaths**. This service model embodies the social model of health care and speaks to the development of new population based health services, led by the new Accountable Care Organisations. Practically, this could mean a 'wrap around' service that offers a

home visit as part of a designated health pathway, such as COPD or a targeted offer to vulnerable residents in the community, such as older people or families.

Local Citizens Advice can help provide the local referral services recommended by NICE, particularly where these do not already exist, and have put in place a number of referral services around the country to demonstrate our potential role. This report provides further details of our work. It first describes why such services are important.

The health impact of cold homes and unaffordable fuel

The impact of fuel poverty and cold homes on the physical and mental health of adults and children is now well established.

In the starkest terms, an average 9,000 excess winter deaths each year in England and Wales are attributable to cold homes[2]. Cold homes and unaffordable fuel bills have a significant effect on the mental health of adults and young people and on children's respiratory health, infant weight gain and susceptibility to illness (Gilbertson et al, 2012; Liddell and Morris, 2010).

For people with long term health conditions and older people, cold homes exacerbate existing medical conditions, increase the risk of falls, increase hospital admissions and slow down recovery following discharge from hospital (Bashir et al, 2016).

While much of the evidence relates to cold homes, it is important to recognise that some low income households, particularly those with young children, try to keep their homes warm. However, many will struggle to pay their fuel bills as a result.

This leads to households cutting back on other essential items, such as food, accumulating fuel debt or restricting the number of rooms kept warm - referred to as spatial shrinkage (Shortt & Rugkasa, 2007). These forms of coping strategy give rise to stress, anxiety and deterioration in mental health (Liddell & Guinney, 2014).

This report therefore refers to the health problems arising from both cold homes AND unaffordable fuel bills.

[2] The average annual excess winter death rate in England and Wales is 30,000. This equates to 9,000 excess winter deaths being attributed to cold homes, based on the WHO estimate.

Addressing the physical and health impact of cold homes and unaffordable fuel bills has a significant impact on the NHS, particularly during winter periods. The cost of treating ill health either caused or exacerbated by cold homes in England and Wales is estimated at around £1.36bn per year and this doesn't include the costs relating to mental health issues (Age UK, 2012). The Building Research Establishment (BRE) estimates that reducing hazards arising from cold homes could reduce NHS costs by £850m per year (Nicol et al, 2015).

The benefits of tackling cold homes and unaffordable fuel bills

Evidence of the health and well-being benefits of improved energy and heating standards in the home (and indirectly of improved energy affordability) is considerable. They include:

- Reduced incidence of respiratory disease
- Reduced asthma attacks
- Reduced absences from work and education
- More rooms heated and hence usable space
- Improved social relationships and mental health
- Reduced contacts with health services
- Reduced hospital emergency admissions for cardiovascular and respiratory conditions

See Thomson et al, 2013; Milner & Wilkinson, 2017; Welsh Government, 2017; and Maidment et al, 2013, for detailed evidence of these benefits.

The NICE guideline is designed to specifically tackle cold-related ill-health and forms part of a broader trend in health circles to focus on prevention. For example, the NHS Future Forum stated:

> "Over its lifetime, the NHS has become an effective service for the treatment of ill-health. If it is to remain successful for another 60 years, it will need a cultural change towards the prevention of poor-health" (NHS Future Forum, 2014)."

This emphasis on prevention, coupled with moves to develop population-based health models led by Accountable Care Organisations, is clearly identified in the strategic vision of the NHS Five Year Forward Plan (NHS, 2014) and the practical implementation of the Better Care Fund. The Better Care Fund, for example,

requires clinical commissioning groups and local authorities to pool certain budgets and agree integrated spending plans (DoH & DCLG, 2017).

Similarly, the transfer of public health from the NHS to local government in 2012 was intended to encourage action on tackling the wider socio-economic determinants of ill-health, including cold homes. However, some contend that subsequent cuts to public health and local authority budgets in general have undermined this goal (House of Commons Health Committee, 2016).

Agencies have responded to the prevention agenda in two ways. One response emphasises the importance of individuals making healthy choices, such as eating healthy food, managing household budgets responsibly or taking control of household energy consumption. The other response emphasises the impact of social and economic factors on people's health. This contends that being healthy is not an individual choice, it is shaped by our circumstances. And the more limited those circumstances, the more limited the choices.

Citizens Advice aims to both address the structural causes of ill health through its policy and advocacy work and to provide practical help to people vulnerable to ill-health through its provision of advice and other support. This report focuses on the practical support we give to vulnerable people experiencing ill-health as a result of living in a cold home and struggling to pay their fuel bills.

Response to NICE guideline

One year after publication of the NICE guideline, NEA carried out research to assess the extent to which health and wellbeing boards were taking action on cold-related ill-health, for example by establishing housing and health referral services (NEA, 2016).

NEA found that only 32% of boards referenced actions in their Joint Strategic Needs Assessments (JSNA) or strategies to address at least one of the 12 recommendations in the NICE guideline. The research noted that action may be taking place in some areas which was not documented in the local JSNA or strategy. However, it argued this undermined accountability within the commissioning process.

Since 2016, a number of policies and programmes have sought to encourage improved local action on cold-related ill health. These include:

- the inclusion of a local flexibility element within the Energy Company Obligation (ECO) energy efficiency programme in which councils are

encouraged to refer people who are vulnerable to cold-related ill-health to ECO (BEIS, 2017a).

- The National Grid's Warm Homes Fund, launched in 2017, includes a programme to encourage energy efficiency solutions to poor health[3].
- BEIS has sponsored the production of two toolkits to provide guidance on taking local action (described in more detail later)
- BEIS has also sponsored research into the extent to which the health sector is helping fund affordable warmth initiatives (NEA, 2018).

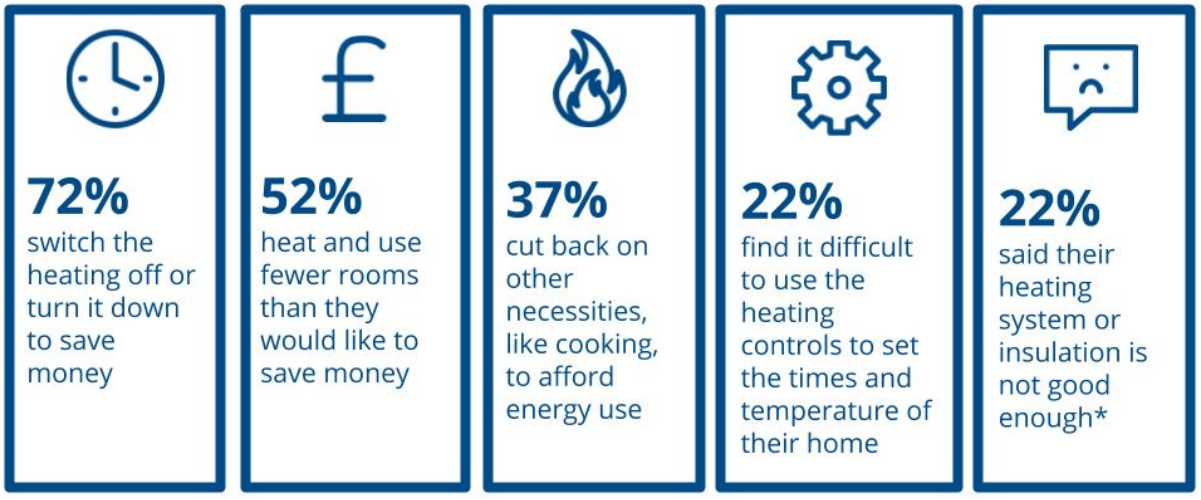
These initiatives should encourage more local authorities and health partners to set up the health and housing referral services recommended by NICE. They should also encourage action on the other related recommendations in the guideline, for example develop a local strategy to address the health consequences of cold homes and train health care and other front line workers to help people whose homes may be too cold.

The role of local Citizens Advice

A key driver for our work on tackling cold-related ill-health is the sheer extent of energy problems experienced by our clients.

Our 2017 'Outcomes and Impact Research' found that around **400,000 clients** said that they were not able to keep their home warm enough (Citizens Advice, 2017)[4].

Of these clients:



[3] See www.affordablewarmthsolutions.org.uk/warm-homes-fund/overview for details.
[4] Data based on a representative sample of our 2 million clients in 2017.

We also found that:

- 34% of all clients had switched energy provider (electricity or gas) in the last 2 years
- 27% had switched to a better deal with their existing energy provider in the last 2 years

UK Government statistics show that there were 2.5 million households in fuel poverty in England in 2015, based on the official 'Low Income High Costs' fuel poverty indicator (BEIS, 2017b). While our statistics do not record the fuel poverty status of our clients according to the official indicator, it is clear we are reaching a significant proportion of fuel poor households in England ('difficulty in keeping homes warm during winter' is a good proxy for fuel poverty).

Furthermore, many of our clients will have sought advice on other issues, such as benefits or debt, rather than problems paying fuel bills or keeping their homes warm. Yet we often find energy issues are common for such clients through the process of addressing their presenting problems.

Nearly two in three local Citizens Advice clients live in households below the average income. We reach 17% of the 8.6 million individuals living on a low income in England and Wales. 40% of our clients also have a long term illness or disability. The comparative national figure is 18% (Citizens Advice, 2017).

Given our existing clients' circumstances, Citizens Advice considered it important that our local offices worked with health services to provide support on cold homes and fuel affordability to vulnerable households. We felt that we were in a good position to provide the referral service recommended by NICE, particularly where these did not already exist. This was because we can:

- provide support on other client issues related to energy, such as benefits and debt
- develop our existing relationships with local authorities and health agencies to establish the referral pathways recommended by NICE
- use our strong partnerships with other local agencies who can help deliver the tailored solutions recommended by NICE
- build upon our experience of coordinating, or participating in, existing local referral services.

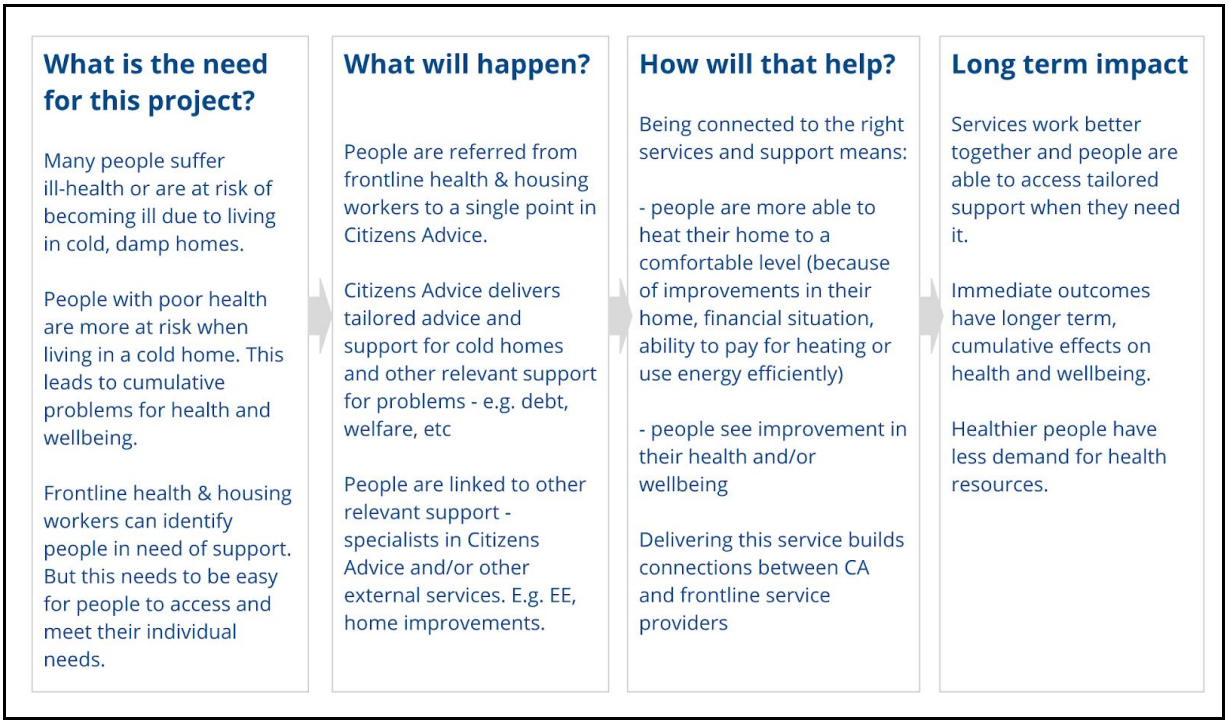
The Citizens Advice winter resilience project

In 2016 we provided seed corn funding to pilot the provision of a housing and health referral service, named the winter resilience project. We recruited seven local Citizens Advice across England to trial and test different referral pathways with health partners. We wanted to find out what worked and what didn't.

When developing a new service, or amending an existing service, Citizens Advice first puts in place a theory of change to describe the objectives of the planned new service. This sets out the need we want to address, the changes we want to see (outcomes) and the actions we plan to undertake (activities) to achieve our goals (the impact) (Harris et al, 2014).

The diagram below sets out our theory of change for establishing the winter resilience project.

Winter resilience project: theory of change



An Advisory Group of senior representatives from BEIS, Public Health England, local government, National Energy Action, Chartered Institute of Environmental Health, Royal College of GPs and NICE provided guidance to the pilot. An internal evaluation of the processes developed by the pilot offices was carried out, while the Centre for Sustainable Energy carried out an external evaluation of the impact of the service on clients (available here). The external evaluation assessed the impact of the pilot on the following client outcomes:

- Energy efficiency measures installed
- Additional benefit claims
- Switching tariffs and payment type
- Use of energy, heating controls and 'coping mechanisms'
- Physical health, using the EQ-5D-5L instrument (van Reenen & Janssen, 2015)
- Wellbeing, using the ONS wellbeing survey (ONS, 2017)

The first phase of the pilot has now finished (see Appendix for details of each of the pilot offices) and we recently started a smaller second phase to carry out further development work. The evaluations of the first phase are now complete and provide rich material on our experience. A summary of the findings is given below. They are interspersed with case studies of some of the clients we helped.

Steve's story

One of the people helped through the pilot was Steve, a 63 year old single man living in a private rented flat referred by his nurse.

Steve has poor health, including Chronic Obstructive Pulmonary Disease. He heated his flat with one fan heater because his central heating did not work. He hadn't topped up his gas prepayment meter for 3 years ago due to a dispute with his supplier. Steve relied on an electric nebuliser and on one occasion, Steve self disconnected during the night and tried to go to the shop to top up his prepayment meter. However, he was unable to breathe properly so an ambulance was called.

Following our help, Steve successfully claimed the Warm Home Discount, worth £140 per year. Steve now has a gas supply after we persuaded his suppliers to change both prepayment meters to credit meters to avoid self-disconnection in future. His gas supplier agreed to write off the standing charge and debt on his prepayment meter too. He also has a new efficient cooker (funded from an application we wrote to a local trust) and a new boiler funded through the Energy Company Obligation programme.

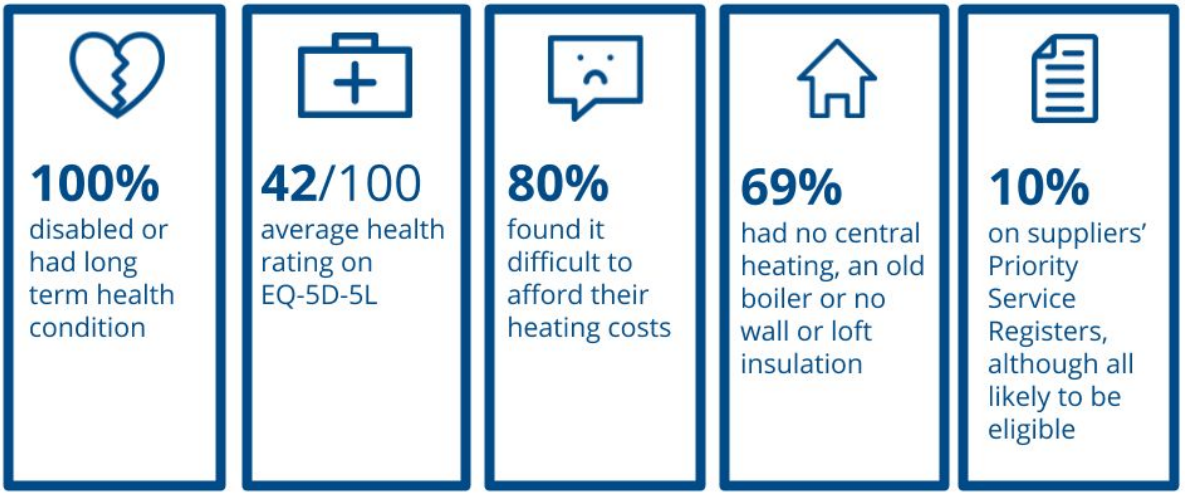
As a result, Steve now saves £400 per year on his fuel bills while his flat is considerably warmer. Steve is now on both suppliers' Priority Services Registers. This means, for example, he has access to emergency electricity in the event of a power failure. After a benefits check, Steve receives the Personal Independence Premium and Employment Support Allowance severe disability premium, worth an extra £115 per week.

Since receiving this package of support in spring, 2017 Steve hasn't had one visit or stay in the local hospital. Before support, Steve visited or stayed on frequent occasions. The reduction in NHS costs is considerable, while Steve says he feels happier, warmer and more in control of his fuel use.

We reached the right people, and learned a lot about their needs

Steve's story is typical of the clients we worked with on the pilot. Poor housing, poor health, difficulty affording fuel bills and lack of knowledge of services were common issues for clients of the winter resilience project, as illustrated below:

Profile of winter resilience clients*



* Statistics quoted are for Manchester and Stockton clients only

Many of the clients referred had health issues so severe that they needed home visits from our advisers.

Other client statistics included:

- 48% were social tenants and 16% private renters
- 45% were aged 65 or over; and
- 10% were from black or minority ethnic groups.

Giving back a sense of control

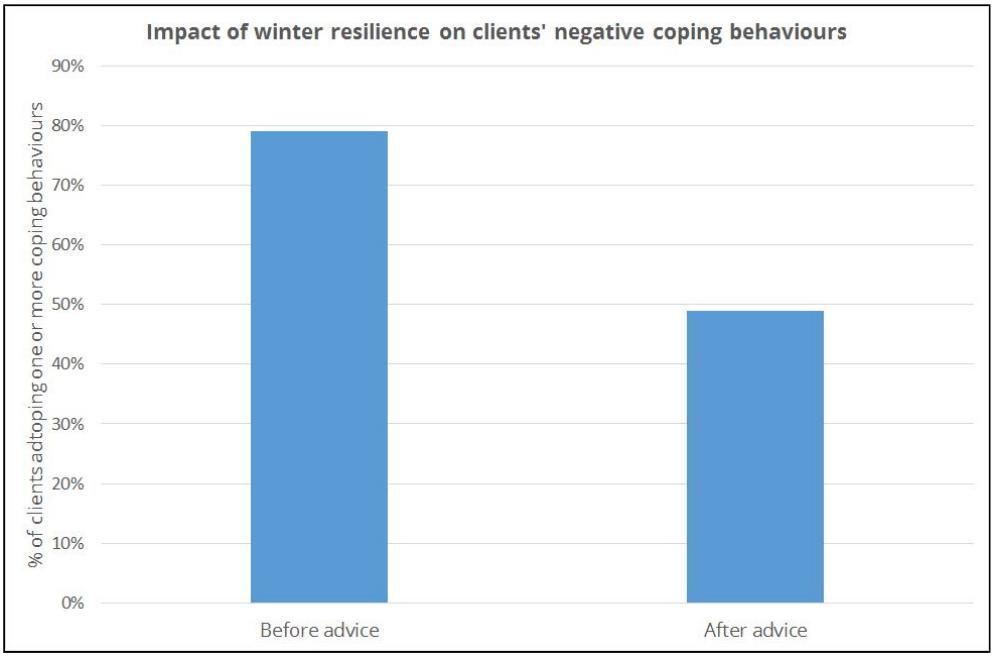
The external evaluation involved carrying out 'before and after surveys' of the impact of the pilot on client outcomes, with a 6 month gap between the two surveys. The evaluation focussed on the impact of Manchester Citizens Advice and Stockton Citizens Advice because they had the most complete datasets of the 7 pilot offices (110 clients). The other offices struggled to carry out the full surveys, for reasons outlined in Appendix 1.

The surveys found that the pilot's biggest impact was on clients' feelings of control of their energy use, ability to keep warm and pay their fuel bills. For example, most clients adopted one or more of the following coping behaviours before being helped by the winter resilience project:

- turned down their heating more than they would have preferred

- only heated one room
- had fewer hot meals or drinks than they would have liked.

This figure dropped considerably following receiving help from the project, as illustrated below:



There is a growing evidence of the close links between cold homes and mental health issues. Reducing the stress and anxiety arising from high fuel bills can have a positive impact on clients' mental health. It is therefore likely that the pilot will bring about long term improvements to many of their clients' mental health.

Even over the short term, the surveys found a modest improvement in the mean scores on three of the four ONS wellbeing indicators, with a 15% improvement in mean score for clients' satisfaction with life.

The surveys found that the majority of clients experienced little change in their physical health, with some clients' health continuing to decline. This was in the context of the very poor health of clients referred and the relatively short period between the two surveys. Lack of a control group meant that we were not able to establish whether the pilot slowed down the rate of decline.

The finding showed that the pilot's biggest impact was on well being and mental health, rather than physical health, is common to evaluations of the impact of similar energy projects on client outcomes, for example the evaluations of the Wigan AWARM scheme, Oldham Warm Homes scheme and Foundations Warm at Home scheme (Eadson & Leather, 2017; Bashir et al, 2016; Bennet et al, 2016).

What we learned about delivery

Making sure that clients got the right support package often required skilled advisers carrying out face to face case-work on complex problems. The advisers taking part in the pilot provided a wide range of support on energy issues, for example:

- how to use heating controls
- claiming the Warm Home Discount
- sorting out energy arrears dispensation
- changing suppliers and/or tariffs
- registration on fuel companies' Priority Service Registers

Advisers also often provided help on claiming benefits, managing debts or sorting out care needs. Our ability to provide holistic advice is a particular benefit of local Citizens Advice's involvement in referral services.

Arranging the installation of energy efficiency measures was difficult as most suppliers were running down their ECO (energy efficiency) programmes at the time of the pilot due to meeting their targets earlier than anticipated. Nevertheless, we still managed to sort out energy efficiency improvements for about a third of the clients referred, mainly through Trust fund applications.

Sue's story

Sue is a 78 year widow who was about to go to hospital for a hip operation. Sue has complex health issues including coronary heart disease, arthritis, osteoarthritis, high blood pressure, deep vein thrombosis, anxiety and depression.

Sue owns her own home, but had no heating or hot water for 5 weeks after her boiler broke down.

Following our help Sue now receives the Warm Home Discount, worth £140 per year. We also helped Sue apply to a trust fund for a new boiler worth £3,000. This will save her £350 per year on her heating and hot water bills.

Sue is also now on her supplier's Priority Services Register, which means she can take advantage of a password scheme for meter readers and receive accurate quarterly fuel bills.

Having access to heating and hot water in her own home has helped Sue's discharge from hospital and supported her recovery and wellbeing following her operation.

Working with health partners

We learned that developing relationships with health partners takes a long time and requires sustained input from senior managers. Whilst GPs often did not have time to participate in referral pathways, we found that other staff in GP surgeries such as care coordinators were enthusiastic participants. We found that respiratory nurses, who often see at first hand the cold conditions their patients endure, were particularly willing to engage and were a good source of referrals.

We successfully involved health partners in developing the referral service through, for example:

- running multi-agency design workshops
- carrying out surveys of health professionals and their clients
- regularly attending team meetings to raise awareness
- asking frontline health workers to test-drive elements of the service, such as referral forms, before they went live.

The pilot offices encountered a range of data protection issues, both with respect to making sure referrals met their own standards of data security and with respect to meeting NHS standards. Manchester Citizens Advice found that its local hospital still used fax to send information and therefore used this mode for taking referrals from the hospital. Others relied on NHS staff encouraging their patients to self-refer to the referral service, rather than staff making a direct referral itself. The local authority toolkit provides advice on different approaches to sharing data and information (pages 26 & 27).

The pilot offices also found that health partners were in high demand, with strong competition from other services seeking their collaboration. It was important to make clear how the referral service could help health organisations meet their targets and needs and the value of working across organisations to align services and projects.

Case study: Feedback from Manchester COPD specialists

We carried out a survey of the COPD specialists Manchester Citizens Advice worked with. Of the 5 responses received:

- 4 said the service was **exceeding their expectations**, 1 said it met expectations.
- 3 out of 5 said the referral volumes were higher than expected, 2 as expected

Quotes from COPD specialists:

"Since receiving help (from Citizens Advice), the quality of life for patients has greatly improved"

"I really enjoyed working with Kate and the Citizens Advice with this scheme and would love it to continue as it is very beneficial to our patients"

"Patients feel more supported - more holistic care, addressing their concerns as well outside of the usual health sphere"

See Appendix and the housing and health referral service toolkit (page 37) for more details of Manchester CA's work.

From pilot to mainstream service: Gloucester Healthy Homes

Gloucester CA has established a far reaching partnership with the Gloucester Clinical Commissioning Group and Severn and Wye Energy Agency in which the service, called 'Healthy homes', will take referrals from all health care professionals within the Gloucester and district area. This includes health care workers in GP surgeries, the Gloucestershire Respiratory Team and self-referrals from people who see publicity about the service.

The new project is funded through the Better Care Fund – a fund specifically designed to encourage integrated services. Gloucester CA has employed a case worker to provide advice and coordinate help, with home visits forming an important part of the service. The project is using baseline and evaluation surveys similar to those developed for the winter resilience pilot to assess the impact of the project on clients' health and related issues. See the Local Authority fuel poverty toolkit for more details of the project (page 32).

Other local Citizens Advice housing & health referral services

Warm & Well in North Yorkshire

Warm & Well in North Yorkshire is a housing and health referral service coordinated by Citizens Advice Mid-North Yorkshire, which started in September 2017. The project is the successor to a year long project with the same name, funded by the British Gas Energy Trust (BGET), which finished in December 2016.

The original Warm & Well in North Yorkshire project consisted of a consortium of 30 partners from the public, private and voluntary sectors coordinated by

Community First Yorkshire who also provided the single point of contact referral service. An evaluation of the project found that it had the following impact.

Client outcomes

- 4,400 beneficiaries, over a third of whom were over 75 years old (62% were over 65)
- 810 home visits and face to face advice sessions
- 215 practical interventions, such as energy efficiency improvements
- 128 hardship interventions.

The project carried out simple before and after surveys of its impact on client outcomes, with a gap of 3-6 months between the 2 surveys. Clients were asked to say whether their health had improved (a lot, improved or somewhat), had not improved or had declined. The surveys found:

- 46% reported their health had improved, somewhat improved or improved a lot
- 32% reported no improvement
- 11% reporting their health had declined

Note: the results of this evaluation are not directly comparable with those for the winter resilience pilot due to the different evaluation methodology used.

The new Warm & Well in North Yorkshire service

Following the ending of BGET funding, North Yorkshire Council decided to provide 3 years funding for a lead organisation to provide the single point of contact housing and health referral service and to coordinate related activities.

Citizens Advice Mid-North Yorkshire was a key partner in the original project and won the contract to provide the successor referral service. Referrals can be made on-line and over the telephone to the new service.

The main sources of referrals are other charities, e.g. Age UK, foodbanks, other Local Citizens Advice; Home Improvement agencies (HIAs); Councils and self-referrals. Health referrals mainly come about as a result of self-referrals following publicity for the service in CCG newsletters and other health literature. Citizens Advice Mid-North Yorkshire is developing partnerships with practice managers in GP surgeries to encourage direct referrals.

Energy efficiency measures are delivered by HIAs or Better Homes, with funding from ECO. Citizens Advice Mid-North Yorkshire also hopes to secure funding for heating measures from National Grid's Warm Homes Fund.

The service received 123 referrals in its first quarter of operation:

- 73% were either disabled or had a long term illness

- 53% were aged 60 or over
- 22% were private tenants and 40% social housing tenants

The service, like its predecessor project, is therefore receiving referrals from a wide variety of partners or via self-referrals. To date, it is not receiving direct referrals from health partners, although it hopes to set up arrangements at a later date.

Warmth for Wellbeing

The Warmth for Wellbeing project was a 15 month housing and health referral service coordinated by Citizens Advice Brighton & Hove, with funding from British Gas Energy Trust (BGET) that started in late 2015. The project was supported by Brighton & Hove City Council and Brighton & Hove Clinical Commissioning Group and involved 13 partners from the voluntary and community sectors.

Citizens Advice Brighton & Hove coordinated a free phone helpline for people with health conditions who were either referred from health and other front-line workers or who self-referred. The helpline then referred people to the following agencies:

- advice agencies (including Brighton & Hove CA itself) for benefits, debt and housing issues
- a local energy services cooperative (Bhesco) for energy efficiency assessments and low cost improvements
- British Red Cross home from hospital service for 'warm packs' and
- Five local charities that support vulnerable people for hardship grant payments.

Warmth for Wellbeing set up a shared online referral system which allowed the first project partner that came into contact with a client to carry out an initial assessment and record this on the system. This meant that clients receiving support from more than one project partner were only assessed once. It also allowed the secure sharing of data across the partners.

Client outcomes

The Universities of Brighton and Sussex carried out an independent evaluation of the project, using the 'most significant change' method for assessing impact[5] (Darking & Will, 2017). The evaluation found that the project had a 'significant impact' on the lives of the 555 vulnerable households that received support. It attributed the project's success to the model of partnership working and

[5] Note that the results of this evaluation are not directly comparable with those for the winter resilience pilot due to the different evaluation methodology used.

leadership adopted and to the in-depth casework and follow-up carried out with clients.

The evaluation also found that a significant proportion of clients required multiple forms of intervention in order for them to heat their home adequately.

Few clients received substantial energy efficiency measures, such as loft and wall insulation or new boilers due to lack of funding for these measures. However, once other barriers to staying warm in the home were removed or reduced, clients experienced multiple benefits, including improved mental and physical health and reduced social isolation.

 "Clients described regaining a sense of control over their domestic environment, finances and care that fundamentally improved their wellbeing."

The evaluation highlights the value of providing both specialist energy help and equally specialist debt and benefits advice. However, it also points to the broader structural factors that create fuel poverty, such as poor housing and complex energy systems, over which individual citizens have little control. It goes on to suggest that this also created barriers over the extent to which Warmth for Wellbeing could fully address fuel poverty.

Citizens Advice Brighton & Hove tried to secure replacement funding once the BGET funding finished but was unsuccessful, in part because of substantial cuts to its local Clinical Commissioning Group finances (seen as the most likely funder). However, it has managed to revive elements of the service, such as a single point of contact for debt and benefits advice and energy efficiency assessments which are funded by the local authority (Public Health and Adult Social Care).

Our legacy

We always wanted other local Citizens Advice to learn from the experiences of the winter resilience project. So we developed an internal toolkit to help do this.

 The toolkit gives lots of useful tips on who to talk to in local health services and councils, language and acronyms, how to help meet health priorities and targets, how to set up or extend a referral service and where to find further information. It also describes the pilot office experiences and gives some powerful case studies of clients helped.

The toolkit is also intended as a resource for our energy champions to enable them to support local Citizens Advice develop or take part in housing and health referral services in their area. Local Citizens Advice with experienced energy advisers, typically those delivering Energy Best Deal and Energy Best Deal extra, are particularly likely to get involved[6].

Since the successful launch of our toolkit we have collaborated with Cornwall Council on the development of two further toolkits commissioned by BEIS, one on setting up housing and health referral services, the other on council action to tackle fuel poverty and cold homes. We also agreed to host the toolkits on our website and to help Cornwall County Council and BEIS promote them to their target audiences, namely local authorities, health agencies and other organisations wanting to tackle cold-related ill-health.

 The toolkits are available at:
www.citizensadvice.org.uk/cold-homes-toolkit/

Conclusion

This report describes the experience of some of our local Citizens Advice in coordinating the single point of contact housing and health referral service recommended by NICE. It also refers to wider initiatives to encourage more local authorities and health agencies to set up such services. Citizens Advice considers it incumbent upon public agencies to work with third sector agencies, such as ourselves, in setting up such services and make sure they are widely used and supported.

Local authorities, or consortia of local authorities, are often ideally placed to provide the single point of contact referral service due to, for example:

- their existing statutory links with local health agencies
- responsibilities for public health, housing and social care
- profile with local residents
- ability to coordinate packages of appropriate support
- knowledge and data on the circumstances of their residents.

See the toolkits for further examples of relevant local authority responsibilities.

[6] Further details of our energy programmes are listed on the Big Energy Saving Week section of our website.

Alternatively, local authorities and their health partners can commission third sector agencies such as local Citizens Advice to provide the referral service. This will still require close liaison between the referral service and council and health services and will need to make sure data sharing and data security issues are addressed. The North Yorkshire Warm & Well service provides a good example of such an arrangement.

The winter resilience pilot shows how specific health pathways, such as respiratory nurses or care coordinators, can link patients with often extensive health problems to local Citizens Advice. Local Citizens Advice can then coordinate a wide range of support for addressing patients' non-medical needs. There is clear evidence that this leads to positive improvements in patients' well-being and particularly in patients' ability to cope with their heating and energy needs.

The winter resilience pilot offices focused on a few local providers, such as a hospital, within a particular health pathway, for example respiratory illness. However, with funding and strong partnerships it is possible to considerably expand such arrangements to other pathways in the local area. The Gloucester Citizens Advice project illustrates this through the substantial expansion of its referral service in the Gloucester area.

Finally, some local Citizens Advice may not currently be in a position to provide the coordination and strategic liaison arrangements essential for making the NICE referral model work. However, they can still play an important role in tackling cold-related ill health, namely through their responsibilities for providing advice on benefits, debt, housing and employment (and many other issues). It is therefore important that all putative referral services make sure their local Citizens Advice is included as an essential partner in the service.

In conclusion, we think all local Citizens Advice can play a valuable role in housing and health referral services, whether as the overall service coordinator, coordinator of support for specific health pathways or as a provider of services that address some of the wider determinants of ill-health. But most importantly, we urge all local authority and health providers to act upon the NICE recommendations and play their part in tackling the ill health arising from cold homes and unaffordable fuel bills.

Recommendations

We want all people vulnerable to cold-related ill health, and front-line workers who support them, to have access to a local housing and health referral service. For this to happen, we recommend:

1. **All local authorities and local health agencies should work with voluntary sector agencies, like Citizens Advice, to provide a housing and health referral services in accordance with NICE guideline NG6**[7]. The voluntary sector is a vital resource in this service model and strong partnership working is key. Warm & Well in North Yorkshire is a good example of such an arrangement.
2. **Providing support to the most vulnerable population is key to alleviating winter pressure on health services.** NHS Trusts should work with CCG commissioners and local authorities to prioritise housing and health referral services for more vulnerable people by focussing on key health pathways.
3. **Public Health England should work with national partners, including NHS England and relevant government departments**, to establish a national oversight and review mechanism for monitoring implementation of NG6 and promote good practice.
4. **Local authorities and health agencies should consult the Cold Home Toolkits** for practical guidance on how to set up a housing and health referral service and tackle fuel poverty in their area. This is available on the Citizens Advice website.
5. **Local authorities and health agencies should work together to provide adequate and sustainable resources** for housing and health referral services. Many people vulnerable to ill health from cold homes and unaffordable fuel bills have complex needs, requiring skilled case workers and often home visits.

[7] Other key recommendations in the guideline include: develop a local strategy to address the health consequences of cold homes, train front-line workers to identify people vulnerable to cold-related ill health and make sure vulnerable households discharged from health and social care settings return to a warm home.

Appendix: Local Citizens Advice taking part in the winter resilience pilot

The winter resilience project was set up as a small scale pilot – the seven local Citizens Advice (LCA) taking part did not aim to provide the full comprehensive service recommended by NICE, but instead target specific priority client groups and referral pathways pertinent to their local areas.

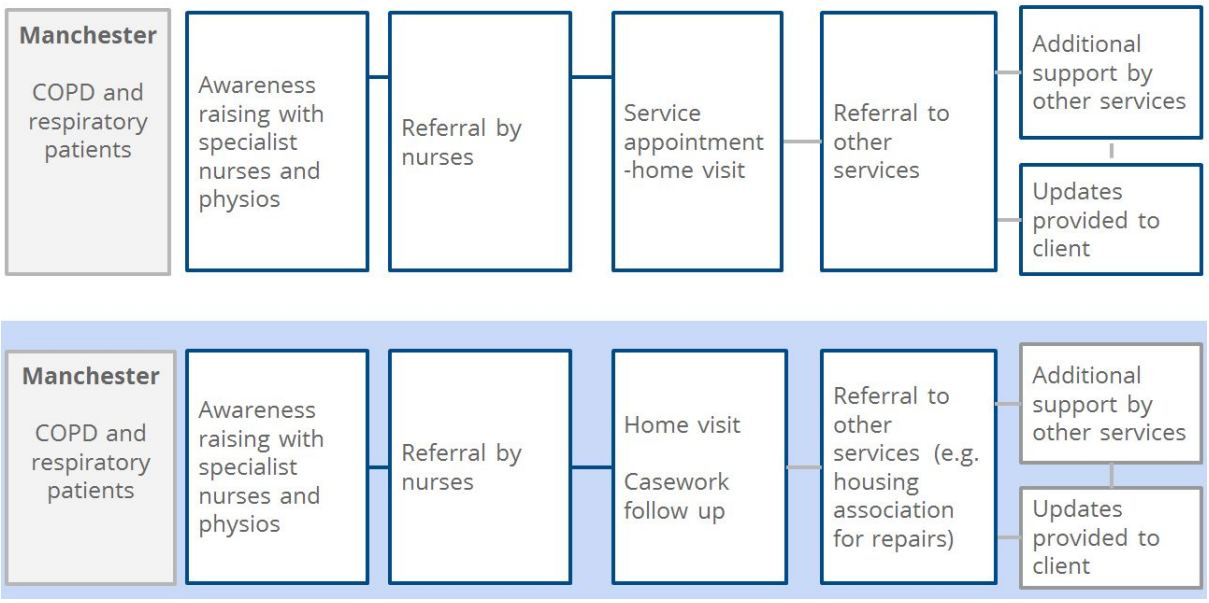
Each of the pilot offices designed their own service model, responding to local circumstances, and each started with a different service context. For example, they had different levels of experience in delivering energy and cold homes advice, different levels of pre-existing partnerships with health partners and very different local authority and health structures, e.g. urban/rural; unitary/two tier councils.

The Appendix gives details of the referral pathways the pilot offices either set up or aimed to set up in their local area. It also gives further information about some of the issues encountered by the five offices. A diagram for each pilot gives an overview of the referral pathway adopted, with the top row representing the intended delivery and the bottom the actual delivery, including any adaptations made once the service went live.

Citizens Advice is currently carrying out a second development phase of the pilot with four of the original seven pilot offices (Manchester, Stockton, Wealden and Uttlesford). This will run from late 2017 to October 2018. One of the core aims of the extension is to build relationships with new health partners, such as dementia teams, care navigators and hospital discharge teams to help provide further understanding and evidence of what works. Citizens Advice will carry out a separate evaluation of this second phase. The following makes occasional reference to Phase 2 of the pilot.

Manchester

Manchester CA is a large office that covers the Manchester local authority area. It has a specialist energy team with a long established track record for addressing energy issues. The diagram below gives an overview of the referral pathway developed by Manchester CA.



Commentary

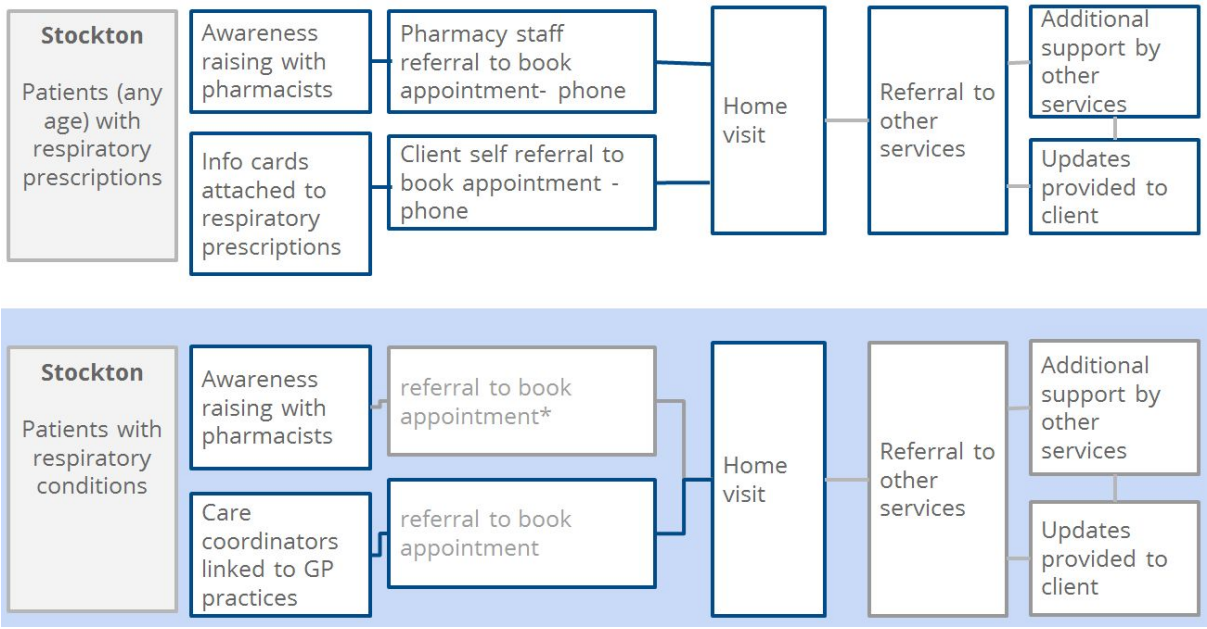
Manchester CA was able to put in place its service delivery model as planned, with delivery starting in October 2016. Manchester CA had already developed strong partnership arrangements with health service providers as part of its work for a related project well in advance of 'going live'. This reduced the work required before the project started and enabled a longer referral period than the other pilot offices.

Manchester CA received referrals from COPD nurses for patients receiving home visits. Referral details were sent by fax. An experienced advisor with prior experience of delivering energy advice undertook home visits. A high proportion of cases required follow-up case work. See health professionals toolkit for further details (page 36).

Stockton

Stockton CA is a relatively large office that covers the Stockton local authority area. Stockton CA has an experienced energy team working from its own high street premises (the Home & Energy Advice Centre).

The diagram below gives an overview of the referral pathway developed by Stockton CA.



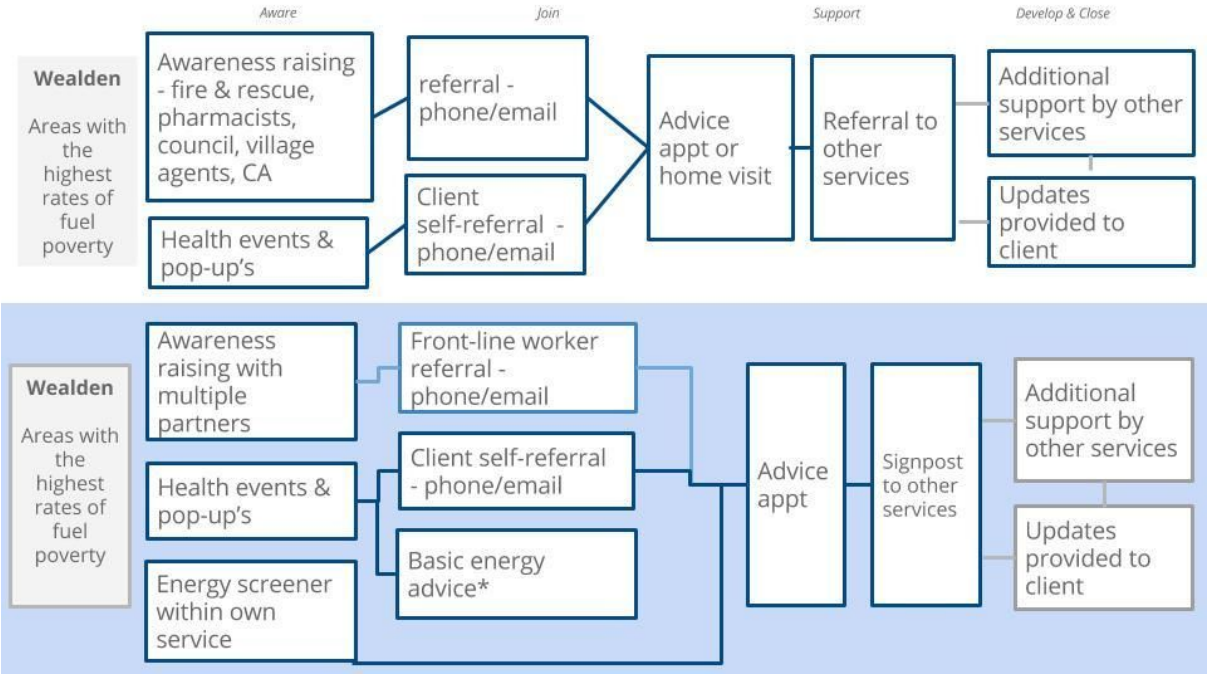
Commentary

Stockton CA had to make changes to the referral partners and process after the project started. It originally planned to receive referrals from pharmacists but found that despite the enthusiasm of pharmacists participating in the service, there was low engagement from patients. In response, Stockton CA changed the referral mechanism to community care workers in GP practices. These are non-clinical staff who visit the top 2% of patients in need from each practice. Referrals were made using email.

As a result of changing its referral pathway, Stockton CA successfully increased the number of referrals received. Home visits were carried out by an experienced energy adviser.

Wealden

Wealden CA is a small office covering a large rural area. It relies extensively on volunteers to provide advice. Wealden aimed to reach remote rural households who often miss out on mainstream services. The diagram below gives an overview of the referral pathway developed by Wealden Citizens Advice.



Commentary

Wealden CA reached out to multiple partners with respect to seeking potential referrals. It also carried out a range of community outreach activities itself to promote the service. Wealden had some success in getting referrals from the local Council and from its outreach work but less so, initially, with health partners. However, by the end of the pilot period it had successfully engaged with the local dementia support team and the multi-agency care team. This was too late for referrals from these sources to contribute towards the evaluation of the pilot's impact.

Wealden is one of the four offices taking part in the second pilot phase and will thus be able to provide evidence of the extent to which these new pathways have generated referrals.

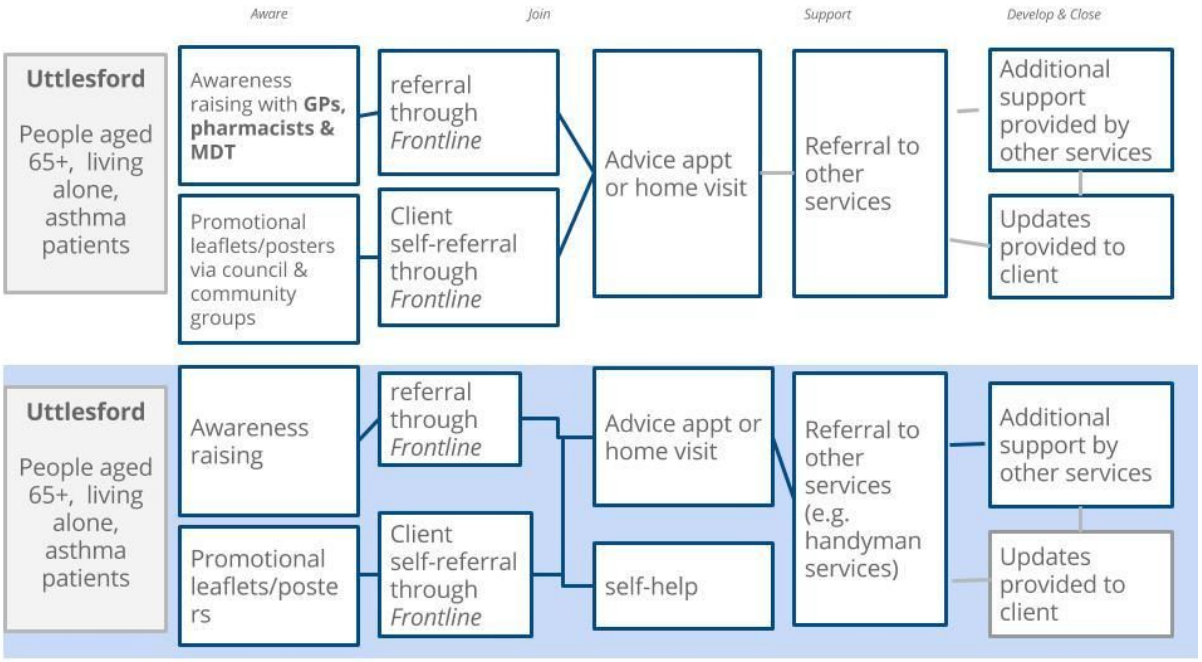
While Wealden received a significant number of referrals during the pilot period (35), little impact data was collected on these referrals. This was in part because the volunteers did not feel comfortable asking questions about clients' health and in part because few of the referrals were generated by health partners. The experience of Stockton and Manchester shows that clients referred by health partners are generally comfortable about answering questions about their health status. It appears this is less likely to be the case when referrals come from other sources.

These problems should be reduced for Phase 2 of the pilot due to the recent engagement of health partners in the project and because the data collection

requirements have been considerably reduced (while still adhering to validated health surveys).

Uttlesford

Uttlesford CA is another small office covering a large rural area served by a complex range of health structures and two tier councils. Uttlesford also relies extensively on volunteers and before the pilot had little experience of providing energy advice.



Commentary

Uttlesford CA aimed to build upon an existing referral platform, *Frontline*, to which the winter resilience referral service was added and promoted. The platform is widely used by different agencies in Uttlesford. The 'Keeping warm in Uttlesford' was branded as a separate service on Frontline and widely promoted through GP practices, libraries, children's centres, Council offices and other outlets.

Referral numbers were not as high as expected (54 clients, with 16 recorded in the project reporting system). This was because:

- *Frontline* allowed many people to contact the service they wanted directly, rather than through the referral service
- The Citizens Advice client management system made it difficult to identify clients that were specifically routed through the referral service.

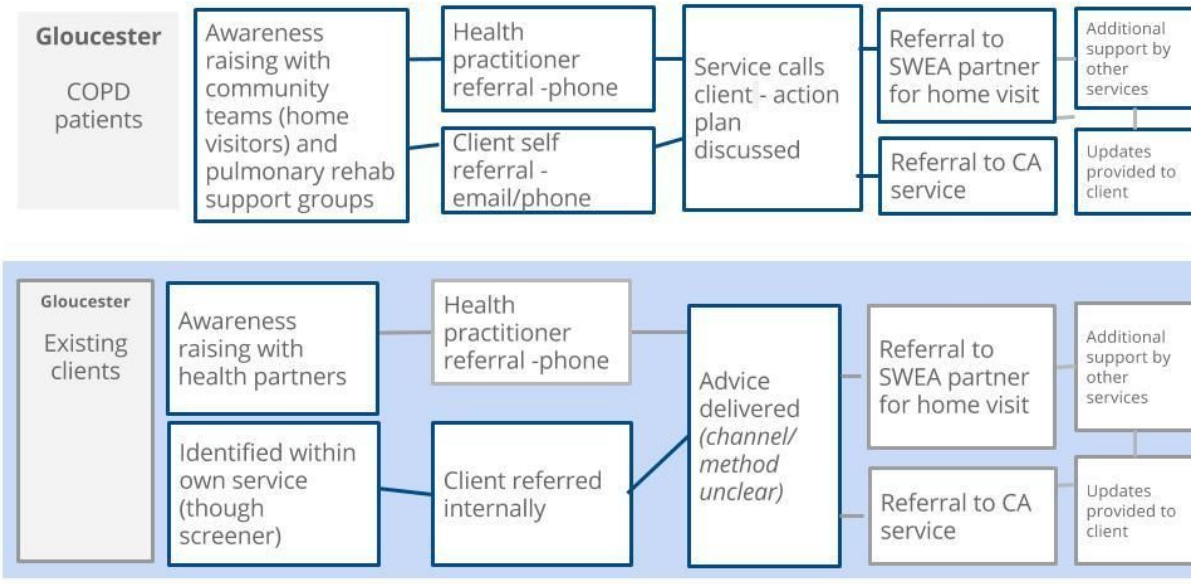
- Confusion from potential referral partners over which service they were using.

Like Wealden, the volunteer advisers struggled with the volume of reporting and felt uncomfortable asking clients about perceived complex health problems.

Towards the end of the pilot period Uttlesford CA developed good relationships with local health partners, including a CCG and the Council's environmental health team, and is now receiving referrals from both partners. Uttlesford CA is also taking part in the second pilot phase and will thus be able to provide evidence of the extent to which these new pathways have generated referrals. It is also envisaged Uttlesford's advisers will be more willing to carry out the simplified reporting requirements.

Gloucester

Gloucester CA covers Gloucester city and surrounding rural areas. Gloucester CA developed a partnership arrangement with Severn Wye Energy Agency (SWEA) in which the CA developed the referral service with health and other partners and SWEA provided energy advice and referrals to fuel company ECO programmes for energy efficiency improvements.



Commentary

Gloucester CA put a lot of effort into developing a referral pathway with a particular hospital respiratory team. However, this fell through due to key contacts leaving and a restructuring of the team. Gloucester CA therefore

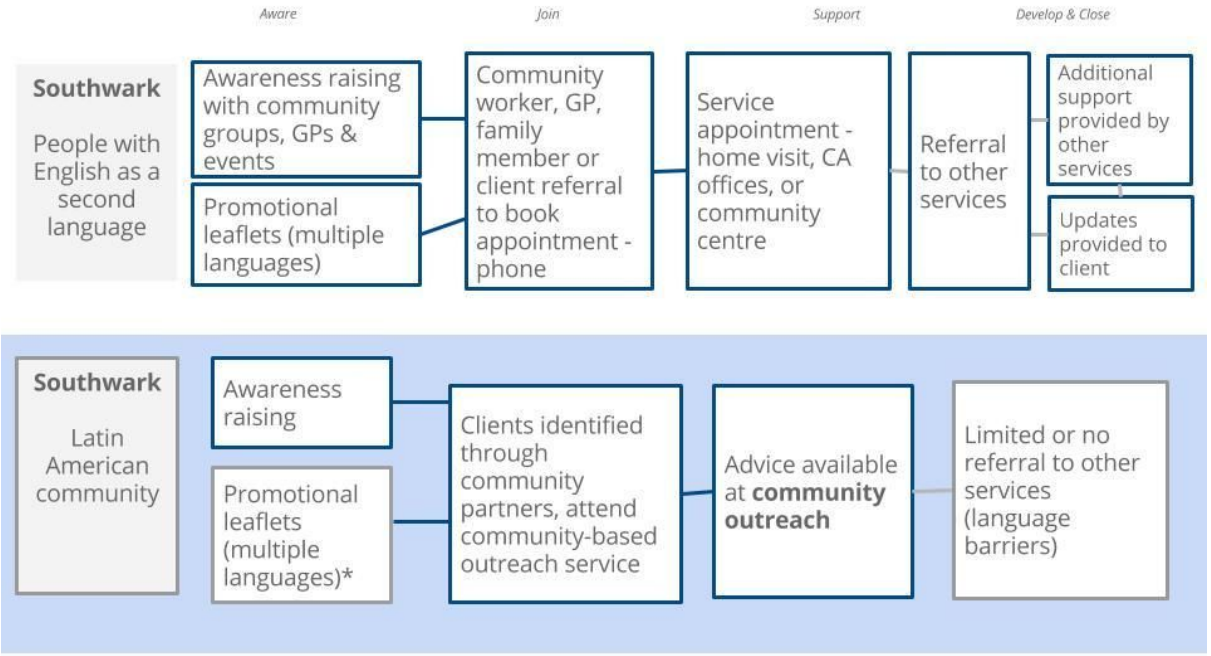
switched its approach to taking internal referrals from the office's clients who were screened to see if they had a respiratory condition. However, this only started relatively late in the project's development – thus only nine clients were subsequently helped through the project during the pilot period.

As highlighted in the main report Gloucester CA subsequently established a partnership with the Gloucester CCG, again involving SWEA, to provide a referral service for all health care professionals in the Gloucester and district area.

The project has only been running for a little while; however, it is already coordinating support for around 30 clients a month. The project will provide quarterly reports on its impact, using similar evaluation tools to those deployed for the winter resilience pilot.

Southwark

Southwark Citizens Advice aimed to focus on the large Latin American community in its area and encourage referrals from groups active in this community. Southwark CA advice workers attended outreach sessions with their community partners.



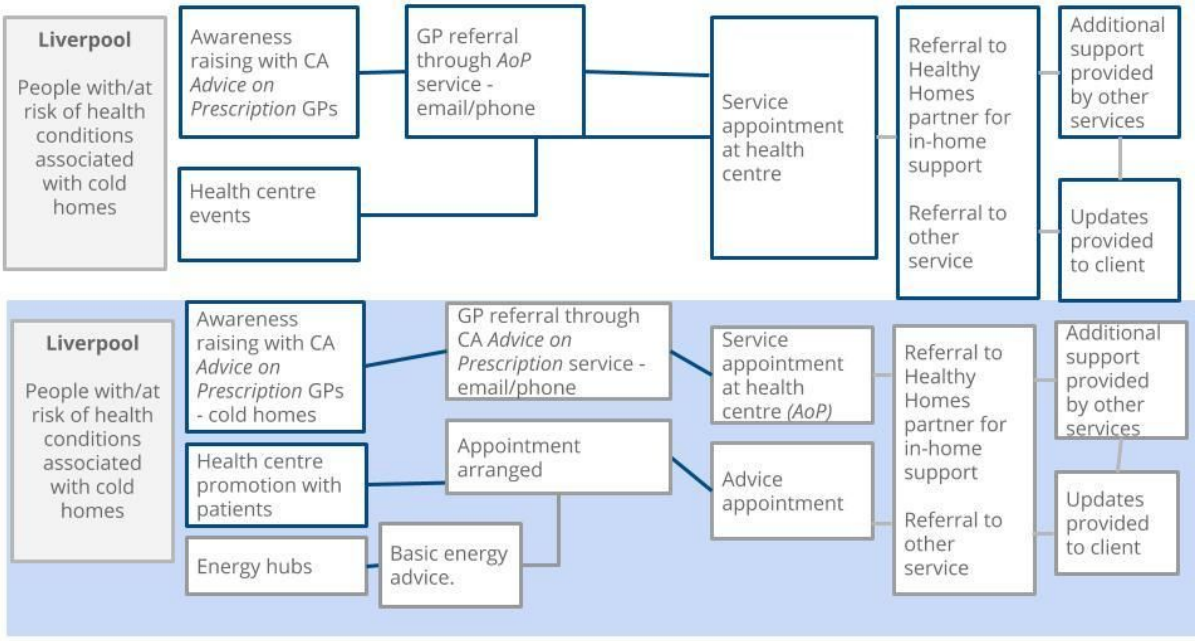
Commentary

Southwark CA found that language barriers prevented onward referrals or further case work for most clients (8 clients were referred on). Language translation services were provided for the first advice appointment but were not available for the more intensive referral process. Nevertheless, the project found

that many of the households they spoke to were living in very poor housing. This suggests there is considerable unmet need for a cold homes referral service.

Liverpool

Liverpool Citizens Advice aimed to develop the cold homes referral service by building upon its very successful 'advice on prescription' initiative in GP surgeries. This generates around 600 referrals a month across Liverpool.



Commentary

Liverpool CA planned to work with Liverpool City Council's 'Healthy Homes' project which provides energy efficiency and other fabric measures, mainly to households in the private rented sector (notorious for poor housing and low energy efficiency standards). Liverpool CA wanted to promote 'cold homes' as a reason for support. GPs and children's centres would identify people through a checklist and refer to Citizens Advice. Citizens Advice would then arrange energy efficiency support with Healthy Homes, who would also refer people needing other support, e.g. benefits advice, to Liverpool CA.

The project found it difficult to differentiate the cold homes service from the existing 'Advice on Prescription' service. GPs, for example, would often send people straight to Advice on Prescription without necessarily identifying the client had health problems associated with cold homes. Similarly, Healthy Homes would often refer people to Liverpool CA for debt advice but Liverpool

CA was not sure which particular referral service it should report on, i.e. winter resilience or debt.

Liverpool's experience highlights the fact that many people on low incomes have a wide variety of health problems that may or may not be related to cold homes; some, for example, arise from the stress of living on a low income. Given the existing volume of referrals Liverpool CA already receives from an important component of the health sector, it is possible that many of the client groups identified by the NICE guideline are already receiving support in Liverpool. Of course, it is very likely to be the case that many more still need support.

It may be useful to carry out further analysis of clients receiving support from Advice on Prescription to establish the extent to which they suffer health problems closely associated with cold homes and difficulties in paying fuel bills.

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