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Citizens Advice Scotland's response to the Scottish Government's Consultation on the Enhanced Heating Regimes within the new definition of Fuel Poverty (August 2019)

Who we are

The policy teams at Citizens Advice Scotland use research and evidence to put people at the heart of policy and regulation in the energy, post and water sectors in Scotland. We work with government, regulators and business to put consumers first, designing policy and practice around their needs and aspirations. We aim to represent the views of different consumer groups using evidence of consumer views and supporting research wherever possible.

Citizens Advice Network in Scotland

Citizens Advice Scotland (CAS), our 59 member Citizen Advice Bureaux (CAB) and the Extra Help Unit, form Scotland's largest independent advice network. Advice provided by our service is free, independent, confidential, impartial and available to everyone. Our self-help website Advice for Scotland provides information on rights and helps people solve their problems.

In 2017-18 the Citizens Advice Service network helped over 295,100 clients and dealt with almost 800,000 advice issues for clients living in Scotland. With support from the network clients had financial gains of almost £142.2 million and our self-help website Advice in Scotland received approximately 3.2 million page views. On energy consumers issues in particular, we advised on over 41,000 energy-related issues in 2017-18, generating over £1.8m in client financial gain[1].

Our extensive footprint is important in helping us understand how issues impact locally and nationally across the country and the different impacts that policies can have in different areas.

[1] https://www.cas.org.uk/system/files/publications/cas_energy_advice_detail_2017_18_published.pdf

Overview

As stated in the consultation guidance notes, the Enhanced Heating Regimes (EHR) will be a key part of the methodology by which the Scottish Government defines fuel poverty. What is less clear, however, is how the EHR will be used to determine who is eligible for support under the new Fuel Poverty Strategy and accompanying delivery programmes, and how the EHR will interact with other proxies for identifying the fuel poor. Determining the eligibility criteria for the new EHR is important to ensure that the Strategy better targets resources and strengthens support for those in fuel poverty and extreme fuel poverty.

We support the inclusion of the three EHR scenarios to capture all the possible variants between temperature and duration of heating, as laid down in the Fuel Poverty Bill. While other assessments such as an EPC rating can determine to what extent energy efficiency contributes to fuel poverty, the EHR considers the importance of heat for comfort, health and wellbeing for those in vulnerable situations. There may be some householders who live in well-insulated, energy efficient properties yet still suffer fuel poverty because of their higher-than-average heating demand. It is these households that we need to ensure are supported.

We understand that there is a balance to be struck in determining the eligibility criteria for an EHR; if the criteria are too broad it risks spreading precious budgetary resources too thinly across the populace and potentially mis-directing support, yet too narrow and it risks missing out vulnerable people who need it most to avoid cold related ill-health and financial detriment.

25. Enhanced Heating Regime 1: Enhanced Heat and Time

25.1. CAS supports the inclusion of those with a long-term mental or physical illness in EHR1. There is evidence to suggest that an EHR is essential to both the recovery from a physical illness and to the improvement of mental wellbeing.[2] This is particularly relevant if the member spends more time at home during the winter, as this will mean they are more susceptible to the cold, damp and also significant changes between room temperatures (i.e. the detriment associated with moving from a heated room to an unheated/underheated room). Furthermore the inclusion of mental health issues is important as it recognises that vulnerability comes in many forms; someone with a mental health issue such as Alzheimer's disease for example, may not have the capacity to use heating controls or may be liable to under-heat the home.

Despite this, we take issue over the time period of 'lasting or expected to last 12 months or more'. This means potentially missing out people who have recently been

[2] Public Health England; UCL Institute of Health Equity: *Local action health inequalities: Fuel poverty and cold-home related health problems*, 2014

discharged from hospital after a prolonged stay, and in need of an EHR to ensure a full recovery. *Home to the unknown*[3], a recent report from the British Red Cross, highlighted the problem of discharging patients into a home environment where they might not have adequate heating or food.[4] This can delay recovery from illness and even lead to readmission to hospital. One way to counter this is to extend the self-reported statement to "do you or a household member have a long-term mental or physical illness lasting, or expected to last 12 months or more, or have recently been discharged from hospital in the last month after an extended stay of 7 days or more". The duration in hospital would need to be defined with expert guidance from NHS Scotland, as 7 days is a nominal figure only. Alternatively it could be based on an NHS definition whereby a patient assessment is made upon discharge and an EHR is identified as being required.

Self-reporting an illness that will last for 12 months or more risks missing out households where a member is convalescing but not as long as 12 months, or is receiving palliative care at home and in need of EHR but who may not live as long as 12 months. This is a sensitive situation and self-reporting on such situations risks householders under-reporting on their situation; in many cases a householder may not know how long an illness is due to last. It is critical that householders (including a member who is a full-time carer of an ill member) are adequately supported with an EHR and avoid falling into fuel poverty/further illness at an already vulnerable time. As such we suggest that the EHR1 definition is revised to 'do you or a household member have a long-term mental or physical illness lasting or expected to last 6 months or more, or have recently been discharged from hospital in the last month after an extended stay of 7 days or more".

The SCHS already captures self reported information, but our 2018 report *Speaking Up* raised concerns about reliance on self-reporting as an identification mechanism. The report found that many of those struggling with fuel costs were reluctant to admit this; pride was cited as a factor and this was particularly true for older people who were often willing to do without essential goods and services rather than request help.[5] The draft Fuel Poverty Strategy made reference to the development of a doorstep assessment tool[6], but no further information on how this will work in practice has been provided so it is assumed that this idea has been dropped.

We recognise that a period of '12 months or more' helps meet the logistical requirements of the SHCS. In other words, it avoids more frequent reporting of the SHCS. A shorter period of '6 months or more' for example, risks that these households remain in the EHR even after they had recovered, making fuel poverty reporting inaccurate. However, for the reasons outlined above, these households are arguably in as great a need of an EHR and it could reduce hospital readmissions, or/and exacerabating health issues, which is a potential argument for adopting a

[3] https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-social-care-and-support/british-red-cross-home-to-the-unknown-full-report.pdf
[4] https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-social-care-and-support/british-red-cross-home-to-the-unknown-full-report.pdf
[5] CAS Consumer Futures Unit, *Speaking Up: Understanding Fuel Poverty Support Needs*, 2018
[6] Scottish Government, *Draft Fuel Poverty Strategy for Scotland*, 2018

time period shorter than 12 months. CAS does not claim to have medical expertise, hence our practical and analytical approach to such questions. NHS Scotland would need to be consulted in this regard.

25.2 CAS supports the inclusion of households where a member is in receipt of benefits received for a care need or disability in EHR1. This seems like a fair proxy for determining those who are in vulnerable situations, with a carer and/or limiting disability, and likely to be in need of an EHR. It may help to capture those people who may not be known to the DWP (or awaiting for their application to be processed). The need for an EHR is defined further by the co-joining statement "AND regularly spend more time at home during winter" which recognises that not all those in receipt of said benefit will need to be indoors regularly.

In 2017/18, benefits accounted for 43% of all cases in our Bureaux network, making it was the most common advice code in Scotland.[7] CAS has longstanding concerns about the reserved benefits system in its current form; it is evident that many people who require assistance for a care need or disability from the state are not receiving it, and these difficulties are compounded by a complex system of bureaucracy, assessments and penalties, which can have a dehumanising effect. For this reason, CAS would be concerned if the 'receipt of a benefit' was the sole criteria for EHR1, as this would result in many people being missed from fuel poverty statistics, but we are satisfied that the other criteria for inclusion in EHR1 more than compensates for this, namely having a long term illness or having a member of the household aged over 75 years.

25.3 CAS supports the inclusion of households with a member over the age of 75 in EHR1. Pensionable age as a proxy for fuel poverty is inadequate as it does not accurately reflect the characteristics of an ageing population, but this has largely been revised in the new definition of fuel poverty by strengthening the link between fuel poverty and income poverty. In our response to the Fuel Poverty Strategy consultation, we argued that "those over the age of 60 should not be assumed to be vulnerable."[8] Between the ages of 60 and 75, there is an increased likelihood of developing health problems, with Scottish Government statistics from 2009 indicating that two-thirds of individuals over 65 will have a long-term health condition.[9] Although this suggests a requirement for enhanced heating, CAS is satisfied that these members are sufficiently covered by other EHR proposed groups. It is noteworthy here that a number of energy-related support schemes are already targeted at those of pensionable age, namely the Warm Home Discount Core Group and the proposed Winter Heating Assistance.

There is evidence to suggest that those over the age of 75 are likely to have reduced mobility and strength; for example, a recent study in Japan cited these factors when calling for the redefinition of "elderly" as aged 75 and over.[10] The guidance notes for

[7] CAS, *Advice in Scotland*, 2019
[8] CAS Consumer Futures Unit, *Consultation Response – A Fuel Poverty Strategy for Scotland*, 2018
[9] http://www.gov.scot/Publications/2009/12/03112054/4
[10] Japan Geriatrics Society, *Redefining the elderly as aged 75 and older*, 2017

this consulatiation correctly point out that eligibility for EHR1 is consistent with the criteria for the Warmer Homes Scotland fuel poverty scheme, which the Scottish Government developed with input from CAS.[11] We do, however, raise a question over the definition of "regularly spend more time at home during winter". This would need to be quantified in some way as to capture more accurate answers. This is a subjective question and it is not clear what 'regularly' is defined as and whether 'more time' is relative to the summer for example, or 'more time' relative to an average benchmark. Some qualification around this question will be required in the SHCS.

The criteria for EHR1 are listed separately, which indicates that a household needs only to fulfil one of the three criteria for inclusion. However, it would be useful if this was made more explicit in the text by stating 'AND' or 'OR' as applicable. For example, we are proposing that EHR1 would be applied to households:

- where a household member has a long-term mental or physical illness lasting or expected to last 12 months or more AND they regularly spend more time in the home during the winter, OR;
- where a member is in receipt of benefits received for a care need or disability AND they regularly spend more time the home during winter, OR;
- where a member of the household is aged 75 and over AND they regularly spend more time in the home during winter:

(i) where a member is in receipt of benefits received for a care need or disability AND regularly spends more time at home during winter, OR;

(ii) to those households with an individual who has a long-term mental or physical illness lasting or expected to last 12 months or more

25.4 CAS is satisfied with the groups proposed for inclusion in EHR1 if there is a provision to include those recently discharged from a prolonged stay in hospital where an EHR is required for recuperation.

27. Enhanced Heating Regime 2: Enhanced Heat

27.1 CAS supports the inclusion of those with a long-term mental or physical illness in EHR2, on the basis outlined previously (see 25.1) that it is within a 6 month or more period, not 12 months. It stands to reason that by spending less time in the home during winter, this group will still require enhanced heating when in the home, but not for the extended time period as under EHR1.

27.2 CAS supports the inclusion of households where a member is in receipt of benefits received for a care need or disability in EHR2, on the basis outlined previously (see 25.2). It stands to reason that by spening less time in the home during winter, this group will still require enhanced heating, but not for the extended time period as under EHR1.

[11] Scottish Government, *Consulatation on the Enhanced Heating Regimes within the new definition of Fuel Poverty*, 2019

27.3 CAS supports the inclusion of households with a member over the age of 75 in EHR2, on the basis outlined previously (see 25.3). It stands to reason that by spening less time in the home during winter, this group will still require enhanced heating, but not for the extended time period as under EHR1.

27.4 CAS is satisfied with the groups proposed for inclusion in EHR2.

30. Enhanced Heating Regime 3: Enhanced Time

30.1 CAS supports the inclusion of households with a child under the age of 3 in EHR3. There is evidence to suggest that extended exposure to inadequate temperatures can affect the development of young children; Friends of the Earth has stated that the "significant negative effects of cold housing are evident in terms of infants' weight gain, hospital admission rates, developmental status, and the severity and frequency of asthmatic symptoms."[12] CAS called for those with lived experience of fuel poverty to be consulted in the development of the Fuel Poverty Strategy, so it is important to advocate on behalf of young children in vulnerable situations, to ensure that they are not excluded from this process. Children do not start to properly regulate their own temperature until around age of 2, and if we operate on the presumption that children of this age spend a majority of their time in the home, their inclusion in EHR3 is essential.[13]

Nursery places funded by the Scottish Government start at the age of 3, which ensures provision of a sufficient heating regime for at least part of each weekday.[14]There is a concern about mis-targeting here, as children who have turned 4 within the 12 month reporting period of the SHCS will be included under EHR3. However, we believe that a cut-off age is required, and we agree that self-reporting that children under 3 are present at the property at the time of the survey is satisfactory.

30.2 CAS is satisfied with the groups proposed for inclusion in EHR3.

32. Other

32.1 CAS is satisfied with the groups proposed for inclusion in the three EHRs. The Scottish Government's Island Communities Impact Assessment correctly makes reference to the challenges faced in island communities as a result of lower household temperatures.[15] It may have been possible to make an argument for the inclusion of additional groups on that basis; however, as the new definition requires households to be both unable to operate an adequate heating regime and maintain an appropriate standard of living, CAS is satisfied that the separate Minimum Income Standard uplift for island areas will ensure that these communities are accurately

[12] Friends of the Earth; Marmot Review Team, *The Health Impacts of Cold Homes and Fuel Poverty*, 2011

[13] https://www.climakid.com/en/vos-enfants/everything-you-need-to-know-about-regulating-your-baby-s-temperature-b68.html

[14] https://www.mygov.scot/childcare-costs-help/funded-early-learning-and-childcare/

[15] Scottish Government, *Island Communities Impact Assessment for the Fuel Poverty (Target, Defintion and Strategy) (Scotland) Bill*, 2019

represented in fuel poverty statistics - CAS called for the introduction of this measure in 2018.[16]

[16] CAS Consumer Futures Unit, *Speaking Up: Understanding Fuel Poverty Support Needs*, 2018