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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: Conffederasiwn GIG Cymru | Evidence from: Welsh NHS Confederation

	The Welsh NHS Confederation's response to the Local Government and Housing Committee inquiry on the Homelessness and Social Housing Allocation (Wales) Bill.
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Introduction

1. The Welsh NHS Confederation welcomes the opportunity to respond to the to the Local Government and Housing Committee inquiry on the **Homelessness and Social Housing Allocation (Wales) Bill**.
2. The Welsh NHS Confederation is the only membership body representing all the organisations making up the NHS in Wales: the seven local health boards, three NHS trusts (Velindre University NHS Trust, Welsh Ambulance Services University NHS Trust and Public Health Wales NHS Trust) and two special health authorities (Digital Health and Care Wales and Health Education and Improvement Wales). We also host NHS Wales Employers and are part of the NHS Confederation.
3. Housing is undeniably a fundamental determinant of health. The quality, stability, and affordability of housing directly impact physical and mental well-

being, influencing everything from respiratory conditions and cardiovascular disease to mental health and social isolation. Implementing better systems for communication and collaboration across sectors is not merely beneficial, but crucial for the well-being of vulnerable individuals and for the efficiency of the healthcare system.

4. Quality housing acts as a wider determinate for good physical and mental health, and when investing in good quality housing there is a proven return on investment in health benefits. The impacts of poor housing are reflected in health inequalities across Wales and have a disproportionate impact on the most vulnerable populations of society. As stated in the Welsh NHS Confederation's briefing, "**How does housing influence our health?**", poor housing costs the Welsh NHS £95 million per year in the first five years of treatment charges and costs Welsh society over £1bn a year.

5. The Welsh NHS Confederation, aligning with the "A Healthier Wales" vision, advocates for seamless services delivered through strong partnerships between health, social care, housing, and wider public and third sector. Good housing is not just about bricks and mortar, but also encompasses affordability, security, safety, and connection to community services.

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?

6. Our members broadly agree with the general principles of the Bill and that there is a need for legislation to deliver the stated policy intention.

7. Our members emphasised that from a public health perspective, the Bill acknowledges the well-established link between housing and health. It specifically addresses the severe health issues faced by those without stable housing, such as rough sleepers, and recognises the complex interplay between co-occurring substance misuse and mental health conditions.

8. A significant strength of the Bill is its focus on preventing homelessness. This is achieved through the introduction of Prevention, Support and Accommodation Plans (PSAP), which are designed to enhance the ability of Local Authorities to intervene effectively. Furthermore, the Bill extends the homelessness prevention period from eight weeks to a more substantial six

months, providing a much-needed safety net to mitigate the risks of individuals becoming homeless.

9. The Bill also places a crucial duty of co-operation on public services to ensure its policy intentions are realised. While existing multi-disciplinary and multi-agency forums, like the Homelessness and Vulnerable Groups Health Action Plan and the Hywel Dda University Health Board (UHB) Co-occurring Mental Health and Substance Misuse Board already facilitate this collaboration at local and regional levels, our members suggest that legislation might be beneficial for effective performance management.

10. While supportive of the Bill, successful implementation will likely hinge on reaching clear agreements among partners and may necessitate additional resources, including for primary care. The severe housing and homelessness situation frequently presents in primary care through requests for supporting documentation for housing applications or appeals, such as housing letters or the sharing of medical records. While the need for clinical corroboration of health-related housing needs is understood, the current system places a significant administrative burden on GPs. This burden is exacerbated by a lack of integrated service provision, collaboration, and effective communication tools to support these processes.

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?

11. Our members support the provisions set out in Part 1 of the Bill – Homelessness (sections 1-34).

12. Our members agree with Part 1 of the Bill for its aim to prevent homelessness, a welcome policy given the well-documented negative effects homelessness has on individuals, their health, and the broader economy. The provisions within this section offers a strong framework to tackle these issues.

13. In particular, sections 1-34 of the Bill lay out a thorough strategy that emphasises early identification, prompt intervention, collaborative efforts, and solutions developed jointly by public bodies and non-statutory services. Our members suggest organising these efforts into locally tailored and practical delivery streams should be achievable.

14. Our members highlight that a particularly promising aspect of the Bill is the proposed amendment to the definition of "threatened with homelessness," which would expand the reach of services to more people before they reach a crisis point, allowing for earlier partnership intervention.

15. While supportive of the provisions within Part 1, a potential challenge lies in the workforce and resourcing requirements, especially if there's a high demand for services across various partnerships. The text also highlights a limitation in the healthcare response within the Bill, noting that it primarily focuses on secondary care services. It suggests that the role of primary care services might need to be re-evaluated, as individuals at risk of homelessness may interact with their GP or Community Pharmacist without necessarily being involved with secondary care. While acknowledging that many at-risk individuals may already be receiving secondary care, there appears to be a gap concerning the involvement of primary care teams that needs addressing.

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

16. While our members support the aims within Part 2 of the Bill, they have recommended that further improvements could be made to the provisions.

17. In relation to Part 2, our members have highlighted that while the Bill's provisions appear practical and are expected to achieve their stated policy goals, real-world implementation might present challenges. For instance, there could be disparities between the demand for services and the available accommodation supply. To mitigate this, it is crucial that the duty of co-operation among public service organisations extends beyond individual local authority boundaries. Therefore, adopting regional approaches to this work might be a prudent step to ensure that the Bill's provisions are effectively delivered and its stated policy objectives are met in practice.

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?

18. Our members agree with the provisions set out in Part 3 of the Bill and though concise, contain provisions that are deemed reasonable, workable, and aligned with its stated policy goals. More significantly, Schedule 1 introduces

substantial and welcome elements that appear practical for achieving the Bill's intentions. These include a "duty to ask whether a person is homeless or threatened with homelessness" and a corresponding "duty to act where a person is homeless or threatened with homelessness." In practice, these duties represent a significant and proactive step towards empowering local authorities and their partners in homelessness prevention efforts. While acknowledging the importance of a local connection test, it also highlights the necessity for broader regional co-operation.

19. However, the precise role of healthcare services in supporting these provisions is less clear within the Bill. While a partnership approach is acknowledged, healthcare, despite not being a housing provider, holds influence and can play a crucial role in identifying patients at risk of homelessness. This identification could occur in various settings, such as emergency care, or even at an in-patient level by ascertaining housing circumstances prior to discharge. There is also potential for primary care services (as mentioned earlier) to contribute significantly to this effort.

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

20. Our members agree that there are some potential barriers to the implementation of the Bill's provisions.

21. While the Bill has received widespread positive feedback from homelessness charities and housing agencies, from an NHS and public health standpoint, there are specific areas that must be considered. The first crucial point is to shift the approach from a medical model to a social model of health, embedding this perspective across all levels of healthcare delivery, including primary, secondary, acute, and emergency care.

22. The second potential barrier is logistical: creating sufficient time within healthcare delivery to ensure healthcare staff are fully aware of the Bill's provisions. This awareness is vital for enabling appropriate referrals, or at minimum signposting, for individuals with housing needs. To support this, there's a potential for needs assessment work using healthcare records, coupled with a "mapping and gapping" analysis of current service supply and demand.

23. The third potential barrier concerns prioritising these efforts. Impact measurement will be essential, and this could be further enhanced by

developing a health economic case, demonstrating how housing interventions can reduce healthcare demand. If the integration of housing and healthcare services is to be taken seriously, there's an opportunity for housing discussions to become part of the "**Making Every Contact Count**" initiative, where conversations about topics like vaccination uptake could expand to include housing. Conversely, when individuals experiencing housing crises present in healthcare settings, broader conversations about their overall health should also take place.

24. Regarding the Bill's current effectiveness in addressing these points, more work is needed. The Bill primarily places a duty of co-operation on the NHS, but the specific impact of this duty remains unclear. While local partnerships exist and there's a basic duty of good practice within this framework, the full implications for NHS involvement are yet to be seen.

How appropriate 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?

25. Our members agree that it is reasonable for Welsh Ministers to make subordinate legislation as set out in Chapter 5 of Part 1 of the Explanatory Memorandum.

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

26. Our members agree that they cannot foresee any additional unintended consequences likely to arise from the Bill. As highlighted previously, resources and awareness across the healthcare workforce, and wider, may be a challenge.

What are your views on the Welsh Governments assessment of the financial implications of the Bill as set out in part 2 of Explanatory Memorandum?

27. Regarding views on the Welsh Government assessment of the financial implications of the Bill as set out in Part 2 of the explanatory memorandum, our members have highlighted that it is hard to comment as the model is limited by the absence of what would be the outcome for a homeless person if they were not homeless. There does need to be some further return on investment analysis undertaken.

Are there any other issues you want to raise? Summary of our position below.

28. Our members largely view the Bill as a positive step, primarily for its focus on establishing a robust framework for early identification and intervention in homelessness. Our members welcome this potentially transformative change for individuals, families, and communities in Wales, given the well-documented detrimental impacts of homelessness on individuals and also communities.

29. The primary responsibility for delivering on accommodation issues will fall to local authority housing teams and their partner organisations. However, a significant concern is the deliverability of these duties, especially considering the existing imbalance between the supply of services and the demand for accommodation in Wales. The current statistics highlight ongoing challenges, with a rising number of households assessed as homeless and a high number of individuals in temporary accommodation.

30. The Bill's economic case is not clear, and there's no apparent immediate investment, which presents a challenge in transitioning from current provisions to the desired future state. Despite these concerns, the multi-agency partnership approach is seen as a major opportunity within the Bill and supported by our members.

31. Regarding NHS implications, our members strongly welcome the inclusion of health boards in the duty of co-operation across public bodies. There are significant opportunities within healthcare settings to identify individuals at risk of homelessness. This is particularly evident for those already accessing mental health and/or substance misuse services, where the "housing first" principle is already well-established in Wales and has shown impressive tenancy sustainment rates (around 91%). This principle, which prioritises stable housing before addressing other complex needs, offers significant potential for individuals with co-occurring mental health and substance misuse issues, though its resource dependency is acknowledged.

32. A key concern, however, is the lack of clarity surrounding the role of primary care services. Many individuals with poor health who are at risk of homelessness frequently interact with their GP or seek advice from a pharmacist, yet primary care seems to be a significant omission in the Bill's explicit provisions. There's a strong argument that primary care's involvement should be strengthened within the Bill. Discussions with primary care

contractors would be crucial to determine how they can contribute effectively. This proactive engagement is essential to avoid an "inverse care law" situation, where those most in need of healthcare—including many at risk of homelessness—are paradoxically the least likely to receive it, particularly as some may not even be registered with a GP.

33. Additionally, the impact of inadequate housing has a broader impact across the health service. Secondary care clinicians also face pressures to validate housing needs and facilitate safe hospital discharges. Unstable or insufficient housing can directly block discharge planning, leading to bed blocking and increased strain on the healthcare system. Ultimately, our members experiences place them at the intersection of social need and clinical care, and they welcome more joined-up approaches to improve outcomes for some of the most vulnerable members of our communities.

34. Furthermore, there is a notable absence of systematic communication between housing, social services, and health providers, despite clear benefits for patients. Historically, health-related needs often receive low weighting in local authority housing prioritisation frameworks. To address this, our members highlight the need for structured collaboration and the development of digital solutions to support better information exchange.

35. Regarding digital solutions and information sharing, our members advocate for a secure, structured digital pathway to share relevant health information with local authorities and housing associations, and other key stakeholders, ideally with patient consent and appropriate safeguards. Current processes often rely on outdated or inefficient communication routes, despite the security of NHS email systems.