The Health of the Nation

Analysis of cost effectiveness and success factors in health-related fuel poverty schemes

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EXECUTIVE SUMMARY

Whilst operating in a challenging environment, local organisations are delivering and supporting health-related fuel poverty schemes, working creatively and flexibly to reach those who are genuinely vulnerable and making a real difference to the people they support.

This report presents the findings of a research project carried out between September and December 2016 by SE² Ltd and Lewisham Council. The research aimed to contribute to an evidence base on health-related fuel poverty schemes in the UK which can be used to inform both policy and practice. The research was funded by Eaga Charitable Trust, and we would like to thank them for their support and guidance throughout this project.

Research context

Fuel poverty is a complex issue that is the result of an interplay of household income, energy prices and the energy requirements of the household. The physical and mental health effects of living in a cold home are well-evidenced. However, despite this understanding of the issues and implications of fuel poverty, the problem persists. Fuel poverty is not static. The changing cost of energy affects people’s ability to afford what they need. And whilst there have been significant programmes of insulation and heating improvement, they have not been at sufficient scale or consistently targeted at the people most likely to be in fuel poverty, although they may have been effective in preventing more people from becoming fuel poor.

Some aspects of fuel poverty are inherently local and many local authorities, and others, have recognised this. Local support services for those in fuel poverty have been part of the solution for some time. Nonetheless, provision of local fuel poverty referral schemes is patchy across the country. Even where schemes exist, the difficulties in identifying people who are in fuel poverty means proxies are often used and it is hard to monitor the effectiveness of interventions on tackling fuel poverty per se.

All of this takes places against a background of reduced public sector funding which means it is ever more necessary to reduce costs where possible. ECO funding has also fluctuated over recent years, and it has been difficult for under-resourced organisations – or those with hard-to-treat housing stock - to access, meaning that opportunities to help those in fuel poverty are being missed.

Research need

Fuel poverty figures published in 2016 (for the period 2013-14) showed the number of households in fuel poverty was relatively unchanged, although low income households have seen larger rises in incomes and a smaller increase in fuel costs than the overall population. The fuel poverty gap – the additional amount of money which a fuel poor household would have to spend to achieve an adequate level of warmth – reduced by 2% from the previous year but still sits at £371 per year.

Growth in the number of local fuel poverty projects in England was catalysed by the introduction of the ‘Warm Homes, Healthy People’ scheme by the Department of Health in 2011 and sustained for a time by the availability of ring-fenced public health funding for local authorities.

The broad cuts required of local authorities and the limitations they have in raising additional revenue mean local resources for scheme delivery are being removed or at least squeezed. This report seeks to shed light on costs which are usually invisible and therefore offers a way for local fuel poverty scheme commissioners and managers to assess how best to deploy the resources they do have.
Given resource allocation is also an issue across the wider public sector, research such as this can strengthen the potential for joined-up working and try and develop shared approaches based on a range of success factors.

A further driver for this research is rooted in the complexity of fuel poverty, with complex situations requiring packages of interventions, which need coordination from a trusted intermediary. Targeting and reaching those in fuel poverty is challenging, therefore the more robust the methods to identify and refer people where support is available, the greater the chance of getting help to where it is most needed.

From a policy and guidance perspective, the more the sector is able to demonstrate and articulate specific, tangible issues and suggestions, the more likely it is to be able to make progress. Increasing the evidence base should therefore help support both policy makers and practitioners.

**Research aims**

The research is aimed at providing an evidence base which can be used to inform both policy and practice:

- Develop an evidence base for cost-effective referrals into health-related fuel poverty schemes
- Help improve both the effectiveness and the cost effectiveness of current and future schemes
- Analyse referral routes and processes to identify factors which indicate where referral routes are more successful
- Use the evidence base to inform policy development at all levels, national funding scheme design and project development and delivery

**Research methodology**

The research methodology took the following approach:

1. *Literature review:* identifying schemes that exist around the country and conducting a review of the policy drivers and performance indicators which encourage action on fuel poverty
2. *Research with health-related fuel poverty scheme providers:* a mixture of online surveys and semi-structured interviews to derive information from scheme providers. These were augmented by evaluation reports, financial information and publicity materials provided by scheme managers, thinktanks and campaigners in the fuel poverty sector.
3. *Referral organisations research:* an online survey was issued via networks of charities and health practitioners, with the aim of capturing views from organisations making referrals
4. *Analysis of the data:* data was analysed through a process of coding responses to identify areas of commonality or difference. Survey findings and emerging themes were tested during the interviews. An extensive cross-referencing exercise was conducted to see if there are relationships between different factors. The cost analysis seeks to standardise forms of data to allow for calculations and comparisons
5. *Workshop:* an opportunity to present and discuss initial findings and insights with a range of policymakers, influencers, local authorities, scheme managers and other fuel poverty stakeholders to gather views on what we have learned and the implications for policy and project development
6. *Providing guidance to scheme managers and policy makers:* in addition to the report, guidance documents have been developed to provide a set of useful, practical information for project design and delivery.

7. *Monitoring and evaluation:* the intention is to review take-up of the report and the guidance to see if and how people find them useful and to seek to update or amend them if people identify specific changes which will make them more useful.

**Research questions**

The research questions were designed to provide a deeper understanding of the objectives and targets of fuel poverty schemes and the mechanics of referral networks, to help assess not just the costs of referral networks but also their effectiveness. The questions focused on the following key themes:

- Scheme details
- Success factors
- Number and source of referrals
- Engaging organisations
- ‘Quality’ referrals
- Costs and resources

**Findings**

The key findings from the research were:

**Scheme objectives and focus**

- Schemes tend to combine multiple objectives, for example, reducing fuel poverty and improving health.
- Schemes are more focused on the health and social outcomes of interventions rather than carbon reductions.
- Schemes draw on a variety of local strategies to inform their scheme objectives, but there is significant variation in how this is done.

**Duration**

- Schemes that are sustained usually manage to offer a basic level of service, which is then supplemented as other support becomes available or by creatively patching together services offered by different local organisations.
- Fear of stop / start is very real and can deter scheme managers from trying to do things that take a long time.

**Scale**

- Schemes are operating at scale. All but four of the schemes in our sample generate over 200 referrals per annum. Over a quarter are achieving 800+ referrals each year.
- The limiting factor in relation to size seems to be about managing scarce resources, rather than an inability of organisations to reach those in need.
Targeting

- Most schemes are targeted towards groups based on specific criteria. This is most commonly a combination of health and income criteria.
- No schemes were specifically using the Low Income High Costs or 10% definitions to target households, although some were using these retroactively for monitoring purposes.
- Many schemes allow their staff some flexibility and discretion when dealing with individual household circumstances. This means that people in need do not miss out, even if they are not technically in fuel poverty.

Services

- Schemes are able to offer a wide range of services. Three quarters of the schemes in this research offered more than 8 services.
- Most schemes have some element of “tiered” service, with different offers available based on different eligibility criteria or in response to a fluctuating level of funding.

Referral networks

- There appear to be 4 main models of referral network based on the main source of referrals received: public sector led; health led; charity and voluntary sector led; or from individuals.
- Setting up referral networks seems to be the most time-intensive element of developing a scheme.
- Stop-start conditions jeopardise the ability of scheme providers to sustain relationships with referral partners and have a negative impact on trust in the scheme.

Quality

- Good quality referrals tend to come from partners who are used to operating with referral systems, perhaps on other projects, and so have a familiarity with the process.
- Good quality referrals also tend to come from partners who spend more time with the resident, particularly in their home. There is often a close alignment of objectives between these organisations and the fuel poverty scheme.

Monitoring

- Schemes find it easier to monitor activity and outputs rather than outcomes.
- Most schemes were not specifically monitoring whether a resident was taken out of fuel poverty as a result of an intervention. Rather they were monitoring based on proxy indicators (eg, presumed reduction in energy bills following an energy efficiency measure, presumed savings from switching supplier).
- Health and wellbeing questionnaires were a common method of evaluation. Some schemes were issuing these both before and after interventions. A small number of schemes were looking at longer term evaluation of health outcomes.

Staffing

- Schemes are achieving a lot with limited resource, but they are often having to repeat the same activities as a result of stop-start funding and market conditions.
More than half of schemes in the survey had less than 1 full-time equivalent (FTE). Most schemes had fewer than 2 FTE staff.

Costs

- Schemes which have been running for less than a year typically have a smaller budget than those that have been running for longer (5 years or more).
- Costs per customer seem to vary significantly in the 200-400 referral range but become more settled once schemes are achieving 600+ referrals.
- A benchmark cost per customer of £100-£150 was suggested by our research; this includes the cost of providing advice services to households, but not the cost of energy efficiency measures. This is the first time this benchmark has been created and we advise that it is used with caution as it is based on a limited data set.

Funding

- The schemes in this study are reaching a significant number of householders but are only able to offer a limited number and range of energy efficiency measures.
- Fuel poverty and carbon reduction targets are more challenging and costly to meet as a result of the missed opportunities to insulate homes having identified people and homes in need.

Referring organisations

- Organisations value a variety of services, particularly the provision of advice which increases the ability of the resident to take informed action.
- Referral partners seemed to place a higher value on inputting into how the scheme works than on receiving feedback on specific referrals.

Conclusions

The key conclusions are:

- Continuity of schemes helps create stronger referral networks, because setting up networks and relationships is the most time-intensive part of the process.

- Referral networks work where there is trust in the scheme. Networks can be flexible over time, enabling the scheme to refocus eligibility within the same referral network as funding or policy change.

- A broad referral network means that schemes should be better able to generate more referrals, respond to new opportunities and remain resilient against changes within that network.

- Referral partners value variety in terms of the offer, because it makes it more likely that a scheme is going to have a service that can benefit a wider group of people.

- Schemes are reaching people in need but, without additional funding, they are limited in the support they can provide. There is a need to move away from ‘low hanging fruit’ to find policy routes which will offer more detailed support for fuel poor households.
• Fluctuations in funding for energy efficiency measures means that households need to be re-identified should funding become available. The current approach focuses on the cost of an individual measure, rather than on the full cost of delivery per household. Were the latter approach taken, this would highlight the increased cost per home of targeting and outreach, and should help drive a more strategic and cost-effective approach to reducing carbon, increasing energy efficiency and addressing fuel poverty.

• Small schemes are managing to operate effectively but are under increasing resource pressure. Putting in place a base-level scheme which can operate with less than 1 full-time equivalent (FTE) and link in to other support services seems to be a good way to protect options. This then provides the ability to expand and contract over time as funding and resources come and go.

• If the schemes in our study were scaled across the country, they would reach 220,000 households each year. This would make a significant impact on fuel poverty rates, but it would still take 17 years to reach every fuel poor household based on the current level of resource for local referral networks.

• The level of fuel poverty in an area is not the limiting factor when it comes to size of project; rather the issue is the lack of resources available.

• In the focus upon delivery, monitoring and evaluation tend to be the elements which are quickly cut. This has a longer term impact for individual schemes, because they are less able to demonstrate their successes.

• Improved data sharing and the ability to access follow-up information would help all involved to be able to provide evidence for the efficacy of schemes.

• A large amount of costs are getting passed around the public sector, principally from the health sector to other parts of the public sector. A better cost-benefit analysis of the benefits of local fuel poverty schemes is needed to try and drive meaningful NHS engagement with them.

• The lack of a clear statutory function in this area for local authorities seems to act as a constraint upon resources being deployed. This has a clear postcode lottery implication which is further entrenched as organisations with a track record of delivery are then better placed to bid for other sources of funding.
1. INTRODUCTION

This report presents the findings of a research project carried out between September and December 2016 by SE² Ltd and Lewisham Council. The research was funded by Eaga Charitable Trust, and we would like to thank them for their support and guidance throughout this project.

The research aims to contribute to an evidence base on health-related fuel poverty schemes in the UK which can be used to inform both policy and practice. We sought to understand:

- The types of local fuel poverty referral schemes that are being delivered
- The approaches that those schemes are taking, and their reach
- The referral routes used by fuel poverty schemes, and the factors which make some referral routes more likely to be effective
- The resources, costs and funding of local fuel poverty referral schemes

With this evidence, we hope to help improve both the effectiveness and the cost effectiveness of current and future fuel poverty referral schemes. We also seek to inform policy development at all levels, funding scheme design and scheme development and delivery.

This report begins with some contextual background to the research, considering the persistent challenges of fuel poverty and the national and local policy context within which fuel poverty schemes operate. We then describe our methodology, before moving on to examine and analyse the findings from this study.

This report will be accompanied by two further documents:

- A practitioners’ guide – aimed at those developing and managing local fuel poverty referral schemes and drawing together some of the practical insights and experiences that we found, with a view to helping improve scheme effectiveness
- A policymakers’ guide – aimed at those creating policy in relevant areas, such as fuel poverty, energy efficiency, carbon reduction, housing and public health. This will feed some of the insights gained from local scheme managers in to thinking about the future direction of policy and programmes.
2. RESEARCH CONTEXT

Fuel poverty is the result of three key elements:

- Household income
- Energy prices
- The energy requirements of the household. This is a combination of the energy performance of the home (for example, the efficiency of its heating system), the requirements of the individual (compare, for example, the energy requirements of a person at work during standard office hours to those of a someone who is at home all day), and the effect of local weather conditions.

This interplay of factors can make it difficult at an individual level to identify people who are in or at risk of fuel poverty. There are a variety of technical definitions of fuel poverty (see section 3.1 below), but latest statistics suggest that fuel poverty is both common and persistent. An estimated 3.9 million households across Great Britain and Northern Ireland are in fuel poverty.

Fuel poverty is most likely to affect the following groups:

- People on low incomes, whether working, non-working or on pensions
- People with higher than typical energy requirements. This could include those who spend a lot of time at home, for example, parents of young children or those with mobility issues. Many long-term health conditions are also associated with higher energy requirements
- People living in homes with poor energy performance, for example, those with poor levels of insulation or those facing higher heating costs because of lack of access to gas. Fuel poverty is also disproportionately high in the private rented sector

People face a dilemma – use the energy they need and risk falling into debt, or under-use energy and live in a cold home.

The health effects of living in a cold home are well-evidenced, but worth repeating to illustrate the real impacts of fuel poverty. Cold homes:

- Contribute to ill health, particularly for those with respiratory or cardiovascular conditions and musculoskeletal conditions
- Have an effect on asthma, particularly among children
- Exacerbate other long-term or chronic conditions and can lead to secondary complications, for instance in people with cancer or diabetes. Studies have identified a strong association between excess winter deaths and lower indoor temperatures
- Alongside the fear of falling into debt, cold homes can also lead to occupants having significant mental health impacts from increased stress and anxiety, and social impacts related to educational outcomes and fitness to work

If we understand what causes fuel poverty, why does the problem persist? Firstly, fuel poverty is not static. Different people move into and out of fuel poverty as a result of changes in their personal circumstances, for example, changes in their family or employment situation. Secondly, the changing cost of energy affects people’s ability to afford what they need. Thirdly, whilst there have been significant programmes of insulation and heating improvement, they have not been at the scale required to tackle the problem. Nor have they always been effectively targeted at the people most likely to be in fuel poverty, although they may have been effective in preventing more people from becoming fuel poor. Finally, there are limited drivers to improve the energy efficiency of homes.

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from the rental or sellers markets, government regulation or social norms. Taken together, these factors combine to make fuel poverty difficulty to eradicate.

Some aspects of fuel poverty are inherently local: the housing stock, local economic conditions and even the local weather play a part. Many local authorities, and others, have recognised this, and local support services for those in fuel poverty have been part of the solution for some time.

Local schemes tend to resonate with residents because they are built from within the community, they reflect particular local circumstances, they link to other support services, and they come from trusted local partners. The schemes that we studied in this research all fulfil this definition, and reach a combined 220,000 households each year.

Despite this, provision of local fuel poverty referral schemes is patchy across the country. Some areas with high levels of fuel poverty do not appear to have a local scheme. Schemes start and stop subject to the availability of funding, whether from local authority sources or external funders. Schemes also operate in different ways, with different priorities and targets, and different levels of resourcing.

Even where schemes exist, the difficulties in identifying people who are in fuel poverty means proxies are often used. Understanding the different ways in which schemes identify and deliver resources to those in need should be helpful in providing feedback for the sector, enabling them to have more options about how best to allocate resources. Having this evidence base should also provide a way to engage with policy makers, helping them understand where there are gaps and opportunities.

All of this work takes places against a background of reduced public sector funding which means it is more necessary to reduce costs wherever possible. There is a small and decreasing staff capacity for project development and delivery generally, and especially in relation to energy efficiency work, which isn’t a statutory function. Public Health ring-fencing has ended and this has created a more challenging context within local authorities for accessing funding, particularly in the absence of funding for these type of schemes from the Department of Health. ECO funding was reduced and has been difficult for organisations to access. The low rates of funding mean that ECO does not even fully fund smaller measures such as loft or cavity wall insulation.

There are a number of case studies and research reports which identify the good work that local fuel poverty referral schemes are doing, supporting residents to reduce their energy costs, improve the energy performance of their homes, escape the grip of debt and maximise their incomes. With this research, we wanted to know more about how they operate, to see if there are changes in policy or in practice that can help local schemes start and sustain themselves and to deliver the best outcomes for those struggling with the physical and mental health impacts of living in cold homes.
3. POLICY CONTEXT

3.1 National drivers

Local authorities (and other scheme providers) operate within a context of policy drivers and indicators, much of which is driven at national level. These can be divided into six main categories:

- Fuel poverty drivers
- Health drivers
- Housing objectives
- Social objectives
- Climate change drivers
- Drivers imposed as part of specific funding streams

We have outlined some of the key drivers below, drawing attention to the main distinctions between devolved nations where appropriate.

3.1.1 National fuel poverty drivers

The UK Government’s fuel poverty strategy for England sets out a pathway for improvements in housing energy performance to reduce fuel poverty. It sets a milestone for 2020 for as many F and G rated properties as reasonably practicable to be improved to a minimum Band E standard. Further milestones call for as many fuel poor homes as reasonably practicable to be improved to Band D by 2025 and Band C by 2030. The strategy also proposes the introduction of minimum energy efficiency standards for the private rented sector from 2018.

In England, a household is categorised as fuel poor under the Low Income High Costs (LIHC) definition. Under the LIHC indicator, a household is considered to be fuel poor if:

- They have required fuel costs that are above average (the national median level)
- Were they to spend that amount, they would be left with a residual income below the official poverty line.

The fuel poverty strategy for England sets out some additional indicators that the Department for Business, Energy and Industrial Strategy (BEIS) wishes to monitor:

- Presence of a central heating system in fuel poor households
- Number of fuel poor households with non-condensing boilers
- Number of fuel poor households with loft and cavity wall insulation
- Proportion of fuel poor households with renewable energy technologies
- Distribution of households across the energy efficiency bands for fuel poor households and for all households
- The fuel poverty gap for households living off the gas grid

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2 Policy and funding landscapes change on a regular basis; this information was produced in March 2017 and was correct to the best of our knowledge at the time of writing.

The number of fuel poor households with a child under 16

The Government’s Committee on Fuel Poverty published an initial report in September 2016 on progress towards the interim milestones and 2030 fuel poverty target. The conclusion of the Committee was that without urgent action targets within the National Fuel Poverty Strategy would not be met.

Scotland has a strong policy focus on energy efficiency and fuel poverty, reflecting the challenges it faces around off-grid homes, a higher requirement for energy spend (because of a colder climate) and the energy efficiency of its housing stock. The Scottish Government had retained a duty to tackle fuel poverty; however, this expired in November 2016. The Scottish Government has said that it will reset the target but that it will review the definition of fuel poverty and establish its strategy first. At present, Scotland uses the definition that a person is in fuel poverty if they have to spend more than 10% of household income (including Housing Benefit or Income Support for Mortgage Interest) on fuel to maintain an adequate heating regime.

Wales has also retained its obligation to remove fuel poverty – as far as is practical – in all households by 2018, and, like Scotland, uses the 10% definition. The Welsh Government estimates that 23% of households in Wales are in fuel poverty according to the 10% definition. Energy efficiency in Wales sets out a strategic direction on energy efficiency, including fuel poverty, for the period to 2026. The Welsh Government’s NEST programme brings £80m of funding for energy efficiency improvements.

In Northern Ireland, there is no legislation requiring the eradication of fuel poverty, although that ambition was stated in the policy document Ending Fuel Poverty: A Strategy for Northern Ireland, with an end goal of eliminating fuel poverty for all households by 2016, subject to necessary resources. Many homes in Northern Ireland are reliant on oil for heating, and are subject to volatile prices. This combined with a low level of energy efficiency in homes means that fuel poverty remains a significant and persistent problem. Northern Ireland also uses the 10% definition for fuel poverty.

At a GB level, Ofgem also has a series of indicators related to fuel poverty, capturing data on:

- Levels of debt
- Disconnections
- Installations of insulation
- Energy spend as a proportion of household expenditure

### 3.1.2 National health drivers

The NHS publishes a detailed set of indicators for England. This includes outcome indicators for CCGs across five domains:

- Domain 1: preventing people from dying prematurely
- Domain 2: enhancing quality of life for people with long-term conditions

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4 Committee on Fuel Poverty Initial Report


- Domain 3: helping people to recover from episodes of ill health or following injury
- Domain 4: ensuring that people have a positive experience of care
- Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm

Of the wider set of data, those which are relevant to health-related fuel poverty schemes cover the following areas:

- Illness specific: e.g. cardiovascular; pulmonary; COPD; cancer; mental health
- Emergency admissions
- Hospital readmissions
- Inability to work due to health conditions
- Limiting long-term illness
- Life expectancy at different ages
- Potential years of life lost from causes considered amenable to healthcare
- Mortality rates: overall; by cause; age; from causes considered amenable to health care

The Public Health Outcomes Framework\(^7\) sets out the vision for public health in England alongside desired outcomes and key indicators.

The Cold Weather Plan for England\(^8\) sets out the roles and responsibilities for dealing with public health during periods of cold weather in England. It provides a system for cold weather alerts, winter preparedness and responsive action, and structures for communicating with the public and among service providers.

The National Institute for Health and Care Excellence (NICE) sets out quality standards which cover the priority areas for quality improvement. The quality standards cover healthcare, social and public health issues and cover the processes and standards which should be applied. These include aspects which are affected by fuel poverty:

- Illness specific: e.g. cardiovascular; pulmonary; COPD; cancer; mental health
- Hospital readmissions
- Preventing excess winter deaths and illness and the health risks associated with cold homes

NICE also has a set of indicators which measure outcomes that reflect the quality of care, or processes linked, by evidence, to improved outcomes. In 2015, NICE published guidance on *Excess Winter Deaths and illness, and the health risks associated with cold homes*\(^9\).

Scotland has said it has no plans to adopt the NICE guidance. However, there is some momentum towards greater visibility of issues related to cold homes within the health sector. NHS Scotland is developing a Housing and Health Inequalities Briefing which will recognise the health impacts of cold

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\(^7\) [http://www.phoutcomes.info/](http://www.phoutcomes.info/)

\(^8\) [https://www.gov.uk/government/collections/cold-weather-plan-for-england](https://www.gov.uk/government/collections/cold-weather-plan-for-england)

\(^9\) Excess winter deaths and illness, and the health risks associated with cold homes – NICE, March 2015. See [https://www.nice.org.uk/guidance/ng6](https://www.nice.org.uk/guidance/ng6)
and damp housing. The Scottish Public Health Network has recently published fuel poverty guidance for Directors of Public Health\textsuperscript{10}.

The Welsh Government is carrying out research into which low income individuals or households are most at risk from living in a cold home to help support targeting of energy efficiency improvements.

In Northern Ireland, the Public Health Agency aims to ensure a decent standard of living for everyone with a focus on poverty, including fuel poverty. The UK Fuel Poverty Monitor suggests that there is a strong strategic focus but that this needs to be translated into meaningful practical action\textsuperscript{11}.

3.1.3 Housing objectives

Minimum energy efficiency standards are being introduced for the private rented sector in England and Wales from 2018. These will require landlords to improve the least energy efficient dwellings, but subject to them facing no upfront cost (since at the time the regulations were drafted, the Green Deal represented a loan finance offer available to tenants). It remains to be seen the form that the final regulations will take.

Also, in England and Wales, local authorities have powers to enforce improvements to private rented homes through the Housing Health and Safety Ratings System. Cold is identified as a priority (category 1) hazard which landlords should rectify. However, local authority environmental health resources are often limited, and tenants are often wary of reporting issues for fear of rent increases or retaliatory evictions.

The Repairing Standard in Scotland covers the legal and contractual obligations of private landlords to ensure that a property meets a minimum physical standard. Amongst the compliance requirements is that installations for supplying water, gas and electricity and for sanitation, space heating and heating water must be in a reasonable state of repair and in proper working order.

The Welsh Housing Quality Standard places minimum performance standard on social housing. In Scotland, the Energy Efficiency Standard for Social Housing sets minimum energy efficiency ratings based on type of property and fuel. In Northern Ireland, a Decent Homes standard requires social housing to have a reasonable degree of thermal comfort; this standard is also sometimes used as the trigger for private sector housing grants.

3.1.4 Social objectives

The government compiles and monitors the Index of Multiple Deprivation (IMD) which is the official measure of relative deprivation for Lower Super Output Areas. This covers the following aspects:

1. Income deprivation
2. Employment deprivation
3. Education, skills and training deprivation
4. Health deprivation and disability
5. Crime


6. Barriers to housing and services
7. Living environment deprivation

These indicators have been used in some funding streams, for instance, the Community Energy Saving Programme was targeted at areas in the lowest 10% of the IMD.

In 2010, the Child Poverty Act was passed, enshrining a pledge to end child poverty by 2020. In 2016, the Welfare Reform and Work Act abolished the Child Poverty Act; however, the government has committed to reporting on these statistics on an ongoing basis.


Government also measures the following social justice indicators:

1. Supporting families
2. Realising potential in the education system
3. Stopping young people from falling into a pattern of reoffending
4. Tackling entrenched worklessness
5. Helping those receiving treatment for drug or alcohol addiction turn their lives around
6a. Proportion of adult offenders who did not re-offend
6b. Proportion of adult offenders in P45 employment one year on

The Office for National Statistics (ONS) publishes statistics on a range of income and equality indicators including:

- Average incomes, taxes and benefits
- Household disposable income
- Household expenditure
- Variety of cross-tenure housing costs

They also monitor a range of well-being, life satisfaction and happiness indicators.

Local authorities in England have a general power of competence which was introduced in the Localism Act 2011. This power gives local authorities the opportunity to focus upon social issues where they may not otherwise have a specific duty, target or indicator. It enables local authorities to take action in the best interest of their voters even if there is no specific legislation supporting their action. Local authorities do not have the power to do anything unlawful, to raise taxes or to alter their own political structures. Northern Ireland established a similar power for local authorities in 2014. The Local Government (Wales) Bill 2016 seeks to extend a similar power to Welsh local authorities. Welsh and Scottish authorities already have a similarly general power based on ensuring wellbeing of communities.

Some limited devolution from central to regional or local authority areas has taken place in England and this offers opportunities for areas to have more of a focus on social issues. The Greater London Authority has a wider remit on areas including housing, health and wellbeing that enables it to set higher standards than national guidance. Greater Manchester is being given control of its health and
social care budget which should offer opportunities to look more holistically at these issues across the city-region.

3.1.5 National climate change drivers

The Climate Change Act 2008 sets out a target of an 80% reduction in carbon dioxide emissions against a 1990 baseline by 2050. The Climate Change (Scotland) Act 2009 sets out a similar long-term ambition.

In November 2016, the UK Government ratified the Paris Agreement, part of the United Nations Framework Convention on Climate Change. The Agreement commits countries to taking action to hold in the increase in the global average temperature to well below 2°C above pre-industrial levels.

The Committee on Climate Change (CCC) has reviewed the issues of fuel poverty and carbon reduction and uses this information to feed back to government to highlight issues and also to propose the carbon budgets.

The Fifth Carbon Budget is the most recent one to be adopted and sets a target of limiting annual emissions to an average 57% below 1990 levels by 2032.

3.1.6 Drivers imposed as part of specific funding streams

The Energy Company Obligation (ECO) is a government energy efficiency scheme in Great Britain to help reduce carbon emissions and tackle fuel poverty. Larger energy suppliers have to deliver energy efficiency measures to homes with targets based on their share of the domestic gas and electricity market. The scheme focuses on the installation of insulation and heating measures and particularly supports vulnerable householders.

In their 2015 Manifesto, the Conservative Party committed to install low cost insulation measures in 1 million homes over the course of the current parliament. This compares to the estimated 4 million homes insulated from 2010 to 2013.

From April 2017, the obligation will go through an 18-month transition period towards a four-year programme to 2022. The final programme is expected to focus almost exclusively on the fuel poor, while 70% of the transition phase will focus on these households. Until September 2018, ECO will be split into two parts which are targeted based on different criteria:

- Carbon Emissions Reduction Obligation: promotion of energy efficiency measures, including roof and wall insulation and connections to district heating systems.
- Affordable Warmth: measures which improve the ability of low income and vulnerable households to heat their homes.

Within the Affordable Warmth strand, there is a new element called ‘flexible eligibility’ which will allow local authorities to identify and designate households as eligible. This could enable local authorities to more closely link local health-related fuel poverty schemes to funding for more meaningful measures.\(^\text{12}\)

The scale of ECO has fluctuated significantly in recent years. At the time of writing, ECO is emerging from a period of very limited activity as arrangements have become clearer about the shape that a future Supplier Obligation will take.

In 2015, BEIS (as DECC) launched a Central Heating Fund; several of the fuel poverty referral schemes covered in this report were funded through this route. This was designed to help local

\(^{\text{12}}\) At the time of writing, BEIS guidance on how flexible eligibility might work has not been finalised so we are unable to comment on specific points.
authorities improve the housing of those in fuel poverty living in their area. The scheme was intended to incentivise the installation of first time central heating systems in fuel poor households who do not use mains gas as their primary heating fuel.

The funding did not set out specific targets for organisations but the eligibility criteria were:

- The number of fuel poor households supported
- Strategic fit of the project with the Fuel Poverty Strategy
- Value for money, including the ability to leverage in funding
- The benefits of the intervention (increases in energy efficiency, savings in fuel bills)
- Supporting households’ use of new central heating

3.2 Local drivers

3.2.1 Fuel poverty and energy efficiency

There is no requirement on local authorities in England to have a fuel poverty strategy.

On energy efficiency, every local authority in England is required to submit a Home Energy Conservation Act (HECA) report to BEIS setting out the energy conservation measures that the authority considers practicable, cost-effective and likely to result in significant improvement in the energy efficiency of residential accommodation in its area.

HECA guidance provides a template for information, which includes details on activity around fuel poverty, partnership working and any targets the local authority may have. HECA does not require local authorities to take action in any of the areas it requests information on.

In Scotland, local authorities are required to report on the progress of actions towards eradicating fuel poverty in their Local Housing Strategies.

3.2.2 Local health drivers

In England, local authorities, Clinical Commissioning Groups (CCGs) and other public sector partners are required to produce a Joint Strategic Needs Assessment (JSNA) of the health and well-being of their local community. This looks at the wider determinants of health, and supports partnership working between CCGs, local authorities and third sector providers.

The JSNA can identify area-specific issues where health indicators or outcomes are of particular concern. The JSNA also enables local targets and indicators, set at a level which relates to the issue (e.g. focused on a specific illness, health issue or geographic area). The JSNA can then proscribe actions, outcomes, targets or indicators which relate to this.

Research by NEA identified that just over half of all Health and Wellbeing Boards had referenced action to address fuel poverty in their JSNA13.

4. RESEARCH NEED

Health-related fuel poverty schemes have been running for a number of years.

Growth in the sector was catalysed by the introduction in England of the ‘Warm Homes, Healthy People’ scheme by the Department of Health in 2011 and sustained for a while by the availability of ring-fenced public health funding for local authorities. However, the removal of the ring-fence, and other pressing public health priorities, mean that some areas are not able to provide the same level of support for fuel poor residents. At the same time, funding through ECO has shrunk in the last two years, reducing the availability of support for larger energy efficiency measures.

Despite this work, fuel poverty figures for 2014\(^{14}\) showed the number of households in fuel poverty was relatively unchanged, although low income households have seen larger rises in incomes and a smaller increase in fuel costs than the overall population. The nature of the Low Income High Costs (LIHC) definition of fuel poverty means that there will always be an element of structural fuel poverty in society, so the “fuel poverty gap” is often considered a more effective metric. This gap is the additional money that a household would need to spend to maintain an adequate level of comfort at home. Between 2013 and 2014, the gap fell by 2.1% from £379 to £371 per year. The need to engage with this issue is not going away and there is a clear need to direct resources as effectively as possible.

The broad cuts that are being required of local authorities and the limitations they have in raising additional revenue, mean that local resources for scheme delivery are being removed or at least squeezed. There is a small and decreasing level of staffing available for project development and delivery within the public and voluntary sectors, particularly in relation to energy efficiency which is not a statutory function for local authorities.

So, one factor influencing this research was the question: what types of fuel poverty referral schemes are local authorities able to deliver in a time of shrinking or uncertain resources?

A further driver for this research is rooted in the complexity of fuel poverty. We have seen that it is caused by a combination of factors - from the insulation and heating systems of the home, to the personal and financial circumstances of the household, their energy consumption patterns and the tariffs they are on for the energy. Single interventions such as changing tariff are unlikely to be sufficient to take a household out of fuel poverty (and provide no protection against future price rises). So, complex situations require packages of interventions, which need coordination from a trusted intermediary.

Targeting and reaching those in fuel poverty is challenging. Assessing whether someone is in fuel poverty requires gathering a lot of information (more so for the Low Income High Costs definition of fuel poverty). Fuel poverty is fluid: people move in and out of fuel poverty as a result of changes to one or more of the factors which are determinants of fuel poverty. There is no one organisation which holds all of the information needed to pinpoint people and, to date, there is no single indicator which enables the home or the person that is in or at risk of fuel poverty to be identified. Therefore, the more robust the methods to identify and refer people where support is available, the greater the chance of getting help to where it is most needed.

We wanted to understand more about how fuel poverty schemes are targeted and how schemes providers use the different definitions – or proxies for them – on a day to day basis. Maximising the

scope of referrals in to schemes increases the likelihood of reaching people in need, whether they are already in or are at risk of fuel poverty. However, this chase for referrals has to be balanced by the resources and capacity within the scheme provider to offer an effective package of support.

Resource allocation is an important theme in this report. Scheme providers have to weigh the balance between what they want to achieve and the resources available to help them with this. Understanding referral routes and how to make them as effective as possible is a way of doing this, and through this report and the accompanying guidance, we hope to help policy makers and project managers conceptualise and deliver their schemes in as cost-effective a way as possible. This report also seeks to shed light on costs which are usually invisible and therefore offers another way for people to assess how best to deploy the resources they do have.

Resource allocation is also an issue across the wider public sector. Failure to address fuel poverty leads to people placing greater demands on the health sector as cold homes lead to increased symptoms. Any ways of reducing overall costs helps ameliorate this system burden. Research such as this can strengthen the potential for joined-up working and try and develop a shared approach which addresses a range of success factors.

Taken together, all of these factors mean there is a need to strengthen the potential for joined-up working, and this research is designed to support policy makers and practitioners across the spectrum in doing so. If we can understand the experiences and lessons learned from practitioners, we can help to inform practice across the sector and to help policymakers develop approaches that are most likely to lead to positive local outcomes. The more that people are able to draw upon best practice to short-cut inefficient or ineffective approaches to delivery, the better.

From a policy and guidance perspective, the more the sector is able to demonstrate and articulate specific, tangible issues and suggestions, the more likely it is to be able to make progress. Increasing the evidence base should therefore help support both the policy makers and practitioners.
5. RESEARCH AIMS

The research is aimed at providing an evidence base which can be used to inform both policy and practice:

- Develop an evidence base for cost-effective referrals into health-related fuel poverty schemes
- Help improve both the effectiveness and the cost effectiveness of current and future schemes
- Analyse referral routes and processes to identify factors which indicate where referral routes are more successful
- Use the evidence base to inform:
  - Policy development at all levels
  - National funding scheme design
  - Project development and delivery
6. METHODOLOGY

This section sets out an overview of the approach taken to collect and analyse the data.

6.1 Data collection

6.1.1 Literature review

A literature review and desktop study was carried out looking at two key areas:

- Identification of the health-related fuel poverty schemes around the UK. Building upon work which had been conducted by the NEA, each local authority area was checked to identify schemes taking place and a record was made with the key elements of each scheme, where they existed.
- A review of performance indicators to map health, fuel poverty, energy efficiency and housing policies and indicators. The findings of this review are set out in the policy background above and were also used to consider how fuel poverty schemes are setting objectives and monitoring performance.

6.1.2 Research with health-related fuel poverty scheme providers

Through the literature review, we identified 279 local authorities who offer some sort of fuel poverty or energy advice scheme and 19 schemes run by other sectors. We gained more detailed information on 66 health-related fuel poverty schemes from a variety of data collection methods.

An online survey was issued through a variety of health, fuel poverty, energy efficiency and carbon reduction contacts and networks to try and encourage take-up and reach as many organisations running schemes as possible. Information collected as part of the literature review also helped to identify specific contacts within organisations where schemes were running.

In total, 55 responses were received to the survey, of which 36 responses were from local authorities. 11 responses were provided by charities, 1 by a Clinical Commissioning Group (CCG), 1 by a company and 1 by a university. 5 respondents did not provide details of their organisation.

Some organisations provided information on their schemes in different formats, which either sat alongside their survey response or was in lieu of responding to the survey. This information included details of the schemes, publicity materials, evaluation reports and more detailed budget breakdowns.

7 semi-structured interviews were conducted by telephone. Organisations chosen were picked to try and ensure a geographic spread from across England and Scotland, in rural and urban areas, and to cover schemes managed by a cross-section of organisations. 5 interviewees were from local authorities, one from a charity running a scheme, and one from a delivery agent which manages various health-related fuel poverty schemes on behalf of others.

The interviews also reflected a split between schemes which focus upon health as their main criterion and then fuel poverty as a secondary factor, and those for whom fuel poverty was the main criterion who then use health factors as a way to target their support.

6.1.3 Research with referral organisations

An online survey was issued via networks of charities and health practitioners, with the aim of capturing views from organisations that make referrals into fuel poverty schemes. The survey was also sent out through scheme providers, particularly local authorities, with a request to pass it on to organisations with which they work.
29 responses were received, but many of these were partial. The analysis presented below draws on the 10 most comprehensive responses, and as such is illustrative rather than representative. Respondents came from a range of sectors, including environmental, health, housing and regeneration, poverty, fuel poverty and disability focused organisations.

6.2 Analysis

Data was analysed through a process of coding responses to identify areas of commonality or difference. This helped to identify qualitative themes to sit alongside the quantitative findings from the survey. We tested survey findings and emerging themes during our interviews with scheme managers.

We also carried out an extensive cross-referencing exercise. We wanted to see if there were relationships between different factors of schemes. For example, does the length of time that a scheme has been running have a relationship to the level of staffing the scheme has? Do schemes with fewer staff offer fewer services to residents? We were looking for correlations and trends, to see if we could pick out any combinations for factors that appeared to have a strong influence on scheme effectiveness.

The cost analysis involved some work to normalise data as far as possible. Where schemes had provided details on staffing levels but not the internal staff costs, we constructed these using public sector pay scales. This research represents a first-pass analysis of cost data.

6.3 Workshop

Lewisham Council hosted a workshop at which we shared initial findings and insights with a range of policymakers, influencers, local authorities, scheme managers and other fuel poverty stakeholders to gather their views on what we have learned and the implications for policy and project development.

At the workshop we provided feedback on the approach to the research, before moving on to the initial findings and providing an opportunity for people to question and test these, looking at ways in which they would be interested in the research exploring particular elements which hadn’t been picked up to date. We then set out our early thoughts on recommendations to gather stakeholder feedback and to set the future direction for the research project.

6.4 Guidance for practitioners and policymakers

Guidance for practitioners and policymakers has been developed alongside this research report. It is designed to provide a set of useful, practical information that can provide assistance whether read in conjunction with this report or on its own.

The toolkit for practitioners is split up into sections which mirror the different elements of the research:

- Setting objectives
- Targeting residents
- Services
- Referral networks
- Staff/resourcing
- Costs and funding
- Monitoring and evaluation
- Future-proofing and resilience

Separate guidance is also being for policy makers working in energy, fuel poverty, health and housing, and for funders or those administering funding schemes. This aims to give the local practitioners’ perspective on what good policy or programme design looks like, so that the system can work more effectively together.

6.6 Monitoring and evaluation

The intention is to review take-up of the report and the guidance to see if and how people find them useful and to seek to update or amend them if people identify specific changes which will make them more useful.
7. RESEARCH QUESTIONS

The research questions are intended to cover the different aspects of managing a health-related fuel poverty referral scheme, to get a clearer sense of many aspects of scheme design and delivery.

In developing the research, analysing the outputs and identifying recommendations, the research seeks to take a holistic view of the referral process and to provide feedback which can be of use in setting up and running a variety of different schemes, to reflect the variety of approaches and scales of support which are being provided.

- Scheme details
  - Objectives of the schemes
  - The focus of scheme, that is, whether they are leading on health or if the main focus is fuel poverty and then health factors are secondary
  - To try and understand the different schemes people are running and therefore use this to see if there are similarities/differences between schemes with different focus areas
- Success factors
  - What are the things that people/organisations have identified as important in terms of their schemes?
  - Is there a follow-through from overarching objectives to scheme targeting and the services available?
- Number and source of referrals
  - Looking at how many referrals organisations are trying to generate
  - Mapping referral routes into schemes and get an insight into those routes which are more or less effective
- Engaging organisations
  - Which organisations or types of referral organisations are easy or difficult to engage?
  - What factors make different sectors more or less easy to engage, and what, if anything, can be done to address this?
  - Insights into how to engage people and organisations to improve the process of generating referrals in to schemes
  - The extent to which organisations that are easier/harder to engage with translates into the quantity and quality of referrals received
- ‘Quality’ referrals
  - In this context, the quality of the referral isn’t making any judgement about the extent to which the person does or does not meet the eligibility criteria. Our focus is purely about the extent to which the organisation receiving the referral gets the information they need and is able to process this immediately without having to do any further work.
• Trying to understand if there are any specific or common factors which mean that organisations find a referral to be of good quality

• Why people drop out of the process, and the steps that schemes take to mitigate this

• Costs and resources
  
  • Seeking to identify the costs of schemes and to identify a cost effectiveness indicator
  
  • Comparing costs to the numbers of referrals received and the types of services provided
  
  • Staffing levels for overall scheme delivery and also in terms of the amount of time taken up in generating referrals into a scheme
8. FINDINGS

8.1 Focus of the scheme

Key findings:

- Schemes tend to combine multiple objectives, for example, reducing fuel poverty and improving health.
- Fuel poverty objectives are usually expressed broadly – “reduce fuel poverty” - or be more targeted to a specific group - “reduce fuel poverty among people with a long term health condition”
- Only one scheme expressed a fuel poverty objective in the language used in the fuel poverty strategy for England related to improving SAP ratings
- Health objectives were more likely to be expressed in terms of improving health and quality of life than about reducing Excess Winter Deaths
- Energy efficiency objectives are often more about activity levels (installations) than about outcomes (improved energy performance / SAP ratings)
- Schemes are more focused on the health and social outcomes of interventions rather than carbon reductions; only 2 schemes had specific objectives around reducing carbon emissions
- Schemes with external funding set their objectives based on the requirements of the funder. It is not clear if there is always a match between funders’ requirements and local needs
- Schemes draw on a variety of local strategies to inform their scheme objectives, but this is not consistently done

8.1.1 Scheme objectives

We asked scheme providers about the objectives of their work.

Our analysis of 55 fuel poverty schemes identified a number of core objectives:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Number of schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressing fuel poverty</td>
<td>23</td>
</tr>
<tr>
<td>Improving health</td>
<td>21</td>
</tr>
<tr>
<td>Improving energy efficiency</td>
<td>12</td>
</tr>
<tr>
<td>Reducing pressures on the NHS</td>
<td>6</td>
</tr>
<tr>
<td>Reducing carbon emissions</td>
<td>2</td>
</tr>
<tr>
<td>Economic development / creating jobs</td>
<td>1</td>
</tr>
</tbody>
</table>

Most schemes had more than one objective, as shown in the chart below.
Schemes most frequently linked health and fuel poverty objectives; for example:

“The aim of the service is to contribute to a reduction in the number of households living in fuel poverty, the number of unnecessary cold weather related GP visits and hospital admissions, and the number of excess winter deaths.”

“To relieve fuel poverty in [the area] by providing debt and benefits advice. To improve vulnerable people's health by reducing the effects of the cold weather.”

For many schemes, energy efficiency was not an objective in itself but could be a route to tackling fuel poverty and health challenges:

“To improve health and wellbeing and reduce pressure on health services by offering energy efficiency improvements and advice to residents with a respiratory illness or a cardiovascular disease.”

We have looked in more detail at how scheme objectives are expressed.

### 8.1.2 Fuel poverty objectives

Schemes had different ways of expressing their fuel poverty objectives. For 12 of 23 schemes, they used language around “reducing fuel poverty” often in a specific geographical area or among a specific target audience, such as those on low incomes or with specific health conditions. 4 schemes used language which related to reducing energy bills, whilst 2 schemes referred to the twin issues of fuel poverty and fuel debt. 5 schemes referred to an objective which was about identifying people in fuel poverty and then offering them a range of support.

One scheme works in an authority which has a strategic target to reduce fuel poverty by 1% each year. This is measured using BEIS fuel poverty statistics at a local authority level. The scheme manager acknowledged that not only is this not truly measurable (as it is modelled data rather than actual), it is also not deliverable with current resourcing levels, as it equates to helping over 3000 households per year. That said, the presence of the target in local strategies has helped to galvanise and sustain action on fuel poverty.

We will explore how schemes are targeted in a later section of this report. However, it is worth noting here that no schemes contributing to our research used LIHC as a definition or means of
targeting. One interviewee said that, given how time-consuming it is to identify people using this methodology, they preferred to spend the time in a home visit in a more practical, useful way.

8.1.3 Health objectives

There was also some variation in how schemes expressed their health-related objectives.

4 schemes gave broad statements about wanting to help improve residents’ health and wellbeing; 2 schemes specifically mentioned mental health. One scheme had an objective to “improve quality of life for those with disabilities or long term health conditions”.

13 schemes expressed their health objectives by referring to the condition of the property; for example, “to aid those with long-term health conditions exacerbated by living in a cold / damp home”.

7 schemes expressed their health objective in relation to reducing the number of Excess Winter Deaths. This was the most frequently mentioned specific health outcome, although it was usually cited in the context of a wider approach. For example, one scheme talked about contributing “to a reduction in the number of households living in fuel poverty, the number of unnecessary cold weather related GP visits and hospital admissions, and the number of excess winter deaths”.

6 schemes said they were aiming to reduce pressures on the health service. This was expressed both in terms of reducing the number of hospital admissions and reducing the number of visits to GPs. Some schemes, which took a wider view of health issues, were actively making referrals to different parts of the health service, for example, falls clinics or smoking cessation.

One scheme had an objective to reduce health inequalities.

8.1.4 Energy efficiency objectives

12 schemes gave energy efficiency as one of their direct objectives, for example, “improve thermal comfort in poor housing” and “to fit energy efficiency measures into the most vulnerable households”. Note that for many, energy efficiency is a core activity of their scheme; however, the majority did not see it as an objective in itself, but as a means to achieving other ends.

One scheme gave its energy efficiency objective in terms of improving the SAP rating of the property, in line with the way that the Fuel Poverty Strategy for England is written.

Another scheme had a much more closely defined objective: “to reduce fuel poverty...and specifically assist vulnerable low income home owners who have broken or ineffective heating”. This highly focused approach to supporting householders with certain measures seems to have been driven by the requirements of an external funder rather than by the scheme provider themselves.

8.1.5 Carbon reduction objectives

Only two schemes specifically said that they aimed to reduce emissions of carbon dioxide, despite many of them being run by energy teams. Given that 23 schemes said they were aiming to reduce fuel poverty and 12 schemes that they were aiming to improve energy efficiency, this suggests a focus more on the social and health benefits of energy efficiency rather than its environmental benefits. Our interviews identified that there may be activities within schemes which increase emissions, for example, income maximisation which enables a household to use more energy.

Many people receiving support from fuel poverty schemes may currently be under-heating their homes. This means that energy consumption could increase as a result of the scheme. Our interviews identified that there may be activities within schemes which increase emissions, for example, income maximisation which enables a household to use more energy.
8.1.6 Funders’ objectives

4 schemes noted that their health objectives were specifically driven by funders. Of these, 3 were referring to external funders and one to Public Health within the local authority. One followed the funder’s requirements but supplemented these with guidance from NICE.

Another scheme specifically talked about trying to bridge the gap between need and funding saying one of their objectives is to “supplement other national and local funding sources”.

The influence of funders was more strongly felt when it came to targeting schemes towards local residents (see section 8.5 below).

8.1.7 Delivery objectives

7 schemes talked about approaches to delivery as part of their objectives.

In some cases this was about how they are looking to deliver the project from an organisational perspective, with one scheme talking about running “a partnership project” to another stating that one of their objectives is to “work with partners in the borough to identify households who are living in fuel poverty”.

For other schemes, the delivery objective was around the kind of service they look to provide residents, with references to offering a “first point of contact for all Fuel Poverty referrals” or seeking to offer “a quality, hand-holding, free of charge service that takes all the worry away from clients”.

8.1.8 Alignment with national drivers

23 schemes in this analysis had direct objectives to reduce fuel poverty. However, it is as if different languages are being spoken at national and local level when it comes to how objectives are expressed and measured.

The Fuel Poverty Strategy for England is based around improvements in average SAP ratings over time. However, scheme providers tended to define objectives, and measure progress, based on the outcome for the person, not for the property.

No schemes were reporting based on improvements in EPC ratings; only one scheme was reporting based on improvements in SAP rating.

As mentioned in section 3.1.1 above, BEIS and Ofgem both gather large scale data sets to monitor progress against the Fuel Poverty Strategy and the delivery of ECO, for example, the number of fuel poor households with non-condensing boilers or energy spend as a proportion of household expenditure. We did not find any examples of schemes which had aligned their objectives or their monitoring with these criteria.

Health drivers are more closely aligned with national priorities. This can be demonstrated through use of national guidance to inform schemes e.g. NICE, Royal College of General Practitioners, Cold Weather Plan. It may also be associated with the move over recent years from considering fuel poverty as an energy issue to considering it as a health issue as well, and the trend for more funding for fuel poverty schemes to come from Public Health budgets.

2 schemes had carbon reduction objectives and 4 schemes were reporting carbon savings.

Funders’ criteria are a powerful driver where activity is dependent on that funding. It may be that scheme providers’ relatively loose definitions of target audiences – for example “vulnerable” or “with a health condition made worse by the cold” are deliberate and effective tactics to allow schemes to remain flexible as new funding streams become available (see section 8.5 for more on how fuel poverty referral schemes are targeted).
8.1.9 Alignment with local drivers

Some schemes were specific about how local issues and strategies had driven their activity:

- The Warm Homes Healthy People scheme in Stockton-On-Tees was designed to reflect the Joint Strategic Needs Assessment for the area with the support of Public Health and the Health and Wellbeing Board
- Energy Advocacy Renfrewshire provides services mainly to young, low-income families, reflecting demographic need within the area
- Bury Council’s Fuel Poverty Funding project targets residents based on evidence within local health strategies and informed by the work of other local authorities in Greater Manchester
- Derbyshire Health Homes targets conditions based on a list provided by Public Health, which commissions their service
- Warm Homes Healthy People in Lewisham targets on health condition based on the existence of local service delivery teams for that condition

We expect that English local authorities’ fuel poverty schemes will be included in their HECA reports, although HECA does not place any specific requirement on authorities to run schemes or guide how they might be delivered. In Scotland, local authorities will report on them under their Local Housing Strategies.

8.2 Duration of schemes

Key findings:

- There has been significant turnover in local schemes since 2015
- Most often, schemes start and stop because of changes to funding, whether external funding for measures or internal funding for staff
- The mix of services offered by schemes changes over time, again usually because of changes in funding
- Schemes that are sustained usually manage to offer a basic level of service, which is then supplemented as other support becomes available or by creatively patching together services offered by different local organisations
- Fear of stop / start is very real and can deter people from trying to do things that take a long time. This leads to a focus on quick wins, working against some of the more complex interventions that might be needed.

The starting point for our desk research was the Catalogue of Health-Related Fuel Poverty Schemes produced by NEA for DECC in early 2015. One of the most interesting findings was that a significant number of schemes listed 2015 have either disappeared or been replaced by something new.

This issue of stop / start among fuel poverty schemes was a recurring theme of our discussions with scheme providers, policymakers and others, and we will go on to explore some of its impacts.

The chart below shows the duration of the schemes that responded to our survey:
Scheme providers told us that the most common reason for schemes to start and stop is a change in funding. Although this seems obvious, it is a finding which manifests itself in a variety of ways across schemes. Findings outlined elsewhere also provide some insights into ways in which some schemes have managed to continue despite challenging circumstances.

In the simplest cases, the removal of funding means that a scheme stops completely. Where schemes have been sustained, it is often because the scheme manager has been able to navigate the funding landscape and identify both internal and external sources of funding that can be patched together to ensure continuity. Many schemes have differing levels of service provision – a baseline service which can be run all of the time (or at least seasonally) and the flexibility to offer additional services as further funding becomes available.

The Department of Health’s Warm Homes Healthy People programme was a catalyst for the creation of a large number of health-related fuel poverty schemes. In some areas, schemes set up as a result of this funding have been able to continue by leveraging in Public Health funding, particularly when this was ring-fenced within local authorities.

In some cases, funding cuts have led to the removal of staff posts which were charged with delivery of these kind of schemes. This has led some local authorities to reduce or close their services, whilst others have retained budget if not headcount and have been able to commission their fuel poverty services to third party providers, e.g., other local authorities or specialist energy advice agencies.

The mix of support that is offered through schemes can also change over time, with energy efficiency measures being the most commonly affected. Again, this tends to relate to the availability of funding. For instance, when changes are made to obligations placed upon energy companies, schemes expand and contract in size, availability of measures and their use of eligibility criteria. Stakeholders at our research workshop noted that the fear of schemes stopping and starting may deter people from trying to offer services or build relationships that are going to take some time and effort. Schemes may also be driven by the need for quick wins. This can mean that they place less priority on building longer term relationships which could provide the basis for a longer term scheme in the event of their current funding getting cut.

One scheme which has been running for over five years noted that their devolution deal included energy efficiency. Their work in the lead-up to the devolution deal helped to secure its inclusion in the deal and, now it is there, provides an ongoing justification for delivery of work in this area.
8.3 Scale of schemes

Key findings:

- Schemes are operating at scale. All but four of the schemes in our sample generate over 200 referrals per annum. Over a quarter are achieving 800+ referrals each year.
- Schemes that have a broad energy efficiency focus and wide eligibility aim for higher numbers of referrals. These also tend to be schemes that have existed for longer.
- Schemes with a tighter focus on specific health conditions aim for lower numbers of referrals.
- The limiting factor in relation to size seems to be about managing scarce resources, rather than an inability of organisations to reach those in need.

The chart below sets out the number of referrals received by schemes per annum. The orange bars are for schemes operating across multiple local authority areas and the blue bars represent those schemes which are just operating within one local authority area.

The target number of referrals is less than 1% of total population for all the areas covered by these schemes. Two schemes are aiming to reach around 0.65% of their total population; these are the two largest blue / single-area schemes shown at the left hand side of the chart. On average, schemes are aiming to reach just 0.18% of their total population in a given year.

We can look further into the data and compare the target number of referrals with the population in fuel poverty in a given area. Here, the highest penetration rate is 6%, that is, a schemes is securing enough referrals to support 6% of its fuel poor population, assuming that all those who are supported are in fuel poverty. Rates of 3-4% are more typical for the larger schemes shown above. Most of the smaller schemes would still only reach less than 1% of their fuel poor population in any given year, although there are some exceptions in areas of high fuel poverty and low population, where small schemes can have a bigger reach.

All but 4 of the schemes who provided information on the number of referrals they receive are generating over 200 referrals a year.
The smallest scheme in this sample is a one-year project focused on providing heating improvements to around 35 households based on health and income criteria.

The larger schemes tend to be those which have been running for longer, where the service has become embedded as part of business-as-usual within the providing organisation. Most of these tend to be focused on fuel poverty and energy efficiency, with a very wide range of services and broad eligibility.

It is interesting to note that the multi-area schemes (which would have a higher potential population) are not necessarily the largest; in fact they tend to cluster more at the smaller end of schemes. This is likely to be a reflection of greater targeting of measures, for example on health criteria, rather than the broader availability of measures and support seen in some of the larger, fuel poverty oriented schemes.

The size of a scheme seems to reflect the capacity and resources available, rather than the extent of local need. That is to say, the limiting factor on size doesn’t seem to be the ability of schemes to be able to identify those who are in need, as much as a need to use their resources effectively.

“[The team] are swamped so there’s a limit to how much they can do. We’d be looking at quality over quantity but then that ties in to specific client needs.”

The average number of householders supported across the schemes in our survey is just over 500, although this is somewhat skewed by a few schemes that are much larger. Nonetheless, if this were replicated across each of the 434 local authority areas in the UK, this would equate to over 220,000 homes being reached and supported each year. By way of context, the latest Fuel Poverty Statistics report from BEIS suggests that there are 3,905,000 homes in fuel poverty across Great Britain and Northern Ireland.

8.4 Scale compared to duration

We were interested to see whether there is a relationship between the duration of a scheme and the number of referrals it receives.

The bars in the table below reflect the number of referrals each scheme targets per annum. The approximate length of time the schemes has been operating is shown by the square markets, plotted against the right hand axis\(^{15}\).

\(^{15}\) Note: these are derived from a survey questions which offered ranges. The options were less than 1 year; 1-3 years; 4-5 years; more than 5 years. These have been translated on the chart as 0.5 years; 2 years; 4.5 years; 6 years. Some schemes may have existed for more than 6 years.
We can see that there are long-term schemes at all sizes – from 1500 referrals per year down to 200 referrals per year. Equally, there are schemes which have only started within the past year which are aiming to attract significant numbers of referrals.

That said, there is a broad trend for schemes that have been running longer to have a higher number of referrals – compare the distribution of schemes running for 4-5 years compared to those running for 1-3 years.

This suggests that continuity of a scheme can help it to grow and reach more people. One of the clear themes we found in our survey (which we will discuss more below) is that it takes time to build the relationships which form an effective referral network – in fact, this can be the most labour-intensive part of the process. Continuity of provision helps those relationships to be set up and sustained, rather than having to start over again.
8.5 Targeting of schemes

Key findings:

- Most schemes are targeted towards groups based on specific criteria. This is most commonly a combination of health and income criteria.
- Although the local JSNA and the NICE guidance are used, the most common way of setting criteria is through the scheme managers’ own definitions of health conditions made worse by the cold.
- Schemes do not use either the LIHC or the 10% definition of fuel poverty in their targeting. Rather they use proxies such as receipt of benefits (for low income) or age (for likely health risk).
- Tenure is also a factor in targeting; this tends to relate to the availability of grant funding. Funder requirements also play a part in setting eligibility criteria, particularly around income.
- Unless there is specific funding available for energy efficiency measures, schemes are not typically targeted based on property type or geography.
- Many schemes allow their staff some flexibility and discretion when dealing with individual household circumstances. This means that people in need do not miss out, even if they are not technically in fuel poverty.

8.5.1 Targeting - overview

We asked scheme providers whether they target support to specific groups of people.

The majority of schemes were targeting their services and support to specific groups. Many take a tiered approach even within broad overall eligibility, for example, telephone advice might be available for all but heating grants are only available for owner occupiers.

The table below shows the target groups described by schemes and the number of schemes focusing on that specific group. The orange rows show health conditions, whilst the blue rows show housing tenure.

<table>
<thead>
<tr>
<th>Targeting criteria</th>
<th>Number of schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabilities/long-term illness</td>
<td>29</td>
</tr>
<tr>
<td>Owner occupiers</td>
<td>27</td>
</tr>
<tr>
<td>Low income</td>
<td>26</td>
</tr>
<tr>
<td>Older people</td>
<td>25</td>
</tr>
<tr>
<td>Families</td>
<td>24</td>
</tr>
<tr>
<td>Private tenants</td>
<td>23</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>21</td>
</tr>
<tr>
<td>Social tenants</td>
<td>16</td>
</tr>
<tr>
<td>Homeless</td>
<td>11</td>
</tr>
<tr>
<td>Immigrants / asylum seekers</td>
<td>9</td>
</tr>
<tr>
<td>People in fuel poverty</td>
<td>2</td>
</tr>
<tr>
<td>------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Vulnerable young people</td>
<td>2</td>
</tr>
<tr>
<td>Off-gas</td>
<td>1</td>
</tr>
<tr>
<td>Homes with damp &amp; mould</td>
<td>1</td>
</tr>
<tr>
<td>People in emergency accommodation</td>
<td>1</td>
</tr>
</tbody>
</table>

Most schemes target based on a combination of factors. Typically, this was a combination of health and income factors. Some health-focused schemes used a combination of health and tenure. Energy efficiency schemes, particularly those drawing in external funding, tended to use income and tenure for targeting.

### 8.5.2 Health

The links between cold, damp homes and certain health conditions are well-evidenced. Some schemes focus on very specific health conditions but the majority had broader parameters. This was often expressed as ”any health condition made worse by living in a cold or damp home”. Section 8.6 below looks in more detail at how schemes are targeted based on health.

A small number of schemes emphasised the importance of mental health as a factor in targeting households for support. This is an emerging trend, which presents opportunities for improving mental health but also provides challenges in offering support services to people with complex needs, and in understanding how best to monitor outcomes.

### 8.5.3 Age

Age is often used as a proxy for health condition: older people are more likely to suffer from conditions which make them more vulnerable to cold and have always accounted for the majority of excess winter deaths. Age is also, in theory at least, relatively easily measured and verified.

More and more schemes, however, are starting to consider fuel poverty as an issue affecting all ages and influenced more by health and income than by age itself. This can be seen by the 24 schemes which actively target young families and the 21 schemes targeting pregnant women.

The merit of this shift in terms of need does seem to be borne out by ONS figures\(^{16}\) which show a shift in wealth from younger to older generations. Although it is still the case that those under 65 are better off than those over 65, this does seem to be changing. ONS figures show the over 65s went from having 29% of total household wealth in 2006-08 to having 35% in 2012-14 - the latest years covered by the data. Given the rising costs of housing and education for younger generations, this trend seems likely to continue for the short-medium term and may therefore have implications for scheme targeting.

### 8.5.4 Income

Low incomes are usually (but not always) a contributing factor to fuel poverty, and local authorities in particular are used to targeting based on proxies for low income, such as receipt of certain

\(^{16}\) Based upon an ONS breakdown of total wealth by age band of the Household Reference Person - [https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/adhocs/006054breakdownoftotalwealthbyagebandjuly2006tojune2014](https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/adhocs/006054breakdownoftotalwealthbyagebandjuly2006tojune2014)
benefits. These have also been commonly used criteria for national and energy company grant schemes.

However, some scheme managers reported that there has been an increase in working adults who are on low incomes but not on benefits, and that these groups may fall outside standard eligibility criteria based on benefits.

8.5.5 Tenure

Schemes often target specific services based on housing tenure; this is usually the case for grants, whether provided by a local authority or another funder such as energy companies offering ECO. Local authority grants are generally targeted at improvements in the private sector, with both the owner occupier and private rented sector being targeted in different situations.

Other services (eg, advice, referrals for Warm Home Discount, switching) are not generally targeted based on tenure.

8.5.6 Requirements of the funder

Some of the schemes in the research had been specifically set up in the past year to deliver a grant-funded project. For these, their objectives and criteria were almost totally driven by the requirements of funders (though there would be some alignment with local priorities). These criteria might relate to health, age, income or tenure.

The research showed the influence of funders in the availability of services to residents in different tenures. More schemes targeted owner occupiers and the private rented sector for energy efficiency measures, in large part because of the availability of ECO funding in those tenures. Social housing tenants were targeted by fewer schemes and generally could not take advantage of grant funding.

8.5.7 Fuel poverty

Some criteria were not used by schemes in this research, and it is interesting to acknowledge these:

There was no evidence of schemes in England targeting based on the Low Income High Costs definition of fuel poverty. Similarly, respondents from Wales and Scotland were not using the 10% definition to target their services. Rather, schemes were targeted based on more easily assessed aspects of a household which might make fuel poverty more likely, such as age or income. Some schemes used the Low Income High Costs approach retrospectively to calculate whether people they had helped had been in fuel poverty.

The Low Income High Costs approach to assessing fuel poverty was seen by many as too time-consuming, requiring too many data sets from a household. Some scheme managers highlighted specific cases where individual households who were struggling on a daily basis were technically not in fuel poverty but were still in need of support. Proxy indicators, though an imperfect match, are a very practical shorthand for scheme managers.

The other implication of not assessing fuel poverty up front is that it is then hard to evaluate the impact that schemes have had on fuel poverty. Targeting based on proxies was likely to lead schemes to evaluate based on those proxies, for example, targeting low income households leads to evaluation based on income improvement or savings on energy bills.

8.5.8 Property type

At the time of the research, scheme managers were not generally targeting based on property type, for example, house or flat. There was some targeting based on the property’s energy-related characteristics, for example, near-grid properties for connection to the gas network, but not on a
home’s energy rating (A – G). Targeting based on property type is generally closely aligned with the availability of funding for specific measures and has been a characteristic of area-based, measures schemes in the past.

8.5.9 Geography

In addition, schemes were not targeting smaller areas than local authorities (eg, neighbourhoods, estates, LSOAs). In part, this is a function of scale – larger, broader schemes tended to cover whole local authority areas; smaller, more focused schemes tended to focus on the specific needs of the individual resident. Area-based approaches were extremely widespread under earlier funding programmes focused on replicable measures such as loft and cavity wall insulation.

The implication is that the remaining unfilled lofts and cavities are pepper-potted around a neighbourhood so a street-by-street or blanket area-based approach based on these measures may be less cost-effective.

8.5.10 Flexibility and discretion

Some scheme managers reported that they had flexibility within their criteria and that they gave their advisors some discretion over who they could support. Schemes were generally able to offer a tiered service where people in need would receive advice or signposting but where grants were limited to specific eligible groups.

Schemes would target residents within a broad group; work to prioritise residents in greatest need was then done by the people working on the front-line. Over time, this can lead to changes in a scheme – one interviewee noted they had adjusted their scheme criteria because they had been concerned that people were buying homes which had inefficient boilers and then trying to secure grant support towards the cost of a replacement, when they weren’t in genuine need.

Another scheme manager noted that flexibility and discretion were encouraged through their referral network:

“[The scheme] is open to any vulnerable resident in [the borough], regardless of housing tenure. [The Council] did not set a specific eligibility criteria around age, disability or circumstance but gave guidance as to what kinds of social groups (including age groups) might be most important. These groups are: people aged over 70; people with long-term health conditions, in particular people with cardiovascular and respiratory illnesses; low income families with children under the age of five. [The Council] wanted to keep the criteria flexible and allow the referrer to use their discretion and decide if someone was suitable for the scheme or not.”

At the time of writing, BEIS have not published final guidance on how targeting may be carried out under ECO flexible eligibility. Flexibility for local authorities has to date meant a relaxing of criteria, to enable more vulnerable households, those at the margins of fuel poverty or those facing a short-term crisis, to be included in a scheme.

17 It will be interesting to see if the introduction of minimum energy efficiency standards in the private rented sector will have an impact on fuel poverty scheme targeting in future.
8.6 Targeting by health condition

**Key findings:**

- Most schemes targeted based on health conditions; the eligible conditions were usually determined by the scheme’s own definition, although some schemes were using the NICE guidance or working with local Health and Wellbeing Boards or colleagues in Public Health to set priorities.
- An increasing number of schemes are including mental health as a condition when targeting their support services.

Around 80% of the scheme providers who responded in the survey (29/36) said that they targeted residents based on health conditions. We asked how they had identified which health conditions to target.

Just under half of the schemes targeting on health (11/25 respondents to this question) selected conditions based on their own definition, usually derived from the experience and insight of the scheme manager. This was usually expressed in language such as “health conditions that are made worse by living in a cold home”. These schemes did not report any other input into how they selected health conditions.

“We’ve kept the conditions broad as we do not have the medical training to decide on which we should target. We assume that if someone has a long-term significant illness, then they will benefit from being in the warm/dry. By "significant", we mean to discount things like skin conditions.”

The remaining schemes that targeted based on health condition (13/25) used specific guidance, either to develop or support their planned approach (the numbers of schemes using each approach is shown in brackets):

- NICE guidance (4)
- Based on discussions with local Public Health or the Health and Wellbeing Board (4)
- Based on the requirements of a funder (3)
- Royal College of General Practitioners (2)
- Joint Strategic Needs Assessment (2)
- Cold Weather Plan (1)
- Eligibility for flu jab (1)
- Local teams working on that issue (1)
- Referring to criteria used in other authorities’ schemes (1)
- Public Health England (1)

We asked schemes which conditions they chose to target. Only one scheme specifically focused on one condition (a dedicated COPD scheme). Others targeted a range of conditions:

<table>
<thead>
<tr>
<th>Health condition</th>
<th>Number of schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory conditions</td>
<td>21</td>
</tr>
<tr>
<td>Asthma</td>
<td>20</td>
</tr>
</tbody>
</table>
The table suggests that the link between respiratory and cardiovascular conditions and living in a cold home is well understood by scheme developers and managers. This understanding is important given the fact some scheme designers noted they did not receive input from the health sector in developing their targeting approach.

Beyond that, the specific elements identified reflect a mixture of longer-term or chronic health conditions which can be exacerbated by living in a cold home and issues – such as mobility or falls – which tend to be linked to age and the wider eligibility criteria that people use to bring people in to the scheme.

17 schemes identified mental health issues as part of their targeting. This suggests that the wider, non-physical impacts of cold homes are also understood. One interviewee commented on the effectiveness of working with mental health services:

“[We work with the] local mental health service. They understand if they can alleviate fuel debt, they will be eliminating a stressor and can see changes in how their client is doing. They make a lot of referrals and are looking at the benefits directly. [It is] more difficult with hospital based NHS officers because they just see the patient in front of them and don’t necessarily equate [them] to the home environment and what their situation is.”
8.7 Services

**Key findings:**

- Schemes are able to offer a wide range of services. Three quarters of the schemes in this research offered more than 8 services.
- A large majority of schemes were offering home visits, despite often having low staff resources
- Many schemes offer “easy measures”, such as radiator panels or draught excluders. These can help bring quick wins across different tenures.
- About two thirds of schemes were offering funding towards larger energy efficiency measures (whether externally funded or from the providers’ own funds). Smaller numbers of schemes offered funding for other services such as loft clearance or would make contributions to householders’ bills.
- There is a slight trend for schemes with more staff to offer more services, but even schemes with limited resources are able to offer a broad suite of services to local residents
- Schemes seeking fewer than 200 referrals tended to offer more limited services. Above 200 referrals, schemes typically offered 13-15 services.
- Most schemes have some element of “tiered” service, with different offers available based on different eligibility criteria
- Where services cannot be provided directly by the scheme, managers have become adept at leveraging them in from other partners, for example, the local voluntary sector
- Schemes are spending more time with residents, particularly those with complex needs. A “casework” approach is becoming more common among schemes with higher levels of staffing.

37 schemes provided information about the mix of services that they provide.

There are a variety of different types of service provided which cluster into the following areas:

- Energy efficiency advice and support
- ‘Easy’ measures – such as radiator panels or Warm Packs
- Direct funding for larger energy efficiency measures – typically heating and insulation
- Direct funding for other activities
- Signposting and referrals to other support
  - Health and wellbeing
  - Energy efficiency
  - Income maximisation – e.g. benefits check
  - Debt advice

**8.7.1 Energy efficiency advice and support**

The most common element of the support provided was home visits to offer information on energy efficiency, with 33 of 37 schemes offering this support (28 schemes said that they offered a telephone helpline, although all have some way for residents to make contact by phone). The home
visits typically cover behavioural aspects of home energy efficiency: ‘myth-busting’ various aspects of energy efficiency; helping people use their homes in as efficient a way as possible; adjusting boiler settings, for instance.

The second most common service offered by schemes is signposting people to other sources of funding for energy efficiency works. This seems to be a reflection of the fact many schemes had no direct funding of their own, or were trying to leverage in external funding so that their own funding could be better targeted or blended to the needs of target householders. 26 schemes were able to offer funding directly. The fact that 24 of the 26 schemes providing direct funding are also signposting people to other sources of funding suggests that the level and type of direct support provided isn’t sufficient to meet the needs of those that they are working with – either because measures aren’t fully funded or because there are a wider range of measures which the home and householder could benefit from.

30 schemes offered help with switching tariffs or suppliers as part of their service. This is interesting as it suggests that health-related fuel poverty schemes are still addressing income-related issues (rather than purely focusing on services which will lead to improved physical health outcomes).

8.7.2 ‘Easy measures’

27 of the 37 schemes provide low-cost energy efficiency measures, typically letter-box draught excluders, radiator panels and energy efficient lightbulbs. Each individual element won’t necessarily have much of an effect on fuel poverty, health and well-being or carbon emissions but these measures do provide a way for schemes to try and engage with the building and the resident in a way that is cheaper than larger measures.

This offer may well come from pragmatic grounds: beyond the fact these measures are cheap in a sector that has limited access to funding for larger measures, they are also a way of having an offer that works for all tenures. Getting permission for larger measures from landlords, whether private or social, can be complicated and time consuming, whereas these smaller measures typically do not require permission and can be relatively easily installed.

21 schemes provide Warm Packs, containing items such as gloves, scarves or thermos flasks. This is probably a legacy from the Department of Health Warm Homes Healthy People programme and the Cold Weather Plan, which supported “everyday” interventions to improve people’s ability to keep warm.

21 schemes provide emergency heating. 5 of these had no direct grant funding for energy efficiency measures (i.e. new boilers), meaning that residents may be provided with a temporary heating solution but have to wait for third party funding to become available to them before longer-term improvements can be made.

8.7.3 Larger energy efficiency measures

26 schemes offer direct funding for energy efficiency measures. This could be full or partial funding. Measures included heating system installations or replacement and insulation. Direct funding from local authorities tended to be geared more towards heating upgrades / installations, with schemes looking to bring in ECO funding for insulation measures.

In some instances, schemes would offer the larger measures but these were not available to all residents.

One scheme provider noted that:

“For many vulnerable people, the thought of more intrusive measures can be off-putting. They are not interested in contemplating larger measures, despite the longer-term benefits.”
Even measures like loft or cavity wall insulation, which typically take less than a day to install, can seem too much for some people. The perception of mess and disruption can be enough to turn some people off and smaller measures are therefore easier and more appealing in comparison.”

8.7.4 Direct funding

Some schemes were able to provide other types of directly funded support to residents. This could be in the form of:

- Direct funding for other services, such as loft clearance (9)
- A direct contribution towards energy bills (7)

8.7.5 Signposting and referrals to other support

Signposting is a core part of most schemes, with 27 schemes providing signposting or more time-intensive referrals to home safety support, 26 to debt advice and 25 to health services. These services link in with the different aspects of health and well-being that schemes are offering, showing that schemes are trying to focus on offering a holistic service.

24 of the 27 schemes providing direct funding (whether for measures, other services or towards bills) are also signposting people to other sources of funding. This suggests that the level and type of direct support provided are not sufficient to meet the needs of all clients. Schemes are remaining flexible to leveraging in external funding. This might be to help target the provider’s own budget on residents who are in greatest need, or those who fall through gaps in eligibility in third party schemes, or to help the householder access a wider range of measures than the scheme can directly support.

Examples of further signposting offered by schemes included:

- Energy efficiency/fuel poverty
  - Support dealing with energy companies and individual debt issues
  - Securing the Warm Homes Discount
  - Winter Fuel Payment

- Home improvements
  - Home adaptations
  - Handyperson service

- Safety
  - Carbon monoxide alarms
  - Smoke alarms
  - Slips, trips and falls surveys and advice

- Health & well-being
  - Smoking cessation
  - Alcohol support
  - Befriending service
8.7.6 Variety of support offered

We were interested not just in the types of services that fuel poverty referral schemes were offering, but also in the variety of interventions provided. The table below sets out the spread in the number of services offered by schemes:

<table>
<thead>
<tr>
<th>Number of services offered</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of schemes</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

There is quite a wide spread of services offered, from a scheme which was set up with a very narrow criteria and just offers new boilers, to a scheme offering 21 different services.

The average number of services provided by these schemes was 10. Three quarters of the schemes in our survey offered at least 8 different services.

We were then interested in the relationship between the number of services provided and the number of staff working on each scheme. We wanted to see if there was a correlation between staffing levels and the range of offers available to residents. The chart below shows the distribution of services by staffing. Schemes indicated in blue cover one local authority area; schemes in yellow cover multiple areas. A further distinction is shown in the shape of the markers – round markers indicate directly managed schemes, whereas triangular markers are for schemes where services are outsourced or commissioned from other providers.

There is a slight trend for schemes with more staff to offer more services, but it is not a particularly strong correlation. We will look at staffing and resourcing in more detail in section 8.11, but it is clear from the above that many scheme managers are able to offer a great deal of support to local residents with limited resources.

We were also interested in whether schemes which received more referrals were offering more services than those receiving fewer referrals. Again, yellow bars are multi-area schemes; triangles
indicate schemes which are largely outsourced. And again, there is no strong correlation between these two factors. Smaller schemes do tend to offer fewer services but once schemes exceed approximately 200 referrals per annum, they offer a fairly consistent number of services (13-15).

As mentioned previously, schemes did not offer all services to all residents. Those who were offering grant funding tended to limit access to that funding to certain groups (usually based on a combination of tenure and health or income characteristics). One scheme manager described the stratification of services as follows:

“We offer a range of different services and different services are available to different people. Support from our two caseworkers and advice through our outreach events and helpline are available to anyone living in [the two counties]. Home visits are available for owner occupiers and private tenants with a respiratory illness or cardiovascular disease. Grants for capital improvements are only available for owner occupiers with a cardiovascular disease or respiratory illness.”

This tiered approach to services means that schemes can fit to the eligibility criteria of different funders, for example, but still offer a basic level of service to all. The manager of an externally funded, one year heating programme said:

“It’s a one year scheme that started in April and runs until the end of December. However, the energy team still exists outside of this time and will offer some of the services.”

Flexibility for scheme managers may act to the benefit of the resident but can cause confusion for referral partners who may want more clarity on what is available for whom. We will explore the views of some referral partner organisations in section 8.14 below.

8.7.7 Rationale for services provided

The most common rationale cited by respondents is that they are trying to address a need identified by or for residents. One survey respondent noted that they have increased the range of services over time as they’ve been able to make more connections with different services but this tends to be where there is felt to be a benefit, rather than simply making a scheme broader for the sake of it.
The level of funding will dictate the types of measures that can be offered and/or the number of people who can be supported by a grant.

Schemes that offer signposting often work in a ‘you scratch my back, I scratch yours’ kind of way. Organisations provide referrals in to fuel poverty schemes and also get referrals from the scheme into their services. This is common for services like befriending or for home safety referrals, for example, to the Fire Service.

In a number of instances, the support that is offered is a result of previous knowledge and links. One interviewee said:

“As a large partnership bid, it was a joint job to identify [services]. We drew on experience of previous projects that had been run in this type of sector and what does or doesn’t work. A variety of different groups were also delivery partners.”

Another talked about the evolution of services over time:

“The scheme has evolved. We’ve provided a basic scheme throughout, looking at fuel poverty and its impacts, telling agencies about it - getting referrals but then we’ll do the assessment of what’s available to the resident. We have two case workers who get to know the (funding) landscape and get the best thing they can for residents. It’s not always as quick as we would like, it can take 3, 6, 9 months to get works done.”

8.7.8 Scheme variation

In addition to the variation between schemes in terms of the services offered, there were also variations between schemes in terms of the level of support provided by each scheme and the follow-up support provided to the resident.

The funding available for energy measures is a significant factor which impacts upon the effectiveness of schemes in addressing some of the energy-related issues relating to health, fuel poverty and carbon emissions. One interviewee who manages a variety of local authority schemes described one which covered two boroughs, with streets on one side of the boundary having some of the most generous funding for energy efficiency measures in any scheme they’ve worked on, whereas the other side of the boundary received nothing at all.

A further difference between schemes is in the amount of time spent with residents. These differences can arise as variations between the types of support being offered, with some residents receiving in-home visits and others receiving advice from a telephone support service, as well as the duration and depth of the home visits.

The other key difference in the schemes is the amount of support that is provided by the coordinators. In many schemes, the resident is referred in and then, typically following a home visit or telephone call, gets referred on to other aspects of the support package. They are then contacted by the organisations who have received these onward referrals to arrange or provide further support. In a few schemes, more ongoing support is offered and the resident effectively remains with the scheme managers to oversee the delivery of support and works. One scheme manager noted:

“Many of our clients have severe mental health, drug and addiction issues; they live ‘chaotic’ lives and we offer a service that takes this into account and is tolerant of any behaviour.”

Another scheme has put a schedule in place to reduce variation as far as possible:

“Clients are supported clearly from start to finish. This has been helped by following a 21-day rule (clients contacted following a referral within 7 working days; support put in place within
21 days). All partners in the project work to this timescale and it is beneficial to the service user.”

8.8 Referral networks

Key findings:

- There appear to be 4 main models of referral network based on the main source of referrals received: public sector led; health led; charity and voluntary sector led; or from individuals.
- That said, no two referral networks look the same!
- Setting up referral networks seems to be the most time-intensive element of developing a scheme.
- Stop-start conditions jeopardise the ability of scheme providers to sustain relationships with referral partners and have a negative impact on trust in the scheme.
- Success in engaging referral partners comes from a number of factors: alignment of goals; building relationships over time; the amount of time that the referrer spends with the resident particularly at home; and aligning with key moments in a resident’s lifetime (for example, discharge from hospital).
- Good relationships are still largely about individuals more than organisations.
- Different parts of the health sector can be difficult to engage. Schemes had almost universally found it difficult to engage GPs, yet could identify other teams who were now generating good numbers of referrals (for example, occupational health, mental health, respiratory clinics).
- Larger energy efficiency led schemes tended to place more emphasis on self-referrals and general marketing rather than network engagement.

Respondents were asked to provide information on both the source of their referrals and also the number of referrals they get from these sources.

Most of the schemes in the research received referrals from a range of different organisations and sectors. There was no “standard pattern” for referral routes and rates. However, some broad trends did emerge.

In almost all cases, schemes were receiving referrals from a combination of the local authority and voluntary sectors. Schemes were generally less likely to receive referrals from the health sector. Scheme managers said that they found it easier to engage with the voluntary sector and within a local authority; they found the health sector more difficult to navigate, although many could identify specific teams or areas within the health sector where they had had some success in generating referrals.

Schemes tended to fall into one of four main models in terms of where their referrals came from. These are described below and illustrated by Wordclouds.

8.8.1 Local authority led networks

In this model, which is usually directly delivered by a local authority, referrals predominantly come from within that local authority.

This is illustrated by the Wordcloud below. The size of each word indicates the number of referrals that group provides, with the larger words providing the most referrals.

This scheme depicted below aims to ensure that all clients are able to achieve affordable, effective heating and electricity use so is focused on the provision of energy efficiency advice and measures.
Its target audience is “vulnerable households”, which could relate to physical or mental health vulnerability or to income vulnerability. The scheme is delivered by the local authority in partnership with a local energy advice agency.

In schemes which predominantly generate referrals from the local authority sector, Adult Social Care generally provides the highest number of referrals. Other sources also contribute referrals, typically a blend of:

- Housing
- Environmental Health
- Benefits
- Home Improvement Agency/Handyperson
- Councillors
- Children’s Services
- Children’s Centres

There were some benefits to working with local authority teams:

- They were seen as having a holistic approach to helping those who are most vulnerable.
- They were often delivering related services, so could see an alignment between the fuel poverty scheme and their own work; this was particularly the case with housing and environmental health teams who were not only working on related issues but also spent time in the resident’s home so could see the reality of issues of cold and damp for themselves.
- One third sector scheme manager said that it had been relatively easy to engage with local authorities, because the scheme meets their fuel poverty agendas.

Local authorities presented a number of challenges to securing referrals, however. One interviewee felt that, given the large size of local authorities, it can take a while for different parts of the organisation to find out about the scheme and then generate referrals in. That said, some of the longest-running schemes had been able to make fuel poverty referrals part of business-as-usual, for example, by embedding the issue into training received by other teams. Again, having time and continuity of service helps to build relationships to this level.
8.8.2 Charity and voluntary sector led networks

The charity and voluntary sector led approach to generating referrals is the second model.

The scheme which generated the Wordcloud below offers home visits to residents who are older, have a disability or have a long term health condition. The home visits identify ways of tackling fuel poverty and minimising the effect of cold homes on health with a particular emphasis on signposting and making onward referrals. The scheme is coordinated by a local authority, with the visits provided by an external third party.

The voluntary sector was seen as a valuable referral route by many scheme managers. The alignment of goals and the shared idea of working in the best interest of the client meant that there was common ground. In addition, charities often had ongoing relationships with residents, which included home visits, so they had a good understanding of resident need which just required a complementary understanding of the existence of the scheme.

Scheme providers felt that charities were best able to provide referrals when they already had processes in place to make referrals into multiple different schemes (across different topics). It was then easy for the charity to add in new referral opportunities as and when they appeared.

The focus of the charitable organisation seems to be less important to generating relevant referrals, subject to them having a clear understanding of the eligibility criteria.

Some groups, such as faith-based organisations and BAME groups, appear to provide fewer referrals into schemes than other third sector organisations (survey respondents were able to select faith based organisations and BAME groups separately from charities in defining the sources of their referrals. Only one scheme said that they received a high number of referrals from faith groups or BAME groups; this scheme operates in a very diverse urban area and has been running for 16 years, so has set up a very strong network of referral relationships. Greater engagement with BAME and faith groups could bring more referrals in to other schemes.

Environmental charities were felt to be helpful when the focus was on renewables or carbon reductions, or if the scheme was taking an area based approach to energy efficiency. However, in health-related fuel poverty schemes, they were felt to be less effective at generating referrals in. This is likely to relate to the issue of goal alignment.

8.8.3 Health sector led networks
Feedback about working with the health sector was mixed. Some schemes have productive relationships with parts of the health sector, including one scheme that is predicated solely upon referrals from the NHS. However, the majority found it difficult to engage with the health sector, reporting that the amount of time that went in to trying to generate engagement and referrals was not matched by the amount of referral received.

The scheme shown below is based on gathering referrals from health and social care professionals in order to support people with respiratory or cardiovascular conditions. It is a new scheme and its experiences are perhaps a useful illustration of some of the challenges of engaging different parts of the health sector.

“We have had the least positive response from GPs, as they often say they are too busy to make referrals and some don’t consider it NHS work. Although most of our referrals have come from GPs, this is largely due to GPs verifying self-referrals rather than making proactive referrals themselves.”

The vast majority of survey respondents said that they had attempted to engage GPs; this may be because GPs are seen as the frontline practitioners working with local residents across a wide range of health issues. However, all schemes had found it difficult to engage GPs. Various reasons were given for this, particularly:

- GPs’ lack of time to engage with a scheme amidst already busy schedules
- The fragmentation of GP surgeries, meaning that they had to be engaged individually rather than as a group
- The short amount of time that GPs are able to spend with each patient, making it difficult to ask detailed diagnostic questions about the home environment
- The lack of alignment between some fuel poverty issues (eg, income) and the interactions that GPs have with their patients
- The way different areas’ CCGs and GP surgeries are arranged. Scheme managers reported that there was no clear role that has responsibility for these issues and that it can be difficult to find a specific person to contact.

As one scheme manager explained:
“GP surgeries [were most difficult to engage], despite the high number of referrals reported from this route. These referrals were mainly received in the first year of the programme as a result of extremely intensive briefing and support, which could at times be difficult. All surgeries are effectively small businesses run along very tight financial lines and with very little spare capacity to engage with this or preventative programme.”

Where GPs had engaged with a scheme, it was often because they were signing letters or forms to verify health conditions; there was often a charge for this, which some scheme providers found frustrating.

In another case, one scheme achieved good engagement from GPs because of their having a link in to a specific person with the right remit, someone who was on the board of the charity delivering the fuel poverty scheme and who also worked in a GP surgery. The same scheme manager said that they also invested significant time translating their materials into “NHS language”.

Importantly, many in the sector – including stakeholders in our workshop discussion – felt that there was a tendency to become obsessed with GPs, and that a broader perspective on the health sector could lead to higher numbers of referrals.

Where people have been able to generate significant referrals from the health sector, this has been because of good working relationships, finding services where they can make a clear link and where the health professionals work with patients on a broad range of related issues.

Clear links or aligned objectives are important. It seems that the more a health professional is focused upon treating immediate symptoms, the less likely they are to provide referrals in to a scheme. One interviewee said they had tried to engage with teams responsible for admitting people to hospital but hadn’t had any success; however they had been able to get involvement from teams responsible for discharging people from hospital. The less time-pressured context helped, as did the fact these practitioners were responsible for ensuring that residents were going back to a suitable home environment.

Occupational Health also seems to be an area where schemes have had better results in generating input; reflect the fact that their role is to look at the person’s health in a broader way. Occupational therapists were reported as providing a good level of referrals into a large number of schemes. There was no negative feedback in relation to the ease of getting occupational therapists involved.

Two interviewees had very successful input from mental health teams because they could see the difference that the scheme made to the wellbeing of the residents they were working with. Respiratory teams were also regarded as making effective referrals, because of the clear crossover between their work and the support offered by the scheme.

By contrast, in spite of their ongoing engagement with residents, midwives and district nurses were not found to be a very consistent source of referrals.

The following quote comes from a scheme manager and is provided in full as it provides a useful summary of the challenges faced by schemes in engaging the health sector:

“Significant resource [is] needed behind this, which we did factor in, but even this has had limited return and results. It is mainly because primary and secondary care is not yet integrated to a great extent with the voluntary sector, nor with local authorities and Public Health. CCGs are difficult to engage and pin down, alongside GPs and practice managers, who simply do not have the time or capacity to promote your project and its referral route. We made this as easy as possible and as un-time-consuming as possible, but still faced issues. Nurses were easier to engage with, and once the right contact was found within a hospital, it became easier to get info out to wards and sisters. It is important to have
appropriate literature for healthcare professionals and a targeted marketing approach. It is also important to use different language when communicating with the health sector, and to ensure that you have a clear and focused product to offer them.”

Note: The research project itself mirrored the situation faced by many local schemes in struggling to get health sector engagement. We were unable to find someone in the Department of Health who has responsibility for fuel poverty. We found it difficult to navigate around the different parts of the NHS; it was unclear where responsibility ultimately lies for this subject. In addition, though keen, Public Health England were unable to attend our stakeholder workshop. We are looking at further ways to engage the sector to inform later versions of this report.

8.8.4 Individual led networks

The final model of referral network identified by the research is where individuals refer into the scheme. This can come from self-referrals or by carers, friends or neighbours.

The scheme depicted in the diagram below gets its highest rate of referrals directly from residents and from carers. Like many of the schemes in this group, it has been in place for a number of years, has a high level of staffing and has a broad focus on energy efficiency for all, rather than a particularly targeted focus. These schemes tend to prioritise scale first, gathering large numbers of referrals then filtering to see which services fit, rather than designing services and then going to seek out residents who meet criteria.

Not all schemes allow for individuals outside of organisations to provide referrals in and so the extent to which, where they are used, they provide a good level of input into schemes shows that they can be an effective means to spread the word.

Sometimes the emphasis on self-referrals or carers comes from a sense of fatigue about running a referral network:

“When we originally set up, it was referrals based. We went out to agencies. You speak to 20 people, 8 listen, 1 makes a referral. You spend a lot of time to get one referral so we realised we might as well go and speak to the public directly. In Year 1, we got maybe half a dozen people who made a lot of referrals, but they leave and the referrals stop - it’s a lot of effort for very little return. You have to keep going back.”

The connection to carers allows for some element of health-based referrals.
Word of mouth was mentioned as a very powerful source of referrals, across a wide range of schemes and locations.

### 8.8.5 Other sources of referrals

In addition to the sectors listed above, schemes also mentioned getting referrals from other sources:

- Fire service
- Registered Social Landlords
- Community Policing
- Local energy agencies
- Private healthcare providers
- Credit unions
- Job Centres

Housing organisations were seen as having similarly aligned goals. The Fire Service were also valued as they encountered some very severe cases of fuel poverty when visiting people’s homes for other purposes; they were also seen as “practicing what they preach” about partnership working.

### 8.8.6 Success factors

Some key success factors emerged for generating referrals, from any kind of organisation:

- **Alignment of goals** – referrals were more likely to come from people or organisations who were working towards the same, or related, aims, particularly where those aims were focused on the best outcome for an individual resident.

- **Building relationships over time** – most scheme managers said that the best referrals came from organisations with whom a relationship had been built over time. Again, this leads back to the issue of start / stop within schemes; if relationships have to be “rebuilt”, then it will take more time for the rate of referrals to increase. Relationships established over time are also likely to be more resilient to changes in what is on offer from the scheme.

- **Identifying key individuals** – at the early stages of a scheme, it was the ability to find key individuals which really helped to establish relationships between organisations. The challenge for many scheme managers was how to then sustain organisational relationships even if the individual job holders changed.

- **Identifying referral partners at key points in a process** – this was seen as valuable in engaging with the health sector, in particular. Discharge teams at hospitals have an interest in the home environment of the individual patient, as do occupational therapists. Midwives are working with future mothers, whose demand for heating and power are likely to increase once their child is born.

- **Relationship with the client** – referrals were more likely to be of better quality if the referrer was spending a good amount of time with the client, over a period, and ideally in the home.

- **Links in to existing processes** – where organisations are used to thinking about the support they can provide and to making referrals to other services, they tend to be more likely to make referrals. This means that scheme managers might need to dedicate more time to organisations that are not used to working in this way, to help build understanding and capacity.
- Clarity and simplicity of process – referrals were more likely if the referral process was simple and quick. For some referrers, this meant an online form; for others, the ability to simply email details in.

- Gaining trust – this was most effectively done by demonstrating positive outcomes for residents. To achieve this, schemes established strong feedback loops.

Where schemes were seeking self-referrals (that is, direct enquiries from residents), they identified a number of success factors:

- A flexible offer – so people who are not eligible for some services (such as funding) can still access others
- Identifying effective marketing channels - scheme managers had positive feedback about the number of clients engaged through flu jab clinics, at foodbanks, pharmacies, and word of mouth.

As noted above, schemes that were seeking self-referrals tended to be larger and more general in their offer.

### 8.9 Quality of referrals

#### Key findings:

- Good quality referrals are those where the resident is eligible and the process is quick and straightforward
- Referral partners need to trust that the scheme will be able to provide some element of support for their clients
- Good quality referrals tend to come from partners who are used to operating with referral systems, perhaps on other projects, and so have a familiarity with the process
- Schemes don’t tend to get many people dropping out, which increases cost-effectiveness

We wanted to try and understand what organisations consider to be a ‘good quality’ referral to see if there are any methods or processes which seem to be more effective. The focus of this investigation wasn’t on the extent to which the person being referred into the scheme is or isn’t in need, rather on the extent to which the referral is one that can be processed straightaway without recourse to the referrer for further information.

Organisations seemed to identify the common factors which generate a good quality referral as:

- Resident is:
  - Eligible; health need; knows what they are being referred to and why
  - Where the referrer trusts the scheme and thinks that it will help the resident

- Process:
  - The right information, with good supporting notes sent through
  - Straightforward and quick process, aligned with existing activities
  - Flexible mechanisms to send information through

- Provided by:
- Trained referrers, who are used to referral schemes
- People who make a higher number of referrals
- Where the referrer spends a good amount of time with the resident (particularly in the home)

In relation to drop outs, feedback seemed to be that drop-out rates overall were low. This helps to increase the cost-effectiveness of each referral because schemes do not have to spend time generating a higher level of referrals to ensure that they will be able to reach their target. That said, achieving a referral target does not necessarily equate to achieving the overall objectives of a scheme (see section 8.10 on monitoring below).

The low drop-out rate is also a further demonstration of the fact that the networks do seem to be able to find and engage people in the process. Scheme managers say that residents stay engaged with the process because:

- They meet eligibility criteria
- They have a clear need; they are often “desperate for help”
- There is no alternative source of funding
- The referral partner is trusted, so the scheme has credibility

A number of schemes which had experienced drop-out rates after referrals recognised that this often occurred among families with "chaotic lives". One scheme adjusted its method of providing support to be more on an ongoing, casework basis to ensure that they could continue to support residents throughout the process.

The other key reasons for drop-outs tend to be practical ones; sometimes people cannot be contacted, or there is upheaval or wider disruption related to energy efficiency works which deters people from going further. In some cases, the issue is one of a lack of consent for works, where the person who has been referred into the scheme doesn’t own the property.

### 8.10 Monitoring

<table>
<thead>
<tr>
<th>Key findings:</th>
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<tbody>
<tr>
<td>Schemes find it easier to monitor activity and outputs rather than outcomes</td>
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<tr>
<td>It was not clear if schemes were able to dig deeper into referral numbers to map these by tenure, age, income or health condition. Some schemes gave specific examples of how they did this, but most did not. So it remains unclear if schemes are monitoring the effectiveness of their targeting and referral networks, or simply just monitoring levels of activity.</td>
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<tr>
<td>Only 3 schemes directly measured whether a household had been taken out of fuel poverty. Most relied on financial proxies such as estimated savings on energy bills or increases in benefits received.</td>
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<tr>
<td>Health and wellbeing questionnaires were a common method of evaluation. Some schemes were issuing these both before and after interventions. A small number of schemes were looking at longer term evaluation of health outcomes.</td>
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<tr>
<td>4 schemes measured the carbon reductions associated with their services, although only 2 schemes had this as a formal objective</td>
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<tr>
<td>Monitoring is often foregone in a time of limited resources</td>
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Schemes measure their performance in a range of ways. All of the schemes which provided data used multiple methods to measure and report performance. Most used a combination of qualitative and quantitative measures, recognising that quantitative data was easier to access.

The majority of schemes track the number of referrals that they receive. Most combine this “output” measurement with some sort of “outcome” measurement, that is, what happened after the referral?

Only 2 schemes said that they specifically reported on numbers of referrals from people with specific health conditions.

Other general outputs that were measured were numbers of householders receiving advice (4 schemes), numbers of home visits (2 schemes) and numbers of households “helped” (3 schemes).

8.10.1 Fuel poverty

Only 3 schemes measure whether fuel poverty has been reduced / removed for households as a result of interventions.

Two schemes had tried to measure fuel poverty using the LIHC definition before and after any interventions. One of the schemes which had tried to measure fuel poverty beforehand using the LIHC definition had been discouraged:

“For the Central Heating Fund, we did an LIHC test. We found that we can’t predict who’s a Yes and who’s a No. Criteria become arbitrary – for example, if someone has a disability and takes a Motability vehicle, their income is lower because the value of the vehicle isn’t calculated as income. But if they can’t drive, and take the monetary value instead, that does count as income even though that person has higher costs as they have to take taxis - so you could fall out of LIHC.”

Most schemes tended to use proxy methods of measuring their impact on fuel poverty. Some were output driven, for example, number of interventions delivered (7 schemes). Others related to outcomes, for example, financial savings to residents (15 schemes). The widespread reporting of data on financial savings suggests that this is a common proxy for addressing fuel poverty.

8.10.2 Energy efficiency

There was a mix of output and outcome measurement for monitoring improvements in energy efficiency. 5 schemes said that they reported on the number of energy efficiency measures installed and one reported the costs of works. 2 schemes captured resident feedback on whether levels of warmth or comfort had been improved. One scheme tracked improvements in SAP ratings.

8.10.3 Health

14 schemes measured improvements in health and wellbeing by surveying participating residents. Some specified that they carried out before and after surveys. One scheme issues a second health and wellbeing survey at a later date, to track change over a longer period of time. 4 schemes said that they gathered feedback on wellbeing but did not specify how.

Some schemes were carrying out more formal measurement or evaluation of their activities. One is working with a University partner to carry out a full Health and Wellbeing evaluation; whilst two use the Housing Health Cost Calculator to assess the savings to the NHS and society delivered by their schemes. One noted that using the Housing Health Cost Calculator enabled them to demonstrate the value of their work and thus to secure ongoing funding.
Two further schemes were trying to establish routes by which they could get data from GPs about reductions in the numbers of visits made by residents. One of these was a specific "boilers on prescription" scheme whilst the other was a more general energy efficiency scheme.

One scheme captures data on the age of the beneficiary.

8.10.4 Carbon reductions

Despite only 2 schemes saying that they had carbon reduction objectives, 4 schemes said that they measure carbon savings resulting from their work. These schemes use calculations rather than doing their own testing to identify the pre- and post-intervention carbon emissions.

8.10.5 Other factors that are measured or reported

7 schemes said that they gathered feedback on client satisfaction with the process, usually through a formal questionnaire.

4 schemes said that they gathered insight for use in case studies. These could be used for external promotion or, in one case, for internal reporting purposes. One was looking to develop a video case study. One scheme was using the Most Significant Change methodology to collect stories of the impact of their work.

2 schemes said that they monitored on a geographical basis. One looked at the area of the city where households were being supported. The other looked at where their scheme was delivering in relation to Indices of Multiple Deprivation, health data and the likelihood of fuel poverty.

Other factors that were noted were:

- Number / range of partners in referral network (2 schemes)
- Funding levered in (1)
- Number of onward referrals made to other schemes (1)

8.10.6 Experiences of monitoring

Scheme managers in our research identified that it was easier to monitor some things than others. As mentioned above, outputs (i.e. levels of activity) are easier to measure. These might include:

- Numbers of referrals
- Funding levered in
- EPC ratings before and after measures
- Financial gains from income maximisation or switching.

Even here there are complexities.

- Schemes will measure numbers of referrals, but it is only by breaking them down further that they can assess whether targeting has been effective, for example, by geography, tenure, age or health condition. One scheme reported an objective that 95% of all referrals should meet the health criteria in the NICE guidance, but it was rare for schemes; a small number of schemes recorded geographical location to identify neighbourhoods from which referrals were being made.
- EPC ratings will generally only be measured before and after works if that is a requirement of the project as surveys have budget implications
- Financial gains can be calculated, but they are usually hypothetical / estimated rather than actual
Health improvements were seen as harder to measure, as they can take a long time to monitor robustly. That said, many schemes used before and after health questionnaires to gather residents’ views of their own health and to track improvements.

Mental health improvement is a new area of monitoring and evaluation for many scheme managers. Before and after health questionnaires were also being used to collect evidence on mental health, but it was not clear whether any guidance was being followed, for example, with regard to ways of asking questions.

Some scheme managers had developed systems for data management which would enable flexibility to changing services and funding opportunities:

“We collect about 85 pieces of data and then slice this up to meet the reporting requirements of different funders. This has evolved over time and we keep reviewing it. It’s now easy to adapt what we do to suit new funders, and we can also go out and look proactively for funding.”

There are some interesting examples of innovation taking place in fuel poverty referral scheme monitoring across the country:

- One scheme is using the “Most Significant Change” methodology. Researchers gather “stories” from project beneficiaries. These are then discussed by project stakeholders to select the most significant, capture project impact and identify the value of these changes. The methodology is quite structured (see link to guidance below), but is helpful for monitoring project impact on an ongoing basis, to identify opportunities for improvement or further roll-out of successful activities.
- Another scheme uses an evaluation form after any significant intervention to collect data on health, wellbeing, feedback on the process and outcomes. This creates a baseline which is then re-evaluated using a follow-up form to help the scheme monitor improvement (or deterioration) over time. As well as helping to inform service improvement, this data will feed into an overall evaluation identifying whether the scheme has achieved its objectives and desired outcomes.
- A further scheme is monitoring the change in use of NHS services. They have secured consent from residents to enable the scheme provider to access anonymised data using people’s NHS numbers. Data is provided centrally by the CCG.

8.11 Staffing

**Key findings:**

- Schemes are achieving a lot with limited resource, but they are often having to repeat the same activities (e.g., rebuilding relationships)
- There is a general lack of confidence about whether schemes can be sustained.
- More than half of schemes in the survey had less than 1 full-time equivalent (FTE). Most schemes have fewer than 2 FTE staff.
- Even with less than 1 FTE people are able to deliver schemes and make a real difference
- Schemes with more staff tend to be longer established, more focused on energy efficiency and very broad in terms of eligibility
- Smaller schemes may have broader and more active referral networks because they have less internal capacity for marketing activity
- Setting up referral networks is the most time-intensive part of scheme development
Most schemes have fewer than 2 full-time equivalent (FTE) staff to run them and 55% have less than 1 FTE.

Despite this, schemes are still able to reach a significant number of residents.

Although much of this report is about identifying processes and approaches to try and increase or enhance the success and cost-effectiveness of referral schemes, it is worth noting how much is already being accomplished by the individuals involved. All of the schemes we identified are providing some level of support to a significant number of people each year; much of this support is about joining up different services and smoothing processes, filling gaps and trying to provide as much help as possible to vulnerable residents. The creativity and determination of the people involved with fuel poverty referral schemes was a constant theme in this research.

Schemes with more staff tend to be longer established, to be more energy efficiency focused (rather than health) and to have very broad eligibility criteria. However, we have seen that low levels of staffing do not necessarily restrict the number of services that schemes are able to provide.

The research also suggests that there is no correlation between the number of staff and the number of referral routes that a schemes uses. Smaller schemes may actually use more referral routes because there is less officer time available for direct engagement with the public.

Rather, limits to the number of staff working on a scheme are more likely to restrict the number of referrals that a scheme seeks, as shown in the chart below. Again, yellow markers represent multi-area schemes, and triangular markers indicate schemes with an element of outsourced service provision:

Interview feedback suggests that setting up the networks and relationships is the most intensive part of the process.

“Initially setting up links and delivering training [took] 60% of the time. Today it is more like 10%.”
“[We are] starting to build up the capacity into the scheme. It’s taken a year to get up to the point where we think we are able to provide the level of referrals needed into the scheme.”

The stop / start impact of changes to funding regimes is potentially damaging to schemes. One interviewee who had been involved in a variety of similar schemes in the past described the process of restarting a scheme as “effectively starting from scratch” because they had to build or rebuild links. Another said:

“It’s a constant learning point that we get it up and working right and then have to close it down. Stop-start funding doesn’t help.”

When asked about things that schemes would do differently if they had more resources, a common theme was around doing more monitoring and evaluation. This seems to be something that falls by the wayside; one interviewee said they used to monitor the health impacts of the scheme after 6 months to assess the changes but this had stopped because of pressure on staff resources.

Being able to conduct technical monitoring was also cited as something individuals would like to do. At the moment, where there are calculations done on the impact of the measures this would be through the use of proxies or deemed scores for the impact on energy consumption, fuel bills or carbon emissions.

8.12 Costs

Key findings:

- 6 schemes had management costs over £100,000 per annum, whilst 11 schemes had management costs below £50,000 per annum
- Staffing costs account for the majority of internal costs
- Marketing budgets are typically around 3% of management costs
- Schemes which have been running for less than a year typically have a smaller budget than those that have been running for longer (5 years or more)
- Newer schemes also tend to have lower targets. So despite their lower overall costs, they may have a higher cost per customer than more established schemes. This suggests a need to allow time for schemes to mature, as costs per customer seem to come down over time.
- Our data set is too small to offer a “cost per customer” benchmark with any confidence. However, we would suggest that a range of £100 - £150 per customer seems typical from the schemes that have been included in our analysis. This is the cost of both acquiring and providing services to the customer.
- Costs per customer seem to vary significantly in the 200-400 referral range but become more settled once schemes are achieving 600+ referrals
- A higher budget for measures usually correlates to higher scheme management costs. This may be a factor of larger schemes being better able to bid for funding based on their existing delivery capacity.

We asked scheme managers to provide us with a cost breakdown for their schemes based on a set of categories:

- Internal staff costs (ie, officer time)
- External management costs (eg, the cost of employing a managing agent)
- Training / outreach costs
- Marketing costs
- Costs of direct provision of small measures, such as warm packs
- Grant funding provided directly by the scheme manager’s organisation
- Grant funding provided by third parties (eg, through ECO)

Data provided in response was limited; some schemes did not provide financial data, some said that they did not feel it was appropriate, for example, if data might reveal commercially confidential information. In other cases, it was unclear what assumptions were being used, for example, whether internal staff costs included overheads or benefits such as pension contributions.

We are cautious about the findings below, because of the small scale data set and because we have not been able to check the quality of the data provided. That said, we were keen to provide an initial set of data which could then be developed further, perhaps into more robust benchmarks.

### 8.12.1 Scheme costs, excluding costs of measures

The cost of measures (whether funded directly by the scheme provider or by a third party) can skew the overall costs of a scheme. We will look at the ratio of management costs to measures costs in a later section of this report. Here, however, we focus on the costs of managing a scheme, namely:

- Internal staff costs
- External management costs
- Training / outreach costs
- Marketing costs

We have good data from 22 schemes regarding these costs. The chart below shows the range of scheme costs among these schemes. Schemes shown in blue are single area, those in yellow are multi-area.

![Scheme costs, excluding any budget for measures](chart)

Costs ranged from £5,000 to £272,000 per annum, with average scheme management costs of £74,000. Staffing costs, whether internal or external, dominated most schemes’ financial profiles.

5 of the 22 schemes (schemes 4, 6, 8, 10 and 11 in the above chart) were based on predominantly outsourced models and, so, had higher external management costs than internal staff costs. The majority though were largely delivered by the scheme provider, so internal costs dominated.

Most schemes (17 out of 22) had no dedicated budget for training or outreach activities with their referral networks. Instead these activities were seen as embedded within the staffing costs of...
schemes. Of the 5 schemes that had a budget for training or outreach, most dedicated around 13% of their management budgets to these activities.

Marketing costs were on average 3.3% of management costs. 8 of the 22 schemes in this analysis had no marketing budget. Two schemes had marketing budgets of £10,000 (representing around 10% of their management costs). Generally, the smaller a scheme, the less likely it was to have a dedicated marketing budget. This was not always the case, however; two of the largest schemes in this analysis had zero marketing budget, relying wholly on “free” marketing channels such as their referral networks or word of mouth.

Marketing costs may be kept deliberately low to manage demand. One scheme manager said:

“[the scheme is] not marketed to the public due to limited funding.”

We will now look at how these costs compare in terms of staffing levels, numbers of referrals targeted and amount of funding for measures for each scheme.

8.12.2 Scheme costs compared to staffing levels

The charts below compares overall scheme costs to internal staffing levels, in terms of numbers of full time equivalents.

This first chart presents the schemes shown above, in descending order of costs, compared to their staff (in full time equivalents (FTE)). Those with a triangular marker are those with predominantly outsourced delivery approaches.

Generally there is a clear correlation between increased internal staffing and increased scheme costs. Note that schemes 4, 6, 8, 10 and 11 are those which have a higher element of outsourced activity, hence their number of FTE looks low compared to their costs.

The chart below presents this same data in a different format, to make clearer the trendline for increasing costs alongside increasing staff numbers:
8.12.3 Scheme costs compared to duration of scheme

Schemes which have been running for less than a year typically have a smaller budget than those that have been running for longer (5 years or more). This may be a factor of some of the older schemes being established during periods of higher public sector funding and through the period of the Department of Health’s Warm Homes Healthy People programme, thus enabling them to access and sustain a higher budget level.

Newer schemes also tend to have lower targets. So despite their lower overall costs, they may have a higher cost per customer than more established schemes. Recognising this trend can help to provide a pathway for schemes, allowing them to invest the time and resources required to build referral networks in Year 1 on the basis that their schemes may grow and improve their cost effectiveness over time. This also reinforces the damage that can be done by stop / start. The lowest cost per customer comes with the longest established schemes – they are able to gain traction and recognition which enables them to deliver cost effectively at scale.

8.12.4 Scheme costs per customer

The relative scale of schemes is better measured by considering how costs are spread across the number of customers supported each year.

We were interested in trying to find a cost per customer which could act as a benchmark for fuel poverty referral schemes. Unfortunately, our data set is too small to offer something with confidence here. However, we would suggest that a range of £100 - £150 per customer seems typical from the schemes that have been included in our analysis. Note that this is the cost of both acquiring the customer and supporting them with services, but that it excludes any grant funding.

The following chart shows the same schemes as above, again in descending order of costs, but this time identifying the cost per customer based on their target number of referrals. Here we can see significant variation.
8.12.5 Factors affecting the cost per customer

We then considered whether there were factors about schemes which would affect the cost per customer. We assessed three factors, which may have an effect:

- The services on offer – do schemes that offer home visits have a higher cost per customer?
- The budget available for measures
- The scale of the scheme – do schemes that support a larger number of customers have a lower management cost per customer?

**Services**

We were interested in whether the variation in scheme costs related to the services that schemes offered. All of the schemes shown in the chart above offer home visits, which we took as the most time intensive, and therefore costly, service to deliver. It is therefore not possible to assess whether scheme costs are lower if home visits are not offered.

**Budget for measures**

We then interrogated whether the variation in costs related to the type or value of funding for measures that schemes were administering. Where there is a budget for measures, this tends towards correlation with the costs of scheme management – so a higher measures budget corresponds to higher management costs. That said, there are some striking examples of schemes with high budgets for measures but relatively low management costs. Schemes 14, 16 and 19 on the chart below illustrate this point and we will go on to describe these schemes.
It should also be noted that the measures budget for scheme 13 is not shown on this chart. Scheme 13 has a measures budget in excess of £2 million which affects the scaling of the chart above.

Note, again, that Scheme 13 is not shown in this chart as its very high measures budget affects the scale of the chart.

**Examples of schemes with high measures budgets but relatively low management costs**

**Scheme 14**

This scheme has management costs of £41,000 and a direct grant fund for energy efficiency measures of £500,000.

The scheme is very focused on providing heating measures to vulnerable householders, offering a basic service level of home visits, grant funding and signposting. It is targeted at owner occupiers on
low incomes and with a health condition made worse by living in a cold or damp home. Most referrals come from carers or charities working with the same clients.

The management cost per customer for this scheme is £205.

**Scheme 16**

This scheme has management costs of £35,500 and a grant fund of approximately £260,000, from a combination of local authority and third party funds.

The scheme is coordinated by 1.4 FTE members of staff and received around 370 referrals per year. The scheme has a strong energy focus, providing heating and insulation measures to vulnerable householders, complemented by advice on switching and debt, and an emergency fund for contributions towards residents’ bills. Vulnerability could relate to age, income or physical or mental health. Most referrals come from other teams within the local authority, with some from charities and via word of mouth.

The scheme has a management cost per customer of £96.

**Scheme 19**

This scheme has management costs of £25,500 for the allocation of a third party grant fund of £183,000.

The scheme has 0.2 members of staff with some support from an external agency. It aims to provide heating installations for 140 low income households where a resident has a long term health condition; it also offers advice around energy, switching and debt. It generates most referrals from charities with whom the local authority has a long-standing relationship for winter preparedness and warmth projects.

The scheme has a management cost per customer of £182.

**Scale effects**

The size of a scheme – that is, the number of residents it supports each year – does have an effect on its cost per customer. This is shown by the trendline in the chart below.
new and the scheme manager reports feeling under-resourced, so perhaps the more appropriate level is the cluster at around £80 - £95 per customer. Each of these schemes has fewer than 1FTE; two are delivered directly by the local authority, one is in partnership with an external provider – this provider is fully funded by a third party so again scheme costs may be deceptive here.

The main driver of higher costs per customer among this group is staffing costs. Schemes with larger teams in the 200-400 referral range have higher costs per customer because of their higher staffing costs. As referral numbers go up, schemes with similar sized teams are achieving much lower costs per customer. The chart suggests that there is a “sweet spot” of around 600 referrals, where costs come down to a steadier level in the £100 - £150 per customer range.

8.13 Funding

<table>
<thead>
<tr>
<th>Key findings:</th>
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<tbody>
<tr>
<td>▪ Schemes were able to leverage in external funding for energy efficiency measures, but reported that the amount of funding had declined over time</td>
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<tr>
<td>▪ Many schemes were also able to offer grant funding from within their own organisations’ budgets</td>
</tr>
<tr>
<td>▪ Only 4 schemes had secured funding towards core costs such as staffing from external funders. So, whilst resource may be available for energy efficiency works, it can be hard for schemes to afford the extra staff and capacity required to coordinate these. Those organisations who already have staff in place may be better placed to bid for funding.</td>
</tr>
<tr>
<td>▪ The schemes in this study are reaching a significant number of householders but are only able to offer a limited number of energy efficiency measures. This means that schemes have to plan to “re-recruit” households into schemes at a point in the future when support for measures becomes available. It costs more to have to keep going back to households that it does to find them once.</td>
</tr>
<tr>
<td>▪ Carbon targets are more challenging and costly to meet as a result of the missed opportunities to insulate homes having identified people and homes in need</td>
</tr>
<tr>
<td>▪ Costs could be managed more efficiently across the public sector – failure to invest in preventive energy efficiency works means that there are greater costs to the health sector for treatment than there need to be</td>
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8.13.1 Direct funding

In relation to identifying the cost of their scheme to run, respondents were asked about direct funding from their own organisation and third party funding towards the cost of measures provided in their schemes.

We have already seen that 27 schemes were providing some sort of direct funding. 26 of these offered funding for / towards energy efficiency measures, 9 towards other services such as loft clearance and 7 as direct contributions to help people with their energy bills.

Direct funding for energy efficiency measures ranged from £12,000 to £2.3million. Excluding this large outlier (which was almost five times higher than the next largest project), the average amount of direct funding for measures across 15 schemes was £152,000.

External funding leveraged in for energy efficiency measures ranged from £5,000 to £500,000. Here the average across 10 schemes was £122,000. Several scheme managers noted that the amount of
external funding levered in had fallen significantly, due to the hiatus in ECO at the time of the research.

Funding is most commonly directed towards measures or services. It is less common for schemes to receive core funding from third parties. Only 4 schemes reported receiving contributions towards the cost of staffing from third party funders.

### 8.13.2 Impacts of funding on schemes

There is limited funding available for staff costs from third party funders, and headcount limitations among many local authorities. This means that those organisations who already have staff in place are better placed to be able to run scheme. This may then create a vicious or virtuous circle whereby those organisations with resources are better placed to bid for discretionary pots of funding which arise on an ad hoc basis, both because they have the resources to do so but also the track record to demonstrate they can deliver. Some schemes have overcome this issue by having the capacity to bid for funding but then an outsourcing or partnership arrangement for scheme delivery. As one scheme manager noted:

> “It’s a partnership approach - everyone bids for what they can and we all put it together. [The scheme] is about pulling together what we can to make it as straightforward as possible and provide one customer route into the service.”

Many scheme managers are frustrated by the variability in funding, but others have been able to navigate the system, even with limited staff resources. As part of this research project, we are also producing guidance for local authorities and others to help share ideas and practices which might strengthen different organisations’ capacity to bid for funding and to deliver schemes.

The schemes in this study are reaching a significant amount of householders, but only a limited amount of energy efficiency works are being carried out. Residents may receive support, for example income maximisation, but then have to be re-contacted for larger energy efficiency measures as the funding landscape shifts. This creates more work recruiting people into schemes, which can be particularly time-consuming if households are hard to reach.

It costs more to keep going back to homes in the longer term than to find them once. Given that much of the funding for measures is paid for by the household, whether directly through the installation of measures or indirectly through energy bills, this issue is serving to increase costs for them. The very householders whose circumstances mean that they are being targeted by a fuel poverty programme are having to contribute more to the delivery of future fuel poverty programmes because we are unable to provide measures in a timely and efficient fashion.

In addition to costs getting passed on to householders, they also seem to be getting passed around the public sector. Failing to resolve issues around health and fuel poverty at home means that residents are likely to place higher demands on the health services because of cold-related illnesses. Apart from one scheme in our study which receives funding from the CCG, there seems to be little support from the health sector to fund the cost of works, or indeed the cost of delivery more generally.
8.14 Referring organisations

<table>
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<tr>
<th>Key findings:</th>
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<tr>
<td>- Organisations that make referrals tend to have the interests of the resident as their priority</td>
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<td>- Organisations value a variety of services, particularly the provision of advice which creates agency for the resident</td>
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<tr>
<td>- Referral partners seemed to place a higher value on inputting into how the scheme works than on receiving feedback on specific referrals</td>
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<tr>
<td>- Building up trust in the schemes is crucial to getting longer-term engagement; loss of trust can lead to a referral channel drying up</td>
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<tr>
<td>- Online referral routes – whether an online form or email – were most popular among referring organisations</td>
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The sample for our questionnaire to referring organisations was small and, as such, it is difficult to draw firm conclusions or develop correlations between different factors. This was particularly the case in relation to the questions we asked about the cost of generating referrals in, even where organisations had been able to provide information on other aspects of the process.

All respondents had been providing referrals to local fuel poverty schemes for at least 3 years.

8.14.1 How they became involved

The majority of the organisations were contacted by the scheme managers or delivery agents who were looking to publicise their schemes. This contact either came directly through an approach from the scheme manager or indirectly through existing joint networks.

Only one organisation had investigated to see what was out there to support the people they are working with and had found that support existed.

This seems to reflect capacity issues within organisations and also links to earlier findings that generating and building the connections is the most time-intensive part of the process.

8.14.2 Feedback loops

When asked about the communication between themselves and the schemes, organisations reported that they felt valued, despite receiving little regular feedback.

There was very little sense of regular feedback on what has happened to referrals that they have sent through to schemes. However, increasing the feedback on referrals wasn’t raised by anyone as something that would encourage them to generate more referrals.

Nonetheless, referring organisations reported feeling that they felt valued and that the information they receive is sufficient.

Referring organisations need to have trust that a scheme will deliver for their client group. One interviewee said that their scheme had struggled to generate referrals from one partner after an initial wave of referrals had not been able to access the support that they had expected. This left the referrer feeling that they had let their clients down and unwilling to provide any further referrals.

For many organisations, they are able to get feedback on support that has been received from the resident themselves, so additional feedback does not seem to be a priority for them.
Most of the referring organisations who responded to the survey felt that they were able to feed in to the development and delivery of the scheme in some ways, which may contribute to their feeling less need to be kept up to date with the detail.

E-mail seems to be the most commonly used method of staying in touch.

**8.14.3 Valued aspects of scheme(s)**

The variety of support provided to residents is highly valued by referring organisations. The mixture of measures available is welcomed and the advice is also appreciated.

From an advice perspective, the combination of behavioural, financial and health advice was seen to be a positive thing. The behavioural advice and financial information were particularly cited as being of use; these aspects of the service align more directly with the focus of the referring organisations in the survey, reinforcing the earlier point that alignment of goals can be a powerful motivator for referral participants to be active in a scheme.

The impartiality advice is also welcomed, with one respondent saying:

> “There seem to be lots of agencies competing to do work on this issue in the borough with a lot of cross referrals and it is not always clear which ones are linked to individual energy providers. Our charity is keen not to be seen to be endorsing or recommending any specific products, particularly given the recent public controversies.”

The perception of reduced reputational risk when referring in to local authority led schemes is something that seems to be of value to other organisations.

The range of interventions offered, relative to the single piece of work they have to do to link people in with the support, may be a factor in welcoming the breadth of support.

Overall, the different aspects of the scheme mean that people feel more confident that the people they are referring in are going to get some kind of benefit from the scheme.

A consistent approach to fuel poverty across a borough is something which is appreciated by some of the referring organisations. This presumably makes it easier for them to refer people in because once they have identified someone is in need as a result of their personal circumstances, they do not then have to do a further check on whether they live in the ‘right’ geographical location.

**8.14.4 Referral process**

There is an element of subjectivity about whether people see the referral process as “quick”. Some referring organisations were happy to spend 20-30 minutes gathering information before spending 2-3 minutes completing an online referral form. Others, however felt that 5 minutes was too long and that they would like a quicker or easier process to make referrals. This wasn’t straightforward; one respondent said that they might choose to spend more time on providing referrals where it was a complex case and they wanted to ensure the organisation receiving the referral had the information needed to be able to support the person properly.

One respondent suggested allowing self-referrals to reduce the time they had to spend on this process and another said it would be helpful if there was more general publicity about the scheme so they didn’t have to spend as much time explaining it when putting the referral through.

Online referral routes – whether an online form or by email – were preferred by referral partners.

**8.14.5 Generating more referrals**
When asked what would help generate more referrals into schemes, the most common answer was around increased organisational capacity, rather than any changes within the scheme.

Funding seems to be the limiting factor in terms of capacity: from having staff or an office, to the limit of what can be provided to residents.

Funding pressures on referral organisations could have an impact in terms of the support they can offer and the extent to which they can provide referrals into schemes. Managing this risk is not easily within the remit of scheme managers. However, it does suggest that scheme managers should try and increase the range of partners they work with so as to future-proof their schemes should any one organisation be unable to provide referrals.

Continuity also seems to help generate more referrals. This was particularly expressed in terms of being able to get clarity on the services that are available to residents. This again links back to reducing the pressure on referring organisations; the more changes which are made to a scheme, the more time they have to invest in keeping up to date.
9. CONCLUSIONS

9.1 Setting up schemes v continuing schemes

*Continuity of schemes helps create stronger referral networks:* Evidence seems to suggest that the most intensive part of a fuel poverty referral scheme is setting up the referral network and that, whilst there is still some work involved in managing the network and keeping people updated on the scheme, this is still less time intensive than having to restart schemes from scratch and rebuild networks.

*Trust matters:* The benefits of continuing a scheme rather than starting afresh seem to be a reflection of the fact it can take time to build up trust in a scheme, so that people referring into it can see that the people they’ve referred through are genuinely going to be helped. Where referrals have been made and the person who went into the scheme did not receive the help that was anticipated, partners are less likely to provide subsequent referrals because they feel like they have let their client down. The stop-start nature of schemes also undermines trust because it creates an unreasonable pressure on the referring organisations to constantly be checking if a scheme still exists.

*Flexibility:* Networks seem to be flexible enough to adjust to changing parameters so it is better to provide general guidance on what services people might be able to get and then proceed from there. It can be more resource intensive to provide very detailed information which is constantly changing – for both the scheme provider seeking referrals and for those making the referrals.

*General guidance is enough:* Further, providing detailed information to referral partners means having to dedicate resource to keeping this information up to date. If referring organisations find that they have not been informed about changes to the detail of a scheme, then this can undermine trust. Referrals might be made for people who are not eligible for the detailed support that they were anticipating. Staying on top of scheme details is also time intensive for the referring organisation; given their own staffing constraint, this could mitigate against their involvement with the scheme. It is worth assessing the extent information will be helpful in getting appropriate referrals in before telling partners about detailed changes. The key factors to consider seem to be where the eligibility criteria are significantly changing in a way that means referrals are no longer going to be accepted; where the scheme is going to be finishing at an earlier date or where there is a substantial reduction in the service(s) provided.

9.2 Generating referrals

*4 approaches:* Broadly speaking there appear to be 4 models of how schemes attract referrals, albeit they also generate referrals from other sources too:

1. *Public sector led:* predominantly generating referrals from across local authorities, for example, from housing teams, environmental health, adult social care and – less frequently – children’s services.
2. *Health sector led:* in this approach, the health sector is the main source of referrals. In some instances, schemes have been able to build referral numbers solely upon this source. However, this is rare and most health-led schemes still rely on referrals from a wider range of sources.
3. *Charity & voluntary sector led:* the organisations which are best placed to provide these referrals seem to be those who are already set up to make referrals as they understand the process. Environmental charities were felt to be more appropriate if the scheme has carbon reduction or area-based objectives but tend to be less engaged with dedicated fuel poverty projects.
4. **Individuals:** schemes that allow people to self-refer, either directly or on behalf of friends, family or neighbours reported that it is a successful mechanism. Although there are risks in exploring this approach, it can be worth considering, particularly where the objectives are quite broad.

**How to identify referral organisations:** Certain key messages came through in terms of identifying organisations to generate referrals into schemes:

- Scheme providers should start with those organisations that are easiest to engage to see whether they are able to reach people that fit the scheme’s eligibility criteria
- Providers should work through existing contacts and networks to see who can be reached this way
- Occupational Health and hospital discharge teams may be the best starting points for health sector involvement
- Unless there are existing connections into GP surgeries, it does not seem to be cost-effective to try and generate referrals from that sector
- Scheme providers should focus upon the type of organisations who already provide advocacy services and are used to cross-referring in to schemes, as they are likely to be familiar with the process and can more easily absorb a new scheme into their way of working

**Referral process:** The simpler the process can be, the more likely a scheme is to get referrals. This is partly about the referral mechanism; providing a range of ways to generate referrals is helpful but email and online should be the priorities.

**Clear but brief information:** Make information as clear and succinct as possible on the scheme. The more you can reduce complexity, the easier it is for referring organisations to understand and engage.

**Two-way communication:** Enabling referring organisations to feed in issues and ideas to the scheme seems to be more of a priority to them than getting feedback on the outcome of specific referrals.

**Manage expectations:** Where the expectations of referring bodies are higher than can be delivered by a scheme, this can have a significant negative impact on future referral numbers.

**Self-referrals:** Providers should consider whether self-referrals are appropriate for their scheme. In deciding whether to encourage self-referrals, factors to be considered are the longevity and complexity of the scheme, the provider’s ability to offer support if the resident does not meet the criterion and the scheme’s links into sources of funding. If referrals are encouraged this way and the scheme ends or changes, there is a higher risk that people will call in to get support and be disappointed than if the referrals come through third parties.

**Health-care can-do:** Securing referrals from the health sector can understandably be a focus for these type of schemes. However, the sector can also be the most challenging source of referrals. Although some schemes have had success in generating referrals from GPs, this group are often cited as being difficult to engage. The key success factors tend to be either where there is a direct contact into a GP surgery or where the scheme is able to get referrals from other parts of the health sector. The parts of the health sector which seem to be the easiest to engage with are those where practitioners are focused upon the wider health context of their patients, and also where they spend
more time with their clients, particularly at home. Occupational Therapists are regarded as being a group that are well placed to make referrals into schemes.

**Referrals reach those in need:** Drop-outs tend not to be an issue for many schemes, suggesting that people who are in need are being reached. Where drop-outs happen, this can be because of complex householder needs, which may mean that a change in approach towards greater handholding is required.

### 9.3 Focus

**Diversify the network:** A broad referral network means that schemes should be better able to generate more referrals, respond to new opportunities and remain resilient against changes within that network. Working with a wide range of partners also broadens the range of services that can be provided across that network.

### 9.4 Resources

**More with less is happening:** Despite the pressures on public services, a key finding has been that it is possible to deliver a scheme with little internal resource. Schemes with more internal resources can provide a more detailed level of support (such as home visits) but low-level support is still valued and of benefit to residents. There may however be a knock-on pressure on the voluntary/community sector if the scheme provider relies on them to deliver complementary services such as benefit checks. The more time they are dedicating to delivering services, the less capacity they might have for identifying new referrals.

**Tiny is mighty:** Small schemes are managing to operate effectively but are under increasing pressure. The difference that a scheme can make to residents, even where they are offering a very basic service is impressive. However, the fact that 45% of schemes are operating with less than 1 FTE, with most having less than 2 FTEs, shows how vulnerable these schemes are to further cuts.

**Variety is the spice of life:** Referral partners value variety in terms of the offer, because it makes it more likely that a scheme is going to have a service that it can offer to a wider group of people.

**Advice is welcomed:** Although advice services offer seemingly less tangible outcomes than the provision of measures, they were nonetheless valued by referring organisations and can be lower cost to offer. Having something running means that schemes can link in to other sources of funding as and when they arise to complement the services they are already providing.

**Monitoring & evaluation lose out:** In the focus upon delivery, monitoring and evaluation tend to be the elements which tend to be quickly cut. This has a longer term impact for the individual schemes because they are less well placed to demonstrate value for money, success or the difference their scheme has made. It is also an issue for the sector more broadly given it can be more difficult to get the necessary evidence base to support proposals for changes in the policy or funding landscape.

**Scope to scale up exists:** The level of fuel poverty in an area is not the limiting factor when it comes to size of project, rather the issue is the lack of resources available. More can be done with more resources – both in terms of the number of people that can be supported and the level of support which is provided to each individual.

### 9.5 Health sector

**Passing the buck:** A large amount of costs are getting passed around the public sector, principally from the health sector – which has low levels of engagement relative to the savings which could be generated and the links between this agenda and the health sector’s work – to the public and voluntary sector. There also seem to be costs moved around within the health sector, from GPs to
less front-line services. Unless this is changed, it will continue to place greater pressure upon the public sector generally and schemes will not be able to help reduce pressure upon the NHS as much as is needed.

**Prevention needed:** Despite the NICE guidance, which has influenced the development of a number of schemes, stronger emphasis is needed upon prevention of illness than is currently the case. Making this more of a priority should help to drive health sector engagement with fuel poverty referral schemes and reduce costs.

**Cost-benefit analysis needed:** A better cost-benefit analysis of the benefits of these type of schemes is needed by the NHS to try and drive engagement in them. Some work is already happening in this area, particularly around the ‘boilers on prescription’ schemes; however, this work needs to be broadened out to provide a stronger evidence base.

**Carrots & sticks:** To increase health sector engagement in this area, there is a need to use both carrots and sticks. This could range from process improvements allowing GPs to make direct referrals to schemes to better linking performance in this area into contract design. Performance bonds are being used in some areas and extending this could encourage take-up.

### 9.6 Energy and fuel poverty

**Don’t aim for the ‘low hanging fruit’:** The biggest difference between services offered by schemes is their provision of large energy efficiency measures, such as boilers and insulation. Schemes are reaching people in need but without funding they are limited in the support they can provide. As such there is a need to move away from ‘low hanging fruit’ to try and offer more detailed support for people. This will reduce costs in the longer term as well as making a greater contribution towards carbon targets.

**ECO flexible eligibility:** The variety of schemes shows that organisations are able to find people in need. Scheme providers do feel that there are more people in need than they can reach but, given the limits on their resources, this does not undermine their schemes. The majority of schemes are unable to provide insulation measures as a result of a lack of funding. Flexible eligibility under ECO could provide a way to address this, subject to it being able to provide funding for the right measures, for example external wall insulation as well as measures like loft or cavity wall insulation. A key aspect of how workable the funding will be relates to the reporting requirements that are put in place. We believe this research helps demonstrate that organisations are able to reach those in need but that they often sacrifice monitoring and reporting to make sure that resources are allocated to residents as far as possible. If flexible eligibility carries a high reporting load, scheme providers will be less able to take advantage of it. Flexible eligibility is a new and emerging area within ECO, and as such there is no body of practice to inform further recommendations. It is likely to drive partnerships across sectors and geographical areas, and to inform how local schemes are targeted, so we recommend that it is a topic for further review by researchers and Eaga Charitable Trust.

**Postcode lottery:** Given the uneven spread of schemes, and the lack of a clear correlation between the existence of schemes and fuel poverty levels, there is a risk that the only organisations which access funding are those that already have schemes in place and that there will be continued, growing division between those areas that access funding and provide support and those which don’t.

**Missed carbon reductions:** Funding for measures has generally come from schemes such as CERT and ECO which have focused upon carbon reductions. However, there are many missed opportunities to deliver higher carbon savings. Many of the people getting support might be under-
heating their homes which means that interventions, particularly related to incomes, might lead to an increase in energy use and therefore emissions.

**Slow and steady isn’t enough:** If the schemes in our study were scaled across the country, they would reach 220,000 households each year. This would make a significant impact on fuel poverty rates, but it would still take 17 years to reach every fuel poor household based on the current level of resource for local referral networks.

**Use what works:** Many local schemes provide effective and cost-effective routes for funders to link in with people in need. Using schemes as a way to direct funding towards householders can reduce the internal costs to suppliers of delivering insulation and energy efficiency measures to homes. This would enable suppliers to meet their obligations at lower internal cost (as they are not paying their own “search” costs); this could indeed provide leverage to encourage the Government to increase the size of the obligation! There is scope for local authorities and other referral agencies to negotiate with suppliers about resources for referrals, if the costs associated with outsourced delivery are lower to the suppliers than the use of in-house resources.

**9.7 Housing**

**Social Housing can lose out:** Many schemes are prioritising support to those who are not in social housing, in large part because of a lack of funding which can be used in this tenure and in part because local authorities have a more defined role in working with the private sector. One implication of this is that there may be less support than is needed going to those residents in social housing who are vulnerable as a result of their health conditions.

**Permissions for works in tenanted properties:** Currently this is a complex process which reduces take-up. It is hoped that the minimum EPC standards will drive improvements in this area, but without enforcement there is a risk that the energy standards in this tenure will continue to lag behind the others.

**9.8 Funders**

**Stop stop-starting:** Many of the schemes covered by this research came into being because of funding from the Department of Health’s Warm Homes, Healthy People programme. These schemes have been able to continue through creative approaches since then. However, as we have seen in reviewing the Catalogue of Health-Related Fuel Poverty Schemes (NEA / DECC, 2015), many schemes have not been able to survive. Policymakers need to place greater emphasis on the legacy implications of short-term funding, with particular regard to the pressures that stop-start places on delivery organisations, referral partners and residents who find themselves unable to access vital services.

**Support cost-effective interventions:** It is inefficient that there is often no funding for basic but highly effective measures such as loft and cavity wall insulation, meaning the household needs to be re-identified should funding become available. The current approach seems to be to focus on the cost of an individual measure, rather than on the full cost of delivery per household. Were the latter approach to be taken this would highlight the increased cost per home of targeting and outreach, and should help drive a more strategic and cost-effective approach to reducing carbon, increasing energy efficiency and addressing fuel poverty.

**9.9 Role of local government**

**Lack of statutory function in this area:** The feedback from organisations seems to be that local authorities are well placed to deliver schemes which are trusted by referring organisations and residents. However, the lack of a clear statutory function in this area seems to act as a constraint upon resources being deployed across local authorities. This has a clear postcode lottery implication...
which is further entrenched as organisations with a track record of delivery are then better placed to bid for other sources of funding.

9.10 Data

Data sharing: Data sharing and the ability to access follow-up information would help all involved to be able to provide evidence for the efficacy of schemes. Although it has been time consuming, one scheme was able to use NHS numbers, with permission and without any identifying data, to track GP visits, hospital referrals and other indicators. This in turn helps to build the cost-benefit analysis needed.

Identifying LIHC: Currently the LIHC indicator of fuel poverty (which drives activity in England) is little used. Organisations rarely have access to enough information to be able to identify those who fit the criteria, and are often surprised that people who they expect to be in fuel poverty are not technically so. If this definition is to form the basis of future funding, then enabling data sharing between different organisations will be helpful in reducing the cost of identifying those in fuel poverty.

9.11 Future proofing of schemes

Build a base camp: Putting in place a base-level scheme which can operate with less than 1 FTE and link in to other support services seems to be a good way to protect options. This then provides the ability to expand and contract over time as funding and resources come and go.

Choose your words carefully: Language used to describe the scheme can make a difference in terms of being able to access funding but there may be more scope to deliver programmes in ways which provide support to a wide group.

9.12 Recommendations for future research

Outcomes: Research looking at the health outcomes relative to the types of intervention offered would be helpful in further building an evidence base to inform and direct funding into schemes and particular services.

Prevention costs: There is already a small evidence base for the costs and benefits of preventative measures. Increasing this base could help build understanding about the merits of a shift in emphasis from treatment to prevention. There is a need for greater longitudinal evidence about the health impacts of poor quality, cold or damp homes and the health benefits that can be brought about by energy efficiency.

Carbon cutting: An assessment of the impacts of different types of scheme on reducing carbon would help in identifying the most appropriate focus for different types of funding – whether it is on the home, the individual or specific measures.

Cutting interventions: Understanding how many interventions are likely to be needed to get a home to bring a household out of fuel poverty or improve a home to a certain energy performance standard would provide a really helpful basis on which to rationalise and focus resources. If a home needs to be visited x amount of times before all possible measures are installed, how much will this cost in the total process and therefore how much could be saved if more is done on each visit?

LIHC and targeting: Scheme providers in England are keen to learn more about the interplay between LIHC and the benefits and welfare system to identify unintended consequences, particularly where people who would seem to be fuel poor are excluded from support on technicalities.