Housing support for vulnerable people – additional information from The Salvation Army

- **(Cross-sector working) Is there any good practice in relation to service users who may be too complex for traditional housing support because of their long-term health and social care needs?**

I would like to draw on the good practice and collaboration work within our Housing First Project in Cardiff, where we have established excellent working relationships with health. Together with the level of intensive and flexible support provided by our team we have been able to continue quality of end-of-life care with several of our clients residing within the community.

As part of our support within Housing First, we work closely and collaboratively with a variety of health agents. Here is a case reflection for your consideration.

" Client Lukasz* (name changed for anonymity) came into our Housing First Project with a variety of chronic health issues, including HIV and Mollescum (skin disorder). During his time receiving support from Housing First Lukasz* unfortunately developed cancer, which despite extensive treatment became terminal. During Lukasz* diagnosis and battle cancer, his Housing First support team navigated a variety of health relationships including gaining support from; Cardiff Multi-Disciplinary Team nutritionist, adult Social Services, his local GP, BBV Nurses based at UHW and later his palliative care and nursing team based at Velindre. By having a Specialist Support Worker responsible for navigating these partnerships it ensured that Lukasz* was able to have his pain managed, his dietary needs met and ultimately enabled him to pass away at home, which was his choice. Without these strong operational partnerships Lukasz* experience would likely have been very different."

Another positive example of cross sector working is the introduction of Cardiff Multi-Disciplinary Team based within Cardiff Local Authority, which has offered an extensive and systematic flexibility to accessing health care for our clients.

This has seen the introduction of CAVIS for prison leavers, virtual gp access and even a respiratory consultant attending the day centre. I would however stress that these bespoke one-off projects (such as the respiratory consultant) are often based on good will and already established relationships between health colleagues. They are also readily subject to change when the rotation of that personnel means they have to move to another department. We saw this particularly starkly during Covid19, where many practitioners and our homelessness nurses were recalled to ward based NHS work.

- **What should the future of housing support look like?**

The importance of a very adapting and responding housing support model is vital to its success. Anything that we wish to care for and offer sustainable longevity for people (staff & clients) then we need to future proof by ensuring financial support matches our living and working environment. Also, that staff feel cared for, and clients are not stigmatised and having the only options to reside in tired low resourced buildings.

With this in mind I would welcome commissioning to recognise and financially offer contract up lifts throughout the term. That there wish for a PIE framework means a commitment to funding reflective practise and training, away days and how to celebrate and recognise service achievements.

True systemically motivated collaboration across county and statutory organisations.

Better connections with prison release and no longer release days just been on a Friday.

Health and substance misuse specialists are well resourced, and collaborative roles are built into NHS Wales staff structures, rather than good incentives being based on professional interests, personality, and good will.

The value of our work is recognised, and the social return on investment is properly explored and noted.

HPG should not be held within the same pot as HSG as it could get lost and not used effectively to prevent homelessness – we would advocate for this to held separately with principles and guidelines on how to use for the LA.

Again, the same for Housing First Trailblaizer, ensuring the financial flexibility of the model is not lost.

Understanding the impact of the RHWA has on our staff and client wellbeing together with the financial impact on service delivery.

- **The Welsh Government says it wants Housing First to be the default approach for people with high levels of support need. How far away are we from that, and what barriers need to be overcome?**

We discussed the matter of lack of funding increase and the impact this has had on our existing services, such as staff reductions and lack of flexibility to the number of people we are able to support and how our support looks. We are currently not funded at a level that makes this aspiration a reality

There is also the issue of lack of available properties and commitment from SRL/PRS to house our clients.

There is a sense of a lack of growth and commitment towards HF, due to the extensive pressures faced by WG and Las as named above. How in this, do we remember that HF is a lifelong model of support. How can this be commissioned and financed in the longer term to ensure sustainability?

There was a discussion raised about the HF model in Finland. I feel this requires further discussion and maybe a visit to our TSA HF service in Finland, in which we will note that this is a congregate HF model and was created when the Government decided to close all homelessness supported residential accommodation. Culturally Finland is also very different to Wales, and it is these changes that we need to recognise and consider when thinking of all alternative version of HF for our cities, semi-rural and rural communities across Wales.