

Finding Hidden Need

How Data, Partnership and Prevention are Tackling Rural Fuel Poverty in Fife

The HEART Project

Health • Energy • Advice & Resilience Team

**Prepared for
Association for Public Service Excellence (Scotland)**

**Scott Fell
St Andrews Environmental Network**

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Why We Needed a New Approach

Fuel poverty is about more than keeping homes warm. It affects health, financial resilience and community wellbeing, requiring coordinated public service responses.



Cold and inefficient homes

Poor energy efficiency, rising energy costs and difficult-to-heat homes place increasing pressure on household finances.



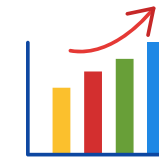
Fragmented Support

Households often require support from several organisations, yet services have traditionally operated independently.



Health Impacts

Cold homes contribute to respiratory illness, cardiovascular disease, poor mental wellbeing and increased pressure on health services.



Need for Evidence-Led Targeting

Limited resources require support to be targeted where need is greatest, ensuring the greatest impact for households and communities.



Understanding The Evidence Base

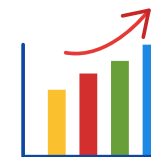
Using the Fuel Poverty Composite Index (FPCI) to identify communities most at risk

The HEART project adopted an evidence-led approach from the outset. Using the Fuel Poverty Composite Index (FPCI), developed by Fife Council, we identified communities where fuel poverty was most likely to affect health, wellbeing and financial resilience.

Three Key Observations



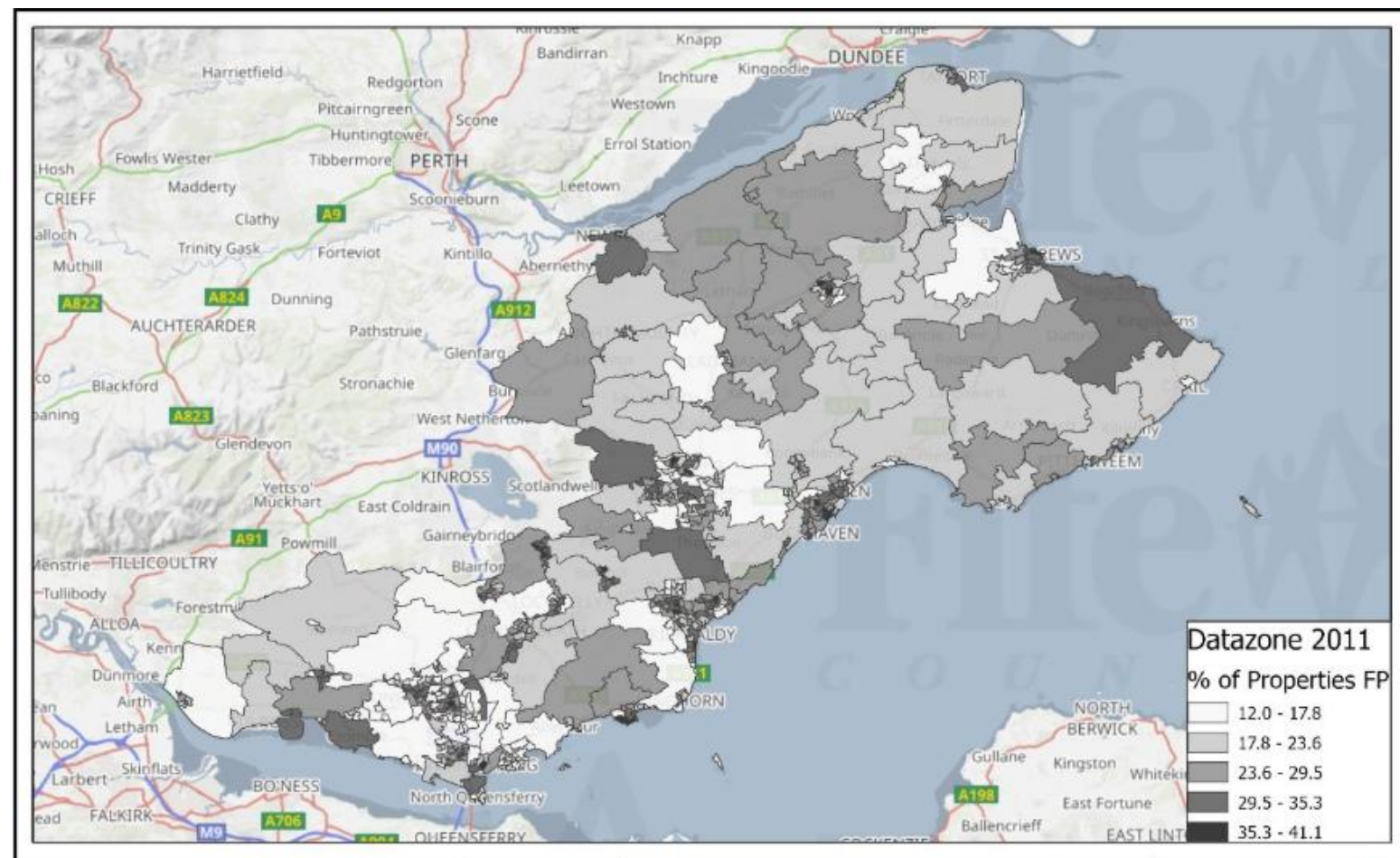
Fuel poverty affects communities across Fife, although the level of risk varies considerably.



The FPCI combines housing, demographic and socio-economic indicators to identify areas with the greatest potential need.



The index provides an objective evidence base for targeting limited resources where they are likely to achieve the greatest impact.

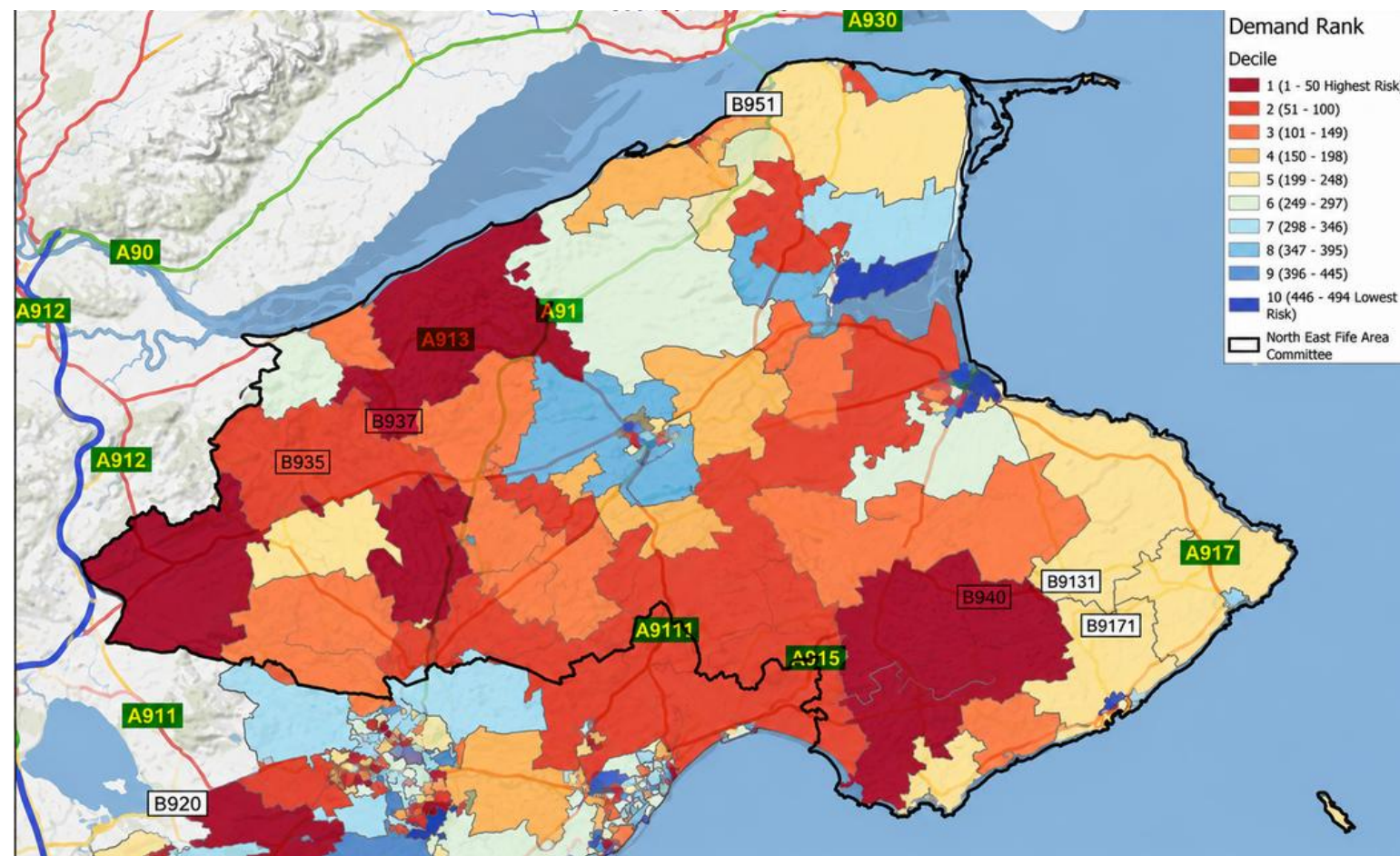


Targeting Communities Most At Risk

Using local intelligence to identify where support could have the greatest impact

The county-wide analysis provided the strategic picture. We then examined North East Fife in greater detail to identify communities where targeted intervention would deliver the greatest benefit.

Three Key Observations



The FPCI identified communities with the highest levels of fuel poverty demand, allowing support to be directed where it was most needed.



The analysis highlighted that fuel poverty is experienced in both rural settlements and urban communities, although the contributing factors often differ.



The mapping enabled HEART and partner organisations to plan proactive engagement, home visits and community outreach where they were most likely to improve outcomes.



From Evidence To Action

Turning evidence into co-ordinated community support

The Fuel Poverty Composite Index identified where support was most needed. The HEART partnership transformed that evidence into coordinated action, ensuring households received the right support, at the right time, from the right organisations.



Evidence only creates value when it leads to coordinated action that improves people's lives.

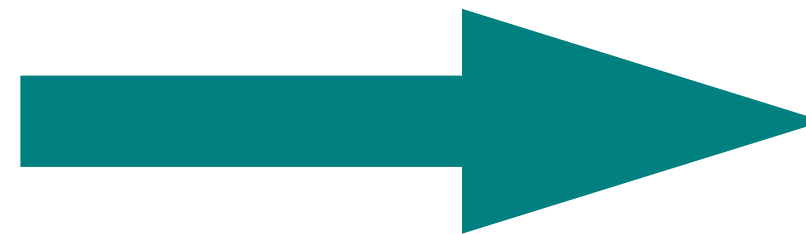
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The HEART Partnership

Working together to provide coordinated support for households across North-East Fife

No single organisation can address the complex challenges associated with fuel poverty alone. HEART brings together partners with complementary expertise to deliver coordinated, person-centered support.



Collaboration *Working across organisational boundaries.*



Person-centered *Support tailored to individual household needs.*



Evidence-led *Resources targeted using local intelligence.*



Prevention *Intervening early to improve long-term outcomes.*

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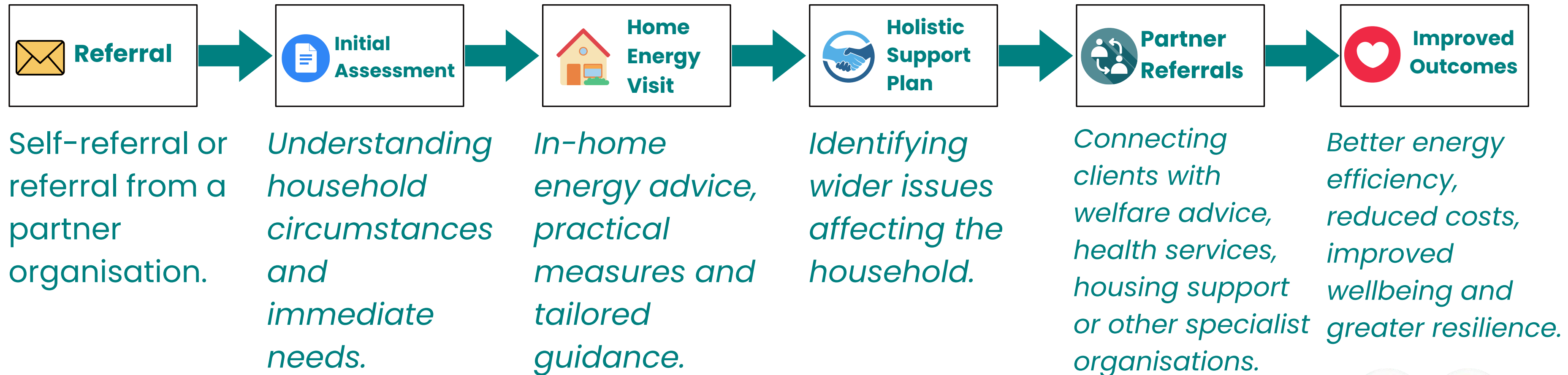


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The Client Journey

From referral to long-term resilience

Every household's circumstances are different, but the HEART approach provides a coordinated pathway that ensures people receive the right support, from the right organisation, at the right time.



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What Happens During a HEART Home Visit?

Every visit is tailored to the household's individual circumstances

No two households are the same. Every HEART home visit begins with understanding the client's circumstances before providing practical advice, immediate support and referrals to wider services where required.



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HEART In Practice

Mari-Anne's Story (Anonymised)

Mari-Anne's story



- Female, age 57
- Lives in NEF
- Disabled
- Socially isolated

Mari-Anne's Conditions



- Low mood
- Depression
- Health issues

Mari-Anne's Hopes



- To feel more connected – reduce isolation
- Improve energy efficiency and lower bills
- Enhance digital skills
- Support with travel options

Actions Agreed



- Implement low/no cost energy efficiency measures
- StAndEN referred to The Well & Welfare Support
- Face to face visit to The Well

Outcomes Achieved



- Hospital travel options provided by Welfare Support
- Greater awareness of support for digital skills
- Enhanced understanding of ways to save energy and reduce bills

Mari-Anne said

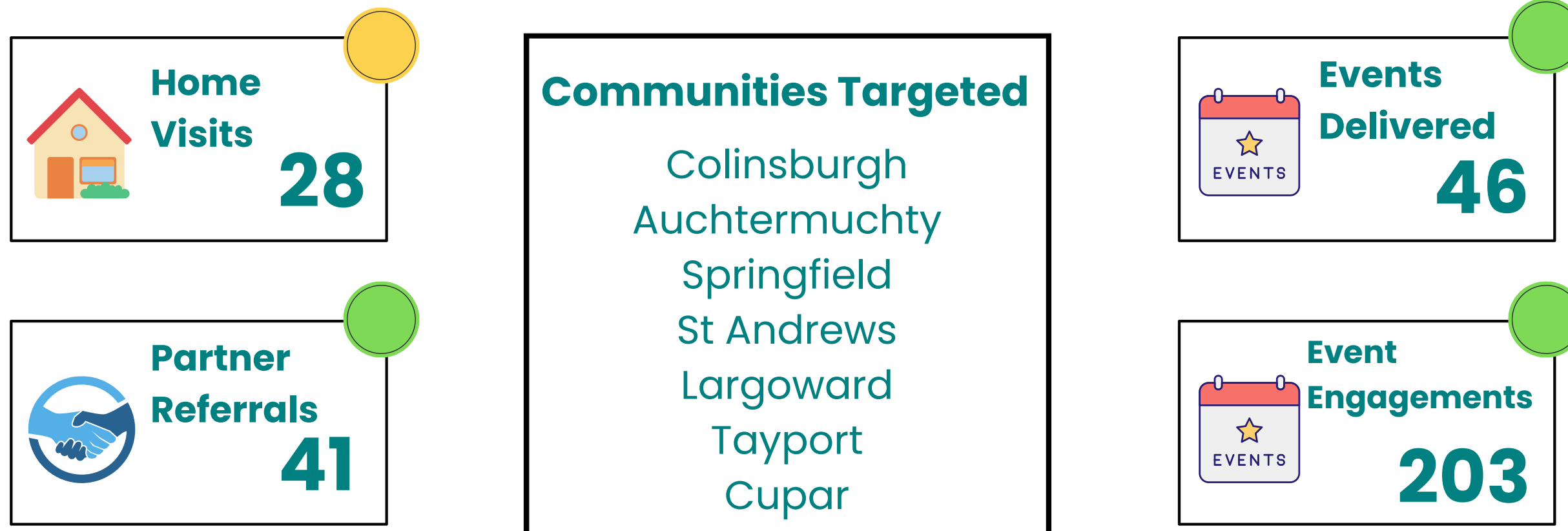
"I was unaware of the support available and I'm extremely grateful."



Measuring Our Impact

Evidence of a coordinated, community-based approach to tackling fuel poverty

The success of the HEART project is measured not only by the number of households supported, but by the wider impact on health, wellbeing, financial resilience and partnership working.



Behind every number is a household that received coordinated support to improve comfort, affordability and wellbeing.

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Lessons For Public Services

What HEART taught us

The HEART project demonstrated that tackling fuel poverty is about more than delivering services. It showed how evidence, partnership and prevention can help reshape service delivery.



Let evidence guide investment



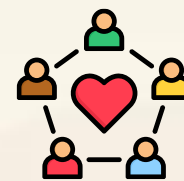
Build genuine partnerships



See the whole household



Invest in prevention



Design services around communities



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Recommendations for Public Services

Five practical actions to strengthen local responses to fuel poverty

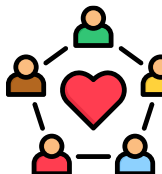
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Target resources using local intelligence and robust data rather than assumptions.



Develop trusted relationships across local government, health, housing and the voluntary sector.



Provide holistic support that recognises the links between energy, health, income and wellbeing.



Early intervention can reduce crisis demand and improve long-term outcomes for households.



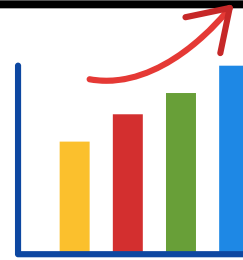
Work with local organisations that understand their communities and can engage residents effectively.



Key Takeaways

The HEART project shows that meaningful change happens when evidence, partnership and people come together.

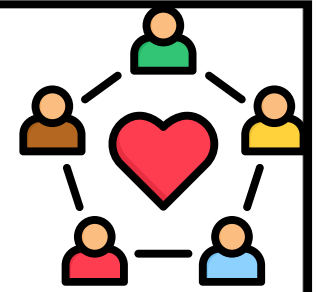
Evidence
drives
better
decisions



Partnership
creates
better
outcomes



People
must
remain at
the centre



Working together to reduce fuel poverty, improve wellbeing and build stronger communities.

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What Comes Next

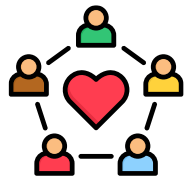
Strategic development of the HEART project is in progress. Having proven the concept, the following initiatives are currently in flight



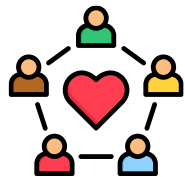
Development of the Fuel Poverty Composite Index with additional data sets



Development of CRM to enhance partner collaboration and reporting



Widening of service provision to target additional geographical areas in North-East Fife



Increased outreach and engagement in target areas to find hidden need

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Thank You

Questions



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