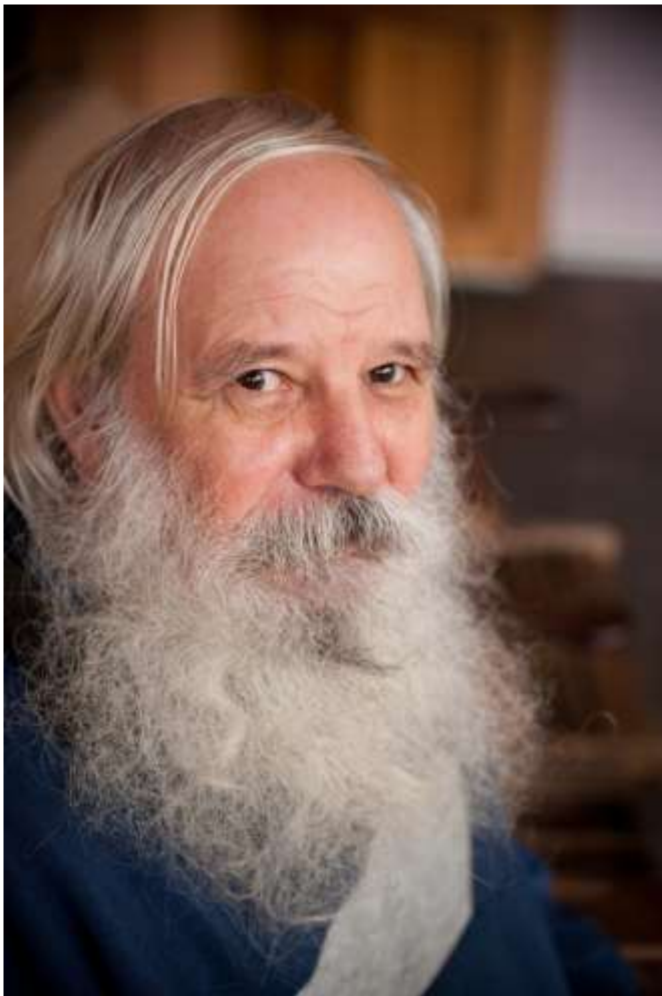
Wintringham
SPECIALIST AGED CARE

Aged Care (Living Longer Living Better) Bill 2013

WINTRINGHAM SUBMISSION TO THE
Senate Standing Committees on Community Affairs



Contents

PREFACE ... 3
Wintringham: some background information ... 3
Elderly and homeless: shifting the paradigm ... 4
THE LIVING LONGER LIVING BETTER BILL 2013 ... 5
The impact of the introduction of ACFI on services to the Elderly Homeless ... 5
Figure 1: RCS & ACFI Subsidy 2007 and 2012: ... 8
Figure 2: ACFI subsidy growth 2010 to 2011 ... 9
RECOMMENDATION 1 ... 10
Community Care ... 10
RECOMMENDATION 2 ... 11
Fees in Community Care ... 11
RECOMMENDATION 3 ... 11
Dementia Supplement ... 11
RECOMMENDATION 4 ... 12
Capital ... 12
RECOMMENDATION 5 ... 13
The role that Housing and Support can play in aged care ... 13
RECOMMENDATION 6 ... 14
RECOMMENDATION 7 ... 15
Gateway ... 15
Exit point: a pathway out of homelessness ... 16
SUMMARY ... 17

PREFACE

Wintringham welcomes the opportunity to comment upon aspects of the *Aged Care (Living Longer Living Better) Bill 2013.*

Wintringham's response to the LLLB Bill will concentrate exclusively on the area we have expertise in, namely the elderly homeless. Having said that, we believe that some of the responses that we have developed to the problem of delivering services to aged men and women who are homeless have clear implications to the development of a range of programmatic policy settings for the delivery of aged care services to all elderly people who do not fit neatly into existing mainstream groups.

The following paper concentrates on the single biggest issue Wintringham has ever faced in securing the ongoing viability of the organisation, namely the dramatic effects that the impact of the ACFI has had on our recurrent income.

Although we have also taken the opportunity to highlight some other concerns with the LLLB Bill, we would ask Senators to take particular note of our commentary on ACFI. In particular we would ask that you note carefully our belief that the continued access to quality aged care services for elderly homeless people will inevitably cease unless a resolution can be found to our funding crises.

Wintringham: some background information

Wintringham was established in 1989 as an independent not-for-profit welfare company to provide high quality aged care services to frail elderly homeless men and women. Today we provide a range of services to approximately 1,300 elderly people who are homeless or at risk of becoming homeless each night, including low and high care residential homes, community care packages, State funded support packages, a range of housing services and options, street based outreach work, advocacy services, as well as our work representing the interests of the homeless elderly on a variety of State and national ministerial advisory committees. More details about these services and further background to the company can be found at www.wintringham.org.au.

Wintringham is today the largest provider of services to the elderly homeless in Australia. Of the approximately 700 residential aged care beds in Australia, Wintringham has more than 200 reserved exclusively for the homeless. In addition to the four Registered Aged Care Facilities (both low and mixed care) Wintringham has designed and build the first nursing home for homeless people in Australia, and quite possibly the first one in the world.

In 2011, Wintringham was award the United Nations Habitat Scroll of Honour, the first time an Australian organisation has achieved this award which is the highest award for human settlement provided by UN-Habitat.

The vision at the start of Wintringham was simple. The company would be a social justice organisation that would care for older homeless people whom the aged care industry had turned its back on.

Our view of social justice, and the rights that flow as a result of social justice, is that it is a basic and fundamental right and should not be consequential on the personal values of a worker or an organisation. So, for Wintringham, older homeless people have a right to decent aged care services and housing simply because they are Australian citizens.

The elderly homeless remain one of the most disadvantaged and powerless groups in Australian society. At a time of life when most people would be enjoying their retirement, elderly homeless men and women live outside mainstream society making do with inadequate food, clothing and housing.

In 2008, Wintringham Housing Limited, a wholly owned subsidiary of Wintringham, was established to concentrate exclusively on delivering housing services for the elderly poor.

Elderly and homeless: shifting the paradigm

At the time of the formation of Wintringham, many hundreds of elderly men and women were living and dying in homeless persons' night shelters unable to access mainstream aged care services even though these services were often run by Church and charitable organisations who received tax concessions in order to provide for the disadvantaged.

The prevailing view in the 1970's and 80's was that as these elderly folk were homeless, it was appropriate that they were in a homeless service. In short, these aged people were being seen as *homeless and elderly* and as such it was the responsibility of the homeless sector to provide for them. Wintringham reversed that expression, arguing that aged homeless people were *elderly and homeless.*

Changing the description of aged homeless people from being *homeless and elderly* to *elderly and homeless* is not merely semantics: it creates a new paradigm and a new way of thinking about the elderly homeless. It involves acknowledging that the person is aged and therefore entitled to normal aged care services. If we say they are homeless it perhaps makes some sense of the fact that they are living in a homeless persons' night shelter, but if we say that they are aged (and just happen to be homeless) then the next question surely is "why are they not part of the aged persons' service system?"

The principle that Wintringham has operated on from its inception is that the aged homeless should have the same right as any other elderly Australian to access mainstream aged care services.

The aged care system is not allowed to discriminate against any minority group on the basis of their ethnicity, religion or personal views. Why then should they not be required to make welcome the elderly homeless?

Unable to place our elderly homeless clients in mainstream aged care services, Wintringham resolved to build its own.

THE LIVING LONGER LIVING BETTER BILL 2013

The impact of the introduction of ACFI on services to the Elderly Homeless

Wintringham's argument that the Elderly Homeless were entitled to access services delivered from the Commonwealth Age Care Program was accepted by the then Government in that late 1980's and importantly, has been reaffirmed by all subsequent Governments and Aged Care Ministers.

There are, however, major financing problems arising from that decision as the Aged Care Act has essentially been designed around the needs and resources of an elderly Australian who has little in common with a homeless person. Homeless people cannot pay Accommodation Bonds (except in the most unusual circumstances), rely solely on the Aged Pension and usually have no additional financial resources with which to make any additional contribution, and in the main, have no family upon whom they can rely for either emotional or financial support.

Organisations such as Wintringham, who work exclusively with the elderly homeless, can therefore rely on no income stream other than government recurrent funding. Up until 2008, this was delivered by the RCS (Resident Classification Scale).

Wintringham's financial records and analysis shows that under the RCS system and in the years preceding the introduction of ACFI, we earned on average about $90 a day per resident which was equivalent or perhaps $0.50 cents above the national average RCS figure. Although we had a far more complex client group, many with alcohol related brain injuries and associated behavioural problems, and received very few Accommodation Bonds, the income earned from the RCS was sufficient for Wintringham to remain financially viable.

Under ACFI, however, our income dramatically fell largely due to the different weighting the instrument placed on ADLs (Activities of Daily Living) as distinct from behavioural interventions.

Principally, ACFI was not designed to meet the needs of our client group. In 2007 the designer of the ACFI model, Professor Richard Rosewarne noted:

> *"What is clear is that the type of resident supported at the Wintringham Port Melbourne facility is highly atypical of the general residential aged care population in both low and high care (diagnosis evidence was often found in the ACAS ACCR forms with alcoholism and acquired brain damage commonly diagnosed. Cognitive impairment or memory loss was also more common than a dementia diagnosis). Residents in this facility have significant behavioural support issues and accommodation and social support needs but have generally quite low activities of daily living dependencies and low levels of complex health care needs.*
>
> *The current RCS funding is achieved by higher ratings in the ADL RCS items and Medication and Complex Health areas than would be expected. This is a function of the methodology used with RCS that relies on documentation*

> *and care provided to validate claims. The ACFI in contrast relies on the assessed care needs relating to their underlying impairments."*

Subsequent analysis by both Wintringham and DoHA has revealed that there is not a simple cause for the failure of ACFI to adequately reflect the cost of providing for homeless particularly those with alcohol related brain injuries, nor is there a simple way to adjust the ACFI to remove this unintended distortion.

Behavioural issues , which resulted in high overall RCS claims, are not able to be claimed at the same rate under ACFI. Behavioural issues require vast amounts of staff time and patience, these care requirements then 'leech' into the care provided in the other two ACFI domains, to an extent, governing how care is provided overall.

The three ACFI 'silos of care' do not allow this to occur – for example, should resident be reluctant to shower, this is classified as a behaviour and can only be claimed in this silo. Under RCS, this behaviour leeched out into the ADL category and was able to be claimed in both areas. In addition, in comparison to the other two ACFI silos (ADLs and Complex Health Care), the ACFI the Behaviour 'silo' is poorly funded and cannot be easily adapted to acknowledge the high cost of catastrophic behaviours.

The following case example of a current resident at Wintringham is a real example of the problems we have with ACFI

> *Jason has a very significant brain injury which results in extremely violent outbursts which have seen him oscillate between homelessness and a variety of care facilities all of which have been unable to cope with his behaviours resulting in his eviction.*
>
> *Through setting a strict regime of routines that Jason was comfortable with, Wintringham has successfully provided for his needs within the aged care program and importantly given him a safe home – probably the first time this has happened to Jason.*
>
> *In spite of this apparent success, Jason's temper flairs violently if he perceives that he has been wronged. Usually this will occur if there has been an unintentional change to his routine.*
>
> *On one occasion, when Jason's medication was not provided to him at the agreed time, he became violent and charged our young (female) worker. Terrified, she retreated into a staff room. Jason punched his way through the glass door and was only subdued when the police arrived. Three divisional vans, 7 police and 3 cans of capsicum spray were needed to bring Jason under control. Jason is not the kind of client the aged care industry usually sees.*
>
> *Upon an internal investigation as to what prompted the outburst, we discovered that Jason had become violent because we had failed to change the clock in his room when day light saving finished, thereby confusing him as to the real time. When Jason's routine was disrupted, he lacked the cognitive ability to see anything other than his rights had been violated.*
>
> *Wintringham calls these events 'catastrophic' but they can all be managed and usually prevented. By having a routine in place that keeps Jason calm, staff are able to effectively work with him in a relatively safe environment.*

> *Jason requires nothing more than a regular routine – but he requires a regular routine for all ADLs, Medication and Complex Health Care needs.*
>
> *Under the RCS system, the routines that we developed for Jason were claimable under a wide range of RCS Questions, but under ACFI the only claim that can be made is a 'Low' claim for the one-off violent outburst and the claim is only applicable to the ACFI Behavioural Domain.*
>
> *It is also worth noting that if, on the other hand, Jason had a mild form of Alzheimers' that presented itself as gentle confusion that required hourly minor prompts from staff, these interventions would be eligible for a 'High' claim under this same domain.*

The RCS system was by no means perfect, but Wintringham was able to make it work for a client group that it was not designed for. We are unable to do this with ACFI.

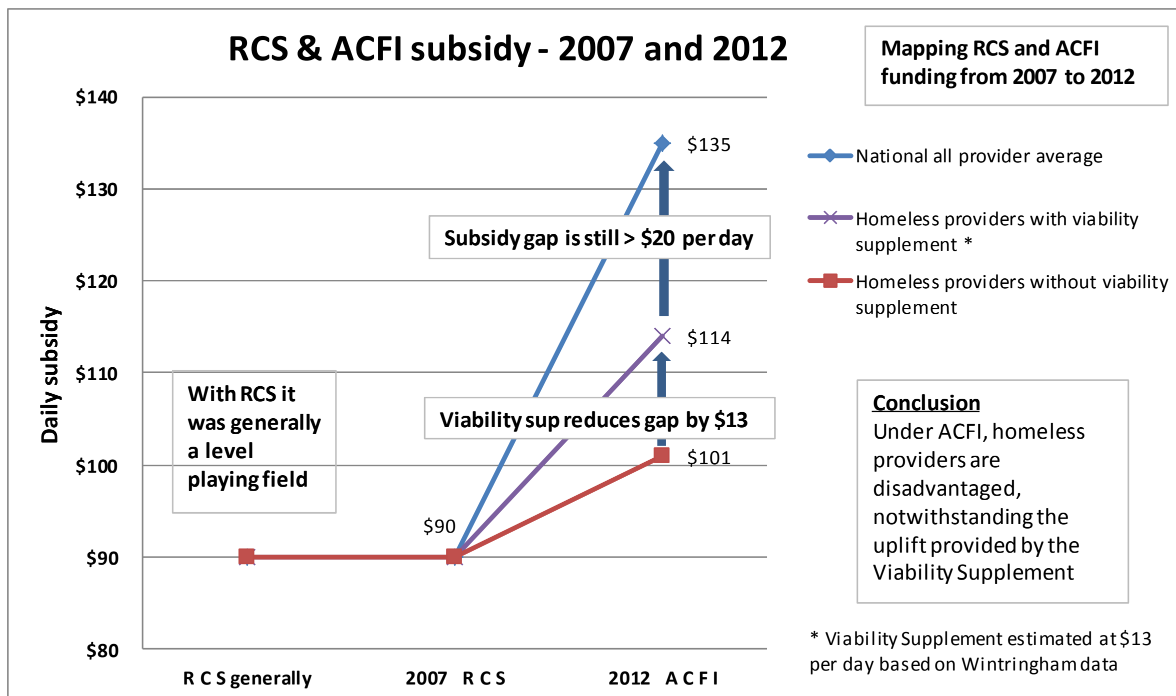
The introduction of the ACFI has had the unintended consequence of transferring income from elderly homeless service providers to the wealthier mainstream providers.

There is also the ethical issue of Wintringham agreeing to take some of the most difficult clients in the aged care sector and then being expected to provide for those clients with far less money available that the rest of the industry which studiously avoids such clients.

This is simply intolerable: mainstream aged care providers deliberately choose not to provide services to the homeless largely because of the complexity of the issues presented, yet as a result of ACFI now receive higher subsidy rates than do homeless providers.

As a result of continued lobbying and the positive response we received from both DoHA and the Aged Care Minister (initially Justine Elliot and now Mark Butler), the response to this unintended consequence was to make homeless providers as strictly defined, eligible for additional funding via a Financial Viability Supplement that was incorporated into the Rural and Remote Subsidy. Wintringham's experience is that a homeless service provider in the metropolitan area can expect to receive on average about $13 per day which, while covering some of the loss, does in no way match what we were previously receiving under the RCS system.

Figure 1: RCS & ACFI Subsidy 2007 and 2012:

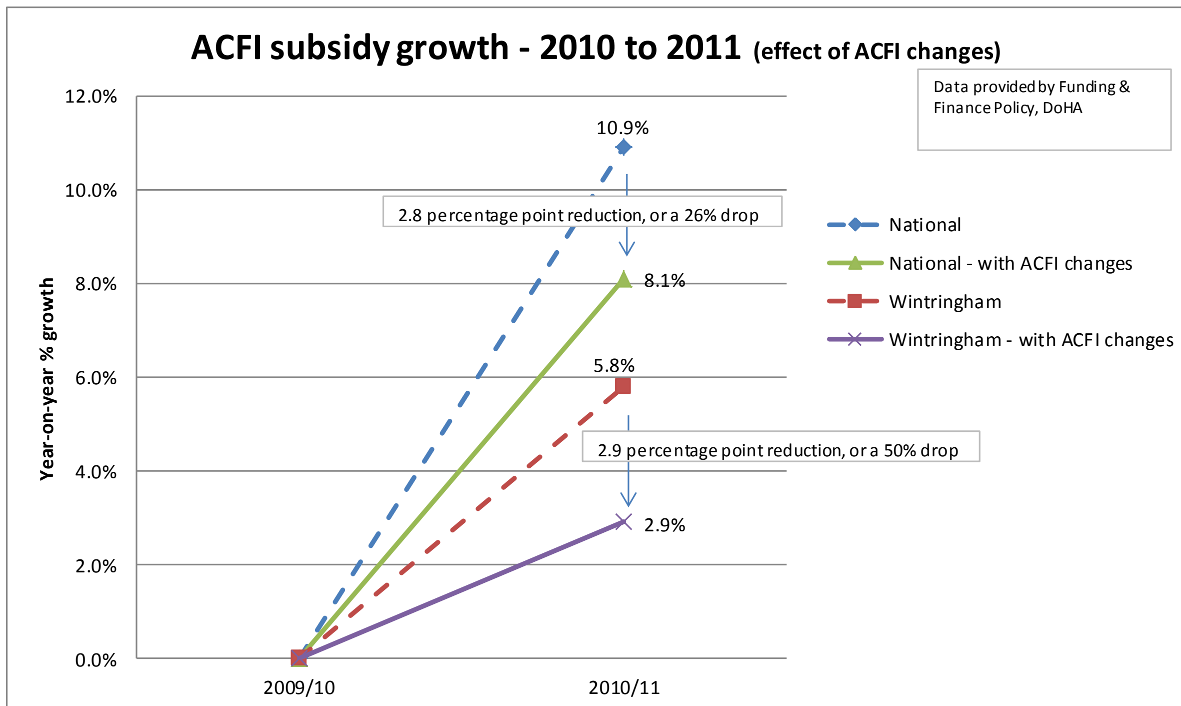


This resolution however, has not seen the end of the troubles facing homeless providers. There have been comments made that the aged care industry engaged in "gouging" which amounts to inflated ACFI claims generating additional income to the provider and serious expense problems for the Department.

Regardless of the accuracy of those claims, it is important to note that Wintringham at least, did not engage in such practices. During the period both prior to and post implementation of the ACFI, DoHA actively audited Wintringham to test our claims that ACFI was not working for us. In some instances, 100% of clients at one of our residential sites had their ACFI claims audited. During all of that time, there was not a single audit result that was led to a rejection of a Wintringham claim.

Nevertheless, Wintringham was immersed like the rest of the industry in the consequences of the ACFI 'blowout' which resulted in further adjustments to ACFI on July 1, 2012 which sought to recover about 2.8% of funding via firstly a rewording of one of the ACFI funding domains, and secondly a withholding of a COPO (funding indexation rate used by DoHA) increase for 12 months.

Figure 2: ACFI subsidy growth 2010 to 2011



The data in Figure 2 has been provided by DoHA to Wintringham. The data highlights actual ACFI growth from 2010 to 2011 and then overlays on this growth, the effect of the 1 July 2012 ACFI changes had they occurred in the 2011 financial year.

As can be seen in Figure 2, as a result of the changes to ACFI the national average subsidy level has fallen 2.8% from 10.9% to 8.1%. Similarly Wintringham's subsidies have also fallen 2.9% but the important point to note is that this fall comes from a much lower base. As a result of perceived over claiming by the industry as a whole, Wintringham has been made to suffer a similar percentage drop in income driving it a level that is now below inflation rates.

Our services to elderly homeless people are now simply unviable. It is distressing that DoHA and the ACFI monitoring group still insist on saying that Wintringham and other homeless providers have not suffered any greater hardship that the rest of the industry, and continue to overlook these figures which have been presented to them.

There is no cogent argument why elderly homeless service providers should earn substantially less than mainstream providers. Invariably our clients are homeless because in part, they have been rejected by mainstream aged care providers either because they cannot pay Accommodation Bonds or because of perceived lifestyle or behavioural problems associated with homelessness. Put quite simply, we take on some of the most difficult of aged care clients yet are required to do so with substantially less income.

We believe that specialist homeless aged care providers should be eligible for at least the same levels of funding as the rest of the industry. Indeed if we are serious about isolated and impoverished elderly people being able to access quality aged care services, we must make it attractive for mainstream providers to make such admission decisions. At the moment there is a definite financial disincentive to do so.

Although we have significant problems with the ACFI and how it unintentionally discriminates against homeless clients that have a relatively low requirement for assistance with Activities for Daily Living (ADLs) but who often have high behavioural issues, we would strongly recommend against any changes to ACFI. Our experience is that it would be extremely difficult to quarantine any changes to ACFI that could be limited to our client group and not bleed-out to the industry as a whole.

Our advice would be to address the problem using the existing Viability Supplement as a guide.

RECOMMENDATION 1

In order to restore the equity that existed under the previous RCS system between mainstream aged care providers and the few specialist homeless providers, an additional supplement of $20 a day should be paid to those specialist organisations that can demonstrate that they are providing care to elderly homeless people. The relatively few beds that are targeted at the homeless (700 only nationally) would mean that this supplement would be a minor cost impost to the Aged Care program.

We believe that the financial gap that has opened up since the introduction of ACFI is unintentional and has not been introduced to penalise homeless providers. Nevertheless, the burden that this has placed on homeless aged care providers threatens our ongoing viability and our capacity to provide care to the elderly homeless.

Community Care

The difficulty that specialist providers have in delivering financially viable residential aged care services to elderly homeless people is replicated with community or home care services.

Home based care is built around central concepts of ‘home’ and ‘family’, neither of which are likely to have much direct relevance to homeless people, or indeed to those elderly people who are at grave risk of becoming homeless.

Wintringham’s community care services have their roots in our Outreach teams who search out or follow up on leads concerning elderly people who are homeless. Our aim has always been to develop a suite of services that are instantly available to our outreach workers which they in turn can offer to their homeless clients. These services range from advice and support to housing and aged care services whether community based or residential.

The commonalities which unite most of our community clients are their experiences of absolute poverty, their consistent lack of family contact or support, and the instability of their housing.

It is readily apparent that managers of community care programs that deliver care to homeless people face different financial pressures to those in mainstream programs. Using a personal example, when my mother was in receipt of a CACP package, because the family was able to provide support, outings, clothing and a range of

other items that a supportive family would unhesitatingly provide, the CACP package could concentrate on applying resources to enable mum to stay at home.

At Wintringham, most of our clients have no contact with anything like a supportive family, which means that the resources of the package have to cover items that it would be presumed would be picked up by the clients family. This combined with the continual stress of inappropriate housing such as caravans or boarding houses, results in a very different CACP program to those provided by mainstream providers.

RECOMMENDATION 2

There is therefore a need for the aged care program to recognise that a homeless supplement is required to help address the imbalance of services provided to homeless clients as compared to other elderly people in the community.

Fees in Community Care

As mentioned above, our clients struggle to meet their week-to-week financial commitments. Once the bills are paid, those in private rental, on a single, pension-only income, cannot afford to pay 17.5% of their pension as fees. We understand that the Hardship Supplement will be introduced into Community Care, however, the process required to determine individual eligibility for the Supplement is onerous and where no family or friends are available to assist the care recipient, usually become another Provider responsibility. We understand that consideration is being given to the Minister proclaiming certain Special Needs Groups as eligible for the Supplement – presumably without application – but we are concerned that these funds may be limited to specific packages designated for these Special Needs Clients – rather than being available to all care recipients who meet specified, but easily measured criteria.

RECOMMENDATION 3

Wintringham recommends the payment of a Hardship Supplement to any care recipient whose income and assets are below a certain dollar value (ie assets <$15,000 and pension only income). Those whose income and assets were above these amounts could still apply for consideration for a Hardship Supplement through the usual processes.

Dementia Supplement

Wintringham are appreciative that new home care packages will be supported with a behaviour supplement (also known as a dementia supplement). We believe many of our clients should be entitled to the supplement as most of them have behaviours of concern.

Although there have been several inferences delivered at meetings with DoHA representatives that have suggested Wintringham client group would benefit from

the supplement, we understand a definitive tool for assessment of an individual's behaviour is yet to be formally announced.

Of concern however is that "through the grapevine" we have heard that the Psychogeriatric Assessment Scales (PAS) is being considered as the preferred tool for assessing community clients behavioural care needs.

While we understand that PAS may well work in a mainstream client cohort, we are not satisfied that it is reliable with homeless clients who have atypical forms of dementia. As detailed elsewhere in this submission, Wintringham has a high proportion of clients with behaviours of concern that are more related to brain injury, particularly alcohol related brain injury. As such we are concerned that the use of PAS exclusively for assessment of behaviour with community clients may inadvertently discriminate against our clients behavioural care needs.

Since the introduction of ACFI in Residential Aged Care, our clinical and care staff have found the PAS to be unreliable in terms of predicting our residents behavioural care needs. Department representatives have themselves acknowledged our concerns with using PAS for our client group during 2009 – 2010 when a full ACFI review occurred at Wintringham.

Further to this, the Psychogeriatric Assessment Scales User Guide indicates that sufficient data has not yet been collected to use the PAS reliably for people with alcoholic dementia (which constitute a large cohort of Wintringham's clients).

(http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-pas-guide.htm)

RECOMMENDATION 4

Wintringham advises that the PAS is not a valid assessment tool for homeless clients with a alcohol related brain injury or dementia. We would ask that DoHA works with Wintringham to determine a more appropriate assessment tool or method.

Capital

Policy settings around the capital funding of residential aged care facilities are based on a user-pay system with residents expected to pay an Accommodation Bond which is in part refunded when the resident leaves the facility. Not all residents pay these bonds, but it is presumed that there will be sufficient bond paying customers to finance the construction and continuing maintenance of a new aged care facility.

Clearly, if a provider caters for homeless people, its capacity to raise capital from Accommodation Bonds is minimal. Wintringham therefore recommends that the Government introduce a Capital Funding program which would contain a highly targeted funding pool to be made available to facilities which undertake to provide in excess of 90% of residential places to the elderly homeless, or those at risk of becoming homeless.

A similar scheme, titled the Variable Capital Funding Program, was in existence in the 1980's and it allowed for a capital subsidy to be paid to providers on a sliding scale that was dependent upon the number of Financially Disadvantaged People the provider undertook to provide for. Under this scheme, Wintringham developed the first three of its aged care residential facilities.

RECOMMENDATION 5

Wintringham advocates that either that the Variable Capital Funding Program be re-introduced or, if the capital cost proved to be unacceptable, that the above recommendation of a limited capital pool be reserved for organisations that contract with the DoHA to deliver services to homeless elderly men and women

The role that Housing and Support can play in aged care

Wintringham is almost alone among aged care providers in that it sees itself essentially as being a housing provider into which it delivers appropriate care, whether that be minimal tenancy support, CACP, EACH or full nursing or hospice care. What changes is the level of care: the housing is a constant. The aged care industry recently introduced the term "ageing in place" to cover part of this concept, but for Wintringham, the concept of linking housing and care has a considerably deeper meaning.

Our clients themselves have alerted us to the notion that the most worthwhile thing that we do is to provide them with housing. The care we provide is often only grudgingly accepted as a necessary part of securing the housing. What is important to most of our clients is that for the first time for many years, they now have a safe and secure home where they will not be abused or robbed and where they have certainty that they can be there tomorrow.

It is also clearly difficult to provide home-based community care to a homeless person; indeed, the very notion of home-based care presupposes a home.

> *Viv is an elderly Irish man with Alcohol Related Brain Injury. His ability to look after himself has deteriorated and as a result his accommodations have similarly deteriorated. After being evicted from his privately rented flat, he moved into an inner urban hotel. He then moved to his present accommodation in a private boarding house, where his room has periodically been changed as he became less able to assert his rights. His current room is half of a previous bathroom.*
>
> *The partition wall separating his 'room' from another resident does not reach the ceiling. Viv most days sits on his bed which is against one wall. From his bed he can reach the opposite wall. There is no window. The only door cannot be opened more than half way and this combined with the lack of space means that a visitor cannot enter the room unless either Vivian gets out of the room first or if he lies on the bed. For food, Viv relies on the generosity of an intellectually disabled couple who live in a slightly larger room in the same boarding house. He is now too frail to negotiate the steps out onto the street, so cannot either go to the bank or buy food. His bed and*

> *mattress are so old and damaged that there is a permanent depression which curls further and appears to envelope anyone sitting on the bed. The fetid smell of the room is completely overpowering even to the most experienced homeless person worker. Throughout the boarding house run unsupervised little children with their voices echoing through the building.*

The catalyst that drives many elderly men and women into homelessness is usually the loss of their housing. In a recent international study that Wintringham co-authored, two-thirds of a newly homeless older population had never been homeless before.

It is difficult to imagine the stress, fear and associated health risks that elderly people are exposed to if they have no place to live. This is clearly in contrast to most elderly people entering mainstream residential aged care who would invariably be transferring from their family home.

The provision of housing to our elderly clients is now seen to be so important to Wintringham that we have created a housing subsidiary, Wintringham Housing Ltd, which is the only registered Housing Association in Victoria that is also an aged care provider. The links that we have established between aged care and housing have enabled us to construct housing in a variety of Melbourne suburbs and nine regional cities in Victoria.

The existence of this extensive housing portfolio, combined with extensive Outreach social work teams and significant CACP and EACH services, have assisted Wintringham to develop new aged care service models that are based around housing rather than Registered Aged Care facilities.

Wintringham would wish to stress that it is the provision of appropriate support services that enable our housing model to work to the benefit of both the tenant and the community.

Commonwealth funded aged care support services of this nature do exist and are provided under the excellent Assistance with Care and Housing for the Aged program (ACHA): one of the most innovative and creative programs within the DoHA. While the program has had a substantial impact upon the lives of elderly homeless people, there has been little change to its core funding since its inception in 2000, although there has been some extension of its services into regional centres as a result of the Road Home White Paper on Homelessness.

ACHA is not just a feel good service that throws up stories of how people can transition out of homelessness: ACHA is much more than that. Apart from the positive impact the program has on the lives of elderly homeless people, it is a good example of successful public policy. ACHA saves more than lives – it saves public money.

RECOMMENDATION 6

Wintringham strongly recommends that the role of Support is recognised and acknowledged for the contribution it makes to the aged care system, and that a program such as ACHA is sufficiently resourced to enable organisations who work with the elderly marginalised, to expand both the range of services they can offer and the numbers of at-risk elderly people they can reach.

RECOMMENDATION 7

Wintringham also recommends that the role of housing is given more emphasis within DoHA and not left exclusively to FaHCSIA. To that end, we would recommend that ACHA be given a housing subsidy that it can apply to the elderly homeless.

While acknowledging that housing sits within FaHCSIA's responsibility, DoHA should be empowered to broker funds from FaHCSIA for older persons housing, and particularly for those elderly people who are living on statutory incomes who often find it difficult to access housing managed by aged care providers.

Ron Conn was a homeless man who accepted an offer to live at Wintringham's Atkins Terrace. Within months Ron was diagnosed with cancer to which he eventually succumbed.

During his more than two years of illness, Ron lived entirely at Atkins Terrace, initially receiving simple assistance, through to a Community Aged Care Package and then finally full hospice care delivered to his unit. For two years, as Ron's health progressively deteriorated, he was surrounded by his mates, many of whom would sit in his room all day yarning about the past, and was even reunited with his first girl friend from 40 years ago.

Ron eventually died, but spent only his final few days in hospital. Wintringham, aided by Ron's indomitable spirit, was able to care for a homeless elderly man simply through being able to provide a home and home-based care. The saving to Ron in not having to endure the misery of hospital or to the community in dollars saved, is significant.

Shortly before his death, Ron was told that we would be naming our new nursing home in his honour. It is not inconceivable to think that a significant percentage of the costs associated with building the nursing home were met through savings that Ron provided to the community by remaining "at home".

Gateway

The LLLB Bill introduces the Gateway concept that is in principle readily accepted by Wintringham. We would however caution that very little is known about the how the Gateway will operate and whether certain existing service programs such as ACHA will be folded into its general operation.

Wintringham seeks reassurance that the operation of the Gateway will ensure that the needs of the homeless are met. We are at this stage uncertain of the composition of the Gateway and whether the staff involved will be trained to identify and understand the particular needs of the homeless and whether they can respond appropriately.

We would also note that we have over many years developed relationships with a variety of Aged Care Assessment Teams (ACATs) who now have a far better understanding of issues impacting upon the homeless, in particular premature

ageing. We are somewhat concerned that the introduction of a more centralised system such as the Gateway can potentially undermine that work.

Exit point: a pathway out of homelessness

Wintringham has been able to demonstrate that if services are carefully thought out and designed, and if they are adequately resourced and maintained, that it is possible to provide a permanent exit point to homelessness, and that this outcome can be almost universally achieved.

This may seem like an outstanding statement to make but is one that other specialist providers of quality aged care services to older homeless people can probably also make. Wintringham endeavors to provide “A Home Until Stumps”: that from the time an outreach worker makes contact with an elderly homeless man or woman, we can provide a pathway from the streets into housing (which preferably we own or manage), into which we can begin to provide appropriate levels of community care and support that are packaged according to the needs of each individual person, through to full residential care in one of our Low or High Care Facilities if required.

In spite of initial concerns from the Commonwealth at the time of the formation of Wintringham in 1989, we have almost zero instances of aged people voluntarily leaving our services. In spite of providing for a wide range of people, some with severe brain injury, we find that beneath their sometimes fiercely independent nature, nearly all of our clients are capable of distinguishing between the services we can offer and life on the streets. In the jargon of the market, they are rational consumers.

It is important to note that this exit point is not just for the very frail who are physically unable to return to their previous life style, but includes our younger aged clients who are in receipt of either or both housing and community aged care services. Many of these clients still struggle with a variety of addictions or disabilities, yet are able to be maintained in stable and permanent housing, and choose to continue receiving these services.

Many of these clients have a long history of failed tenancies. The following study highlights the importance not of a selective process for entry into community housing, but for a rigorous support program to assist the client to maintain the housing.

> *Barry is an elderly man who lived in an inner city boarding house with his brother until a fire destroyed the building about a decade ago. Barry and his dog managed to escape the blaze, but his brother perished.*

Barry found lodgings in a notorious North Melbourne rooming house where the violence was such that community workers would only enter in pairs. Barry and his dog managed to survive in the house until Wintringham's ACHA (Assistance with Care and Housing for the Aged) outreach worker was informed of his plight.

There was no hope of getting him into public housing at such short notice and there were no vacancies at the crisis accommodation centres. Timing is everything, however, and Wintringham had just opened up a 7 bed rooming house for men in Flemington. Barry and his dog became one of the first residents of the rooming house.

Barry now had his own bedroom, a great kitchen to cook in, a bathroom with hot water and clean towels, and a lounge to watch the tele. Wintringham also cared for his personal needs through a Community Aged Care Package. Barry became a familiar identity around the neighbourhood as he pushed his old pram around the shops.

As his health and mobility began to deteriorate, Barry moved to McLean Lodge, our low care residential facility which is located just up the lane from the rooming house. He already knew most of the residents from the many parties and get-togethers engineered by our energetic Recreation staff.

Barry is now wheelchair-bound and has moved to the Ron Conn Nursing Home where he will see out his days. Instead of his final years being blighted by insecurity, exploitation and isolation, Barry has found a true home with Wintringham. He is content with his lot, surrounded by people who he knows will ensure him the options, dignity and rights he is entitled to.

SUMMARY

Wintringham together with the Federal Government established in 1989 the right of Elderly Homeless people to access the mainstream aged care program. While that victory for homeless people is still resonating around the aged care community, a fundamental problem continues to plague the delivery of these services. The problem is that the aged care program and all of the various alterations, additions, reforms and innovations are designed around the needs of an elderly person who has little in common with a homeless person.

A common theme running through this Submission is that Wintringham far from being critical of the LLLB Bill is very supportive. However, it is important to realize

that there have been some unintended consequences of the introduction of these reforms which have impacted quite disastrously upon the elderly homeless.

Wintringham would respectfully ask that the Senate Community Affairs Committee take note of our concerns and the consequent recommendations and works with us to help ensure that the elderly homeless can continue to access aged care services.

Unless these recommendations are acted upon, and in particular Recommendation 1 relating to ACFI, Wintringham's services to elderly homeless people will become financially unviable.

Bryan Lipmann, AM
Chief Executive Officer
April 2013