HSHAWB 11 Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

Senedd Cymru | Welsh Parliament

Y Pwyllgor Llywodraeth Leol a Thai | Local Government and Housing Committee

Bil Digartrefedd a Dyrannu Tai Cymdeithasol (Cymru) | **Homelessness and Social Housing Allocation (Wales) Bill**

Ymateb gan: Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Evidence from: Cardiff and Vale University Health Board

1. What are your views on the general principles of the Bill, and whether there is a need for legislation to deliver the stated policy intention?

1. Duty to "Ask and Act":

CVUHB recognises and supports this as an important part of preventing homelessness, or supporting those experiencing homelessness more effectively. This is already in place within Cardiff and Vale Health Board through CAVHIS with in-reach into the Emergency Unit.

This duty necessitates changes in practice and potentially the GMS contract to ensure compliance. The effectiveness of the bill will be limited without a duty being placed on primary care. Most of the healthcare interactions happen in primary care and this is where those who are at risk of homelessness in the next 6 months would present and need referral. Those who are homeless and presenting at the EU/Secondary care are likely to already be known to services and have a duty open. There will of course be those who are not known to services and present at EU where CAVHIS can pick them up and this is a good start, but unless the duty comes into primary care via the contract, its effectiveness will be restricted.

For primary care, there should be a tiered model, which would directly impact on people accessing support through the EU:

Tier 1: ability to respond, ask and act as people at risk presenting to GMS as part of universal GMS services and the universal care offer

Tier 2: Immediate inclusion services and care for areas with lower numbers of excluded groups. Working as an MDT with partners to provide effective

coordinated assessment and support, particularly in areas of high deprivation. A DSS or LES may provide a suitable mechanism to support this.

Tier 3: Specialist inclusion health services for areas with high numbers and/or complexity

2. Integrated Care Models

Health Boards will need to adopt integrated care models, working closely with housing services to provide holistic support. This includes addressing both health and wider social needs simultaneously.

This is in place through CAVHIS, however to be effective, mechanisms will need to be established in GMS, and potentially other primary care providers, to work in a coordinated and collaborative way with key agencies (probation, DWP, mental health, drugs and alcohol services, social services, housing etc)

3. Training and Resources

There are significant education and training implications across all parts of the Health Board and primary care as individuals could come into contact with any service. There will be significant costs and time associated with this to deliver it effectively. Whilst CAVHIS and other specialist services that come into contact regularly with people at particular risk of homelessness will be well informed, other services will not. We would suggest that there should be a short mandatory training module for the NHS (and other partners) as part of the introduction of the new arrangements.

Health Boards would need additional resources to invest in training for healthcare professionals to better understand and address the unique health challenges faced by homeless individuals. This includes mental health support, substance abuse treatment, and chronic disease management .

4. Data Sharing and Management

Improved data systems and data-sharing practices will be essential for tracking the health outcomes of individuals affected by the Bill and ensuring that they receive continuous and coordinated care. There is not currently adequate funding nor national support to achieve integrated electronic care records across multiple systems.

2. What are your views on the provisions set out in Part 1 of the Bill - Homelessness (sections 1 -34)? In particular, are the provisions workable and will they deliver the stated policy intention?

N/A

3. What are your views on the provisions set out in Part 2 of the Bill – Social Housing Allocation (sections 35 – 38)? In particular, are the provisions workable and will they deliver the stated policy intention?

N/A

4. What are your views on the provisions set out in Part 3 of the Bill – Social Housing Allocation (sections 39 – 43 and Schedule 1)? In particular, are the provisions workable and will they deliver the stated policy intention?

N/A

5. What are the potential barriers to the implementation of the Bill's provisions and how does the Bill take account of them?

The following are potential barriers for the Health Board alone – we have not addressed the wider implications for Local Authorities.

1. Integrated data and care records across organisations: lack of integrated data and shared systems will mean duplication of referrals and over-referral as health colleagues will refer all those who are homeless whether they have an open duty or not and the frontline homeless intake/assessment teams will have to field these referrals, unless there are local pathways and mechanisms in place via CAVHIS-style arrangements.

2. The lack of coding and data holding/sharing around those who have NRPF is a problem here when frontline staff come across those with unclear immigration status and who may have NRPF and LAs not having a duty to accommodate. They will likely be repeatedly referred as the NRPF status is very poorly understood by NHS staff. The development of local NRPF pathways needs to happen alongside implementation of the bill.

3. Training and education across a wide spectrum of NHS clinicians and other staff.

4. Ability to verify addresses and citizenship

4. Alignment of services and eligibility across Health Boards and LAs

5. GMS contract if no duty placed on GMS and included within the GMS contract.

6. How appropriate are the powers in the Bill for Welsh Ministers to make subordinate legislation, as set out in Chapter 5 of Part 1 of the Explanatory Memorandum)?

N/A

7. Are there any unintended consequences likely to arise from the Bill?

1. Increased identification of individuals needing additional support will create additional demand on services, some of which will require a highly specialised response. There will be challenges in securing appropriate staff with those specialist skills.

2. Mainstream services will need to adapt access criteria and service delivery models to support this highly vulnerable group. 'Ask and act' may increase case finding as intended, however organisations will need time to build their capacity and capability to respond.

3. The social, health, housing and wellbeing needs of this vulnerable cohort of people can be highly complex and multifaceted and require support from many different services whose criteria and operating models may work against delivering a coordinated approach. There will need to be significant investment in developing an integrated delivery model

8. What are your views on the Welsh Government's assessment of the financial implications of the Bill, as set out in Part 2 of the Explanatory Memorandum?

N/A

9. Are there any other issues you would like to raise about the Bill and the Explanatory Memorandum or any related matters?