STATEMENT OF CONSTANCE ERIN LONGBOTTOM 7 JUNE 2024

PROCEEDING DETAILS	
Matter:	Special Commission of Inquiry into Healthcare Funding
WITNESS DETAILS	
Name	Constance Erin Longbottom
Address	390 Victoria Street, Darlinghurst
Occupation	Nursing Unit Manager

STATEMENT

On 7 June 2024, I Constance Erin Longbottom, state:

1 This Statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**Special Commission**) as a witness. The Statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false, or do not believe to be true.

2 In this Statement, I explain St Vincent's Homeless Health Services (**Homeless Health**), including its funding arrangements and the implications of those arrangement on service delivery.

My background

3 I am known as, and prefer to be addressed by my middle name, Erin.

4 I have held the role of Nursing Unit Manager for the Homeless Outreach Services of St Vincent's Hospital Sydney Limited (**SVHS**) since 1 February 2016. In this role I lead the Homeless Outreach Team and After Hours Team. I am also the professional supervisor of all of the nurses working in Homeless Health.

5 Attached and marked **EL-1** is a copy of my curriculum vitae.

6 Prior to my current role I was the acting Assertive Outreach Services Manager from September 2014 – February 2016.

7 I hold a Bachelor of Nursing and Post Graduate Certificate in Clinical Redesign.

Homeless Health

8 Homeless Health is a dedicated unit within St Vincent's Public Hospital Sydney (**SVHS**). It is a multispecialty service (including general medicine, psychiatry, nursing, social work, Aboriginal Health, Allied Health and peer support) supporting people experiencing homelessness to access mainstream or specialist health services of their choice. It is the only dedicated unit of its kind that I am aware of in NSW.

9 Traditional health and hospital services are difficult to access for many people experiencing homelessness. This includes because:

a. the healthcare system is complex and difficult to navigate, particularly for people living in crisis or with poor health literacy;

b. accessing health care often requires identification and a Medicare card;

c. there are many healthcare services that are cost prohibitive for people experiencing poverty such as access to bulk billing GP's, psychologists, certain medical tests and medication

d. people experiencing homelessness are more likely to experience discrimination, shame and fear connected with accessing health services. This is often due to past previous negative experiences with health and other government agencies; and

e. many of the contributors to wellbeing, such as diet, exercise, regular medication and routine primary health care, are unachievable without safe and stable housing.

10 SVHS' Homeless Health has 40 full time equivalent staff and comprises the following services:

a. two residential services:

i. Tierney House, a 12 bed facility established in 2012 providing short stay care (up to two weeks) for persons experiencing homelessness with subacute health issues; and

ii. Stanford House, a four bed facility established in 1991, which came under the stewardship of SVHS in 2016, providing residential care for persons experiencing homelessness and living with HIV for up to three month stays;

b. the Community Access and Assessment Team, which provides short term multidisciplinary support to clients of the Homeless Health Service and Mental Health Services experiencing complex health and social needs to navigate support options available to them, including the NDIS, Aged Care Assessment Team and NSW Civil and Administrative Tribunal Guardianship Division. The team consists of a Manager, Social Worker, Occupational Therapist, Clinical Nurse Specialist and Neuropsychologist;

c. Assertive Outreach Services which comprises of multiple care co-ordination teams. Care coordination itself involves the integration of care across all providers, for people living with complex health and support needs, to facilitate access to healthcare, accommodation and support. It involves advocacy and open communication, bringing together a range of health and social care services and sectors together, and ensuring that everyone is working safely and effectively towards the client's goals. The care co-ordination teams are:

    i. Assertive Outreach Team, which delivers healthcare to people experiencing primary homelessness (sleeping rough) and who are not accessing health services. The goal of this team is to assist the most underserved people in our community and facilitate access to sustainable mainstream and specialist health care, and obtain stable long term accommodation. Without this team this cohort of people would otherwise have no access to these services;

    ii. A Complex Care Co-ordinator, who provides intensive care coordination to people with complex co-occurring health and support need who are also experiencing secondary (eg, residing in crisis accommodation) or tertiary (eg, residing in a boarding house) homelessness; and

    iii. Wesley Mission Therapeutic Support team. SVHS provides two senior mental health clinicians, who work in partnership with Wesley Mission case workers. This team engages with adults experiencing homelessness who have mental health issues, outside the inner city and in the 9 LGAs within the metropole of Sydney;

d. Homeless Outreach Services which assess and triage all referrals into the service as a single point of entry as follows:

i. Homeless Outreach Team, a community health outreach service for people experiencing or at risk of homelessness in the City of Sydney LGA. The

team proactively patrol hotspot areas initiating contact with people where they sleep on the street and identifying the services they need, including healthcare, accommodation and other support needs. The team also runs a Mobile Clinic Service and a number of hubs, drop in clinics and mental health clinics in local refuges and homelessness services. This diverse multidisciplinary team includes a GP, registered nurses, Mental Health Clinicians, psychiatry, Peer Support Workers, Aboriginal Health Workers, and Allied Health. The Homeless Outreach Team also partners with multiple local stakeholders, including Homes NSW, to provide a 'no wrong door' approach to healthcare, ensuring that the right services are available to people at the right time; and

ii. After Hours Team, which operates in the same way as the Homeless Outreach Team, but outside of usual business hours.

11 I lead the Homeless Outreach and After Hours Team.

Benefits of Homeless Health model of care – integration and partnerships

12 A primary benefit of the Homeless Health model of care is the integrated nature of the care that is provided to people experiencing homelessness. This results from:

a. the multidisciplinary nature of the model; and

b. the Homeless Health team's integration with other health care services within St Vincent's Hospital, which have a strong focus on mental health and drug health, given its inner city location.

13 Homeless Health can better address the complex health and support needs of our homeless community because of the range of specialist expertise that the service provides access to, for example:

a. Primary healthcare, including General Practitioners and vaccination;

b. Mental health services and psychiatry;

c. Drug and alcohol treatment;

d. Podiatry;

e. Aboriginal health;

f. Peer Support Work; and

g. Oral health.

14 Homeless Health also has strong partnerships, both referral and other, with many adjacent care services, including

a. GP practices and other local health care providers, such as Kirketon Road centre;

b. LHDs;

c. Aboriginal Community Controlled Health Organisations;

d. Primary Health Networks;

e. The City of Sydney Local Council;

f. The Department of Communities and Justice, including Homes NSW; and

g. Specialist Homelessness Services (government funded homelessness agencies).

15 These partnerships and relationships enable Homeless Health to coordinate a person's care, which improves the accessibility of health care and housing. These diverse arrangements also allow the team to assess the needs and priorities of an individual and design individual care to address those needs.

Potential cost benefits of Homeless Health

16 Providing health care tailored to the specific needs of the homeless population can result in improvements in the health and wellbeing of those who receive care, as well as savings to the health system, by reducing the incidence of emergency department presentations and avoidable acute care admissions.

17 Tierney House is one example which demonstrates this. Tierney House was set up by SVHA in 2012 to seek to address the average length of hospital stay of people facing homelessness, which is generally longer than the general population. The objective of Tierney House is to assist residents to stabilise their health conditions and improve their functional health status, providing a 'medical respite unit' outside of the acute clinical environment.

18 In 2016, the efficacy of Tierney House was evaluated by comparing the costs of the program and the estimated cost savings achieved through the reduction in average hospital bed days and emergency department presentations per patient using the service. The study conservatively estimated that, in 2014, the saving was $8,276 per patient using the service. While this study was completed some time ago, in my observation the provision of services through Tierney House continues to reduce the overall costs of providing care to those experiencing homelessness who

are able to access the service. Referrals to Tierney House continue to grow significantly. Over the last five years, the annual number of referrals to Tierney House has been, on average, 567.

19 The Homeless Outreach program is another example. I have observed that it has a direct impact on the wider healthcare system by increasing access to primary healthcare, chronic disease management and mental health care for people experiencing homelessness in the community. This not only likely results in hospital avoidance, but there is also a reduction in the overall burden on the mental health service. The study I refer to at [18] also evaluated the Community Outreach Medical Emergency team (COMET), which is a component of the Homeless Outreach Service. The study was conducted over a two year period, and conservatively estimated cost reductions of $2,023 per patient through a reduction in average hospital bed days and emergency department presentations, which can be observed from the second year post contact with the patient as the person experiencing homelessness. From my observation I would expect that this benefit be replicated if not increased in subsequent years. Attached and marked **EL-2** is a summary of the study I refer to.

Funding of Homeless Health

20 I manage the cost centres for the Homeless Outreach Team and After Hours Teams.

21 The funding of Homeless Health is complex. This is primarily because the various components of the service are funded through a range of different sources and methods. For example:

a. Tierney House is block funded by the Mental Health Branch of NSW Health, which is supplemented by philanthropy for capital maintenance and one position, a 0.8 FTE Peer Support Worker;

b. the Homeless Outreach Team is also funded by the Mental Health Branch of NSW Health, through a mix of block funding and activity funding. There are also two full time CNC's and a peer worker that are funded philanthropically;

c. the Community Access Team receives activity based funding from the Ministry of Health (the **Ministry**) under SVHS' service level agreement;

d. the SVHS clinicians working in the Wesley Mission team are subcontracted by Wesley Mission, through funding provided to Wesley by the Department of Communities and Justice; and

e. the After Hours Service is funded by the Central and Eastern Sydney Primary Health Network annually, via a time-limited Commonwealth funding source.

22 The funding of many of the above services is often supplemented by philanthropic funds raised through the St Vincent's Curran Foundation.

23 This diversity of funding arrangements and sources creates a level of uncertainty and complexity that has an adverse impact on the service. As Commonwealth and State funding is year on year, with no certainty about future years, the availability of funding to pay for various positions is often unknown when staffing Homeless Health. This means that we can only fill many roles for fixed terms, and then this creates attraction and retention issues meaning we often work at lower staffing levels, which impacts service provision. There is a significant reliance on philanthropy for positions not funded by government, in circumstances in which this funding cannot be guaranteed on an ongoing basis.

24 For those Homeless Health services which are funded on an activity basis, the "activity" in question is often extremely difficult to measure and capture. For example, when our Homeless Outreach Teams engage with rough sleepers on the street, it is often not possible to capture the information required to code an activity, such as name and date of birth.

25 Based on my experience, funding for Homeless Health has not increased proportionately with increasing demand on the service. Currently our Outreach Services are working at capacity, with anywhere between 600-700 direct contacts with clients per month, although as described above, this direct contact is not easily captured in formal reporting numbers and may be underrepresented. The Assertive Outreach Team has a maximum caseload of 70 highly complex clients at any one time.

26 Factors impacting demand on Homeless Health include:

a. new referrals cannot be accepted until existing clients are safely discharged from the service. As many clients need to be discharged into a mental health service and there is a critical lack of capacity in mental health outpatient services, this can delay the discharge of Homeless Health clients;

b. Lack of accessibility to bulk billing GPs, which is critical for continuity of and access to primary healthcare, significantly increases the demand on Homeless Health; and

c. There are significant barriers to accessing accommodation, including social and affordable housing, meaning patients are discharged from hospital to

homelessness, which creates a cycle of readmission, poorer health outcomes and increased demand on the Homeless Health Service.

27 My further individual observations about Homeless Health are as follows:

a. the General Practitioner position in the Homeless Outreach Team is a trainee position. It therefore has a high turnover and is very difficult to fill. A full time qualified GP position would improve retention and increase the expertise the position brings to the service more broadly;

b. in 2020, three Clinical Nurse Consultants and a Peer Support Worker in the Outreach Services were added to the services through philanthropic funding. These positions are critical to keeping people experiencing homelessness safe and well in the community, while working towards stable housing. There is currently no ongoing funding available to support these roles; and

c. The Assertive Outreach Team experiences high demand for mental health care coordination of people sleeping rough. This means that the Homeless Outreach and After Hours Teams often sit with high risk clients that require care coordination, outside of their scope of work. Increasing the mental health capacity of the Assertive Outreach Team to respond to referrals would improve access to care for the most underserved community members, and alleviate pressure on the mental health service and homeless outreach services.

Signature of witness