

Aged Residential Care Services

A Service Development Roadmap For the Wairarapa DHB¹

SITUATION

1) **Serious lack of ARC Resource**

Not only is the Aged Residential Care (“ARC”) bed capacity in the Wairarapa exhausted, but there is also a requirement for:

- a) an immediate 20 additional beds,
- b) an additional 113 beds by 2011
- c) an additional 441 beds by 2026

2) **Financial instability of some Providers**

Many of the providers are too small, and/or have inadequate resources to be financially sustainable, even in the medium term. One provider recently went into receivership and the DHB has a serious risk if another follows.

3) **Fragmented nature of the ARC Service Providers**

The DHB works with over twelve ARC providers and working with a smaller number of larger providers would have inherent efficiencies. There could be more cooperation in terms of sharing the scarce pool of Wairarapa Registered Nurse skills, and in cost saving by cooperative purchasing.

4) **ARC Providers are providing too narrow a service. There is little focus on rehabilitation.**

Often clients are entering rest homes too early because of an inadequate number of intermediate ARC options. Once in a rest home it is difficult for most clients to return to greater independence even if their physical ability to be independent improves.

¹ This report is prepared by Elysium Services Limited (“ESL”) for the Wairarapa DHB and is subject to the Disclaimer in Section 6.

Examples of intermediate services include some ARC providers in Wairarapa who are providing rental units (which can help to avoid residents entering rest homes too soon), and meals being provided to Villa residents. The providers should look at providing more intermediate support levels. More intermediate options could result in a reduced growth in the need for rest home and continuing care beds.

5) **The structure of the National Service Framework impedes the ability of the DHB to contract for optimal services to the Aged.**

The rules associated with the NSF restrict the flexibility of arrangements for clients.

OUTCOMES DESIRED BY THE WAIRARAPA DHB

The Wairarapa DHB urgently needs to address both the immediate and longer term requirement for a large number of Aged Residential Care beds and services to be provided by financially secure providers.

Following the meeting with the providers the Wairarapa DHB will immediately initiate a process to address the ARC beds and services requirements. The Wairarapa DHB would appreciate, as the first step, every provider in the Wairarapa to respond to a Registration of Interest to show how they wish to participate in these services in the immediate and medium time frame.

1. FEEDBACK on SURVEY and PROJECTIONS

1.1 Current Contracted Capacity – by Location²

Table 1.1 Current contracted beds

Location	Facility	Contracted Beds				Total
		Rest Home	Hospital	Dementia	Flexible short term	
Martinborough	Wharekaka	19				19
Greytown	Arbor House	20				20
Greytown	Palliser	17	15		1	33
Carterton	Carter Court	38				38
Carterton	Roseneath	23	18		1	42
Masterton	Aversham House	20				20
Masterton	Cornwall Rest Home	20				20
Masterton	Kandahar Rest Home	45	18			63
Masterton	Lansdowne Court	6	27		1	34
Masterton	Lyndale Rest Home	22				22
Masterton	MetlifeCare	27	17		1	45
Masterton	Glenwood Private Hospital	2	24		2	28
Masterton	Henley Care Centre			32		32
Total		259	119	32	6	416

- Rest home level care is 259 contracted beds with average occupancy of 98%
- Continuing care is made up of 125 contracted beds³:
 - 119 Hospital level care beds with average occupancy of 98%, and
 - 6 Flexible short term care beds with average occupancy of 97%
- Dementia care is 32 contracted beds with average occupancy of 64%⁴
- The Slice of Time - 29th November 2005 survey showed 403 beds occupied on the 29th November 2005 compared with the 416 contracted beds shown above (giving 97% occupancy)⁵.
- An occupancy of 97% in reality indicates full capacity as any vacant beds are normally the result of turn-around time required after departures
- The increased threshold for asset testing has removed some barriers for people seeking residential care beds
- The Wairarapa DHB believe that there is an immediate requirement for an additional 20 beds (6 rest homes beds and 14 continuing care beds):
 - *“The problem is particularly acute in Masterton*
 - *Lack of access to ARC beds is adversely impacting on Masterton hospital’s ability to discharge patients from acute beds*
 - *As beds become available they quickly get filled up”.*
- There is also a requirement for approximately 3 psycho geriatric beds (currently this requirement is being provided by other DHB’s)

² Wairarapa DHB paper; Medical Care of Rest Home Patients; January 2006

³ Throughout this report the term “Continuing care” is used to include both Hospital and Flexible short term beds

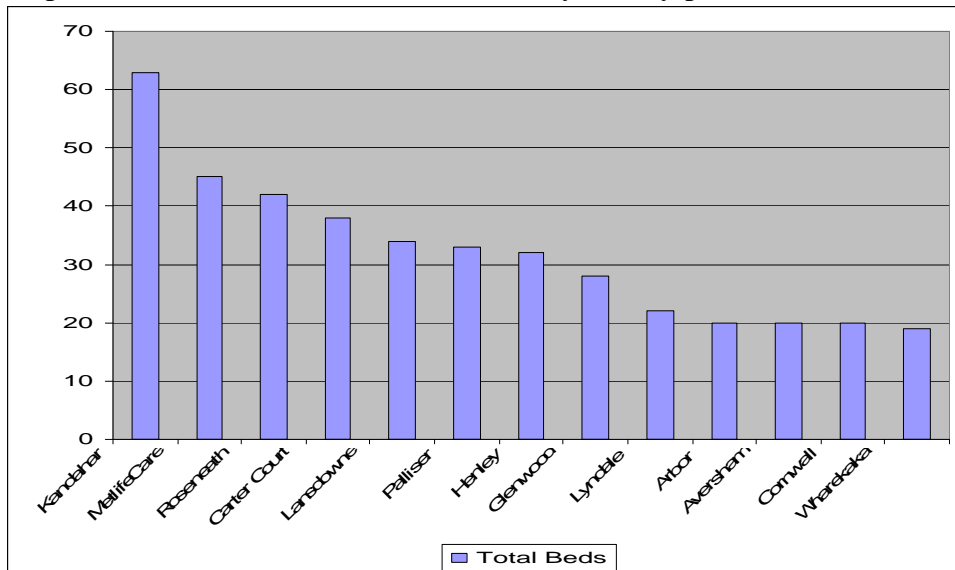
⁴ Currently Henley Care Centre is dedicated to dementia care

⁵ The Slice of Time – 29th November 2005 survey gathered data related to occupancy and subsidised residents from the Wairarapa providers for one day – 29th November 2005.

- Adding this requirement for an additional 20 beds to the current contracted capacity would mean that the current ARC bed requirement is:
 - Rest home: 259 currently contracted beds plus an additional 6 beds means that **265 beds are required**
 - Continuing care **139 beds are required:**
 - Hospital level - 119 currently contracted Hospital beds plus an additional 14 beds means that 133 beds are required
 - Flexible short term – no change to the current contracted 6 beds
 - Dementia level – no change to the current contracted **32 beds**
 - Psycho geriatric – about **3 beds**
 - Total ARC contracted beds required immediately is **439 beds**.

1.3 Current Contracted Capacity – by Size of Facility/Provider⁶

Graph 1.2 Number of contracted beds by facility/provider



- There is an economic sustainability risk amongst the providers as few have critical mass in their local facilities (explained in more detail in Section 3):
 - Five rest homes have 22 or fewer beds
 - Two facilities have 45 or more beds (Only one facility has over 60 beds)

None of the above are totally green field, purpose built facilities (which results in inefficiencies of usage).

- Partly as a result of the above (the non purpose built facilities and small size) economic stress develops resulting in there being too little reinvestment in facilities by many providers.
- There is an urgent need for providers to achieve critical mass to obtain cost economies so that they are both profitable and are sustainable in the long term

⁶ This information results from sorting the Current Contracted Capacity shown in Table 1.1

- The present situation is a large risk to the Wairarapa DHB as it has ultimate responsibility for the residents.

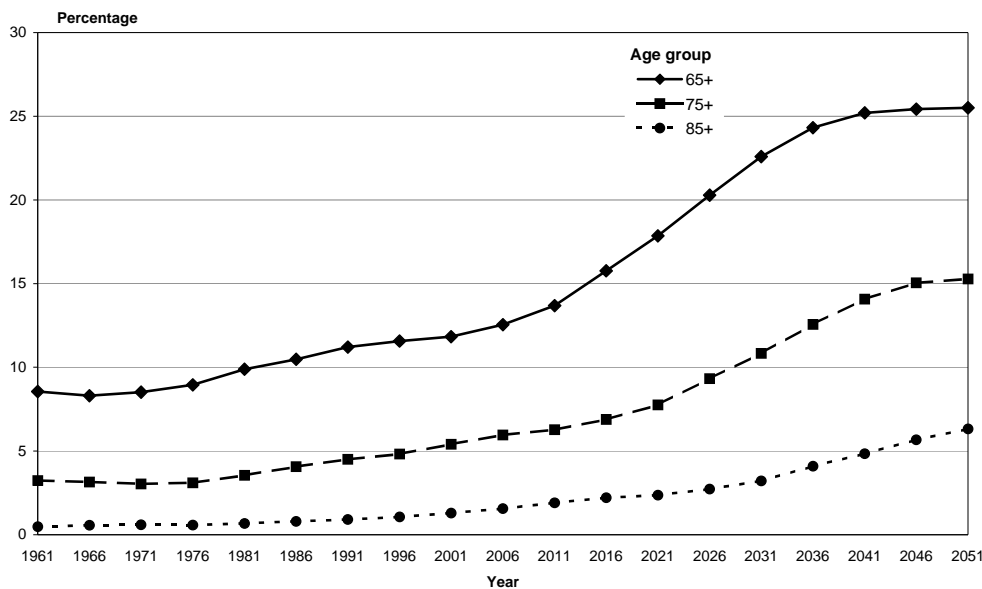
1.4 Work Force Issues

- There is an inherent risk to the DHB in the lack of Registered Nurse and management skills utilised by some of the providers. There is also a lack of investment in work force development. This problem is demonstrated by a *“too many formal complaints and, even worse, some clients feel that they must make anonymous complaints”*.
 - Highly skilled nurses could often be shared across facilities to allow more efficient usage of their skills
 - Registered Nurses seldom have adequate
 - Professional supervision
 - Mentoring
 - Technical training, and
 - Management training
 - Registered Nurses with lack of triage skills can result in higher costs for rest homes by resulting in ;
 - Higher GP costs
 - Higher admission rates to hospitals

1.4 Forecasted Capacity Requirements for ARC Beds

Although New Zealand’s total population is not growing at fast levels, the population is ageing quickly, with the over 65 age group anticipated to grow from 11.5% of the population in 2001 to 25% in 2051.

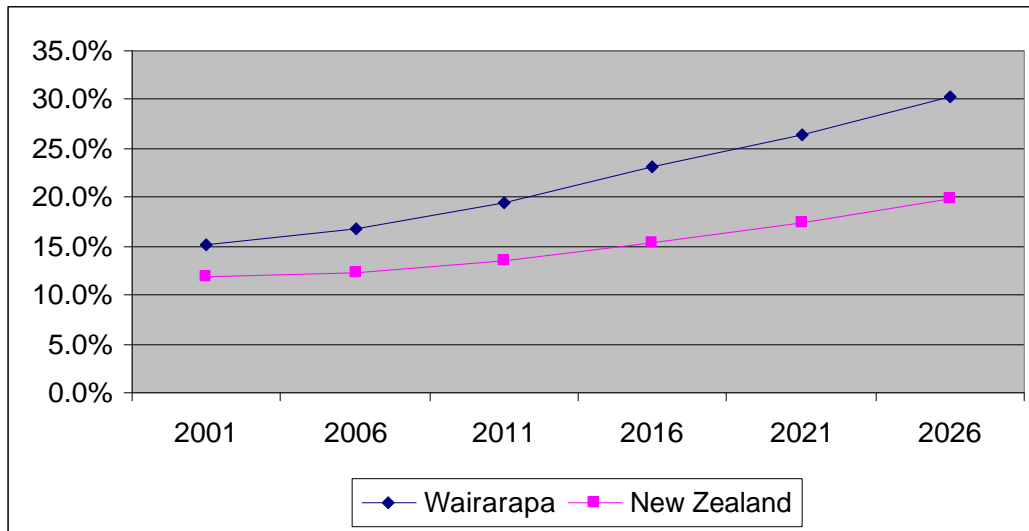
Graph 1.3 New Zealand over 65 age population as a percentage of the total population⁷



⁷Health of Older People in New Zealand – A Statistical Reference – Ministry of Health; 2002

However, the Wairarapa area has a proportionately older distribution of population compared with New Zealand:

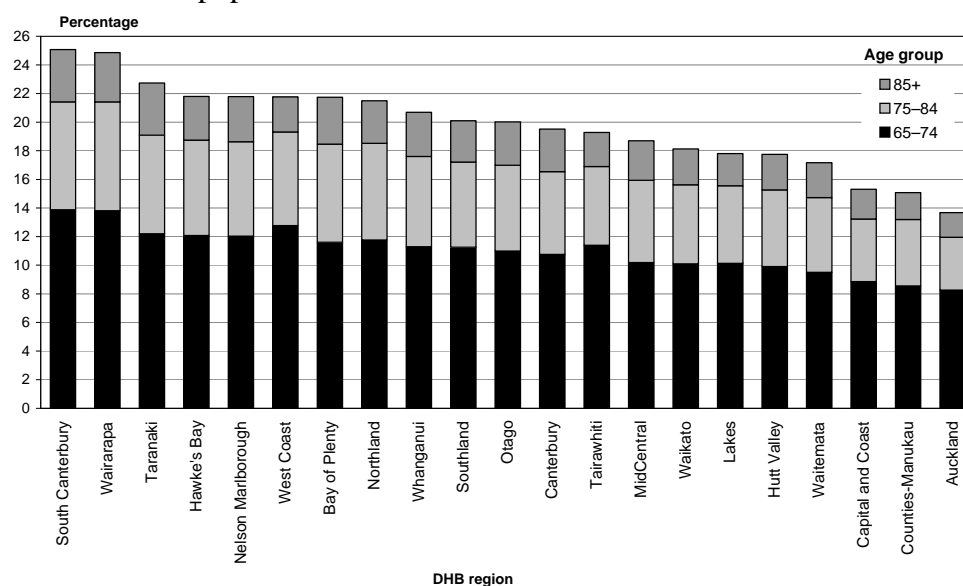
Graph 1.4 Comparison of both the Wairarapa AND New Zealand over 65 age population as a percentage of the total Wairarapa and NZ population respectively.⁸



- The Wairarapa over 65 age group as a percentage of the total Wairarapa population is both larger AND growing faster than the equivalent New Zealand percentage
- 25% of the Wairarapa population is forecasted to be 65 and over by 2021 (compared with less than 18% for all the New Zealand population)
- 30% of the Wairarapa population is forecasted to be 65 and over by 2026 (compared with less than 20% for all the New Zealand population)

⁸ Department of Statistics population projections

Graph 1.5 Projected DHB population 65 and over as a percentage of the total population - 2021⁹



The following table shows the forecasted ARC bed requirements through to 2026.

Table 1.3 Forecasted capacity requirements for ARC beds¹⁰

Mid-year:	Rest Home	Continuing Care	Sub Total	Dementia	Total Beds
2005	253	131	384	19	403
2006	269	138	408	20	428
2007	279	143	422	21	443
2008	292	150	442	22	464
2009	303	155	457	23	480
2010	316	161	477	24	500
2011	329	168	497	25	521
2016	401	203	604	30	634
2021	467	236	702	35	737
2026	549	276	825	41	866

Current Bed Requirement at 1/02/2006	265	139	404	Current capacity + extra 20 beds (as detailed in Section 1.1 above)	
Average 2005/2006	261	135	396	from data above (to obtain a January 2006 requirement)	

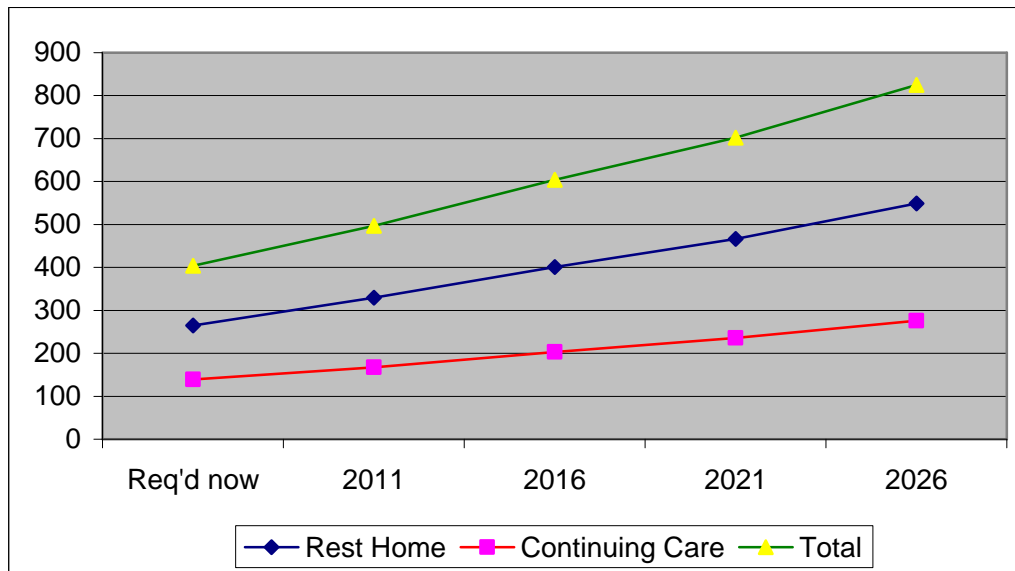
- The “Current Bed Requirement” (which includes the Current Contracted beds plus the additional 20 beds required immediately) approximates the forecasted requirements shown as mid-year 2006. This shows that the Forecasted Capacity requirements in Table 1.3 may be understated already.
- There is an immediate need for both additional continuing care and rest home beds

⁹Health of Older People in New Zealand – A Statistical Reference – Ministry of Health; 2002

¹⁰Information supplied by the Wairarapa DHB; based on Department of Statistics population projections together with actual ARC beds taken from a “Slice of Time” survey, November 2005

- Although the projected increase needed in bed numbers is dramatic, in reality any gains in implementing further ‘Aging in Place’ initiatives is unlikely to significantly reduce these projections. This is largely due to the high percentage of the older age group currently in residential care. In Wairarapa, over 80 year olds account for 80% in rest homes and 60% in continuing care. Nationally (between 1996 to 2001), growth in residential care has been strongly concentrated in the 85 plus age group¹¹. The older age group tend to have diminishing social support and increasing frailty/health needs.

Graph 1.5 Forecasted capacity requirements for ARC beds (from the data in Table 1.3)

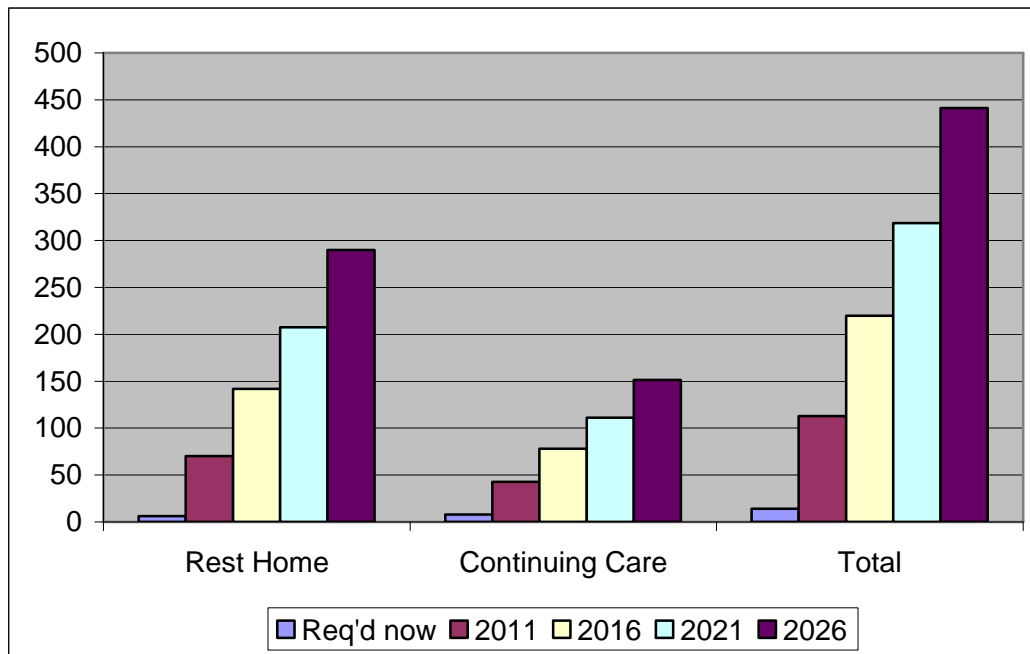


The above table shows a compound annual growth rate of ARC bed requirements of 3.6%.

Looked at from the view of additional beds required, we see:

¹¹ Davey Judith A and Gee Susan: “Life at 85 Plus: A Statistical Review”, New Zealand Institute for Research on Ageing, Wellington, 15 August 2002.

Graph 1.6 Number of additional rest home and continuing care beds required (in addition to the beds currently contracted)



And, numerically:

Table 1.4 Number of additional rest home and continuing care beds required (in addition to the beds currently contracted)

	Rest Home	Continuing Care	Total
Req'd now	6	14	20
2011	70	43	113
2016	142	78	220
2021	208	111	318
2026	290	151	441

- These figures show that Aged Residential Care bed provision is a dependable and reasonable growth industry
- There is a requirement for substantial commitment and investment that is required urgently and immediately for the Wairarapa

Key Messages from the Survey and Projections:

1. Currently, there is no spare capacity of either rest home or continuing care beds. All providers have close to 100% utilization and any lesser utilization is probably due to turn around time.
2. Very few of the current providers have critical mass that can give them profitable and sustainable operations. The size of the five smallest rest homes as stand-alone facilities is of particular concern.
3. There is an immediate and continuing demand for Aged Residential Care beds – both rest home and continuing care beds:
 - a. There is an immediate requirement for 6 rest home and 14 continuing care beds¹²
 - b. By 2011 there is a forecast demand for an additional 70 rest home beds and 43 continuing care beds¹³
 - c. By 2026 there is a forecast demand for an additional 290 rest home beds and 151 continuing care beds
 - d. There is adequate capacity for dementia beds at Henley Care Centre through to 2016. This does raise the question whether some of the spare capacity should/could be used for either rest home or continuing care capacity (even though there may be some co-location issues)
 - e. There is a requirement for a small number of psycho geriatric beds, about 3. This is a fairly constant need.
 - f. There is a need to reduce the demand for ARC beds by providing intermediate support options.

¹² From the Wairarapa DHB planning department

¹³ Information supplied by the Wairarapa DHB; based on Department of Statistics population projections together with actual ARC beds taken from a “Slice of Time” survey, November 2005. The forecast demand assumes the same proportion of population use of ARC facilities as the current proportion as detailed in the Slice of Time – 29th November 2005 survey that gathered data related to occupancy and subsidised residents from the Wairarapa providers.

2. THE PROVIDERS' POINT OF VIEW

2.1 Quotable Quotes – New Zealand

- Radio Insight programme
 - Martin Taylor – Chief Executive Healthcare Providers New Zealand
“Ten years ago there was a return on capital so that when the providers got into the sector, that they knew that the risk they were taking on balanced with the benefits they received from the government. Since that day the government has never kept up with the funding, so that we now have a situation where the providers cannot pay decent level of wages, they have to pay low wages, because that’s the only way they can survive, and there is no return on their investment.”
 - Presenter – Jane O’Loughlin
“... not only has government funding scarcely kept pace with inflation, the sector’s under pressure from extra costs imposed by things like the Holidays Act, and the battle to recruit and retain staff on low wages. One big issue is the recent pay settlement between the District Health Boards and nurses, which will see nurses in public hospitals being paid an estimated 30% more than their colleagues in rest homes and geriatric hospitals.”

Val Sugrue – CEO of the Baptist Home and Hospital in Howick
“..our hospital is 12% underfunded and our rest home is 24% underfunded ... and that’s threatening their long term viability.”
 - Hiatt Cox – Chairman of the board, Wharekaka
“It costs us about \$92 a day to run the home if we’ve got 15 people in it. And our subsidy is \$77.53 so we’re short \$14 per day per person ... it really has had a big impact on our maintenance ...”
 - Judy Glackin – Manager Health of Older People, Ministry of Health
“Because of the burgeoning numbers of those over 85, the overall requirement for residential beds will go up, but it is likely those beds will be for hospital level or dementia care.”

Pete Hodgson – Minister of Health
“ we do accept that there is a funding gap and we do accept that the government has an obligation to address it.”
 - Presenter – Jane O’Laughlin
Rest homes are expecting a spike in applications in July [2005], when the asset testing threshold for residential care is raised. That change is going to cost the government more than a hundred million dollars a year extra, as more people qualify for residential care subsidies. And of course it will only add to the government’s misery over how to

spend its already stretched health budget. With so many demands on the public purse, its hard to see how the problems in the elderly care sector can be fixed quickly or easily.”

- Miles Wentworth – CEO and Director of Calan Healthcare Properties Trust¹⁴
 - The problems of Aged Care

“..with the government being the predominant funder, they control the revenue rates of those operators. The revenue increases have lagged significantly the actual costs of running those places so they’ve had a margin squeeze over a significant period of time...what you need to have is an operator of a number of sites to get administrative efficiencies and buying power in terms of supplies and negotiating contracts.”
 - Question – How will an economic slowdown in New Zealand affect the trust?

“Not significantly. When you look at the health sector, you’ve got an ageing population and you’ve got a growing population. Within New Zealand, with these two drivers, demand for health services will continue to grow at unprecedented levels. Within that comes new technology, new solutions to health issues.”

Key Messages from the Providers

1. Government/DHB funding is not keeping pace with cost and return on capital pressures
2. The current tenure of government funding and DHB contract terms do not allow providers to easily raise capital for ARC beds.
3. Banks do not see Aged Care Services as a good investment.
4. Major issues exist with low level of wages with follow-on problems of recruiting, training and retaining staff
5. Providers need to get administrative efficiencies and better buying power of supplies
6. Small providers will be increasingly non-viable

¹⁴ ShareChat Investor Interview by Jenny Ruth

3. ECONOMIC and SUSTAINABLE MODELS

3.1 Key Factors Influencing Profitability

The PricewaterhouseCoopers (“PwC”) Pricing Report¹⁵, although completed in June 2000, has some important pricing principles which are still relevant today. The main components are:

- 1) Operating cost components; influenced by
 - a) Bed numbers
 - b) Roster requirements
 - c) Wage rates
 - d) Occupancy
- 2) Capital cost components; influenced by
 - a) Size
 - b) Building cost
 - c) Land cost
- 3) Productivity and cost benefits are influenced by a greenfields purpose built facility
This assumes:
 - a) All facilities and equipment are optimised to industry standards, efficiency, and being purpose-built
 - b) Establishing operating standards for each cost category dependent on quantity standard (e.g. nurse hours) and pricing standards (e.g. nurse cost/hour)

3.2 The Importance of Salaries and Wages on Operating Costs

From an operating cost view, the key cost is salaries and wages. The table below shows the mean cost of salaries and wages compared with the total cost per bed day is approximately 70%.

Table 3.1 Salaries & wages cost as a percentage of operating cost

	Cost per Bed-day		
	Salaries & Wages	Total Operating Cost	Percentage of Total Operating Cost
Rest Home model	\$40.01	\$59.25	68%
Hospital model	\$79.26	\$106.98	74%
Dementia Unit	\$49.06	\$70.34	70%

¹⁵ PriceWaterCoopers; Aged Residential Care Pricing implementation – Final Report; June 2000

This is a similar percentage to that found in Australia¹⁶, where salaries and wages on average make up around 66% of the total operating costs of aged care providers:

1. Low care providers (formerly hostel beds) – labour 61% of total expenses
 2. High care providers (formerly nursing home beds) – labour 72% of total costs
 3. Mixed care providers – labour 66%.
- Given that salaries and wages are approximately 70% of the total operating costs, it is essential to optimise the numbers of staff to the number of beds, whilst complying with the staffing requirements as detailed in the contract between the Wairarapa DHB and the Provider. (Though note, that fewer and/or lower paid staff does not necessarily save costs. Appropriate skills can save costs by enabling “best practice”.)
 - The Salary and Wages costs, and their percentage of Total Operating Cost, are probably understated in this data as changes in the Holidays Act, and stricter compliance standards and costs have raised these costs further.

3.3 The Importance of Facility Size

From a capital charge view, it is important to make efficient use of required “support” facilities¹⁷ e.g. *“All facilities require an amount of administrative and support space which can be seen as a stepped cost function. Entrance/reception, dining area, kitchen, laundry, administrative office area, are some examples of such facility spaces. Based on expert input, it was determined that facilities within a range of 30-45 beds would tend to have similar support space requirements. Hence, the addition of resident living space (rooms) between 30 and 45 beds serves to reduce the construction cost per bed.”*

The table below shows indicative prices for different sized facilities (modelled for a Large Provincial location and 95% occupancy – note that the percentage reduction for a Small Provincial location are identical)

Table 3.2 The economies of scale - Reduced cost of a 45 bed facility compared with a 30 bed facility

		Total Cost per Bed Day	Percentage Reduction
Rest Home model	30 beds	\$95.28	
	45 beds	\$85.69	10%
Hospital model	30 beds	\$135.42	
	45 beds	\$122.90	9%

¹⁶ Review of Pricing Arrangements in Residential Aged Care; W P Hogan; April 2004

¹⁷ PriceWaterCoopers; Aged Residential Care Pricing implementation – Final Report; June 2000

The “optimum” facility size in 2000 was modelled as a greenfields purpose-built facility:

1. Rest home – 45 beds
2. Hospital – 45 beds, and
3. Dementia unit - 15 bed annex

Again, a similar trend can be found in the Australian residential aged care sector¹⁸: Based on submissions from 912 facilities the “profitability” of the providers was measured by EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation i.e. revenue less direct operating costs. A large positive EBITDA is needed to pay for capital charges and capital improvements, as well as ultimate profitability of earnings after tax)

Table 3.4 Average EBITDA per bed year

	Number of Beds				Average EBITDA
	0-30	31-60	61-90	90+	
EBITDA by Number of Beds of ARC Providers	\$152	\$2,526	\$3,862	\$977	\$2,001
EBITDA of Top Quartile of ARC Providers					\$9,116
EBITDA of Bottom Quartile of ARC Providers					-\$5,771
EBITDA of Comprehensive Providers					\$5,642

1. The most profitable facilities were those providers with 61-90 beds, followed by those with 31-60 beds.
The top quartile had an average EBITDA of \$9,116 per bed year
The bottom quartile had an average EBITDA of -\$5,771 per bed year
 2. There was a large variation in profitability in all segments, including location, ownership, and size indicating the importance of good management and good processes to profitability
 3. The comprehensive providers had activities in addition to their ARC services. They reported excellent average EBITDA of \$5,642. This was probably because they were in other ARC services such as retirement village and rental accommodation to the Aged. It is a significant message that these comprehensive ARC providers had excellent profitability.
- Profitability is sensitive to:
 - Greenfields and purpose-built facilities
 - Size, 45 to 60 beds is probably ideal in the Wairarapa
 - Offering multi- (comprehensive) services
 - Combined purchasing power and staff rationalisation across facilities. (None of these reports referred to above considered the savings that could be made by cooperation between ARC facilities in terms of; combined purchasing power, cross facility staff rostering, and sharing of expensive assets.)

¹⁸ Review of Pricing Arrangements in Residential Aged Care; W P Hogan; April 2004

3.5 Infrastructure

Where industries are not obtaining an adequate profit or return on their capital there is a risk that reinvestment in infrastructure and staff training. It is also a warning sign that the Provider may not be sustainable.

One way to consider this is whether assets are being replaced, or a major re-fit is provisioned, according to the economic life as allowed by the IRD tax depreciation rates.

Table 3. Average economic life of assets

	Average Tax Depreciation Rate	Average Economic Life	Expected Residual Value
Buildings - shell	4.0%	40 years	Nil
Buildings - fitout	12.1%	15 years	Nil
Chattels	26.4%	5 years	Nil
Equipment	21.6%	10 years	Nil

3.6 ARC prices and related Wairarapa DHB Payments

The CGNZ Report – March 2003¹⁹ updated the pricing parameters of the PWC Pricing Report - 2001 to reflect changes to costs and charges. The report showed increases ranging from 7.2% to 10.6% with the main causes of the variation being changes in Operating Costs (approximately 15.7%) offset by decreases in Capital Charges (-5.2% to -7.4%).

The Table below shows a representative example for a Large Provincial centre together with the current Wairarapa DHB payment.

¹⁹ CGNZ; Aged Care Facility Land Value Analysis; March 2003

Table 3.3 Comparison of total cost per bed day from both PwC (2000) and CGNZ models (2003) together with the current Wairarapa DHB Payment

Rest Home			
	Operating Costs	Capital Charges	Total Cost per Bed Day
PwC model (year 2000)	\$54.68	\$31.01	\$85.69
CGNZ model (year 2003)	\$63.29	\$28.76	\$92.05
ARC contract price (year 2006)			\$83.23
Hospital/Continuing Care			
	Operating Costs	Capital Charges	Total Cost per Bed Day
PwC model (year 2000)	\$92.53	\$30.37	\$122.90
CGNZ model (year 2003)	\$107.68	\$28.20	\$135.88
ARC contract price (year 2006)			\$137.73

- For rest homes the current ARC contract price is less than the PwC recommended payment
- For continuing care the ARC contract price payment is similar to the PwC recommended payment
- There have been additional cost pressures on providers in recent years from:
 - Changes in the Holidays Act
 - Multi-employer Collective Agreement
 - Increased costs in products and medications
 - Increased compliance costs
- Therefore, the total cost per Bed Day will be significantly higher today, than in 2003.

Combined Purchasing Power and Staff rationalisation across Facilities.

None of these reports referred to above considered the savings that could be made by cooperation between ARC facilities in terms of; combined purchasing power, cross facility staff rostering, and sharing of expensive assets.

Key messages on Economic and Sustainable Models

- 1) Some ARC providers in the Wairarapa are at risk of failure.
- 2) The present number and size of providers (with their inherent inefficiencies) is not sustainable
- 3) It is difficult for providers to raise capital because the financial institutions do not consider the industry viable
- 4) The most profitable/sustainable providers will probably have:
 - a) Purpose-built greenfields facilities with a minimum of 45-60 beds
 - b) A variety of services i.e. a multi-facility
 - c) Room for additional expansion
- 5) Compliance audits will be at a higher level in the future
- 6) There is a correlation between profitability and service excellence demonstrated by excellent:
 - a) Reputation
 - b) Governance
 - c) Management,
 - d) Registered Nurses with triage skills
 - e) Business processes.
 - f) Breadth of ARC services.
- 7) The end objective should be both:
 - a) a few large, economic sustainable multi-facility providers providing a combination of service types, and
 - b) some smaller, but still economically sustainable, focussed providers providing services within their communities e.g. rest homes
- 8) The smaller providers must investigate ways of becoming more sustainable by:
 - a) Expansion to achieve critical mass e.g. by merger
 - b) Partnership with other providers to share and reduce costs (including improvement of buying power)
 - c) Partnerships to share in staff skills in a way to bring efficiencies and career development to skilled staff.

4. POSSIBLE OPTIONS FOR THE FUTURE OF WAIRARAPA ARC BEDS

- 1) A few large, (45 bed purpose built appears to be the minimum size for long term sustainability) economically sustainable multi-facility providers providing a combination of service types
- 2) The large multi-facility providers might offer a range of services (some of which may be partly or not at all funded by the Wairarapa DHB) including:
 - a) Co-ordinated flexible package of care for people living in their own homes
 - b) Continuation of care from home support packages to, rental or rest home
 - c) Retirement village
 - d) Rental units
 - e) Rest homes could offer expanded services e.g. more medical treatments could be given to the residents to avoid hospital visits
 - f) Continuing care
- 3) Some local rest homes, of economic sustainable size, to satisfy “local” needs
- 4) Possibly one of the larger providers to be based South of Masterton
- 5) Total dementia requirement relatively small – so should remain as a specialist Provider
- 6) The small requirement for a few Psycho geriatric beds could be linked to Henley
- 7) The option of more intermediate options is seen as an important component to reduce the growth in the future requirement for rest home and continuing care beds. More intermediate options would also allow the option of more appropriate life styles for the Clients’ needs.

5. WHAT NEXT?

5.1 The Timetable

1. Validate this report's findings with the providers	23 rd March
2. Amend or correct any aspects after feed back from the providers (leading to point 3 below)	
3. Issue a Registration of Interest ("RoI") to all providers to understand their desired participation in the Wairarapa DHB ARC service requirements roadmap	21 st April
4. Receive responses from RoI	12 th May
5. Commence discussions with selected parties to provide solutions to the Wairarapa DHB ARC service requirements roadmap	26 th May
6. Issue Request for Proposal ("RFP") to ascertain the feasibility and details of future proposed partnerships.	16 th June

- The objective of this process is to understand how each Provider would like to participate in the Wairarapa ARC service requirements e.g.
 - Providing multi-facility services, or
 - Providing rest home and/or continuing care services
 - Willingness to partner with other providers; e.g.
 - Sharing resources
 - Sharing purchasing and/or other processes
 - Legal partnership
 - Merger, etc
- With the above in mind, a RoI will be issued as soon as possible to understand each Provider's potential participation. (However, the providers can start to prepare their response to the RoI immediately, with the assistance of this draft report.)
- When the RoI responses from the providers are received the Wairarapa DHB will select some or all of the responses to progress possible solutions to the ARC service roadmap. This will include a customised RFP so that each party understands the business plan being offered.

5.2 Scoring of the RFP

Scoring of the RFP will be weighted to benefit the proposals that have the following approaches.

- 1) Professional business plans to demonstrate a partnership approach with the DHB which offers flexible package of multi services types for Aged Persons,
- 2) More specialised proposals are also encouraged that are complementary to the multi service proposals but on the proviso that the DHB must reduce the number of providers to a more manageable number.
- 3) An approach that will satisfy the DHB's short term and medium term ARC bed requirements
- 4) Proposals from organisations that have demonstrateable. financial sustainability
- 5) Quality system with regard to the care and management of aged persons
- 6) Best practice in terms of staff career planning , training and general HRM

5.3 Information Required in the ROI/RFP

Information required in the ROI/RFP will include:

- 1) The Provider's offering/solution to assist solve both the short term and longer term ARC service requirements for the Wairarapa
- 2) Provider reputation
 - a) Past clients satisfaction
- 3) Proposed facilities
 - a) Purpose Built
 - b) Suitability for Residents.
- 4) Partnership with DHB
 - a) Ability to provide an effective partnership with the DHB
 - b) Demonstrated flexibility
- 5) Financial – current position
 - a) Profit and loss
 - b) Balance sheet
 - c) Cashflow
- 6) Financial – longer term
 - a) Robust business plan
 - b) Likelihood of funding
- 7) Operating effectiveness – current position
 - a) Audit results
 - b) Processes including quality
 - c) Staff and training programmes
 - d) Purchasing
- 8) Operating effectiveness – longer term
 - a) Any pertinent changes

6. DISCLAIMER

This report has been prepared by Elysium Services Limited (“ESL”) pursuant to a letter of agreement dated 11 January 2006 with the Wairarapa DHB (“WDHB”) and has been provided on the following terms and conditions.

This report has been prepared solely for the purpose of assisting the WDHB with the preparation of a “preferred solution” for the WDHB’s Aged Residential Care (“ARC”) Services and may only be used for that purpose. This report is not, nor does it purport to be, all inclusive or contain all of the information that the WDHB may desire or should obtain in connection with the ARC Services.

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