Edinburgh Integration Joint Board

REPORT

Health and Social Care Contribution to addressing the City's Housing Emergency

Edinburgh Integration Joint Board

9 February 2024

Executive Summary	1. The purpose of this report is to: a. Outline the Council's response to the City's Housing Emergency b. Update the EIJB on the existing contribution of the Edinburgh Health and Social Care Partnership to homelessness pressures c. Propose that services provided by the Health and Social Care Partnership are reviewed to ensure that we are maximizing opportunities for collaborative and transformational change with our partners to meet the needs of people with complex needs of which homelessness is a significant factor.

Recommendations	It is recommended that the EIJB: 1. Note the progress made and the plans underway to address the Housing Emergency 2. Agree that the services identified should be reviewed to ensure opportunities are maximised, care pathways are improved, and we minimise failure demand 3. Agree that a senior officer from the EHSCP is identified to lead on this work working closely with Council Services and 3rd sector colleagues. 4. Agree the Chief Officer will provide an updated paper in 3 months detailing the HSCP interface with the Housing/Homelessness Rapid Rehousing Transition Plan. This report will further outline the limitations, pressures and challenges in developing this work.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations		
	No direction required	
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	To follow

Report Circulation

The progress and recommendations of this report have not been discussed at any other meeting.

Main Report

National Policy and Legislative Context

1. The *Housing to 2040* strategy sets out a vision for housing in Scotland to 2040 and a route map to get there. It aims to deliver Scottish Government's ambition for everyone to have a safe, good quality and affordable home that meets their needs in the place they want to be (Scottish Government 2021). Within the strategy there are commitments to:
    a. work with LAs to audit empty homes and determine those that should be brought back into use.
    b. support the work of the SEHP and continue to roll out the approach across Scotland.
    c. give LAs the powers they need to regulate and charge owners appropriately for homes lying empty and ensure they have the mechanisms to bring them back into productive use.
    d. create a support package for homeowners in trouble to help them stay in their home, if that is right for them, and to prevent homes falling into disrepair or becoming empty in the first place.

2. The Scottish Government instructed all local authorities to develop, produce and cost a five-year Rapid Rehousing Transition Plan (RRTP) by 31 December 2018. Further to this, local authorities were asked to submit updated RRTPs. The second iteration of the Edinburgh RRTP was agreed by Committee on 18 September 2020 and subsequently submitted to Scottish Government. The third annual update covering the period from April 2022 to the end of March 2023 was presented to the Committee in August 2023

3. As set out in the second iteration of Edinburgh's RRTP, there are several legislative changes which will come into force during the lifetime of the plan

which may impact on the Council's ability to deliver rapid rehousing:

a. **Homelessness etc (Scotland) Act 2003 (Commencement No.4) Order 2019 - Removal of Local Connection –** the changes to this legislation mean that households will be able to present and receive homelessness assistance, including accommodation, in any Scottish local authority area of their choice. Following a delay to the commencement date, this came into effect in November 2022.

b. **Extension of the Homeless Persons (Unsuitable Accommodation) (Scotland) Order 2004 -** This legislation extending the Unsuitable Accommodation Order came into force from 1 October 2021. This means that all homeless households, staying in accommodation deemed as 'unsuitable' for more than seven days constitutes a breach of the Order. Shared houses and bed and breakfast accommodation are deemed unsuitable.

c. **Homelessness Prevention Duty -** An expert group were asked by Scottish Government to investigate the possibility of establishing a prevention duty in Scotland. The group published their recommendations, which were submitted to Scottish Government on 18 February 2021. These recommendations are far reaching and include a duty on wider public services to 'ask and act' about people's housing situation and an extension to the time that households can be assessed as at risk of homelessness to six months.

4. A Temporary Accommodation Standards Framework was published by Scottish Government in April 2023. This follows the publication of advisory standards for temporary accommodation in the interim Code of Guidance on Homelessness in November 2019. The standards are currently not legally binding and do not form part of the Scottish Social Housing Charter.

Edinburgh Response

5. The second iteration of the Edinburgh Rapid Return to Housing Transition Plan (RRTP) was aligned around four key objectives:

a. Preventing homelessness in the first place.
b. Where temporary accommodation is required, this will meet the needs of the household.
c. Supporting people to access settled accommodation as quickly as possible.
d. Reducing the number of people sleeping rough.

6. A comprehensive update was submitted to the Housing, Homelessness and Fair Work Committee in August 2023. You can access the report here https://bit.ly/3SdirCP.

7. On 2 November 2023 the City of Edinburgh Council voted unanimously to declare a housing emergency in the city.

8. On 18 December 2023, the Simon Community's Rough Sleeper Count identified 42 people bedded down. The average number of people known to be sleeping rough for the month of December 2023 was 37 of which 10 were people with no recourse to public funding.

City of Edinburgh Council Commissioned Services

9. Bethany Christian Trust is funded by the City of Edinburgh Council, the Scottish Government, and a range of voluntary income to run the Rapid Re-accommodation **Welcome Centre** in the Haymarket Hub Hotel. Operating for 30 weeks each year, incorporating the winter months, the service provides emergency accommodation (65 rooms) to divert people from sleeping rough, and to support rapid move on to more appropriate accommodation. Their stats suggest that 89% of those who are accommodated there would be rough sleeping if it were not for the Welcome Centre.

10. The Welcome Centre opened on 4th October and filled up in the space of two days. It has been operating at capacity since. During the first 42 nights it was open, the Welcome Centre has accommodated 265 individuals for varying periods of time.

11. Vacancies are filled very quickly as people are being supported to move on. When the Centre is at capacity they refer people to City of Edinburgh Council Out of Hours Service, Rapid Access Accommodation.

12, There are three rapid access accommodation (RAA) services in Edinburgh with accommodation and support i commissioned by the City of Edinburgh Council, providing a total of 68 rooms. These rooms are specifically for rough sleepers and all referrals are made by Simon Community Scotland's street-based outreach team.

- Hopetoun RAA is a 12 roomed female single sex service. Hopetoun has 12 rooms available. Simon Community Scotland provide on-site support 7 days a week.
- Salvation Army Pleasance is a mixed sex service 38 rooms including 3 double rooms. This service has support on-site 24 hours a day.
- Spring Gardens is a mixed sex service with 18 rooms available, including 2 double rooms. Your Home Service provides on-site support 7 days a week between 8am and 8pm

13. In responding to the housing emergency, a whole Council approach is being taken and an action plan (included at appendix 1) has been developed with two actions for the EIJB:

a. Work with the Integrated Joint Board (IJB) to reduce incidences of delayed discharge due to unsuitable or unavailable housing through improved preventative and discharge planning.

b. Work with IJB to address housing needs of older people.

Current Health and Social Care delivery

14. Through IJB programmes such as Discharge without Delay and New Era Cultural Change Programme (focusing on people in rehabilitation at the Royal Edinburgh Hospital) we are ensuring that the housing status of inpatients is considered as early as possible within the person's admission.

15. In addition to embedding housing considerations within care pathways and planning, there are several services wholly or partly funded and commissioned by the EIJB and the Edinburgh Alcohol and Drug Partnership to provide health and social care to people who are homeless and experiencing multiple challenges. These are briefly described below:

16. The Access Place

a. The Access Place is a "one stop shop" offering integrated treatment, care, accommodation, and support to people experiencing homelessness who have additional needs. The vision for the service is that "*People experiencing homelessness who have multiple and complex needs receive high quality, timely and co-ordinated care and support to access permanent 18 accommodation, improve their health, maximise life opportunities, increase hope and move on into communities where they are active citizens*". The definition of multiple and complex needs correlates with severe and multiple disadvantages.

b. The core service offers primary care, social care and housing and provides regular GP support to Milestone Intermediary Care Unit. A range of other key partners work within the service such as Welfare Benefits, Turning Point, Change Grow Life Services and the Cyrenians. Recent additions have included: NHS podiatry, an increase in psychiatry and counselling through Social Bite.

c. To remove barriers and improve access to health, housing and social care, services are delivered both on site and through outreach work for example: setting up drop-in clinics within partner agency premises, outreach pharmacy project, outreach vaccination programmes, hospital housing assessments.

d. Lived experience continues to remain at the core of the service influencing re- design. The views of people who use support are sought regularly and improvements progressed in response to this.

e. Reducing harm caused by substance use is a key feature of the service's daily Recovery Clinic, alongside a robust response to nonfatal overdoses and implementation of Medically Assisted Treatment (MAT) Standards

f. More recently in partnership with the Cyrenians and Royal Society for the Protection of Birds Scotland (RPBS) has introduced nature health plans which include activities such as: Nature health walks led by Edinburgh and Lothians Greenspace Trust, 'Branching out' – a 12-week programme of nature and conservation activities in a nearby woodland, RSPB nature prescription – suggested activities to do by yourself or with a friend, garden-based activities at The Access Place.

g. All staff working within The Access Place are trained in trauma informed practice which is grounded in recognition that exposure to trauma can impact on an individual's neurological, biological, psychological, and social development. Training has increased staff awareness of how trauma can negatively impact on individuals and their ability to feel safe or develop trusting relationships with services.

17. Cyrenians Hospital In-reach Service

This service was developed as a pilot project funded by a private grant making Trust and was designed to support patients that may be at risk of, or experiencing homelessness, a situation ultimately rendering them unable to manage or maintain their treatment. The service was introduced in late February 2020 for:

a. patients being discharged from the Regional Infectious Diseases Unit at the Western General Hospital at the Western General Hospital who experience a higher instance of admission because of additional vulnerabilities caused by ongoing challenges of; addiction, lack of secure housing, significant financial hardship, age related health complications, and chronic conditions such as Alcohol Related Brain Damage (ARBD).

b. patients being discharged from the Royal Infirmary who are known to be homeless, including those in temporary or inappropriate accommodation.

c. The service was evaluated by Edinburgh University and their comprehensive report demonstrated that the pilot had significant success in meeting its intended objectives with key findings demonstrating
   - a significant reduction of 68.7% *(n=66)* in readmissions compared to the 12 months prior to Hospital in reach referral.
   - a high proportion of study patients who were given targeted interventions completed inpatient treatment courses (86%), were linked with primary care providers (75%), or had appropriate accommodation sourced prior to discharge (56%) *(n=70)*

- reduction in readmissions was due to the work of the Hospital In-reach team in acting as a bridge, connecting hospital secondary care services and homelessness/housing services in the community *(statement derived from 17 interviews conducted)*

d. The improved identification of People Experiencing Homelessness (PEH) was also attributed to the development and application of an algorithm to assist clinicians in identifying such individuals.

e. The Hospital In-reach project fills a gap in service provision by facilitating communication between hospital and community homelessness/housing services, which improved decision making. This was widely seen by staff and patient interviewees as key to preventing discharges to inappropriate accommodation or to no accommodation, and in reducing readmissions to hospital.

f. Community homelessness/housing services attributed improvements in services to their ability to readily contact the Hospital In-reach team within secondary care settings to ensure housing was retained for people experiencing homelessness (PEH) during hospital admission and to start earlier planning for discharge.

g. Due to these findings the service has now been enhanced to include the Royal Edinburgh Hospital and funding was secured from the Alcohol and Drug Partnership to continue the programme for a further three years.

18. Milestone Intermediate Care Unit

This unit is a residential service provided by Waverley Care in partnership with Edinburgh Health and Social Care Partnership, NHS Lothian Acute Services, and the Cyrenians Hospital In-reach Team. It provides short-term residential care and support for vulnerable individuals recently discharged from the hospital who are homeless, at risk of homelessness, and living with or at risk of HIV/hepatitis C. Support to individuals in the community, where admission to the unit can lead to early intervention, prevent hospitalization, or mitigate serious harm is also offered.

a. The Milestone Intermediate Care Unit operates a ten-bed registered residential care facility, offering round-the-clock care to individuals who meet the following criteria:
   - Vulnerable or at high risk of homelessness
   - Experiencing multiple complex needs including physical health conditions, mental health issues, and morbidity
   - In need of initiation/stabilization on medication-assisted treatment for addiction
   - Initiating or changing treatment for blood-borne viruses
   - Requiring management of complex wound infections and trauma related to drug use

b. Referrals are from both in-patient care (step-down pathway) and the community (step-up pathway). The service provides a patient-centered and trauma-informed holistic package of care, facilitating recovery, addressing health needs, and offering social, welfare, financial,

c. Healthcare professionals from the Royal Infirmary of Edinburgh, St John's Hospital, or Western General Hospital and more recently the Royal Edinburgh Hospital can make referrals. Referrals are also accepted from community partners, including the Access Place, Recovery services, hostel and supported accommodation staff, and social work.

d. Referrals for vulnerable, homeless patients, or those at high risk of homelessness with multiple complex needs, discharged from the hospital, should meet one or more of the following criteria:
   - Ready for discharge but lacking access to safe or secure accommodation in the community
   - Other complex and vulnerable individuals admitted to inpatient acute settings, such as those requiring ongoing antibiotic therapy, trauma-related injuries, social work input, or at high risk of drug-related death

e. Patients referred for the step-down pathway from the hospital undergo a comprehensive assessment by a member of the Cyrenians Hospital In-reach Team to determine their needs and the reason for the referral.

f. Referrals for vulnerable, homeless patients, or those at high risk of homelessness with multiple complex needs are accepted when:
   - They have self-discharged from the hospital and are at high risk of readmission.
   - Their clinical needs cannot be met in the community following a clinical assessment of their level of need.
   - This may include individuals requiring stabilization from drug/alcohol/mental health issues, assessment, and treatment for significant physical and mental health conditions, monitoring of ongoing health issues, or support to access end-of-life care, existing health/social care/housing services, or additional support services.

g. All referrals and assessments are reviewed during weekly multidisciplinary team meetings to determine the need for admission. The team also regularly reviews the progress, recovery, and discharge planning of individuals currently in the service. The multidisciplinary team comprises Waverley Care managers and care team staff, Cyrenians manager, a clinician from the Regional Infectious Diseases Unit, and the community palliative care team.

h. The service was established during the early days of the pandemic however longer term funding has now been secured and discussions are advancing regarding future commissioning and procurement process.

19. In addition to these developments our mental health and substance use services provide a wide range of support for people. However, as several national reports have highlighted over the years, there is a lack of clear pathways and treatment models for people with “dual diagnosis” or co-occurring problems and some mental health service provision require people to be abstinent before they will intervene. A Working Group has been established to reshape care pathways and address barriers and criteria.

20. The Partnership are also experiencing an increase in the number of people admitted to psychiatric wards who are homeless and experiencing multiple disadvantages. Their length stay is often prolonged due to the individual housing situation. The recent expansion of the Cyrenians Hospital In-reach Service was in direct response to this identified need.

21. We are currently exploring the different approaches to harm reduction that are used in community and hospital settings across Edinburgh and will review this against best practice nationally and internationally.

Opportunities for deeper collaboration enabling transformational change

22. Within Edinburgh, there are some excellent examples of partnership working, of pooling budgets and integrating not just health and social staff but third sector staff in single teams with a shared vision, values, and practice model. There are further opportunities for deeper collaboration to effect and sustain greater transformational change across a range of settings and services which provide touch points for people experiencing severe and multiple disadvantages.

23. A host of enablers such as the developing Action Plan to respond the Housing ` Emergency Crisis, Getting it Right for Everyone, the developing EIJB Prevention and Early Intervention Strategy, the refreshed Drugs and Alcohol Strategy and the New Era programme which is focusing on supported living and accommodation for people leaving institutional settings, can be used to maximum effect supporting radical transformative acts such as for example: Removing referral criteria; adopting a no wrong door, ask once approach; embedding evidence based practice; people with lived / living experiences led change and delivery.

24. The services commissioned by the EIJB (as detailed in sections 14 to 19) should be reviewed as a priority whilst we improve our connections and opportunities for joint planning and delivery with other city partnerships to address the needs for people who are experiencing severe and multiple disadvantage including the Community Safety Partnership, the Alcohol and Drugs Partnership, the Childrens Partnership, and the Edinburgh Community

Planning Partnership Board. We have a shared vison to end the housing emergency and all partnerships have a role and contribution to make which will be further enriched, enhanced, and strengthened through collaboration, skill sharing and pooling of resources.

25. A researcher in residence from Edinburgh University has been undertaking research in homelessness and is due to share initial findings in February 2024. These will be considered alongside feedback and reflections garnered over recent months from staff and partners,

Implications for EIJB

Finance

26. It must be noted that Homelessness Services are not delegated to EIJB and in that regard strategic planning, statutory responsibilities and funding arrangements are not the responsibility of EIJB. In common with most public services, the IJB is agreeing a budget at a time when demand for our services is increasing, costs are rising, and we are striving to improve performance. All of these factors will seriously impact on our ability to augment and develop plans to support council Homelessness Services. This will be exacerbated by continuing public finance constraints, unmet need in our communities, and the impact of pay awards and fair work measures across the health and social care system compounding the critical risks around provider sustainability.

27. In a bid to adopt a longer term, strategic approach to financial planning which drives improvement and savings, the board has supported the development of a medium-term financial strategy (MTFS). This takes a longer-term view of our finances and is aligned to a set of longer-term transformation change programmes and projects.

28. This proposed work will form part of the workstreams for the medium-term financial strategy.

29. Cost benefit studies, which have tended to focus on people with high needs, with sustained experience of homelessness, have highlighted how some long-term and repeatedly homeless people can be individuals who start off physically and mentally well, but experience rapid deteriorations in health and well-being, making them more expensive for the public sector over time and making their homelessness more costly to resolve as their needs become complex. Edinburgh HSCP have a strong commitment towards effective early intervention and prevention. In this regard we recognise the major benefits in designing services that are targeted, joined up and are evidence informed however we must recognise that the financial challenges faced by the IJB will impact on our ability to introduce new initiatives and that there will be a

requirement to ensure we are functioning as efficiently as possible with secured outcomes.

Legal / risk implications

30. A risk registers with mitigation will be created to form part of an ongoing governance for the programme.

Equality and integrated impact assessment

31. Across the city, it is estimated that 1 in 5 children and young people are in poverty. Poverty and homelessness are often linked, and there are currently around 1200 children and young people in temporary and unsuitable accommodation. After decades of improvement, Scotland's health is worsening - with the gap in life expectancy between the poorest and wealthiest growing. Poverty is one of the main causes of this inequality in health, social, economic and environmental factors in our lives make up around 50% of the building blocks of our health and wellbeing. Poverty limits access to these important building blocks of health therefore where we live, the income we have, and the conditions in which we live, and work really matter. The lack of control, worry and uncertainty that poverty creates can be stressful, and damaging to our mental and physical health. This proposed work has a focus on preventing homelessness occurring, providing secure permanent accommodation timeously where homelessness can't be avoided, and ultimately supporting and enabling families and households to thrive.

32. It is acknowledged that people with a range of protected characteristics are currently seeking a Council home, through EdIndex or having presented as homeless and currently being supported in temporary accommodation. This work will help us target more effectively

Environment and sustainability impacts

33. This work will also provide an opportunity to consider in a more collective and cohesive way environmental and sustainability impacts including an increased focus on removing financial barriers through changing funding mechanisms,

Quality of care

34. The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. This suite of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers, and their families. These outcomes focus on improving how services are provided, as well as the difference that integrated health and social care services should make, for individuals.

35. In line with the Measuring and Evidencing Change theme, which emerged from the formulation of the Edinburgh Wellbeing Pact, we will be using different methodologies and approaches demonstrating "distance travelled "to achieving outcomes. This will be fully detailed in the evaluation framework to support this workstream,

Consultation

36. A people with lived experience advisory group will be created to inform this work. The group will use different methods and approaches to engage with people. This will connect with current collective advocacy groups across the city.

37. Previous service evaluations and reviews which have included people with lived experience will be drawn upon.

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Background Reports

- Ending Homelessness Together High-Level Action Plan (2018) and Updated Action Plan (2021) Scottish Government
- Preventing Homelessness in Scotland (2021), Prevention Review Group
- National Health and wellbeing framework (2015) Scottish Government
- Shared Spaces: Final Report (2021), Indigo House, Homeless Network Scotland
- Johnsen (S) et al (2021) Scotland's Housing First Pathfinder Evaluation, First Interim Report
- Bramley G et al (2019) Hard Edges Scotland, Lankelly Chase and The Robertson Trust
- Drug and alcohol services - co-occurring substance use and mental health concerns: literature and evidence review'; Mental Welfare Commission (2022)

- [1]Homeless Deaths 2021, Report (nrscotland.gov.uk)[1]https://www.scotphn.net/wp-content/uploads/2015/10/Restoring-the-Public-Health-response-to-Homelessness-in-Scotland-May-2015.pdf

Appendices

Appendix 1 Draft Housing Emergency Action Plan (as of 5 December 2023)

Appendix 1 Draft Housing Emergency Action Plan

The following action areas will require a cross Council partnership-based approach. Each Directorate of the Council will be involved in development these areas, and a deepening of partnership across the sector will be put in place.

1. Increase the return rate of void Council property to lettable standard and allocate them, bringing a significant number of Council homes back in to use.
2. Secure additional 'off the shelf' Council homes available through the Council's acquisitions policy.
3. Increase the number of empty homes brought into use and allocated to homeless people through the Empty Homes Partnership.
4. Continue to focus on seeking land opportunities for direct development, purchase suitable completed new build homes from the private sector and work with landowners on partnering opportunities on strategic sites.
5. Continue working towards the Strategic Housing Investment Plan target of over 9,500 new homes in the city by 2029.
6. Work with partners and with COSLA to investigate funding solutions to meet the identified funding gap of £665m to deliver the Strategic Housing Investment Plan.
7. Purchase additional properties for use as temporary accommodation, with a corresponding reduction in B&B use.
8. Increase the number of Private Sector Leasing properties available to the Council.
9. Ensure the availability of additional supported accommodation bed spaces for homeless people.
10. Accelerate purchase of existing homes aligned to the Council's asset management strategy.
11. Significantly reduce the use of unsuitable accommodation by March 2025.
12. Develop targeted approaches to prioritise permanent housing for those in unsuitable accommodation, recognising the correlation between unsuitable accommodation and children placed on the child protection register and becoming Looked After.
13. Make a minimum 70% of housing allocations to homeless applicants.
14. Target interventions to prevent homeless presentations, using data to support those with protected characteristics, and families supported by protective services.
15. Delivery of the Rapid Rehousing Transition Plan.
16. Continue delivery of the Housing First model to reduce repeat homelessness.

17. Reduce the average time taken for a new tenant to move into their home.
18. Reduce the average time to complete emergency and non-emergency repairs.
19. Improve tenant satisfaction with their Council home.
20. Optimise the role of the voluntary and community sectors in delivering and sustaining tenancies.
21. Identify dedicated resource to consider the needs of Unaccompanied Asylum-Seeking Children and children and families with No Recourse to Public Funds.
22. Put in place dedicated resource to work across housing and children and justice services to prevent homelessness and ensure the principles of The Promise are incorporated into the approach, recognising the discreet needs of families, individual adults, and young people, including access to the exceptional housing award for Care Leavers.
23. Develop amended models to finance housing delivery utilising all powers available to the Council.
24. Work with the Integrated Joint Board (IJB) to reduce incidences of delayed discharge due to unsuitable or unavailable housing through improved preventative and discharge planning.
25. Work with IJB to address housing needs of older people.

Actions needed as part of partnership approach

25.1. Work with other local authorities within COSLA to agree temporary reforms in resource allocation policy to ensure Edinburgh receives an appropriate level of funding through the Affordable Housing Supply Programme.

25.2. The Edinburgh Housing Partnership Compact: Work with RSLs and other key third sector agencies across all ages on:

a. Tenancy readiness
b. Allocations policy
c. Investment policy
d. Homelessness prevention
e. Family and household support

25.3. Work with COSLA to raise the rate at which local authorities are entitled to claim housing benefit for temporary accommodation with the Department of Work and Pensions and seek to ensure that payment is made in line with current LHA rates in future.

25.4. A new deal for housing in Edinburgh: a partnership between the Council and Scottish Government to deliver sufficient, long-term resourcing for homelessness, new build, and acquisitions