

Citizens Advice Winter Resilience Pilot Impact Evaluation

Final Research report to Citizens Advice
Winter Resilience Advisory Board

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Executive summary

Purpose and approach

Citizens Advice set up the Winter Resilience project to design and pilot the implementation of a single point of contact for housing and health referral services, as recommended by the NICE guideline for tackling ill health due to cold homes¹. Citizens Advice provided a small amount of seed funding to seven local Citizens Advice offices to learn about what works by trialling and testing different referral pathways. This independent evaluation of the pilot project considers the project's impact and its viability for wider rollout. The impact analysis focuses on the Manchester and Stockton pilots, which were able to collect sufficient baseline and follow-up data to measure impact.

Findings

Client referral numbers

- Overall, 179 clients received advice as part of the Winter Resilience pilot project
- Manchester received 86 client referrals from Chronic Obstructive Pulmonary Disease (COPD) specialist staff, of whom 67 received advice as part of the Winter Resilience pilot (the remainder were either out of scope or declined the support offered)
- Stockton received 42 client referrals, 5 from pharmacists and 36 from community care workers in GP practices. All 42 received advice as part of the pilot
- Other offices struggled to achieve sizeable numbers of referrals, largely due to the greater than expected challenges involved in setting up referral partnerships

Key characteristics of clients supported

- All clients in the Manchester and Stockton pilots either have a long-term health condition or are disabled. All Manchester clients have COPD. Clients had extremely low health and wellbeing at baseline
- 57% (91) of clients reached were aged 65+. The largest age group reached was people aged 50-64
- At baseline, 79% (48) of Manchester clients and 26% (11) of Stockton clients said they find it fairly or very difficult to pay their energy bills
- 29% (18) of Manchester clients receive pension credit and 35% (19) receive income-related employment support allowance. 21% (9) of Stockton clients receive pension credit

¹ NICE <https://www.nice.org.uk/guidance/ng6>

- 11% (7) of clients live in homes with an EPC rating of E or worse. A further 69% (120) of clients don't know their home's EPC rating, but report that either they have no gas central heating, have an old boiler or have no wall insulation or no loft insulation
- At baseline, just 10% (15) of clients knew they were registered on their supplier's Priority Services Register, even though all are likely to be eligible on grounds of age, disability or health condition

Advice and referrals provided

The Manchester pilot conducted 63 home appointments: most clients received advice on 6 or 7 issues. Advice issues covered were: fuel (34%), benefits (32%), financial capability (14%), energy efficiency, debt, housing, health and social care and legal advice. 'Fuel' advice covered heating controls, switching, tariff issues, methods of payment, Warm Home Discount, Priority Service Register and heating controls use. The Manchester pilot made 107 onward warm referrals, including 55 to suppliers' priority services. At follow up, 10 (31%) of 32 clients had since had energy efficiency or heating measures installed, at least 5 of which were the result of onward referrals^{2,3}.

The Stockton pilot conducted 42 home appointments: most clients received advice on 2 or 3 issues, with key areas of advice covered being benefits and switching. The Stockton pilot signposted 36 clients to supplier priority services registers.

With respect to qualitative feedback on the service provided by the pilot offices, clients gave overwhelmingly appreciative feedback on their experience of the service they received.

Findings - Outcomes

Measures installed and additional benefit claims

- 30% (16) of clients received a new energy efficiency or heating measure following advice
- 24% (13) of clients received additional benefit payments as a result of the project
- 28% (9) of clients in the Manchester pilot were newly signed up to the Warm Home Discount
- 57% (31) of clients benefitted from at least one new measure, new benefit or new Warm Home Discount following the advice
- Up to a 35% increase in PSR registration amongst Manchester and Stockton clients following advice

² Note, the national rate of energy efficiency measures installed under the Energy Company Obligation programme was very low during the implementation stage of the pilots due to most energy companies having met their targets earlier than anticipated.

³ It is possible that not all onward referrals for measures advice were recorded.

Switching tariffs and payment type

- 38% (12) clients in Manchester and 27% (6) clients in Stockton switched energy supplier following advice. A further 10 had compared supplier but not switched
- In Manchester, of 17 who were paying for gas by prepayment meter at baseline, 36% (6) had switched to credit payment (12%, (2) to direct debit)

Reduced use of 'coping mechanisms'

There was a marked reduction in clients reported use of 'coping' heating behaviours to minimise heating costs and/or keep warm (such as turning heating down by more than would be comfortable) following receipt of advice. This will in part be due to seasonal differences.

- The number of Manchester clients reporting high energy costs (over £1400 per year) fell from 47%(15) to 25% (8) following advice

Heating controls and behaviours

- 56% (18) clients in the Manchester pilot who completed a follow-up survey reported using their improved understanding of heating controls to regulate their heating better.
- 78% (17) of clients in Stockton reported they do not use any coping mechanisms at follow-up compared to 56% (12) at baseline, an improvement of 22%.
- 60% (32) of clients overall reported finding it easier to manage their energy bills following advice. In Manchester, 74% (23) reported finding it easier.

Changes in health and wellbeing

There is a modest improvement in the mean scores on three of the four ONS wellbeing indicators, with a 15% improvement in mean score for life satisfaction. Between 7% and 15% of individuals recorded improvements in the scores. For the majority of clients, their wellbeing scores either remained the same or declined on each of the indicators.

- Manchester clients achieved, on average, more marked improvements in their wellbeing than Stockton clients.
- Clients with Housing Association-RSL tenure were more likely to report improved wellbeing scores than clients in other forms of tenure.

The findings from the client Visual Analogue Scale (VAS) are consistent with the ONS wellbeing indicators. The EQ-5D-5L measure shows more clients reporting a decline in health status than those reporting an improvement, with the majority reporting no change. Nevertheless, the mean score again shows a slight improvement.

In interpreting these findings, it is important to keep in mind that clients in Manchester and Stockton reported markedly low scores for wellbeing at baseline. All have a long term health condition or disability and have a high dependency on health services. The lack of a control group limits our ability

to identify whether the pilots helped slow any decline in health and/or wellbeing than would otherwise been the case, given the very poor health of the clients helped. Small sample sizes limited the ability to identify significant changes, whilst the relatively short period of time (6 months) between intervention and follow-up will have limited the extent to which the benefits of other outcomes were felt by clients.

Challenges in setting up and delivering a pilot winter resilience service

Five of the pilot sites experienced challenges in pilot set up, delivery and reporting which affected the ability to evaluate the impact of the service. These challenges include the amount of time and effort required in establishing functional referral pathways with health partners, skills and capacity requirements for delivery of follow-up casework, accurate routing and recording of referrals in multi-referral (including self-referral) mechanisms and having appropriate interpreter support for services targeted at linguistically diverse communities.

Conclusion

The Manchester and Stockton pilots conducted as part of the Winter Resilience project demonstrated two different referral pathways from health practitioners to an integrated advice service, reaching people at risk of harm from the health effects of cold homes. These pilots reached people with very poor health and wellbeing and a high dependency on health services.

The use of a well-defined referral pathway from health providers who narrowly focus on working with patients with directly relevant health conditions enabled the pilots (specifically Manchester and Stockton) to achieve referrals for target client groups, though at lower volumes than hoped.

The use of cold homes advice staff experienced in delivering complex advice who could collect data and provide follow-up case work support proved important in helping clients maximise their income, get improvements made to their homes, afford their bills, and access additional support.

Over the period of the impact evaluation, the pilot showed that changes can be made to improve the energy efficiency of homes, increase the income of households, reduce the share of income spent on heating costs, increase confidence in using heating controls and register vulnerable clients for additional support from their supplier.

The achievement of only modest improvements in average wellbeing and the fact that by some measures, average health had worsened is somewhat disappointing, though may still be better than would have been the case otherwise. This result needs to be understood in terms of the very poor health of clients at baseline, the influence of other significant changes to clients' circumstances, limited sample size and limited elapsed time for other changes to be felt in terms of wellbeing benefits.

Recommendations

The following are recommendations to Citizens Advice.

1. Local Citizens Advice wishing to develop cold home referral services similar to those provided by Manchester or Stockton should recognise the importance of partnership building, using skilled case workers and investing in training. This has time and resource implications.
2. Providing a cold home referral service is more feasible for local Citizens Advice with a track record of delivering high quality Energy Best Deal sessions and Energy Best Deal Extra one to one appointments.
3. The pilots' experience suggests there are two broad approaches to developing referral schemes:
 - a. Target those with particularly poor health, or
 - b. Target a wider group of those vulnerable to the effects of cold homes but who are not necessarily severely unwell.

Local Citizens Advice may wish to target both groups, however this entails developing very different referral pathways. Manchester and Stockton successfully focused on the first group: their schemes identified and negotiated a suitable specialist health referral pathway and focused on health specialists who worked directly with target groups at risk of the health effects of cold homes. Referral schemes which aim to tackle the second group will need to investigate alternative referral pathways. Any extension of the pilot should aim to develop referral pathways that embrace this broader, more preventative approach.

4. Allow more time for otherwise promising pilots that were slow to get started to continue so that the effectiveness of other potential referral routes can be better understood. However, short term funding often militates against this. This decision needs to take into consideration whether other identified challenges to delivery can be successfully overcome.
5. Embed evaluation and design early on in the development of new projects. With respect to cold home services, carry out an early phase of pilot testing and recognise that it may be necessary to change the referral pathway. Outcome evaluation should only take place once the delivery model is established and the service operational.
6. Scaling up capacity to deliver services as they grow is likely to present a future challenge for those pilots that currently rely on a single advisor to provide a complex service to a limited number of clients. The requirements are demanding and resource intensive.
7. The pilot offices were asked to collect a substantial amount of data to allow in-depth evaluation. However, a number of the offices found this very burdensome, particularly those reliant on volunteers. Simplify minimum data collection requirements for future cold home services to those essential for internal reporting and the effective delivery of tailored advice.
8. For cold home referral services with a health partner referral pathway, the choice of health outcome measurement instruments should be agreed with the health partner. For cold home referral services with more general referral pathways that choose to collect such data, it is recommended that the ONS wellbeing questions be adopted rather than EQ-5D-5L. The

wellbeing questions are relatively simple to ask and there is suitable national comparator data for people by age / by health condition. The analysis of ONS wellbeing questions is more straightforward for Citizens Advice to undertake in-house.

9. Time the future impact evaluation of any ongoing service to collect baseline information at an early stage and to conduct follow-up surveys a full winter heating season following advice delivery. Depending on numbers of clients reached, a sample survey approach may be appropriate. This will minimise demand on staff. Data collection should be the responsibility of staff, not volunteers.
10. Home visits are of key importance for any future service, as this allows demonstration of how to use heating controls such as TRVs, thermostats and programmable heating devices. Home visits also allow more tailored advice in relation to the condition of the home. With the smart meter rollout, advice on how to use the in-home display to help clients better understand and control their energy use will be of increasing importance. This needs to tie in with advice on heating controls. However, home visits are expensive and may need to be limited to consumers in particularly vulnerable circumstances.
11. Ongoing casework following a home visit also appears to be an important contributor to clients achieving successful outcomes. Again, case work is resource intensive and may need to be limited to those consumers who are considered unable or unlikely to take recommended actions themselves without additional support.
12. Give attention to solving problems of accurate routing of referrals in multi-referral mechanisms, including to support accurate self-referral. Relatedly, make sure that Citizens Advice and partner recording systems enable accurate reporting of referrals to and delivery of Winter Resilience support. This is likely to be an issue that social prescribing initiatives more generally have had to address and design solutions.

1 Introduction

This is the final report of the Citizens Advice Winter Resilience pilot impact evaluation report. The evaluation focused on understanding the impacts of the scheme for health and wellbeing. It reports findings from analysis of monitoring and survey data collected by seven local participating Citizens Advice offices. These include findings from the process evaluation and evaluation of the scheme's impact on client's health and wellbeing.

This independent assessment of the pilot project's impact and its viability for wider rollout is intended to help Citizens Advice to:

1. Evaluate the delivery models used in the pilot phase to assess their impact and the relative merit of the different design approaches taken
2. Develop a viable single point of contact cold homes support service model and associated toolkit
3. Make the case to health services that there is value in commissioning a single point of contact cold homes referral service
4. Ensure the rollout of a model that is accessible and can be promoted to frontline health staff to encourage them to make referrals

1.1 Background

Cold homes are bad for people's health; they aggravate many existing health conditions and create an additional burden on a health service that is already short on resources. Even in relatively mild winters, every drop in temperature of 1°C results in 8000 excess winter deaths on average. Those most vulnerable are elderly people and people with respiratory problems including Chronic Obstructive Pulmonary Disease (COPD)⁴. Many more people suffer worsened health from cold homes. With effective support to keep vulnerable households warm, these health problems and deaths can be reduced.

COPD is the name for a group of lung conditions that cause breathing difficulties, including emphysema and chronic bronchitis. The damage to the lungs caused by COPD is permanent and the condition can't be cured or reversed, though treatment can keep it under control to limit the severity of its impact on daily activities. Smoking is the main cause of COPD and stopping smoking can help prevent further damage. Treatments include inhalers and medications to make breathing easier and pulmonary rehabilitation. Surgery or a lung transplant is an option for a small number of people. However, COPD can continue to get worse despite treatment, with a significant impact on quality of

⁴Age UK. The Cost of Cold. https://www.ageuk.org.uk/Documents/EN-GB/Campaigns/STW/The_cost_of_cold_2012.pdf?dtrk=true

life. It can eventually reach a stage where it becomes life threatening. Rates of emergency admissions to hospital for COPD were higher in the north of England compared with the UK generally.⁵

A home which is warm and dry especially during cold spells is critical for people with COPD, as cold damp homes can make their symptoms worse. Good ventilation is also important to maintain good indoor air quality, in terms of oxygen, humidity and levels of particulates and allergens, including mould spores.

The cost of cold homes has been recognised by the National Institute for Health and Care Excellence (NICE), who have produced guidance on excess winter deaths and illness and the health risks associated with cold homes⁶. The guidance includes 12 detailed recommendations, in summary covering the following key points:

- Cold homes are a health issue. Substantial evidence shows that living in an under-heated home is bad for people's health. Making homes easier to keep warm can improve the health and wellbeing of vulnerable groups and reduce the pressure on health and social care services.
- Health and Wellbeing Boards must act. They should develop a strategy to address the health consequences of cold homes and planning should include identifying relevant providers of support from all relevant sectors.
- Every contact must count. Identifying and supporting people at risk is the responsibility of all those services that come in contact with vulnerable people, particularly the health service.
- A single point of contact for cold homes support should exist. All relevant organisations, sectors and interest groups should be included in this, but to reduce complexity and costs there needs to be a single point of contact so that anyone who comes into contact with vulnerable groups can easily refer people for support. The single point of contact should provide access to a variety of services to improve housing energy performance, help households reduce their fuel costs and improve their ability to manage their heating.

Citizens Advice has a network of 300 local Citizens Advice offices and delivers advice services from over 2,700 community locations in England and Wales. It considered local offices were well placed to deliver the single-point-of-contact cold homes referral services recommended by NICE. Many local offices already have relationships or contracts with the local health service that can easily be built on to provide this service.

To this end, Citizens Advice wanted to establish a robust and innovative model for a local housing and health referral service, delivered through local Citizens Advice offices. In order to work out how best to do this, Citizens Advice provided seed-funding to 6 local offices (with a 7th office taking part on a self-funding basis) to put theory into practice and explore the challenges and opportunities involved. It is important to appreciate that this was a small scale innovation pilot which wanted to learn about what works by trialling and testing referral pathways, rather than the comprehensive referral service recommended by NICE.

⁵ British Lung Foundation <https://statistics.blf.org.uk/copd>

⁶ NICE <https://www.nice.org.uk/guidance/ng6>

Delivery of a cold homes advice service requires a demanding combination of skills, knowledge and technical expertise in a range of relevant areas including energy tariffs, energy efficiency, supply issues, heating systems, damp problems, income maximisation, debt issues and understanding of relevant health conditions. Delivery staff need to be able to work effectively with referral partners and judge where further case work support is needed. Training and quality assurance are important to support delivery of a high quality service. Citizens Advice operates its own advice quality standards and training for local Citizens Advice centres.

An effective service also needs to be able to make referrals to services for installation of household energy efficiency measures. However, over the period of project delivery, there were very low rates of energy efficiency measures being installed at a national level – January and February 2017 saw amongst the lowest numbers of Energy Company Obligation (ECO) funded measures installed since the start of ECO, although numbers were higher in March 2017. This was largely due to most of the energy companies reaching their targets earlier than anticipated.⁷

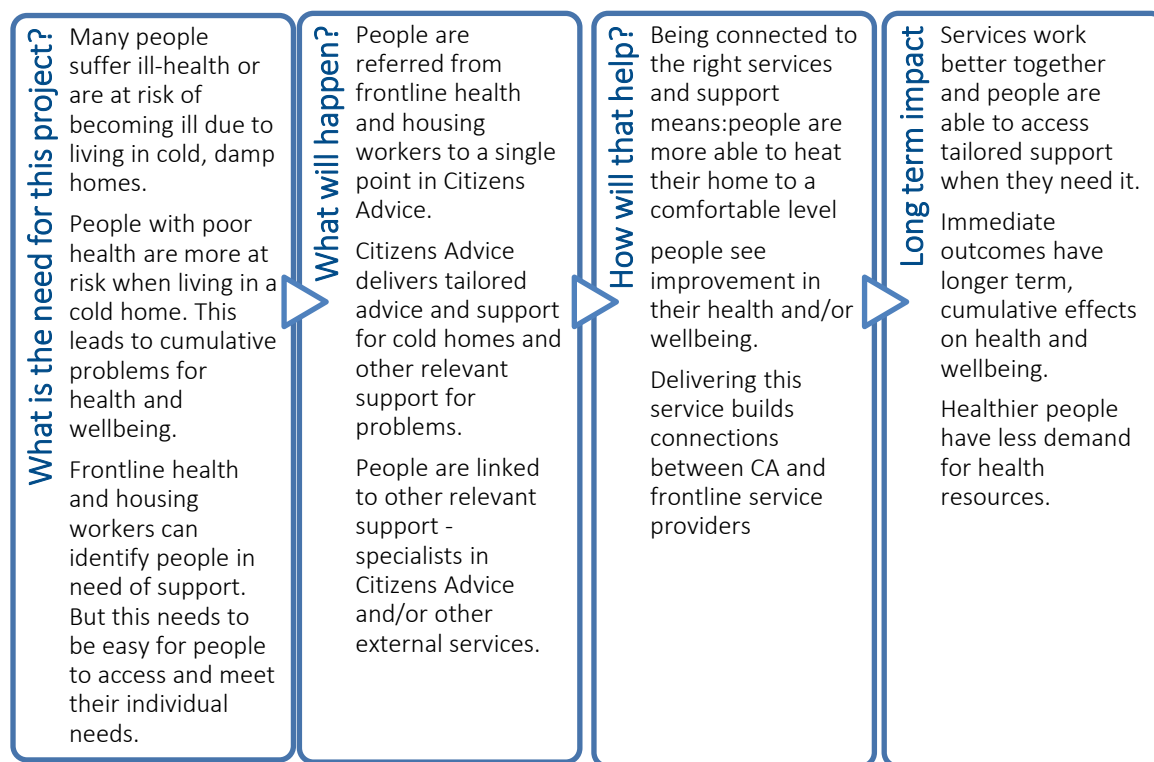
1.2 Project design and implementation

The Winter Resilience pilot project was set up to design and implement single point of contact housing and health referral services. Seven local Citizens Advice offices took part in a service design programme.

1.2.1 Project design

The projects aimed to provide tailored practical support to make homes warmer and more energy efficient. These were small scale pilots: they didn't aim to provide the 'full' single point of contact service recommended by the NICE guideline, but to target relevant clients and referral pathways in their area and test what worked and what did not. The summary theory of change for the project is shown in Figure 1.

⁷ BEIS, Household Energy Efficiency National Statistics, headline release (May 2017)

Figure 1: Winter resilience pilot project theory of change

1.2.2 Project implementation

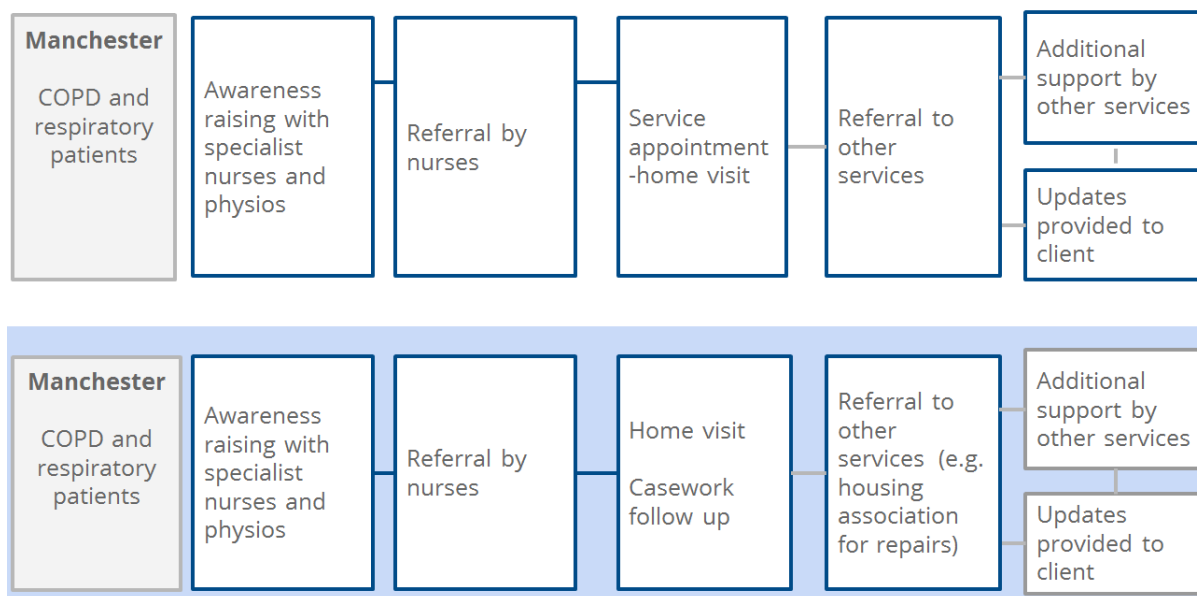
The process evaluation reported on project implementation across the different pilot locations. Each pilot designed their own service model, responding to their local context. The starting service context, in terms of prior experience of delivering energy/cold homes advice and status of partnerships with potential referral partners varied between the pilots. Table 1 summarises the different levels of implementation achieved by the different pilots.

Table 1: Implementation achieved by different pilots

	One (Manchester) had a pre-existing cold homes advice service, established a new referral process and successfully implemented the model as they planned (n = 86 clients).
	Two had trouble establishing the referral process, changed approach, then increased volumes of clients (~30-40 clients) (Stockton and Wealden).
	One had an existing referral process, adding promotion to a specific cold homes service, but low volumes of client referrals (<20 clients).
	Three struggled to implement a referral process and saw very low numbers of clients (<10).

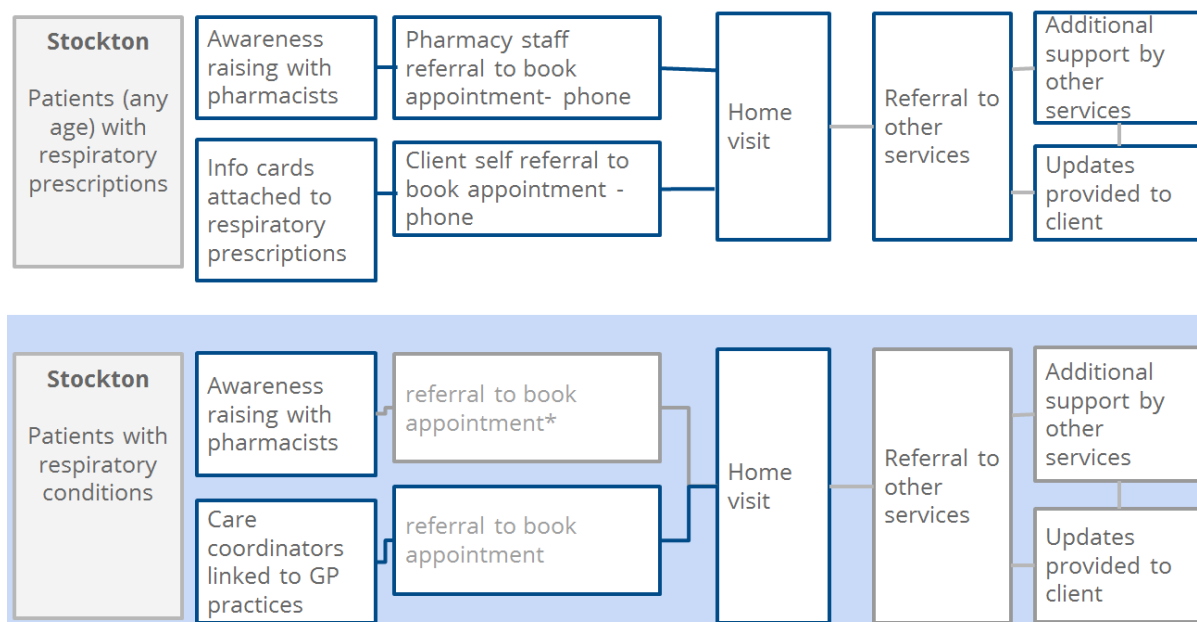
The Manchester pilot was able to put in place its service delivery model as planned (see Figure 2), with service delivery starting in October 2016. Manchester had the advantage of having carried out a lot of the preparatory work, for example developing partnerships with health providers as part of its work for a related project well in advance of 'going live'.

Figure 2: Intended (top) v actual (bottom) implementation - Manchester



The Stockton pilot had to make changes to the referral partners and process after 'going live' (see Figure 3). These changes did result in an increased number of referrals from care coordinators linked to GP practices.

Figure 3: Intended (top) v actual (bottom) implementation - Stockton



Other pilot offices were not ready to implement the service at the beginning of the planned delivery period, had to make changes to their intended model and took longer to establish partnerships than expected. Changes to the intended model included changes to their:

- Referral partners and process
- Referral route (using outreach, Citizens Advice internal referrals or self-referral)
- Onward referral (lack of available referral options for efficiency support)

Further information on the project delivery, taken from the process evaluation report, is reported in Chapter 8.

2 Impact evaluation method

2.1 Overall approach

The approach to evaluation included:

- Analysis of monitoring data collected by Citizens Advice and recorded in its client records database
- Analysis of baseline and follow-up survey data collected by Citizens Advice
- Measurement of health outcomes for clients
- Use of process evaluation findings to aid interpretation of outcomes achieved
- Development of recommendations for rollout drawing on the findings of the impact and process evaluation

2.2 Monitoring and survey data

The quantitative data were collected by Citizens Advice. Monitoring data captured in the Citizens Advice client database comprised:

- Gender
- Ethnicity
- Household income
- Housing tenure
- Long term health conditions and disability

Additional information was collected through monitoring forms, including

- Details of referral
- Household composition and demographics
- Physical condition of home, including insulation and heating system
- Types of support provided to client
- Signposting and referrals made
- Notes on barriers to supporting clients

Questionnaires were developed for use at the first intervention and 6 months after this intervention.

Baseline data was collected at the first contact with the client, in December 2016 to March 2017.

Follow-up surveys were conducted 6 months after the first contact, from June 2017 to September 2017. These asked a range of questions concerning:

- Energy supply and payment methods
- Ability to keep warm at home
- Ability to afford cost of heating
- Coping behaviours to balance costs and keeping warm
- Benefits and energy related services
- Use of health services

- Subjective health and wellbeing, including use of the Office of National Statistics (ONS) personal wellbeing questions and the EuroQol group's EQ-5D-5L instrument

The questionnaires used are in Appendix B. Further detail on the health and wellbeing survey instruments is provided below.

2.2.1 ONS personal wellbeing questions

The baseline and follow-up survey included the ONS personal wellbeing questions. ONS uses four survey questions to measure personal wellbeing. People are asked to respond to the questions on a scale from 0 to 10 where 0 is 'not at all' and 10 is 'completely'. The four questions are:

"Overall, how satisfied are you with your life nowadays?"

"Overall, to what extent do you feel the things you do in your life are worthwhile?"

"Overall, how happy did you feel yesterday?"

"Overall, how anxious did you feel yesterday?"

ONS first added these four questions to the Annual Population Survey (APS), in April 2011. The APS is the source of the national estimates of personal well-being in the UK that are published annually by ONS. This provides a national comparator dataset for surveys using the personal wellbeing questions.

2.2.2 EQ-5D-5L

The EQ-5D-5L comprises the:

- EQ-5D descriptive system of five dimensions of mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 5 levels: no problems, slight problems, moderate problems, severe problems and extreme problems. The individual is asked to indicate his/her health state by ticking the box next to the most appropriate statement in each of the five dimensions. This decision results in a single digit number that expresses the level selected for that dimension. The digits for the five dimensions can be combined into a 5-digit number that describes the individual's health state.
- EQ visual analogue scale. The EQ VAS records the patient's self-rated health on a vertical visual analogue scale, where the endpoints are labelled 'The best health you can imagine' and 'The worst health you can imagine'. The VAS can be used as a quantitative measure of health outcome that reflects the patient's own judgement.

The EQ-5D-5L instrument is included in the surveys in Appendix B. There is a country-specific value set for the EQ-5D-5L for the UK. This study is registered to use the EQ-5D-5L instrument.

2.3 Analysis

Descriptive statistics of clients reached and the support provided is reported for all clients and for separate pilot locations.

Analysis of outcomes was conducted for Manchester and Stockton pilots only. Changes in circumstances (including ability to pay bills, health and well-being) were analysed by comparing responses to pre-intervention and post-intervention using paired t-tests. Differences in outcomes between subgroups were tested using the Analysis of Variance (ANOVA) t-test. All outcomes analysis was undertaken at 95% confidence using SPSS software. A table outlining confidence intervals for the different datasets used to assess outcomes can be found at Appendix A.

Certain limitations are important to note. The follow-up questionnaire was administered 6 months following the intervention, in July – September 2017. This is better than the 3 month period originally planned. The project team and advisory group had discussed carrying out the follow-up 12 months after the intervention. This would have allowed more time for measures to be installed and to record the effects over a winter heating season following referral, advice delivery and any measures installed and behaviour change. The 6 month follow-up meant that seasonal impacts would not be fully reflected, as follow-up responses will have reflected clients' health, wellbeing and ability to keep warm in the spring and summer following advice delivered in the preceding winter.

However, the project team was concerned that 12 months follow-up might have resulted in many respondents not recalling the original intervention, as well as a likely considerable drop out in those willing to take part in follow-up interviews. The 6 month period was therefore considered an acceptable compromise between 3 and 12 months. In retrospect, it might have been preferable to have allowed a 12 month gap and Manchester is indeed considering doing this.

Analysis of outcomes was not conducted for all pilots due to the varied completion rates to the pre-intervention and follow-up surveys achieved by different pilots. Only 2 of the 7 local Citizens Advice achieved sufficient numbers of completed post-intervention surveys to enable analysis of the impacts achieved for the pilot at that location. Overall the post-intervention completion rate was much less than the pre-intervention survey completion rate. The process evaluation report found that advisers struggled with the volume of reporting / length of questionnaires and some felt uncomfortable asking clients to answer complex questions. Some clients were also reportedly reluctant to engage with questions that they felt were unrelated to their issue.

2.4 Process evaluation input

The process evaluation collected data from interviews with local Citizens Advice, feedback in workshops, case studies and a survey of referral partners, in addition to data collected for the impact evaluation. The process evaluation reported overall and for each of the pilots run by local Citizens Advice on:

- What partnerships with frontline health and housing workers were established
- How partnerships were established and maintained
- Whether the service reached people in need
- Whether the service provided tailored support to meet people's needs
- To what extent the actual delivery matched the intended delivery
- The practical experience of implementing the service

These findings were used to aid interpretation of the impact findings and to inform the development of recommendations for rollout of cold homes single point of contact services by Citizens Advice.

2.5 Development of recommendations

Based on the analysis of data from both the process and impact evaluations, recommendations were developed to build the case and inform the design of future cold home referral services Citizens Advice would provide at other local offices should external funding be made available. The development of recommendations has also drawn upon the lead author's insights from past experience in undertaking evaluation of Citizens Advice Energy Best Deal and Energy Best Deal Extra programmes over the past two years.

3 Project reach

3.1 The overall sample

This chapter briefly outlines the profile of clients reached and of clients who completed the baseline questionnaire and post-intervention surveys. Table 2 presents the breakdown of clients reached by office and the sample size for which monitoring and survey data was collected. Overall, 203 clients were recorded, of whom 179 received advice. The baseline survey was completed for 147 clients. The post-intervention survey was completed for 56 clients. The project originally set itself a target of reaching 100 clients per local Citizens Advice, although with hindsight this was probably unrealistic given the level of funding, the complexity of local health structures and the time required to set up the referral services. The overall number of clients who received advice was 25% of the target. In Manchester, of 86 referred, 67 received support. Ten clients were deemed 'not in scope' as they did not live in a cold home and 9 clients declined the support offered. In Stockton, all 42 clients referred received advice.

Table 2: Summary of overall sample

	Clients referred	Received advice	Baseline survey	Matched Citizens Advice client record	Follow up survey
Manchester	86	67	62	79	33
Stockton	42	42	42	40	21
Wealden	38	32	16	19	2
Uttlesford	16	16	6	14	0
Liverpool	4	4	3	0	0
Gloucester	9	9	9	8	0
Southwark	8	8	8	0	0
n	202	179	147	160	56

The confidence intervals of the results vary according to the questions under consideration.

3.2 Client characteristics

The characteristics of clients for whom the survey was completed and who matched Citizens Advice client records are available are reported below. These cover a range of demographic, health and socio-economic characteristics and household energy supply types. Client characteristics are reported

for participants across all pilots, and separately for Manchester and Stockton – the two pilots that achieved the highest numbers of follow-up survey completions. Throughout this report, the reported average refers to the mean.

In the tables below, the total number of clients for whom a matched Citizens Advice client record or baseline survey was completed is reported at the bottom of the relevant column (eg n= 160 matched Citizens Advice client records across all pilots). The breakdown by characteristic (eg age group) is shown as % of the total number of clients (eg 2% of all clients with a matched Citizens Advice client record was completed were aged 25 – 34). All percentages are rounded to nearest percentage point.

3.2.1 Age

Table 3 shows the age of clients reached. The largest group reached by age was people aged 50-64, both from the matched client record of clients and those who responded to the follow-up survey, with the exception of Stockton, where the 75-84 age group was slightly bigger amongst those with a matched Citizens Advice record. Over 90% (150) of clients were aged 50+ across all pilots, 57% (91) of clients reached were aged 65+. Older people aged 65+ are identified as at greater risk of the harmful health effects of cold homes. The risks of having specific health conditions which have an associated vulnerability to harm from cold homes (including COPD, high blood pressure and stroke) also increase with age.

Table 3: Age of clients by Citizens Advice office

Age	All pilots	Manchester	Stockton
25 – 34	2%	0%	0%
35 – 49	6%	5%	3%
50 – 64	39%	46%	28%
65 – 74	25%	28%	28%
75 – 84	24%	19%	33%
85 +	4%	3%	10%
n	138	79	40

3.2.2 Gender

More women than men were reached by the project, as shown in **Table 4**. This is likely to reflect the longer life expectancy of women. It is in line with the gender profile of wider Citizens Advice services.

Table 4: Gender of clients by pilot location

	All Pilots	Manchester	Stockton
Male	44%	47%	30%
Female	56%	53%	70%
n	160	79	40

3.2.3 Ethnicity

The project reached people from a range of ethnic backgrounds, roughly consistent with the overall population of Great Britain. The higher share of Black people reached in the Manchester pilot reflects the ethnic profile of the city: 8.6% of the city's population recorded their ethnic identity as Black or Black British in the 2011 Census.⁸

Table 5: Ethnicity of clients by Citizens Advice office

	All Pilots	Manchester	Stockton	GB Profile (Census 2011)
White	84%	76%	90%	87%
Asian or Asian British	3%		10%	2%
Black or Black British	4%	8%	0%	3%
Mixed	1%	0%	0%	1%
Unknown	9%	16%	0%	
n	160	79	40	

3.2.4 Health conditions

The pilots were designed to target people with specific health conditions associated with increased risk of vulnerability to the harmful effects of a cold home. Table 6 shows that 91% (113) of clients reached had a long-term health condition, indicating the pilots were effective in reaching people with target health conditions. Information on specific health conditions was not collected. However, all Manchester clients were referred by COPD specialists and had a COPD diagnosis.

Table 6: Clients with a disability or long-term health condition by pilot location

	All Pilots	Manchester	Stockton
Disabled	5%	3%	5%
Long-term health condition	91%	97%*	95%**
Not disabled/no health problems	4%	0%	0%
n	124	66	37

*in Manchester, 20% of those with a long term health condition reported multiple ailments

**in Stockton, 68% of those with a long term health condition reported multiple ailments

3.3 Socio-economic characteristics

3.3.1 Household tenure

The housing tenure of those reached is shown in Table 7. Almost half of all clients reached are social housing tenants. This is well above the share of the UK population living in social housing. The high numbers of social tenants amongst those reached may reflect greater need amongst social tenants.

⁸ ONS, Census 2011 KS201 EW

By contrast, home owners were under-represented amongst all clients relative to levels of home ownership in the UK. Half of clients in Stockton were home owners. The smaller share of private tenants reached is somewhat below what might be expected relative to UK rates of private rental, particularly given poor levels of energy efficiency in private rental housing stock. This may also have been a factor of the age of the clients reached in the pilots, given that private rented tenants are predominantly younger than the UK average. However, in Manchester, 40% (26) of clients were private renters.

Table 7: Housing tenure of clients – for all Winter Resilience pilots clients, Manchester and Stockton pilots

	All Pilots	Manchester	Stockton	UK average (households) EHS 2015/16
Social tenant	48%	43%	30%	17%
Private tenant	16%	40%	18%	20%
Home owner	34%	17%	50%	63%
Other	2%	0%	2%	
n	147	64	40	

3.3.2 Energy efficiency performance of homes

The most common banding for clients whose home has an Energy Performance Certificate (EPC) is band D, as shown in Table 8. In Stockton, 9% (4) clients reported their home had an EPC ranking of E or F, indicating poor energy performance. For 52% (22) Stockton clients the EPC banding of their home was not recorded. Information collected about the insulation, energy efficiency measures, boiler and heating system in a home indicate that all 22 of these clients live in homes with poor energy efficiency ratings. All had solid fuel or oil as their main source of heating and 55% (12) had a boiler which is 12 years old or older.

In England, the energy efficiency rating of social housing is generally higher than in the private sector. The high proportion of clients who live in social housing may explain why, of those clients with a reported EPC rating, these are generally banded D or higher.

Table 9 shows that the clients in social housing report higher EPC ratings and fewer unknowns than private tenants and homeowners.

69% (120) of clients don't know their home's EPC rating: this may be because an Energy Performance Certificate has never been produced for their home or that they are unaware of it. 38% (57) of clients reported high fuel costs of over £1400 a year, which suggests many of these are likely to be living in inefficient homes. 22% (37) of homes have a boiler over 12 years old that is likely to be much less efficient than a new boiler. 40% (66) of clients do not have gas central heating and either use solid fuel / oil as their primary form of heating (25%, 43) or electricity (15%, 23).

In Manchester 3% (2) clients reported their home had an EPC rating of E or F, indicating poor energy performance. For 28 Manchester clients, the EPC banding of their home was not recorded.

Information collected about the insulation, energy efficiency measures, boiler and heating system in a home indicate that a further 32% (20) of clients live in homes with poor energy efficiency ratings. This includes (16%) 10 properties without gas central heating, a further 10% (6) properties with a boiler which is 12 years old or older and a further 5%(3) properties with no wall insulation.

In Stockton, 4 clients reported their home had an EPC rating of E or F, indicating poor energy performance. For 22 Stockton clients, the EPC banding of their home was not recorded. Information collected about the insulation, energy efficiency measures, boiler and heating system in a home would indicate that all 54% (22) of these clients live in homes with poor energy efficiency ratings. All had solid fuel or oil as their main source of heating and 54% (12) had a boiler which is 12 years old or older.

Table 8: EPC rating of clients' homes

EPC Band	All Pilots	Manchester	Stockton	National average- all tenures (2014)
A/B	1%	3%	0%	1.3%
C	12%	29%	7%	24.9%
D	15%	21%	31%	51.1%
E	3%	3%	7%	17.1%
F	1%	0%	2%	4.3%
G	0%	0%	0%	1.3%
Don't know	69%	44%	52%	
n	175	63	42	

Table 9: EPC rating by housing tenure

Tenure	B	C	D	E	F	Don't know	n
Home owner	0%	4%	8%	8%	0%	80%	50
Social rented	2%	29%	29%	0%	0%	41%	56
Private rented	0%	5%	18%	0%	5%	73%	22
n	2	21	26	4	1	85	

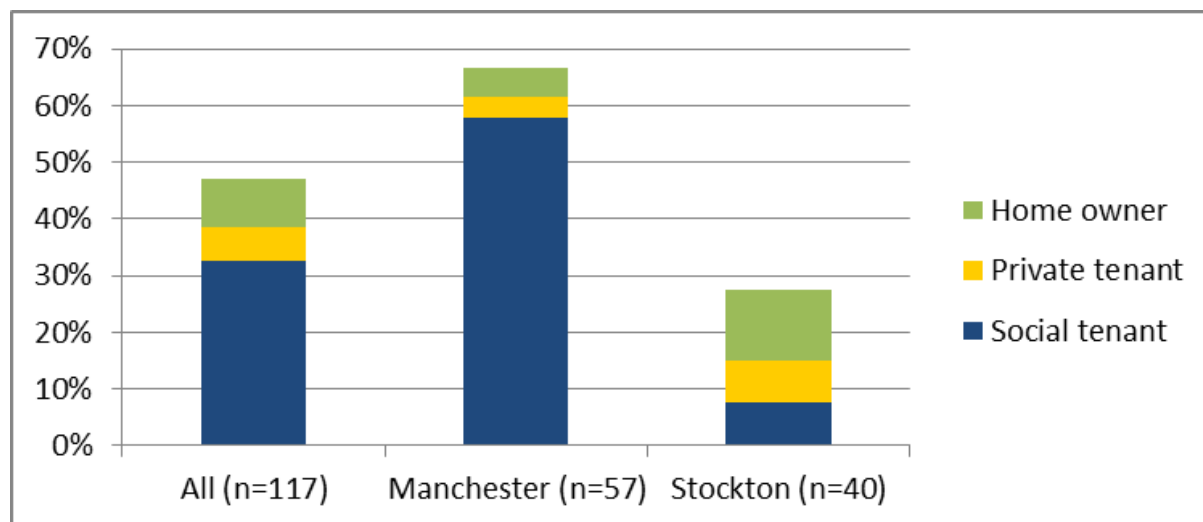
3.3.3 Income and receipt of benefits

The baseline questionnaire included a question about income levels, asking clients to indicate whether their household income fell within three broad tiers. The response rate to this question was poor across all pilots. This is in part due to volunteers and staff feeling uncomfortable about asking intrusive questions at their first contact with the client. It may also be that clients who were asked the question chose not to answer the question. Due to the poor response rate to this question, a proxy measure for low income was used, based on whether they were in receipt of the following means-

tested benefits: pension credit, income support, income-based jobseekers allowance and income-related employment support allowance.

Figure 4 shows 47% (70) of all clients are classified as low-income. 32% (38) of all clients are low income and live in social housing. In Manchester 58% of clients are low-income and live in social housing. In Stockton less than 30% (12) of clients are low income.

Figure 4: Low income clients by tenure



Clients were also asked about what means-tested benefits they received. Table 10 shows the benefits claimed. The most common two means-tested benefits claimed are income related employment support allowance (ESA) and pension credit. This demonstrates that the pilots were successful in reaching low-income households, including those of working age and of retirement age.

Table 10: Benefits claimed by clients

Benefit	All Pilots	Manchester	Stockton
Pension credit	29%	29%	21%
Income support	3%	3%	2%
Income-based jobseeker's allowance	1%	0%	0%
Child tax credit	9%	6%	0%
Working tax credit	5%	0%	0%
Income-related ESA	30%	35%	7%
None of these	61%	31%	74%
Don't know	3%	3%	0%
n	115	62	42

3.3.4 Fuel poverty estimate and difficulty paying energy bills

Due to the poor response rate to the question about clients' household income, households were estimated to be low income if claiming pension credit, income support, income-based jobseekers allowance or income-related employment support allowance. Clients claiming any of those benefits, and reporting high fuel bills (more than £1400 a year, £120 a month) were estimated to be fuel poor.

In reality this is likely to be an under estimate as not all low income households will be claiming the named benefits. The proportion of clients meeting these criteria is shown in Table 11. Across the baseline sample 19% (28) were in fuel poverty, high levels of fuel poverty were seen amongst Manchester clients (33%, 21) and low levels (2%, 1) amongst Stockton clients.

Table 11: Estimated proportion of clients in fuel poverty

Fuel poverty status	All Pilots	Manchester	Stockton
Fuel poor	19%	33%	2%
Not fuel poor	81%	67%	98%
n	149	63	42

Table 12 shows proportions of clients reporting finding it difficult to manage their energy bills. Overall 64% (93) of clients responding to the baseline survey reported finding it difficult to pay their energy bills. In the baseline survey, 79% (48) of clients in the Manchester pilot reported paying their bills as difficult. At baseline, 26% (11) of clients in the Stockton pilot reported paying their bills as difficult. This suggests the intervention has reached those struggling to pay their fuel bills.

Table 12: Self-reported difficulty in paying energy bills by Citizens Advice office

	All Pilots	Manchester	Stockton
Very difficult	22%	28%	5%
Fairly difficult	42%	51%	21%
Neither easy nor difficult	20%	16%	33%
Fairly easy	13%	5%	31%
Very easy	3%	0%	10%
Don't know	1%	0%	0%
n	148	61	42

3.3.5 Energy payment methods

Clients were asked about how they pay for their energy – both gas and electricity. Electricity payment method is reported in

Table 13 and gas payment method is reported in

Table 14. Rates of all clients using prepayment meters for electricity and for gas are above national rates at baseline and at follow-up. The proportion paying by prepayment in Manchester is considerably higher than the national average. This is a group at high risk of fuel poverty, due to the high energy tariffs paid by prepayment customers, particularly prior to the introduction of the prepayment price cap introduced in April 2017. All baseline surveys were conducted prior to the price cap being introduced. Even with the price cap, households with prepayment meters may still be affected by past debt and/or have low incomes that cause them to choose prepayment as a way of helping them budget.

Table 13: Electricity payment method by Citizens Advice office

Payment method	All Pilots	Manchester	Stockton	GB Average (2015)
Direct debit or standing order	50%	27%	73%	70%
On receipt of bill	10%	20%	2%	9%
Prepayment	30%	53%	2%	16%
Other	9%	0%	22%	3%
n	129	55	41	

Table 14: Gas payment method by Citizens Advice office

Payment method	All Pilots	Manchester	Stockton	GB Average (2015)
Direct debit or standing order	50%	27%	73%	71%
On receipt of bill	10%	20%	2%	7%
Prepayment	30%	53%	2%	15%
Other	9%	0%	22%	3%
n	129	55	41	

3.3.6 Priority Services Register status

Around 3 million customers were registered with their electricity and gas suppliers' priority services register (PSR) in 2015.⁹ This enables customers to ask for advance notice if supply is going to be interrupted and to be at the front of the queue to be reconnected. It also allows customers to access other free benefits and support according to their circumstances and needs. Until recently, the main reasons for being registered were age (60+), communication barrier, medical dependence on electricity or other long term health conditions. This has been broadened by Ofgem to recognise a wider range of vulnerabilities, including adding households with a child aged under 5 as a core eligibility criteria.

Of those clients with complete data on age, health status or disability, 97% (155 of 160) of all clients with complete Citizens Advice records are likely to be eligible to be registered on their supplier's PSR, with the main reason being their health. All clients from Stockton and Manchester are eligible to be on the PSR due to age or having a long term illness or disability.

However, from the baseline survey, just 10% (15) of all clients knew they were registered on their suppliers' PSR. Most people (58%, 85, of all clients at baseline) didn't know if they were on their supplier's PSR or not, whilst 33% (49) stated they are not on their supplier's PSR (see

⁹ https://www.ofgem.gov.uk/system/files/docs/2016/10/monitoring_social_obligations_-_2015_annual_data_report.pdf

Table 15). Given that customers normally have to request to be put on the PSR, it is likely that most of those who 'don't know' are not on their suppliers' or network operators' PSR register.

Again, this demonstrates that the pilots were successful in reaching clients who would benefit from additional support and who are not currently recognised as vulnerable by their energy suppliers or network operators.

Table 15: PSR status of clients by Citizens Advice office

	All Pilots	Manchester	Stockton
On PSR	10%	5%	12%
Not on PSR	33%	27%	7%
Don't know	58%	68%	81%
n	147	62	42

4 Referral routes

4.1 Sources of referral

The process evaluation found that a variety of referral processes were used in the delivery of the pilots, including from health partners, social workers, housing officers, community groups, council officers, internal referrals within Citizens Advice and self-referrals. An overview of the different sources of referrals is shown in Table 16, with a more detailed breakdown of the referral by health providers shown in Table 17.

The pilot offices originally tried to target their target groups through a range of referral routes that seemed promising in their particular locations. A number of the pilot offices later decided to focus on very specific health referral pathways, following Manchester's approach, to generate larger volumes of referrals. Several of the offices, notably Uttlesford and Wealden, also found the complexity of local health structures made it difficult to establish clear referral pathways with health workers in their areas.

The Manchester and Stockton pilots were most successful in achieving referrals from a health partner (Manchester 86, Stockton 41) whereas most other pilots achieved few or no referrals from health partners. Wealden achieved 28 self-referrals and 10 referrals from social workers or housing officers. Southwark achieved 8 referrals from community groups. Uttlesford and Gloucester achieved smaller numbers of referrals from other sources, mainly internally from Citizens Advice or from the local council. Overall, referral numbers were lower than hoped, although as noted above the original targets were probably unrealistic.

Table 16: Sources of referral used in pilots

	Health partner	Self-referral	Social worker / housing officer	Community group	Other (internal, council etc)	All
Manchester	86	0	0	0	0	86
Stockton	41	1	0	0	0	42
Wealden	0	28	10	0	0	38
Uttlesford	2	5	3	0	6	16
Gloucester	1	0	0	0	7	8
Southwark	0	0	0	8	0	8
Liverpool	4	0	0	0	0	4
All	134	34	13	8	13	202

4.1.1 Referrals from health providers

In total, 134 referrals were received from health practitioners. Manchester and Stockton were most successful in achieving referrals from health providers. Manchester received 86 referrals from Chronic Obstructive Pulmonary Disease (COPD) specialist staff. Stockton received 5 referrals from pharmacists, but after a slow uptake, switched referral process and achieved 36 referrals from community care workers in GP practices. Liverpool and Uttlesford also each received small numbers of referrals from GPs or other practice staff, whilst Gloucester received 1 referral from COPD specialist staff.

Table 17: Referrals by health practitioners

	COPD specialist staff	Community care worker in GP practice	GP	Other GP practice staff	Pharmacy	All
Manchester	86	0	0	0	0	86
Stockton	0	36	0	0	5	41
Liverpool	0	0	1	3	0	4
Uttlesford	0	0	2	0	0	2
Gloucester	1	0	0	0	0	1
All	87	36	3	3	5	134

5 Support provided

A wide range of types of advice was provided to clients as part of the Winter Resilience pilots, as shown in Table 18 and Table 19. The most frequently provided forms of advice were about benefits, switching or support and financial capability. Manchester, Stockton and Wealden provided the widest range of advice. Southwark focused advice on energy efficiency and heating and on switching energy supplier and did not record providing advice on wider financial or housing topics. This is likely because Southwark partnered with another advice agency who delivered benefits and financial advice. Table 18 and Table 19 demonstrate that the average number of advice topics covered with a client varied considerably between the different pilots. On average, the Manchester pilot provided advice and support on around 7 issues per client. On average, the Stockton and Uttlesford pilots provided advice and support on between 2 and 3 issues. However, it is possible that part of the difference in range of advice issues might have been due to variations in recording procedures in the different offices.

Table 18: Type of support and advice provided

	Benefits	Switching advice or support	Financial capability	Grant eligibility	Energy efficient behaviour
Manchester	62	63	58	48	62
Wealden	32	32	31	24	7
Stockton	39	17	4	6	3
Gloucester	9	9	9	5	0
Southwark	0	7	0	0	8
Uttlesford	8	3	3	4	0
Liverpool	1	2	0	0	0

Table 19: Type of advice provided (continued)

	Use of heating systems	Home improvement for energy efficiency	Debt	Housing options	Other support	Average number of advice topics per client
Manchester	59	23	25	5	19	6.7
Wealden	6	18	9	1	9	4.9
Stockton	0	0	2	2	26	2.6
Gloucester	0	1	3	1	2	4.3
Southwark	8	5	0	0	1	3.6

	Use of heating systems	Home improvement for energy efficiency	Debt	Housing options	Other support	Average number of advice topics per client
Uttlesford	1	1	3	1	3	2.5
Liverpool	0	0	0	0	0	1
All	74	48	2	10		4.1

Monitoring records for the Manchester and Stockton pilot provide more information on 'other' support provided.

Nineteen clients in the Manchester pilot also received other support, of whom:

- 4 received a referral for a care needs assessment
- 4 received help with personal independence payment issues
- 4 received support with switching their prepayment meters to credit meters

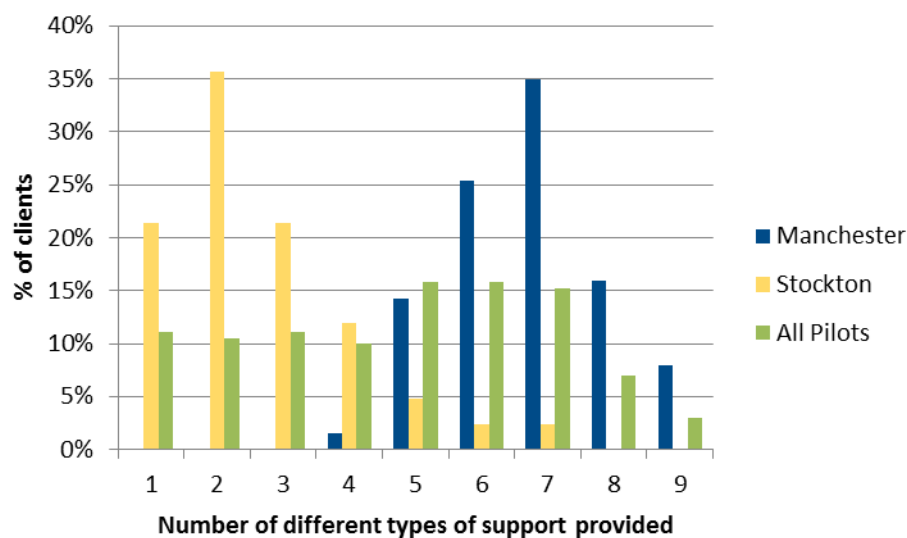
Other advice issues covered with individual clients included water meters, water arrears, council tax debt, an application for a new dryer, signposting to a support group and referral to a benefit specialist.

- 26 clients in the Stockton pilot also received advice on a number of other issues:
- 10 received advice on a care needs assessment, of whom
 - 2 also received advice on under-occupancy rules
 - 4 also received advice on Blue Badge scheme
 - 1 also received a GP referral
 - 1 also received advice on Severe Disability Premium
- 4 received advice on Carers Allowance, of whom 1 also received advice on Severe Disability Premium, an extra amount included in some means-tested benefits
- 5 received advice on Water Sure scheme
- 2 received advice on power of attorney, 1 of whom also received advice on care home fees and property issues

Other advice issues addressed with individual clients included NHS penalty notice, motability vehicle, road vehicle tax exemption, occupational pension and early/ill-health retirement.

Figure 5 shows that clients in Manchester typically received more support than those across other pilots. Most of the clients in Manchester received advice on 6 or 7 advice issues, and none were provided with less than 4 types of support. In Stockton, most clients received advice on 2 issues.

Figure 5: Number of types of support provided to clients in Manchester (n=86), Stockton (n=42) and all (203) pilots



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Figure 4 shows that clients in Manchester typically received more support than those across other pilots. Most of the clients in Manchester received advice on 6 or 7 advice issues, and none were provided with less than 4 types of support. In Stockton, most clients received advice on 2 issues.

The most frequent type of advice appointment offered was advice provided in the clients' home. However, these were largely accounted for by Manchester and Stockton, with Uttlesford the only other local office to provide advice in the home. Wealdon, Southwark and Uttlesford mainly offered one-to-one advice appointments. Gloucester, Uttlesford, Liverpool and Manchester also delivered appointments in other settings eg a community venue.

Table 20: Type of appointment delivered by office

	Advice in the home	One - to- one advice appointment	Other	All
Manchester	63	0	1	64
Gloucester	0	1	8	9
Stockton	42	0	0	42
Liverpool	0	2	2	4
Wealden	0	38	0	38
Southwark	0	8	0	8
Uttlesford	2	9	5	16
All	107	58	16	181

Table 21 and Table 22 show the referrals for further support that were made for Winter Resilience Pilot clients, either to signpost the client to access the support themselves or with a warm referral, where they contacted the support provider on behalf of the client. The Manchester pilot made 107 warm referrals, including 55 warm referrals to supplier priority services register. Stockton signposted 36 clients to supplier priority services register.

Table 21: Referrals for further support

	Priority Services Register		Referral for flu jab		Referral to fire service	
	signpost	warm referral	signpost	warm referral	signpost	warm referral
Manchester	6	55	0	0	0	0
Stockton	36	3	0	0	0	0
Wealden	17	0	1	0	1	1
Uttlesford	1	0	0	0	0	0
Southwark	0	0	0	0	0	0
Liverpool	0	0	0	0	0	0
Gloucester	0	0	0	0	0	0
All	60	57	1	0	1	1

Table 22: Referrals for further support

	Grants or schemes for energy efficiency improvements		Other		All	
	signpost	warm referral	signpost	warm referral	signpost	warm referral
Manchester	6	5	4	30	13	107
Stockton	0	0	0	0	36	3
Wealden	8	2	3	4	30	7
Southwark	0	0	8	0	8	0
Liverpool	0	0	0	2	0	2
Uttlesford	0	0	1	1	2	1
Gloucester	0	0	0	0	0	0
All	14	7	15	11	89	120

Monitoring records for the Manchester pilot provide more information on further referrals to support. Seven clients in the Manchester pilot were also referred to further sources of support:

- 14 clients were referred to their housing association, to address damp issues, problem draught, heating issues or other repairs, for a boiler upgrade or for help with benefits
- 13 clients were referred to adult social care for aids and adaptations advice, 3 of whom were also referred either to Care and Repair and 2 to their housing association
- 6 clients were referred to Citizens Advice debt or benefit advice specialists
- 3 further referrals were made to Care and Repair only (in addition to 3 above)
- Individual referrals to other sources of support included referral to the water supplier for water charge cap, application for a nebuliser, applications for white goods, help with energy arrears and referral to a private landlord for boiler repair

Further information on advice provision to clients as part of the Winter Resilience Pilots in Manchester and Stockton is available from collated data held by Citizens Advice. The number of 'advice issues' is much higher than the total number of individual clients. This demonstrates that clients received advice on multiple issues. The pie charts below for the Manchester pilot demonstrate that advice provided covered a range of issues, including a variety of fuel-related issues, fuel debt, energy efficiency benefit issues and other issues. Figure 6 shows an overview of the total advice issues covered in sessions. Note that one client may receive advice on more than one topic; therefore the chart does not show the proportion of clients receiving advice. The most common issue advised on was fuel: Figure 7 provides a breakdown of this issue, although 23% (76) were not specified.

Figure 6: Overview of issues advised on as part of the Winter Resilience Pilot in Manchester (n=957)

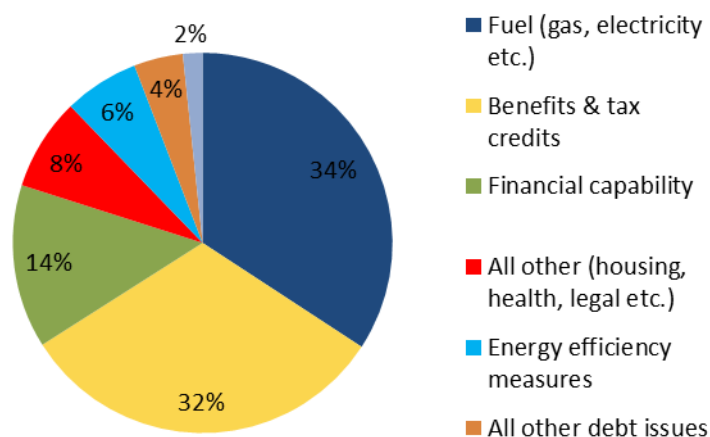
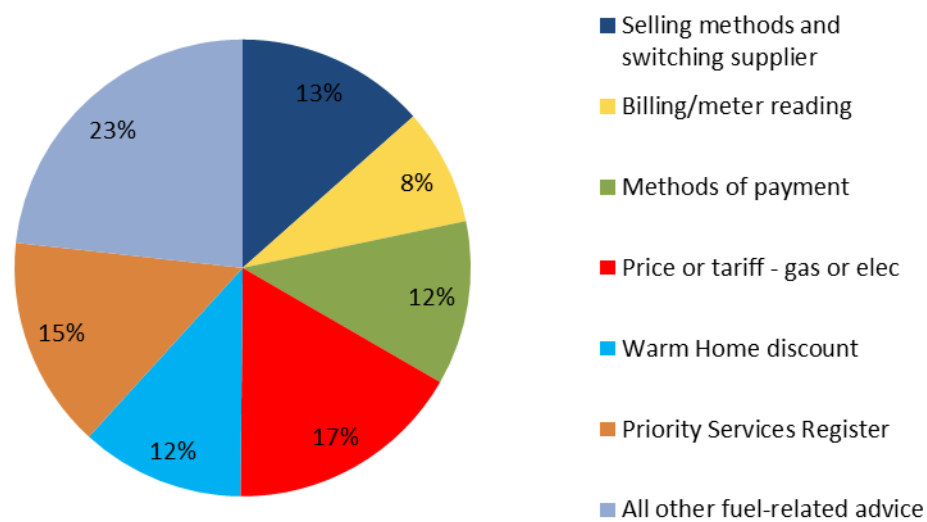


Figure 7: Detailed breakdown of 'fuel' advice delivered as part of the Manchester pilot (n=327)

Benefits-related advice delivered as part of the Manchester pilot covered (from highest to lowest number of advice items recorded) personal independence payments, employment support allowance, housing benefit, pension credit, attendance allowance and a variety of other benefits.

6 Outcomes

This chapter presents the headline findings from the baseline and post-intervention surveys. Analysis is based on matched responses, looking at individuals' responses to the baseline and follow-up surveys. The first section reports measures received that are likely to improve the efficiency of their homes and decrease fuel poverty.

The second section includes self-reported behaviours and comfort levels. These may be considered as 'interim outcomes' for which changes may be identifiable sooner following advice delivery than changes in health and wellbeing outcomes.

6.1 Changes in factors influencing fuel poverty status and ability to keep the home warm

The definition of fuel poverty is based on a calculation of household income relative to modelled energy costs, taking into account household size. A large number of data points are required to accurately identify whether a household is in fuel poverty as officially defined. Efforts to minimise the data collecting burden meant that, whilst baseline information was collected on the housing condition and simple indicators of income level and household size, insufficient information was collected to determine whether households were lifted out of fuel poverty. In order to be able to do this, more precise and detailed data on income, household energy performance, household structure and changes in income following advice would be required.

This section reports on changes that may impact on a household's risk of being fuel poor and on the ability of a household to keep their home warm. This includes installation of measures that improve the energy efficiency performance of the home, income maximisation and installation of measures that improve the ability to heat the home or improve the ability to control energy use in the home.

Improvements in the energy efficiency performance of a client's home can help them achieve important savings in the costs of heating their home to a recommended temperature. It can also help to lift a household out of fuel poverty. At baseline, clients were asked for information about the energy efficiency of their home, including the EPC rating of their home if known. At follow-up, clients were asked if any energy efficiency measures have been installed, or are scheduled to be installed in their home since the help provided. Interviewers also recorded any other improvements, including measures to help them heat their home or keep track of their energy use. Installation of new heaters will not change the energy efficiency performance of the home but may improve the ability of the household to keep warm. Likewise, installation of smart meters will not change the energy efficiency performance of the home but may improve the ability of the household to control their energy use.

As shown in Table 23, 64% of clients received at least one of: energy efficiency or heating measure, additional benefit payment, Warm Home Discount payment or was added to their suppliers PSR. In Manchester, 81% of clients received at least one of these.

Table 23: Clients receiving energy efficiency measure(s) or additional benefit(s)

Support and benefits	All (n=54)	Manchester (n=32)	Stockton (n =22)
New measure	30%	31%	27%
New benefit payment	24%	13%	41%
New WHD	17%	28%	0%
Received at least one of the above	57%	56%	59%

- Table 23 shows energy efficiency measures and other benefits received, of 32 clients in Manchester who responded to the follow-up survey: 19% (6) had received energy efficiency improvements, including loft insulation (3%, 1), double glazing (3%, 1), draught proofing (12%, 4)
- 9% (3) had received a new boiler and central heating system, and a further 6% (2) had received a new boiler only
- 6% (2) had damp issues addressed
- 6% (2) received other energy efficiency improvements
- 56% (18) reported using their improved understanding of heating controls to regulate their heating better

13% (4) clients received additional benefits in Manchester:

- 1 newly received income support
- 1 newly received employment and support allowance
- 1 newly received universal credit
- 1 newly received attendance allowance

Out of 22 Stockton clients who completed a follow-up survey and received energy efficiency or heating measures installed (Table 23):

- 9% (2) had since had double glazing installed in their home
- 9% (2) had a new gas fire or additional radiator installed
- 14% (3) had smart meters installed

51% (9) clients in Stockton received addition benefits:

- 6 newly received attendance allowance
- 2 received employment and support allowance
- 1 received income support

These changes were achieved as a direct result of the pilot intervention and not as part of any other intervention.

The low rates of installation of ECO funded measures during the project period is likely to be an important factor which reduced how many clients reported having measures installed following advice.

6.1.1 Priority Services Register sign-up

Manchester warm referrals and Stockton signposting led to clients being newly signed up to their supplier's Priority Services Register. This brings various benefits, including prioritization for reconnection in case of a power cut, advance notice of planned power cuts and free meter readings. It is also a way of flagging to the supplier if a customer has additional communication needs.

Table 24: Clients newly registered to supplier PSR

New PSR signups	All (n=54)	Manchester (n=32)	Stockton (n =22)
Minimum	19%	28%	5%
Maximum	35%	47%	18%

As shown in Table 24, the Manchester pilot led to an increase in the range of 28% - 47% of new sign-ups amongst those who responded at follow-up. The Stockton pilot led to an increase in the range of 5% - 18% of new sign-ups.

The reason for reporting a minimum and a maximum of new sign-ups is because a high proportion of clients did not know if they were on the PSR at baseline. Some of these clients may already have been on the PSR without being aware. However, since you have to request to be added, it is likely that most were not signed up at baseline. The 'minimum' includes those who said 'no' to being on a PSR at baseline and 'yes' at follow-up. The 'maximum' additionally includes those who said 'don't know to being on a PSR at baseline, and 'yes' at follow-up.

6.1.2 Change in tariff or in payment method

Changes in tariff can bring important savings in the amount paid for energy. The elapsed time between baseline survey and follow-up survey is sufficient for clients to have switched tariff and possibly to have received a first bill but may be insufficient to know how much a client has actually saved over a year. In both the baseline and follow-up survey, clients were asked their overall energy costs per year.

Clients were also asked if they had compared tariffs or switched tariffs. People who report having compared tariffs may go on to switch to a cheaper tariff, though this is not certain.

Clients were also asked about their payment method at baseline and in follow-up. The cheapest energy tariffs are generally those which are payable by direct debit, whereas prepayment tariffs (particularly prior to the price cap introduced in April 2017) are the highest. Payment on receipt of bill, either monthly or quarterly, can often be an indicator of being on a standard variable tariff, which is usually the most expensive credit tariff offered by suppliers. Thus changes in payment method from prepayment to a credit or from payment on receipt of bill to direct debit are likely to indicate a switch to cheaper tariff.

Out of 32 Manchester clients who completed a follow-up survey:

- 38% (12) had switched energy supplier since receiving advice and a further 16% (5) had compared supplier but had not switched supplier

- Of 17 who were paying for electricity by prepayment meter before the intervention, 41% (7) had switched to a different payment method, 5 to monthly or quarterly bill and 2 to direct debit
- Of 17 who were paying for gas by prepayment meter before the intervention, 35% (6) had switched to a different payment method, 24% (4) to monthly or quarterly bill and 12% (2) to direct debit

Out of 22 Stockton clients who completed a follow-up survey:

- 27% (6) had switched energy supplier since receiving advice and a further 23% (5) had compared supplier but had not switched supplier
- 81% (18) clients were already paying for electricity by direct debit before the intervention. None were using prepayment meters. As most clients in Stockton were likely to be using cheaper payment methods, changing payment method is unlikely to have been appropriate.

6.2 Self-reported changes in energy behaviour and comfort levels

6.2.1 Change in heating behaviours

Figure 8 shows clients self-reported changes in 'coping' heating behaviours at baseline and in follow-up to support. The baseline and follow-up survey asked about a number of coping mechanisms that clients may use in response to being unable to afford to heat their home to a recommended safe temperature. These include:

- Turning the heating down even though they would have preferred to be warmer
- Only heating and using one room in their house for periods of the day
- Used less hot water than they would have preferred
- Had fewer hot meals or hot drinks than they would have liked

Figure 8 shows that following support, the number of clients who say they do not resort to any coping strategies has increased from 42% to 79%. Most encouraging are reductions in the number of clients who employ coping strategies to limit their use of heating. However, this change in reported behaviour may in part be associated with seasonal effects, since the baseline data was collected in winter and the follow-up data in spring or summer.

Figure 8: Coping strategies adopted by all clients before and after intervention (n=24)

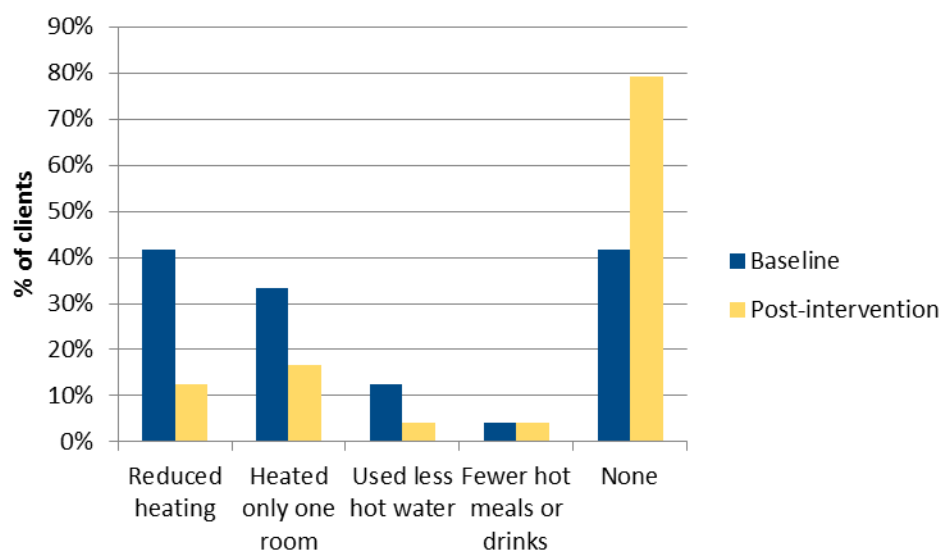
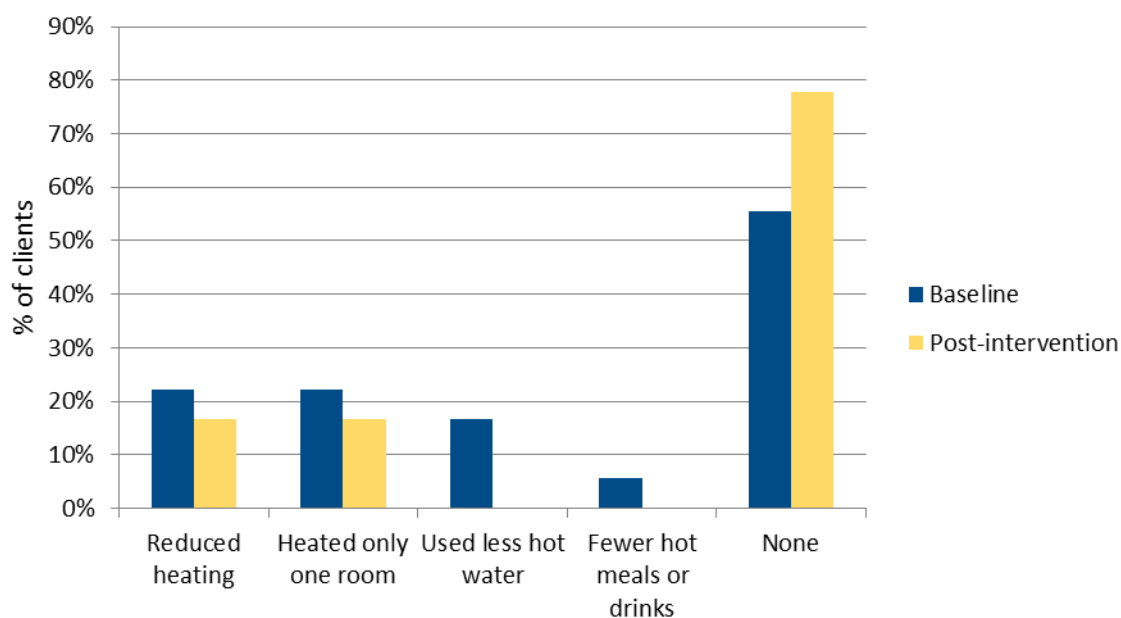


Table 25: Heating coping strategies reported at baseline and follow-up

	All (n=32)			Stockton (n=22)		
	Baseline (%)	Follow-up (%)	Change (%)	Baseline (%)	Follow-up (%)	Change (%)
Reduced heating	42	13	-19	22	17	-5
Heated only one room	33	17	-16	22	17	-5
Used less hot water	13	4	-9	17	0	-17
Fewer hot meals or drinks	4	4	0	6	0	-6
None	42	79	+37	56	78	+22

Amongst Stockton clients, Figure 9 shows 78% (17) of clients reporting they do not use any coping mechanisms at follow-up compared to 56% (12) at baseline, an improvement of 22%.

Only 6 Manchester clients completed this question both at baseline and at follow-up. All 6 reported turning heating off or down despite preferring to be warmer and 4 reported only heating one room at baseline. At follow-up, 5 of the 6 Manchester clients reported they were not using any of the coping mechanisms.

Figure 9: Stockton clients' use of coping strategies at baseline and follow-up (n=18)

6.2.2 Energy Costs

Clients were asked about their annual energy costs at baseline and in the follow-up survey. Most people (86%, 56) didn't feel able to give an exact figure, but instead indicated if their costs were under or over a threshold £1400 a year. For the purposes of analysis, those with costs under £1400 a year are deemed to have low energy costs, and those with costs over £1400 are deemed to have high energy costs. As shown in Table 26, 24% (13) of all clients reported a decrease in their energy costs. In Manchester, 31% (10) of clients reported a decrease in energy costs. This should be interpreted with caution as follow-up surveys were conducted at a different time of year, less than one year from the intervention, so this likely to explain some of the differences between reported annual energy costs.

Table 26: Changes in heating costs before and after the intervention

	All (n = 54)	Manchester (n=32)	Stockton (n=21)
Decrease	24%	31%	10%
No change	67%	59%	81%
Increase	9%	9%	10%

6.2.3 Changes in perceived ability to manage to pay their bills

Figure 10 shows clients self-reported ability to manage to pay their bills at baseline and in follow-up to support. The graph shows a shift from clients reporting finding it difficult to manage to pay their bills before the intervention towards clients finding it easier to manage to pay their bills following the intervention.

For the purpose of analysis, responses were converted to a numerical scale 1-5 where 1 = very difficult and 5 = very easy, giving a mean score of 2.72 at baseline and 3.80 at follow-up. A paired

samples T-test shows a significant difference between baseline and post-intervention responses for all pilots at a 95% confidence level ($p < 0.001$, $n = 50$).¹⁰

Figure 10: Clients self-reported ability to pay their bills at baseline and follow-up (n=53)

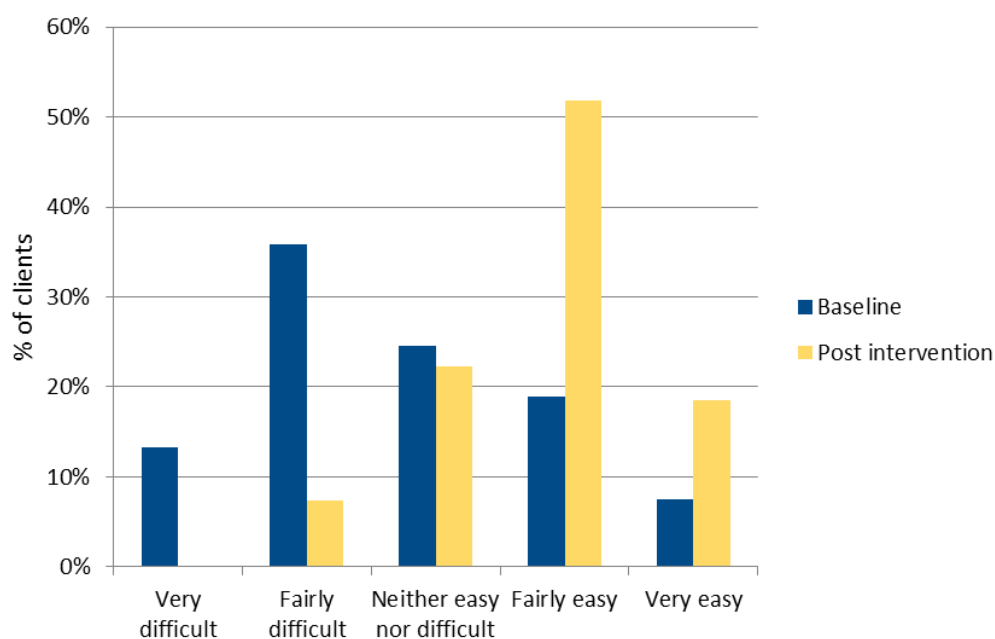


Figure 11 shows the change in self-reported ability to pay bills at baseline and at follow-up amongst clients reached by the Manchester pilot.

Figure 11: Manchester clients' self-reported ability to pay bills at baseline and follow-up (n =32)

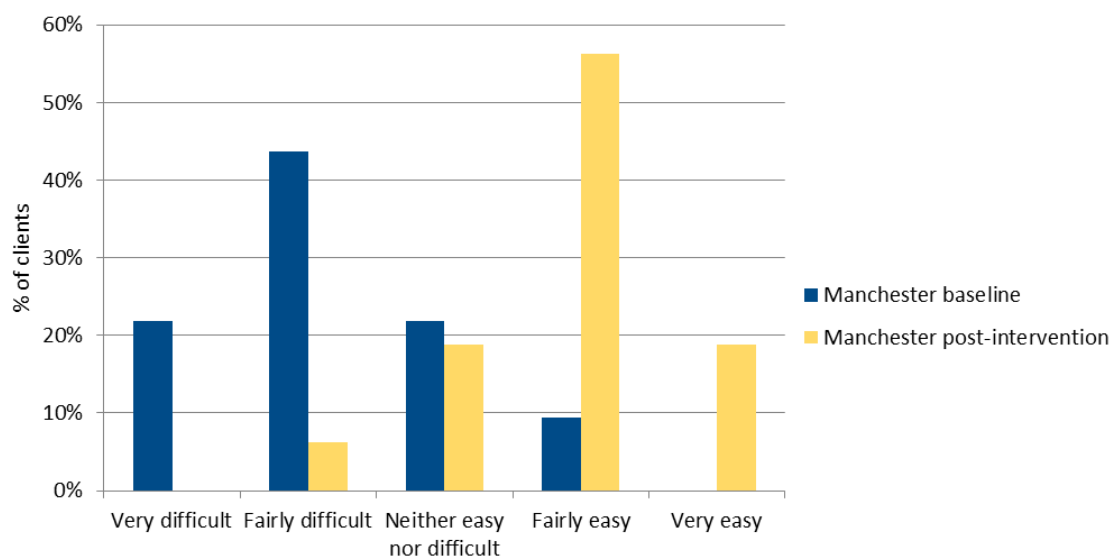
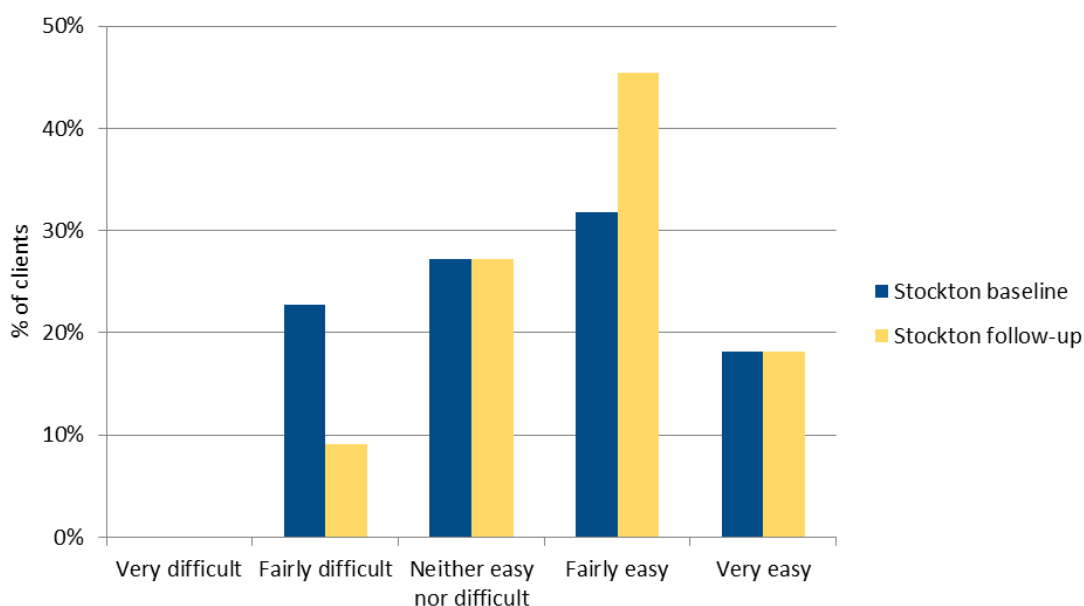


Figure 12 shows the change in self-reported ability to pay bills before and after the intervention amongst clients reached by the Stockton pilot. For the purpose of analysis, responses were converted to a numerical scale 1-5 where 1 = very difficult and 5 = very easy, giving a mean score for Manchester of 2.21 at baseline and 3.86 at post-intervention, and for Stockton 3.43 at baseline and 3.71 post-intervention. A paired samples T-test shows a significant difference between baseline and post-intervention responses for Manchester at a 95% confidence level ($p < 0.001$, $n = 29$). The same test for Stockton showed no significant difference between baseline and post intervention responses ($p = 0.11$, $n = 21$).

Figure 12: Stockton clients' self-reported ability to pay bills before and after intervention (n=22)



The increase in self-reported ability to pay bills was greater amongst clients in Manchester than in Stockton. In Manchester, 53% (29) of clients used prepayment meters at baseline whereas the majority of clients at Stockton (73%, 30) paid by direct debit. At follow-up 7 out of 17 (41%) prepayment users in Manchester had switched to a different payment method. Clients on pre-payment meters or who have recently switched from pre-payment are more likely to have noticed a difference in the amount they pay than those with existing direct debit arrangements in the elapsed time between baseline and follow-up. Those who pay by direct debit are only likely to report any difference in their ability to pay bills where their supplier adjusts their monthly payments in response to a change in their energy use. A variety of differences in the referral pathway and advice delivery may also account for differences between the Manchester and Stockton pilots.

Table 27: Changes in self-reported ability to pay energy bills

Change in ability to pay bills	All (n=53)	Manchester (n=32)	Stockton (n=22)
Easier	60%	74%	41%
No change	30%	19%	45%
Harder	9%	6%	14%

The increase in self-reported ability to pay bills was greater amongst clients in Manchester than in Stockton. Again, this may have been due to the high proportion of Manchester clients paying by prepayment meter at baseline, compared to the high proportion of Stockton clients paying by Direct Debit.

At follow-up 7 out of 17 (41%) prepayment users in Manchester had switched to a different payment method. Clients on pre-payment meters or who have recently switched from pre-payment are more likely to have noticed a difference in the amount they pay than those with existing direct debit arrangements in the elapsed time between baseline and follow-up. Those who pay by direct debit are only likely to report any difference in their ability to pay bills where their supplier adjusts their monthly payments in response to a change in their energy use. A variety of differences in the referral pathway and advice delivery may also account for differences between the Manchester and Stockton pilots.

6.3 Other changes in circumstances

In order to understand how far other changes in circumstances may have influenced changes in health and wellbeing, clients were asked if they had experienced significant changes in their circumstances which had made a difference to how they manage their energy bills or how they use energy at home.

Out of 33 Manchester clients who completed a follow-up survey, 30% (10) reported a significant change in their circumstances. Whilst the survey did not require an explanation of the nature of the change, in one case this was reported as a significant deterioration in their health.

Out of 22 Stockton clients who completed a follow-up survey, 14% (3) reported a significant change in their circumstances. In one case this was reported as a significant deterioration in their partner's health.

7 Health and Wellbeing Analysis

The following section contains analysis of the health and wellbeing data collected at baseline and post-intervention. Where changes are reported, they are based on paired responses from individuals pre and post intervention responses.

7.1.1 ONS Wellbeing Measure

The Office for National Statistics (ONS) Wellbeing measures were included in the Winter Resilience Pilot questionnaire (WRPQ) to measure client wellbeing. The ONS measure and dataset was established in 2011. It is an annual survey that embraces a large sample of 150,000 adults. This allows researchers to have an understanding of national wellbeing to which comparisons can be made. It also permits an analysis of wellbeing over time.

Wellbeing is reported for all clients across pilots, with comparison to national wellbeing statistics, as published by the ONS. ONS personal wellbeing questions asked clients to respond on scale of 0 to 10, where 0 is “not at all” and 10 is “completely”, to the questions below:

- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

54 clients (all from the Manchester or the Stockton pilot) answered the personal wellbeing questions at baseline and in the follow-up. Clients reported very low scores for wellbeing at baseline. **Table 28** shows the average personal wellbeing ratings across all four measures of personal well-being for all clients. It shows that at baseline clients were much less satisfied with life, less happy, more anxious and more likely to say that life was not worthwhile compared to the adult population in the UK. Most of these baseline scores came from just two local authorities Manchester (n= 62) and Stockton (n=42) and these client scores were much lower even than the local authority mean (see

Table **28**). Note that whereas for life satisfaction, worthwhile and happiness, a high score indicates higher wellbeing, for anxiety a high score indicates worse wellbeing.

Table 28: Client baseline wellbeing scores compared to UK

ONS Wellbeing Indicator	Mean ratings (1-10)			
	Mean client baseline scores	Manchester LA adult scores	Stockton LA adult scores	Mean UK adult scores ¹¹ (2016)
Life satisfaction (n=126)	4.91	7.23	7.69	7.7
Worthwhile (n=126)	5.31	7.49	7.89	7.9
Happiness (n=126)	4.79	7.18	7.48	7.5
Anxiety (n=121)	5.83	3.0	2.81	2.9

Looking at the ONS wellbeing indicators (Table 29), overall there is modest improvement in the mean scores on each of the four wellbeing indicators, with a 15% improvement in life satisfaction mean score. However for the majority of clients their wellbeing scores either remained the same or declined on each of the indicators. Comparing clients who improved their wellbeing scores with those who did not there was no discernible difference in terms of gender or ethnicity. People aged over 65 were less likely to show any improvement in their wellbeing scores. Unfortunately, the n values are too small to do any reliable test of significance.

Manchester clients had, on average, higher levels of improved wellbeing than Stockton clients. Clients with Housing Association-RSL tenure were more likely to report improved wellbeing scores than clients in other forms of tenure.

Table 29: ONS Wellbeing Indicators – Change (n=54)

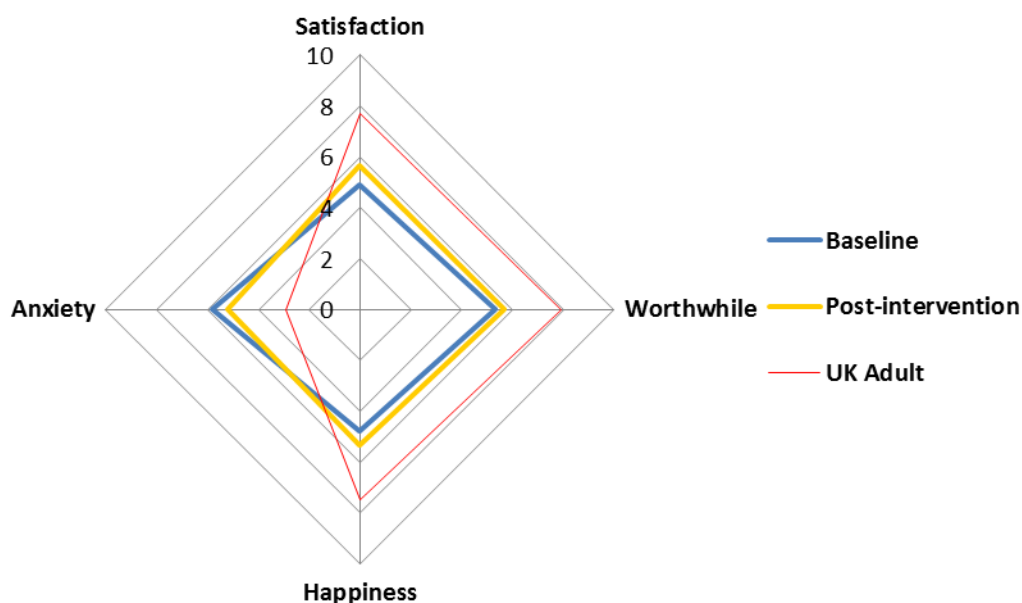
ONS Wellbeing Indicator	Mean score at base	Mean score at follow-up	Change	Percentage improvement in mean score
Life satisfaction (n=54)	4.91	5.67	0.76	15%
Worthwhile (n=54)	5.31	5.67	0.36	7%
Happiness (n=53)	4.79	5.32	0.53	11%
Anxiety (n=53)	5.83	5.21	0.62	11%

Figure 13 shows the improvement in mean wellbeing scores between baseline and follow-up, and how much lower clients' baseline wellbeing scores are than UK average.

¹¹

<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/jantodec2016>

Figure 13: Mean ONS Wellbeing indicators of clients at baseline, post-intervention and UK mean



7.1.2 EQ-VAS

The findings from the client Visual Analogue Scale (VAS), shown in Table 30, tend to reinforce the results recorded on the ONS measures for wellbeing. The VAS is a measurement instrument that tries to measure a characteristic or attitude that is believed to range across a continuum of values and cannot easily be directly measured. It is often used in epidemiologic and clinical research to measure the intensity or frequency of various symptoms and can be used with other measures to calculate the quality-adjusted life year (QALY). The QALY is often routinely used as a summary measure of health outcome for economic evaluation. It attempts to incorporate the impact on both the quantity and quality of life by asking clients to report how good or bad their health is on the day the WRPQ is completed. The scale ranges from 100 (the best health you can imagine) to 0 (the worst health you can imagine).

Table 30: Baseline and follow-up health rating VAS scores

	Mean VAS score at base	Mean VAS score at follow-up	Change	Percent of people improved
VAS score (n=51)	42.7	44.5	1.8	54%

Again, roughly half the clients reported that their health had improved while the other half reported it was the same or worse. Age and ethnicity had very little effect on the scores. Again, clients with Housing Association-RSL tenure were more likely to rate their own health higher at follow-up rather than any other tenure.

7.1.3 EQ-5D-5L

Clients were also asked to complete the EQ-5D-5L item. The EQ-5D-5L item is a standardised measure of health status developed by the EuroQol Group. It aims to provide a simple, generic measure of health for clinical and economic appraisal. It is often referred to as a quality of life questionnaire. The EQ-5D-5L, is a very simple measure which clients can complete at the start and end of treatment. Its name means: 'EuroQol – five dimensions – five levels'. It comprises five dimensions of health: mobility, ability to self-care, ability to undertake usual activities, pain and discomfort, and anxiety and depression. There are five options (levels) under each domain. As such it is a more dynamic way of assessing client health than the VAS because it gives more information. Table 31 shows a slight improvement in mean score, in line with changes to the VAS and ONS measure. However, this slightly cumulative improvement in the mean is somewhat undercut by the fact that 2 in 3 clients reported that their quality of life had deteriorated or remained the same. The mean improvement is accounted for by the fact that a small number of individuals reported more sizeable improvements in their individual health scores.

Table 31: Baseline and follow-up health rating on EQ-5D-5L

	Mean EQ-5D-5L score at base	Mean EQ-5D-5L score at follow-up	Change	Percent of people improved
EQ-5D-5L score (n=52)	15.3	15.66	+0.36	22%

If we explore the five dimensions we find on 4 of the 5 dimensions there are more clients reporting a decline in health status than those reporting improvement. It is only on the anxiety/depression dimension where more clients were reporting an improvement compared to a decline. This is shown in Table 32.

Table 32: Changes in EQ-5D-5L scores

EQ-5D-5L score Dimension (n=52)	Percentage of clients with DECLINING health scores at follow-up compared to baseline	Percentage of clients with the SAME scores at follow-up compared to baseline	Percentage of clients with IMPROVED scores at follow-up compared to baseline
Mobility	35%	46%	19%
Self-care	33%	46%	21%
Usual activities	39%	40%	21%
Pain/discomfort	35%	40%	25%
Anxiety/depression	23%	46%	31%

7.2 Health service usage

The Winter Resilience Pilot questionnaire sought to collect self-reported health service usage data. It shows that some of the clients in the sample have a high dependency on health services, as shown in

Table 33. This may explain why there is little change in the VAS and the ONS scores. Clients were asked to report on their health service usage in the last three months. Considering that on average adults in the UK attend a GP practice six times¹² a year (Kimberlee, 2015) these three month figures of primary care usage are quite high.

Table 33: Primary care service usage at baseline and follow-up

Type of health service usage	Average reported usage at baseline	Average reported usage at follow-up	Difference
GP/ Doctor Appointment (n=33)	4.06	4.67	+0.61
GP/Doctor Home visit (n=5)	4.2	6.0	+1.8
GP/Doctor Phone (n=10)	5.2	3.4	-1.8

The number of responses is too small to enable any further meaningful analysis of relationships between the support provided and any change in demand for health services. The data on primary care usage is reported here solely to demonstrate the above-average dependency on health services of the client group supported.

12 Kimberlee, R. (2015) What is social prescribing? Advances in Social Sciences Research Journal, Volume 2, No1

8 Project delivery

The in-house process evaluation produced information which is useful to informing understanding of the approach to delivery, the challenges encountered, the impacts achieved and the reasons for variations in impact achieved across different pilots comprising the overall Winter Resilience project. This section draws on the process evaluation findings to provide an overview of the project delivery. It describes the approach and experience from the Manchester and Stockton pilots for which impact evaluation was conducted. These are followed by a summary of the approach and experience of the other pilot sites, identifying some of the challenges faced by those pilot projects that struggled to either achieve referrals or collect data for inclusion in the impact evaluation. A summary of each pilot site is provided in Appendix B: Overview of the Local Citizens Advice taking part in the winter resilience pilot

This includes for each of the other pilot sites, details of pre-project activity, new scheme set-up, intended and actual referral pathway and delivery activities and commentary on the pilot phase experience and prospects for continuation into a second pilot phase.

8.1 Overview of delivery

The process evaluation found that the majority of the pilot offices were not ready to implement the service at the beginning of the 'delivery period' and had to change their referral or service model during delivery. Manchester and Stockton pilot offices were the only two pilot sites to achieve sufficient referrals and collect information for sufficient numbers of clients to include in the impact evaluation. The other 5 pilot sites (Wealden, Uttlesford, Gloucester, Southwark and Liverpool) faced difficulties either to achieve sufficient numbers of referrals or to collect information for use in the impact evaluation.

An overall finding of the process evaluation was that the provision of comprehensive 'cold homes' support is resource intensive, requires skilled advisers and often requires ongoing casework to meet the needs of individuals.

8.2 Manchester

8.2.1 Referral and partnerships

The Manchester pilot differed from others in that it was able to put in place its service delivery model as planned, with service delivery starting in October 2016. Manchester Citizens Advice had already developed partnerships with health providers as part of its work for a related project well in advance of 'going live'. This reduced the work required before the project started and enabled a longer referral time than other pilots.

The Manchester pilot received referrals from COPD nurses for COPD patients receiving home visits. Referral details were sent by fax. An experienced advisor with prior experience of delivering this type of advice undertook home visits. A high proportion of the cases involved follow-up case work. The new referral partner and pathway was added to the existing advice service.

8.2.2 Cold homes support service

During the home visit, the advisor used an existing action plan and home visit pack that had been pre-tested. The established home visit procedure included a triage and assessment, Priority Services Register check, a tariff check, practical demonstrations of how to use heating controls, identification of problems of damp and mould and advice on how to address these, advice on grants and trust funds which can help with arrears, discussion of insulation and energy saving measures and, where required, help dealing with energy suppliers. Each visit varied in length but each generally took at least an hour. The advisor found that use of a laptop with internet access at home visits was essential. The advisor found that a lot of casework activity was required, which was manageable but challenging for a single advisor. The severity of clients' health issues meant in a small number of cases some visits could not take place as planned.

Referral volumes from COPD teams dropped off from the early months, with a pattern of high referral volumes at the beginning and fewer in subsequent months. For an ongoing project, referral volumes would be likely to be steadier over time.

8.2.3 Feedback on delivery

Feedback from COPD partners was predominantly positive, as exceeding the expectations of 4 out of 5, whilst referral volumes were reported to be either higher than expected or as expected. COPD partners felt that the service improved the quality of life for their patients and considered that the service helped patients feel more supported, with more holistic care, addressing their concerns beyond the usual health sphere.

8.2.4 Effect on project outcomes

The established advice delivery approach and experienced advisor in place appear to be important enabling factors for the Manchester pilot to achieve higher numbers of referrals and positive outcomes for clients, even in the short time frame from baseline to follow-up survey. Positive feedback from COPD referral partners demonstrates support for the value of the pilot.

8.3 Stockton

8.3.1 Referral and partnerships

The Stockton pilot had to make changes to the referral partners and process after the project started. The Stockton pilot had planned to receive referrals from pharmacists but found that there was low engagement from patients. In response, the pilot changed the focal referral mechanism to community care workers in GP practices. These are non-clinical staff who visit the top 2% of patients in need from each practice. Referrals were made using email. These changes were effective in increasing the number of referrals received within the timeframe of the pilot phase.

8.3.2 Cold homes support

Home visits were made by an experienced advisor. Limited detailed feedback was provided on the procedure followed. A wide variety of onward referral pathways was noted, including to:

- Priority Services Register
- Warm Home Discount
- mentoring/befriending services
- carers assessments
- disabled facilities grants through the local authority
- re-housing
- statutory sources for assessment and need
- fire service
- LA heating and handyman service

8.3.3 Feedback on delivery

The efforts to achieve referrals from an advisor visiting pharmacies proved an inefficient approach. In reflecting on the reason for this, it was thought that the pharmacy setting is too transactional, though it was felt that a community pharmacy or hub pharmacy might have yielded more referrals. This was despite the enthusiasm of the pharmacists and was the same in both pharmacies visited, which each cater to different local demographics. Efforts to initiate referrals from GPs were also unsuccessful and this lack of success was considered to reflect limited take-up of social prescribing approaches in the local area. The referral pathway from community care workers located in GP offices with a focus on patients with the most acute needs proved more successful.

8.3.4 Effect on project outcomes

The change of referral pathway contributed to achievement of a fair number of referrals and, in turn, positive outcomes for clients, even in the short time frame from baseline to follow-up survey.

8.4 Other Pilot Sites

8.4.1 Referral and partnerships

All the other pilot sites found that the actual referral pathways used did not fully fit with what had been planned. Establishing partnerships took longer than expected and required a lot of managerial resource. Challenges in establishing partnerships included other demands on potential health partners and competition with other services. Delays or difficulties in establishing partnerships and functioning referral pathways severely limited the numbers of referrals achieved during the intended pilot delivery period.

Two projects (Uttlesford and Liverpool) sought to build on existing referral mechanisms, including an Advice on Prescription scheme and a multi-agency referral system. In both cases, this gave rise to routing issues, which made it hard for pilot staff to know whether a client had been referred for cold homes advice or other forms of advice from Citizens Advice. These pilots also considered it likely that potentially eligible clients had not been identified (or self-identified) as having target health conditions and so had not been directed to the Winter Resilience service in their use of the referral mechanism.

Establishing partnerships and referrals from health partners took longer than expected and did not generate the volumes of referrals hoped for. The Gloucester pilot's initially agreed health referral

pathway fell through due to changes affecting the health partner. The Uttlesford and Liverpool pilots both used established referral mechanisms which include GPs as referrers, though it was unclear to what extent GPs were accurately identifying and referring people with target health conditions to the Winter Resilience service. The Gloucester and Wealden pilots were both successful in establishing referral arrangements with health provider partners but too late for sufficient referrals to feed into the impact evaluation. Pilots relied on non-health referral partners, including Citizens Advice internal referrals, to achieve referrals where health referral pathways were unsuccessful.

The Southwark pilot received referrals from community partners by attending events where interpreter services were available for provision of advice at the event. However a lack of interpreter provision for follow-on advice meant that further onward referral did not occur.

8.4.2 Cold homes support service

The actual delivery pathways for the other five pilots indicate that the service provided was not as complete as planned. In several of the pilots, it appears clients received one off advice appointments with limited additional support. For example, the Wealden pilot signposted clients for further support rather than the intended warm referrals with further updates provided to clients. The Southwark pilot provided one-off advice at community outreach events but was unable to provide follow-on home visits or onward referrals due to language barriers. It is understood that resourcing issues affected the ability of pilots to deliver the intended referral and delivery pathways.

In the case of both Gloucester and Liverpool, problems with client case recording mechanisms meant that these pilots were unable to accurately report on which clients received advice from different providers, including the intended Winter Resilience provision. Generally the pilots struggled to follow up on support to provide updates to clients or get feedback on follow-up support provided by other services.

8.4.3 Feedback on delivery as part of trial

Volunteers and staff found that the challenges of trying out new referral methods was harder than expected and meant that most of the pilots reached far fewer clients than hoped. For a number of the pilot projects, the volunteers and staff found the amount of information collection for evaluation purposes onerous. This limited the number of baseline and follow-up interviews completed. Together problems of readiness and capacity to collect information are reflected in the lower-than-hoped numbers of clients and low numbers of baseline and follow-up surveys completed.

8.4.4 Effect on project outcomes

The challenges which affected achievement of target (or sufficient) numbers of referrals and delivery against the planned complete referral pathway necessarily meant that these pilots will not have achieved the size or extent of outcomes envisaged. In addition, capacity issues combined with the extent of information collection requirements for evaluation purposes prevented reporting and analysis of the outcomes.

It is likely that for those pilot sites that have subsequently been able to establish partnerships with health providers for referrals and which have sufficient capacity to deliver against their planned pathway and to collect information, there will be good prospects for achieving and demonstrating

outcomes. For some of the pilots, critical changes need to be made to overcome barriers for any likelihood of outcomes being achieved. These include further improvements to referral pathways, making changes to referral mechanisms to enable correct routing of referrals, providing interpreter services to enable further support to be delivered and onward referrals to be made.

8.5 Qualitative feedback reported in follow-up survey

When asked for further comments about the service during the follow-up survey, clients who chose to respond gave overwhelmingly appreciative feedback on their experience of the service received. This feedback included specific examples of improved personal wellbeing felt by the individual, expressed in terms of feeling less scared of bills and more able to manage them; more aware of what services are available, feeling more at ease, increased confidence and feeling happy as a result of the support received. It is notable that several clients in the Manchester pilot mentioned the advice provider by name and included particularly warm feedback on the quality of the support provided by them.

9 Discussion

9.1 Introduction

There was varied success in achieving hoped-for numbers of referrals across the 7 pilots. Overall numbers of clients referred were far fewer than hoped and in 3 offices there were fewer than 10 clients. Manchester and Stockton stand out for achieving higher numbers of referrals. For this reason, the discussion mainly focuses on the achievements of the Manchester and Stockton pilots.

9.2 Success in reaching target groups

The project proved successful in reaching target groups of people who are at particularly high risk of health effects from living in a cold home, including older people and people with particular health conditions, as well as households at risk of fuel poverty. The project also reached clients who may be vulnerable in power cuts but who were not known to their supplier as vulnerable customers. All the pilots reached target client groups, even without referrals from health providers, though the numbers reached varied considerably.

The clearly defined referral pathway from COPD specialist nurses enabled Manchester to achieve a relatively large numbers of referrals, whilst Stockton's shift to referrals from community care workers located in GP offices enabled Stockton to make up for a slow start from its initial unsuccessful focus on referrals from pharmacies. In both Manchester and Stockton, the referral was from staff with a specialist focus on patients with specific health needs that fit the eligibility criteria of the pilot. In contrast with these two pilots, other pilots had more diverse referral pathways or used partners serving a more general client group but these proved much less successful in securing referrals (though whether this was down to the pathway or the level of effort applied to it is not clear).

9.3 Outcomes achieved

The small scale of the project and short time period from baseline to follow-up survey for reported changes to happen are likely to have limited the potential for statistically significant changes to become visible. A wider point to recognise is how far it is reasonable to expect a change in wellbeing or in health as a result of a single advice session. The findings are limited by an inability to identify how many points of contact there were between the advisor and the client. However it does highlight that in Manchester, where clients received help on more issues, outcomes were greater. The process evaluation findings also indicate that the Manchester clients benefitted from case work in follow-up to at least one home visit. The quality of the advice provision and the number of points of contact may have been important factors in influencing the success in outcomes achieved by Manchester clients.

9.3.1 Heating and energy efficiency measures installed

Despite the limited availability of public funding for installation of measures, out of the 32 clients in Manchester who responded to the follow-up questionnaire, 31% (10) had measures installed following the advice. The improvements to their heating or to the energy efficiency of their home are

likely to contribute to improved ability to stay warm and to reduce their energy costs over the longer term. Depending on the timing of installation, it is possible that the consequent benefits for wellbeing were not yet apparent at the time of the follow-up questionnaire. A related important outcome was that half of Manchester clients reported that they had an improved understanding of their heating controls to regulate their heating better. This has the potential to bring benefits in the heating season, allowing them to better regulate the temperature of their home during cold spells, potentially helping them avoid flare-ups in their condition.

In Stockton, the only energy efficiency measure installed was double-glazing. None had received insulation. Three clients had either heating or energy efficiency measures installed. This may reflect lack of available funding for measures in Stockton. The low numbers of heating and energy efficiency measures installed is likely to limit the longer term impact of the advice provided on client's health and wellbeing.

9.3.2 Income maximization

Out of the 32 clients in Manchester who responded to the follow-up questionnaire, 44% (14) received additional benefit payments as a result of the advice received. Out of 22 clients in Stockton who responded, 41% (9) received additional benefit payments, with attendance allowance payments being the main new payment received. This improved income is likely to support the ability of individuals to afford their energy bills as a key part of their overall household expenditure. Increased uptake of Warm Homes Discount will directly reduce their electricity bill over the winter period, supporting clients to stay warm affordably.

9.3.3 Priority Services Register

The advice resulted in an increase in the number of clients with long term health conditions signed up to their supplier's PSR, with 69% (22) of Manchester clients signed up at follow-up, as compared to 5% (2) definitely signed up at baseline. This will mean that in future more clients will be flagged by their supplier as requiring additional support, including prioritisation for reconnection in the case of a power cut.

9.3.4 Ability to pay bills

Manchester clients achieved a more marked improvement in their ability to manage and pay their bills following advice delivery than Stockton clients. This may be in part because Manchester clients with prepayment meters are likely to have found it easier to observe savings than Stockton clients paying by direct debit.

9.3.5 Change in heating behaviours

Significant changes were identified in clients' heating behaviours before and after the intervention. As considerably less clients reported turning their heating down or off even though preferring to be warmer, and more clients reported not adopting any coping mechanisms due to being concerned about heating costs. This suggests clients feel better able to heat their homes to an adequate temperature.

9.3.6 Reducing fuel poverty

As explained above, it is not possible to make robust estimates of the numbers of households taken out of fuel poverty following their involvement in the project.

However, 31% (1) of Manchester clients reported no longer having high fuel costs after the intervention, therefore were likely to have moved out of fuel poverty. Households gained additional income and/or had measures installed in their home following the advice. This indicates that the project contributed towards reducing the proportion of income spent on fuel by those households.

9.3.7 Health outcomes

The analysis of changes in wellbeing and health provide a mixed picture. Whilst the ONS wellbeing scores showed a modest improvement in the mean scores on each of the four wellbeing indicators, with the VAS scores also showing a slight improvement in mean VAS score at follow-up, the EQ-5D-5L measure suggests that for a majority of clients, there was no change or even a decline, though a small number of Manchester clients had higher scores at follow-up. The number of clients providing baseline and follow-up data is too low to do any reliable test of significance.

The more promising outcomes of self-reported changes in ability to pay bills, changes in heating behaviours, improved understanding of heating controls, installation of heating and energy efficiency measures and uptake of additional welfare payments by clients may over the longer term contribute to health benefits that were not evident at follow-up. However, this is speculative and relies on assumptions that such changes will trigger felt benefits to health and wellbeing.

The lack of a control group with similarly severely poor health, whose health may have deteriorated over the same time period, means it is important not to entirely disregard the value of the support provided. Given that all clients have serious long term conditions, including COPD, it is understandable that reported improvements in health and wellbeing are less than hoped for. The support provided may have slowed any deterioration in their health from what would otherwise have been the case.

10 Conclusions

The Manchester and Stockton pilots conducted as part of the Winter Resilience project demonstrated two different referral pathways from health practitioners to an integrated advice service, reaching people at risk of harm from the health effects of cold homes due to their long term health condition. Important elements contributing towards the success of the services developed include prior experience of advice delivery, provision of a wide range of advice to each client, ongoing case work, signposting and onward referrals to other support. As such, the delivery models used by the Manchester and Stockton pilots offer promise as potentially replicable models, with the Manchester pilot emerging most strongly as a fully-developed delivery model for replication.

However, the experience of the overall Winter Resilience project would suggest that Citizens Advice should be cautious in trying to apply a 'one-size-fits-all' approach across very diverse contexts. The planned second pilot phase should provide an opportunity to better understand which models are suitable for different contexts. It is evident that considerably greater time than previously envisaged is required to develop effective referral pathways with health providers. Even when adding on to existing social prescribing models, attention needs to be given to achieving effective routing of target clients towards the service. The skills and capacity requirements of Cold Homes advice provision and follow-up casework should not be under-estimated, including for expansion from initial pilot to a longer term service.

Drawing on the process and impact evaluation findings, tentative conclusions can be made that the use of a well-defined referral pathway from health providers who narrowly focus on working with patients with directly relevant health conditions is an effective way of achieving appropriate volumes of referrals for target client groups. The pilots that chose to use more general referral pathways, either from more generalist health providers or from other organisations found that it took more time than expected to set up the service, which in turn made it harder for them to get referrals and collect data to demonstrate pilot impact. Hence it is too early to conclude whether more general pathways can work well to identify and refer suitable volumes of eligible individuals.

The use of cold homes advice staff experienced in delivery of complex advice, with the capacity to collect data and provide follow-up case work support is important in contributing to and demonstrating the achievement of benefits by clients.

Over the period of the impact evaluation, the pilot showed that beneficial changes to the energy efficiency of homes, household income, share of household income spent on heating costs, client confidence in use of heating controls and risk of fuel poverty of clients can be achieved by such a service. The pilot also demonstrated that such a service can identify vulnerable clients to their supplier as requiring additional support.

The evidence on health and wellbeing outcomes achieved by clients is inconclusive, with a mix of modest improvements in average self-reported wellbeing but with many individuals' self-reported health and wellbeing actually worsening over the period of the research. It is important to keep sight of the fact that the clients reached had much worse than average health at baseline so the interventions may have slowed the worsening of their condition. The lack of a control group means it is not possible to demonstrate whether this is the case, or the extent of any such effect..

11 Recommendations for next steps

The following are recommendations to Citizens Advice.

1. Local Citizens Advice wishing to develop similar cold home referral services to those provided by Manchester or Stockton should recognise the importance of partnership building, using skilled case workers and investing in training. This has resource implications.
2. Providing a cold home referral service is more feasible for local Citizens Advice with a track record of delivering high quality Energy Best Deal sessions and Energy Best Deal Extra one to one appointments.
3. The pilots' experience suggests there are two broad approaches to developing referral schemes:
 - a. Target those with particularly poor health, or
 - b. Target a wider group of those vulnerable to the effects of cold homes but who are not necessarily severely unwell

Local Citizens Advice may wish to target both groups however, this entails developing very different referral pathways. Manchester and Stockton successfully focused on the first group: their schemes identified and negotiated a suitable specialist health referral pathway and focused on health specialists who worked directly with target groups at risk of the health effects of cold homes. Referral schemes which aim to tackle the second group will need to investigate alternative referral pathways. Any extension of the pilot should aim to develop referral pathways that embrace this broader, more preventative approach.

4. Allow more time for otherwise promising pilots that were slow to get started to continue so that the effectiveness of other potential referral routes can be better understood. However, it is recognised that short term funding often militates against this.
5. Embed evaluation and design early on in the development of new projects. With respect to cold home services, carry out an early phase of pilot testing and recognise that it may be necessary to change the referral pathway. Outcome evaluation should only take place once the delivery model is established and the service operational.
6. Scaling up capacity to deliver services as they grow is likely to present a future challenge for those pilots that currently rely on a single advisor to provide a complex service to a limited number of clients. The requirements are demanding and resource intensive.
7. The pilot offices were asked to collect a substantial amount of data to allow in-depth evaluation. However, a number of the offices found this very burdensome, particularly those reliant on volunteers. Simplify minimum data collection requirements for future cold home services to those essential for internal reporting and the effective delivery of tailored advice.

8. For cold home referral services with a health partner referral pathway, the choice of health outcome measurement instruments should be agreed with the health partner. For cold home referral services with more general referral pathways that choose to collect such data, it is recommended that the ONS wellbeing questions be adopted rather than EQ-5D-5L. The wellbeing questions are relatively simple to ask and there is suitable national comparator data for people by age / by health condition. The analysis of ONS wellbeing questions is more straightforward for Citizens Advice to undertake in-house.
9. Time the future impact evaluation of any ongoing service to collect baseline information at an early stage and to conduct follow-up surveys a full winter heating season following advice delivery. Depending on numbers of clients reached, a sample survey approach may be appropriate. This will minimise demand on staff. Data collection should be the responsibility of staff, not volunteers.
10. Home visits are of key importance for any future service, as this allows demonstration of how to use heating controls such as TRVs, thermostats and programmable heating devices. Home visits also allow more tailored advice in relation to the condition of the home. With the smart meter rollout, advice on how to use the in-home display to help in understanding and better controlling energy use will be of increasing importance. This needs to tie in with advice on heating controls. However, home visits are expensive and may need to be limited to consumers in particularly vulnerable circumstances.
11. Ongoing casework following a home visit also appears to be an important contributor to clients achieving successful outcomes. Again, case work is resource intensive and may need to be limited to those consumers who are considered unable or unlikely to take recommended actions themselves without additional support.
12. Give attention to solving problems of accurate routing of referrals in multi-referral mechanisms, including to support accurate self-referral. Relatedly, make sure that Citizens Advice and partner recording systems enable accurate reporting of referrals to and delivery of Winter Resilience support. This is likely to be an issue that social prescribing initiatives more generally have had to address and design solutions.

Appendices

A: Confidence intervals

Confidence intervals express the likely 'margin of error' within a response to a particular question. For instance, if 50% of respondents give a particular response to a question, with a 3% confidence interval at 95% confidence, we can be 95% confident that the 'true' value across the population is between 47% and 53%. Generally speaking, fewer respondents results in a greater margin of 'error' in the data.

There were, in effect, three samples for this dataset, the baseline survey, matched Citizens Advice client records and the follow-up survey.

Table 34: Confidence intervals for samples in the data set

	Matched Citizens Advice client record	Baseline survey	Follow-up survey
Sample size	160	147	56
Population	179	179	179
Confidence interval	2.53%	3.43%	10.89%

Table 34 shows the confidence intervals for each sample where 50% of respondents select one response (this gives the highest confidence interval), and where all respondents answer that particular question. Note that these will vary where respondents do not answer all questions, and different proportions of respondents give particular responses.

Where samples are broken down, for example between Manchester and Stockton confidence intervals will be higher.

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

Introduction

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

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

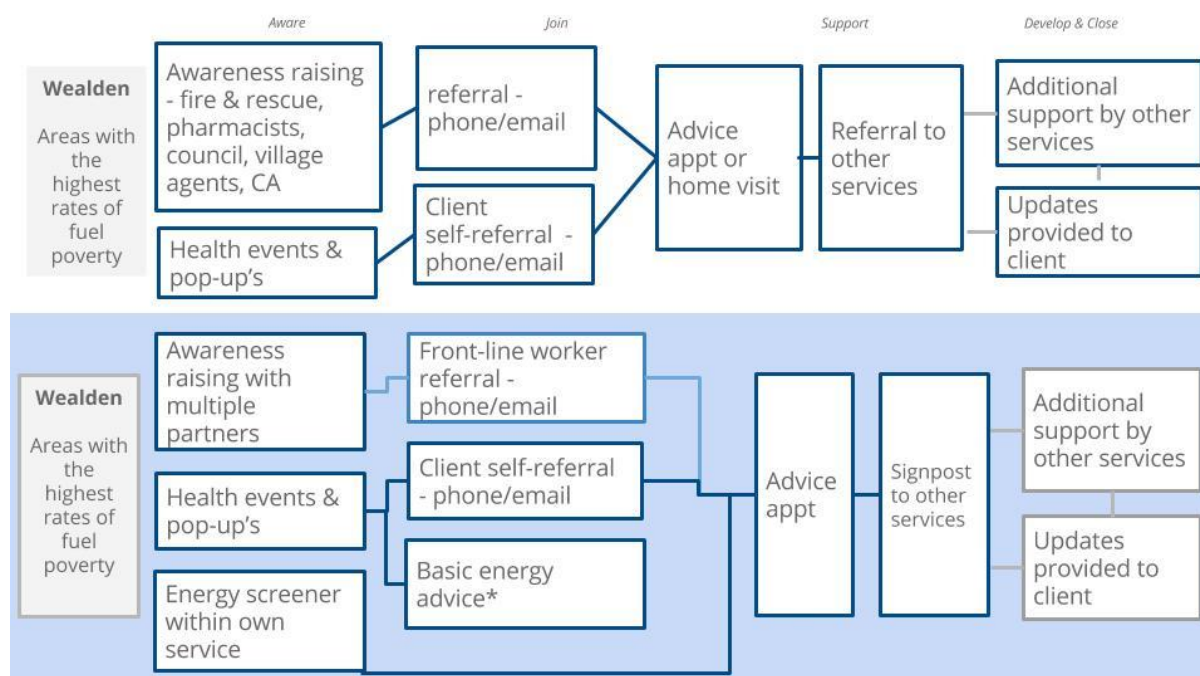
The main report already describes the approach adopted by Manchester and Stockton Citizens Advice – see Section 1.2.2 and Chapter 8. This appendix gives more details of the referral pathways the remaining Local Citizens Advice either set up or aimed to set up. It also gives further information about some of the issues encountered by the five offices. A diagram for each pilot gives an overview of the referral pathway. In each, the top row represents the intended delivery and the bottom is the actual delivery, including adaptations made once the service went live.

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

Wealden

Wealden Citizens Advice is a small office covering a large rural area. It relies extensively on volunteers to provide advice. Wealden aimed to reach remote rural households who often miss out on mainstream services.

Figure 14: Wealden pilot intended (top) and actual (bottom) referral pathway and delivery



Commentary

Wealden CA reached out to multiple partners with respect to seeking potential referrals. It also carried out a range of community outreach activities itself to promote the service. Wealden had some success in getting referrals from the local Council and from its outreach work but less so, initially, with health partners. However, by the end of the pilot period it had successfully engaged with the local dementia support team and the multi-agency care team. This was too late for referrals from these sources to contribute towards the evaluation of the pilot's impact. However, Wealden is one of the four offices taking part in the second pilot phase and will thus be able to provide evidence of the extent to which these new pathways have generated referrals.

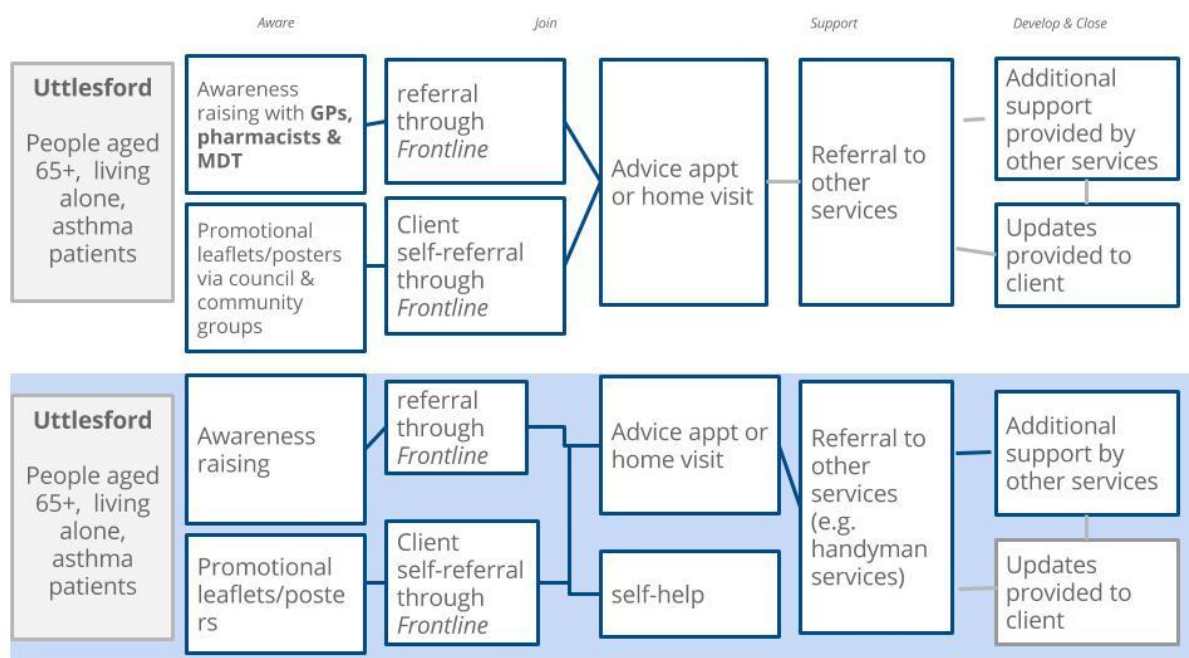
Wealden received a reasonable number of referrals during the pilot period (35). However, little impact data was collected on these referrals. This was in part because the volunteers did not feel comfortable asking questions about clients' health and in part because few of the referrals were generated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

These problems should be reduced for Phase 2 of the pilot due to the recent engagement of health partners in the project and because the data collection requirements have been considerably reduced (while still adhering to validated health surveys).

Uttlesford

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

Figure 15: Uttlesford pilot intended (top) and actual (bottom) referral pathway and delivery



Commentary

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

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

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

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

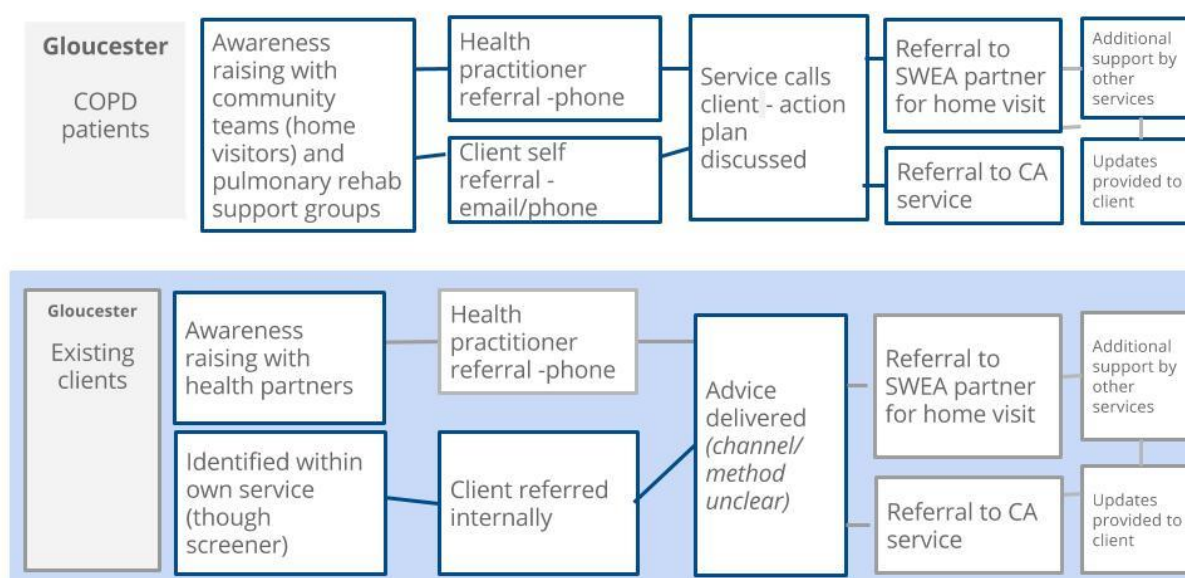
Towards the end of the pilot period Uttlesford Citizens Advice developed good relationships with local health partners, including a CCG and the Council's environmental health team, and is now receiving referrals from both partners. Uttlesford Citizens Advice is also taking part in the second pilot phase

and will thus be able to provide evidence of the extent to which these new pathways have generated referrals. It is also envisaged that advisers will be more willing to carry out the simplified reporting requirements.

Gloucester

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

Figure 16: Gloucester pilot intended (top) and actual (bottom) referral pathway and delivery



Commentary

Gloucester Citizens Advice put a lot of preparatory effort into developing a referral pathway with a particular hospital respiratory team. Unfortunately, this fell through due to key contacts leaving the team and a restructuring of the hospital respiratory team. Gloucester Citizens Advice therefore switched its approach to taking internal referrals from the Citizens Advice office's clients screened as having an underlying respiratory condition. However, this revised referral pathway started relatively late and only nine clients were helped through the project during the pilot period.

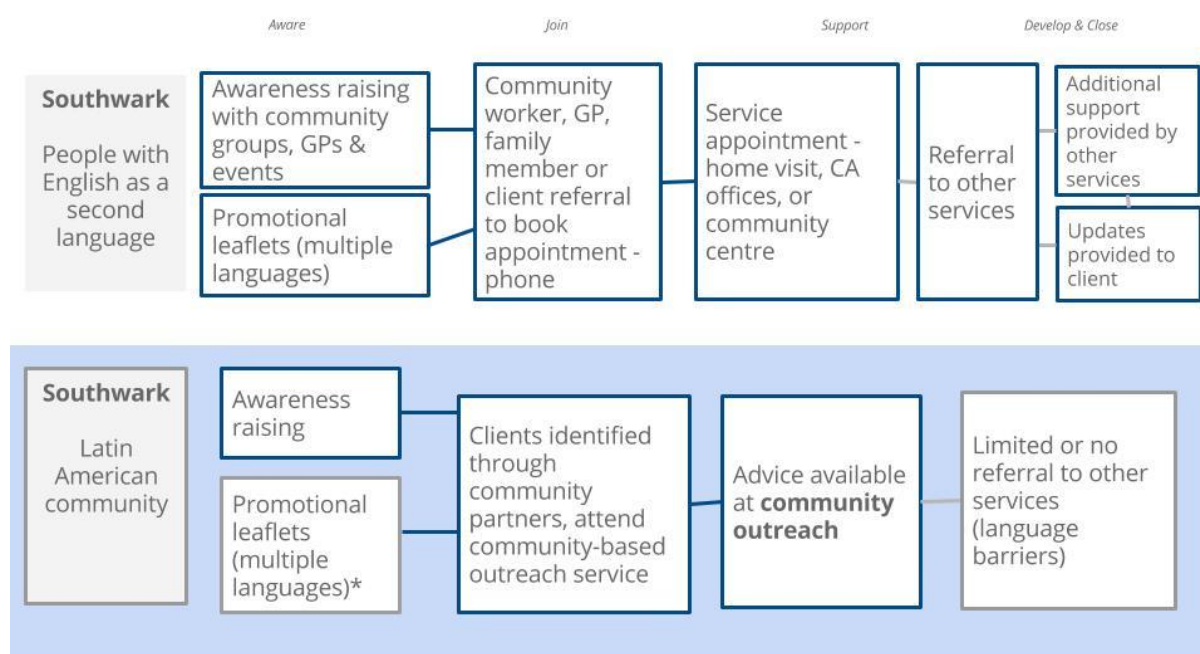
Gloucester Citizens Advice has, following negotiations over a period of 18 months, established a formal partnership with Gloucester CCG, again involving Severn Wye Energy Agency, in which the service will take County Council -wide referrals from health care professionals in GP surgeries, the Gloucestershire Respiratory Team and self-referrals from people who see publicity about the service.

The new project is funded by the Better Care Fund¹³ programme designed to join up health and care services. Gloucester Citizens Advice has employed a case worker to provide advice and coordinate help, with home visits forming an important part of the service. The project is using baseline and evaluation surveys similar to those developed for the winter resilience pilot to assess the impact of the project on clients' health and related issues.

Southwark

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

Figure 17: Southwark pilot intended (top) and actual (bottom) referral pathway and delivery



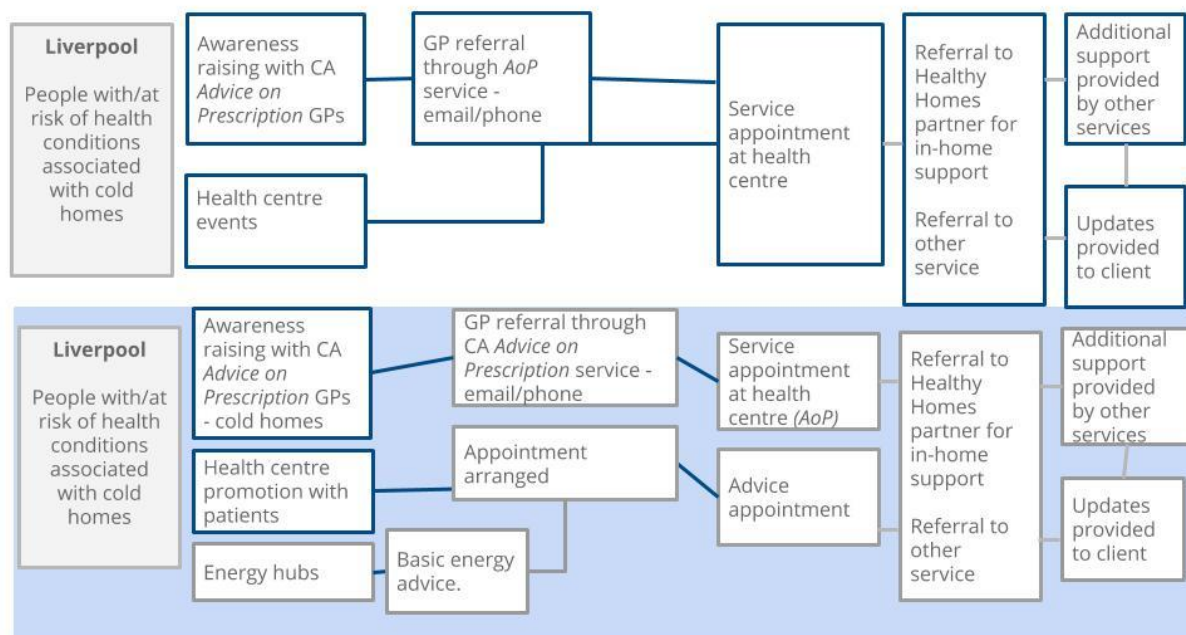
Commentary

Southwark Citizens Advice found that language barriers prevented onward referrals or further case work for most clients (8 clients were referred on). Language interpreter services were provided for the first advice appointment but were not available for the more intensive referral process. The project found that many of the households they spoke to were living in very poor housing. This suggests there is considerable unmet need for a cold homes referral service.

Liverpool

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

¹³ <https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>

Figure 18: Liverpool pilot intended (top) and actual (bottom) referral pathway and delivery

Commentary

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

The project found it difficult to differentiate the cold homes service from the existing 'Advice on Prescription' service. GPs, for example, would often send people straight to Advice on Prescription without necessarily identifying the client had health problems associated with cold homes. Similarly, Healthy Homes would often refer people to Liverpool Citizens Advice for debt advice but Liverpool Citizens Advice was not sure which particular referral service it should report on, i.e. winter resilience or debt.

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

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

C: Data collection instruments



Winter resilience pilot

Consent and contact details form

We are delivering a new service for clients that offers advice and support to help people heat their homes.

We want to know whether this service is helpful for our clients. We are asking people some questions about themselves and their situation now and in 6 months time, we will ask some people about any changes that have happened because of our service. You can choose whether or not to answer these survey questions. Everything you tell us will be treated confidentially.

We have a trusted research partner who will use the **anonymous** survey responses to evaluate whether our service is helpful for people. We will not share your name or other personal information that can identify you with anyone outside Citizens Advice.

We may want to contact you again to see if this service was useful for you. This would include asking some questions very similar to the ones in this survey. We may ask some people if they are happy to talk to us in more detail about their situation and provide examples for a case study.

Can we contact you again in 6 months time?

If you are happy for us to contact you in 6 months, please sign your name below and provide your contact phone number.

I agree for Citizens Advice to contact me to take part in the survey

☐ Yes ☐ No

Signed:	Date:
---------	-------

Phone number		
Can we leave a voice message or send a text message?	Yes / No	
Preferred time of day to call or message?		



Winter resilience pilot: Baseline Evaluation Questions

Introduction

This document outlines all the baseline information you need to collect for the clients you see in your pilot.

The information you need to capture when you follow up with clients (after they have received your support) is covered in the separate Follow-up Evaluation Questions document.

A. Information about the client and their circumstances

This is information you should try to gather as part of your conversations with your client. You will always capture some of this information as part of your standard processes anyway, but there is some extra information that will help us understand more about the clients using the pilot and how they are using the service. There is no fixed process by which you need to gather this information - it is down to you to decide the most appropriate way for your project and local processes.

Some of this data will be recorded in Petra, but some will need to be recorded in the Project Monitoring spreadsheet - the Project Recording guidance explains in detail how and where to record the information.

B. Baseline survey information

You should carry out the baseline survey in the first advice session with a client. It gathers information about the client's energy use, wellbeing and health circumstances. To enable an effective comparison with the follow-up survey for each client, as well as to allow comparison between clients, the survey contains validated question sets. It is important you follow standard format for these questions.

You should record the baseline survey information in the Project Monitoring spreadsheet.

Gathering all this information will allow us to evaluate the impact the service has on your clients. Thank you for your help.

A. Information about the client and their circumstances

The information we would like you to gather about your clients is covered in the checklist below:

About the referral

Record in the Project Monitoring spreadsheet:

- ☐ Which organisation referred the client to you for support
 - ☐ Hospital
 - ☐ GP
 - ☐ Other GP practice staff (e.g. practice nurse, manager, receptionist)
 - ☐ COPD specialist staff
 - ☐ Pharmacy
 - ☐ Other frontline health worker
 - ☐ Social worker / housing officer
 - ☐ Community group
 - ☐ Charity
 - ☐ Family
 - ☐ Self-referral
 - ☐ Other (specify) _____

- ☐ When the client was referred to you - date _____

- ☐ How the client was referred to you
 - ☐ Email
 - ☐ Online
 - ☐ Postal
 - ☐ Fax
 - ☐ Telephone
 - ☐ In person
 - ☐ other (please specify)

About the client

Record in Petra:

- ☐ Age _____
- ☐ Gender _____
- ☐ Employment status _____
- ☐ Any disability or health conditions - please specify _____
- ☐ Home postcode _____

Record in the Project Monitoring spreadsheet:

- ☐ The ethnic group or background of the majority of occupants of the property _____
- ☐ How many people live in the property _____
- ☐ The age of the youngest person living in the property, including any baby _____
- ☐ If any of the people living in the property are aged 65 or over - Yes / No

About their home

Record in Petra:

- ☐ Housing tenure
 - ☐ Social rented
 - ☐ Private rented
 - ☐ Owner occupied
 - ☐ Other (please specify) _____

Record in the Project Monitoring spreadsheet:

- ☐ The current SAP/ EPC certificate for the property if known?

G / F / E / D / C / B / A / don't know

(check online via www.epcregister.com before meeting with the client)

☐ Year of most recent SAP/ EPC certificate for the property? _____

☐ What is the primary form of heating used in the property?

☐ Central heating

☐ Storage (night storage/Economy 7)

☐ Fixed room heating

☐ Portable heating

☐ The age of their current heating system -

☐ <3 years

☐ 3-12 years

☐ more than 12 years

☐ unknown

☐ The measures the property already has - *select all that apply*

☐ Loft insulation

☐ Cavity wall insulation

☐ Solid wall insulation

☐ Draught-proofing

☐ Double or triple glazing

☐ Secondary glazing

☐ Home energy monitor

☐ Central heating

☐ Condensing boiler

☐ Other

(specify)_____

About the support the client needs

Record in the Project Monitoring spreadsheet:

☐ What support has been provided to the client - *select all that apply*

- ☐ Debt advice
- ☐ Benefits advice - entitlement and/or applications
- ☐ Financial capability (incl Income maximisation or money saving advice)
- ☐ Switching support or advice (inc. price comparisons) about tariffs, payment methods or suppliers
- ☐ Advice on use of heating system
- ☐ Energy efficient behaviours
- ☐ Advice on housing options (e.g. if under-occupying)
- ☐ Advice on energy efficient home improvements
- ☐ Eligibility or application for grants, discounts or trust funds
- ☐ Other (specify) _____

- ☐ If applicable, which organisation/s you referred the client onto for further support. Please specify whether they were signposted to the organisation or you provided a warm referral. *Select all that apply*

Further support	Signpost or warm referral?
Referral for flu jab	
Referral to fire service (for trip and fall prevention etc)	
Priority Services Register (PSR)	
Grants or schemes for energy efficiency improvements	
Other (specify)	

- ☐ If applicable, what further support the organisation/s can offer the client

- ☐ If applicable, were there any barriers to providing the support needed by the client, e.g. no referral partners available in your location to provide specific support needed, client unable to switch, or unable to make changes in their home, etc.

Please remember to also add the relevant AIC codes in Petra

B. Baseline survey information

This survey is designed for use with clients participating in all pilot projects. Please ask the client referred to your project these questions. The same person should be asked to complete the follow-up questionnaire in 6 months' time. Only one person per household should be interviewed. Their responses should be recorded in the Project Monitoring spreadsheet.

Instructions for interviewers are in italics.

Baseline survey questionnaire

To be completed by Citizens Advice staff during your first advice meeting with the client. Given the nature of the questions it may not be appropriate to ask the client all these questions at the very beginning of the session - please use your judgement to ask them at a suitable time during the session.

Date data collected: _____

Client ID reference (copied from Project Monitoring spreadsheet): _____

Consent form (attached) approved and signed - Yes / No

Introduction

Citizens Advice wants to find out how useful this service is for [clients/people who receive help] like yourself. To help us do this, before we get started, I would like to ask you a few questions about yourself and your home. If there are any questions you don't want to answer you don't have to.

This should take about five minutes. Are you happy for us to do this? (Yes/No)

Consent to follow-up - At a suitable point in the session also explain the follow-up consent and contact details form and ask the client to complete.

First, I have some questions about your household energy costs and the energy efficiency of your home

- Which company supplies your electricity/ gas/ other fuel?

☐ Gas _____

☐ Electricity_____

☐ Other fuel_____

- Which methods do you use to pay for your electricity/ gas/ other fuel? - Direct debit or standing order / monthly or quarterly bill / pre-payment meter / included in rent / Other / don't know

☐ Gas_____

☐ Electricity_____

☐ Other fuel_____

- What are the overall household energy costs per year? £_____ / don't know*

**If the answer is 'don't know, please answer the following additional question, otherwise go to the next question:*

- What is the estimated total energy cost per year?
Is it more than £1400 (more than £120 per month) - Yes / No

Or less than £1400 (less than £120 per month) - Yes / No

- Did you cut back on fuel use at home in any of these ways last winter, because you were concerned about the costs?

Select all that apply

- ☐ Turned the heating off or down, even though you would have preferred to be warmer
- ☐ Only heated and used one room in your house for periods of the day
- ☐ Used less hot water than you would have preferred
- ☐ Had fewer hot meals or hot drinks than you would have liked
- ☐ None of these

- How easy or difficult is it for you to afford your heating/fuel costs?

Select one

- ☐ Very easy
- ☐ Fairly easy
- ☐ Neither easy nor difficult
- ☐ Fairly difficult
- ☐ Very difficult
- ☐ Don't know (*select only if response provided unprompted*)

Now I have some questions about any benefits you or your household receive

- Do you or anyone else in the household receive one or more of the following means-tested benefits?

Select all that apply

- | | |
|--|--|
| ☐ Pension credit (not State pension) | ☐ Universal Credit (and you earned £1,250 or less after tax in any assessment period in the last 12 months) |
| ☐ Income support | ☐ None of these |
| ☐ Income-based Jobseeker's allowance | ☐ Don't know |
| ☐ Child Tax Credit | ☐ Prefer not to answer |
| ☐ Working Tax Credit | |
| ☐ Income-related Employment and Support Allowance | |

- Do you or anyone in the household receive the Warm Homes Discount?
Yes / No / Don't Know*

**If reply 'Don't Know' and are aged 60 or over, ask:*

- Do you receive the guaranteed credit element of Pension Credit?
Yes / No / Don't Know
- Are you registered with your energy supplier's Priority Services Register? Yes / No / Don't Know

Now I have some questions about your use of health services, either for yourself or for another member of the household who you care for

- In the last **3 months**, how many times have you used health services in the following ways?

- ☐ For yourself
- ☐ OR for a child living in the same household that you care for
- ☐ OR for another adult living in the same household that you care for

(tick which applies – should be for one person only, who requires most health visits)

[Ask them to provide a number. This can be an estimate, if they are not sure. If they say 'never', enter 0]

	Visited	Been home visited by:	Received over the phone advice from:
Your doctor / GP			
A walk-in centre			
Any other care team			
A hospital		n/a	

Next I would like to ask you 4 questions about your feelings on aspects of your life. There are no right or wrong answers. For each of these questions I'd like you to give an answer on a scale of nought to 10, where nought is 'not at all' and 10 is 'completely'.

a) Overall, how satisfied are you with your life nowadays?

b) Overall, to what extent do you feel that the things you do in your life are worthwhile?

c) Overall, how happy did you feel yesterday?

d) On a scale where nought is 'not at all anxious' and 10 is 'completely anxious', overall, how anxious did you feel yesterday?

Next I have some questions to find out what you think about your health

Ask **Euroqol EQ - 5D - 5L** questions using separate paper version in Appendix A. This 2-side form has instructions for the person completing it. They should be able to complete it themselves. If they aren't sure, tell them to use their own judgment.

Once they've completed the Euroqol EQ - 5D - 5L, thank them and proceed with advice session.

And finally I have a couple of questions about how you accessed our help

This is to gather feedback from the client about the start of the process, including their referral to the service, locating service, communications, reception, waiting times, appointments and accessibility.

■ How easy or difficult did you find it to access the service?

- ☐ Very easy
- ☐ Fairly easy
- ☐ Neither easy nor difficult
- ☐ Fairly difficult
- ☐ Very difficult
- ☐ Don't know

■ Do you have any further comments about how you accessed the service?

APPENDIX A Euroqol EQ - 5D - 5L

(Paper version)

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

- I have no problems in walking about ☐
- I have slight problems in walking about ☐
- I have moderate problems in walking about ☐
- I have severe problems in walking about ☐
- I am unable to walk about ☐

SELF-CARE

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

USUAL ACTIVITIES (*e.g. work, study, housework, family or leisure activities*)

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

PAIN / DISCOMFORT

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

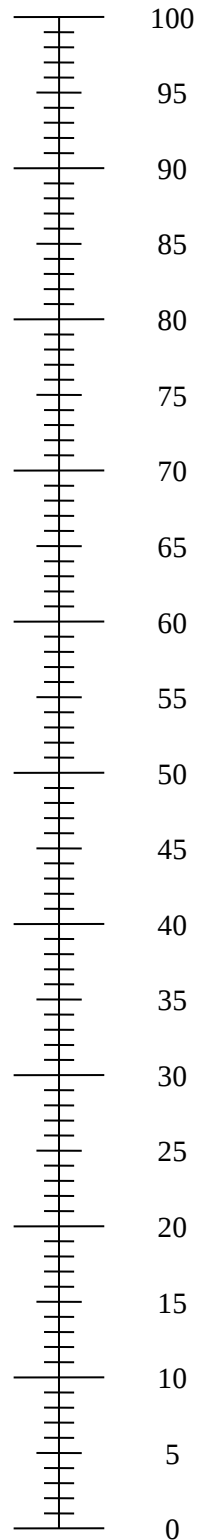
ANXIETY / DEPRESSION

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

The best health
you can imagine



The worst health
you can imagine



Winter resilience pilot: Follow-up Evaluation Questions

Introduction

This document outlines all the follow-up information you need to collect for the clients you see in your pilot.

[Follow-up survey information](#)

The follow-up survey will allow us to analyse what impact the service has had on the client. There is a standard set of questions you should use for those clients who have consented to take part in a follow-up survey 6 months after they have used the service. The follow-up guidance document provides tips on how to deliver the follow-up survey successfully.

You should record the follow-up survey information in the Project Monitoring spreadsheet.

Gathering all this information will allow us to evaluate the impact the service has on your clients. Thank you for your help.

Follow-up survey information

To be completed no less than 6 months after you advised the client. The period of time between the pre- and post- surveys should be consistent for all households interviewed as far as possible. Please make sure you survey the same member of the household (client that generated the referral) that answered the survey at the start of the project. Responses should be recorded in the Project Monitoring spreadsheet.

Instructions for interviewers are in italics.

Follow-up survey questionnaire

The questions include ones which may be easiest to answer with an EPC certificate and latest fuel bills to hand and record of any money spent on new energy measures installed in their home. If you pre-arrange a time to call, it would be worth asking the client to have these to hand when you call. Or at the start of the call, ask if they have these available.

Date data collected: _____

Client ID reference (copied from Project Monitoring spreadsheet): _____

Introduction

I am calling you from Citizens Advice in follow up to the help you received as part of the *(local project name)* project. Citizens Advice wants to evaluate how well the project has helped improve the situation of people who received advice or support. We will use this information to inform decisions about possible expansion of the project to other areas. To help us do this, I would like to ask you a few questions about your experience of keeping your house warm and your thoughts about your health. If there are any questions you don't want to answer you don't have to.

Are you happy to continue with the survey? (Yes / No)

You previously completed a consent form for taking part in this project. That included consent to share anonymised information about yourself with a third party. Are you still OK with that?

Client has confirmed their consent to take part in follow up survey

☐ Yes

☐ No- do not continue

First, I have some questions about your household energy costs and the energy efficiency of your home

- Which company supplies your electricity/ gas/ other fuel?
 - ☐ Gas _____
 - ☐ Electricity_____
 - ☐ Other fuel_____

- Which methods do you use to pay for your electricity/ gas/ other fuel? - Direct debit or standing order / monthly or quarterly bill / pre-payment meter / included in rent / Other / don't know
 - ☐ Gas _____
 - ☐ Electricity_____
 - ☐ Other fuel_____

- Since receiving advice from Citizens Advice, have you:
 - Compared energy tariffs? Yes / No
 - Switched energy tariff? Yes / No

- What are the overall household energy costs per year? £_____ / don't know*

**If the answer is 'don't know, please answer the following additional question, otherwise go to the next question*

- What is the estimated total energy cost per year?
Is it more than £1400 (more than £120 per month) - Yes / No

Or less than £1400 (less than £120 per month) - Yes / No

- Since you received help from Citizens Advice, can you normally keep comfortably warm in your living room during the cold winter weather?

Select one

- ☐ Yes
- ☐ No
- ☐ Don't know (*select only if response provided unprompted*)

- If 'No' , is this because?

Select one

- ☐ It costs too much to keep your heating on
- ☐ Or because it is not possible to heat the room to a comfortable standard
(includes heating equipment that is broken or under repair)
- ☐ Neither
- ☐ Don't know (*select only if response provided unprompted*)

- Since you received help from Citizens Advice, how easy or difficult is it for you to meet your heating/fuel costs?

Select one

- ☐ Very easy
- ☐ Fairly easy
- ☐ Neither easy nor difficult
- ☐ Fairly difficult
- ☐ Very difficult
- ☐ Don't know (*select only if response provided unprompted*)

- What energy efficiency measures, if any, have been installed (or are booked to be installed) since the help provided to you?

Select all that apply

- | | |
|---|---|
| ☐ Boiler | ☐ Cavity wall insulation |
| ☐ Loft insulation | ☐ Solid wall insulation |
| ☐ Double glazing | ☐ Draught proofing |
| ☐ Secondary glazing | ☐ Other (please |
| ☐ Central heating system | specify)?_____ |

☐ Did you/will you receive any grants to cover all or part of the costs? Yes / No

- Could you please describe any other changes in your ability to keep your home warm since the help you received? (e.g. how they use energy more efficiently, removal of draughts, ability to understand energy usage, understanding heating controls, changing controls on boiler)

Now I have some questions about any benefits you or your household receive

- ☐ Do you or anyone else in the household receive one or more of the following means-tested benefits?

Select all that apply

- | | |
|--|--|
| ☐ Pension credit (not State pension) | ☐ Universal Credit (and you earned £1,250 or less after tax in any assessment period in the last 12 months) |
| ☐ Income support | ☐ None of these |
| ☐ Income-based Jobseeker's allowance | ☐ Don't know |
| ☐ Child Tax Credit | ☐ Prefer not to answer |
| ☐ Working Tax Credit | |
| ☐ Income-related Employment and Support Allowance | |

- ☐ Have you applied for and received (or been informed you will receive) any new welfare benefits since the help from Citizens Advice? Yes / No / Don't Know

- ☐ Do you or anyone in the household receive the Warm Homes Discount? Yes/ No/Don't Know*

**If reply 'Don't Know' and are aged 60 or over, ask:*

- ☐ Do you receive the guaranteed credit element of Pension Credit?
Yes / No / Don't Know

- ☐ Are you registered with your energy supplier's Priority Services Register? Yes / No / Don't Know

Now I have some questions about your use of health services, either for yourself or for another member of the household who you care for

- Since the support you received, how many times have you used health services in the following ways?

EITHER:

- ☐ For yourself
☐ OR for a child living in the same household that you care for
☐ OR for another adult living in the same household that you care for

(tick which applies – should be for one person only, who requires most health visits)

[Ask them to provide a number. This can be an estimate, if they are not sure. If they say 'never', enter 0]

	Visited	Been home visited by:	Received over the phone advice from:
Your doctor / GP			
A walk-in centre			
Any other care team			
A hospital		n/a	

Next I would like to ask you 4 questions about your feelings on aspects of your life. There are no right or wrong answers. For each of these questions I'd like you to give an answer on a scale of nought to 10, where nought is 'not at all' and 10 is 'completely'.

[Ask these questions in full and exactly as they are worded]

a) Overall, how satisfied are you with your life nowadays?

b) Overall, to what extent do you feel that the things you do in your life are worthwhile?

c) Overall, how happy did you feel yesterday?

d) On a scale where nought is 'not at all anxious' and 10 is 'completely anxious', overall, how anxious did you feel yesterday?

Now I have some questions to find out what you think about your health

Use the 'EQ-5D-5L' script for telephone interview. This is available in Appendix A. Complete a paper copy of the EQ-5D-5L questionnaire (Appendix B) with the responses they give to you.

If you visit someone in their home, use the face to face paper version.

And finally I have a couple of questions about the help we provided

This is to understand what the client thought of the cold homes service you provided. Please note in the comments section if the client has any separate feedback about the service provided to them by referral partners (including other CA services)

- As a result of the support provided to you through this project has anything else changed for you?
(e.g. outcomes in relation to debts, arrears, other issues they were advised on, their use of health services)

- Please rate your overall experience of the service

- ☐ Very good
- ☐ Fairly good
- ☐ Neither good nor poor
- ☐ Fairly poor
- ☐ Very poor
- ☐ Don't know

- Do you have any further comments about the service you received from us?

Thank client for their help.

Please remember to also add the relevant Outcome codes to Petra

Appendix A *EQ-5D-5L' Script*

For telephone interview

SCRIPT FOR TELEPHONE INTERVIEW

GENERAL INTRODUCTION

It is suggested that the telephone interviewer follows the script of the EQ-5D. Although allowance should be made for the interviewer's particular style of speaking, the wording of the questionnaire instructions should be followed as closely as possible. In the case of the EQ-5D descriptive system on pages 2 and 3, the precise wording must be followed.

It is recommended that the interviewer has a copy of the EQ-5D in front of him or her as it is administered over the telephone. This enables the respondent's answers to be entered directly on the EQ-5D by the interviewer on behalf of the respondent (i.e. the appropriate boxes on pages 2 and 3 are marked and the scale on page 4 is marked at the point indicating the respondent's 'health today'). The respondent should also have a copy of the EQ-5D in front of him or her for reference. If the respondent asks for clarification, the interviewer can help by re-reading the question verbatim. The interviewer should not try to offer his or her own explanation but suggest that the respondent uses his or her own interpretation.

If the respondent has difficulty regarding which box to mark, the interviewer should repeat the question verbatim and ask the respondent to answer in a way that most closely resembles his or her thoughts about his or her health today.

INTRODUCTION TO EQ-5D

(Note to interviewer: please read the following to the respondent)

We are trying to find out what you think about your health. I will first ask you some simple questions about your health TODAY. I will then ask you to rate your health on a measuring scale. I will explain what to do as I go along but please interrupt me if you do not understand something or if things are not clear to you. Please also remember that there are no right or wrong answers. We are interested here only in your personal view.

EQ-5D DESCRIPTIVE SYSTEM: INTRODUCTION

First I am going to read out some questions. Each question has a choice of five answers. Please tell me which answer best describes your health TODAY. Do not choose more than one answer in each group of questions.

(Note to interviewer: it may be necessary to remind the respondent regularly that the timeframe is TODAY. It may also be necessary to repeat the questions verbatim)

EQ-5D DESCRIPTIVE SYSTEM

MOBILITY

First I'd like to ask you about mobility. Would you say that:

- 1. You have no problems in walking about?**
- 2. You have slight problems in walking about?**
- 3. You have moderate problems in walking about?**
- 4. You have severe problems in walking about?**
- 5. You are unable to walk about?**

(Note to interviewer: mark the appropriate box on the EQ-5D questionnaire)

SELF-CARE

Next I'd like to ask you about self-care. Would you say that:

- 1. You have no problems washing or dressing yourself?**
- 2. You have slight problems washing or dressing yourself?**
- 3. You have moderate problems washing or dressing yourself?**
- 4. You have severe problems washing or dressing yourself?**
- 5. You are unable to wash or dress yourself?**

(Note to interviewer: mark the appropriate box on the EQ-5D questionnaire)

USUAL ACTIVITIES

Next I'd like to ask you about usual activities, for example work, study, housework, family or leisure activities. Would you say that:

- 1. You have no problems doing your usual activities?**
- 2. You have slight problems doing your usual activities?**
- 3. You have moderate problems doing your usual activities?**
- 4. You have severe problems doing your usual activities?**
- 5. You are unable to do your usual activities?**

(Note to interviewer: mark the appropriate box on the EQ-5D questionnaire)

PAIN / DISCOMFORT

Next I'd like to ask you about pain or discomfort. Would you say that:

- 1. You have no pain or discomfort?**
- 2. You have slight pain or discomfort?**
- 3. You have moderate pain or discomfort?**
- 4. You have severe pain or discomfort?**
- 5. You have extreme pain or discomfort?**

(Note to interviewer: mark the appropriate box on the EQ-5D questionnaire)

ANXIETY / DEPRESSION

Finally I'd like to ask you about anxiety or depression. Would you say that:

- 1. You are not anxious or depressed?**
- 2. You are slightly anxious or depressed?**
- 3. You are moderately anxious or depressed?**
- 4. You are severely anxious or depressed?**
- 5. You are extremely anxious or depressed?**

(Note to interviewer: mark the appropriate box on the EQ-5D questionnaire)

EQ VAS: INTRODUCTION

(Note to interviewer: if possible, it might be useful to send a visual aid (i.e. the EQ VAS) before the telephone call so that the respondent can have this in front of him or her when completing the task)

Now, I would like to ask you to say how good or bad your health is TODAY.

I'd like you to try to picture in your mind a scale that looks a bit like a thermometer. Can you do that? The best health you can imagine is marked 100 (one hundred) at the top of the scale and the worst health you can imagine is marked 0 (zero) at the bottom.

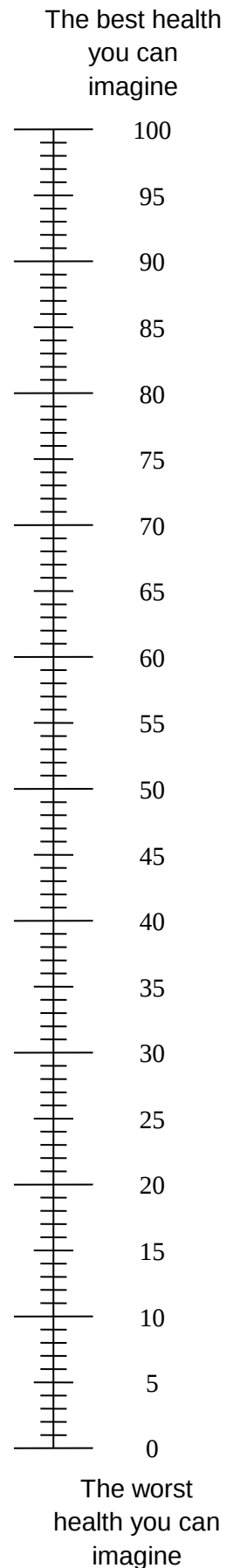
EQ VAS: TASK

I would now like you to tell me the point on this scale where you would put your health today.

(Note to interviewer: mark the scale at the point indicating the respondent's 'health today'. Now, please write the number you marked on the scale in the box below)

THE RESPONDENT'S HEALTH TODAY

Thank you for taking the time to answer these questions.



APPENDIX B *Euroqol EQ - 5D - 5L*

(Paper version)

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

- I have no problems in walking about ☐
- I have slight problems in walking about ☐
- I have moderate problems in walking about ☐
- I have severe problems in walking about ☐
- I am unable to walk about ☐

SELF-CARE

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

USUAL ACTIVITIES (*e.g. work, study, housework, family or leisure activities*)

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

PAIN / DISCOMFORT

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

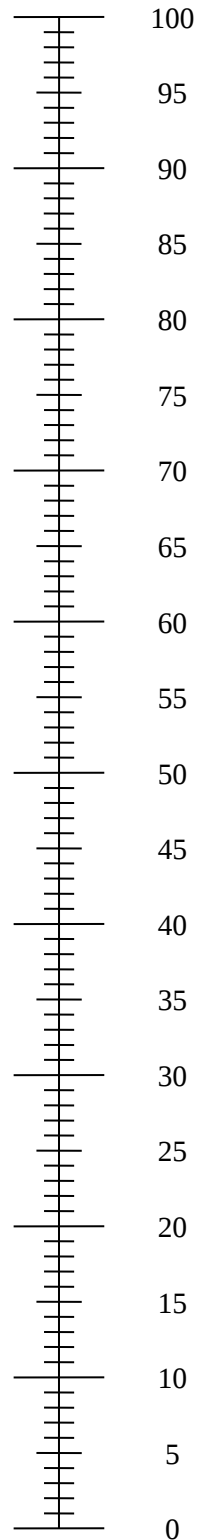
ANXIETY / DEPRESSION

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

The best health
you can imagine



The worst health
you can imagine

Winter Resilience Pilot:

Project reporting guidance



Introduction

This guidance paper outlines how and where you will record information about the service you're delivering as part of the Winter Resilience pilot. This information will be used for project reporting and to evaluate the pilot. We want to learn how your referral service works and what outcomes this achieves for clients.

As this is a pilot, we will need you to collect some information in addition to the information you routinely record about clients in Petra.

This additional information will be recorded in the Project Monitoring spreadsheet. Please ensure you still record all required information in Petra. Using these two sources together for project reporting will give us a much more complete understanding of how your service is being delivered and what this achieves for clients.

	What works for clients?	How it works?
How we know this	Recorded information about where clients were referred from	Recorded information about how clients were referred to the service
	Recorded information about clients in the pilot and their circumstances	Recorded information about advice and support given during the winter resilience appointments
	Survey of clients' health and wellbeing and energy situation at the first appointment (their 'baseline')	Feedback from you about your experience delivering the service
	Follow-up survey about changes to client's health and wellbeing and other outcomes that happen after advice and any onward referrals	

Recording information in Petra

Please continue to record information in Petra for clients who are involved in this pilot. We will report on the demographic information for clients who take part, so please ensure these fields are completed and up to date.

On the enquiry:	
Record the project using the local code:	This is how clients are identified as part of this pilot. Each record must include the winter resilience code to the enquiry record . Recording this is necessary for the client to count towards the target for the pilot.
Consent to follow up	If you have permission to follow up with the client, please record this on the 'General Tab' and update their preferred contact details.

On the client profile:	
Complete client profile demographics and other information	This project is aiming to reach clients who have specific needs to do with their health and cold homes. Recording all profile information about the clients in this pilot is essential to understand if the project is reaching the intended target groups and whether the service helps . Ensure you record the age, gender, employment status, housing tenure, location and whether the client has any disability or health conditions (please specify disabilities and conditions)
Record relevant Advice Issue Codes and Outcomes	Ensure that when a client is given advice the appropriate advice issue code(s) is/are recorded on Petra. We know that the available AICs will not address all the issues you're likely to be advising on - the Project Monitoring spreadsheet has been designed to capture the details of the support you provided. Please remember to also record any relevant AIC outcome codes. These may become evident during subsequent contact you have with a client in delivering advice or support or when conducting 'follow up' surveys for the evaluation. In Petra, each outcome is associated with an AIC at part 2 level. See further guidance in the 'recording outcomes in Petra' guidance available on Cablink.

Recording information in the Project Monitoring spreadsheet

Some of the information needed in this project is not accommodated in Petra recording. We have created a spreadsheet to capture this information - this is the Project Monitoring spreadsheet

The project monitoring spreadsheet is for you to record the client's Petra reference number, create a unique Client Project ID and record when you have collected key evaluation information. It's designed so that you can keep adding and updating information for each client as the advice and follow-up process progresses. To make it easier to navigate it is split into 4 tabs:

- Client admin
- Client info & circumstances
- Client baseline survey
- Client follow-up survey

<i>Client admin tab</i>	
Copy and paste the client Petra ID	Copy and paste the full client Petra ID (e.g. CLI-xxxxxxx-xxxxx). Please double check this is correct as this number is how we link the information in your project monitoring spreadsheet with the information in Petra.
Keep track of the status of the client	Please record the status of the client and the type of appointment they receive. Record if the client was out of scope of the service (if the client was not at risk from a cold home). It would also be very helpful to understand the referral drop-out rate - the clients who were referred into the service but who did not take up the offer of an appointment. Please record if any clients dropped out following referral/did not take up the offer of support.
Keep track of evaluation information	Please update, as necessary, whether whether clients have given consent to take part in evaluation surveys and if/when these are complete.
<i>Client info and circumstances tab</i>	
Record referral information	Please record where the client was referred from, the way you received the the referral (the channel) and the date you received the referral.

Record additional information about the client	To help us understand the use of the service by the vulnerable groups identified in the NICE guidelines, please record additional information about the client's household in the spreadsheet: • The ethnic group or background of the majority of occupants of the household • How many people live in the property • The age of the youngest person in the property • Whether any people living in the property are aged 65 or over
Record information about the client's home	If the client knows any of the following about their property please capture this information: • Their SAP/EPC certificate • The type of heating they have • The age of their heating system • Any existing energy efficiency measures their property has
Record information about the support you provide	It's important to understand what support is being provided to clients in this pilot. Please record the types of support you provided to the client.
Record onward referral/ signpost information	We need to know where you are referring or signposting clients onto for further support (e.g. for home improvements). Please use the spreadsheet to record which organisations the client has been referred or signposted on to (if applicable) and what support the referral partners can offer the client.
Record details of any barriers to support	There may be reasons why the client is not able to receive all the help that you identify they need - this could be because services don't exist locally, they're unable to make changes to their property etc. Where this is the case, please record any barriers to providing the support needed
<i>Client baseline survey tab</i>	
Record the baseline survey	Enter the data you collected from the baseline survey into each field in the spreadsheet.
<i>Client follow-up survey tab</i>	
Record the follow-up survey	Enter the data you collected from this survey into the spreadsheet. This is completed 6 months after advice.

Recording client consent for follow up

NOTE - please check that your data protection forms cover data storage and protection. The standard Citizens Advice data protection form can be found on [CABlink](#)

This project will involve you contacting clients to 'follow up' with them about their progress and collect information about outcomes for the evaluation.

Your data protection forms should already cover permission to do this, however, we are asking you to gather the client's explicit consent for this phone call. This is both so the client knows to expect your call and so you have an up to date record of their contact details.

Please ask clients if they give their consent for you to follow up with them to ask about their outcomes, progress and any feedback they have about the project. If yes, have them complete the 'Winter resilience pilot Consent and contact details form' and record this on 'General Tab' of the Petra enquiry. Ensure you also make a record of their contact details in Petra so you have these available for follow up.

Submitting monthly reports

Throughout the pilot, we are asking you to submit the project monitoring spreadsheet on the first Friday of each month. As the sheet is in Google sheets you do not need to send a copy of the spreadsheet, just let Sarah Jeffrey know when your spreadsheet is ready and she will access and make a local copy. You can let her know by emailing sarah.jeffrey@citizensadvice.org.uk. At the end of the pilot we will ask for a short final project & lessons learned report, a template for this will be provided closer to the time.

Other information and feedback during the pilot

We will also collect feedback from you/your Citizens Advice during the pilot, so we can learn from your experience delivering the pilot. To do this, we will ask for your feedback during project workshops or short online surveys. We may also arrange to have a short interview with you over the phone or to visit your office to observe your service. This would be discussed and agreed with you individually during the pilot.