WINTRINGHAM

SUBMISSION TO THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

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CONTENTS PAGE

EXECUTIVE SUMMARY

Wintringham welcomes the opportunity to make a written submission to the Royal Commission into Aged Care Quality and Safety.

WINTRINGHAM

Guided by the principles of social justice, Wintringham has a single mission to provide dignified, high-quality care and accommodation to those who are profoundly financially and socially disadvantaged, especially those elderly men and women who are homeless, or at risk of homelessness.

Our organisation operates an innovative and integrated range of programs providing a continuum of care; ranging from assertive outreach, social housing (600 units; all with housing support), in-home aged-care (700 packages), a registered Special Residential Service (SRS), and six residential aged-care sites (289 beds), all of which are in receipt of the Homeless Supplement.

With 650 dedicated staff, Wintringham supports 2,000 clients each day across metropolitan Melbourne and regional Victoria. The organisation is the largest provider of aged care services to the elderly homeless in Australia.

KEY RECOMMENDATIONS - OVERVIEW

Our submission and recommendations focus solely on matters particular to consumers aged 50+ who come from a homeless background or are at risk of homelessness, and the specialist organisations that provide services to these marginalised and disadvantaged men and women.

Our recommendations are as follows.

RESIDENTIAL AGED CARE

1. The Aged Care Funding Instrument (ACFI) must be replaced with a fit-for-purpose funding tool that recognises the unique costs associated with providing high quality care to consumers from a homeless background.

2. A guaranteed and strictly quarantined capital funding allocation be available in order to build services that are exclusively available to consumers from a homeless background.

CONSUMER DIRECTED CARE (CDC) HOME CARE

3. Case Management for homeless clients should be separated out of the Home Care Package and adequately funded under a separate program.

4. The Home Care funding model must be refined to recognise the unique and episodic care needs of people experiencing homelessness.

SUPPORTING ACCESS TO AGED CARE SERVICES

5. Consumers experiencing homelessness require support and resources during the period from when they are deemed eligible to access Home Care services, to when they secure a package.

6. The Assistance with Care and Housing (ACH) program is an effective program and must be adequately funded on an on-going basis.

7. Prioritise referrals to MyAgedCare over NDIS for homeless clients aged between 50 and 65.

8. The establishment of 'care navigators' to provide advocacy support for homeless clients to access MyAgedCare and subsequent aged care services.

9. Special Needs Groups, including people who are homeless or at risk of becoming homeless and people who are financially or socially disadvantaged, must secure prioritised access to CDC Home Care packages.

OTHER MATTERS

10. Improved funding of social housing with appropriate supports for the elderly homeless will reduce premature access to aged care services.

11. If a sustainable future for aged care in Australia includes moving to a greater 'market' driven model, unintended consequences such as limiting access to quality services for homeless consumers must be addressed.

EXPLAINING WINTRINGHAM

WHO WE ARE AND WHAT WE DO

Guided by the principles of social justice, Wintringham has a single mission to provide dignified, high-quality care and accommodation to those who are profoundly financially and socially disadvantaged, especially those elderly men and women who are homeless, or at risk of homelessness.

Our organisation operates an innovative and integrated range of programs providing a continuum of care; ranging from assertive outreach, social housing (600 units; all with housing support), in-home aged-care (700 packages), a registered Special Residential Service (SRS), and six residential aged-care sites (289 beds), all of which are in receipt of the Homeless Supplement.

With 650 dedicated staff, Wintringham support 2,000 clients each day in Melbourne and regional Victoria.

Working with the elderly homeless presents particular problems for service delivery, in part because the often-noted incidence of premature ageing and complexity of care needs (physical, psychological and social), combined with a general reluctance to accept services due in part to a strong sense of independence and demeaning experiences with a range of previous health or community care providers.

Our model of care has been developed in direct response to these 'special needs' of our client group.

We are the largest provider of aged-care services for elderly homeless Australians, yet we are required to operate in a paradigm that governs aged care programmatic funding based around a typical client type (older, female with a family who can provide support and advice). Our clients are more likely to be younger, have a long and appalling history of disadvantage, no family support, behavioural and mental health challenges and a significant distrust of any service delivery system.

All Wintringham clients are elderly (aged 50 and over) and in greatest need of housing and related support. Our specialisation and focus means that we often support clients that other organisations find too challenging and whom would remain or become homeless if Wintringham did not exist. At Wintringham, we provide a 'home until stumps' for clients that the mainstream aged care system refuse to accept.

Our innovative continuum of care model is recognised internationally, with Wintringham awarded the United Nations World Habitat Scroll of Honour in 2011, the first Australian organisation to secure this prestigious award and the only recipient that specialises in supporting the elderly homeless.

HOW WE CAME TO BE

Wintringham was founded in 1989, in response to the frustration of watching elderly men and women die in homeless persons' night shelters, unable to access services from an aged care sector that wanted nothing to do with them.

At that time, elderly homeless people lived and died at homeless persons' night shelters that were run by a variety of charitable services and funded under the Supported Assistance and Accommodation Program (SAAP; a Federal Government multi-lateral agreement with the States and a separate bi-lateral agreement with each individual State).

These shelters were often violent places where people were routinely bashed, raped and on occasions, murdered. It hardly needs to be stated that these environments were totally inappropriate for frail aged people, yet many of the residents were elderly and in desperate need of aged care services.

In spite of the best efforts of social workers at places such as Gordon House in Melbourne, Australia's largest night shelter, it was almost impossible to have any successful referrals to aged care residential services.

In 1988, Gordon House could accommodate 300 people each night, of which we estimated more than half of the residents were elderly and over 110 people eligible for Commonwealth aged care services. Not one of those residents were in receipt of such services.

It is difficult to explain just how appalling conditions were in these night shelters for frail elderly men and women, but a simple comparison is that Gordon House provided 20 hours per week of personal care for the 300 clients. Our estimate is that a Commonwealth funded aged care service catering for 300 people would provide up to 5,000 hours of personal care. It is important to note that in both instances, the clients are the same people - it is the accommodation and resultant eligibility for care that differs.

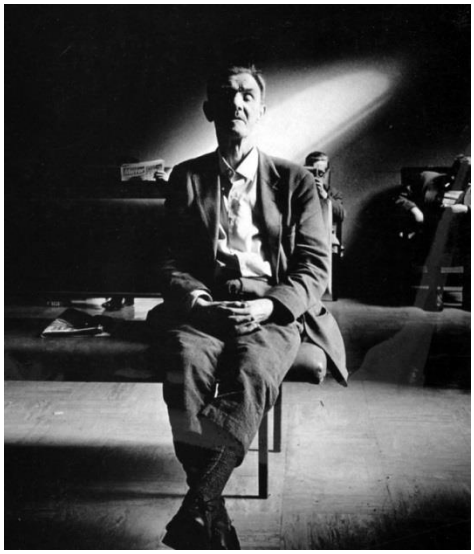
Given the unwillingness of aged care providers to accept referrals on behalf of elderly homeless people, Wintringham was established to provide this care. The initial reaction from both the aged care sector and public service was one of resistance, with claims from providers that the problem did not exist, and from the Government that homeless clients were being provided for via the SAAP system. (The SAAP homeless services system was very poorly funded compared to Aged Care and is essentially a crisis program that had no expertise or experience in providing appropriate services to frail elderly people).

In response to the claim that our clients were homeless and aged, and therefore part of the homeless services system, we argued that they were **not homeless and aged but aged and homeless** and should therefore be entitled to aged care services. This argument was not simply semantics but signalled a new paradigm in viewing the rights of the elderly homeless. The representation was successful and eventually the then Federal Minister for Aged Care, Peter Staples, approved funding for Wintringham to develop three aged care facilities for elderly homeless people.

UNDER 65: HOMELESS PEOPLE AGE PREMATURELY

Importantly, we were able to secure acknowledgement from the Government, that the lifestyle of many of our homeless men and women had prematurely aged them, and that similar to the argument that Aboriginal representatives were making, this premature ageing should make them eligible for Commonwealth aged care from the age of 50 years.

As a result Wintringham (and now other homeless aged care providers), provides residential and community based aged care services to clients that also includes those aged 50 to 65.



Many of our homeless clients arrive at Wintringham in very poor health, undernourished and frequently frightened, or so 'battle hardened' that they are initially difficult to engage with respect to their care and support needs. In addition, it is quite normal for our clients to have had a very isolated life with little or no contact with family members.

SPECIAL NEEDS OF A HOMELESS CLIENT GROUP

Apart from the major financial challenges in managing an aged care service for impoverished clients, there are clearly major differences in how we relate to our clients and the special arrangements we must put in place that differ from mainstream aged care providers.

With little or no contact with family members, our staff work directly with new clients, initially to win their trust and allay their fears and expectations, borne from previous life experiences that they may be abused, taken advantage of, or evicted on short notice.

Regular meals and assistance with personal care needs, adequate sleep and rest, and the slow removal of fears and tension, often results in weight gain and an improvement in health. As clients begin to feel better and take more of an interest in life around them, staff work with them to articulate their wants and desires. Key to this is the Wintringham Recreation Program.

Recreation plays a pivotal role at Wintringham.

We currently employ over 50 trained Recreation and Diversional Therapists, and provide services seven days a week at our residential and community based housing and Home Care services.

Staff are equipped with budgets and resources including wheel chair accessible buses (donated by philanthropy), and provide individually tailored programs for each client. These activities can be passive such as reading, chess or fishing, but can also include more adventurous activities including hot air ballooning, sky diving and travel.

An immediate outcome of the Program is that for many clients, recreation takes the place of an absent family. The process of building a community at each of our facilities is in part designed to replace a lost family and to re-create a sense of belonging. The sense of community is palpable at all of our residential services and one that is frequently commented on by visiting Commonwealth Ministers. Clients take a genuine interest in the lives of their neighbours and in the comings and goings and personalities of the staff. Importantly we have instructed our architects to build homes where people live in, not where staff work.

Relaxing by the Maribyrnong River.

Roy's skydiving dream accomplished.

COSTS UNIQUE TO SPECIALIST HOMELESS PROVIDERS

It is widely acknowledged that our existing aged care system relies heavily on the work undertaken by a huge unpaid workforce comprising family, friends, neighbours or the ability of older people to purchase these supports privately. If we flip this over though, this same system greatly disadvantages those who have no social resources or the financial means to purchase these services.

As a specialist homeless service provider, we step into this gap, build a relationship and provide support - no matter how simple or complex the problem is.

Our services are tailored to meet the needs of our clients and can range from facilitating community inclusion, assistance to negotiate rents or find alternate accommodation, taking a client to a health or specialist appointment, purchasing clothing, sorting out what has gone wrong when the power is disconnected, through to negotiating on disputes with neighbours and helping to escape from violent or abusive situations.

These services are important. They help to say to the person that they matter, they are important, they have choices, they have rights and it helps them to meet their goals and care needs. On a more

pragmatic note, provision of these supports helps to reduce costly interactions with our emergency services.

Subsequently, Wintringham operates in a cost environment impacted by providing these necessary services. These costs are not incurred in the mainstream aged care environment and not recognised within the policy and funding framework.

Special Staff and Client Relationships

Wintringham supports and encourages staff to create homelike environments and to develop individual relationships with each resident. This important part of our model of care can create challenges for our managers, for example, when a death at one of our facilities occurs. The passing is commemorated with a simple service (religious or otherwise depending on the client's wishes) where frequently the only people present are staff and other residents. For individual staff members who form close (and caring) relationships with their elderly residents, it can be very confronting to be with them when they die and to know that it will be unlikely that any family will attend the funeral. Wintringham managers carefully monitor staff who are affected and will frequently utilise external counselling / Employee Assistance Program resources if required.

Complaints As a Mark of Our Success

Wintringham clients have generally had very different life experiences from those using mainstream aged care services and this directly influences our approach. A lifetime of disadvantage and disempowerment has not only made many of our clients wary and somewhat suspicious of people offering to help them, it has also taught them not to complain. We work hard to ensure staff regularly ask clients what's working for them or what's not, in a constructive, non-judgemental and open environment.

All complaints are properly investigated and actions communicated to the client, but it needs to be stressed that at Wintringham, complaints are seen almost as 'a badge of honour'. We are constantly aware and new staff are educated to understand that many of our homeless clients have experienced the harsh consequences of complaining and have learnt that the best way of surviving is to keep a low profile and not to draw attention by complaining.

For an elderly person who has experienced the humiliation and unfair consequences of complaining, for them to now feel that they can make a complaint or raise a concern and suffer no adverse consequences is an outcome we are proud of. It is not uncommon for staff to record the complaint against themselves from a disgruntled client or resident whose illiteracy prevents him from doing so personally.

This approach to complaints has led the Aged Care Quality and Safety Commission (and predecessor agency) to not only view our complaints files with great interest, but to regularly invite Wintringham executives to speak at their staff meetings or at their conferences on the relationship between complaints and empowerment.

Case Study

I can remember counselling a young personal carer who had been working with one of our newer residents. She was upset that in spite of the care and affection, he was receiving and the beautiful accommodation he was now living in, he complained regularly and often about what appeared to be minor issues. She said, "He's living in a place much nicer than where I live yet he is always complaining". I tried to reassure her that his complaints should be seen as a huge complement to her work. She had given him the power to complain knowing that the complaint would not result in his eviction or bashing.

HOW THE AGED CARE SYSTEM NEEDS TO BE IMPROVED TO APPROPRIATELY SUPPORT THE ELDERLY HOMELESS

At the time of establishing Wintringham in the late 1980s, the elderly homeless lived and died on the streets or in appalling night shelters. We believe that if the aged care industry had taken sufficient notice and care of the elderly homeless, there would never have been a need to establish Wintringham. The treatment of elderly homeless men and women remains a blight on the aged care industry, as mainstream service providers continue to ignore these vulnerable consumers.

Based on experience and expertise gained from 30 years of supporting elderly men and women who come from marginalised and homeless backgrounds, we believe that the following structural issues need to be addressed urgently. Without change, the existing inequity of accessing aged care services will continue.

RESIDENTIAL AGED CARE

1 ACFI IS NOT AN APPROPRIATE FUNDING TOOL FOR CONSUMERS WHO WERE PREVIOUSLY HOMELESS

ACFI HAS DISADVANTAGED HOMELESS PROVIDERS

Whilst specialist services that provide residential aged care for the homeless face a variety of income and expense imposts that are unique in our sector, the core issue impacting financial viability is the simple reality that the residential aged care funding tool (Aged Care Funding Instrument; ACFI) has inadvertently been designed in a manner that inherently under-funds services that support homeless residents.

This is evidenced in the following table that notes daily subsidy funding per resident at three points over the decade from 2007 when the Resident Classification Scale (RCS) was replaced by ACFI.

	2007 (RCS)	**2012 (ACFI)**	**2017 (ACFI)**	**% change 2007 to 2017**
National average	$90	$135	$172	Up 91%
Homeless service average[1]	$91	$101	$130	Up 43%
Funding gap	**$1**	**-$34**	**-$42**	

[1] Data points that Wintringham have obtained from Dept. of Health; Homeless service average represents average daily funding for services eligible for the Homeless Supplement; most recent provided is for the 9 months to March 2017.

In 2007, homeless providers received $1 per resident per day more than mainstream services, highlighting equity in funding. Once ACFI was introduced, homeless providers have become materially disadvantaged and the gap continues to grow. Organisations like Wintringham take some of the most difficult clients in aged care and provide for them in ways that other services are not prepared to. Yet in spite of this much more challenging client group, specialist homeless services received $42 per client per day less of core funding.

The above table also ignores the reality that mainstream services (both for-profit and NFP) generate additional income streams by charging for extra services (something that homeless clients have no capacity to pay) which further increases the funding gap.

The subsidy gap created by ACFI was unsustainable for homeless services. We acknowledge that because of extensive lobbying by Wintringham, the Australian government accepted this premise through the introduction of the Homeless Supplement and the Viability Supplement in 2014. Both supplements were recently increased by 30 per cent effective March 2019.

Recent modifications to ACFI have a material detrimental impact

Notwithstanding the introduction and recently announced recalibration of the Homeless and Viability Supplements, Wintringham will be materially impacted from the revenue impact of changes to how the Complex Health Care (CHC) ACFI domain is calculated. (The changes include a new scoring matrix for assistance with medication and changes to scores and eligibility requirements for certain CHC procedures.)

These changes came into effect on 1 January 2017 and we expect the full impact to filter through by 2022/23 at which point, all other things being equal, the decrease in ACFI revenue for Wintringham is estimated to be $1.06 million per year.

The CHC calculation change is a blunt instrument to manage growth in ACFI. Whilst the revenue reduction may be manageable for mainstream providers, specialist agencies such as Wintringham have no viable option to replace this income stream, yet our underlying cost base remains the same.

Acquired brain injuries are a form of dementia

Many of the Wintringham client group are deemed ineligible and excluded from specialist behaviour support services and available funding as they do not have the 'correct dementia'. When the eligibility for dementia related services was redefined in recent years, it disregarded the definition in the Diagnostic and Statistical Manual of Mental Health which states that acquired brain injuries that result in reduced cognitive function including all alcohol related dementias or alcohol related brain injuries are considered to be dementia.

RUCS trials and the proposed new funding model

Wintringham welcomed the announcement of the Resource Utilisation and Classification Study (RUCS) in 2017. In light of our concerns with ACFI, our organisation actively participated in the RUCS trials, contributing to Study 1, Study 2 and Study 3. We also attended the Department of Health RUCS Stakeholder Forum held in Canberra on 14 March 2019.

Based on documents and data that is publically available, it appears that the conclusions drawn from the RUCS resulting in the proposed national classification and funding model (AN-ACC), has created a superior tool for providers supporting homeless clients.

As a background note, the AN-ACC captures what drives relative care costs in residential aged care, both at a resident and facility level. It considers the functional consequences of clinical and need characteristics of individual residents, rather than the condition itself; it is these functional consequences that drive staff time and cost. Wintringham supports the principle of establishing three components to the proposed funding model; a fixed, variable and entry cost adjustment component.

In establishing a fixed component, it provides an opportunity to reflect the inherent higher cost base incurred by specialist providers. The AN-ACC clearly identified this reality, noting that there are higher costs for specialised services, such as those caring for homeless people. This is something that we have identified and advocated for over our 30 years of service delivery.

Likewise, AN-ACC identifies several factors that drive individual care costs with the most costly residents - those that have compounding factors such as behavioural issues, a condition that is highly prevalent for homeless people. We are grateful that the AN-ACC recognises the high cost of managing behaviours; it is something that ACFI never did with such a low level of income provided for the Behaviours domain.

Through the AN-ACC, it appears that for the first time, aged care funding recognises that our clients require a specific and higher cost model of care.

Wintringham believe that the Aged Care Funding Instrument must be replaced with a fit-for-purpose funding tool that recognises the unique costs associated with providing high quality care to consumers with a homeless background. We are encouraged that the proposed national classification and funding model (AN-ACC) appears to recognise the true cost of caring for older homeless clients.

2 CAPITAL FUNDING: WITHOUT ACCOMMODATION DEPOSITS, HOW CAN NEW FACILITIES BE BUILT?

A fair and equitable aged care system must enable all aged Australians to access quality aged care services.

Construction of Aged Care facilities are primarily financed through consumer contributed Accommodation Deposits and Accommodation Payments, highlighted by the fact that as at 30 June 2018, the sector held $27.54 billion[2] of such deposits. Organisations such as Wintringham who work with elderly homeless people receive few if any Accommodation Deposits, eliminating access to this core avenue of capital. As a result, each of the six aged care facilities built by Wintringham over the last 30 years have relied on capital grant funding from government and philanthropy. It is inherently very challenging to be successful in this capital funding regime as very limited funding must be shared Australia wide.

Wintringham has long argued that there needs to be a strictly quarantined, appropriately funded capital pool that homeless persons' services can apply to in order to build new facilities. Either that

[2] Seventh report of the Funding and Financing of the Aged Care Industry; Australian Government Aged Care Financing Authority July 2019

or revert to the excellent Variable Capital Funding Program that existed in the early 1990s when Wintringham constructed its first three aged care facilities. Under this scheme, for each resident that could not pay an Accommodation Bond, providers were paid a capital amount equivalent for the cost of constructing a room for them.

Low or no-interest loans from the Commonwealth have occasionally been suggested as a way forward, but this is no solution to organisations that cannot service or repay loans due to the absolute poverty of our clients and the resultant extremely narrow margins that we operate under.

Wintringham recommend that a guaranteed and strictly quarantined capital funding allocation be available in order to build services that are made exclusively available to homeless consumers.

CONSUMER DIRECTED CARE (CDC) HOME CARE

3 THE IMPACT OF CASE MANAGEMENT IN A CONSUMER DIRECTED CARE ENVIRONMENT

Consumer Directed Care (CDC) for Home Care packages, while entirely appropriate for an elderly client who is able to articulate their requirements, or who has a family member or friend who can act in this capacity, is not suited for an isolated homeless person.

Our clients are frequently unaware of their rights, wary of bureaucratic systems, and struggle to 'navigate' their way through a CDC environment. Many have also experienced service exclusion in the past, making the notion that an elderly homeless person can somehow test the market and shop around for the best price or appropriate service, absurd.

If a marginalised and isolated client receives a package, their inherent reluctance to engage with services often results in them utilising a provider who, not understanding lived experience, does not question the clients refusal to accept any services resulting in their health and wellbeing continuing to deteriorate.

Unfortunately though, the additional responsibility of providing those previously mentioned diverse social supports (which include encouraging and working with clients to accept services) means that caseload numbers for Wintringham Case Managers is lower relative to a generalist provider who only offers a case coordination service and the bare minimum of social support. Generalist providers can employ less skilled Case Managers at a lower rate of pay and with a substantially higher caseload.

We are offering a completely different service but this is not apparent in MyAgedCare where every Provider advertises as a 'Homeless Specialist', ultimately to the detriment of clients from a homeless background as the service offered will not support the underlying needs of the individual.

This inequity can be addressed if the full case management cost were to be separated from the Home Care Package for homeless and similarly vulnerable clients. The need for case management would be assessed and provided as a separate service. This would ensure vulnerable consumers would retain their entire home care package for service support but also receive the necessary help they need to make that package work for them, ensuring they can remain safely in the community and have their care needs appropriately met.

CASE STUDY

(a) Beryl is 56 years old and has been on a package with Wintringham since 2007. She has been a victim of domestic violence for many years, perpetrated by her now deceased husband of thirty years. Beryl has often felt unsafe living in her own home. Beryl's husband passed away in front of her in 2011; she was traumatised by his loss and still grieves for him.

Beryl has three children; two sons have committed suicide and she is estranged from her daughter. She managed her complex grief associated with her children and her husband's death with alcohol. Beryl has a history of transience – she will go to hospital or sleep on the street whenever she feels threatened.

Our work with Beryl has been, of necessity, very slow and gradual, however she has now reconnected with her niece who has taken an active role in supporting her, reduced her alcohol intake, has not fled her home for many months, nor has she presented at a hospital Emergency Department. She regularly attends her GP, she purchases and takes her medications as prescribed. She is well connected and feels secure with her mental health practitioner. Beryl's outlook on life has improved and she is stating she wants to live and enjoy what time she has left.

Beryl's outcome cannot be achieved with simple case coordination and there is a doubt that even we could have achieved this outcome today in a CDC environment where Beryl would have seen statements itemising the cost of our work in this area and felt that she was being a pest or a problem.

Wintringham recommend that case management for homeless clients be separated out of the Home Care Package and funded under a separate program.

4 THE NEED FOR A LEVEL OF FLEXIBLE FUNDING WITHIN A HOME CARE PROGRAM

Our experience working with marginalised and homeless clients has taught us that providing case management (which works through a myriad of issues not all related to health or aged care), combined with in-house personal care staff who can establish relationships with homeless clients, prevents either a return to homelessness or early entry into an aged care facility.

Providing home based care to people who do not have a home or who live in insecure, unsafe housing has always presented Wintringham with a real challenge, but we have demonstrated that it is possible, particularly if we include the provision of affordable housing that we either own or manage.

Prior to the introduction of CDC, specialist service providers like Wintringham could use funds flexibly to provide support that responded to the particular episodic needs of clients, especially for those living in very insecure accommodation and who were generally reluctant to engage with service providers. Responding to these episodic needs, especially through early intervention that can be resource intensive, is impossible when funds are reserved exclusively for each individual client.

While fully supporting the concept of full CDC for the wider community, there is a need to allow a portion of the funds available for homeless clients to be pooled and available to respond to intensive episodic care needs when required.

Wintringham recommend the CDC Home Care funding model be refined to recognise the unique and episodic care needs of people experiencing homelessness.

SUPPORTING ACCESS TO AGED CARE SERVICES

5 SUPPORTING CLIENTS UNTIL THEY RECEIVE A HOME CARE PACKAGE

The Royal Commission is aware that there are significant CDC Home Care waitlists resulting in lengthy wait periods between when clients become eligible for a Home Care Package and when they receive a package. Our experience indicates that this wait time is currently over 12 months.

During this period, consumers predominately rely on pre-existing services and the support of family and friends to successfully remain at home. As we have identified elsewhere in this submission, homeless and marginalised clients are excluded from support services and very rarely have traditional family support networks to call upon, resulting in a significant deterioration in their health and well-being during the wait period.

Specific funding is required to support these clients once their eligibility to access CDC Home Care services is confirmed.

Homeless consumers require support and resources during the period from when they are deemed eligible to access Home Care services, to when they secure a package.

Wintringham recommend that specific funding be made available to specialist providers to appropriately support marginalised and homeless consumers whilst they wait to secure a Home Care package.

6 ASSISTANCE WITH CARE AND HOUSING (ACH)

An understated and valuable Commonwealth program is the ACH service that works directly with elderly men and women who are experiencing homelessness or at risk of becoming homeless. Wintringham is an ACH provider and major supporter of this program.

The ACH program aims to reduce the reliance of homeless or at-risk elderly people on emergency services, facilitate shorter hospital admission times, reduce engagement with crisis services and, through long term Case Management, offer the ability to remain safely in the community and to avoid inappropriate early admission to residential care.

ACH programs come in a range of shapes and sizes, with some offering group support, others phone support or others, like Wintringham, offering a one-to-one assertive outreach service actively seeking out clients. Eligible clients are people who are homeless or at risk of homelessness because they have experienced housing stress or do not have secure accommodation.

We have identified three main pathways into homelessness for older people and respond with three different engagement models.

- Homeless/at risk for the first time in their lives, due to a change in personal circumstances, often arising from housing affordability challenges. Most providers can successfully work with this group, the contact with support is brief, can be via phone rather than face to face. Seventy per cent of clients engaging with our current ACH services fit into this group.
- Those who have a history of housing instability and require some low level supports to maintain a tenancy. Support for this group is usually short-term and must be done face-to-

face as they do not readily accept the need for help or have a strong understanding of their social and health care needs.

- Those who have been in and out of institutions and/or homelessness many times and have complex presentations (i.e. drug and alcohol, mental health, disability, chronic illness/disease, frail aged). Early ageing linked to a lifetime of disadvantage is a key factor with this client group. Support must be provided face-to-face. These clients are usually difficult to engage, with no friends or family involved. Staff working with them require high levels of expertise and understanding of the special needs of this client group. Outreach contact times tend to extend. Referrals are usually made by the open doors housing entry points, crisis and emergency services. While this group only represent 10 per cent of all referrals received in our current ACH programs, they absorb almost 90 per cent of funding with their intense support needs. If ignored, they place a huge burden on the community, are frequent users of our emergency services and cycle in and out of specialist support areas without achieving any long-term stability.

One unintended consequence of the long wait for either NDIS or CDC packages is to effectively block discharge from outreach support services such as ACH. In effect, ACH is intended as a first stop sorting place for our most disadvantaged. Those complex few will be held there until appropriate long term supports can be put into place. In the past, the most common long-term support has been through the aged care system. Now, however, our ACH workers spend considerable time wading through bureaucratic processes while a decision about who will take responsibility for the client who is under 65 years is taken – this can take many months before an assessment for services is finally conducted and the client is placed on the wait list for service provision. All whilst the ACH worker is trying to sustain a frail person who has been in and out of institutions and/or homelessness many times, has drug, alcohol, mental health problems alongside disability, chronic illness/disease or frailty.

Whilst long term and complex clients continue to be supported by ACH, it limits the ability to accept new referrals.

Wintringham recommend that ACH is (i) properly funded and then (ii) nominal growth is linked to ABS census data for homelessness.

7 INTERFACE WITH NDIS

A significant concern for Wintringham is how the introduction of NDIS has inadvertently impacted services to elderly homeless people.

As noted earlier in this paper, Wintringham was able to win the right for prematurely aged homeless people (those over 50 years of age) to access Commonwealth funded aged care, a ruling that has continued to enjoy bi-partisan support. This interpretation of premature ageing is consistent with a similar view taken for prematurely aged Aboriginal people.

With the introduction of NDIS, there has been a fundamental and probably unintended consequence. Our clients under the age of 65 are now not assessed by the MyAgedCare Gateway but are referred first to NDIS. Here they suffer long wait times with a system that is complex and struggles to cope with many of our homeless clients who are not willing or used to asserting their rights to a stranger on the telephone. Our workers and/or advocates are often unable to assist as the assessors have been instructed not to engage with them.

The eventual NDIS assessment (if it is carried-out) can take months, only to result in a determination that the individual is not eligible for NDIS services and only then a referral back to MyAgedCare is accepted. In some cases, the MyAgedCare access teams refuse to assess clients under the age of 65. It needs to be said that some of our clients may die or be lost to us during this wait.

Wintringham strongly supports the introduction of the NDIS and can attest that the funding is satisfactory for those clients that are approved. However, the long wait times must be addressed and a simpler way be found to ensure that the previously hard won right of prematurely aged people accessing aged care services be retained.

CASE STUDIES

(a) Robert

Robert is a 60-year-old man living in a public housing unit in Preston. He is a typical client we would have assisted under a low level Home Care Package who seemed to really need services and, importantly, case management. His health and other issues include prostate cancer, significant nerve damage to left hand (following a stabbing two years ago), recent dizziness and falls (cause unknown), ETOH (Ethanol) abuse (drinks daily), sciatica. Robert does not often get to medical appointments and could not remember the name of his GP.

A Wintringham worker called My Aged Care – and was told to contact the Disability service due to his age (under 65). She then called the DHS Disability Line and explained his circumstances and was referred to the local Aged Care assessment service (Bundoora ACAS). She then called Bundoora ACAS and faxed through a SCTT tool with detailed information about Robert's situation. She was called back by intake and was given the number for the local area coordinator for NDIS as she was told she needed to try them first. She then called Brotherhood NDIS and was told they could not tell her whether he would be accepted but based on the information given they did not think he would be eligible for NDIS as he did not seem to have a significant disability.

They suggested she call the National NDIS line who told her that the only definitive way to find out was to lodge an access request. She was also told that it was a lengthy process, which involved the paperwork being sent to Robert. He would then need significant reports, such as an occupational

therapist and doctor's report to attempt to prove a significant disability. When explaining Robert's presenting condition, she thought it was unlikely he would qualify. She also warned he would not know the outcome of this access request for several months. This would mean several months without services for Robert with a likely 'no' at the end of the process before we could even re-apply for ACAS.

After all this, our worker called back Bundoora ACAS and explained this was what she had found out and surely it did not make sense to put all this work into an access request for a service he was unlikely to qualify for and which would take months to receive an answer for. Meanwhile Robert would have no access to services. They then responded she needed to now refer him to the HACC Young Person's Program for assistance. She has not yet received an outcome from this.

(b) Raymond

Raymond turned 65 years old on 27 May 2018, when staff attempted to refer to MyAgedCare (MAC) in February 2018, despite the fact he is so nearly 65, and that both NDIS and ACAS referrals are now waiting over three months before being actioned, we were told he was not of age and to refer once he turned 65 years.

This is a person who is currently not able to cope on his own; he is morbidly obese with severe gout and not able to ambulate, staff attend to his shopping and his next-door neighbour, who is also unwell, is making his meals for him. After a long discussion with the MAC operator this referral failed – there seems no logical explanation for this, and the feeling of pure frustration for staff and the resident themselves is hard to describe.

Wintringham recommend that referrals to MyAgedCare be prioritised over NDIS for homeless clients aged between 50 and 65.

8 SUPPORT TO ACCESS AND NAVIGATING MYAGEDCARE

Navigating the aged care system is challenging for all consumers, however most will have inherently stable arrangements (housing, phone, internet access) and a support network (spouse, children, other nominated representatives, health practitioners) that can assist to navigate the referral system and gain access to assessments and services.

As documented elsewhere in this submission, marginalised and homeless consumers do not have these arrangements and supports in place. Subsequently they find it difficult to gain access to assessments, and when or if they do, will often miss appointments or notifications.

Through the methods of how MyAgedCare is now accessed, the system is inherently biased against homeless and marginalised consumers. They require dedicated advocates to support them in securing access to the aged care system. ACH workers are uniquely qualified to provide this service.

Homeless clients should also secure priority access to aged care assessments and prioritised access to CDC Home Care Packages.

Wintringham recommend that funding is made available to establish 'care navigators' to provide advocacy support for homeless clients to access MyAgedCare and subsequent aged care services.

9 PRIORITISED ACCESS TO CDC HOME CARE SERVICES

It is recognised that there are barriers that reduce the capacity of individuals and/or communities to access aged care services and receive appropriate care. In response to this, the Aged Care Act has legislated to recognise these specific Special Needs Groups. People who are ***homeless or at risk of becoming homeless*** and people who are ***financially or socially disadvantaged*** are two such groups.

Wintringham recommend that all Special Needs Groups secure prioritised access to aged care services including CDC Home Care packages.

OTHER MATTERS

10 LINKAGES TO AFFORDABLE HOUSING AND SUPPORT SERVICES

Wintringham has over 2,000 elderly people on our housing waiting list - 2,000 aged men and women who are homeless or at imminent risk of homelessness and in need of housing and support. Surely a terrible statistic for a country as wealthy as Australia.

The 2016 census shows that there are now 134,000 people aged 65 and over paying rents more than 30 per cent of their income - an increase of 41.7 per cent in five years.

The vast majority of those people are in need of affordable housing.

The number of people aged 55 and over who accessed Specialist Homelessness Services in Australia increased by 37 per cent between 2012-13 and 2016-17, with more than half (56 per cent) of these people being women. Older people in the 55 - 74 age bracket were the fastest growing age cohort within the overall homelessness population, increasing by 55 per cent in the decade to 2016.

In addition, older people represent one of the fastest growing groups seeking assistance from specialist homelessness agencies, with an average annual growth rate of 8 per cent each year between 2011–12 to 2016-17 compared to 4 per cent growth rate for other specialist homelessness services clients.

Older specialist homelessness services clients were more likely to be living alone (59 per cent) when compared to the rest of the specialist homelessness services clients (29 per cent). *(Australian Association of Gerontology: Older Women who are experiencing or at risk of Homelessness, 2018).*

In order to address this massive housing shortfall, Wintringham has become a Victorian Government registered Housing Association and through accessing capital funding, and striking innovative partnerships with philanthropic trusts, Wintringham has now over 600 houses in Victoria that are made exclusively available to elderly homeless men and women, who are then supported by a range of programs including Commonwealth Home Care Packages.

It must be noted that from our 600 housing units, we have approximately 50 vacancies each year. With 2,000 people on our housing waitlist, it highlights that demand far exceeds supply.

There is currently no discernible connection between the Commonwealth Aged Care Program and any Commonwealth or State Housing program. This must change. Residential aged care facilities are

expensive to build and operate. Wintringham's experience is that the provision of affordable housing with appropriate levels of support can eliminate the need for intensive residential aged care.

Similar to our argument relating to capital funding for residential aged care facilities for the homeless, we recommend that there needs to be a strictly quarantined and regular capital supply that enables organisations like Wintringham to build housing that can be rented at affordable rates and combined with appropriate levels of aged care support being delivered on an as-needs basis.

11 SUSTAINABLE FUTURE

The Aged Care Financing Authority (ACFA) is a statutory committee established to provide the Australian Government with independent and transparent advice on the impact of funding and financing arrangements on the viability and sustainability of the aged care sector, the ability of consumers to access quality aged care and the aged care workforce.

A key aspect of ACFA's activities is monitoring and analysis of the overall financial state of the sector and the financial performance of aged care providers. In providing advice on the sustainability of the aged care sector, a key aspect is whether the funding and financing arrangements are such to support the level of investment needed to meet existing and prospective demand for quality aged care services.

ACFA are currently undertaking a project considering the attributes of a sustainable aged care sector. In making recommendations with respect to a sustainable future, it is critical that marginalised consumers, such as those who are homeless, are not inadvertently disadvantaged through the introduction of measures based on market driven principles of efficient service delivery and informed consumers seeking choice.

Homeless individuals currently cannot on their own gain access to mainstream aged care services. There is a serious risk that if the aged care sector becomes further market driven, there will be additional barriers to access and where available, services to homeless clients will become sub-standard.

Wintringham recommends that in such an environment, interventions must be in place to protect equity of service access to homeless clients.

CONCLUSION

Homeless service providers work with a very different client group than mainstream providers, in terms of the absolute poverty of the clients, premature ageing and behavioural issues that arise from multiple complex needs, addictions and acquired brain injury.

Wintringham has demonstrated that it is possible to provide high quality services but the aged care program needs refinement for this to be sustained.

We continue to maintain that there is something deeply troubling that organisations such as Wintringham, who work with and provide services to some of the most difficult and complex aged care recipients, people whom the aged care industry has by and large turned its back on, are expected to provide these services with significantly less resources. As documented earlier in this submission, we receive few Accommodation Deposits, receive little or no support from residents' family, and are severely disadvantaged in both the ACFI and CDC funding models.

If the Federal Government continues to maintain, as it should, that financially disadvantaged elderly homeless people are entitled to receive aged care, then it is time that serious attention is given to ensure organisations, such as Wintringham, who are willing to take on that responsibility, are funded appropriately now and into the future. We want to ensure that elderly homeless men and women receive the same high quality services that we expect for all other Australians, whilst ensuring that organisations that provide these services remain financially viable and sustainable.

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APPENDIX

FURTHER CONTRIBUTIONS MADE BY WINTRINGHAM TO THE ROYAL COMMISSION

Response to questions asked of all aged care providers by the Royal Commission

- Wintringham residential aged care facility; McLean Lodge
- Wintringham residential aged care facility; Port Melbourne
- Wintringham residential aged care facility; Wintringham Williamstown
- Wintringham residential aged care facility; Ron Conn
- Wintringham residential aged care facility; Eunice Seddon
- Wintringham residential aged care facility; Gilgunya Village
- Wintringham Northern Community Housing and Support service
- Wintringham Western Community Housing and Support service
- Wintringham Southern Community Housing and Support service
- Wintringham Southern Peninsula Community Housing and Support service
- Wintringham Regional Community Housing and Support service

Statement of Bryan David Lipmann AM, statement of Kate Rice and their attendance at the Perth hearing on person centred care on 25 June 2019.