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# 1. THE STRATEGY IN CONTEXT

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## 1.1 Background

This strategy is focused on the psychogeriatric services continuing care services for people who require secure, high level 24 hour nursing care due to an age-related condition and dementia or behaviour unacceptable to others which requires support and containment by skilled personnel.

The term BPSD, Behavioural and Psychological Symptoms of Dementia is becoming commonly used. This is defined as symptoms of disturbed perception, thought content, mood or behaviour that frequently occur in patients with dementia. Emergent literature is beginning to categorise people along a BPSD continuum irrespective of the mental health categories.

MidCentral Health, the provider arm of the MidCentral DHB, historically provided psychogeriatric continuing care services (PGCC) from its Clevely site in Feilding. A review of Clevely was conducted recently and resulted in MidCentral Health exiting these services with a new contract established with the Summerset Group providing services from Milvale in Levin. The Clevely review recommended:

*“It is strongly recommended that MidCentral DHB take a long-term strategy regarding psychogeriatric continuing care needs for the region.”*

This recommendation was incorporated into the MidCentral DHB Ageing in MidCentral Strategy – action 30.

*“Complete a review of psychogeriatric continuing care services for the MidCentral District to ensure there are adequate resources available for the provision of services”*

This project is being undertaken as a result of this recommendation and will deliver a psychogeriatric continuing care strategy to guide future service configuration, delivery and investment.

## 1.2 Purpose of the Project

The purpose of this project is to:

*Develop a psychogeriatric continuing care strategy to guide future service configuration and delivery in the MidCentral district over the next 5-10 years.*

This will advance progress towards the MidCentral and Government vision for the health care of our older people:

*Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whanau and community life. They are supported in this by coordinated and responsive health and disability support programmes.*

### 1.3 Scope of this Project

The scope of the project includes:

- PGCC services for older people who require secure, high level 24 hour nursing care due to an age-related condition and dementia or challenging and dangerous behaviour
- Areas that have a significant impact on the incidence, services or support for people with dementia to impact future demand for PGCC services

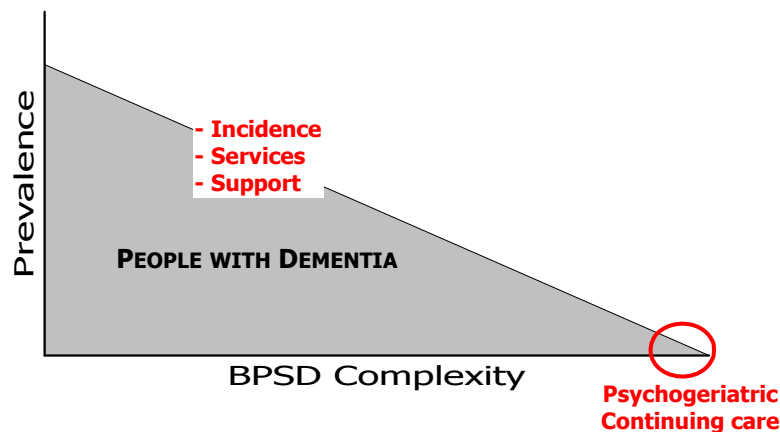


Figure 1 - Project scope

Specifically not included in the scope of strategy development were:

- Services for mental health of older persons in general

### 1.4 Role of this Strategy

In the majority of situations, the actual outcomes delivered are a combination of following a strategic direction (deliberate strategy) and seizing on opportunities and innovative ideas (emergent strategy) that present themselves. This strategy sets out the direction to be followed but it recognises and encourages enhancement of the strategy through innovation.

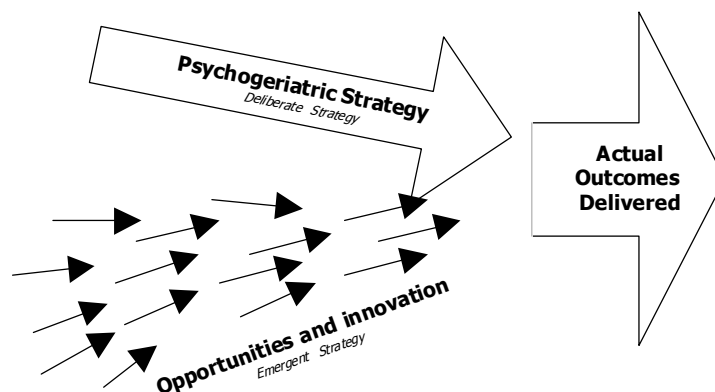


Figure 2 – Deliberate and Emergent Strategy

## 2. ENVIRONMENT

### 2.1 Population Growth and Prevalence

New Zealand, like many countries, is experiencing an ageing of its population. In 2004 3.1% of the population of New Zealand was aged 80+ and it is forecast to increase to 4.6% by 2021 and to 11.4% by 2051. The graph below shows the anticipated effect for other countries.

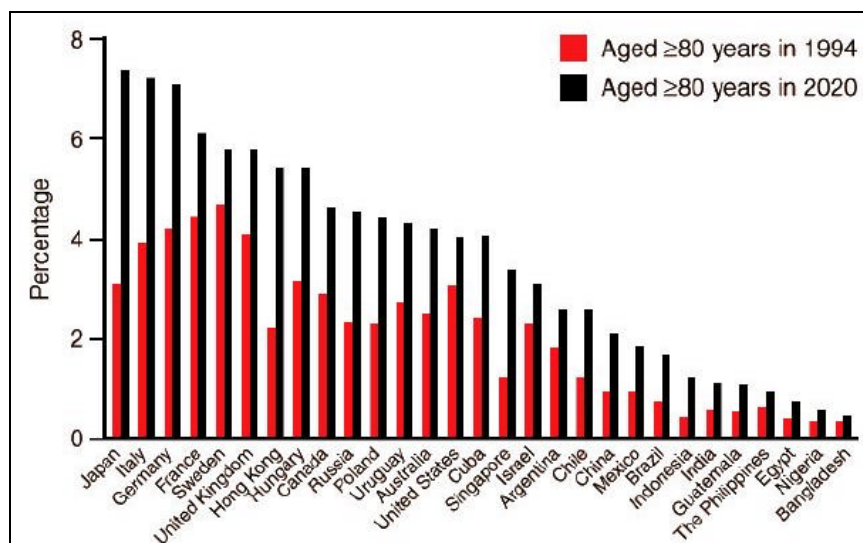


Figure 3 - Effect of ageing population

MidCentral region's future demographic trends for older people are similar to national and international trends. At the 2001 Census, 13.4% of MidCentral's population was aged 65 or over. This is expected to increase to 22.4% by 2026. It is forecast that there will be high proportions of people 65 and over in Horowhenua (30.8%), Tararua (26.9%) and Otaki (26.4%). The MidCentral percentage of people 65 and over is forecast to be 22.4%.

Debate exists internationally on what the effect of the ageing population will have on the demand for disability support services (DSS). The 2004 Ministry of Health report *Impact of Population Ageing in New Zealand on the demand for Health and Disability Support Services, and Workforce Implications*, reviewed the international literature on the subject which suggests three scenarios:

- **The 'crisis scenario'** – where the age of onset of disability or chronic illness remains as at present but mortality is increased leaving an increased interval of disability that drives up demand for health and disability services
- **The 'receding horizon' hypothesis** – where the onset and progression of disease and disability is postponed to the same extent as the age of mortality, so that the number of years with disability or poor health remains unchanged

- **The ‘compressed morbidity’ model** – in which both disability and chronic illness are postponed until closer to mortality with the interval and demand for services reduced.

This debate indicates that simply extrapolating the current statistics into the future is in reality looking at the worst case scenario. It needs to be noted however that even in the second and third scenarios the predicted rise in the over 65 population will increase demand for health and disability services. Models using the compressed morbidity model indicate DSS expenditure will rise 46% between 2001 and 2021<sup>1</sup>.

The following table displays a forecast for the potential increased incidence of dementia due the ageing population assuming the ‘crisis scenario’. It uses the following rates (as described in the Current Environment section of this document):

- Dementia rate = 7.5% of people aged 65+
- People with dementia requiring continuing care = 10%
- People with dementia requiring secure, high level 24 hour nursing care = 1%

**NB** – These projections are from Statistics New Zealand and incorporate medium fertility, mortality and migration assumptions (see Appendix 1 for base information)

### Projected Demand - Dementia services by Territorial Authorities

*Medium series projection*

Territorial Authority <sup>(1)</sup>	Year <sup>(2)</sup>					Dementia	HDU care
		65+	Total	% 65+	Dementia (7.5%)	Care (10%)	(1%)
Manawatu District	2001	3,400	28,200	12.1%	255	26	3
	2006	3,700	28,300	13.1%	278	28	3
	2016	5,000	29,000	17.2%	375	38	4
	2026	6,900	29,300	23.5%	518	52	5
Palmerston North City	2001	8,300	75,200	11.0%	623	62	6
	2006	9,000	78,700	11.4%	675	68	7
	2016	11,900	83,200	14.3%	893	89	9
	2026	15,800	87,700	18.0%	1,185	119	12
Taranua District	2001	2,400	18,300	13.1%	180	18	2
	2006	2,600	17,500	14.9%	195	20	2
	2016	3,200	16,500	19.4%	240	24	2
	2026	4,200	15,600	26.9%	315	32	3
Horowhenua District	2001	5,600	30,600	18.3%	420	42	4
	2006	6,100	30,500	20.0%	458	46	5
	2016	7,300	29,800	24.5%	548	55	5
	2026	8,800	28,600	30.8%	660	66	7
Otaki (est)	2001	1,440	7,116	20.2%	108	11	1
	2006	1,605	7,785	20.6%	120	12	1
	2016	2,010	8,683	23.1%	151	15	2
	2026	2,520	9,499	26.5%	189	19	2
MidCentral district	2001	21,140	159,416	13.3%	1,586	159	16
	2006	23,005	162,785	14.1%	1,725	173	17
	2016	29,410	167,183	17.6%	2,206	221	22
	2026	38,220	170,699	22.4%	2,867	287	29

**Table 1 - Projected demand**

<sup>1</sup> *Impact of Population Ageing in New Zealand on the demand for Health and Disability Support Services, and Workforce Implications*, Ministry of Health, 2004

The following observations can be made:

- The actual numbers of people requiring PGCC services is not forecast to increase substantially, 17 to 29 by 2026
- The number of people with dementia does increase substantially with an additional 1,300 people predicted to have dementia by 2026
- The increase in dementia prevalence accelerates over time. This indicates that investment decisions and service configuration needs to occur in order to minimise future service risk

The following graph displays the forecast growth and requirement for PGCC beds out until 2026.

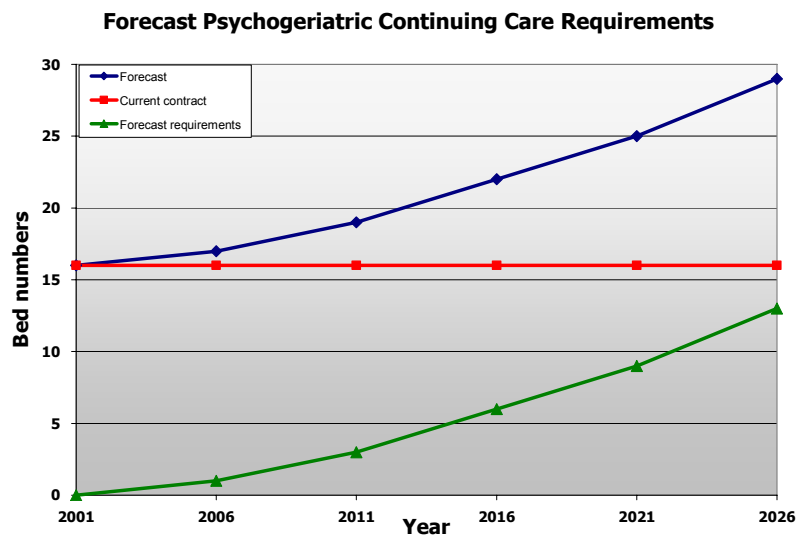


Figure 4 - MidCentral district projected demand

The following pie chart shows the forecast demand in 2006 by Territorial Local Authority.

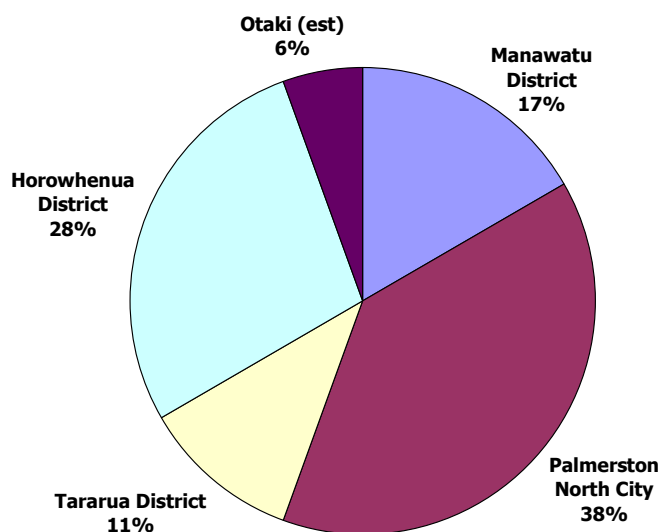
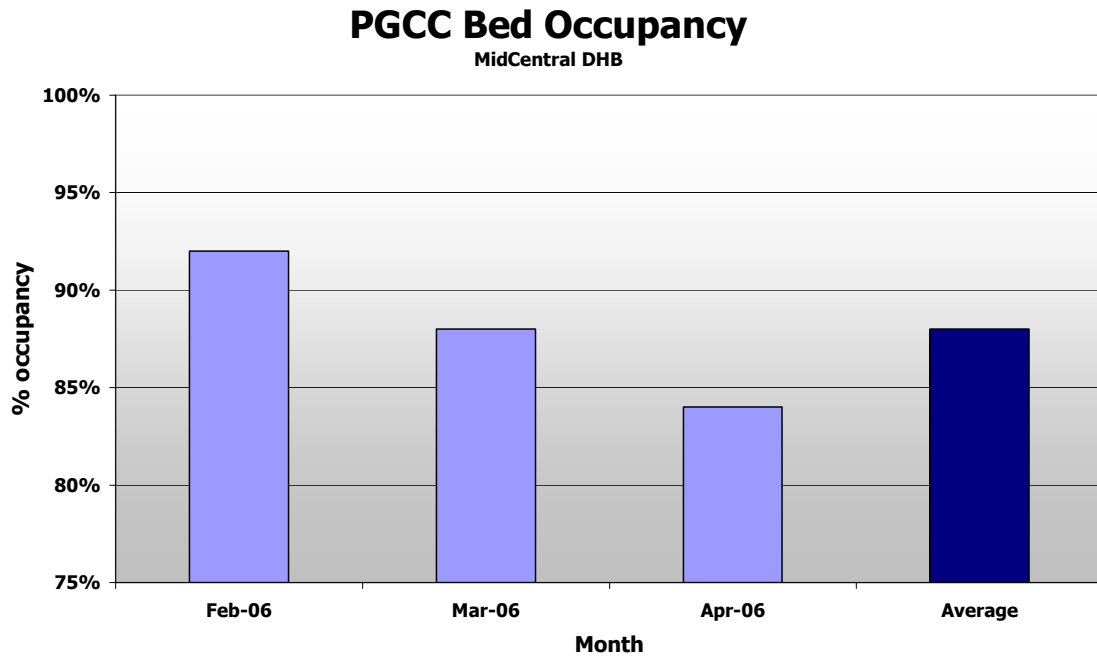


Figure 5 - MidCentral projected demand by TLA

A snapshot of the recent occupancy data suggests that currently there are sufficient beds available to meet demand<sup>2</sup>. A complete breakdown for all classes of residential care is contained in appendix 5.



**Figure 6 - MidCentral occupancy for psychogeriatric continuing care beds**

## 2.2 Ageing Mental Health Patients

It is difficult to estimate the growth in numbers of mental health patients that will require PGCC services. In addition there are other groups such as people with an intellectual disability and people who have suffered head injuries that may require these services. Ideally person centric solutions need to be developed and this could result in additional services being provided in their current residence.

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<sup>2</sup> Occupancy data is restricted to those subsidised residents in contracted beds within MidCentral DHB.

## 2.3 Drivers of Future Change

In order for any strategy to be robust it must be framed within the context of both the current and predicted future environment. It is an unsafe assumption that the next 3-5 years will be a continuation of the current environment. The following PESTE (Political, Economic, Societal, Technological, and Environmental) analysis identifies some of the key drivers in the current environment and their anticipated future effect.

	<b>Observation</b>	<b>Anticipated effect (3-5 years)</b>
<b>Political</b>	The 1 July 2006 inter district flow changes mean DHBs will not, in theory, be negatively financially impacted by people moving into the district	The barrier to aged residential providers attracting business from a wider geographical base is removed. Providers will begin compete for business across DHB boundaries.
	Nursing pay rates in secondary care	The attraction of people to higher paid jobs in the DHB will increase pressure to attract, retain and adequately remunerate primary sector nurses.
	Affordability of health care	The rising costs associated with healthcare for the ageing population will require rationing decisions across the health.
	Change of government	This would require a review of this and other strategies dependent on the focus of the new government.
<b>Economic</b>	Increasing cost of aged care	DHBs will be required to fund this growth. Increase above future funding will need to be through savings in other areas. Greater demand for primary care aged care providers.
	High cost of travel due to petrol prices	This will reduce the ability of family to visit out of town locations and impact on travel of clinical staff.
	Low unemployment and skills shortages will put pressure on carer roles	Many of the carer roles are paid near the minimum wage. If low unemployment continues (which is forecast) many will be attracted to higher paid professions. This will ultimately lead to a reduction in the quality of service able to be provided.
	International competition for health professionals	This will increase pressure on attracting and retaining clinical staff.
	Private business looking for economies of scale	Larger providers will increase in size ultimately reducing the number of providers. This may impact on services for people with dementia who need individualised services. High dependency units also require economies of scale. Centres of excellence may develop around a range of services to gain the required scale.
	The current contracting mechanisms are not providing the correct incentives	Currently the ability to provide services are limited by fixed number contracts. This mechanism does not reward quality service providers by allowing increased market share. It also reduces incentives to innovate.

	<b>Observation</b>	<b>Anticipated effect (3-5 years)</b>
<b>Societal</b>	Ageing population	Increased numbers of people requiring services catering for older persons including health care, transport, accommodation etc.
	Ageing workforce	New entrants to the workforce will be in high demand and may be attracted to the more high profile health areas.
	Low unemployment rate, high work force participation rate, reducing working age population	High demand for skilled workforce will put pressure to fill aged care related positions especially carers Less working age people able to look after disabled family increasing demand for services.
	Declining GP and primary care availability in rural areas	People who level require a high level of primary care will move to larger areas where services are more available. This will increase demand in these larger centres.
	Health Life style factors resulting in high levels of inactivity and obesity are forecast to continue	A higher demand for non age related health services in areas such as diabetes and cardio vascular. This will increase financial pressure on the health system.
	The next generations will be technology and information literate	An increased awareness of conditions and treatments. There will be higher demand for services and treatments provided in other countries.
<b>Technology</b>	Health information technology matures	Health professionals, consumers and family members will have access to more complete medical information and history.
	Medical advances	New treatments, procedures and pharmaceuticals will be available. In the 3-5 year time frame this will not significantly impact on population health statistics but will continue to raise public expectations.
	Communication technology advances	Broadband, 3G etc will mean communication with people in their homes will be increasingly able to provide remote services including interactive health and monitoring.
	Cognitive enhancing pharmaceuticals	Cognitive enhancing drugs will allow people to remain supported in the home longer.
<b>Environmental</b>	Government focus on health promotion	The continued focus in this area will result in a slow change in life style factors such as eating and activity.
	Healthy ageing approaches	Health promotion for older persons may not change environment in the next 3-5 years.
	PHO services begin to mature	The recent establishment of a management services organisation (Compass Health) will rapidly improve the PHOs ability to take responsibility for delivering a wider range of community based services.
	Deinstitutionalisation of Mental health hospitals, including Kimberley	Previous residents of mental hospitals were placed into community settings. These people are ageing and will require both mental health and aged related support.

**Table 2 - PESTE analysis**

## 2.4 Workforce Implications

In December 2004 a paper was prepared for the Ministry of Health entitled, *Impact of Population Ageing in New Zealand on the Demand for Health and Disability Support Services, and Workforce Implications*. It noted the following:

In common with other countries, New Zealand is experiencing difficulties in recruiting and retraining specialists in geriatric care, and concern has been expressed that the training programmes in place do not develop the correct skills needed to care for older people (Associate Minister of Health 2001).

Reflecting trends overseas, the nursing population is also ageing. The average age of nurses was 42.6 years in 1998 (Associate Minister of Health 2001), and the percentage of the nursing workforce aged between 25 and 29 years has decreased from 14.9% to 9% between 1990 and 2000. During the same period the percentage of nurses between 50 and 54 has risen from 9.1% to 12.3%. The rate of retirement among nurses can therefore be expected to increase in the near future (Ministry of Health 2002d).

The demand for GPs will also increase (Health Workforce Advisory Committee 2002a). The growing complexity of health needs is expected to increase the length of consultations, and GPs may reduce the numbers of clients on their books. GPs are also taking on responsibilities devolved from secondary care services, with the result that future demand is likely to outstrip supply.

More generally, there are issues in the recruitment, retention and supply of medical practitioners. The supply of junior doctors is decreasing, with student debt forcing many medical graduates to seek employment overseas. Many other countries are able to offer more competitive salaries to New Zealand medical graduates.

Workforce issues in the health sector are likely to become a critical issue in meeting the challenges of population ageing. This is related to the ageing of the health workforce itself, especially in nursing, but also by the fact that geriatric medicine and long-term care of older people are not popular specialties for medical professionals. New Zealand faces the additional challenge of retaining health care workers in the face of active recruitment from overseas. Planning to meet shortfalls in the health service workforce is essential, given the long lead time required for recruitment, training and certification.

The majority of workforce issues that will affect the delivery of psychogeriatric services are not unique to this area of the health sector. For example the number of General Practitioners in primary care is an issue for the early diagnosis of dementia but it is also an issue for the health sector as a whole. It is outside the scope of this strategy to tackle these issues. Therefore, whilst the development of the strategy needs to recognise the key workforce issues, it is beyond the strategy to develop strategic responses to national workforce issues.

## 2.5 Services for Maori

There are several pieces of work planned in the short-term that will allow for this area to be researched and the development of care options for Maori that are culturally appropriate.

The planned work includes:

- Complete research (Older Maori Disability Support) re feasibility of a Maori Health Residential Provider by 30 September 2006
- Development of a Needs Assessment and Service Coordination (NASC) strategy for Maori
- Develop Maori Disability Provider Strategy by March 2007
- Develop strategy for respite, convalescent and palliative care option for Maori by September 2007
- Implementation of Strategy by December 2008.

## 2.6 Future Perspectives

From key stakeholder interviews the following list of future requirements has been developed.

### **What family and individuals require**

- The right service at the right place at the right time
- The ability to visit family and relatives easily
- To be able to support family and relatives in their own home if they choose
- To have culturally appropriate services
- To have access to quality home based support, carer relief and respite services
- Access to information and support when early onset symptoms present
- Knowledge of what is happening and options they should consider
- Purpose built facilities with the number of beds dictated by the need to provide safe and quality care

### **What service providers require**

- Patient centric systems and processes
- Clear funding streams
- Clear service and quality requirements
- The ability to provide career options for their staff
- Sufficient funding to be able to provide a quality service
- A skilled and well trained workforce
- Privately owned organisations - a return on investment to owners/shareholders

### **What the MidCentral DHB requires**

- Progress towards its vision for the health of older people
- Strong community based services configured to the needs of local populations
- A skilled and well trained workforce
- Choice and independence for individuals and families
- Coordinated services
- Long-term cost effective, and sustainable services
- Systems and processes incentivising quality

### 3. THE PSYCHOGERIATRIC STRATEGY

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*"Without an awareness of the whole, there can be no strategy.  
Without strategy, there is only drift."*

**Thomas Freidman**

Over the next five to eight years MidCentral District Health Board will strive to achieve the following vision:

*Psychogeriatric services will be responsive and community focussed from early diagnosis through to continuing care. This will allow people and families to make well informed decisions about their current and future health and well being.*

The table below shows in high level terms some of the **key differences** between the existing arrangements and those of the future vision:

Old	New
Fragmented information	➤ Coordinated information
Little training and development opportunities for care workers	➤ Training and development qualification framework for care workers
Standard packages of care	➤ Tailored packages of care
General Practice Teams working in relative isolation	➤ Enhanced support for General Practice Teams
Cognitive enhancer pharmaceuticals available for those who can pay	➤ Cognitive enhancer pharmaceuticals based on need <sup>3</sup>
Geographical barriers to continuing care services	➤ Enhanced access to continuing care services
Informal links between providers	➤ Integrated care pathways
Continuing care facilities only for permanent residents	➤ Continuing care facilities to also stabilise patients

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<sup>3</sup> This is dependent on this range of pharmaceuticals being assessed as clinically appropriate by PHARMAC

### 3.1 Phased Approach

The strategy will be structured and implemented in logical phases.

#### Phase 1 – Strengthen Community Services (2006 – 2010)

It is estimated a second high dependency unit will be required around 2011. The focus of the strategy until this time will be on strengthening the effectiveness and capacity of the community and primary care sectors. This will enable these services to more completely support people and families living with dementia with the goal being to reduce the future demand for PGCC services. In addition strengthening the links between community and specialist services will enhance services, develop effective primary/secondary relationships and create educational opportunities.

#### Phase 2 – Service Configuration Changes (2011 – 2015)

By around 2011 there will be a growing need to establish a second high dependency unit to provide PGCC services. The geographical nature of demand will logically mean it needs to be based in Palmerston North. This allows other options to be built into the proposed future service configuration for psychogeriatric services in the district. The 2011 date is an estimate and regular monitoring of demand will allow for proactive action to be taken when it is required.

#### Subsequent Phases (2016 - )

Strategic and operational planning outside 5-8 years becomes problematic due to the assumptions that need to be made. It is anticipated this strategy will be updated before 2016 and the updated strategy will deal with time frames outside, and in all probability before, 2016.

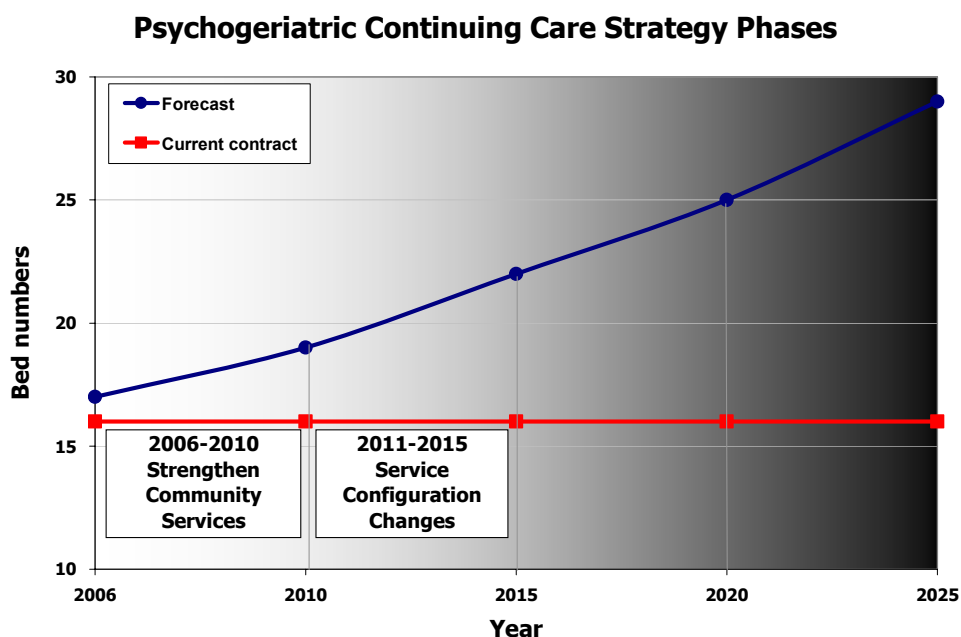


Figure 7 - Phased strategy approach

## 3.2 Strengthen Community Services

The first phase of the strategy is focused on building the effectiveness and capacity of the community environment. Key areas that will be targeted include:

- Information
- Home Based Support
- The role of Primary Care
- Pharmaceuticals
- Care pathways
- Address issues in the funding framework

It is important that the needs of rural communities are incorporated into this phase.

### Information

*“An individual without information can’t take responsibility. An individual with information can’t help but take responsibility.”*

**Jan Carlzon**

In order to allow individuals and families affected by dementia to take responsibility for their own future we need to ensure they have access to appropriate information. People may not immediately seek professional assistance as early symptoms appear choosing instead to understand and cope with the situation within the family. By equipping people with information they will be able to make informed choices how they want to proceed. This in turn will help people seek earlier assistance from health professionals.

The information needs to be tailored to best suit the needs of differing groups. It needs to be remembered the purpose of providing information is to inform the audience and so how information is delivered must suit this audience. Often the internet, although convenient, will not be the most appropriate method of information delivery.

This strategic direction is in alignment with the Ageing in MidCentral Strategy action number 1 which is planned to be completed by 30 June 2007:

“Establish a service model and fund an inter sectoral AIM information and advocacy service available to all older people of the MidCentral district and those who might assist with supporting older people.”

There are a number of organisations who could assist with the provision of a coordinated information service. They include PHOs, Citizens Advice Bureaus, Age Concern, Religious/Welfare groups and the Alzheimer’s Society. In addition there is the potential to collaborate with other government agencies such as the Ministry of Social Development.

• Suggested Next Steps	• Timeframe
Form a joint project with the with the Ageing in MidCentral strategy action 1	30 June 2007

## Home Based Support

To allow people the choice to remain supported in their homes for longer we need to ensure they have access to a wide range of quality support services. There are three key aspects that need to be addressed as part of this strategy:

- Developing tailored packages of care
- Creating a qualification framework for care workers
- Increasing training and education opportunities for paid and unpaid carers

### Packages of Care

Each situation where a package of care is required is, by definition, unique although there will often be many common elements. The current arrangement for allocating packages of care is a budget centric system. This system creates issues for people whose needs do not fit neatly into the boxes. Mental Health patients requiring disability services are a good example of people who need services from different budget areas. A more appropriate model is a person centric system. The three logical steps needed in this type of system are:

1. Determine the services the person requires
2. Develop the package of care that will meet the requirements
3. Determine how the package of care will be funded.

This strategic direction is in alignment with the Ageing in MidCentral Strategy action number 12:

“Increase home-based rehabilitation options and assistance for older people to stay at home as long as possible including respite care options.”

Implementation of this area should look at the benefits and costs associated with a move to establishing a care coordination centre similar to the service established by the Capital and Coast DHB.

### The Carer Environment

Creating an appropriate environment to encourage and support care workers is vital. Increasing pay rates is part of the solution but without addressing the way the environment is structured the solution will not be long-term and it is clear a long-term solution is required.

The environment for elderly care has a fundamental difference compared with child care.

• Child care	• Elderly care
NZQA courses for nannies	1 correspondence course available
Higher pay rates for qualified	Mainly unqualified workforce

**Table 3 - Care comparison**

In economic terms, the qualifications in child care act as a “barrier to entry” creating a smaller supply of people able to provide qualified nanny services. Limiting supply tends to raise prices, i.e. people are prepared to pay more for someone qualified over someone not qualified and even more when they are hard to get. Elderly care with no qualifications creates a higher supply and therefore will tend to pay lower prices.

This strategic direction is in alignment with the Ageing in MidCentral Strategy action number 11:

“Invest in workforce development of carers through the development and funding of a workforce development plan that is targeted to the services for older people.”

There is currently a joint training initiative between the Ministry of Health and CISSITO, an independent training organisation looking at establishing a competency based training framework.

### **Training and Education**

Working, whether paid or unpaid, with people suffering from dementia is rewarding but often challenging. This is especially true when looking after people with higher levels of BPSD.

PGCC facilities provide support and training for their staff but carers in other residential facilities and home based carers in the community will often have had limited training, often none, in dealing with people with higher and more complex needs. The result is often to move the person to a higher level of care which isn’t always required or appropriate.

Targeted training to frontline carers, including family members, who spend the largest amount of time with residents and family members, will improve the quality, levels of care and understanding. Family members could also be integrated into the service provision in a partnership approach which would help with both education and information dissemination.

This strategic direction is in alignment with the Ageing in MidCentral Strategy action number 21:

“Establish a process for training and funding that supports family members and other informal (unpaid) carers involved in providing homecare services.”

• Suggested Next Steps	• Timeframe
Ensure the relevant AIM projects incorporate the needs of dementia and PGCC services. Include a review of the cost and benefits of establishing a care coordination centre	30 June 2009

## The Role of Primary Care

General Practice and GP's in particular are seen as a key point of contact. GP's often will have a history with individuals and families which aids their ability to diagnose early which is important. Even with this history the early diagnosis of people suffering from dementia is often difficult due to the ease of which it can be hidden from the GP in a short consultation.

The time required by individuals and families is often not available due the time pressures on GP's. This is unlikely to change in the short to medium term even given the the changing role of General Practice under the PHO model with relationships able to be developed with a wider range of the General Practice Team. Significant primary care resources are required as there are currently estimated to be 1,725 people in the district with dementia. This is forecast to grow to 2,867 by 2026.

The strategy will focus on increasing the ability of primary care to detect and provide services required for people and families with both mild and more severe BPSD. Options that can be considered include:

- Outreach model supporting primary care
- Increase psychiatric clinical nurse specialist services
- PHO employ resources such as nurse specialists or social workers
- "Specialist GPs" supported by psychogeriatricians
- Enhanced links with Alzheimer's society and the voluntary sector

• Suggested Next Steps	• Timeframe
In association with key stakeholders determine the most appropriate model to implement for the MidCentral district	March 2007

## Pharmaceuticals

Cognitive enhancers are pharmaceuticals that sharpen mental faculties. These pharmaceuticals have the potential to allow people to delay the affects of dementia allowing people to remain in their homes longer and enjoy a higher quality of life.

The New York Academy of Sciences reported that at least 40 potential cognitive enhancers are in clinical development. In New Zealand, in August 2004 PHARMAC considered an application to subsidise Ebixa for use in Alzheimer's disease which was declined. Ebixa tablets have a recommended retail price of \$233 (56 tablets = 1 month) and this price makes them prohibitive for individuals to buy unsubsidised. Part of PHARMAC's rationale was that a move to aged residential care represented cost shifting rather than cost saving. Effectively the cost of a Rest Home versus home based costs + respite + carer/personal

costs. The table below indicates that this may require further analysis as the purely economic benefits appear substantial. This doesn't factor in the intangible benefits such as reducing carer stress and the improved quality of life.

	Day	Month	Year
Cognitive Enhancers	\$8.33	\$250	\$2,999
Aged care	\$84.52	\$2,536	\$30,427
Dementia care	\$102.77	\$3,083	\$36,997
Psychogeriatric care	\$156.98	\$4,709	\$56,513

**Table 4 - Cognitive enhancers and care costs**

Currently there are at least four unsubsidised cognitive enhancer drugs available in New Zealand. These drugs are subsidised in many countries around the world including Australia, USA and the UK. Research has shown a modest effectiveness and savings through delayed entry to residential care<sup>4</sup>. The costs for these pharmaceuticals per person are estimated to be between \$250 and \$300 per month.

• Suggested Next Steps	• Timeframe
In association with PHARMAC, ascertain what future activities are planned with regard the potential introduction of cognitive enhancers	March 2007

## Care Pathways

Clinical pathways are evidence based multidisciplinary plans of care. They may be for patients who have been diagnosed with a specific condition (diagnosis based), who are having a particular procedure (procedure based), or who are presenting with a particular symptom (symptom based).

These time- and stage-oriented tools are used to synchronise the activities of every member of the health care team to achieve predetermined patient outcomes and provide a continuum of care for those patients whose outcomes are predictable 60 to 75 percent of the time. The aim of using a clinical pathway is to increase the probability that the required care will achieve predetermined clinical outcomes and will be provided in a timely way, minimising delays, omissions, cancellations and unnecessary cost

Clinical pathways are best developed by the multidisciplinary team members who are directly or indirectly involved in the care of the patient. It is essential that sufficient flexibility be built into the pathway format so that it can be tailored to individual patient needs.

<sup>4</sup> Professor Henry Brodaty, Presentation to the NZ Alzheimers society, [www.alzheimers.org.nz/d/henrybrodaty2.pps](http://www.alzheimers.org.nz/d/henrybrodaty2.pps)

A care pathway helps the treatment team outline their services and provide a guide to families as to what to expect. The care pathway is person and family/whanau centred thereby acknowledging the involvement of the person’s family. The positive outcomes of the integrated care pathway are noted below.

Early Stages	Middle Stages	Late Stages
Informed patients and carers	Treatment of symptoms	Proper use of resources
Well categorized patients	Better community support	Smoother transition into care
Early treatment interventions	Reduced burden on carer	Dignified decline
Reduced cost of the illness overall, Delay in institutionalisation		

**Table 5 – Outcomes from Integrated Pathways**

The establishment of care pathways needs to be done using all stakeholders to ensure both buy in and as an opportunity to enhance relationships. It needs to be noted the psychogeriatric client group needs support of specialist clinicians and staff with specialist skills. The development of the care pathways needs to take into account these relationships in particular.

• Suggested Next Steps	• Timeframe
Develop a team involving all key stakeholders to develop a care pathway to guide future investment and service configuration	March 2007

### Address issues in the funding framework

The current funding arrangements in place involve three separate streams of funding; Ministry of Health, DHB – Mental Health (which is ring fenced) and DHB – Disability Support Services

For the majority of situations the funding of these services does not present problems. There are several issues however where people are in situations where the boundaries of these services meet. These issues include:

- No Disability Support Services (DSS) funding for people with a diagnosed mental health condition
- The DHB receives population based DSS funding based on its 65+ population. People under 65 who have DSS requirements that are ‘like in age’ will be funded out of this allocation despite the DHB not being provided funding

- As people in mental health facilities age they develop age related requirements which are not catered for in mental health facilities. Transferring people to aged residential care facilities has funding and personal issues
- In some situation funding is provided from other government agencies such as Work and Income for Housing New Zealand and the boundary issues are often not well understood.

Ultimately the funding of services should not dictate service provision. People need the appropriate service, at the appropriate time and in the appropriate place and the funding mechanisms across government agencies must support this.

How services are funded and the associated consequences are a strong driver of behaviour. A frequently used management article<sup>5</sup> entitled “On the folly of rewarding A, while hoping for B” summarised the problems that can, and in most circumstances do, develop when what is rewarded (A) is not what is really wanted (B). In the case of the current funding mechanism, the table below shows what we are want versus what is rewarded today.

• We want...	• We reward...
High quality aged residential care	Occupancy of the least demanding people
Choice for the individual	All providers by capping contracted numbers reducing choice
People to be able to remain at home for as long as possible	Movement to residential care by not having optimal community support
High quality primary care and community services	Movement to employment in secondary care (pay differences)

**Table 6 - The reward system**

• Suggested Next Steps	• Timeframe
Set up a project involving key stakeholders to identify funding gaps, understand what action is occurring nationally and create a pathway forwards	March 2007

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<sup>5</sup> Academy of Management Executive, S.Kerr, 1995 Vol 9 No 1

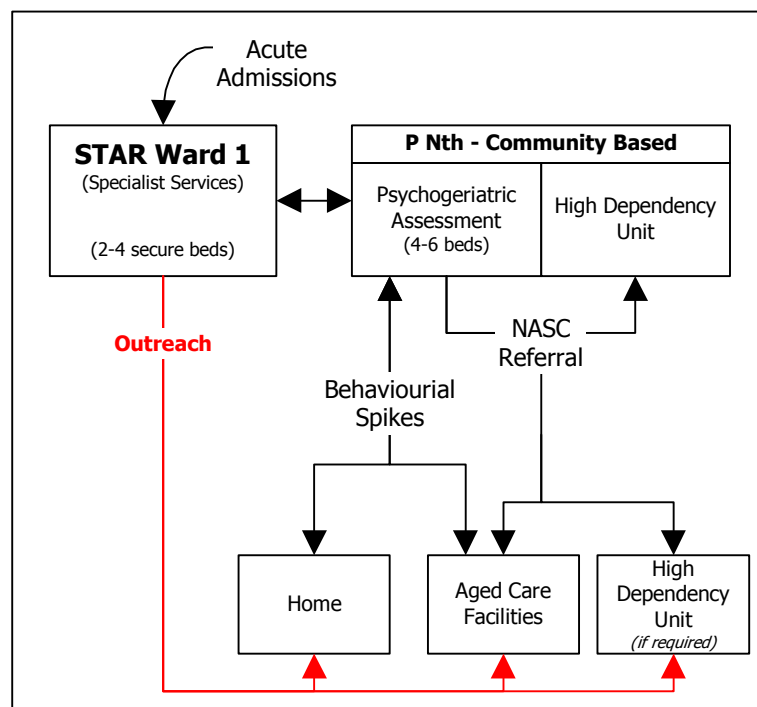
### 3.3 Service Configuration Changes

Due to the specialised nature of PGCC services and the required economies of scale, these services will need to remain a regional resource. A number of factors indicate that MidCentral has the ability to alter the configuration of its PGCC services in the medium term. These factors include:

- It is projected that by 2011 there will be a growing need to establish a second high dependency unit
- The demand for services in the Palmerston North and Manawatu areas and the opportunity this creates
- Move to community based care
- Logistics of people travelling to Levin from both within and outside the district
- Distance between PGCC facility and specialist services
- Current size limitations of STAR Ward 1 secure unit

The geographical nature of demand will logically mean PGCC services need to be provided from within Palmerston North. The proximity to the specialist psychogeriatric services allows other options to be considered as part of any future service configuration.

The following is a potential high level model based on a second high dependency unit being established in Palmerston North.



**Figure 8 - Potential service configuration**

Key points to note are:

### **STAR Ward 1**

- Provides all specialist psychogeriatric services
- Integrated working relationships with the community provider including management of the clinical assessment process
- Secure beds in the STAR Ward 1 would be transferred to the community based unit
- Would provide enhanced outreach services supporting patients in community settings

### **Palmerston North Based Unit**

- Would provide a mix of long-term and assessment beds
- Would provide facilities to stabilise patients having behavioural spikes prior to returning them to other community based care
- Clinical assessment processes would be integrated with specialist psychogeriatric services
- This option could be expanded to be the sole provider of PGCC services in the region if economies of scale were required

### **NASC**

- Would work closely with the assessment centre
- Processes would not be materially affected by the changed service configuration

Benefits of the new model include:

- Provides services where demand is greatest
- Addresses most transport issues as Palmerston North is a hub for public transport
- Provides choice in the district
- Works closely with specialist services
- Lessen pressure on secure unit within the STAR Ward 1
- Opportunity to share technology and gain process efficiency
- May provide an opportunity for a purpose built facility

## 4. APPENDIX 1 - DEFINITIONS

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The following definitions are used in this document:

- BPSD - Behavioural and psychological symptoms of dementia (BPSD), defined as: Symptoms of disturbed perception, thought content, mood or behaviour that frequently occur in patients with dementia. Emergent literature is beginning to categorise people along a BPSD continuum
- HDU – High Dependency Unit for providing services for people requiring secure, high level 24 hour nursing care due to an age-related condition and dementia or challenging and dangerous behaviour. Currently referred to as psychogeriatric continuing care
- Psychogeriatric Services - Psychiatric services provided to older people with functional and organic mental disorders where there are associated significant psychiatric symptoms. Functional disorders include mood disorders and psychoses such as depression, anxiety, bipolar disorder, and schizophrenia. Organic mental disorders include dementia, delirium and personality change or delusional states induced by physical disorders
- Psychogeriatric Continuing Care (PGCC) – Service provided in high dependency units
- Dementia - The loss of intellectual functions (such as thinking, remembering, and reasoning) of sufficient severity to interfere with a person's daily functioning. Dementia is not a disease itself but rather a group of symptoms that may accompany certain diseases or conditions. Symptoms may also include changes in personality, mood, and behaviour. Dementia is irreversible when caused by disease or injury but may be reversible when caused by drugs, alcohol, hormone or vitamin imbalances
- PTAC – Pharmacology and Therapeutic Advisory Committee. Provides independent medical advice to the PHARMAC Board on decisions regarding pharmaceutical listing, subsidy levels and prescribing guidelines and conditions
- IDF – Inter District Flow. The mechanism by which DHBs receive payment for providing services for people who live outside their district.

## 5. APPENDIX 2 – CURRENT ENVIRONMENT

Currently specialist psychogeriatric services are provided primarily by MidCentral Health and PGCC services by Milvale in Levin.

### Specialist care

The STAR Centre is the pivotal part of the current provision of psychogeriatric services in the district.

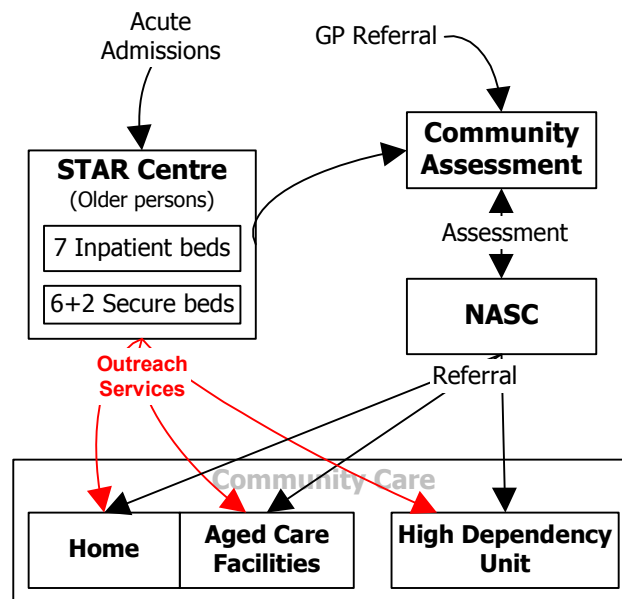


Figure 9 - Specialist care diagram

Specialist services for older people include:

- A community-based service providing AT&R, crisis intervention, arranged acute respite care, oversight of people with chronic mental illness and services for people with drug and alcohol dependence if it was part of complex multiple conditions
- A dedicated 15-bed inpatient unit for AT&R of older people, co-located with the geriatric AT&R unit. It includes a secure 8 bed area.
- Generic older peoples mental health clinics at Palmerston North and an outreach clinic at Levin
- Occupational therapy day programmes, two hours/day, two days/week
- A liaison psychogeriatric and delirium service at Palmerston North Hospital
- Diagnostic and treatment services for people aged under 65 with age-related dementia
- Access to Māori health units, kaumātua and Māori health providers and alternative therapies.

Links to specialist services and the person in their home are provided by Community Psychiatric Nurses and Clinical Liaison Nurses. Two Clinical Nurse Specialist roles, one for

older adult health and one for older adult mental health, have an organisation-wide focus as well as specific 7 service based responsibilities that encompass education, clinical practice and policy development, and advisory functions.

The STAR centre has been very successful in retaining staff and this has allowed strong relationships within the sector, hospital and with primary care providers to develop. It has also allowed a large amount of institutional knowledge to be accumulated. These two factors place the service in a strong position looking to the future.

There are issues in the current environment and these include

- Elderly patients are referred earlier than ideal to reduce pressure on bed availability for medical and surgical lines
- It is difficult to admit patients in residential care directly into the STAR centre so the emergency department is often used
- The transition from hospital to community services is not performing optimally
- There is an six/eight bed secure unit though it's small size is not ideal for patients and staff
- Patients are often required to wait in an inpatient situation due to legal requirements. Court processes can take 28+ days to be completed and this increases the Average Length of Stay (ALOS)

## **PGCC Facility**

There is one contracted high dependency unit provider in the MidCentral district. Milvale in Levin, part of the Summerset Group, holds the contract to provide 16 high dependency beds. The Summerset Group also operate a similar facility at Waikanae in the Capital & Coast district.

The occupancy rate for contracted PGCC places for Feb-April 2006 was 88% (see appendix 2). This indicates the currently contracted number is adequate although there are a number of variables that can influence demand.

## **5.1 Community Services**

Prior to reviewing the services that are currently available for individuals and families it is important to recognise the role families play in long term care. An international policy review of six countries (Australia, Canada, Germany, Japan, United Kingdom and the United States) of public policies to support family and informal care giving noted that in all countries, family members provide the bulk of long term care. International studies cited in this review, estimate that 65-80% of long-term care is provided by informal caregivers, mostly women. The review underscored the importance of family and informal caregivers in the evolution of community-based long-term care initiatives. (Wairarapa DHB, 2003)

This was backed up by information taken from the 2001 Census showing percentage of people involved in caring for an ill or disabled person in an unpaid capacity.

• Age	• Caring for ill/disabled person in same household	• Caring for ill/disabled person in another household
15-19	9%	7%
20-39	16%	13%
40-59	16%	21%
65+	Not recorded	Not recorded

**Table 7 - Unpaid carers**

Recent policy developments in several countries reflect a growing recognition of the pivotal role played by family members and friends voluntarily provide support to the ill and disabled family members when a chronic condition, trauma or illness limits the person's ability to carry out basic self-care tasks. These carers also bear most of the financial, emotional and physical pressures associated with daily care. Caring for people at the higher end of BPSD have higher incidence of depression and physical health issues.

## **Information**

There are many places individuals and family can get information but it is often fragmented. Organisations, in particular government agencies, are often expert in their own area but have little knowledge about what is available from other agencies. Social services organisations and citizen's advice bureaus often have a good broad general knowledge but individuals and families are left to negotiate several agencies to gain the information to understand their rights, options and entitlements.

Recently attempts have been made to centralise information. Enable New Zealand maintains the What Everybody Keeps Asking (WEKA<sup>6</sup>) website and 0800 service which provide information about disability information. The use of the internet to publish information has made it accessible and cost effective for the organisations providing the information though it has several limitations:

- Not all groups in society have the ability to access this information
- Information is often not structured easily
- Information remains fragmented, no real attempt has been made to integrate the information.

## **Community Groups**

There are many community groups and welfare agencies that are able to assist people both with information and services. There are organisations focussed on a specific area such as the Alzheimer's Society and other offer support across a range of issues such as Manchester House in Feilding. Some organisations such as ElderNet are only available on-line whilst others offer a local presence such as the Citizens Advice Bureau.

These groups provide a range of services including:

- Information and advice
- Support groups
- Advocacy
- Social work services
- Day care
- Drop in facilities

These groups play a key role in providing services in the community though often this can be a fragmented approach. In addition, these services are not available in all communities and often they are limited to larger centres such as Palmerston North.

## **General Practice/Primary Care**

Unless there is a need to access emergency services in Palmerston North hospital, general practice is the first option for the majority of people when dementia signs present. General practice can act as the key to accessing other community services by providing the appropriate information. A report, *Combining Work and Elder Care*, produced by the Department of Labour noted a GP can either be a strong or weak link in creating and managing a supportive environment for dependent elderly people.

Early diagnosis of dementia is not straightforward and often early phases of dementia are diagnosed as depression. When dementia is diagnosed, the time needed by individuals and family to fully understand the situation and options available to them is often not available from busy primary care teams. Experience with dementia patients will also be a factor in the level of support able to be offered.

Often symptoms of dementia can remain undetected as both individuals and families

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<sup>6</sup> www.weka.net.nz

attempt to cope with the changes without having to seek assistance. Having access to reliable and appropriate information and services from primary care would assist in bringing independent advice into decision making.

## **NASC**

To access subsidised aged residential care, respite services and home based support an assessment of an individuals need is done. This is performed by the Needs Assessment and Support Coordination (NASC) agency, part of SupportLinks.

Needs assessors complete an assessment of needs with the older person, and service coordinators use this assessment to develop care packages of support services for those able to remain in their home and assist with moving people into residential care if it is required.

## **Aged Care Facilities with Specialist Dementia Beds**

There are 147 funded places for people suffering dementia and requiring continuing care residential services (stage III). Contracts are currently held with:

- Aroha Home and Hospital (Palmerston North)
- Brightwater Centre (Palmerston North)
- Levin Home for War Veterans (Horowhenua)
- Rahiri Home and Hospital (Tararua)
- Garden View Elderly Care (Horowhenua)
- Coombrae rest home (Manawatu)
- Westella Homestead Rest Home (Manawatu)
- Wimbledon Rest Home (Manawatu)
- Woodlands of Palmerston North (Palmerston North)

All providers have capped contracts limiting the amount of subsidised people they can accept.

## **Home based support / carer relief**

Home based care is divided into two types:

- Home Support - This type of care is intended to support disabled people in their own home, allowing them to live as independently as possible
- Carer Relief - These support services are intended to give full-time, unpaid carers assistance. Some examples of unpaid carers include partners/spouses, whanau, and family members, and friends.

On assessment by the Needs Assessment and Support Coordination agency (NASC), part of SupportLinks, packages of carer can be developed for eligible people.

Day care services are provided by the majority of rest homes who provide specialist dementia services. In addition the Alzheimer's Society provides day care services.

The MidCentral *Health Needs of Older People*, analysed people accessing home based support by disability severity and observed that “users of care relief services showed greater disability severity levels when compared to users of home support services. It implies many unpaid carers are bearing high burdens of effort and responsibility, and may indicate higher thresholds of disability severity before residential care is considered.”

Recently there has been a lot of attention on the relatively low pay rates paid to people providing carer services in the community. The current low unemployment rate and skill shortages will increase pressure on the sectors ability to recruit and retain appropriate staff and this will ultimately affect quality.

The Government announced for the 2006 budget, a \$14.5m/annum increase for home based support services which are to be distributed to DHBs based on the population-based funding formula. This approximates to an additional \$600,000 for the MidCentral district.

## 6. APPENDIX 3 - NEIGHBOURING DHBs

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Whilst the scope of the strategy is confined to the MidCentral district it is important to understand two aspects in relation to other DHBs:

1. The potential impacts other DHBs will have on services provided within MidCentral
2. What other DHBs are doing in this area that is working well.

### Inter-district flows (IDFs)

Inter district flows is the mechanism by which all DHBs receive payment for providing services for people who live outside their district. If people from Whanganui DHB receive services from providers in the MidCentral, the Whanganui DHB will reimburse MidCentral.

From 1 July 2006 this system is being altered so the funding for people in aged residential care moving to a different DHB is transferred to the DHB who will be providing the service. The following example demonstrates the materiality of these changes.

The table displays the change in cost as a result of the change in IDF rules for a situation where 1 person eligible for aged residential care move to the MidCentral district.

	1st Year Cost to DHB	
	Other DHB	MidCentral
IDF Rules pre 1 July 06	\$7,607	\$22,820
IDF Rules post 1 July 06	\$30,427	\$0

**Table 8 - IDF changes**

The annual costs are higher for dementia care (\$37,000) and PGCC care (\$56,500). This removes a significant financial barrier to DHBs wanting people from other DHBs to access long-term services provided in their district.

### Whanganui DHB

Since the closure of Jubilee hospital in Nov 2003 the Whanganui DHB region does not a facility that can provide PGCC services. They primarily refer via inter-NASC transfers to Milvale in Levin or Omahanui and Sunhaven in Taranaki.

Wanganui has a higher than average older persons population and this is forecast to grow. The result is that MidCentral can expect to receive increasing patient flows from Whanganui DHB in the future.

## **Wairarapa DHB**

A 2006 report for the Wairarapa DHB noted that there was a requirement for 3 PGCC beds and this commitment was currently being met by other DHBs, most likely to be Hutt Valley or Capital & Coast. The report notes this requirement could be linked in the future to the Henley Care Centre which is contracted to provide 32 dementia places. Due to difference in service requirements between dementia and PGCC places this is unlikely to occur until there is greater demand. Therefore it is likely Wairarapa will continue to use PGCC services provided by other DHBs.

## **Hawkes Bay DHB**

The Hawkes Bay DHB has recently completed a strategy for older persons, *Ageing in Hawkes Bay 2005-2010*. This noted that “whilst there is generally an adequate number of [psychogeriatric] hospital beds available for older people needing them, there have been occasions when no beds were available and discharge delays from Hawkes Bay Regional Hospital were experienced.” Colwyn House is currently contracted to provide 22 PGCC beds.

The strategy does not make any specific reference to changes in psychogeriatric services.

## **Capital & Coast DHB**

The Capital & Coast DHB have recently outsourced their assessment and service coordination processes to the Nurse Maude Association under the Care Co-ordination Service. This service has taken responsibility for assessment and placement of people requiring PGCC services.

There are two contracted providers of PGCC services, Elizabeth Memorial Hospital and Summerset on the Coast (also known as Milvale – Waikanae). In addition a psychogeriatric unit providing ATR services is being built in the Kenepuru Community Hospital and is planned to be operational towards the end of 2006.

## 7. APPENDIX 4 – POPULATION INFORMATION

### Projected Population Change of Territorial Authorities Medium series 2001(Base)–2026

Territorial Authority <sup>(1)</sup>	Year <sup>(2)</sup>	Population by Age Group (years) at 30 June					Components of Population Change, Five Years Ended 30 June				Median Age <sup>(3)</sup> (years) at 30 June
		0-14	15-39	40-64	65+	Total	Births	Deaths	Natural Increase	Net Migration	
Manawatu District	2001	6,900	9,100	8,900	3,400	28,200	...	...	...	...	35.7
	2006	6,400	8,600	9,600	3,700	28,300	1,700	1,100	600	-500	38.1
	2011	5,900	8,300	10,300	4,200	28,800	1,500	1,100	400	0	40.4
	2016	5,600	8,200	10,300	5,000	29,000	1,400	1,100	300	0	42.1
	2021	5,300	8,200	9,900	5,900	29,200	1,400	1,200	200	0	43.6
	2026	5,200	7,800	9,300	6,900	29,300	1,400	1,300	100	0	44.6
Palmerston North City	2001	15,700	31,500	19,700	8,300	75,200	...	...	...	...	31.1
	2006	15,500	32,100	22,100	9,000	78,700	5,100	2,600	2,600	1,000	32.4
	2011	15,000	31,900	23,900	10,100	80,900	4,800	2,600	2,200	0	33.8
	2016	14,400	31,900	25,000	11,900	83,200	4,500	2,700	1,800	500	34.5
	2021	14,000	33,000	24,900	13,600	85,400	4,600	2,900	1,700	500	34.9
	2026	14,000	33,900	23,900	15,800	87,700	4,900	3,100	1,700	500	36.4
Taranua District	2001	4,700	5,600	5,700	2,400	18,300	...	...	...	...	36.1
	2006	4,100	4,900	5,900	2,600	17,500	1,200	800	400	-1,300	38.8
	2011	3,500	4,700	6,000	2,800	16,900	1,000	700	300	-800	41.3
	2016	3,100	4,400	5,700	3,200	16,500	900	800	200	-600	43.7
	2021	2,900	4,500	5,000	3,700	16,100	900	800	100	-500	45.4
	2026	2,800	4,200	4,500	4,200	15,600	900	900	100	-500	45.3
Horowhenua District	2001	7,000	8,700	9,400	5,600	30,600	...	...	...	...	39.2
	2006	6,300	8,000	10,100	6,100	30,500	1,800	1,900	-100	0	42.1
	2011	5,600	7,600	10,500	6,600	30,300	1,600	1,900	-300	0	45.1
	2016	5,000	7,300	10,300	7,300	29,800	1,500	1,900	-400	0	47.8
	2021	4,600	7,000	9,800	8,000	29,300	1,400	2,000	-500	0	50.4
	2026	4,300	6,400	9,000	8,800	28,600	1,400	2,100	-700	0	52.4
Kapiti Coast District	2001	9,200	11,200	13,600	9,600	43,600	...	...	...	...	42.3
	2006	9,100	12,100	15,800	10,700	47,700	2,400	2,400	0	4,000	43.7
	2011	8,900	12,400	17,500	11,800	50,500	2,400	2,600	-100	3,000	45.8
	2016	8,900	12,600	18,400	13,400	53,200	2,400	2,800	-300	3,000	47.6
	2021	9,000	12,900	19,000	14,900	55,800	2,500	2,900	-400	3,000	49.1
	2026	9,100	13,300	19,000	16,800	58,200	2,600	3,100	-500	3,000	50.3

## 8. APPENDIX 5 - OCCUPANCY LEVELS

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Service Category	Territorial Local Authority (TLA)	February 06	March 06	April 06	Average Feb - April
Dementia	Horowhenua/Otaki	88%	88%	87%	88%
	Manawatu	75%	73%	75%	75%
	Palmerston North	85%	79%	79%	81%
	Tararua	100%	97%	100%	99%
	MidCentral total	87%	84%	85%	86%
Continuing Care	Horowhenua/Otaki	61%	63%	62%	62%
	Manawatu	74%	76%	73%	74%
	Palmerston North	91%	94%	94%	93%
	Tararua	86%	87%	86%	86%
	MidCentral Total	78%	80%	79%	79%
Rest home	Horowhenua/Otaki	54%	54%	54%	54%
	Manawatu	61%	62%	62%	62%
	Palmerston North	57%	56%	55%	58%
	Tararua	65%	66%	62%	64%
	MidCentral Total	59%	60%	58%	59%
PGCC	MidCentral Total	92%	88%	84%	88%

**NB** – This occupancy data is restricted to those subsidised residents in contracted beds within MidCentral DHB, we have no way of ascertaining the number of private residents in facilities who may or may not occupy a subsidised bed. Therefore this information needs to be used an indicative rather than exact.