Warm & Well in North Yorkshire

Providing holistic and practical support for cold homes across North Yorkshire

www.first4contact.org

October 2015 – December 2016

Helpline: 01423 740 001

Background

- Operated between October 2015 and December 2016
- 30 supporting and delivery partners involved; led by Rural Action Yorkshire
- British Gas Energy Trust ‘Healthy Homes’ programme (Ofgem redress fines) – just under £400k funding made available for NY
- Reach vulnerable households and people / Raise awareness of the impact of cold homes on health and wellbeing / Refer to the right service or support / Respond to the needs of households and individuals
- Reached over 4,000 beneficiaries during its lifetime
- Winter health ‘single point of contact’ (NICE guidelines)

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Outcomes

- Over 90% of beneficiaries reported that they:

...knew how to keep themselves warmer this winter
...knew how to keep themselves healthy and well this winter
...knew where to go for help and support if they needed it

- Reduced energy consumption for low income and vulnerable households
- People can afford to keep their home warm
- Communities more aware of how to identify vulnerable residents
- Funders and local authority able to use the outcomes and evidence
- No. of households in fuel poverty reduced
- No. of excess winter deaths reduced **(TBC)**
- Frontline staff trained to understand the issue and effects
- Increased numbers of WHD applications
- Increased sign-up to Priority Services Register
- Over £60,000 financial savings through switching, debt etc

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‘Single point of contact’

- Running since February 2016 (NICE guidelines; Public Health)
- Over 700 referrals to end of December 2016
- Funded by BGET to end of December 2016; continuation funding provided by North Yorkshire County Council Public Health to end of March 2017
- Future beyond March 2017?

- Awareness and profile strong among frontline workers across NY
- Growing awareness by Dec 2016 with service users / general public (needs sustained awareness campaign to continue to embed itself)
- A successful pilot for NY and example of good practice
- Relied on the partnership for its delivery as well as ensuring a good overview of referrals by a project manager

- To make a referral before end March visit www.first4contact.org or call the helpline

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Other support & activities

- one-to-ones and home visits

- energy switching and support with fuel debts

- training for frontline workers and health professionals

- emergency interventions and crisis funds

- children's 'cold comic' and other promo materials (Top Tips, leaflets, thermometers, smart monitors, slow cookers, emergency packs)

- energy champions pilot (Scarborough/Ryedale); thermal imaging (Ryedale)

- events and outreach sessions, clinics, (public; park homes; Gypsy/Traveller)

- fun campaigns e.g. draught excluders

- GPs/nurses, CCGs, Health engagement

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Lessons

- Strong partnership working is essential – an organisation lead
- Heavy paperwork and administration involved – can vary
- Need for fuel poverty work all year round, not just during the cold months
- Problems in engagement with health professionals and Health sector
- Duplication of services – needs close attention and stakeholder management
- High demand for home visits and one-to-ones – but most expensive strand
- High demand for events but difficult to track impact and referrals from them
- The ‘grey areas’ of fuel poverty – clients ineligible for other pots of funding
- Single point of contact pilot – success
- Further funding – legacy – continuation

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Recommendations

A lead organisation within a wider, cohesive partnership – steering group meetings, stakeholder engagement, clear roles and buy-in, funding, ownership

Crisis support – engagement needed ASAP due to sometimes chaotic lives

SMART goals e.g. concerning one-to-one appointments and home visits, awareness that some clients take twice as long and this is planned for (CABx)

Non-seasonal-based delivery if possible – prevention is cheaper

Roll of commercial companies and ECO funding / targets

Winter health single point of contact – evolution

“Freebies” – thermometers, promo items, active participation of service users

Sustained awareness campaigns – branding?

Engagement with Health sector – long term

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Finally...

Chicken and the egg scenario: does fuel poverty lead to poor health and wellbeing or vice versa?

The answer is both.

Work undertaken should reflect this, as well as the grey areas of fuel poverty and lifestyles of service users (client-led approach)

Awareness must be sustained and long-term and repetitive

The importance of working in partnership to ensure everyone stands a chance of finding and engaging with the support available

“Thank You” ☺

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