A Consultation on the Draft Respiratory Care Action Plan for Scotland

Energy Action Scotland Response

3 July 2020

Energy Action Scotland is the Scottish charity dedicated to ending fuel poverty. Energy Action Scotland has been working with this remit since its inception in 1983 and has campaigned on the issue of ending fuel poverty and delivered many practical as well as research projects to tackle the problems of cold, damp homes. Energy Action Scotland works with both the Scottish and the UK Governments on energy efficiency programme design and implementation. Energy Action Scotland welcomes the opportunity to respond to this consultation.

Given its remit, Energy Action Scotland's response focuses primarily on those areas that it considers may impact most on fuel poor and vulnerable consumers. Energy Action Scotland is not a health organisation, we are more concerned about the health impacts of living in fuel poverty and that respiratory conditions which are exacerbated by living in a cold, damp home make up a high proportion of Scotland's excess winter deaths, which are linked to living in fuel poverty.

A household is considered fuel poor in Scotland if the household's fuel costs are more than 10% of its income and what is remaining is not enough to maintain an acceptable standard of living.[1] Fuel poverty is driven by four main issues, these being high energy costs, low disposable incomes, poor energy efficiency of homes and how energy is used in the home.

Question 1 – Vision and aims

Do you agree with the overall vision and aims of this draft Plan?

Yes

Please expand on your answer if you wish to.

Energy Action Scotland commends the Plan's vision of "*Everyone with a respiratory condition will be able to access the care and support they need to live well, on their own terms*"

[1] Fuel Poverty (Targets, Definition and Strategy) (Scotland) Act 2019

and notes that sitting above the Plan is Scotland's National Performance Framework. Two of the aims of the Framework are to increase the wellbeing of people living in Scotland and to reduce inequalities.

We contend that living in fuel poverty and living in a cold home is inextricably linked to respiratory conditions and therefore should be a major consideration of this plan. The link between living in a cold, damp home and the stress of attempting, on a regular basis, to make ends meet and poor health has long been recognised and those who are fuel poor are more likely to turn their heating down below the level adequate for their well-being, and more likely to live in energy inefficient homes which are poorly insulated and prone to dampness.

One of the aims of the Plan is to *Improve our understanding of the respiratory population in Scotland*; we believe our response fits in here as:

- for every one degree that the temperature drops below 5 degrees centigrade, the number of older people attending GP for upper respiratory infection increases by 19%
- 9% of hypertension in Scotland could be prevented by maintaining indoor temperature above 18 degrees
- Indoor dampness and mould are associated with increased risk of asthma, dyspnea, wheezing, coughing, respiratory infections, bronchitis, allergic rhinitis and upper respiratory tract symptoms[2]

In addition:

- 30% of winter deaths are caused by cold housing
- 50-70% of winter deaths are attributed to cardio vascular conditions

[2] EAS & NEA, UK Fuel Poverty Monitor 2017-18, September 2018

- 15-33% of winter deaths are attributed to respiratory disease[3]

Question 2 – Our Priorities

Do you think we have included the most important priorities in this draft Plan?

No

Please expand on your answer if you wish to.

Our response focusses on two of the Plan's priorities: Priority 1 Prevention and Priority 2 Diagnosis, Management and Care. We note that Priority 1 talks about preventing respiratory conditions where possible and that the biggest risk factors include tobacco, air quality and respiratory infections. We are surprised that indoor air quality is not recognised in this section, specifically relating to people who live in cold, damp, leaky homes and the issues caused by this. In addition, lower indoor temperatures are closely correlated with excess winter deaths. Prevention, as a priority, needs to include all of the risk factors associated with respiratory conditions.

Some existing health conditions can be affected badly by cold and others can be brought on as a result of prolonged exposure to the cold. Respiratory disorders can be worsened by prolonged exposure to low indoor temperatures and people living in cold homes have an increased tendency to suffer colds, flu, bronchitis and pneumonia.

In addition cold conditions in a home can contribute to condensation dampness and mould growth. This has a detrimental effect on some allergies. Mould spores and dust mites in the air can cause allergic reactions, which in turn can cause problems for people with respiratory illnesses such as asthma.

In Britain, a cold spell during an otherwise mild winter, depending on its duration, can see the following:

[3] World Health Organization, Health Impacts of Low Indoor Temperatures, 1985

- After two days there is a sudden rise in heart attacks, by up to a third;
- After five days there is a big rise in the number of strokes;
- And twelve days into a cold spell there is a rise in respiratory illnesses.

The conditions described above lead to excess winter deaths, also known as increased winter mortality; indeed, there were 2,060 "excess" deaths in Scotland during the winter of 2018/19[4]. Contributing factors include low income, inefficient heating systems, external temperature fluctuations, and excessive dampness and mould growth associated with poor housing stock.

The UK has much higher winter deaths rates than other countries with more severe winter climates, implying that it is not outdoor exposure to cold that is the key determinant. Northern Finland, where winter temperatures regularly drop to -20°C, has a significantly lower rate of excess winter deaths than the UK. However, Finnish buildings have historically had much higher levels of insulation and whole house central heating has been the norm for years.

It is generally accepted that the number of excess winter deaths could be reduced if everyone could be kept warm in their homes during the winter months.

Energy Action Scotland recommends NICE guideline *NG6 - Excess winter deaths and illness and the health risks associated with cold homes*[5] and its recommendations around identifying people at risk of ill health from living in a cold home and this would include people with respiratory conditions, as they are particularly vulnerable to the cold. The guidance suggests that this information should be included in a patient's records and used (with their consent) to assess their risk and take action, such as providing tailored solutions via a referral

[4] National Records of Scotland, Winter Mortality in Scotland 2018/19, October 2019

[5] National Institute for Health and Care Excellence, NG6 - Excess winter deaths and illness and the health risks associated with cold homes, March 2015

system. Some of this is in place but not consistently across Scotland, it really needs to be to ensure a consistent approach to supporting people.

The guidance also suggests developing a strategy to address the health consequences of cold homes. The Respiratory Care Action Plan, and other health plans corresponding to other named conditions should link with the new Fuel Poverty Strategy for Scotland (still to be published). The Respiratory Care Action Plan should sit alongside other action plans and strategies and be co-ordinated by a central point/organisation which needs to update the actions regularly. Respiratory conditions would be included in the Enhanced Heating Regime section of the new fuel poverty definition as they are temperature sensitive conditions. Enhanced heating is a temperature of 23 degrees Celsius for the living room, 20 degrees Celsius for any other room and for a requisite period of 16 hours day and the households identified as requiring enhanced heating include: one where any member of the household has a physical or mental health condition or illness which has lasted or is expected to last for a minimum period of 12 months[6]. The Respiratory Care Action Plan should recognize this as well as how these conditions are vulnerable to the cold. Collaboration with energy suppliers' Priority Service Registers (which is a free service provide by suppliers and network operators for people of pensionable age, or who are disabled or sick, people with a long-term medical condition, or with a hearing or visual impairment, or who are in a vulnerable situation) would be useful and a good example of joined-up working.

With regards to Priority 2 – Diagnosis, Management and Care, Energy Action Scotland would like to highlight our concern about indoor air quality not exacerbating or contributing further to respiratory conditions. It is not desirable or ideal that people with lung conditions continue to live in the environment that is making their condition worse.

[6] The Fuel Poverty (Enhanced Heating) (Scotland) Regulations 2020

The NICE guidance recommends to *discharge vulnerable people from health or social care settings to a warm home* – so there would need to be an assessment on whether the person is vulnerable to the cold (also this ties in with having this information on a person's health record). Actions taken could be turning on the heating before the person is discharged from hospital, providing advice to the person on actions they could take at home to avoid the effects of the cold (turning up thermostats, wearing warmer clothes – energy efficiency tips etc). In Scotland, every NHS Board and social work department has an arrangement in place for the discharge of patients, usually called a Single Shared Assessment (though the SSA is not only used on discharge from hospital – it's for determining care needs for anyone). Energy Action Scotland suggests that a warm home assessment should form part of the overall assessment.

Anecdotally a Scottish discharge team has faced multiple instances where an unplanned admission (e.g. 999 ambulance) has resulted in a hospital stay. Upon discharge the return to home has discovered that self-disconnection from their energy supply has happened due to the length of stay and the patient has had to be returned to hospital as the house is cold and damp. Discharge teams are attempting to pre-empt such occurrences using providers like Red Cross who can make advance visits and settle a patient at home using a more holistic approach than the NHS can undertake.

Question 3 - Early and correct diagnosis of respiratory conditions are a priority

Do you agree with commitments 1, 2 and 3?

Don't Know

Please expand on your answer if you wish to.

Commitment 1 says: *We will support respiratory health training and education for healthcare professionals by working with NHS Education Scotland and other partners to ensure that*

education and training on respiratory conditions is delivered/is available to healthcare professionals.

These professionals should also be trained in how to spot signs of fuel poverty eg living in a damp home there would be signs of damp on walls, condensation on the inside of windows. There are reactive actions that can help improve people's lives such as the training of health professionals in spotting people living in damp homes that will also help to make people's home environments more comfortable and warm. Energy Action Scotland would echo the recommendations of the NICE guidance in terms of ensuring that front line workers with a responsibility for the health, wellbeing and social welfare of vulnerable people receive appropriate training that enables them to identify fuel poverty and signpost effectively. This could link to the Single Shared Assessment.

Question 4 - Increase access to pulmonary rehabilitation

Do you agree with commitment 4?

Yes/No/Don't Know

Please expand on your answer if you wish to.

N/A

Question 5 – Mental health support

Do you agree with commitment 5?

Yes/No/Don't Know

Please expand on your answer if you wish to.

N/A

Question 6 - Transition from child and young people services to adult services

Do you agree with commitment 6?

Yes/No/Don't Know

Please expand on your answer if you wish to.

N/A

Question 7 – Palliative care

Do you agree with commitment 7?

Yes/No/Don’t Know

Please expand on your answer if you wish to.

N/A

Question 8 – Person centred and self-management

Do you agree with commitment 8, 9 and 10?

Yes/No/Don’t Know

Please expand on your answer if you wish to.

N/A

Question 9 – Equal access

Do you agree with commitment 11?

Yes/No/Don’t Know

Please expand on your answer if you wish to.

N/A

Question 10 – Data

Do you agree with commitment 12?

Yes/No/Don’t Know

Please expand on your answer if you wish to.

N/A –

Question 11 – Workforce

Do you agree with commitment 13?

Yes/No/Don't Know

Please expand on your answer if you wish to.

N/A

Question 12 – Wider workforce

Do you agree with commitment 14 and 15?

Yes/No/Don't Know

Please expand on your answer if you wish to.

N/A

Question 13 - EQIA

Do you think there are particular impacts or implications for any equalities groups from any of the commitments in this consultation, either positive or negative?

Yes

Please expand on your answer if you wish to.

The male/female balance of needs is likely to be an issue especially with women living longer than men on average and forming the majority of carers. Recent dissertation research on fuel poverty and gender[7] found that women are more at risk of fuel poverty at various points in their lives although that study did not consider health. Perceptions of thermal comfort of the participants ranged between15 to 25 degrees, with female participants tending to prefer higher temperatures.

[7] Melone, H. Gender-based perspectives of fuel poverty in Scotland, January 2019