Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
carolyn.gullery@cdhb.health.nz

22 February 2019

[redacted]

[redacted]

[redacted]

RE Official information request CDHB 10012 and WCDHB 9265

I refer to your email dated 8 January 2019, requesting the following information under the Official Information Act from Canterbury DHB and West Coast DHB regarding:

- **Details of any issues-based audits or investigations into mental health services in your DHB area carried out, commissioned or provided to the DHB for the past four years (2015-2018). Please provide the name of the service and the year it was audited, a copy of the original complaint (or whatever sparked the investigation) a copy of the completed audit and any follow up reports.**

Canterbury DHB works with contracted providers of mental health services to ensure there is a vibrant sustainable system of care that works in an integrated way with Specialist Mental Health Services. Concerns about performance, sustainability etc can arise in a variety of ways and in general our first response is to engage closely with the organisation and provide support while gaining assurance regarding safety of service users.

Issues based audits are an option when other mechanisms have failed to achieve the desired response. There have been two such audits of mental health services in Canterbury since 2015 as follows: (reports attached as appendix one and two):

- Te Awa O Te Ora Trust – 2015
- Pacific Trust Canterbury – 2016

These organisations were audited after a range of concerns about practice and sustainability from service users, families, other mental health providers and the general public were made informally and support did not address the issues of concern.

In addition to the above, an independent audit of CDHB's ATR services was proactively commissioned by the board to provide an independent assessment of risks in AT&R, with a specific focus on reducing the

injury rate to staff. The board initiated the review based on information it was receiving routinely through accountability reporting to HAC and QFARC by SMHS and P&C (attached as appendix three).

There were two other audits that we are declining to provide under Section 9(2)(a) of the Official Information Act i.e. to protect the privacy of natural persons, including those deceased, as they refer to specific clients.

If you disagree with our decision to withhold information you may, under section 28(3) of the Official Information Act, seek an investigation and review of our decision from the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

MINISTRY OF HEALTH
MANATŪ HAUORA

Final Audit Report

Financial and Claims Audit

Te Awa o Te Ora Trust

483 Tuam Street
Phillipstown
Christchurch

NATIONAL HEALTH BOARD
POARI HAUORA Ā-MOTU

Contents

Appendices

1. Auditee Response to draft audit report
2. Canterbury DHB FTEs October 2013 to September 2014
3. Canterbury DHB FTEs October 2014 to December 2014
4. Accountants allocations of FTE deployment
5. Like Minds Like Mine Expenses April to December 2014

Appendices 2 to 5 are Excel Spreadsheets these were provided separately to this report due to the size of those documents.

Executive Summary

The Ministry of Health and the Canterbury District Health Board requested that Audit and Compliance conduct a financial and claims audit of Te Awa O Te Ora Trust (the Trust) under Section 22G of the Health Act 1956 and the terms of the service agreements.

In summary, we found the Trust had:

- a dysfunctional Board which contributed to the resignation of Board members and the Patron
- a significant and serious employment issue as nine staff employed by the Trust have lodged a collective grievance through their union
- a poor working relationship between the current Board and Management
- dissatisfied tangata whai ora
- a solvent position as at 31 December 2014 but monthly deficits have resulted in a significant deterioration in the Trust's current assets
- historically poor internal controls in respect of the use of the now cancelled credit card
- sale of a motor vehicle that was not in the asset register and the proceeds of the sale was miscoded
- unreconciled petty expenditure of $338.09
- failed to have the required number of FTEs to deliver the Canterbury DHB Mental Health services, resulting in an over-payment of $109,639.75
- failed to have sufficient staff to deliver the Ministry of Health Like Minds Like Mine (LMLM) contract
- reported budget expenditure for LMLM that did not align with the reporting periods
- had an estimated surplus of $42,500 from the LMLM service

Auditee Response – Use of Information

A copy of Te Awa O Te Ora Trust's response to our draft findings is attached as Appendix 1 and should be read in its entirety along with this report. Any variations to our draft findings are a result of the response or further discussion with the Trust.
In summary, the Trust responded to key issues as follows:

The Te Awa Board (the Board) did not consider that the auditors could use the disclaimer in its audit report (refer page 3) to rely on unverified information to support and make conclusions. In particular, the Board requested that the auditors not rely on management reports for the period November 2014 to January 2015 as the Board has not confirmed them as true and correct. The Board also requested that Ron Mark and Henare Edwards not be interviewed as they were not Board members and had no voting rights.

The Board issued Audit and Compliance with an email request dated 9 April 2015 to provide the names of staff and any other persons interviewed during the course of the audit.

We are under no obligation to disclose the names of any person/s that we interviewed or carried out discussions with during the course of the audit. Any persons interviewed were involved in carrying out the duties of the Trust.

Auditor Comment

We refer the Board to clause B15 of its agreement which states:

B15 Access for Audit

B15.1 You and your sub-contractors must co-operate with us fully and allow us, or our authorised agents access to:

a)…

b)…

c) Service Users and their families

d) staff, sub-contractors or other personnel used by you in providing the Services

For the purposes of and during the course of carrying out the Audit.

We have attempted to verify all information received during the course of the audit. Where we have not been able to do so this is stated in the report. We note that some of the information supplied to us by the Trust itself was incomplete, for example Board minutes that were unsigned and undated or, in the case of the minutes for the meeting held on 26 November 2014, signed on two different dates.

Auditee Response-Financial Position

BDO (Chartered Accountants) on behalf of the Board did not agree with our findings in respect of the deterioration in the Trust's financial position as it considered it was in a surplus position from November 2014 to February 2015.

Auditor Response

BDO did not provide any evidence of the surplus. Documentation provided to us during the course of the audit show that a small surplus was achieved in November 2014 but deficits were incurred in all other months from March 2014 to December 2014.

Introduction

Audit Clients:	Ministry of Health Canterbury District Health Board
Auditee:	Te Awa O Te Ora Trust
Audit:	Financial and Claims Audit
Audit Period:	1 July 2012 to 31 January 2015

The Ministry of Health and the Canterbury District Health Board (Canterbury DHB) requested that Audit and Compliance conduct an audit of Te Awa O Te Ora Trust (the Trust) under Section 22G of the Health Act 1956 and the terms of the service agreements.

The Trust was contracted with the Ministry of Health to provide a Like Minds Like Mine (LMLM) service and it was contracted by the Canterbury DHB to provide Mental Health Community Support Services.

The Trust received $220,000 of funding from the Ministry of Health and $1.5 million from the Canterbury DHB during the audit period.

Scope

This report is written on an exception basis. Only summary information is provided unless there are areas of non-compliance or concern.

This audit was conducted as part of the Audit and Compliance assurance programme. This programme focuses on specific financially related matters.

This audit does not purport to review all aspects of service provision. This report details those exceptions or contractually non-compliant matters identified by this audit, but this is not a representation that other matters are contractually compliant.

This audit was performed with all reasonable care but is based upon information provided to Audit and Compliance by the public health service provider. Unless specifically stated, this information was not verified or validated by reference to independent sources.

On 11 February 2015 we visited the Trust at its office situated at 483 Tuam Street, Phillipstown, Christchurch.

Unless otherwise stated, all amounts in this report are GST exclusive.

Nature of Audit

The audit covered the governance, routine financial activities and claims of the Trust to ascertain whether:

- key contractual obligations were being fulfilled,
- the Trust was solvent and viable, and
- financial practices were sound.

In regard to the provision of the Full Time Equivalent (FTE) employees the primary focus of the audit work undertaken was a review of the provider's payroll hours, to

ensure that contracted FTE staff members were employed by the Trust to deliver the agreed services.

Relevant Contractual Provisions

The following contractual provisions are particularly relevant to the findings presented in this report.

Canterbury DHB agreements 320691/00 and 346089/00 stated

B5 Provision of Services

B5.1 You must provide the Services and conduct your practice or business:

a. in a prompt, efficient, professional and ethical manner; and
b. in accordance with all relevant published Strategies issued under the Act and
c. in accordance with Our obligations, and
d. in accordance with all relevant Law; and
e. from the Commencement Date and then without interruption until the Agreement ends or is ended in accordance with the Agreement

B13 Information and Reports

B13.1 You must comply with the information requirements set out in the Agreement

B13.2 you must keep and preserve Records and protect the security of them and make them available to us in accordance with our reasonable instructions

B13.3 …

B13.4 you must keep proper business records and promptly complete a balance sheet, statement of income and expenditure and cashflows in accordance with accepted accountancy principles at the end of each financial year.

Agreement 320691/00 also contained the following clause:

9 Financial Management and Audit

Service providers must maintain and operate sound financial and management systems with appropriate recording and auditing arrangements consistent with recognised best practice.

Service providers must be able to track and report on the volume of services provided, the revenue received and expenditure incurred in providing the services against each purchase unit according to definition. Notwithstanding any clause in the Agreement to the contrary, the Ministry of Health may review any records relating to the volume of mental health services provided and/or the revenue received and/or the expenditure incurred in providing the services. These records must be available for review upon the Ministry's reasonable request. The review of these records may include site visits by the Ministry and/or its authorised agent.

The Ministry of Health agreements 337733/00 and 350647/00 stated:

5 Provision of Services

5.1 You must provide the Services and conduct your practice or business in a prompt, efficient, professional and ethical manner and in accordance with:

- …
- …
- All relevant Law

5.2 You will use funding under this agreement exclusively for delivery of the specified Services, and will not knowingly use funding under this agreement to fund other health services which have separate funding streams.

6 Payments

6.1 We will pay you in accordance with the payment schedule set out in the Provider Specific Terms and Conditions for the delivery of the Services specified in any service specification attached to this agreement

6.2 You agree that all funding provided by us will only be applied to the delivery of the Services specified in the relevant service specification

6.3 Where funding is provided in advance of the delivery of the Services, and those Services are not delivered in accordance with the service specification, you will:

a. with our agreement, reinvest any operating surplus in the delivery of other public health services; or
b. repay the operating surplus to us.

6.4 Where all Services for the financial year have been delivered in accordance with the relevant service specification and an operating surplus exists at the end of any financial year during the term of this agreement, you will:

a. with our agreement, reinvest that operating surplus in the delivery of other public health services; or
b. repay the operating surplus to us.

11 Information and Reports

You must

11.1 keep secure accurate records of the performance by you and your employees, agents and advisors of this agreement (Records) and make them available to us in accordance with our reasonable instructions

11.2 keep proper business records and promptly complete a balance sheet, statement of income and expenditure and cashflows in accordance with accepted accountancy principles at the end of each financial year and

11.3 report to us on the performance of this agreement in accordance with our reasonable instructions and if requested by us send reports directly to any Minister of the Crown or any governmental body in the manner we specify.

Findings

Status and Size

The Trust was a properly registered charity.

Findings

The Trust was incorporated under the Companies Act 1993 on 8 September 1999 under number 980147.

Charitable status

The Trust was registered as a charity from 30 June 2008 under number CC32904, as a registered charity it is not liable for income tax.

The Trust was GST registered.

Size

At the time of our site visit, the Trust had a total of eight full-time and three part-time employees.

Governance

The governance of the Trust deteriorated due to personal conflict between the Trustees and as a result the Board had failed to fully address the monthly financial deficits.

Findings

The Deed of Trust (rules) stated at clause 6.1

> 6.1 The Board will comprise of no less than three (3) Trustees and no more than nine (9) Trustees.

The Board had a policy of assigning portfolios of responsibility to individual Board members.

During the audit period the Board was comprised of the following Trustees and affiliated persons:

Table 1: Trustees and Affiliated Persons

Name	Position	Appointed	Resigned
Ron Mark	Patron (non-executive)	01/06/2012	27/01/2015
Henare Edwards (HE)	Kahui Kaumatua (non-executive)	01/04/2014	27/01/2015
Melanie Mark-Shadbolt (MMS)	Executive Director/Secretary/ HR Porfolio	25/02/2009	27/01/2015
Simon Hearsey (SH)	Finance and Risk	27/03/2014	27/01/2015
Peter Wylie	Legal	29/06/2011	31/07/2014
Iwingaro Neate	Cultural	25/06/2008	27/03/2014
John Clink	Treasurer/Financial	17/12/2009	27/03/2014
Angelia Ria (AR)	Chair/Quality & Risk/Contracts(Projects: Social Enterprise & Rongoa)interim Board Secretary	25/06/2008	
Alan Spicer (AS)	Chair Board meetings/ Tangata Whai ora (Projects Health & Safety and IT)	30/05/2012	
Whiora Horona (WH)	Tangata Whai ora Representation (Projects Rongoa & Respite)	26/11/2014	

The minutes of the Board meeting held on 28 January 2015 contain a decision by the Board (AR, AS and WH) that while it was recruiting for new members, AS would assume a co-Chair's role with AR and chair meetings.

Annual General Meeting

The Annual General Meeting (AGM) for the Trust was advertised as a Board only meeting in the classified section of the Christchurch Press on 25 August 2014.

The AGM was to be held at 7 pm on 2 September 2014. The Board minutes of this meeting were provided with the response to the draft audit report, but were unsigned. Recorded attendees were: AR, SH, AS and HE (Kaumatua).

The current Officers, including MMS, were reappointed to the Board at this meeting although vacancies on the Board remained after J Clink and P Wylie had resigned (Cultural and Treasurer).

An earlier meeting held at 6 pm on the same date (minutes were signed) had a verbal presentation of the Managers report by the Chair (AR) as the Executive Director was absent.

In that meeting the Board altered wording in the Trust deeds and agreed unanimously that no staff members could be Board members.

Board Minutes
We noted that some Board minutes were not signed or dated by the Chair.

We also noted the interest register did not disclose close familial relationships between Trustees and members of the staff.

Special Board Meeting 25 January 2015
A special Board meeting was held on 25 January 2015. Present were AR, WH and AS. Prior to this meeting the Executive Director was asked to stand down from the Board. The reason given was the ongoing conflict between AR and MMS.

On 28 January 2015 a scheduled Board meeting was held. By that date the Patron (RM), the Kahui Kaumatua (HE), Secretary (MMS) and Finance and Risk (SH) portfolio holders are recorded on the Charities Register as having resigned.

Resignations
We obtained information on the resignations of the Trustees. It was apparent they were aware of the personal and professional breakdown in the relationship between the Chair and the Executive Director and that the conflict influenced their decision to resign.

Appointment of New Trustees
The appointment of WH followed due process as she was appointed as a whanau representative by tangata whai ora in a meeting held on 29 September 2014.

The Co-Chair had advised that three new Trustees were to be appointed in February 2015. The positions to be filled were:

- Human Resource (HR) (as a line Manager for the Acting Manager) and Lease and Property acquisition (appointed 3 February 2015).
- Clinical
- Legal.

The Trust had advertised in the Institute of Directors for new Board members. The HR Trustee was recruited by AR and was a previous manager of the Trust.

Strategic Direction
The Board held a strategic plan planning day on 12 December 2014. The Chair explained that this would not be a static document, as it was the intention of the Trustees to adapt to change, identify opportunities and risks and address those where needed.

Financial Management

BDO presented monthly financial reports to the Board that contained the following:

- comparisons of actual costs to budget each month and year to date (YTD)
- profit and loss forecast
- monthly overhead comparisons
- movement in equity
- a summarised balance sheet
- cash flow statement
- holiday pay report.

Any variances were accompanied with a short explanation.

On 29 May 2013 the Board set the Kaiwhakahaere expenditure limit of $2,500 per transaction with a monthly cap of $2,500. The cap could be exceeded by Board approval; this could be agreed by email.

On 8 May 2014, the Executive Director approved a payment of $6,834.80 for the purchase of software for document scanning and folder indexing and document destruction. There was no record of Board approval for this expense.

The Finance and Risk Trustee approved the purchase of a vehicle by email in June 2014.

It did not appear that BDO were involved in decision making regarding the purchase of assets or the increase in overheads (due to restructure and appointment of co-Managers, a Personal Assistant and an Administration employee).

On 2 September 2014 the Board stated in its minutes that the overheads needed to be bought strictly under control and the budget required adjustment. BDO met with the Chair at the end of September 2014 to discuss the consistent monthly deficits.

The Chair sent an email dated 7 October 2014 to other Board members stating that the projected annual deficit was $57,000. The email also contained a proposal for cost cutting measures.

We consider that the operating expenses continued to exceed budget and only minor changes were achieved in reducing expenditure as evidenced by the increase in the forecast deficit to 31 March 2015 to $72,715.

BDO in its response to the draft audit report considered that the Board had taken significant steps to address the deficit and put in control measures to stop sundry spending on the credit card and petty cash. It stated that the Trust was back in monthly surplus by January 2015 and the Accountant considered this was an exceptionally fast turn-around.

The Accountant acknowledged the fact that the Trust is under FTE's (refer to page 20 of this report) and therefore the surpluses are somewhat inflated, but claim that even taking that into consideration the Trust would still be in a surplus position for the period November 2014 to February 2015.

BDO did not provide any documentation to support its claim of a significant turnaround or a surplus position. We acknowledge there was a surplus made in November 2014 but note that another deficit was incurred in December 2014.
Our review of the profit and loss statements provided at the time of the audit showed the following:

Table 2: Profit and Loss statements

Month	Operating Profit/Loss YTD Actual (before depreciation)	Derived Monthly Result
31-Jan-14	$67,499.00	
28-Feb-14	$81,365.00	$13,866
31-Mar-14	$76,805.00	-$ 4,560
31-May-14	-$16,878.00	-$93,683
31-Jul-14	-$27,164.00	-$10,286
31-Aug-14	-$35,709.00	-$ 8,545
30-Sep-14	-$43,704.00	-$ 7,995
31-Oct-14	-$54,623.00	-$10,919
30-Nov-14	-$47,320.00	$ 7,303
31-Dec-14	-$48,844.00	-$ 1,524

The deficit led to a deterioration in the Trust's current assets in the nine months to 31 December 2014 (refer to Table 3 of this report).

Governance vs Operations
The relationship between the Chair (AR) and Executive Director (MMS) deteriorated during the period of co-managing the Trust and, as discussed at page 12 of this report, the relationship with the Board and current management and staff is strained, possibly as a result of that tension.

Conclusion

We consider that the decision to combine Board and management roles contributed to the failure to address the increase in the Trust deficit, as time that should have been spent to curb Trust spending was diverted by tensions within the organisation.

Auditee Response

The Board did not consider it abnormal for Trustees to resign at the same time. It considered the resignation of Ron Mark and Simon Hearsey were not unexpected and have mentioned the personal relationship between MMS and the Patron and a (unsubstantiated) professional relationship between MMS and SH as a reason for those resignations.

The Board do not and never had an investment manager's portfolio combined with finance or otherwise.

Auditor Response

The Board did not advise Audit and Compliance of the resignation or removal from the Board of the Kahui Kaumatua and it was not recorded in the minutes of the Board meeting held on 28 January 2015, although the other resignations (RM, SH and MMS) were.

The resignation of the Kahui Kaumatua was identified by Audit and Compliance from the Charities Register.

The minutes of the Board meeting held on 27 March 2014 welcome SH to the Board and state that SH will take on the Finance and Investment portfolio(s). The change to Finance and Risk portfolio(s) was confirmed at the AGM.

Management of the Trust

The relationship between Management and the Board of the Trust was extremely poor and has contributed to a high level of anxiety by the current staff regarding the operation of the Trust.

Nine staff lodged personal grievances with their Union on 5 March 2015.

Findings

Background

In July 2013 it was proposed to the Board by the Executive Director that a restructure should take place of the Trust management and staff configuration.
Staff were monitored and evaluated over the previous three months and the evaluation concluded there were behavioural problems that needed to be addressed.
It recommended the Board:

(i) Approve the restructure of all staff positions within the Trust
(ii) Appoint a Manager.

There were three options for a managerial appointment. These were:

1. Future focused Manager (experienced and qualified)
2. Replace the Kaiwhakahaere
3. Promote from within placing an existing staff member in the position of Day Manager, who would be responsible for the day to day running of the Trust especially the monitoring and management of staff/contractors.

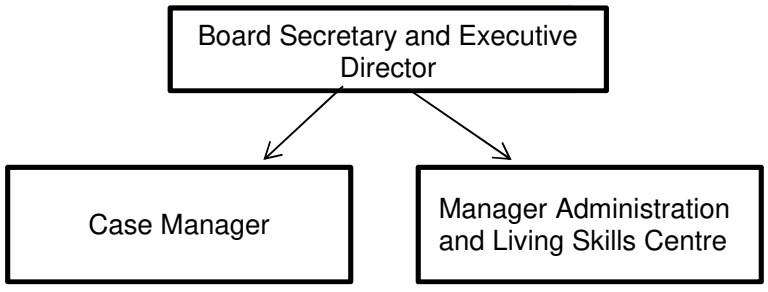
A restructure announcement was made to staff on 19 December 2013. The staff were advised the model included a Manager, Case Manager and a pool of mental health workers.

To manage the restructure the Executive Director (and Trustee) stood down from the Board until her reinstatement as a Trustee on 26 February 2014.

The Trust failed to find a suitable candidate to appoint as the Manager. At the Board meeting of 26 February 2014 it was decided either Te Awa Management Services Ltd (TAMs) or the Chair or current Executive Director take on the management of the Trust for the period of March to September 2014. The Board extended this term to the end of October 2014.

Management Structure

The management structure of the Trust from March 2014 was:



Our review of contracting costs showed that the role of Executive Director was shared with the Chair of the Board who was charging the Trust for "co-managing Te Awa O Te Ora."

The Board minutes do not contain any record that the Chair received approval to co-manage the Trust.

Both the Chair and the Executive Director charged the Trust for 25 hours per week and each approved the payment for the other.

There is no record of what the areas of responsibility were in this co-share arrangement and we are reliant on AR's explanation that she carried out activities at the discretion of MMS.

The Board minutes of 29 October 2014 stated the position of Executive Director was to be disestablished on the appointment of a Day Manager. The Manager Administration and Livings Skills was interviewed by the Chair and Executive Director and was appointed as Day Manager on a fixed term contract, commencing on 3 November 2014 and ending on 31 March 2015.

Staffing Issues

At the time of our site visit the co-Chairs both expressed dissatisfaction with the current Day Manager. It was claimed her appointment solely came about as she was the "highest paid" member of staff at that time.

We observed that there was a poor relationship between the current Day Manager and the Board co-Chairs.

We became aware of tensions during the course of the audit between the Board and staff and were advised on 5 March 2015 that nine staff (including the Day Manager) employed by the Trust lodged personal grievances with the National Union of Public Employees (NUPE). We have sighted correspondence dated 5 March 2015 that confirmed the lodging of the grievances related to staff safety with accusations of alleged intimidation and bullying by the Chair (AR).

Tangata Whai ora

The Chair (AR), in a meeting with a whanau group on 23 January 2015, discussed the impact that negative comments to which whanau had admitted to making about the Trust could be misused by others against the organisation.

In a special meeting held by the Board on 25 January 2015 it was reported that whanau members were concerned about the recruitment of non-qualified staff, as there was only 20 percent of qualified staff in comparison to a ratio of 90 percent qualified staff from the previous year.

Conclusions

We consider that the lack of clear parameters around the roles of the co-managers may have contributed to their subsequent relationship breakdown and it diverted the parties away from providing a unified approach in guiding the new model of service delivery.

The current poor relationship between the Board and the Day Manager has led to a high level of anxiety in the staff about the operation of the Trust. The consequence of these issues is a discontented workforce and tangata whai ora.

We further concluded that unless these matters are addressed immediately it is likely that service delivery may falter.

Recommendation

We recommend that a suitably qualified third party be approached to address the Board and Management relationship issues and act as a guide to the Trust to ensure that staff have the appropriate support to continue to deliver the service for which they are contracted.

Auditee Response

AR as Teota Ltd reported to MMS (Mai Manawa Ltd) and completed back office functions as directed. AR did not co-manage the Trust nor was she involved in the recruitment of staff as stated in the draft audit report.

The Board provided an email dated 29 October 2014 outlining concerns with the appointment of the Day Manager and (allude to) a personal relationship between the appointee and MMS.

The auditors have relied on unverified information and refused to disclose the source stating that nine personal grievances have been lodged by staff with their union. At the date of the draft report (10 March 2015), the Board had not received any personal grievances.

The Board acknowledged there are employment problems and have made three separate attempts to enable staff concerns to be addressed by the Board.

Auditor Response

We have relied on the information provided by Te Awa staff and the Board during the course of the audit for our conclusions about the management of the Trust.

Solvency

The Trust was solvent at 31 December 2014. However, the financial position of the Trust had deteriorated during the last 12 months, and if the Trust had employed the contracted number of FTEs to deliver services this deterioration would have been even more significant.

Findings

We used the Companies Act 1993 solvency test as the basis of consideration of the Trust's solvency. Under this definition, an entity passes the solvency test if:

- it is able to pay its debts as they become due in the normal course of business, and
- the value of its assets is greater than the value of its liabilities, including contingent liabilities.

The Trust's financial year is from 1 April to 31 March each year.

We obtained copies of the financial reports from the Charities Register. These reports showed the following:

Table 3: Financial position

	2011	2012	2013	2014
Revenue	605,806	657,460	601,494	744,506
Surplus/Deficit before Depreciation	61,236	46,851	83,543	74,710
Net Profit/Loss	51,228	36,696	73,599	54,852
Total Current Assets	223,803	272,489	302,675	341,911
Total Current Liabilities	60,663	92,378	51,039	56,257
Net Assets	187,498	227,194	300,793	355,645

At 31 December 2014 the financial position of the Trust was:

Table 4: Financial position to 31 December 2014

	31 December 2014
Total Current Assets	287,518
Total Current Liabilities	66,443
Net Assets	290,115

Current assets have declined by $54,393 in the six months from 1 April 2014.

Hilson Fagerlund Keyes issued its independent audit report for the 2014 financial year on the 26 November 2014. It considered the financial statements complied with generally accepted accounting practice in New Zealand and presented fairly, in all material respects, the financial position of the Trust.

The Management letter raised some concerns regarding a weakness in the internal controls of the petty cash and the remittance advices not being stored with the creditors' documentation.

Conclusion

The Trust was solvent at 31 December 2014. However, there was deterioration in the financial position of the Trust during the past 12 months.

We consider that if the Trust had employed the contracted number of FTEs (see page 20) then this reduction in current assets would have been more significant.

Auditee Response

The Board believes that the Trust was “significantly solvent”. It is the Board’s position that the surpluses posted for the 2011-2014 years have in part drawn attention from funders but that the surpluses are not related to the non-fulfilment of contractual obligations.

Credit Cards and Finances

The Trust had poor internal and management controls in respect of the use of the Westpac MasterCard and the failure by the Trust to ensure all assets were recorded and accounted for.
There is insufficient evidence to conclude that the amount of $338.09 from unreconciled petty cash was used for other than Trust purposes.

Background

The CentralTAS audit report dated October 2014 raised concerns in regard to the use of a Westpac credit card in the name of Miss A H Jones, which was paid in full each month by the Trust. Among the concerns were that the Trust withdrew cash from the card for petty cash purposes and that at the time of that audit, the auditors were unable to reconcile the cash withdrawals on the credit card to the money receipted as petty cash.

Findings

Until 1 September 2014 there was no written business expenditure policy in regard to the use of the credit card. At that date the policy in respect of petty expenditure was updated.

Petty Cash

The petty cash policy prior to 1 September 2014 required the retention of receipts and a reconciliation of the expenditure. The purchases were to be undertaken by the Kaitari and these were to be signed off by the Kaiwhakahaere. Petty cash was to be expended on items such as milk, papers and household items.

Our review identified that purchases were not restricted to household items but included cash paid for cleaning services, vehicle registration, the purchase of a camera and case, and a warrant of fitness.

From 1 September 2014 the petty cash was to be managed by the Administration Manager and used for sundry items that could not be purchased on invoice or account.

Reconciliation

In October 2014 the Trust requested that BDO carry out a reconciliation of the petty cash and cash withdrawals. We were provided with a copy of this reconciliation.

From July 2013 to June 2014 there was $12,592 in cash withdrawals from the credit card attributed to petty cash. Of that amount, BDO identified a total of $338.09 that could not be reconciled between cash withdrawals and the petty cash records.

We were provided with invoices and receipts from April 2013 to March 2014. Up to March 2014, receipts were kept along with a handwritten petty cash record, showing the amounts withdrawn from the credit card and explanations for the amounts expended.

There were some missing receipts and reliance was placed on the explanations provided by the person who kept the manual record for the expenditure.

Excel spreadsheets were prepared for the petty cash up to 10 February 2015. A description of the reasons for the expenditure and the amount is included in these reports.

There was insufficient evidence to conclude that the unreconciled petty cash was used for other than Trust purposes.

Credit cards
The Chair of the Trust advised that the Board commenced corrective action in respect of the use of the credit card on 3 October 2014. The card was cancelled at the end of October 2014 as instructed to the Day Manager, by the Trustee portfolio holder for Finance and Risk.

We were informed that the card was used by several people and our review confirmed this was the case as we identified the Chair, Executive Director and Personal Assistant all had access to the card.

We carried out a review of other transactions on the credit card.

We identified that the credit card was used to pay for ferry and air travel on behalf of the Patron. The Trust was reimbursed for some of that expenditure, and at the time of the audit there was an outstanding balance of $1097.90 that was invoiced to the ex-Patron of the Trust in March 2015.

We were provided with receipts and invoices for expenses charged to the credit card from April 2013 to March 2014.

However, this information was not provided for the period after March 2014 although we made numerous requests for the receipts and invoices relating to the individual transactions made on the credit card up to the date the card was cancelled.

We were provided with some invoices; however this did not include the credit card transactions. A USB with “scanned docs” was also provided but none of these scanned documents were current and were not relevant to credit card charges.

Sale of a Motor Vehicle
Board minutes record the decision to dispose of two motor vehicles - a Nissan and Daihatsu. Our review of the asset register noted that the Daihatsu was not recorded as an asset of the Trust, although expenditure had been incurred for petrol and maintenance.

Board minutes dated 28 May 2014 record that two vehicles were sold. The Nissan was sold to an employee who paid for the vehicle through deductions to her wages.
We were informed by the Chair that the Daihatsu was sold to a family member of an employee for $250. BDO have advised that the payment for the vehicle was received by the Trust but had been miscoded.

Conclusion

There was little control over the use and access to the credit card and this failure must be attributed to poor management practice.

Due to a lack of records post March 2014 there is no evidence that credit card use was reviewed by the Co-Managers, until the Trust instructed its accountants to carry out a reconciliation of the petty cash.

We consider that the failure to record the Daihatsu as an asset and then the lack of controls in regard to ensuring the payment for the sale of vehicle was accounted for correctly is further evidence of poor internal controls by management.

Auditee Response

The Daihatsu was purchased by the Trust pre-2007. At that time record keeping and accounting for the Trust was not of a high standard. When the car was purchased, accounting controls were not in place to record the car as an asset. Therefore the car has never been on the asset register of the Trust.

BDO was reliant on the Manager at the time to provide adequate summaries and documentation in relation to petty cash expenditure. From November 2013 onwards BDO was receiving sporadic, inaccurate and late information in relation to the petty cash reconciliation.

On being made aware of the petty cash issues the Board instructed BDO to undertake a petty cash reconciliation. BDO advised the unreconciled balance for the petty cash is now $338.09 which is at the low end of materiality

The Trust now has accounts with specific suppliers with policies around who can obtain goods and services. It had also ordered a cheque book for petty cash and other sundry expenses. The cheque signatories will be two BDO personnel.

Canterbury DHB: FTEs Mental Health Services FTEs

The Trust failed to engage the required number of FTEs from 30 September 2013 to 21 December 2014. As a result the Trust over-claimed and was over-paid a total of $109,639.75.

Background

Agreement 320691/05 (and variations) commenced on 1 October 2013 and required the Trust to engage the following volume of FTEs:

Table 5: FTE volumes 1 October 2013 to 30 September 2014

Purchase Unit	FTE Volume
MHA21D Kaupapa Maori MH Day Activity	2
MHA20D Community Support Worker	3.5
MHA20F Peer Support Service	2

Agreement 340689/00 (and variations) commenced on 1 April 2013 to 30 September 2014 and required the Trust to engage the following:

Table 6: FTE volume 1 April 2013 to 30 September 2014

Purchase Unit	FTE Volume
MHA20D Community Support worker	1

Table 7: Agreement 320691/06 FTE Volumes 1 October 2014 to 30 September 2015

Purchase Unit	FTE Volume
MHA21D Kaupapa Maori MH Day Activity	2
MHA20D Community Support Worker	3.5
MHA20F Peer Support Service	2
MHA20D Community Support Worker -Earthquake	1

The Nationwide Service Specification – Mental Health Services defined an FTE as a full time equivalent employee who worked for 40 hours per week.

We obtained the MYOB payroll hours for all employees identified by the Trust who had worked in the Mental Health services. These hours were compared to the total hours required to be delivered, hours included all leave (excluding leave without pay, redundancy, extended special leave or ACC hours). We also obtained employment contracts for some staff to confirm their dates of employment and their position in the Trust.

Findings

MYOB Payroll vs MYOB General Ledger

We questioned BDO how the payroll payments recorded in the 2014 financial reports tie in with the wages recorded in the MYOB payroll system. We were advised the payroll breakdown report provided that information. We relied on this advice to arrive at the allocation of staff across the service lines. However, when we attempted to match the payroll breakdown report to the MYOB general ledger we identified that some wages were reallocated across different service lines. We did not consider this

changed our findings as the total hours of availability were not altered in respect of the combined services.

Amended Hours
BDO provided amended hours as part of its response to the draft audit report. Those hours were taken from timesheets that included all staff and their total hours per week excluding time spent in operation activities. Staff hours were spread across several service lines.

It had also included hours for leave without pay and had not allocated or allowed for annual leave that was paid out at the termination of the employees who had lost their positions as a result of the restructure.

We have concurred with the inclusion of one additional staff member who had originally been employed and continued to be paid until her termination in February 2014 under the cost centre for Community Intergrated (sic) (this contract ceased in June 2013).

BDO had not included the hours contributed by the Kahui Kaumatua or Paepae Matua. We consider these positions in a Kaupapa Maori organisation related to service delivery so have included those hours in the service provision calculation.

Hours allocated to Operation Activities
We compared the hours recorded on the timesheet provided by BDO to the employment agreements signed by the staff. We considered that the hours allocated in total (see Appendix 4) did not reflect the employment agreements signed by the administration/management staff in the following instances.

- Ann Jang was employed by the Trust on 22 July 2013 as Day Manager and Peer Support Advocate. The role required her to manage the day to day running of the Trust, staff management, finance and information. This role was to cease in November 2013, however a letter to staff on 17 January 2014 referred to Ms Jang as the Acting Manager.
- Monica Miller was employed by the Trust on 31 March 2014. She had dual roles as Kaiawhina Tari Office Administrator with responsibility to provide office and clerical services. The position description stated that she was also responsible for the administration (management when directed) of the day activities programme and to work closely with the Kaitawhai Tangata Case Manager to support the administration of client/whanau files.
- Tamara Mark was initially employed on 27 February 2014 on a casual basis; there is no job description with that employment agreement. On the 12 May 2014 she entered into a permanent employment agreement for the role of Personal Assistant to the Tumuaki for 40 hours per week.

Ms Jang went on extended special leave from mid-August 2014, this leave was approved by the Board and we considered those hours should have been allocated to the cost of overheads and not included as FTE hours for service delivery.

According to the performance monitoring return filed with the Ministry of Health, four of the staff members coded to the CDHB cost centre provided the Like Minds Like Mine contracted services from 1 July 2014 to 31 December 2014. Those hours of support were not identified by BDO or the Trust and the hours for each of these individuals were included as service hours for Canterbury DHB contracts.

We considered the allocated hours calculated by BDO are not reliable as it had not taken into account the employment agreements, actual paid hours and so on.

Calculation of Hours
Based on our calculations our review considered that the Trust had a shortfall of 0.95 FTE for the pay weeks from 1 October 2013 to 30 September 2014 (as per Appendix 2).

A further shortfall of 2.21 FTEs was identified from 1 October 2014 to 31 December 2014 (as per Appendix 3).

We could not attribute the shortfall to one particular service due to the Trust combining all employees in a "CDHB" cost centre from the pay period recorded as ending on 22 June 2014.

To quantify the value of the under-provision of FTEs we have combined the total payment received by the Trust from the Canterbury DHB and applied that against the FTE shortfall. This has resulted in an overpayment for the period to 30 September 2014 of $69,349.86.

The FTE shortfall for the three months to December 2014 resulted in an overpayment of $40,289.89.

At the time of the site visit in January 2015, the Trust had engaged one FTE to the combined service and had a recorded vacancy of one further FTE. This vacancy was in addition to the vacancy that arose due to the resignation of the Whanau Case Manager.

The Trust management and Board were aware in April 2014 that the Trust did not have sufficient staff. The Board minutes from that month included a Manager's report presented by the Chair and the Executive Director which stated the Trust needed a pool of casual staff and it intended to hold off hiring new "CSW's" at present.

Conclusion

We concluded that the Trust did not engage the required number of FTEs required by Canterbury DHB to deliver the mental health services.

Recommendation

We recommend the Trust discusses with Canterbury DHB whether or not Canterbury DHB will accept special leave hours as service delivery hours.

We further recommend that Canterbury DHB recovers the over-payment of $109,639.75 that arose due to a shortfall in the number of FTEs required to provide the Mental Health services.

Auditee Response

The Board are now cognisant of the fact that masking via reporting to the Board was occurring at least since 1 April 2013 and have taken immediate steps to rectify the situation. The Board confirmed with the auditors at the time of the audit that the

Executive Director for the Trust was not fully compliant with Board instructions to reduce expenditure by terminating a staff member that was on sick leave and this contributed to the over-payment.

The Board also acknowledge the Executive Director failed to recruit FTEs in a timely manner as instructed to do so by the Board in September 2014.

Auditor Response

We have no record of any advice from the Board regarding the termination of the employee and the Board minutes of 26 November 2014 stated the employee in question was to return to work on 5 January and she was to be deployed into the Living Skills Centre and CSW team.

There is no record in any of the other Board minutes instructing MMS to recruit further FTEs.

An email dated 29 October 2014 provided with the response to the draft audit report refers to a proposal to engage three further FTE, but the proposal is not provided and no dates are given.

A December 2014 task list for the Board show that recruitment was the responsibility of MMS/Day Manager and AR, the status had a question mark alongside the first two names with a date alongside AR narrated “27.1.2015 Seek”.

Ministry of Health: Like Minds Like Mine

From 1 July 2014 the Trust did not have a dedicated employee to deliver LMLM services. The six month financial report submitted to 31 December 2014, included expenditure incurred prior to June 2014 as the financial reporting did not align with the Ministry of Health reporting requirements.

Some of the delivered services in the performance monitoring report for the period June 2014 to December 2014 were also funded by the Canterbury DHB.

We recommend the Ministry of Health recover $42,500 from the Trust.

Background

Agreements 337733/00 and 350647/00 required the Trust to report actual staffing levels and actual expenditure for the LMLM service. This service ceased on 31 December 2014.

Performance monitoring reports submitted for the year end 30 June 2014 were reviewed and the Trust provided a copy of the six month report to 31 December 2014. The agreement required the Trust report on the provision of services every three months for the duration of agreement 350647/00 and on the actual staffing and actual expenditure for the six month term of that agreement.

Findings

LMLM Employees

Our review of the LMLM service found that the Trust did not have any employees engaged under this contract from July 2014. The full time employee was made redundant in March 2014 and until June 2014 two employees worked in both the Canterbury DHB and LMLM services, but only 0.4 of their time was charged to the LMLM budget.

In July 2014 one of these employees was transferred to the Canterbury DHB cost centre and the other employee received her final wages as a community support worker. Refer to Appendix 4 for deployment of staff across service lines.

Service Delivery

The December 2014 LMLM performance monitoring report (PMR) identified activities undertaken by the Trust in the previous six months. We understood that of the reported activities, the gym, weaving and Te Reo classes were activities provided under the Day Activity service funded by the Canterbury DHB.

Likewise the employee identified by the Trust who delivered the LMLM service was engaged to deliver peer support services and community support services funded by Canterbury DHB.

The PMR also reported Mr A Spicer would be undertaking training and was identified as the LMLM coordinator. Mr Spicer was a Trustee of the Trust and was not recorded in the wages records for the LMLM service.

We also discussed delivery of this service with an employee who had been recorded as delivering the LMLM service. We were informed that other than attending the LMLM conference, the employee undertook "no real work" in this service.

Expenses
The Trust was required to submit six-monthly financial reports commencing from 1 June of each year.

No financial report was submitted to 30 June 2014 and the financial reports prepared for the Trust had a year end of 31 March. Therefore these did not align with the reporting requirements.

The general ledgers showed that the Trust had incurred $1,620 in direct costs that had been attributed to the LMLM contract from 1 July 2014 to 31 December 2014 (as per Appendix 5)

Indirect costs had not been allocated to the LMLM contract in the general ledgers.

Conclusion

We concluded that the model of service delivery adopted by the Trust has resulted in it being unable to separate costs associated with the delivery of the LMLM services and those provided to Canterbury DHB.

We further concluded that the Trust was unable to provide sufficient assurance that the LMLM service was being delivered over the final six months of the contract.

It is likely that based on the staff allocation to the service that there would have been a surplus to 30 June 2014. However, as the Trust failed to submit the required financial reports this could not be quantified.

Recommendation

We recommend the Ministry of Health recover, under clause 6 of the agreement, the funding paid from 1 July 2014 to 31 December 2014 of $42,500 as no services were provided during that period and we consider that the costs of $1,620 incurred during that period would have been met by any accumulated surpluses to 30 June 2014.

Email: eileen_robertson@moh.govt.nz
"If you see anything that does not seem right – Call the Health Integrity Line"
0800 424 888 (It's anonymous and it's free)

http://www.moh.govt.nz
mailto:Eileen_Robertson@moh.govt.nz

From: Angelia Ria <teota@xtra.co.nz>
To: "Eileen_Robertson@moh.govt.nz" <Eileen_Robertson@moh.govt.nz>,
Cc: "hinerau@pikimai.co.nz" <hinerau@pikimai.co.nz>, "alan@teawatrust.org.nz" <alan@teawatrust..org.nz>, "whiorahorona@hotmail.com" <whiorahorona@hotmail.com>, "blairculling@hotmail.com" <blairculling@hotmail.com>, Kate Dougherty <kmdougherty.lawyer@gmail.com>, Stephen Manning <Stephen.Manning@icfrith.co.nz>, Kristina Muller <Kristina.Muller@crownlaw.govt.nz>, "Sandy.Mclean@cdhb.health.nz" <Sandy.Mclean@cdhb.health.nz>, "graeme.mcglinn@nz.gt.com" <graeme.mcglinn@nz.gt.com>
Date: 02/04/2015 09:34 a.m.
Subject: Re: Te Awa O Te Ora response to draft audit report

Kia ora Eileen,

Thank you for your email. As you know the Board definitely intend to response to the draft report but we are of the understanding that we agreed to submit this Friday, I think we all forgot it was a public holiday.

Some issues raised in the draft report (4 March) coincidentally have been raised by Crown Law for the Attorney Generals (13 March). The Board are understandably concerned about the source of the information, given we have former Board members who seem to be disgruntled but are restricted by confidentiality agreements and the fact that the source may have been the audit.

The Board are comfortable with responding to both the audit report and Crown law but a pressing issue is the inappropriate, unwarranted and possibly defamatory suggestions made as to the capacity of two of our Board members because they are consumers of mental health services, this is an issue that we fully intend to pursue with the appropriate authority given Te Awa o Te Ora is a Peer Support organisation.

With regard to your report, we note that the narrative as opposed to technical information appears to draws conclusions from a specific time period November 2014-February 2015. Can you confirm if your team have sighted Board minutes dated 26 Nov 2014 (amended), 25 Jan 2015, 28 Jan 2015 and 3 Feb 2015 approved by the Board on 25 February. I would also like to point out that Manager's reports to the Board in from the period December 2014 to March 2015 were not accepted or approved by the Board as they were not written by the Manager but rather by Mel Mark-Shadbolt, therefore we ask that if you have relied on the Manager reports in your findings that they be disregarded.

Can you confirm that Friday is acceptable for our response and also whether your team sighted the aforementioned minutes.

With thanks

na, Angelia Ria
Chair
Te Awa o Te Ora Trust

From: "Eileen_Robertson@moh.govt.nz" <Eileen_Robertson@moh.govt.nz>
To: Angelia Ria <teota@xtra.co.nz>
Sent: Thursday, 2 April 2015 10:57 AM
Subject: Re: Te Awa O Te Ora response to draft audit report

Kia Ora Angelia,
in response to your email:

Some issues raised in the draft report (4 March) coincidentally have been raised by Crown Law for the Attorney Generals (13 March). The Board are understandably concerned about the source of the information, given we have former Board members who seem to be disgruntled but are restricted by confidentiality agreements and the fact that the source may have been the audit.

I can assure you that the draft audit report issued to the Board in our meeting on Tuesday 10 March 2015 was not provided by Audit and Compliance to Crown Law or any other individual or organisation. Nor have we provided any other information in respect of Te Awa to Crown Law.

Can you confirm if your team have sighted Board minutes dated 26 Nov 2014 (amended), 25 Jan 2015, 28 Jan 2015 and 3 Feb 2015 approved by the Board on 25 February. I would also like to point out that Manager's reports to the Board in from the period December 2014 to March 2015 were not accepted or approved by the Board

I sighted the Board Minutes for 26 November 2014, 25 January 2015 and 28 January 2015, which were the minutes provided to me. Can you please provide the minutes of 26 November to ensure that we have the "correct" version and minutes of 3 February 2015.

Can you confirm that Friday is acceptable for our response and also whether your team sighted the aforementioned minutes.

That is fine, as it is a long weekend we are quite happy for the response to be provided by 8 April 2015.

As an aside, has the Te Awa Board informed Canterbury CDHB of the contact from Crown Law? Please refer to clause B24(1)(a) of your agreement with Canterbury DHB.

Regards
Eileen Robertson
Senior Auditor
Audit and Compliance | National Health Board
Ministry of Health | PO Box 3877 | Christchurch 8140
DDI: (03) 974-2322 | Mobile: 021 496 504 |

Confidential: Te Awa O Te Ora response to draft audit report (not for distribution)
Angelia Ria
to:
Eileen_Robertson@moh.govt.nz
06/04/2015 01:36 a.m.
Cc:
"hinerau@pikimai.co.nz", "whiorahorona@hotmail.com", Kate Dougherty, "alan@teawatrust.org.nz", "blairculling@hotmail.com", Stephen Manning, Kristina Muller, "graeme.mcglinn@nz.gt.com", "Sandy.Mclean@cdhb.health.nz"
Hide Details
From: Angelia Ria <teota@xtra.co.nz> Sort List...
To: "Eileen_Robertson@moh.govt.nz" <Eileen_Robertson@moh.govt.nz>,
Cc: "hinerau@pikimai.co.nz" <hinerau@pikimai.co.nz>, "whiorahorona@hotmail.com" <whiorahorona@hotmail.com>, Kate Dougherty <kmdougherty.lawyer@gmail.com>, "alan@teawatrust.org.nz" <alan@teawatrust.org.nz>, "blairculling@hotmail.com" <blairculling@hotmail.com>, Stephen Manning <Stephen.Manning@icfrith.co.nz>, Kristina Muller <Kristina.Muller@crownlaw.govt.nz>, "graeme.mcglinn@nz.gt.com" <graeme.mcglinn@nz.gt.com>, "Sandy.Mclean@cdhb.health.nz" <Sandy.Mclean@cdhb.health.nz>
Please respond to Angelia Ria <teota@xtra.co.nz>
History: This message has been replied to and forwarded.

1 Attachment

TAOTO Board Minutes Nov-Jan MOH Auditors.pdf

Kia ora Eileen,

Thank you for your response which is comforting as well as the extension till the 8th (Wednesday). I am in Auckland for the weekend and I am sure the rest of the Board are trying to get away for the long weekend as well, but the additional time gives our consultant a gap to make any further recommendations/adjustments via email. The CDHB are alerted to the AG's enquiry but not the details.

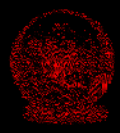
With regard to the minutes dated 25 Jan, 28 Jan and 3 Feb (other than the 26 November which were subsequently amended), I didn't give them to you which is why I enquired if you had them given they are referenced in the report. The minutes weren't approved by the Board until 25 February. I can only assume that on your final visit to the Trust on or about the 27th February, that our acting manager Monica Millar gave you copies of her minutes, they will not be signed as I had the signed copies with me.

Obviously the Board are aware that either Monica Millar or Henare Edwards or both gave you information pertaining to an employment dispute with NUPE. That information is incorrect and also irrelevant to the audit but obviously we are aware that it was proffered to paint a certain picture for both the audit team as well as the CDHB. The Board are primarily concerned with Mel Mark-Shadbolt's mis-management of the Trust as opposed to the "noise" that is being generated to cloud that issue.

Can I just reiterate that the Board informed you that Henare Edwards and Ron Mark were not Board members and seek assurances they were not interviewed for your report.

With thanks

Angelia Ria
Chair
Te Awa o Te Ora Trust



Te Awa o Te Ora Issued-Based Audit - interviewing Board and Staff
Angelia Ria
to:
Eileen_Robertson@moh.govt.nz
09/04/2015 04:15 p.m.
Cc:
"whiorahorona@hotmail.com", "alan@teawatrust.org.nz", "hinerau@pikimai.co.nz", Kate Dougherty, "blairculling@hotmail.com"
Hide Details
From: Angelia Ria <teota@xtra.co.nz> Sort List...
To: "Eileen_Robertson@moh.govt.nz" <Eileen_Robertson@moh.govt.nz>,
Cc: "whiorahorona@hotmail.com" <whiorahorona@hotmail.com>, "alan@teawatrust.org.nz" <alan@teawatrust.org.nz>, "hinerau@pikimai.co.nz" <hinerau@pikimai.co.nz>, Kate Dougherty <kmdougherty.lawyer@gmail.com>, "blairculling@hotmail.com" <blairculling@hotmail.com>
Please respond to Angelia Ria <teota@xtra.co.nz>
History: This message has been forwarded.

Kia ora Eileen,

As per our telephone conversation this afternoon, which I am sorry seemed to upset you greatly, its not personal, it was in fact a heads-up call that an email was coming.

The Board have just realised that staff were interviewed for the report. You mentioned, you had told Alan and I that staff would be interviewed which obviously went completely over heads. The Board thought only current Board members, our acting manager and people who were on the Board during the period of the audit would be interviewed. As you know our acting manager has reported to the Board that she was not interviewed, which is an incredibly odd situation and you have inadvertently identified Maree Hanson and/or Heni Te Kawa as being interviewed for LMLM.

As you mentioned you need to go through your line management to get permission to release any information which is of course understandable. You have previously supplied information to us confirming that Ron Mark and Henare Edwards were not interviewed as Board members given they weren't on the Board (thank you for that).

In order to provide context to the request, I mentioned that the Board are perplexed and have stated so in their response as to why auditors can potentially use unverified data and draw conclusions which the Board have to respond to. Obviously it begs the question where is the "natural justice" in that. Two of our Board members are qualified health auditors so you can imagine they are geared to the process.

You will recall in the meeting about the draft audit report that you were asked who gave you information about NUPE which was a surprise to the Board given we got it at the same time as the auditors. The board point out in their response that the NUPE letter has been relied on to conclude an entire section, odd given it was received on the 5th of March when the audit had already finished.

In any event the Board have the following questions to ask?

Who on our staff was actually interviewed for the audit? Please list the interviewees?
Please confirm whether Henare Edwards was interviewed as a staff member (rather than a Board member)?
Were former staff members interviewed for the audit and if so, who?
Was Heni Te Kawa (former staff member) interviewed?
Did the auditors actually interview any former Board members? (we ask because a current Board member was not interviewed) and if so? Who?
Did the auditors group interview the staff?

Look forward to hearing from you with your response

MINISTRY OF HEALTH
MANATŪ HAUORA

Final Audit Report

Financial and Claims Audit

Pacific Trust Canterbury

189 Montreal Street
Christchurch

MINISTRY OF HEALTH
MANATŪ HAUORA

Contents

Appendices

Executive Summary

Audit and Compliance conducted, at the request of the Ministry of Health and the Canterbury District Health Board, a financial and claims audit of Pacific Trust Canterbury.

The Trust has engaged consultants to assist in the development and implementation of a recovery plan. The plan is under development and will be presented to the Board on 10 August 2016. This report is based on the findings arising from our audit work.

Our findings are summarised below.

- The Trust is in a critical financial position, being currently reliant on a short-term overdraft facility.
- The Trust is forecast to again run out of cash in December 2016, with significantly increasing cash deficits through to a predicted deficit of $665,427 as at 30 June 2017.
- The Trust does not have sufficient realisable assets to secure an overdraft facility of the amount required to meet the forecast deficit.
- The budget predicts an operating loss of $473,687 for the 2017 financial year.
- There are amounts of unspent funding and potential recoveries for under-delivered services exceeding $700,000. The Trust has no ability to meet these liabilities.
- In our opinion, the Trust's proposals to rectify the forecast financial position are unlikely to address the cash shortfall that will occur in December 2016.
- We are also concerned about the longer term financial recovery plan relying on the obtaining of new funding/contracts. This report shows the poor financial position of the Trust and documents on-going under-delivery of services. Both these factors are considerable hurdles to the Trust obtaining new contracts. The Trust acknowledges that the reliance on increasing GP clinic enrolments is unlikely to be successful in rectifying the clinic's large financial deficit.
- We consider that the Trust is in breach of the Notification of Problems clauses in the Agreements as it did not advise the funders of the serious financial position of the Trust, in particular the cashflow forecasts and the need to obtain overdraft financing and defer tax payments.
- The Trust had under-resourced the Canterbury DHB Integrated Contract by 1.2 FTEs per annum and had failed to consistently deliver the volume of required services or support hours in the Mental Health services.
- Reported service delivery volumes for the Mental health services were over-stated.
- The Trust had failed to meet volumes and/or timelines in the majority of the Ministry of Health public health contracts.
- The Trust had used foreign and copyrighted material in the documentation provided to support the delivery of outcomes in the Serau: Pacific Provider and Workforce Development fund.

Summary of Key Recommendations

We recommend that the funders require the Trust to provide monthly financial reporting, including an actual to budget comparison of cash-flow, and to advise the funders immediately of any application for further overdraft funding, breach of overdraft conditions or withdrawal of the overdraft facility by the bank.

We also recommend that the Trustees seek independent legal advice on the consequences of continuing to trade while the Trust is insolvent.

We have identified unspent funding and under-delivered services that result in potential clawbacks available to the funders. We recommend that the funders discuss these with the Trust and each other as the Trust is not currently in a position to repay these amounts or to otherwise rectify the under-delivery of services.

Auditee Response

A copy of the Trust's response to our draft findings is attached as Appendix 1 and should be read in its entirety along with this report. Any variations to our draft findings are a result of the response or further discussion with the Trust.

In summary, the Trust responded to key issues as follows.

- The Trust accepted the findings of the audit report and agreed with the recommendation to provide monthly financial reporting to the funders.
- The Trust has engaged Pasifika Futures, the Whanau Ora Commissioning Agency to provide governance and management expertise and support.
- The support includes the engagement of a team to develop and implement a recovery plan. The team will include an independent Chartered Accountant, a Senior Financial Manager and an experienced Governance and Management expert.
- The restructuring plan is to be presented to and approved by the Trustees by 10 August 2016 and the implementation of the restructuring plan will commence on 15 August 2016.
- A new CEO has been appointed to the Trust and commences on 1 August 2016.
- The Trust is relying on a restructuring of the organisation to address the financial shortfall and it intends to return to a break even position by 30 June 2017.
- The Trust is not in a position to repay any potential liabilities for under-delivery of services in the short-term and the Trust would like to discuss and negotiate alternative service delivery outputs or repayment options with the funders.

Introduction

Audit Clients:	Ministry of Health Canterbury District Health Board
Auditee:	Pacific Trust Canterbury
Audit:	Mental Health, Public and Personal Health claims
Audit Period:	1 July 2014 to 31 May 2016

The Ministry of Health and the Canterbury District Health Board (Canterbury DHB) requested that the Ministry of Health's Audit and Compliance conduct an audit, under Section 22G of the Health Act 1956 and the terms of the Service Agreements, of Pacific Trust Canterbury (Trust).

The Trust was contracted by the Canterbury DHB to provide Mental Health, Outreach services and Whanau Ora – Ola o Aiga services and by the Ministry of Health to provide public health services.

The Trust received $1.8 million of funding from the Canterbury DHB and $3.4 million of funding from the Ministry of Health for the audit period.

Scope

The period covered by the audit was 1 July 2014 to 31 May 2016.

A site visit was undertaken on 13-15 June 2016.

We were provided with full access to all records, management and staff that we required, and received full co-operation from all management and staff with whom we had dealings.

Unless otherwise stated, all amounts in this report are GST exclusive.

This report is written on an exception basis. Only summary information is provided unless there are areas of non-compliance or concern.

This audit has been conducted as part of the Audit and Compliance assurance programme. This programme focuses on specific financially related matters.

This audit does not purport to review all aspects of service provision. This report details those exceptions or contractually non-compliant matters identified by this audit, but this is not a representation that other matters are contractually compliant.

This audit has been performed with all reasonable care but is based upon information provided to Audit and Compliance by the service provider. Unless specifically stated, this information has not been verified or validated by reference to independent sources.

Nature of Audit

Our audit testing was focused on verification that the Trust had appropriate governance, management and financial processes in place, that claiming processes were robust, the services claimed had actually been provided, and that contractual clauses regarding claiming had been met.

This involved discussions with management and administrative staff, review of Board meeting minutes and governance, review of financial transactions, review of claim data, registers and records evidencing the provision of services, and investigation and documentation of claim processes.

Findings

Current Financial Position

The Trust's financial position has declined rapidly and is currently reliant on short-term overdraft funding.

The 2017 budgets predict a loss of $473,687 and a cash-flow deficit of $665,427 as at 30 June 2017.

Documents Reviewed

We reviewed the following documents as part of our audit analysis:

- audited financial statements for 2013-2015
- Monthly management accounts for 31 July 2015 to 30 April 2016
- BDO forecasts dated 17 May 2016 and the Trust's amended forecasts for the period to 30 June 2017
- Aged Payables Report as at 15 June 2016
- ASB Transaction History Reports dated 15 June and 5 July 2016 for the Business Cheque, Savings On Call and Business Saver accounts
- Overdraft facility letter dated 9 June 2016 and extension email dated 27 June 2016
- PTC letter dated 30 May 2016 requesting overdraft and various associated items of email correspondence with the bank over the period 24 May to 8 June 2016
- Board minutes for meetings held from 26 November 2015 to 19 May 2016.

Findings

The Summarised Balance Sheet included in the Board's Financial Dashboard for the month ended 30 April 2016 shows the following position.

Table 1: Summarised Balance Sheet as at 30 April 2016

Cash and Call Account	8,331	
Savings Account	333,595	
Accounts Receivable	291,590	
Other Current Assets	239,717	
Property, Plant and Equipment	754,645	
		1,627,878
Accounts Payable	82,108	
Employee Entitlements	269,862	
GST Payable	79,170	
Income in Advance	499,203	
Healthy Families 2015 Liability	363,147	
Other Current Liabilities	143,691	
		1,437,182
Trust Capital		190,696

By June 2016 the financial position of the Trust had deteriorated significantly. An overdraft facility of $250,000 was initially arranged for the period 9 to 30 June 2016 and then extended to 31 July 2016.

As at 4 July 2016 the bank balances were:

- Business Cheque (158,539)
- Business Saver 393
- Savings on Call 542

  Total (157,604)

Further, GST of $79,000 that was due on 28 May 2016 had, with the agreement of IRD, been deferred until 20 and 31 July 2016. All accounts payables were current as at 15 June 2016.

We have not undertaken a detailed line-by-line review of expenditure items but we note the following contributors to the Trust's poor financial position:

- continued large losses from the GP/health clinic ($216,582 from 1 July 2015 to 30 April 2016)
- leasehold fit-out costs in excess of $500,000 incurred in 2015
- poor cost control in general over a long period, evidenced by savings of over $8,000 per month obtained from July 2016 from reviewing mobile plans and web-page services
- leasehold costs incurred on four buildings (three occupied by the Trust) when the Trust could operate from two, with sub-lease income from the building not occupied by the Trust being less than the head lease cost.

Table 2: Fixed Assets

	Net Book Value 31 May 2016
Land & Buildings	16,947
Plant & Equipment	127,909
Leasehold Alterations - Clinic	558,641
Website	40,864
Total	744,360

Our preliminary claims audit work has identified an under-delivery of FTEs on the Canterbury DHB Integrated Contract that equates to funding of $178,000. No liability for this potential recovery is recorded in the Trust's forecasts.

The Canterbury DHB has included wash-up clauses in the majority of its contracts to allow for a recovery of funds for under-delivery of any of the services.

In addition to the FTE shortfall, on several occasions, the Mental Health service failed to meet the service specifications for the number of supported clients and the number of hours of face to face contact. This is discussed at pages 18 to 22 of this report. We have not calculated the dollar value of any under-delivery of services for those contracts.

Conclusions

The Trust is in a critical financial position, being currently reliant on a short-term overdraft facility.

Budgets predict a loss of $473,687 for the 2017 financial year and a cash-flow deficit of $665,427 as at 30 June 2017.

In addition, there are amounts of unspent funding and potential recoveries for under-delivered services exceeding $700,000.

Auditee Response

The Trust intends to have a recovery and restructuring plan in place by 15 August 2016. The Trust believes its restructuring plan will achieve a break even or small surplus by 30 June 2017.

The Trust will remain reliant on the bank over-draft facility in the short-term. It has implemented daily cash-flow forecasting which will be monitored by the recovery team.

The Trust is not in a position to repay the potential liabilities for under-delivery of the services in the short-term. However, the Trust would like to discuss and negotiate alternative service delivery outputs or repayment options with the funders.

Forecast Profitability

The Trust is forecast to incur a deficit in excess of $450,000 for the year ended 30 June 2017, possibly resulting in negative equity.

Findings

BDO, the Trust's former financial advisors, prepared on 17 May 2016 a monthly forecast of profitability, financial position and cash-flows through to 30 June 2016. The forecasts were amended by PTC to include SIPPC funding income, to increase staff costs to meet the level required for contractual compliance and to reflect some cost savings achieved. Extracts from the amended forecasts are attached as Appendices 2 and 4.

The Draft Budget Profit and Loss (Appendix 4) shows the cumulative projected deficit, which is expected to total $473,687 for the year to 30 June 2017.

This level of deficit, when combined with the financial effects of the service under-spends and under-deliveries identified in this report, will exceed the Trust's equity.

Additional Costs

We note that the Draft Budget does not include the additional cost of interest on the overdraft.

Conclusions

The Trust is forecast to incur a deficit in excess of $450,000 for the year ended 30 June 2017, possibly resulting in negative equity.

Forecast Cash-flow

The Trust is forecast to again run out of cash in December 2016, with increasing cash deficits through to 30 June 2017.

The Trust does not have sufficient assets to secure an overdraft facility of the amount required to meet the forecast deficit.

Findings

The Draft Cash Flow Forecast is attached as Appendix 3.

The current cash deficit is covered by a temporary overdraft facility of $250,000 that expires on 31 July 2016 by which time the Trust expects to have received sufficient contract funding to repay the overdraft.

The forecast is that the Trust returns to a cash deficit position of $183,806 in December 2016 and that the Trust incurs on-going monthly cash deficits from February 2017 until the end of the forecast period of 30 June 2017, at which time the cash deficit is forecast to be $665,427.

The Trust has limited assets against which it could grant security, and most of those assets are leasehold improvements (see Table 2). Therefore, the Trust may not be able to obtain long-term overdraft financing.

The Trust has identified some remedial actions that it considers can address the financial position. These are discussed at page 10.

Additional Costs and Liabilities

We note that the forecast cash-flow does not include overdraft interest expense (19.5% per annum) and does not include the effect of any potential recovery by funders for under-delivered services.

Conclusions

The Trust is forecast to again run out of cash in December 2016, with significantly increasing cash deficits through to 30 June 2017. The Trust does not have sufficient realisable assets to secure an overdraft facility of the amount required to meet the forecast deficit.

Recommendations

We recommend that the funders require the Trust to provide monthly financial reporting, including an actual to budget comparison of cash-flow, and to advise the funders immediately of any application for further overdraft funding, breach of overdraft conditions or withdrawal of the overdraft facility by the bank.

We also recommend that the Trustees seek independent legal advice on the consequences of continuing to trade while the Trust is insolvent.

Remedial Proposals

We concluded the proposals by the Trust to rectify the forecast financial position are unlikely to address the significant cash shortfall.

Findings

We have reviewed a series of proposals put together by the Board and management outlined in an email dated 30 May 2016 and more specific proposals included in the response dated 1 July to the Interim Draft Audit Report and discussed in a meeting with the Trust Chairperson, CEO designate and Financial Administrator on 4 July 2016.

The clinic continues to incur large losses and is a major financial drain on the Trust. We understand that the Trust has been in preliminary discussions with an interested party regarding the clinic, but that no agreement has been reached. The Trust is also attempting to recruit another GP to reduce the reliance on locums and is undertaking promotional activity to increase enrolments. The budget and cash-flow forecast include the effect of increasing enrolments by 200-300 patients per month.

The leasehold costs are a further financial drain, particularly given that the Trust is not utilising all the leased premises and that sub-leases do not cover the lease cost. The leases do not expire until July and August 2017.

Some of the proposals will achieve modest cost reductions (eg, changes to the mobile phone plan will save approximately $2,500 per month and the decision to bring web-site management in-house may save $6,000 per month) and others are long-term. The savings identified to date will be offset by the interest cost of the overdraft facility.

The Trust is aware of some new Government services/contracts that it intends to tender for. We cannot predict the outcome of the tender process but make the following comments.

- In the response to the Interim Draft Audit Report the Trust considers that a point in its favour in obtaining new contracts is its "track record of delivering services to the hard to reach Pacific community". We consider that this "track record" is compromised by the Trust's current and historic level of non-compliance (a claims audit of Ministry of Health services in 2010 identified recoveries of $163,000 relating to under-delivery of services and current non-compliance is outlined in pages 16 to 36 of this report.
- Reliance on new funding to provide a short-term solution to the Trust's financial woes is likely to be misplaced as new contracts may involve set-up costs and modest contribution (operating surplus) margins (below the level of 30% mentioned in discussions).

Conclusion

In our opinion, the Trust's proposals to rectify the forecast financial position are unlikely to address the significant cash shortfall that will occur in December 2016.

This report shows the poor financial position of the Trust and documents extensive under-delivery of services. Both these factors are considerable hurdles to the Trust obtaining new contracts.

Public Health Funding

The Trust has recorded underspent Healthy Families funding of $498,096 and there are further estimated surpluses for 2016 of $19,185 and $50,431 for the NPA and Smoking Cessation services respectively. These amounts, totalling $567,712, are, with the agreement of the Ministry, to be reinvested in services or repaid to the Ministry of Health.

Contractual Provisions

The Ministry of Health Public Health agreements (Healthy Families, Smoking Cessation, Like Minds Like Mine, Nutrition and Physical Activity) have "ring-fenced" funding, that means that the funding is required to be used for the delivery of the contracted services and any surpluses are required to be reinvested in services or repaid to the Ministry of Health.

Relevant extracts from the service agreements are set out below.

<u>Agreements 351568 Healthy Families, 350709 Nutrition and Physical Activity and 353455 Pacific Smoking Cessation</u>

6.1 We will pay you in accordance with the payment schedule set out in the Provider Specific Terms and Conditions for the delivery of the Services specified in any service specification attached to this agreement.

6.2 You agree that all funding provided by us will only be applied to the delivery of the Services specified in the relevant service specification.

6.3 Where funding is provided in advance of the delivery of the Services, and those Services are not delivered in accordance with the service specification, you will:

a. with our agreement, reinvest any operating surplus in the delivery of other public health services; or

b. repay the operating surplus to us.

6.4 Where all Services for the financial year have been delivered in accordance with the relevant service specification and an operating surplus exists at the end of any financial year during the term of this agreement, you will:

a. with our agreement, reinvest that operating surplus in the delivery of other public health services; or

b. repay the operating surplus to us.

6.5 For the purposes of this clause the term "operating surplus" means the difference between the payments we have made to you for a financial year and the amount that you have spent on delivery of the Services specified in the service specification for that financial year.

6.6 We reserve the right to withhold any payments owing to you where you are in breach of this agreement.

Table 3: Agreed Budgets

Planned FTEs and costs	Annual budget		
Agreement	351358-00	350709-00	353455-00
Total FTE:	5.0 FTE	1.0 FTE	2.0 FTE
Salary related costs	$365,000.00	56,000.00	
Indirect costs	$127,750.00	8,000.00	
Direct costs	$126,185.47	21,000.00	
Total Costs Service	$ 618,935.47	85,000.00	170,000.00

343938 Integrated (Smoking Cessation and LMLM)

11. Recovery of Payments

11.1 You will repay a portion of the funding paid by the Funders if:

- You do not satisfactorily provide the Services, or
- You do not maintain the Services as agreed for the full term of the Agreement, or
- You do not provide the Services because your Approval is suspended or this Agreement is terminated.

11.2 The Funders will set the amount to be repaid after discussion with You and with regard to the quantity and quality of the Service that was provided, and You will repay the amount within 30 days of written notice from the Funders.

11.3 Ministry of Health will pay You for the Services as specified in this agreement. Where actual expenditure (as reported on a 6 monthly basis) is less than the funding provided for those Services and there are material surpluses made in the delivery of those Services. You may, if agreed with Ministry of Health, reinvest these surpluses in the delivery of public health services consistent with the Public Health Services Specifications.

Findings

The monthly Profit and Loss (Budget Analysis) reports show surpluses for the Health Promotion (NPA), Stop Smoking and Healthy Families cost centres. However, these "surpluses" do not account for overhead charges as the Trust accounts for these only at the end of the financial year.

However, the Trust does account for underspent funds for the Healthy Families service. The Trust identified unspent Healthy Families funding of $363,147 as at 30 June 2015 and had accrued a further under-spend of $134,959 for the 11 months to 31 May 2016, bringing the under-spent Healthy Families funding to $498,096.

The Health Promotion (NPA) cost centre showed a surplus of $27,185 as at 30 April 2016. After deducting the full contract budgeted figure for overheads of $8,000 the surplus is $19,185.

The Pacific Smoking Cessation cost centre showed a surplus of $84,431 as at 30 April 2016. Agreement 353455 does not specify a budgeted figure for overhead expenditure but applying overhead at 20% of funding (the level in the Healthy Families agreement) results in a surplus of $50,431.

These three services were understaffed for part or all of the audit period (see pages 29, 31 and 34 of this report), contributing to the under-spend/surplus. Therefore clause 6.3 of Agreements 351568, 350709 and 353455 applies and the Ministry of Health can either require reinvestment of the surpluses in service delivery or repayment of the surpluses.

There may be further surpluses for NPA and Smoking Cessation in respect of previous years, but given the financial position of the Trust we do not consider it necessary to quantify these.

Conclusion

The Trust has recorded underspent Healthy Families funding of $498,096 and there are further estimated surpluses for 2016 of $19,185 and $50,431 for the NPA and Smoking Cessation services respectively that are available for reinvestment in services or repayment to the Ministry of Health.

Auditee Response

The Trust is not in a position to repay the potential liabilities for under-delivery of the services in the short-term. However, the Trust would like to discuss and negotiate alternative service delivery outputs or repayment options with the funder.

Notification of Problems

We consider that the Trust is in breach of the Notification of Problems clauses in the Agreements as it did not advise the funders of the serious financial position of the Trust, in particular the cash-flow forecasts and the need to obtain overdraft financing and defer tax payments.

Contractual Provisions

The Trust's agreements with the Ministry of Health and Canterbury DHB contain requirements to advise the funders of any problems, risks, or significant issues which may or is likely to materially affect the Trust's ability to provide the services (for example Clause 16 of Agreements 351568 and 353455 and Clause B24 of Agreements 348578 and 344406).

Findings

The Trust did not advise the funders of the possible threat to the on-going provision of services posed by the forecast financial position of the Trust or the lack of funds that necessitated the obtaining of an overdraft facility in June 2016.

Conclusion

We consider that the Trust is in breach of the Notification of Problems clauses in the Agreements as it did not advise the funders of the serious financial position of the Trust, in particular the cash-flow forecasts and the need to obtain overdraft financing and defer tax payments.

Canterbury DHB Agreements

Background

Canterbury DHB contracted with the Trust to provide the following services under agreement 344406.

Table 4: Integrated agreement 344406 from 1 July 2014

Contract	Purchase Unit	FTE volume	Service Targets	End date
344406	MHP63C	2	12-18 active clients per FTE, 20 hours pw per FTE	30 June 2017
	MHD74C	1	12-18 active clients per FTE, 20 hrs pw per FTE	30 June 2017
	MHP64E	1		30 June 2017
	MAOR0117	0.8		30 June 2017
	MAOR0117	1	20 active clients per FTE per month – 40 p.a.	30 June 2017
	CO1016	1	85 New born babies p.a.	30 June 2017
	MHA20E	4	15 clients per FTE, 20 hrs pw per FTE	30 June 2015

Table 5: Community Navigator Service agreement 354698 commenced 1 November 2015

Contract	Purchase Unit	FTE volume	Service	End date
354698	MHP65E	Not specified	MH clients and Youth (Obesity)	31 Oct 2016

Table 6: Outreach Immunisation Service agreement 334618 commencing 1 July 2014

Contract	Purchase Unit	FTE volume	Service	End date
334618	COSP0002	1.5*	Outreach Immunisation	31 Aug 2016

* The FTE volume was not specified in the agreement but was an "expectation" by Canterbury DHB that there would be a full-time support worker and a part-time vaccinator.

Contractual Clause Agreement 344406

Clause 3 Wash-Up Clause

3.1 Where either party has concern regarding your past or present delivery of any service funded under this Agreement, or where either party has concern about your ability to provide any service funded under this Agreement in the future, that party may initiate a meeting to discuss that concern

3.2…

3.3…

3.4 The steps that may be taken by us following an under-delivery of services under this Agreement may include, but not be limited to:

a. A refund of all or part of the payments received by you for those services for the period of the under-delivery:

b. A variation of the Agreement which may include amendments to:

i. the service specification; and/or
ii. the timeframes for delivery of the services; and/or
iii. the payment terms for the service

c. The termination of the Agreement due to material under-delivery of the services.

Clause 4. Staff Vacancies
The provider should notify the Contract Manager if there are any staff vacancies which last longer than 8 weeks. After that time, the CDHB may withhold payment if an appropriate appointment is not made.

Trust Records
The Trust began using Recordbase from 1 January 2015 to record client contacts for the services it provided.

The staff at the Trust recorded client contacts (face to face, telephone, emails and so on) as well as the number of minutes spent providing support to the clients.

We obtained a sample of reports and records to determine the number of supported clients and the provision of face to face hours.

RecordBase Records
Recordbase had three main reports. Time was recorded as “Activity by Attendee, client contact (face to face, telephone and correspondence) was recorded on “Activity Details” and “Number of People Supported by Services” contained client volumes and service commencement and discharge dates from the services.

PRIMHD data from 1 July 2014 to 30 April 2016 was used for a comparison of recorded client activity between it and Recordbase.

There was frequent use of code T08 (Mental Health care coordination contacts) by the Trust for PRIMHD entries, this required there to be significant contact between mental health professionals and other agencies/person relating to the care of a consumer.

FTE Hours
The Trust provided the payroll hours for all staff and management that it identified as employed in the contracted services during the audit period.

We accessed a sample of 12 staff files to verify the employees were engaged to work the advised hours and services.

Findings

The volume of supported clients by month and face to face contact hours in Recordbase were unreliable and inaccurate. Included in these volumes were clients discharged from the service although there was no contact in that month with the client or activity recorded for client support.

MHA20E Community Support Service Delivery:

This service ceased on 30 June 2015.

Table 7: Purchase Unit MHA20E January 15 to June 15 Child and Youth Recordbase

Activity	Jan 15
Contacts during the month	0
Clients at the end of the month	1
Supported during the month	9
Face to Face Hours	30 min
Hours other (phone, email and so on)	0

Client Activity –Community Support Child and Youth

There were no clients supported in this service after 10 September 2014. Therefore, the data in Recordbase was inaccurate as it contained clients who were no longer in the service but who had not been discharged.

Client Activity – Community Support Adult

We selected two months from Recordbase for review for the MHA20E Adult Community Support work.

The numbers of client contacts were accurate in Recordbase. However, the number of supported clients and the number of support hours for the months were overstated as recorded in Table 8.

Table 8: Purchase Unit MHA20E: Community Support –Adults: Variances

Activity	Mar 15	Apr 15
Supported during the month (Recordbase)	71	53
Activity Details (Findings)	45	30
Variance (Overstated)	26	23

Activity	Mar 15	Apr 15
Face to Face Hours (Recordbase)	392	289
Activity Details (Findings)	353	268
Variance (Overstated)	39	21

Activity	Mar 15	Apr 15
Contacts during the month (Recordbase)	127	81
Activity Details (Findings)	127	81
Variance	0	0

Face to Face Hours
The attendances by clients at a day programme or group session were recorded in one example as 8 hours each. Therefore if there were 4 clients, the day was recorded as 32 hours of face to face contact.

In one instance one client was recorded as attending 12 hours of day programme that covered two sessions on the same day.

Direct face to face contact time recorded by individual CSWs did not match the actual contact time recorded in the Activity Details.

Client Activity
There were a large number of clients in the reports "number of people supported by services during the month" who were discharged from the service in March 2015 or April 2015. Some of these clients were recorded as T08 in PRIMHD but our review of client notes revealed there was no contact between mental health professionals and other agencies/person relating to the care of the client.

We also noted that clients were not being discharged from the service when they clearly had not had contact with the service for a considerable time.

Conclusion

We concluded that the number of supported clients recorded on the Database was not reliable as the volumes included clients who had no recorded activity with the MHA20E Community Support service for several months but had not been discharged from the service.

"Supported in the Month" included clients who were discharged in that month and had no contact with the CSWs or any other recorded support.

We also considered that the number of hours recorded as face-to-face contact by individual CSWs were unreliable as they did not match actual recorded contact times on the activity details records.

We further concluded based on our review that the 3.8 FTEs employed in this service had not supported 15 clients each, each month, and had not provided 20 hours per week of face to face contact in April 2015.

MHP63C Community Clinical Service Delivery:

The reported volumes of supported clients by month and face to face contact hours in Recordbase were unreliable and inaccurate. Included in these volumes were clients discharged from the service although there was no contact with the client or activity recorded for client support.
The FTEs in this service had not provided 20 hours per week of face to face contact and at the time there were two FTEs in this service they did not have 12-18 active clients each.

We compared contacts, client volumes at month end, clients supported in the month and face to face hours in Recordbase to the Activity Details report.

Table 9: Purchase unit MHP63C September 2015 to May 2016: Variances

Activity Contacts During the Month	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Contacts during the month (Recordbase)	32	23	39	29	19	28	36	38	69
Activity Details (Findings)	32	23	39	29	19	28	36	38	69
Variance	0	0	0	0	0	0	0	0	0
Activity Client Volumes at the End of the Month	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**
Client volumes at the end of the month (Recordbase)	26	27	27	27	26	26	27	21	14
Activity Details (Findings)	8	9	15	16	14	14	15	16	13
Variance (Overstated)	18	18	12	11	12	12	12	5	1
Activity Client Volumes Supported During the Month	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**
Supported During the month (Recordbase)	40	28	30	27	28	27	27	28	32
Activity Details (Findings)	14	12	19	19	17	16	17	19	18
Variance (Overstated)	26	16	11	8	11	11	10	9	14
Activity Face to Face Hours in the Month	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**
Face to Face Hours during the month Recordbase	45	30	57	47	34	30	41	43	111
Activity Details (Findings)	41.5	25	52	44	25.5	26	28.5	22	49
Variance (Overstated)	3.5	5	5	3	8.5	4	12.5	21	62

Face to Face Hours

We compared the Activity by Attendee reports to the Activity Details for this service and found that the actual hours of face to face contact had been overstated by the FTEs in the Activity by Attendee reports.

In one example, two clients had on the same day and time received two separate activities T08 and T42 (Individual treatment), the FTE had attributed time to each activity.

Client Activity
The volumes of supported clients at the end of each month were compared with PRIMHD and we also referred back to Recordbase entries to the contact notes. Recordbase clients included those who were discharged during the month and there had been no contact with or on behalf of that client in those months.

Clients were recorded as supported clients when there had been no contact with the client for a considerable time, for example last contact in November 2015 but remained on the list of supported clients up to and including May 2016.

Conclusions

We concluded that the number of supported clients recorded on Recordbase was not reliable as the volumes included clients who had no recorded activity with the MHP63C Clinical Community services for several months and were not discharged from the service.

“Supported in the Month” included clients who were discharged in that month and there was no recorded support of that client in the month.

The times recorded on Activity by Attendee reports were not reliable as they exceeded the actual number of hours provided in face to face contact recorded on the Activity Details reports.

The service had a vacancy for one FTE from January 2016. At the time there were two FTEs (September to December 2015) the service was not supporting the required caseload of 12-18 active clients per FTE.

The number of hours of support did not meet the requirement of providing 20 hours per week of face to face contact in all months.

MHD74C AOD Community Service Delivery:

The volume of supported clients by month and face to face contact hours in Recordbase were unreliable and inaccurate. Included in these volumes were clients discharged from the service although there was no contact with the client or activity recorded for client support.

The FTE in this service had not provided 20 hours per week of face to face contact and in 5 of the 11 months reviewed the FTE did not have 12-18 active clients.

We compared contacts, client volumes at month end, clients supported in the month and face to face hours in Recordbase to the Activity Details report.

Table 10: Purchase unit MHD74C July 2015 to May 2016: Variances

Activity Contacts During the Month	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Contacts during the month (Recordbase)	11	3	16	30	9	5	18	30	53	33	34
Activity Details (Findings)	11	3	16	30	9	5	18	30	53	33	34
Variance	0	0	0	0	0	0	0	0	0	0	0
Activity Client Volumes at the End of the Month	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**
Client volumes at the end of the month (Recordbase)	23	24	21	19	13	8	15	20	26	13	5
Activity Details (Findings)	1	1	12	3	2	2	7	8	8	13	
Variance Over/(Understated)	22	23	9	16	11	6	8	12	18	0	
Activity Client Volumes Supported During the Month	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**
Supported During the month (Recordbase)	24	27	36	22	23	16	15	26	37	37	15
Activity Details (Findings)	4	4	13	15	6	4	9	19	23	19	14
Variance Overstated	20	23	23	7	17	12	6	7	14	18	1
Activity Face to Face Hours in the Month	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**
Face to Face Hours during the month Recordbase	81.5	18	53	85	29	22.5	27.5	52	61	59.5	65.5
Activity Details (Findings)	2	6	31	56	20.5	10	23	33	52	35.5	70
Variance (Over/(Understated)	79.5	12	22	29	8.5	12.5	4.5	19	9	24	-4.5

Face to Face Hours

We compared the Activity by Attendee reports to the Activity Details for this service and found that the actual hours of face to face contact had been overstated by the FTE in the Activity by Attendee reports.

In May 2016 the FTE had recorded 28.45 hours of Did Not Attend (DNA) time in his indirect breakdown time. We cannot establish from the Activity Details report if the DNA time related to any of the entries on that report.

Client Activity
The volumes of supported clients at the end of each month were compared with PRIMHD and we also referred back to Recordbase entries to the contact notes.

Recordbase clients included those who were discharged during the month and there had been no contact with or on behalf of that client in those months.

We identified two clients with duplicate entries.

Activity Details for 6 clients recorded a session on 2 July 2015 as 12 hours for each client. This was recorded in PRIMHD as T08. The clients were discharged from this service on 28 September 2015, this also was recorded as T08. We did not include those 72 hours as face to face contact time as we considered they were unreliable.

Conclusion

We concluded that the number of supported clients on Recordbase was not reliable as the volumes included clients who had no recorded activity with the MHD74C AOD service for several months and were not discharged from the service.

“Supported in the Month” included clients who were discharged in that month and there was no record in Recordbase of support of that client in the month.

The times recorded on Activity by Attendee reports were not reliable as they exceeded the actual number of hours provided in face to face contact recorded on the Activity Details reports.

The FTE in this service did not provide support to 12-18 active clients in 5 of the 11 months reviewed.

The number of hours of support did not meet the requirement of providing 20 hours per week of face to face contact in all months.

Integrated Contract 344406: FTE Volumes

The Trust had under-resourced the Integrated contract held with Canterbury DHB and as a result was paid $178,549 in funding for FTEs that it had not engaged to deliver the specified services.

Full-time employees of the Trust were employed to work 40 hours per week.

The services had Contract Managers, whose time was spent in administration tasks. At the time of our site visit one of the Contract Managers was responsible for 11 contracts. We have not included their time as part of the FTE time as the contract definitions for Clinical FTE, Cultural FTE and Other FTE excludes time that is formally devoted to administrative or management functions.

We reviewed the payroll hours of the staff engaged to deliver the Integrated Health Services to verify the number of contracted FTEs.

FTE vacancies July 2014 to June 2015

Table 11: Value of the FTE Shortfall Integrated Contract July 2014 to June 2015

Service	Value of Under-resourcing	FTE Shortfall
MHD74C	$ 4,138	0.04
MHA20E	$17,241	0.23
MHP64E	$30,165	0.35
MAOR0117	$22,738	0.43
MAOR0104	$16,116	0.16
Total	$90,398	1.21

FTE vacancies July 2015 to May 2016

Table 12: Value of the FTE Shortfall Integrated Contract July 2015 to May 2016

Service	Value of Under-resourcing	FTE Shortfall
MHP63C	$15,812	0.19
MHP64E	$27,535	0.35
MAOR0117	$18,651	0.39
MAOR0104	$26,153	0.29
Total	$88,151	1.22

We were advised that the CEO decided when to advertise and recruit staff.

Conclusion

We concluded the Trust had under-resourced several purchase units in the Integrated contract held with the Canterbury DHB.

As a result of this under-resourcing we concluded that the Trust had been paid $178,549 in funding for FTEs that it had not engaged to deliver the services.

Auditee Response

The Trust acknowledges the Integrated contract was under-resourced by 1.2 FTEs per annum.

The Trustees would like to meet and discuss these issues with the funder with the intention of rectifying the short-fall in the short to medium term of the contract.

Outreach Immunisation Agreement 334618

The Outreach Immunisation service employed staff who provided approximately 0.9 FTEs to this service.

From 1 June 2016 there were no staff working in this service.

Background

Canterbury DHB contracted with the Trust to provide Outreach Immunisation Services.

The aim of the Outreach Immunisation Service was to assist Primary Health Care providers, Well Child providers and Immunisation Facilitators/Coordinators by following up on families who have children that have missed vaccination events as defined by the Childhood Immunisation Schedule.

Contractual Clause Agreement 334618

Clause 3 Wash-Up Clause

3.1 Where either party has concern regarding your past or present delivery of any service funded under this Agreement, or where either party has concern about your ability to provide any service funded under this Agreement in the future, that party may initiate a meeting to discuss that concern

3.2…

3.3…

3.4 The steps that may be taken by us following an under-delivery of services under this Agreement may include, but not be limited to:

a. A refund of all or part of the payments received by you for those services for the period of the under-delivery:

b. A variation of the Agreement which may include amendments to:

i. the service specification; and/or
ii. the timeframes for delivery of the services; and/or
iii. the payment terms for the service

c. The termination of the Agreement due to material under-delivery of the services.

Prior to commencing the audit we had a telephone conversation with Canterbury DHB about its expectations for the delivery of this service. At that time we were advised that it expected the service to have one full time Community Support Worker and a part-time Vaccinator.

This contract ceases on 31 August 2016

We were provided with the names of the staff engaged to deliver the Outreach Immunisation service and their hours of engagement in the service.

Findings

The support worker was employed as 0.5 FTE in this service and 0.5 FTE as a Playgroup Co-ordinator. The worker was supported by an Outreach Immunisation Nurse.

We were advised that the Nurse was delivering 20 hours per week to this service. However a review of her employment contract showed she was employed to deliver 14 hours per week (0.35 FTE) from 13 May 2014 to 24 December 2014, and 16 hours per week (0.4 FTE) from 16 January 2015 until 30 June 2016.

The Outreach Immunisation Nurse left the Trust on 1 June 2016 and the support worker was transferred from this service to the MAOR0104 Mother and Pepi service and the Pasifika Supported Playgroup Co-ordinator positions from 2 May 2016.

At the time of our site visit there were no staff working in the Outreach Immunisation service.

Conclusion

The Trust did not engage the expected number of FTE in this service and from 1 June 2016 it no longer had staff working in the Outreach Immunisation Service.

Recommendations

We recommend that Canterbury DHB recovers all funding for this service for the period from 1 June 2016 ($27,598) as there were no staff engaged to deliver this service.

Navigator Service – Agreement 354698

Pacific Trust employed a nurse practitioner for the navigator service but failed to provide the staff member with an accurate job description.

Background

The Canterbury DHB contracted the Trust to deliver a Community Navigator Service under agreement 354698. This was a programme funded service that was to be based in the Primary Health clinic. The contract commenced on 1 November 2015.

The focus of the service was on clinic mental health and youth health around obesity. The role was to be based in the Primary Health clinic.

Findings

The nurse practitioner advised she had not seen the contract specifications and had relied on the information she was provided with at the time by the Trust. She had created her own job description, focusing on overweight and obese children.

We were advised there had been no Mental Health referrals since the contract implementation.

There were 699 children enrolled into the service and 140 of those children were obese. Contact was made with 18 of the 140 children as well as 40 letters sent out, resulting in 10 responses. All children enrolled were recorded in the clinic Recordbase system and reported monthly to the Ministry of Health.

The nurse practitioner stated it was difficult to enrol and start a plan for overweight or obese children when weight was mentioned.

Conclusion

Pacific Trust left it up to the staff member to work out her own job description. The staff member's professional / qualified experience enabled individual plans to be created for each enrolled child to improve responsiveness to health and social needs with appropriate access to these services.

Ministry of Health – Smoking Cessation Service

The Trust had a Quit Coach vacancy for a period of seven months although it was advised by the Ministry of Health Portfolio Manager to employ someone on a fixed term contract.

While fully resourced the Quit Coaches did not achieve the required output of 120 services users per FTE setting target quit dates.

Background

The Ministry of Health contracted the Trust to deliver a Smoking Cessation Service. During the audit period the Trust had two contracts for this service.

Agreement 343938 was an integrated contract between the Ministry of Social Development and the Ministry of Health and this agreement ceased on 30 June 2015. The Ministry of Health agreement 353455 commenced on 1 July 2015 and ceases on 30 June 2016.

Both contracts required the Trust to engage 2 FTE Quit Coaches for this service.

Each FTE had a service requirement that a minimum of 120 users had set a Target Quit Date each year (to a maximum of 150 users per FTE).

Findings

FTE Volumes

We were provided with the names of the Quit Coach employees, their hours of work and their start and finish dates.

A full-time employee of this service was required by the Trust to work 40 hours per week.

Our review found that the Smoking Cessation service had a vacancy for a Quit Coach from 11 July 2015 until 28 February 2016.

On 10 September 2015 the CEO of the Trust informed the Ministry of Health Portfolio Manager of the Quit Coach vacancy and the CEO suggested that as the contract had only eight months to run, that the Trust would come up with some ideas for a project instead of replacing the Quit Coach. The Portfolio Manager responded by advising the Trust to consider employing a replacement on a fixed term contract

The Trust placed a recruitment notice toward the end of January 2016. We were not provided with any evidence of any earlier recruitment activity for this service.

A further vacancy occurred from 22 March 2016 until 1 May 2016.

Service Delivery
We aggregated the number of referrals and enrolments for the period 1 July 2014 to 31 May 2016 from the Aukati Kai Paipa (AKP) system (smoking cessation service delivering face-to-face coaching).

We were advised by the Trust that it reported total enrolments and referrals from a manual count of service users for each month based on the following method:

Table 13: Enrolled and Referrals

Counted as enrolled	Counted as Referrals
Completed Programme	Referred Only
On the Programme	Pre Enrolment
Exit Programme	

We compared the total reported volumes to the volumes in the AKP database as shown in Table 14.

Table 14: Reported Smoking Cessation vs. AKP database

Year	2014		2015		Annual Actual AKP Totals	Annual Reported Totals	Variance Numbers
Month	Jul - Sept	Oct - Dec	Jan - Mar	Apr - Jun			
Referrals	26	30	55	81	192	198	6
Enrolment	81	21	46	40	188	179	-9

Year	2015		2016	Actual AKP Totals	Reported Totals	Variance Numbers
Month	Jul - Sept	Oct - Dec	Jan - Mar			
Referrals	40	31	16	87	N/A	N/A
Enrolment	57	32	55	144	143	-1

Conclusion
The Trust had under-resourced the Smoking Cessation service by 1 FTE for a period of seven months.

While fully resourced in July 2014 to June 2015 the Quit Coaches did not achieve the required output of a minimum of 120 service users per FTE setting target quit dates.

Ministry of Health – Healthy Families NZ

The Trust did not employ the required number of staff for the Healthy Families NZ service and the Manager of the service did not work exclusively in this service.

Outcome timeframes were not met for staff employment, governance group formation or the roadmap implementation.

Background

The Ministry of Health contracted with the Trust under Agreement 351568 to deliver a Healthy Families NZ service. This agreement commenced on 1 September 2014.

The objectives of the service were to:

- Improve people's health where they live, learn, work and play by taking a dynamic systems approach to chronic disease prevention
- Lead the establishment of Healthy Families NZ in Spreydon-Heathcote Ward by:
    - Establishing a Prevention Partnership of key stakeholders best placed to influence change in the community
    - Establishing Prevention Partnership governance arrangements to guide local action
    - Working collaboratively with the Ministry and key partners to develop a road map outlining the development and implementation of Healthy Families NZ.
    - Employing and maintaining the required number of FTE who will be responsible for the implementation of a road map for collective action in the community.

The Budget for Healthy Families was

Planned FTEs	Salary Related Costs	Indirect Costs
5	$365,000	$127,750

Services were to be delivered and performed under the following Outputs:
Output One: Leadership and Governance
Output Two: Workforce and Learning
Output Three: Implementation Roadmap
Output Four: Programme development and Evaluation

Findings

FTE Volumes

Output 2.1 Performance measure stated that the timeframe for employing the Spreydon-Heathcote Ward Healthy Families NZ team will be by 15 November 2014.

Output 2.2 required that the Healthy Families workforce work exclusively on Healthy Families NZ deliverables, towards Health Families NZ outputs and outcomes, unless otherwise agreed by the Ministry of Health.

Our review of FTE volumes found that with the exception of one month, this service did not employ the five planned FTEs.

The service engaged a Manager for the service on 26 January 2015 and the first Settings Co-ordinator was engaged on 2 June 2015. Three further staff were employed on 20 and 27 July 2015 and 9 March 2016.

The Engagement Co-ordinator received her final wages on 1 May 2016, after being on what was described as 'garden leave' from 11 April 2016.

The Manager of this service resigned effective from 24 June 2016.

Commencing in March 2015, the Manger of the Healthy Families NZ service was also managing agreement 350709 – Health Promotion – Nutrition and Physical Activity, in breach of the requirement to work exclusively on the Healthy Families service.

We also noted that the Health Promoter for the Ministry of Health agreement 350709 (as discussed at page 34) was identified on the Trust's website as a member of the Healthy Families Team.

Service Delivery
We requested evidence of some of the reported activities.

Output One: Chair of the Prevention Partnership Governance Group.
We were advised that this was two separate groups and that the Governance Group was currently under review in partnership with the Ministry of Health, the other group was the Prevention Partnership Group (PPG).

We were provided with the two newsletters published to date by the PPG, these were issued in March 2016 and May 2016.

Output Two: Workforce and Learning
We were provided with evidence of TedX training for Manager and Settings Co-ordinator in October 2015, first aid training for the three staff members in September 2015, plus Media training for the three staff and Manager on 27 August 2015.

Output Three: Implementation Roadmap
The implementation map was to be finalised by 15 March 2015 and was to be signed off by the Governance Group. We were advised that it was approved by the Governance Group on 4 May 2016.

Output Four: Programme development and Evaluation
We were advised that relationships with other Lead Providers occurs indirectly through Healthy Families NZ staff as part of face-to-face teleconferencing and online group hui.

The Manager advised that she attended a 3 day hui hosted by the East Cape Healthy Families team in February-March 2016.

Conclusions

The Trust was in breach of several contractual provisions.

The Trust did not employ staff within the specified timeframe and did not employ the required number of staff for the Healthy Families NZ service over the audit period.

Furthermore, the Manager of this service was not exclusively engaged in delivering the Healthy Families contract.

Outcome timeframes were not met for the implementation roadmap and the governance group.

These factors have all contributed to the under-spend of this service funding (see page 12). The financial position of the Trust is such that the under-spent funds are not available to be utilised for the delivery of this service.

Auditee Response

The Trust is not in a position to repay any potential liabilities for under-delivery of services in the short-term. However, the Trust would like to discuss and negotiate alternative service delivery outputs or repayment options with the funder.

Ministry of Health – Health Promotion

The Trust had under-resourced the Health Promotion service by 0.25 FTE for a period of four months. The Health Promoter position is currently vacant and has been since 1 June 2016.

Background

The Ministry of Health contracted with the Trust under Agreement 350709 to deliver a Health Promotion service. This agreement commenced on 1 July 2014.

The agreement had five short-term outcomes which were:
Short Term Outcome 1: Increased effectiveness of Pacific Trust Canterbury's health promotion programmes through robust and evidence based planning, reporting and evaluation
Short Term Outcome 2: Increased regional and local collaboration and co-ordination to ensure a voice for Pacific people, and Pacific health issues in Christchurch
Short Term Outcome 3: Increased knowledge, skills and changes in attitudes of Pacific Peoples' in Christchurch of the importance of good nutrition, regular physical activity and maintaining a healthy weight
Short Term Outcome 4: Increased accessibility and availability of public health interventions for the Canterbury Pacific Island community that focus on good nutrition, regular physical activity and maintaining healthy weight
Short Term Outcome 5: Increased capacity and capability of Pacific Trust Canterbury's health promotion staff and those outside the organisation working with Pacific Peoples' in Canterbury.

Population Served
Pacific peoples' within the Christchurch region, with a particular focus on children and young people, families and the elderly.

The service required 1 FTE Health Promoter.

Findings

FTE Volume

Our review found that up until 12 December 2014 the Trust had employed 1 FTE. This position was vacant from 13 December 2014 and a replacement Health Promoter was employed on 19 January 2015 as 0.75 FTE.

This resulted in an FTE shortfall of 0.25 FTE from 19 January 2015 to 24 May 2015.

The Health Promoter resigned on 31 May 2016 and the position is currently vacant.

From March 2015 the Manager of this service also managed the Healthy Families NZ service.

Service Delivery
We requested evidence of delivery of some of the Outputs required under the Outcomes contained in the agreement.

Logic Model.
The Manager of the service advised that she has never seen this model and her and the previous Manager of the service did not receive any feedback from the Ministry of Health.

Evidence was provided for work under-taken with other organisations such as Active Canterbury, sPacifically Pacific Collective (SPACPAC), Heart Foundation, Pacific Youth Leadership and Transformation (PYLAT) Council.
The Health Promoter also provided a summary of the frequency of contacts and meetings held with organisations, for example Pegasus Health met monthly with the Pacific Health Manager, SPACPAC met every six weeks and so on.

Activities undertaken included the Matua group in March 2016, recording number of sessions, number of participants and feedback from the participants.

We were provided with a spreadsheet of the Youthtown breakaway activities that occurred in December 2015 and January 2016. This was over a period of four weeks and included activity description, feedback, participant numbers and achievements.

Aranui Health Day, the Health Promoter reported on this activity that took place in August 2015, she was unable to provide further evidence. She had taken sole charge due to the Heart Foundation Health Promoter having to leave the event.

Workforce Development included a first aid certificate gained by the Health Promoter in October 2015 and a Certificate in Public Health.

Conclusion

We concluded that the Health Promotion Service had a shortfall of 0.25 FTE for a period of four months. The position is currently vacant due to the resignation of the Health Promoter.

The Trust had provided evidence for the sample of reported service delivery and we confirmed from that evidence that those activities did take place.

Ministry of Health – Serau: Pacific Provider and Workforce Development Fund

The training leaders output will not be completed in the time specified in the agreement.

The Lomipeau Outcome Framework bears a strong resemblance to a copyrighted framework published in 2014 by the Canterbury DHB.

The financial policies and procedures documents were copied verbatim from a USA website.

No input was obtained from the Financial Administrator or the HR and Quality Advisor employed by the Trust although they both have relevant degrees and professional experience in these matters as they apply to New Zealand laws and regulations.

Background

The Ministry of Health administers the Pacific Provider and Workforce Development Fund (PPWDF) which provides grant funding to strengthen Pacific providers to be sustainable and deliver quality health services that best meet the needs of the Pacific communities.

The Ministry invited applications in early 2013 from Pacific provider collectives seeking to access the PPDWF.

A proposal received from the South Island Pacific Provider Collective (SIPPC) was accepted by the Ministry of Health. The two parties entered into Agreement 348578 that commenced on 1 October 2013.

The five Pacific Providers under the SIPPC are:

- Pacific Trust Canterbury (Lead Provider)
- Pacific Trust Otago
- Vaka Tautua Limited
- Tanagata Atumotu Trust
- Pacific Island Advisory and Cultural Trust

The agreement allowed for additional organisations to join the South Island Collective subject to approval by the Ministry of Health and all of the SIPPC members.

Clause F3.5 Service Components

There are three service components (the Services). The Lead Provider will;

1. coordinate the implementation of the activities and outputs of the Plan and;
2. coordinate the allocation of funding for the joint purchasing plant which will support the implement of the Plan and;

3 manage the performance and reporting of the South Island Collective in accordance with the activities of the Collectives Joint Purchasing Plan …

Service Delivery
We requested evidence (for example policy documents, manuals, minutes and so on) of some of the reported activities. These were to be provided by the Collective;

Table 15: Output Sample

Activities/Deliverables	Output	Start and End Dates	Funding $
Improving leadership skills	Review of leader's capabilities and training for leaders completed	1 July 15 to 30 June 16	130,000
Financial systems and procedures review and implementation	Stocktake of organisations financial systems completed. Financial systems and processes implemented	1 July 15 to 30 June 16	92,500
Review of organisations technology systems	Stocktake of current systems completed, reviewed. Procurement of new technology with prior approval of business case from Ministry of Health	6 January 14 to 30 June 17	65,000
Monitor Outcome	Outcome framework completed	1 July 15 to 30 June 16	140,000
Dispute Resolution	HR Manual reviewed and dispute policy completed for each organisation and collective	1 July 14 to 5 January 15	26,500

The Project Coordinator was appointed on 26 May 2014. She has a very strong background in policy and advisory roles within the New Zealand public service.
A part-time contractor for the role of SIPPC Administrator was appointed on 1 February 2016. She has a Fijian accounting degree and was employed by KPMG as a tax and immigration consultant in Fiji.

It is understood that prior to the appointment of the Project Co-ordinator the role was carried out by the CEO and COO.

Findings

Improving Leadership skills: We were provided with a Governance calendar for the year 1 January to 31 December 2016. This showed that three activities had been undertaken for this output which were:

- 24 February 2016: RBA Training, Shea Pita and Associates, there were 13 attendees (including the SIPPC coordinator and administrator).
- 12 May 2016: Inspirational Leadership Training – trainer M Pasene Pacific Health Manager, Pegasus Health (Charitable) Ltd, Kelera Uluiviti (SIPPC). There were 10 attendees (including the SIPPC coordinator and administrator)
- 13 May 2016: Strategic Plan training – trainer Sana Daunauda Pacific Health Development Manager, Marlborough PHO. There were 9 attendees (including the SIPPC coordinator and administrator).

The next planned Leadership skills training session is in August 2016 with three other sessions planned for September, October and November 2016.

Financial systems and procedures review and implementation:
We were advised that the review had commenced before Christmas 2015. It was explained to us that the organisations have different needs and some hire external accountants. Therefore, the Project Coordinator and Administrator created a document of financial policies and procedures for the smaller Pacific groups – Marlborough Pacific Trust, Nelson Pasifika and Oamaru Pacific Trust.

We identified that the information contained in the policies and procedures had been obtained and copied from articles in the Greater Washington Society of CPA Educational Foundation website.

These policies and procedures were generic in nature, undated, did not refer to the organisation/s it was intended for and it was unclear if these policies had been adopted by these organisations and when or if there had been any review as to the effectiveness of the policies and procedures.

We were advised that the Financial Administrator of the Trust did not contribute to or review these documents.

Review of organisations technology systems:
Four organisations, Fale Pasifika, PIACT Invercargill, Tangata Atumotu and Pacific Trust Otago, completed a stocktake questionnaire. These are undated, although the SIPPC coordinator did advise the stocktake occurred in 2014.
A draft Request For Proposal (RFP) was dated January 2014. The SIPPC coordinator said this was not finalised as the IT providers were not keen due to the geographical spread of the members making the project uneconomical.

Outcome Framework: at the site visit the SIPPC coordinator provided two documents for the outcome framework. We were advised that these documents were the result of input from the Collective and would be used by the members to facilitate the development of community level collaborative outcomes framework.

We were later provided with a further document identified as Lomipeau Outcome Framework. This document bears a strong resemblance to the Canterbury Health System Outcomes Framework – November 2014. This document was copyright of the Canterbury DHB.
It can be viewed on http://ccn.health.nz/Resources/OutcomesFramework.aspx

Dispute Resolution: We were provided with a Human Resources (HR) manual that was developed in early 2016. This document was created by the SIPPC coordinator and the Administrator. We were advised that these were provided to Marlborough Pacific Trust, Nelson Pasifika and Oamaru Pacific Trust for part of their accreditation process.

The document is generic, undated, did not refer to the organisation/s it was intended for and it was unclear if these policies had been adopted by these organisations and when or if there had been any review as to the effectiveness of the policies and procedures.

We were advised that the Trust's HR and Quality Advisor did not contribute to or review the HR manual.

Conclusion

The training of Leaders output in the timeframe specified in the agreement will not be achieved.

The financial policies and procedures document were taken verbatim from an American website and the Lomipeau Outcome Framework bears a strong resemblance to a copyrighted framework published in 2014 by the Canterbury DHB.

The SIPPC coordinator and administrator did not seek input into the financial manual or HR manual from the Trust's Financial or HR employees although both have the relevant qualifications and experience in these areas, especially New Zealand accounting requirements and employment regulations.

Recommendation

We recommend that the Ministry of Health discusses with SIPPC the use of articles and publications that are copyright, or come from a foreign source and may not necessarily contain information that is relevant to New Zealand requirements, for example the reporting rules for New Zealand charities or the 90 day trial period for new employees.

Auditee Response

The Trustees confirm that foreign and copyrighted material was included in the Serau: Pacific Provider and Workforce Development contract. As a result of the audit findings, the documentation will be updated and the foreign and copyright information will be removed.

Appendix 1

19 July 2016

Audit and Compliance
MOH

PACIFIC TRUST
CANTERBURY

Dear Sir

Pacific Trust Canterbury (PTC) Response to the Executive Summary Points in the Second Draft of the Audit Report

Thank you for the second draft of the Audit report for our review and comment.

We would like to assure you that the Board is taking the situation that we find ourselves in very seriously. To this end we have engaged the support and assistance of Pasifika Futures, the Whanau Ora Commissioning Agency to provide us with both Governance and Management expertise and support. This support includes the engagement of a team to provide us with support for the development and implementation and recovery plan. The team will include the engagement of an independent Chartered Accountant to work directly with the trust to provide support for the restructure and recovery, a Senior Financial Manager who will be responsible for working with us to negotiate with funders and liaise with parties regarding our obligations and an experienced Governance and Management expert who will be providing direct advice and support at a a governance level to the Board.

As you may be aware the previous CEO has resigned and we have appointed a new CEO who commences on the 1st August. The new CEO will be working in partnership with the recovery team.

Finally we would like to make the point that we have not yet completed our end of financial year results and need to be able to fully understand our complete position not just the Ministry of Health funding. We have scheduled a Board meeting for this week and will be able to provide more information once the board has met to consider the actions moving forward.

Listed below are the audit report recommendations and the Trust's responses to these points:

The Trust is in a critical financial position, being currently reliant on a short-term overdraft facility.

The Trust is currently reliant on the bank overdraft facility and this will be on going in the short term. The Trust will have a restructuring plan developed by the external recovery Team which includes an independent Chartered Accountant who will be taking a Project Management role in consultation with the Trustees by Friday 5 August 2016.

The restructuring plan will be presented and approved by the Trustees by Wednesday 10 August and the implementation of the restructuring plan will commence on Monday 15 August 2016.

The restructuring will be managed by the recovery Team including the independent Chartered Accountant and newly appointed CEO and progress reports will be provided to the Trustees on a fortnightly basis.

The Trust is forecast to again run out of cash in December 2016, with significantly increasing cash deficits through to a predicted deficit of $665,427 as at 30 June 2017.

A cash flow report has been implemented and the forecast will project the cash flow position from 15 July through to 31 December 2016 and this will be updated on a daily basis.

The cash flow report will be monitored by the recovery team including the independent Chartered Accountant and provided to the Trustees on a fortnightly basis.

The Trustees will approve the implementation of the restructuring project, to ensure the Trust returns to a break even position by 30 June 2017. The Trust does not have the financial reserves or asset backing to sustain a deficit through to the end of the 2017 financial year.

The Trust does not have sufficient realisable assets to secure an overdraft facility of the amount required to meet the forecast deficit

Please refer to the response to bullet point 2 above to see how this issue is being addressed.

Budgets predict an operating loss of $473,687 for the 2017 financial year.

The Trust are not in a financially viable position to sustain an operating loss of $473,687 in the 2017 financial year, a restructuring plan will be developed and implemented to achieve a break even or small surplus position by 30 June 2017.

There are amounts of unspent funding and potential recoveries for under delivered services exceeding $700,000. The Trust has no ability to meet these liabilities.

The Trust is not in a position to repay the potential liabilities for under delivery of services in the short term, however the Trust would like to discuss and negotiate alternative service delivery outputs or repayment options with the funders.

This will enable PTC to continue to provide services under the existing contractual agreements and implement strategies to provide services in arrears over the medium to long term.

In our opinion, the Trust's proposals to rectify the forecast financial position are unlikely to address the cash shortfall that will occur in December 2016.

Please refer to the response to bullet point 2 above to see how this issue is being addressed.

We are also concerned about the longer term financial recovery plan relying heavily on increasing clinic enrolment numbers in a highly competitive market and the obtaining of new funding/contracts. This report shows the poor financial position of the Trust and documents extensive under-delivery of services. Both these factors are considerable hurdles to the Trust obtaining new contracts.

The Trustees and Management have been informed that the reliance on increased enrolled patient numbers in the clinic is unlikely to rectify the deficit position in the short term and the reality is that to increase the clinic enrolled patient numbers by 1,000 is extremely difficult.

The Trustees are in the process of engaging a recovery team provided by Pasifika Futures which includes an independent Chartered Accountant, Senior Financial manager and Governance and Management expert with significant health care experience to develop and implement a restructuring plan that will return the Trust to a financially viable organisation.

If the financially viability issue can be rectified, this will improve the Trust's credibility and should enable the Trust to renew existing contracts and negotiate new contracts with funders in the medium to long term.

We consider that the Trust is in breach of the Notification of Problems clauses in the Agreements as it did not advise the funders of the serious financial position of the Trust, in particular the cashflow forecasts and the need to obtain overdraft financing and defer tax payments.

The Trustees acknowledge that they were in breach of the Notification of Problems clauses in contract, however this was not done intentionally and the Trustees will work closely with the funders during the restructuring process to keep them fully informed of the progress that is being achieved and provide regular financial updates.

The Trust had under-resourced the Canterbury DHB Integrated Contract by 1.2 FTEs per annum.

It is acknowledged that the Canterbury DHB Integrated Contract was under-resourced by 1.2 FTEs per annum. The Trustees would like to meet and discuss the issues with the funder with the intention of rectifying the short fall in the short to medium term of the contract and this will be included in the restructuring plan.

The Trust had failed to consistently deliver the volume of required services or support hours in the Mental Health services.

Please refer to bullet point 9 above.

The Trust had failed to meet volumes and/or timelines in the majority of the Ministry of Health public health contracts.

Please refer to bullet point 9 above.

The Trust had used foreign and copyrighted material in the documentation provided to support the delivery of outcomes in the Serau: Pacific Provider and Workforce Development fund.

The Trustees confirm that foreign and copyrighted material was included in the Serau: Pacific Provider and Workforce Development contract. As a result of the audit findings, the documentation will be updated and the foreign and copyright information will be removed from the document.

Summary of Recommendations

We recommend that the funders request the Trust to provide monthly financial reporting, including an actual to budget comparison of cashflow, and to advise the funders immediately of any application for further overdraft funding, breach of overdraft conditions or withdrawal of the overdraft facility by the bank.

The Trustees agree to this recommendation. Please refer to bullet point 2 above.

Conclusion

The Trustees are committed to returning the Trust to a financially viable and contract compliant organisation and will be doing everything possible to remedy the issues you have highlighted in your audit report.

The engagement of the recovery team through Pasifika Futures with significant experience in the health sector and in particular in supporting organisations to restructure will assist us to achieve our goals for the Trust.

Should you require any additional information or clarification on any of the responses to your audit Executive Summary points, please contact me.

Yours sincerely

S T Scott

Selma Scott
Chairperson

Appendix 2

Pacific Trust Canterbury
Summary of Actual and Forecast Financial Results

	2012	2013	2014	2015	2016			2017
	Audited				Actual - 9/12	Budget - 3/12	Aggregate	Budget
Child Services	839,933.00	891,182.00	846,119.00	895,186.00				
Mental Health Services	785,978.00	839,200.00	859,200.00	741,666.00				
Pacific Health Clinic	694,645.00	738,447.00	753,809.00	713,135.00				
Other Income	572,081.00	586,884.00	1,075,254.00	2,660,895.00				
Total Income	2,892,637.00	3,055,713.00	3,534,382.00	5,010,882.00				
Personnel-related Costs	2,032,057.00	2,371,853.00	2,593,033.00	2,540,777.00				
Direct Service Costs	110,645.00	103,015.00	498,464.00	1,286,713.00				
Other Costs	544,982.00	698,990.00	704,406.00	880,806.00				
Total Costs	2,687,684.00	3,173,858.00	3,795,903.00	4,708,296.00				
Net Operating Surplus/(Deficit)	204,953.00	-118,145.00	-261,521.00	302,586.00				
Land and Insurance Proceeds		48,011.00	217,394.00					
Net Surplus/(Deficit)	204,953.00	-70,134.00	-44,127.00	302,586.00	-344,978.00	15,863.00	-329,115.00	-473,687.00
Bank and Cash	325,851.00	561,514.00	518,738.00	28,048.00			-228,485.00	-665,427.00
Other Current Assets	354,996.00	557,124.00	680,404.00	929,115.00			858,409.00	
Total Current Assets	680,847.00	1,118,638.00	1,199,142.00	957,163.00			629,924.00	
Revenue in Advance	39,075.00	179,103.00	286,769.00	205,707.00			123,950.00	
Other Current Liabilities	379,066.00	432,560.00	470,451.00	581,610.00			597,654.00	
Total Current Liabilities	418,141.00	611,663.00	757,220.00	787,317.00			721,604.00	
Net Current Assets	262,706.00	506,975.00	441,922.00	169,846.00			-91,680.00	
Fixed Assets	874,341.00	207,986.00	212,644.00	803,575.00			735,985.00	
Term Liabilities	351,953.00		0.00	0.00			0.00	
Net Assets/Equity	785,094.00	714,961.00	654,566.00	973,421.00			644,305.00	

Key Concerns

Cash flow forecast (not included here) results in significant cash deficit by 30 June 2017.

The size of the loss and the additional liabilities relating to under-delivery of services is likely to place the Trust into negative equity.

These factors mean that the Trust will be insolvent.

Appendix 3

Pacific Trust Canterbury

DRAFT CASH FLOW FORECAST

July 2016 To June 2017

	July	August	September	October	November	December	January	February	March	April	May	June
CASH INFLOWS												
Debtor invoices	$1,148,994	$239,225	$152,515	$646,076	$141,936	$141,936	$646,076	$141,936	$141,936	$646,076	$141,936	$141,936
177 Sublease	$6,925	$6,925	$6,925	$6,925	$6,925	$6,925	$6,925	$6,925	$6,925	$6,925	$6,925	$6,925
Clinic Income	$36,530	$42,877	$42,877	$42,009	$47,060	$47,060	$47,612	$52,663	$52,663	$54,335	$59,386	$59,386
Interest received	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50
TOTAL CASH INFLOWS	$1,192,500	$289,077	$202,367	$695,060	$195,971	$195,971	$700,663	$201,574	$201,574	$707,386	$208,297	$208,297
CASH OUTFLOWS												
Premise Leases & OPEX	$41,988	$41,988	$41,988	$41,988	$41,988	$41,988	$41,988	$41,988	$41,988	$41,988	$41,988	$41,988
Payments to Suppliers	$160,000	$162,090	$152,942	$159,932	$141,900	$143,864	$141,156	$140,259	$141,645	$141,568	$141,179	$142,392
GP Locums	$33,120	$25,760	$25,760	$25,760	$25,760	$25,760	$29,440	$29,440	$29,440	$29,440	$29,440	$29,440
Wages Paid	$110,000	$120,000	$115,000	$115,000	$173,000	$120,000	$130,000	$130,000	$130,000	$130,000	$195,000	$130,000
PAYE	$64,041	$50,000	$55,000	$52,000	$52,000	$78,000	$55,000	$58,000	$58,000	$58,000	$58,000	$87,000
GST Mar/Apr	$79,170											
GST Payments	$130,000		-$4,957		$52,825		$55,649		-$8,975		$56,743	
Vehicle Leases	$7,481	$7,481	$7,481	$7,481	$7,481	$7,481	$7,481	$7,481	$7,481	$7,481	$7,481	$7,481
Landline Phone	$1,320	$1,380	$1,380	$1,380	$1,380	$1,380	$1,380	$1,380	$1,380	$1,380	$1,380	$1,380
Mobile Phones	$5,321	$2,530	$2,530	$2,530	$2,530	$2,530	$2,530	$2,530	$2,530	$2,530	$2,530	$2,530
Equipment Lease	$808	$808	$808	$808	$808	$808	$808	$808	$808	$808	$808	$808
ACC	$0	$9,455	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Audit Fees Paid	$0	$0	$8,280	$0	$0	$0	$0	$0	$0	$0	$0	$0
Insurance	$0	$2,470	$7,260	$5,479	$0	$0	$4,827	$3,095	$0	$937	$8,342	$0
Fuel	$3,500	$3,105	$3,105	$3,105	$3,105	$3,105	$3,105	$3,105	$3,105	$3,105	$3,105	$3,105
Interests & Fees	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200
Capital purchases	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL CASH OUTFLOWS	$636,949	$427,267	$416,777	$415,663	$502,978	$425,117	$473,564	$418,286	$407,602	$417,437	$546,196	$446,325
NET CASH INFLOWS (OUTFLOWS)	$555,551	-$138,190	-$214,409	$279,396	-$307,007	-$229,146	$227,099	-$216,713	-$206,029	$289,948	-$337,900	-$238,028
Opening Bank Balance	-$130,000	$425,551	$287,361	$72,951	$352,348	$45,340	-$183,806	$43,294	-$173,419	-$379,448	-$89,499	-$427,399
Closing Bank Balance	$425,551	$287,361	$72,951	$352,348	$45,340	-$183,806	$43,294	-$173,419	-$379,448	-$89,499	-$427,399	-$665,427

Appendix 4

Pacific Trust Canterbury
PO Box 13-285
Christchurch

DRAFT BUDGET

Profit & Loss [Multi-Period]

July 2016 To June 2017

Account Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
Income													
Other Admin Income													
Rent Received	$6,021.66	$6,021.66	$6,021.66	$6,021.66	$6,021.66	$6,021.66	$6,021.66	$6,021.66	$6,021.66	$6,021.66	$6,021.66	$6,021.66	$72,259.92
Interest Income	$50.00	$50.00	$50.00	$50.00	$50.00	$50.00	$50.00	$50.00	$50.00	$50.00	$50.00	$50.00	$600.00
Other Income	$0.00	$0.00	$0.00	$0.00	$4.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.00
Total Other Admin Income	**$6,071.66**	**$6,071.66**	**$6,071.66**	**$6,071.66**	**$6,075.66**	**$6,071.66**	**$6,071.66**	**$6,071.66**	**$6,071.66**	**$6,071.66**	**$6,071.66**	**$6,071.66**	**$72,863.92**
Ministry of Health Income													
MoH N & PA													
MoH N & PA - Income	$7,203.75	$7,203.75	$7,203.75	$7,203.75	$7,203.75	$7,203.75	$7,203.75	$7,203.75	$7,203.75	$7,203.75	$7,203.75	$7,203.75	$86,445.00
MoH N & PA - Wages	($4,150.36)	($4,150.36)	($4,150.36)	($4,150.36)	($4,254.12)	($4,254.12)	($4,254.12)	($4,254.12)	($4,254.12)	($4,254.12)	($4,254.12)	($4,254.12)	($50,634.45)
MoH N & PA - IT/Comm	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoH N & PA - Meeting	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoH N & PA-conference/training	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoH N & PA - Travel	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoH N & PA - Resources	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
Total MoH Health Promotion (N & PA)	**$2,953.39**	**$2,953.39**	**$2,953.39**	**$2,953.39**	**$2,849.63**	**$2,849.63**	**$2,849.63**	**$2,849.63**	**$2,849.63**	**$2,849.63**	**$2,849.63**	**$2,849.63**	**$34,610.55**
MoH Stop Smoking													
MoH Stop Smoking - Income	$14,166.67	$14,166.66	$14,166.67	$14,166.67	$14,166.67	$14,166.66	$14,166.67	$14,166.66	$14,166.67	$14,166.68	$14,166.69	$14,166.70	$170,000.07
MoH Stop Smoking - Wages	($9,084.19)	($9,084.19)	($9,084.19)	($9,084.19)	($9,315.90)	($9,315.90)	($9,315.90)	($9,315.90)	($9,315.90)	($9,315.90)	($9,315.90)	($9,315.90)	($110,863.98)
MoH Stop Smoking - Conf/Traini	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoH Stop Smoking - Travel	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoH Stop Smoking - Vehicle	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoH Stop Smoking - Resources	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
Total MoH Stop Smoking	**$4,982.48**	**$4,982.47**	**$4,982.48**	**$4,982.48**	**$4,750.77**	**$4,750.76**	**$4,750.77**	**$4,750.76**	**$4,750.77**	**$4,750.78**	**$4,750.79**	**$4,750.80**	**$57,936.09**
MoH Healthy Families													
MoH - Healthy Families	$51,577.96	$51,577.96	$51,577.96	$51,577.96	$51,577.96	$51,577.96	$51,577.96	$51,577.96	$51,577.96	$51,577.96	$51,577.96	$51,577.96	$618,935.52
MoH Healthy Families - Wages	($34,804.99)	($34,804.99)	($34,804.99)	($34,804.99)	($35,448.09)	($35,448.09)	($35,454.52)	($35,454.52)	($35,454.52)	($35,454.52)	($35,454.52)	($35,454.52)	($422,843.26)
MoH Healthy Families-IT & Coms	($467.83)	($467.83)	($467.83)	($467.83)	($467.83)	($467.83)	($467.83)	($467.83)	($467.83)	($467.83)	($467.83)	($467.83)	($5,614.00)
MoH Healthy Fam - Conf/Trainin	($572.19)	($572.19)	($572.19)	($572.19)	($572.19)	($572.19)	($572.19)	($572.19)	($572.19)	($572.19)	($572.19)	($572.19)	($6,866.28)
MoH Healthy Families - Meeting	($333.33)	($333.33)	($333.33)	($333.33)	($333.33)	($333.33)	($333.33)	($333.33)	($333.33)	($333.33)	($333.33)	($333.33)	($3,999.96)
MoH Healthy Families - Ads	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoH Healthy Families - Koha	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoH Healthy Families - Services	($10,515.46)	($10,515.46)	($10,515.46)	($10,515.46)	($10,515.46)	($10,515.46)	($10,515.46)	($10,515.46)	($10,515.46)	($10,515.46)	($10,515.46)	($10,515.46)	($126,185.52)
MoH Healthy Families - Travel	($1,200.00)	($1,200.00)	($1,200.00)	($1,200.00)	($1,200.00)	($1,200.00)	($1,200.00)	($1,200.00)	($1,200.00)	($1,200.00)	($1,200.00)	($1,200.00)	($14,400.00)
MoH Healthy Families - Resourc	($733.33)	($733.33)	($733.33)	($733.33)	($733.33)	($733.33)	($733.33)	($733.33)	($733.33)	($733.33)	($733.33)	($733.33)	($8,800.00)
MoH Healthy Families - Lease	($4,583.33)	($4,583.33)	($4,583.33)	($4,583.33)	($4,583.33)	($4,583.33)	($4,583.33)	($4,583.33)	($4,583.33)	($4,583.33)	($4,583.33)	($4,583.33)	($54,999.96)
MoH Healthy Families - Electricity	($600.00)	($500.00)	($500.00)	($400.00)	($300.00)	($250.00)	($250.00)	($300.00)	($300.00)	($300.00)	($400.00)	($400.00)	($4,950.00)
MoH Healthy Families - Rates	($230.00)	($230.00)	($230.00)	($230.00)	($230.00)	($230.00)	($230.00)	($230.00)	($230.00)	($230.00)	($230.00)	($230.00)	($2,760.00)
MoH Healthy Families - Insurance	($397.00)	($397.00)	($397.00)	($397.00)	($397.00)	($397.00)	($397.00)	($397.00)	($397.00)	($397.00)	($397.00)	($397.00)	($4,764.00)
MoH Healthy Families - Security	($29.00)	($29.00)	($29.00)	($29.00)	($29.00)	($29.00)	($29.00)	($29.00)	($29.00)	($29.00)	($29.00)	($29.00)	($348.00)
MoH Healthy Families - Cleaning	($558.00)	($558.00)	($558.00)	($558.00)	($558.00)	($558.00)	($558.00)	($558.00)	($558.00)	($558.00)	($558.00)	($558.00)	($6,696.00)
Total MoH Healthy Families	**($3,446.51)**	**($3,346.51)**	**($3,346.51)**	**($3,246.51)**	**($3,789.61)**	**($3,739.61)**	**($3,746.04)**	**($3,796.04)**	**($3,796.04)**	**($3,796.04)**	**($3,896.04)**	**($3,896.04)**	**($43,841.46)**
Total Ministry of Health Income	**$4,489.36**	**$4,589.35**	**$4,589.36**	**$4,689.36**	**$3,810.79**	**$3,860.78**	**$3,854.36**	**$3,804.35**	**$3,804.36**	**$3,804.37**	**$3,704.38**	**$3,704.39**	**$48,705.19**
Canterbury DHB Income													
CDHB - Mental & Primary Health													
CDHB MH & PH - Income	$55,473.83	$55,473.83	$55,473.83	$55,473.83	$55,473.83	$55,473.83	$55,473.83	$55,473.83	$55,473.83	$55,473.83	$55,473.83	$55,473.83	$665,685.96
CDHB MH & PH - Wages	($43,436.40)	($43,436.40)	($43,436.40)	($43,436.40)	($43,967.03)	($43,967.03)	($44,547.10)	($44,547.10)	($44,547.10)	($44,547.10)	($44,547.10)	($44,547.10)	($528,962.28)
CDHB MH & PH - Meeting	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Pacific Trust Canterbury
PO Box 13-285
Christchurch

DRAFT BUDGET

Profit & Loss [Multi-Period]

July 2016 To June 2017

Account Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
CDHB MH & PH - Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
CDHB MH & PH - Travel	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
CDHB MH & PH - Resources	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
Total CDHB - Mental & Primary Health	**$11,937.43**	**$11,937.43**	**$11,937.43**	**$11,937.43**	**$11,406.80**	**$11,406.80**	**$10,826.73**	**$10,826.73**	**$10,826.73**	**$10,826.73**	**$10,826.73**	**$10,826.73**	**$135,523.68**
CDHB OIS													
CDHB OIS - Income	$9,199.58	$9,199.55	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$18,399.13
CDHB OIS - Wages	($3,635.14)	($3,635.14)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($7,270.29)
CDHB OIS - Resources	($35.93)	($35.93)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($71.86)
Total CDHB OIS	**$5,528.51**	**$5,528.48**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$11,056.98**
CDHB - Mental Navigation													
CDHB MentalNavigation - Income	$9,166.66	$9,166.66	$9,166.66	$9,166.66	$9,166.66	$9,166.66	$9,166.66	$9,166.66	$9,166.66	$9,166.66	$9,166.66	$9,166.66	$109,999.92
CDHB MentalNavigation - Wages	($8,343.00)	($8,343.00)	($8,343.00)	($8,343.00)	($8,551.57)	($8,551.57)	($8,551.57)	($8,551.57)	($8,551.57)	($8,551.57)	($8,551.57)	($8,551.57)	($101,784.60)
Total CDHB - Mental Navigation	**$823.66**	**$823.66**	**$823.66**	**$823.66**	**$615.09**	**$615.09**	**$615.09**	**$615.09**	**$615.09**	**$615.09**	**$615.09**	**$615.09**	**$8,215.32**
Total Canterbury DHB Income	**$18,289.59**	**$18,289.56**	**$12,761.09**	**$12,761.09**	**$12,021.88**	**$12,021.88**	**$11,441.81**	**$11,441.81**	**$11,441.81**	**$11,441.81**	**$11,441.81**	**$11,441.81**	**$154,795.98**
Ministry of Education Income													
MoE Playgroup													
MoE Playgroup - Income	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$45,000.00
Other Playgroup Income	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoE Playgroup - Wages	($2,273.14)	($2,273.14)	($2,273.14)	($2,273.14)	($2,330.96)	($2,330.96)	($2,330.96)	($2,330.96)	($2,330.96)	($2,330.96)	($2,330.96)	($2,330.96)	($27,740.23)
MoE Playgroup - Meeting	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
MoE Playgroup - Travel	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoE Playgroup - Vehicle	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MoE Playgroup - Resources	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
MoE Playgroup - Other costs	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($600.00)
Merrington - Electricity	($120.00)	($100.00)	($100.00)	($90.00)	($80.00)	($80.00)	($60.00)	($60.00)	($60.00)	($70.00)	($80.00)	($90.00)	($990.00)
Merrington - Phone	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Merrington - Rent	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($241.00)	$0.00	$0.00	$0.00	($241.00)
Merrington - Building repairs	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($1,800.00)
Merrington - Equipment Repairs	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
Merrington - Insurance	($179.00)	($179.00)	($179.00)	($179.00)	($179.00)	($179.00)	($179.00)	($179.00)	($179.00)	($179.00)	($179.00)	($179.00)	($2,148.00)
Merrington - Security	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($600.00)
Merrington - Cleaning Contract	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($600.00)
Total MoE Playgroup	**$577.86**	**$597.86**	**$597.86**	**$607.86**	**$560.04**	**$560.04**	**$580.04**	**$580.04**	**$339.04**	**$570.04**	**$560.04**	**$550.04**	**$6,680.77**
MoE EPF													
MoE EPF - Income	$6,666.67	$6,666.66	$6,666.67	$6,666.67	$6,666.66	$6,666.67	$6,666.68	$6,666.69	$6,666.70	$6,666.71	$6,666.72	$6,666.73	$80,000.23
MoE EPF - Wages	($5,839.93)	($5,839.93)	($4,551.64)	($4,551.64)	($4,565.46)	($4,565.46)	($4,681.41)	($4,681.41)	($4,681.41)	($4,681.41)	($4,681.41)	($4,681.41)	($58,002.53)
Total MoE EPF	**$826.74**	**$826.73**	**$2,115.03**	**$2,115.03**	**$2,101.20**	**$2,101.21**	**$1,985.27**	**$1,985.28**	**$1,985.29**	**$1,985.30**	**$1,985.31**	**$1,985.32**	**$21,997.70**
MoE Ashburton Playgroup													
MoE Ashburton Playgroup Income	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$3,750.00	$45,000.00
MoE Ashburton Playgroup - Wage	($2,305.63)	($2,305.63)	($2,305.63)	($2,305.63)	($2,364.43)	($2,364.43)	($2,364.43)	($2,364.43)	($2,364.43)	($2,364.43)	($2,364.43)	($2,364.43)	($28,137.95)
MoE Ashburton Playgroup - Rent	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
MoE Ashburton - Resources	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
Total MoE Ashburton Playgroup	**$1,244.37**	**$1,244.37**	**$1,244.37**	**$1,244.37**	**$1,185.57**	**$1,185.57**	**$1,185.57**	**$1,185.57**	**$1,185.57**	**$1,185.57**	**$1,185.57**	**$1,185.57**	**$14,462.05**
Total Ministry of Education Income	**$2,648.96**	**$2,668.95**	**$3,957.26**	**$3,967.26**	**$3,846.81**	**$3,846.82**	**$3,750.88**	**$3,750.89**	**$3,509.90**	**$3,740.91**	**$3,730.92**	**$3,720.93**	**$43,140.52**
Ministry of Social Dev. Income													
MSD/MoH FACS & Home-based													
MSD/MoH FACS - Income	$8,333.33	$8,333.34	$8,333.33	$8,333.33	$8,333.34	$8,333.33	$8,333.33	$8,333.34	$8,333.33	$8,333.33	$8,333.33	$8,333.34	$100,000.00
MSD Home based - Income	$5,380.32	$5,380.32	$5,380.32	$5,380.32	$5,380.32	$5,380.32	$5,380.32	$5,380.32	$5,380.32	$5,380.32	$5,380.32	$5,380.32	$64,563.84

Pacific Trust Canterbury
PO Box 13-285
Christchurch

DRAFT BUDGET

Profit & Loss [Multi-Period]

July 2016 To June 2017

Account Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
MSD/MoH FACS - Wages	($10,385.82)	($10,385.82)	($8,149.50)	($8,149.50)	($8,275.88)	($8,275.88)	($8,418.00)	($8,418.00)	($8,418.00)	($8,418.00)	($8,418.00)	($8,418.00)	($104,130.38)
MSD/MoH FACS - Meeting	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MSD/MoH FACS - Resources	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
Total MSD/MoH FACS	**$3,227.83**	**$3,227.84**	**$5,464.15**	**$5,464.15**	**$5,337.78**	**$5,337.77**	**$5,195.65**	**$5,195.66**	**$5,195.65**	**$5,195.65**	**$5,195.65**	**$5,195.66**	**$59,233.46**
MSD Budgeting Services													
MSD Budgeting Services - Incom	$3,064.28	$3,064.28	$3,064.28	$3,064.28	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$12,257.13
MSD Budget Service - Services	($2,647.61)	($2,647.61)	($2,647.61)	($2,647.61)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10,590.44)
Total MSD Budgeting Services	**$416.67**	**$416.67**	**$416.67**	**$416.67**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$1,666.69**
Total Ministry of Social Dev. Income	**$3,644.50**	**$3,644.51**	**$5,880.82**	**$5,880.82**	**$5,337.78**	**$5,337.77**	**$5,195.65**	**$5,195.66**	**$5,195.65**	**$5,195.65**	**$5,195.65**	**$5,195.66**	**$60,900.15**
Pegasus Health													
PHO - SIA PCW													
PHO SIA PCW - Income	$9,083.00	$9,083.00	$9,083.00	$9,083.00	$9,083.00	$9,083.00	$9,083.00	$9,083.00	$9,083.00	$9,083.00	$9,083.00	$9,083.00	$108,996.00
PHO SIA PCW - Wages	($9,722.96)	($9,722.96)	($8,678.19)	($8,678.19)	($8,812.27)	($8,812.27)	($12,101.28)	($8,447.03)	($8,447.03)	($8,447.03)	($8,447.03)	($8,447.03)	($108,763.29)
Total PHO - SIA PCW	**($639.96)**	**($639.96)**	**$404.81**	**$404.81**	**$270.73**	**$270.73**	**($3,018.28)**	**$635.97**	**$635.97**	**$635.97**	**$635.97**	**$635.97**	**$232.71**
Total Pegasus Health	**($639.96)**	**($639.96)**	**$404.81**	**$404.81**	**$270.73**	**$270.73**	**($3,018.28)**	**$635.97**	**$635.97**	**$635.97**	**$635.97**	**$635.97**	**$232.71**
MBIE													
MBIE - Pastoral Care													
MBIE - Pastoral Care Income	$10,000.00	$10,000.00	$10,000.00	$15,400.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45,400.00
MBIE - Pastoral Care Services	($4,600.00)	($4,600.00)	($4,600.00)	$6,900.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($6,900.00)
MBIE - Pastoral Care Meeting	($500.00)	($500.00)	($500.00)	($1,000.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($2,500.00)
Total MBIE	**$4,900.00**	**$4,900.00**	**$4,900.00**	**$21,300.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$36,000.00**
CLINIC													
Clinic - PHO Other	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$2,400.00
Clinic - SIA	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$10,800.00
Clinic - ACC Claims	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$8,400.00
Clinic - Patient Co-Payments	$4,729.00	$4,729.00	$4,729.00	$3,974.00	$3,974.00	$3,974.00	$4,454.00	$4,454.00	$4,454.00	$5,908.00	$5,908.00	$5,908.00	$57,195.00
Clinice - Insurance (Meds)	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$3,600.00
Clinic PHO - Capitation	$29,105.67	$29,105.67	$29,105.67	$33,498.00	$33,498.00	$33,498.00	$37,890.00	$37,890.00	$37,890.00	$42,282.33	$42,282.33	$42,282.33	$428,328.00
Clinic - VLCA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Clinic - Careplus	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$10,800.00
Clinic - Immunisations	$450.00	$450.00	$450.00	$450.00	$450.00	$450.00	$450.00	$450.00	$450.00	$450.00	$450.00	$450.00	$5,400.00
Clinic - Maternity	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Clinic - Other income	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$2,400.00
Clinic - Wages	($15,758.96)	($15,758.96)	($15,758.96)	($15,758.96)	($15,978.29)	($15,978.29)	($16,159.39)	($16,159.39)	($16,159.39)	($16,159.39)	($16,159.39)	($16,159.39)	($191,948.78)
Clinic - Pharmaceuticals	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
Clinic - Dressings & other	($400.00)	($400.00)	($400.00)	($400.00)	($400.00)	($400.00)	($400.00)	($400.00)	($400.00)	($400.00)	($400.00)	($400.00)	($4,800.00)
Clinic - GP (Locums)	($26,800.00)	($22,400.00)	($22,400.00)	($22,400.00)	($22,400.00)	($22,400.00)	($25,600.00)	($25,600.00)	($25,600.00)	($25,600.00)	($25,600.00)	($25,600.00)	($294,400.00)
Clinic- Locum associated costs	($1,080.00)	$0.00	($1,080.00)	$0.00	$0.00	($1,080.00)	$0.00	$0.00	$0.00	($1,080.00)	$0.00	$0.00	($4,320.00)
Clinic - resources	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($150.00)	($1,800.00)
Clinic - Other costs	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($100.00)	($1,200.00)
Clinic - Lease	($6,630.55)	($6,630.55)	($6,630.55)	($6,630.55)	($6,630.55)	($6,630.55)	($6,630.55)	($6,630.55)	($6,630.55)	($6,630.55)	($6,630.55)	($6,630.55)	($79,566.60)
Clinic - Rates	$0.00	($1,525.16)	$0.00	$0.00	($1,525.16)	$0.00	$0.00	($1,525.16)	$0.00	$0.00	($1,525.16)	$0.00	($6,100.64)
Clinic - Electricity	($800.00)	($820.00)	($880.00)	($740.00)	($730.00)	($720.00)	($740.00)	($720.00)	($770.00)	($750.00)	($750.00)	($750.00)	($9,170.00)
Clinic - Insurance (exp)	($554.00)	($554.00)	($554.00)	($554.00)	($554.00)	($554.00)	($554.00)	($554.00)	($554.00)	($554.00)	($554.00)	($554.00)	($6,648.00)
Clinic - Printing & Photocopy	($60.00)	($60.00)	($60.00)	($60.00)	($60.00)	($60.00)	($60.00)	($60.00)	($60.00)	($60.00)	($60.00)	($60.00)	($720.00)
Clinic - Cleaning	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($12,000.00)
Clinic - Repairs	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($2,400.00)
Clinic - security	($65.00)	($65.00)	($65.00)	($65.00)	($65.00)	($65.00)	($65.00)	($65.00)	($65.00)	($65.00)	($65.00)	($65.00)	($780.00)

Pacific Trust Canterbury
PO Box 13-285
Christchurch

DRAFT BUDGET

Profit & Loss [Multi-Period]

July 2016 To June 2017

Account Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
Total CLINIC	($18,213.84)	($12,279.00)	($11,893.84)	($7,036.51)	($8,771.00)	($8,315.84)	($5,764.94)	($7,270.10)	($5,794.94)	($1,008.61)	($1,453.77)	$71.39	($87,731.02)
Pacific Futures - Whanau Ora													
Pacific Futures WO - Income	$61,079.72	$61,079.72	$61,079.72	$61,079.72	$61,079.72	$61,079.72	$61,079.72	$61,079.72	$61,079.72	$61,079.77	$61,079.77	$61,079.77	$732,956.81
Pacific Futures WO - Wages	($13,164.91)	($8,248.10)	($8,248.10)	($8,248.10)	($9,239.48)	($9,239.48)	($9,239.48)	($9,239.48)	($9,239.48)	($9,239.48)	($9,239.48)	($9,239.48)	($111,825.09)
Pacific Futures WO - IT &Comms	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Pacific Futures WO - Meeting	($300.00)	($300.00)	($300.00)	($300.00)	($300.00)	($300.00)	($300.00)	($300.00)	($300.00)	($300.00)	($300.00)	($300.00)	($3,600.00)
Pacific Futures WO - Koha	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Pacific Futures WO - Travel	$0.00	($800.00)	($800.00)	($800.00)	($800.00)	($800.00)	($800.00)	($800.00)	($800.00)	($800.00)	($800.00)	($800.00)	($8,800.00)
Pacific Futures WO - Vehicle	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Pacific Futures WO - Resources	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Pacific Futures WO - Services	($36,647.83)	($36,647.83)	($36,647.83)	($36,647.83)	($36,647.83)	($36,647.83)	($36,647.83)	($36,647.83)	($36,647.83)	($36,647.86)	($36,647.86)	($36,647.86)	($439,774.09)
Pacific Futures WO-Consultancy	$0.00	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($1,000.00)	($11,000.00)
Pacific Futures WO-Sponsorship	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Pacific Futures - Whanau Ora	**$10,966.98**	**$14,083.79**	**$14,083.79**	**$14,083.79**	**$13,092.41**	**$13,092.41**	**$13,092.41**	**$13,092.41**	**$13,092.41**	**$13,092.43**	**$13,092.43**	**$13,092.43**	**$157,957.67**
SIPPC													
SIPPC - MoH PPDF Income	$47,631.54	$47,631.54	$47,631.54	$47,631.54	$47,631.54	$47,631.54	$47,631.54	$47,631.54	$47,631.54	$47,631.54	$47,631.54	$47,631.54	$571,578.52
SIPPC - MSD PPDF Income	$15,833.33	$15,833.33	$15,833.33	$15,833.33	$15,833.33	$15,833.33	$15,833.33	$15,833.33	$15,833.33	$15,833.33	$15,833.33	$15,833.33	$190,000.00
SIPPC - Networking	$14,416.67	$14,416.67	$14,416.67	$14,416.67	$14,416.67	$14,416.67	$14,416.67	$14,416.67	$14,416.67	$14,416.67	$14,416.67	$14,416.67	$173,000.00
SIPPC - Wages (Coordinator)	($7,836.58)	($7,836.58)	($7,836.58)	($7,836.58)	($8,032.50)	($8,032.50)	($8,032.50)	($8,032.50)	($8,032.50)	($8,032.50)	($8,032.50)	($8,032.50)	($95,606.33)
SIPPC - Wages (Social Worker)	($4,309.44)	($4,309.44)	($4,309.44)	($4,309.44)	($4,417.17)	($4,417.17)	($4,417.17)	($4,417.17)	($4,417.17)	($4,417.17)	($4,417.17)	($4,417.17)	($52,575.14)
SIPPC - Vehicle Lease (Social Worker)	($663.00)	($663.00)	($663.00)	($663.00)	($663.00)	($663.00)	($663.00)	($663.00)	($663.00)	($663.00)	($663.00)	($663.00)	($7,956.00)
SIPPC - Vehicle Insurance (Social Worker)	($164.00)	($164.00)	($164.00)	($164.00)	($164.00)	($164.00)	($164.00)	($164.00)	($164.00)	($164.00)	($164.00)	($164.00)	($1,968.00)
SIPPC - Vehicle Fuel (Social Worker)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($200.00)	($2,400.00)
SIPPC - Other vehicle costs (Social Worker)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($600.00)
SIPPC - Vehicle Lease (Tony F)	($694.00)	($694.00)	($694.00)	($694.00)	($694.00)	($694.00)	($694.00)	($694.00)	($694.00)	($694.00)	($694.00)	($694.00)	($8,328.00)
SIPPC - Vehicle Insurance (Tony F)	($83.80)	($83.80)	($83.80)	($83.80)	($83.80)	($83.80)	($83.80)	($83.80)	($83.80)	($83.80)	($83.80)	($83.80)	($1,005.60)
SIPPC - Vehicle Fuel (Tony F)	($500.00)	($500.00)	($500.00)	($500.00)	($500.00)	($500.00)	($500.00)	($500.00)	($500.00)	($500.00)	($500.00)	($500.00)	($6,000.00)
SIPPC - Other vehicle costs (Tony F)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($50.00)	($600.00)
SIPPC - Direct Cost	($52,000.00)	($52,000.00)	($52,000.00)	($52,000.00)	($52,000.00)	($52,000.00)	($52,000.00)	($52,000.00)	($52,000.00)	($52,000.00)	($52,000.00)	($52,000.00)	($624,000.00)
Total SIPPC	**$11,330.72**	**$11,330.72**	**$11,330.72**	**$11,330.72**	**$11,027.07**	**$11,027.07**	**$11,027.07**	**$11,027.07**	**$11,027.07**	**$11,027.07**	**$11,027.07**	**$11,027.07**	**$133,539.46**
Total Income	**$43,487.97**	**$52,659.58**	**$52,085.67**	**$73,453.00**	**$46,712.13**	**$47,213.28**	**$45,650.63**	**$47,749.72**	**$48,983.89**	**$54,001.26**	**$53,446.12**	**$54,961.31**	**$620,404.58**
Gross Profit	**$43,487.97**	**$52,659.58**	**$52,085.67**	**$73,453.00**	**$46,712.13**	**$47,213.28**	**$45,650.63**	**$47,749.72**	**$48,983.89**	**$54,001.26**	**$53,446.12**	**$54,961.31**	**$620,404.58**
Expenses													
Personnel Costs													
Salaries & Wages	$16,718.32	$27,917.87	$26,824.21	$26,824.21	$27,105.46	$27,105.46	$27,236.70	$27,236.70	$27,236.70	$27,236.70	$27,236.70	$27,236.70	$315,915.72
Clothing Allowance	$26.00	$26.00	$26.00	$26.00	$26.00	$26.00	$26.00	$26.00	$26.00	$26.00	$26.00	$26.00	$312.00
Recruitment Costs													$0.00
Recruitment Advertising	$10,000.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$10,000.00
Workforce Development Costs													$0.00
Prof. Fees/Registration/Superv	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$12,000.00
Conferences	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Staff Health & Well Being	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Personnel Costs													$0.00
ACC Levy	$650.00	$650.00	$650.00	$650.00	$650.00	$650.00	$650.00	$650.00	$650.00	$650.00	$650.00	$650.00	$7,800.00
Kiwisaver Employer Contrib.	$501.55	$837.54	$804.73	$804.73	$813.16	$813.16	$817.10	$817.10	$817.10	$817.10	$817.10	$817.10	$9,477.47
Other Personnel Costs	$100.00	$100.00	$6,000.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$7,100.00
Admin Personnel Cost Allocat'n	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Personnel Costs	**$28,995.87**	**$30,531.41**	**$35,304.93**	**$29,404.93**	**$29,694.62**	**$29,694.62**	**$29,829.80**	**$29,829.80**	**$29,829.80**	**$29,829.80**	**$29,829.80**	**$29,829.80**	**$362,605.19**

Pacific Trust Canterbury
PO Box 13-285
Christchurch

DRAFT BUDGET

Profit & Loss [Multi-Period]

July 2016 To June 2017

Account Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
Property, Plant & Equipment													
Property Rent	$25,270.00	$25,270.00	$25,270.00	$25,270.00	$25,270.00	$25,270.00	$25,270.00	$25,270.00	$25,270.00	$25,270.00	$25,270.00	$25,270.00	$303,240.00
Property Rates	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Electricity	$700.00	$800.00	$800.00	$900.00	$1,000.00	$1,050.00	$1,050.00	$1,000.00	$1,000.00	$1,000.00	$900.00	$900.00	$11,100.00
Security Contract	$130.00	$130.00	$130.00	$130.00	$130.00	$130.00	$130.00	$130.00	$130.00	$130.00	$130.00	$130.00	$1,560.00
Cleaning Contract	$1,342.00	$1,342.00	$1,342.00	$1,342.00	$1,342.00	$1,342.00	$1,342.00	$1,342.00	$1,342.00	$1,342.00	$1,342.00	$1,342.00	$16,104.00
Cleaning Consumables	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$2,400.00
Repairs & Maint - Buildings	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$1,200.00
Repairs & Maint - Plant&Equip	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$1,200.00
Repairs & Maint - Furn & Fitt	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$1,200.00
Insurance - Plant	$606.00	$606.00	$606.00	$606.00	$606.00	$606.00	$606.00	$606.00	$606.00	$606.00	$606.00	$606.00	$7,272.00
Depreciation - Buildings	$41.67	$41.67	$41.67	$41.67	$41.67	$41.67	$41.67	$41.67	$41.67	$41.67	$41.67	$41.67	$500.04
Depreciation - Plant & Equip	$2,500.00	$2,500.00	$2,500.00	$2,500.00	$2,500.00	$2,500.00	$2,500.00	$2,500.00	$2,500.00	$2,500.00	$2,500.00	$2,500.00	$30,000.00
Depreciation - L'hold Alterat.	$4,583.33	$4,583.33	$4,583.33	$4,583.33	$4,583.33	$4,583.33	$4,583.33	$4,583.33	$4,583.33	$4,583.33	$4,583.33	$4,583.33	$55,000.00
Misc Prop Plant & Equip Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Property, Plant & Equipment	**$35,673.00**	**$35,773.00**	**$35,773.00**	**$35,873.00**	**$35,973.00**	**$36,023.00**	**$36,023.00**	**$35,973.00**	**$35,973.00**	**$35,973.00**	**$35,873.00**	**$35,873.00**	**$430,776.04**
Telecommunication & IT Costs													
Telephone Call Charges	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$14,400.00
Mobile Phones	$2,200.00	$2,200.00	$2,200.00	$2,200.00	$2,200.00	$2,200.00	$2,200.00	$2,200.00	$2,200.00	$2,200.00	$2,200.00	$2,200.00	$26,400.00
Computer User Support	$3,900.00	$3,900.00	$3,900.00	$3,900.00	$3,900.00	$3,900.00	$3,900.00	$3,900.00	$3,900.00	$3,900.00	$3,900.00	$3,900.00	$46,800.00
Depreciation - Telecomm & IT	$833.33	$833.33	$833.33	$833.33	$833.33	$833.33	$833.33	$833.33	$833.33	$833.33	$833.33	$833.33	$10,000.00
Misc Telecomm & IT Costs	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$1,200.00
Total Telecommunication & IT Costs	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$8,233.33**	**$98,800.00**
Transport Costs													
Vehicle Lease Costs	$5,150.00	$5,150.00	$5,150.00	$5,150.00	$5,150.00	$5,150.00	$5,150.00	$5,150.00	$5,150.00	$5,150.00	$5,150.00	$5,150.00	$61,800.00
Fuel Costs	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$24,000.00
Repairs & Maint - Vehicles	$1,000.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$3,200.00
Parking Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxi Fares	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$1,800.00
Insurance - Motor Vehicles	$780.00	$780.00	$780.00	$780.00	$780.00	$780.00	$780.00	$780.00	$780.00	$780.00	$780.00	$780.00	$9,360.00
Other Transport Costs	$80.00	$80.00	$80.00	$80.00	$80.00	$80.00	$80.00	$80.00	$80.00	$80.00	$80.00	$80.00	$960.00
Total Transport Costs	**$9,160.00**	**$8,360.00**	**$8,360.00**	**$8,360.00**	**$8,360.00**	**$8,360.00**	**$8,360.00**	**$8,360.00**	**$8,360.00**	**$8,360.00**	**$8,360.00**	**$8,360.00**	**$101,120.00**
Management/Administration Cost													
Accounting Fees	$1,500.00	$900.00	$1,500.00	$2,500.00	$900.00	$900.00	$900.00	$900.00	$900.00	$900.00	$1,500.00	$2,500.00	$15,800.00
Audit Fees	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$700.00	$8,400.00
Bank Charges & Fees	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$2,400.00
Advertising & Marketing	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$1,200.00
Photocopier Charges	$400.00	$400.00	$400.00	$400.00	$400.00	$400.00	$400.00	$400.00	$400.00	$400.00	$400.00	$400.00	$4,800.00
Postage	$300.00	$200.00	$200.00	$300.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$2,600.00
Printing	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Stationery	$900.00	$300.00	$300.00	$300.00	$300.00	$300.00	$600.00	$300.00	$300.00	$300.00	$300.00	$300.00	$4,500.00
Subscriptions & Memberships	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,167.25	$0.00	$0.00	$0.00	$1,167.25
Equipment Lease	$703.00	$703.00	$703.00	$703.00	$703.00	$703.00	$703.00	$703.00	$703.00	$703.00	$703.00	$703.00	$8,436.00
Insurance	$344.75	$344.75	$344.75	$344.75	$344.75	$344.75	$344.75	$344.75	$344.75	$344.75	$344.75	$344.75	$4,137.00
Legal Fees	$100.00	$2,000.00	$2,000.00	$2,000.00	$2,000.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$8,800.00
Consumables	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$2,400.00
Meeting Expenses	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$1,200.00

Pacific Trust Canterbury
PO Box 13-285
Christchurch

DRAFT BUDGET

Profit & Loss [Multi-Period]

July 2016 To June 2017

Account Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
Other Assets	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$1,200.00
General Expenses	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$300.00	$3,600.00
Gifts & Staff & Xmas Functions	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$2,400.00
Manag/Admin Cost Allocation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Management/Administration Cost	**$6,147.75**	**$6,747.75**	**$7,347.75**	**$8,447.75**	**$6,747.75**	**$4,847.75**	**$5,147.75**	**$4,847.75**	**$6,015.00**	**$4,847.75**	**$5,447.75**	**$6,447.75**	**$73,040.25**
Governance Costs													
Directors' Fees	$3,200.00	$1,200.00	$1,200.00	$2,400.00	$1,200.00	$1,200.00	$5,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$1,200.00	$21,600.00
Directors' Meeting Expenses	$150.00	$150.00	$150.00	$1,500.00	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$150.00	$3,150.00
Board Training/Professional development	$250.00	$250.00	$250.00	$250.00	$250.00	$250.00	$250.00	$250.00	$250.00	$250.00	$250.00	$250.00	$3,000.00
Whanau Ora Committee Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Directors' Expenses	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Governance Costs	**$3,600.00**	**$1,600.00**	**$1,600.00**	**$4,150.00**	**$1,600.00**	**$1,600.00**	**$5,600.00**	**$1,600.00**	**$1,600.00**	**$1,600.00**	**$1,600.00**	**$1,600.00**	**$27,750.00**
Total Expenses	**$91,809.96**	**$91,245.50**	**$96,619.02**	**$94,469.02**	**$90,608.71**	**$88,758.71**	**$93,193.89**	**$88,843.89**	**$90,011.14**	**$88,843.89**	**$89,343.89**	**$90,343.89**	**$1,094,091.48**
Operating Profit	**($48,321.98)**	**($38,585.91)**	**($44,533.36)**	**($21,016.02)**	**($43,896.58)**	**($41,545.43)**	**($47,543.26)**	**($41,094.16)**	**($41,027.24)**	**($34,842.62)**	**($35,897.76)**	**($35,382.57)**	**($473,686.90)**
Net Profit/(Loss)	**($48,321.98)**	**($38,585.91)**	**($44,533.36)**	**($21,016.02)**	**($43,896.58)**	**($41,545.43)**	**($47,543.26)**	**($41,094.16)**	**($41,027.24)**	**($34,842.62)**	**($35,897.76)**	**($35,382.57)**	**($473,686.90)**

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Mental Health

GENERAL MANAGER
Administration Building
Hillmorton Hospital
Private Bag 4733
Christchurch 8140

Phone: (03) 339 1133
Facsimile: (03) 339 1111

M E M O

TO: All AT&R Staff

COPY TO: Peri Renison, Chief of Psychiatry
Stu Bigwood, Director of Nursing
Sandy Clemett, Director of Allied Health
Barbara Wilson, Quality Manager
Michael Frampton, Chief People Officer
Mary Gordon, Executive Director of Nursing

FROM: Toni Gutschlag - General Manager

DATE: 19th March 2018

SUBJECT: **AT&R EXTERNAL REVIEW**

Please find attached the Independent Review Team Report, of the external review commissioned by Canterbury District Health Board in 2017. This report has now been received by the Board and approved for release, the report was received as is and no amendments or edits have been made.

The report is comprehensive and the reviewers make numerous recommendations, some of which I know have already been implemented.

Now that the review has been completed and we move into the implementation phase, the executive sponsorship has transition from Michael Frampton (People and Capability) to Mary Gordon (Nursing).

I anticipate that implementation will require several different phases.

1. What is required and able to be done immediately, within our current environment (building)?
2. What is required and able to be done in the short-medium term, ie is going to take some time to set up?
3. What is required when the pods are operational (2020)?

These are important considerations for you to make as a team and service to ensure we prioritise the things that you support and believe will make a difference.

As you become clearer about how and what you want to progress, we can then advise the executive team and work through their required processes.

Your service leadership team will ensure your clinical leads and myself are kept well informed about your processes and progress with this however I am also really happy to meet with you directly if you would like, as are the divisional clinical leaders.

Kind Regards

Toni Gutschlag

Independent Review Team Report to General Manager, People and Capability, Canterbury District Health Board

Paul White
Dr David Bathgate
Murray Gordon

29 November 2017

CONTENTS

EXECUTIVE SUMMARY

1. The review team has had no difficulty with engaging with stakeholders, and enjoyed open access to any information it asked for. As a result of the team's inquiries, the review team easily reached a consensus view on the following points/recommendations:

    1.1. The staff in the AT & R Unit are extremely dedicated, but are also frustrated and at risk of burnout.

    1.2. The current building in which the AT & R unit is based is unsatisfactory for its purpose.

    1.3. The current building is also not being used to its full potential and other steps could be taken that are easier to implement than obtaining a new facility.

    1.4. Areas of the ward could be more attractive so as to attract patients to utilise areas on the unit.

    1.5. The Occupational Therapist employed on the ward should be taken "out of numbers" on the ward, and activates staff employed to support the occupational therapist in keeping patients active.

    1.6. Nurses should be empowered to formulate and write behavioural plans for patients.

    1.7. Greater consistency needs to be developed between patients' behavioural plans and treatment plans, which should occur if nurses take a greater role in the formulation of behavioural plans.

    1.8. Observational visits to other similar units in New Zealand for nursing staff would be useful.

    1.9. SPEC trainers should be involved in reviewing the appropriateness and effectiveness of any restraints used in the AT & R Unit.

    1.10. Greater consideration should be given to staffing mix on any shift to ensure that there is always sufficient staffing to conduct a safe restraint.

1.11. Consideration should be given to automatic control of the airlock entry to the Unit from a remote position.

1.12. Consideration should be given to improved duress alarms that notify where on the Unit an event is located.

1.13. A clear procedure should be developed for non AT&R staff coming onto the ward to assist when a duress alarm is activated.

2. These comments /recommendations are set out in more detail below.

TERMS OF REFERENCE

3. The review team has operated under terms of reference that were provided for the review of the AT&R service. The purpose of the review as set out in those terms of reference was:

> "*To provide information, advice and guidance to the CDHB that will assist in the identification of risks present in the AT&R service and appropriate strategies to eliminate or reduce those risks. In particular, the review group is expected to:*
>
> *(a) Identify all stakeholders involved in the provision of healthcare to consumers through AT&R.*
>
> *(b) Identify the key risks to consumers and staff present at the AT&R service, including any legal requirements to take consumers or refuse access to the service based on the current model of care.*
>
> *(c) Advise on and review the effectiveness of the current strategies stakeholders use to manage the identified risks.*
>
> *(d) Review the model of care with reference to alternative models applied nationally or international including strategies to manage the identified risks.*
>
> *(e) Advise on addition, or modification to, strategies for managing the identified risks with a view to:*
>
> *(i) Achieving the best outcomes for staff and consumers,*
>
> *(ii) Reducing the current injury rate of staff, and*
>
> *(iii) Taking into account any potential impact on other services provided by CDHB or other providers within Canterbury or across New Zealand.*"
>
> "*Identify measures to evaluate the success of the review.*"

4. The terms of reference also set out an ambitious timeline. Early on in the review team's progress it was identified that that timeline would not be practical to achieve, but the review team has completed this review as expeditiously as possible.

5. Consistent with the operating principles set out in the terms of reference, the review team members have found no difficulty in obtaining a consensus in their decision making. This report presents that consensus view.

6. The review team has also had no difficulty in working collaboratively and cooperatively with stakeholders. All of the individuals that were spoken to, which represented all of the stakeholders identified, spoke to us freely and provided useful information. The review team found no difficulty in having everyone providing information as requested.

7. The review team considers all information that it has received has been provided in good faith. In order to maintain confidentiality of the information, and particularly the sources of that information, no individuals are identified in this review report.

8. The review team has provided some initial advice orally to the senior leadership team at the completion of a two day visit to the AT&R unit at Hillmorton Hospital. That was a preliminary view. However, the ultimate findings of the review team as set out in this report do not differ markedly from those initial comments that were made.

CONFLICTS OF INTEREST

9. None of the review team members have any conflict of interest in conducting this review. But, in the interests of being completely open with any person who might read this report, it was identified that certain review team members have had interactions with CDHB and the service in the past. Those interactions include the leader of the review team regularly providing external legal advice to CDHB on various matters. That has included in the distant past providing advice and representation on health and safety matters within the wider mental health service at CDHB. The leader of the review team has not had any previous involvement with the AT&R service.

10. Dr David Bathgate has been involved with the peer review of treatment plans around one of the current patients in the AT&R unit. That patient was regularly referred to by a number of persons who spoke with the review team. However, the review team was not focused on individual patients in completing their review. The review team took the approach that it would be inappropriate to focus on specific patients (other than in

one particular regard that is referred to later in this report) as patients on the unit will change from time to time. In order to ensure a sustainable approach to reducing risks in the unit, matters need to be addressed in a systemic fashion to apply to any potential patients and patients in the unit, rather than focusing on individual current patients.

11. Dr Bathgate was also involved in the credentialing process for the AT&R service this year.

STAKEHOLDERS

12. The review team identified the following groups as stakeholders for this review:

    (a) Patients;

    (b) Patient whanau/families;

    (c) Staff; and

    (d) CDHB management.

13. Representatives from all but one of those stakeholder groups were spoken to by one or more members of the review team. Ideally, the review team would have had the opportunity to speak with more representatives of the patient whanau/families than was able to be achieved. However, the review team does not consider that they have been deprived of any information as those representatives who were spoken to, and also the CDHB mental health service's family advisor who also provided information, contributed valuably.

14. The exception to the review team group speaking with all of the identified stakeholders is that patients themselves were not spoken to about the review and its purpose. The review team instead took into perspective the patients' perspectives by speaking with the patient advisor and also the Pukenga Atawhai.

BACKGROUND AND CONTEXT

15. The background to this review was set out in the terms of reference, which is attached to this review report as an appendix.

16. The review team also understood that the instigation behind this review was a view by the CDHB Board that the level of injury to staff in the AT&R unit was unacceptably high. It was also understood that, over recent years, the overall staff injury rate across

the DHB has substantially reduced, as has been desirable. The same level of reduction was not apprehended to have occurred in the AT&R unit. The AT&R unit is viewed as having a disproportionately high staff injury rate compared with other areas of the DHB.

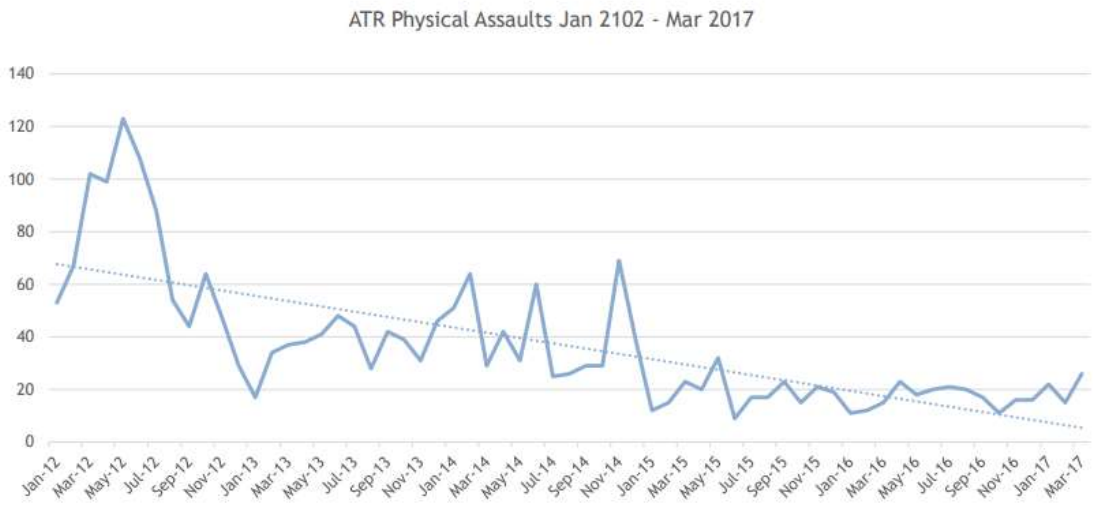
17. The review team also understands that preceding that event, there were already seven members of staff from the AT&R unit off on long-term leave through injuries sustained in the unit.

18. This background suggests a focus on staff injuries. But the review team has approached its task, and made recommendations, on the risk of injury to all persons in the unit, including the patients. It was evident to the review team from information it viewed and the reports of people spoken to that there were a number of incidents of patients being assaulted in the unit by other patients. That phenomenon needs to be addressed the same as the phenomenon as injuries to staff. The review team's focus has included this issue in its considerations, and in making its recommendations.

19. Regrettably, on the eve of the review team attending at the AT&R unit, there was a significant event in the AT&R unit. That event, as described to the review team, resulted in several staff injuries, some of them serious, including two hospitalisations of staff. That event featured in accounts provided by persons spoken to.

Overall injury rates

20. The review team was cognisant of this background, but also considered it significant that when the overall statistics of the unit were looked at over the years, there appears to still be a downward trend in the level of staff injury rates. That is shown in a Powerpoint presentation entitled AT&R Update on the Intellectually Disabled Person's Health Service dated April 2017 that the review team was provided (extract below).



21. As the above graph shows, in 2012 the total number of physical assaults, which is taken to include assaults on staff and also other patients, was extremely high. That has reduced significantly through until early 2016. Since that time there has been a less dramatic increase. Some of the peaks and troughs in those reported numbers of assaults will be attributable to the different patients, and mix of patients, on the unit at the particular time. That factor of a variable rate of assaults and therefore risk of assaults underlines the review team's focus on systemic issues that might address these risks rather than having to focus on individual patients, with future patients' characteristics being unknown.

22. The review team did not identify anything throughout its enquiries that indicated anything in the AT&R update provided in April 2017 was incorrect. All of the comments within that update, including the clinical challenges and the resource challenges identified are accurate along with the health and safety challenges. The April 2017 AT&R update is attached as Appendix 2.

Staff

23. It was apparent to the review team that the staff in the AT&R unit are extremely dedicated. They are also frustrated and at risk of burn out. They face the real prospect of suffering injury every shift that they work. That situation is not fair to them. It also potentially increases the risk of injury in the unit. Staff under such conditions will inevitably act differently in pressured situations at work. While the review team saw no evidence that such behaviour has occurred, it is realistic that staff could have a lower threshold for utilising seclusion on patients due to their perceptions of risk.

24. This scenario adds to the reasons why quick steps to improve safety are necessary.

The building

25. The other material piece of background information is that it has been identified that the current building that the AT&R unit is based in is unsatisfactory for its purpose. It was a facility built in the 1970s, and never designed as a secure unit. It is required to be a secure unit now due to the nature of the patients who are referred into it through the justice system under the IDCC&R Act. Similarly, other patients that are in the unit under the Mental Health Act are also required to be in a secure environment.

26. The unit is also difficult to modify as it is understood to contain asbestos. That creates practical difficulties in making structural changes.

27. The physical environment is commented on further specifically below, but there are plans to make a significant modification to the unit as a compromised option to a full rebuild of the unit – which would be an ideal scenario. That ideal scenario is not understood to be planned currently, and also would be unlikely to be completed within a timeframe of less than the next 10 years.

The seclusion area

28. The review team considered a one month summary of incident reports submitted for the AT&R service. Those reports did not reveal any apparent pattern. While it had been reported by some stakeholders that the assaults were primarily caused by staff restraining particular patients, and in particular when a patient in a restraint was being moved to the area of seclusion, other anecdotal information provided was that assaults on staff could usually be predicted, and also that one or two particular patients were responsible for the injuries reported. The summary information did not fit with any of these accounts, and the nature of the incidents appeared more varied. The reports that the review team saw actually included unprovoked assaults on other patients and staff. It was therefore clear that not all of the assaults occur during restraints, and some of these are unprovoked. It is possible that if the actual events were more closely considered some of the reported features may have been evident.

29. The summary may also have been influenced by changes already made to the AT&R unit to minimise the risk of such injuries. Those steps include widening the doorway between the unit and the seclusion area to allow better access during a restraint. The flooring material has also been changed from carpet to another material that is not so likely to cause burns to staff should they fall onto the floor during the restraint.

30. What is not ideal, but cannot be easily remedied, is the fact that the seclusion area is a considerable distance away from the general unit area. Any person being placed into seclusion has to come out of the locked area in the unit, through a widened doorway, down a short corridor and into the seclusion area. That route also requires the doors of offices off the hallway to be closed while the person is transited. There is no easy way to remedy that situation other than building a new unit.

31. The location of the seclusion area also does not lend itself to having a de-escalation area where a person may be placed short of being actually in the seclusion and allowed to de-escalate if possible prior to the use of a restraint. Again, that could only be remedied with the construction of a new unit.

32. In terms of addressing these risks and trying to minimise the risk to both patients and staff, the review team has come up with several recommendations for CDHB to consider. These recommendations are at several levels. The ideal, is that work is undertaken to try and arrange for the construction of a new dedicated facility that is fit for purpose. The review team is mindful that that will not be a short and easy outcome to achieve, but it would assist in a significant way to the safety of patients and staff in the unit.

KEY RISKS TO PATIENTS AND STAFF

33. Item (b) under the review team's terms of reference required the identification of key risks to patients and staff present at the AT&R service. That identification process was specified to include any legal requirements to take patients or refuse access to the service based on the current model of care.

34. There is a clear risk to patients and staff of violence within the unit. That risk is posed by the behaviours of certain individuals that are housed in that facility. Those behaviours may be made more likely to manifest by the stressful environment that people are placed in which is an inevitability of going into such a service. In addition, long term residents in the AT&R unit are likely to become institutionalised and comfortable in controlling certain areas of the unit. The review team is conscious that this may be occurring within the unit, and several of the recommendations are focused on this particular issue.

35. CDHB has appropriately identified the risk of violence and aggression in the health and safety documentation present for the AT&R unit.

41. Steps have also been taken to try and reduce the risk of aggression on the AT&R unit. Those steps have included additional senior staffing on afternoon shifts, and reducing the number of patients in the AT&R unit so as to drop the staff:patient ratio.

42. The steps utilised in the AT&R unit can also include employing the use of seclusion, consistent with the legislation requirements on using seclusion.

43. Those strategies, while normal for a unit like the AT&R unit, will not eliminate the risk. The review team saw and heard information about assaults by patients that were unexpected and seemingly unprovoked. Such events do not allow the use of seclusion to prevent the assault as it cannot be predicted.

44. Further, the location of the unit's seclusion room increases the chances of an injury to staff (or the patient) when a restraint is used to get a patient into the seclusion area. So seclusion can, and has, on occasions caused injuries.

45. Additional comments on the effectiveness of current strategies is incorporated into the recommendations below.

REVIEWING MODEL OF CARE

46. Since 2015, the AT&R service has used a behavioural model of care. That model of care is generally appropriate, and would be consistent with similar models of care employed elsewhere. The real difference between various institutions providing a behavioural model of care is the extent to which different professions are involved in the provision of that care. CDHB's model as it was originally framed is reliant on psychologists and behavioural experts. The difficulty in providing the care under that model is that it is very difficult to recruit to those positions. CDHB is experiencing that difficulty.

47. The recommendations made do not suggest a different model of care, but do address how that model might be modified in light of the recruitment challenges.

RECOMMENDATIONS

48. While the report above makes some specific comments in relation to the particular points set out in the terms of reference, the review team has taken a more holistic approach to addressing matters and formulating recommendations that might assist in improving the safety of the service.

Rebuilding AT&R unit

49. In making its recommendations, the review team has been conscious that any rebuilding, even with the compromised add-on that is understood to be contemplated, will take time. That means that the review team has focused on making recommendations that could be relatively quickly implemented with far less cost. These are seen to be more achievable and realistic, and are suggested to try and use the existing ward to its full potential. However, the review team in making these suggestions does not intend to suggest that a significant rebuild of the facility, and ideally a completely new facility, would be an ideal situation. However, even that rebuild would not be a complete panacea for the issues that are currently evident on the AT&R unit. Other steps should be taken as well.

Proposed building work

50. The actual plans for the proposed building work have not been sighted by the review team. However, the review team, while considering some additional building could be beneficial (as a distant second-best alternative to a completely new build), recommends consideration of certain features in any building modification.

51. It is understood that the proposed addition involves a pod-type scenario where certain patients could be placed. That scenario will benefit the unit in being able to separate certain individuals who may pose a risk when placed together. If possible, it will be worth CDHB considering whether that new build should also include an additional seclusion space with a de-escalation area. That would allow patients within that pod structure to be dealt with more effectively when seclusion may be necessary, including the ability to de-escalate the patients. That could then be done without having to transit through the existing hallway into the seclusion area. Additionally, if there was any way to allow this seclusion area to be accessed from both the existing unit and the new area without the risks associated with accessing the existing seclusion area, then that would be beneficial.

52. Even the modified addition to the facility is going to take some time to complete (assuming it can be progressed). There are other additional steps that the review team considers could be taken in the interim.

Attractiveness of unit

53. The first recommendation that the review team has in this regard (and the order of these recommendations do not indicate a specific priority) is to address the

attractiveness of other areas of the unit that are further away from the area of focus in the unit.

54. Currently, there is an emphasis on the area of the unit that is most proximate to the nursing office area. That is where most activity in the unit appears to be conducted. Patients will naturally follow staff. If patients locate themselves in that area it maximises their interaction with, and ability to observe, staff that are coming and going from the office area. It also allows viewing of any people entering the unit from outside.

55. Additionally, this area is right next to the lounge area that is the most attractive environment in the unit. Not only is it most attractive in terms of its appearance, but there is stimulation provided by the TV in that lounge area.

56. It was also apparent that a particular long-term resident patient dominates the lounge area watching a certain channel on Sky TV. That allows him to dominate the TV in terms of what channel is watched, and also dominate the area by observing anybody in that area including in the adjacent vestibule. That domination lends itself to conflict with other residents who may have a different preference as to the television channel watched or other activity in the area.

57. In contrast to this area, there is a significant area of the unit that appears less attractive, and under-utilised. Recently, doors have been placed along the hallway that leads to that area so as to allow the separation of the unit into different areas. That usefully allows the separation of certain individuals that may provoke each other and lead to an increased risk of violence.

58. What should be done in the review team's view, is to increase the attractiveness of the end of that unit beyond those doors. There is an under-utilised lounge area in that area. If that additional lounge area could be made more attractive such as the current lounge area more adjacent to the nurses' station, and the particular patient that dominates that area could be enticed to spend more time in that space, that would allow greater utilisation of the unit by others, with less opportunity for conflict.

59. Enticing the particular patient being referred to into the other lounge area would obviously require the equipping of that area with another TV, with the channel that that patient chooses to watch available on it. It will be necessary though to make the area more attractive as well. Staff utilisation of the other office area adjacent to this additional lounge would assist in attracting patients to the lounge. If the staff are there, patients will follow.

60. In addition, given that the patient is so institutionalised in terms of having a habitual focus on the existing lounge area, there will need to be behavioural techniques employed to incentivise him to use the other area.

61. In making this recommendation the review team is conscious that any attempt to modify entrenched behaviours by a resident may create an increased risk of violence on the unit. Any move therefore has to be carefully planned, with consistent management strategies employed to address any behavioural outbursts.

62. If this strategy was considered too difficult by staff with a greater understanding of the patients' behaviour than the review team has, then an alternative option could be considered. That alternative option could involve maintaining the patient in the current lounge area with the door closed, and development of the other (currently underutilised) lounge in the ward for the remaining patient group.

Stimulation in unit

63. A further recommendation is around the level of stimulation provided in the unit. With the way that the unit was structured back in 2015 in terms of its staffing, the occupational therapist was "put on numbers". That meant that 0.5 FTE of the occupational therapist's time is spent effectively working as a nurse/healthcare assistant in the unit providing direct care to the patients.

64. That placement compromises the OT's ability to construct programmes in the unit for the patients' stimulation. In addition, the practical reality of the structure is that the OT also gets called back "into the numbers" on short notice to cover any staff absences. With the long-term staff absences through to injury this calling back into the numbers is happening with greater frequency. That disrupts any programmes that the OT wishes to implement, and further compounds the issue of a lack of stimulation for the patients.

65. A firm recommendation that the review team makes is that the occupational therapist is taken "off numbers" to allow her to be totally devoted to occupational therapy activities in the unit.

66. It would also be beneficial to employ activities staff, not counted in numbers, to run 1:1 sessions with patients, facilitate groups, and take patients on outings. These activities staff would ease the pressure on nurses, and support the occupational therapist. The emphasis in recommending this approach is that programmes are developed for the occupation of the patients in the unit so as to provide a greater level of stimulation to

them. If patients' time is occupied through activity, it will assist in reducing the risk of assaults and injury.

Behavioural plans

67. Along a similar vein to the recommendation that the OT be brought back out of numbers, is a further issue that the review team identified with the behavioural model of care. There is no doubt that when this behavioural model of care was implemented in around 2014/2015 that it made a huge difference in the injury rates within the AT&R unit. That is evident from the graph shown above. It also appears to be of an appropriate focus in terms of the maximising of independence of the patients with intellectual disabilities.

68. However, that behavioural model of care as it was set out by CDHB was dependent on having qualified staff appointed to positions in the structure. Those positions include a psychologist and behavioural specialist.

69. Particularly in recent times, there has been an absence of persons able to fill those roles, with there only currently being one behavioural specialist and one psychologist that are employed and who are shared with other wards.

70. In short, if a behavioural model of care is going to be utilised, which the review team agrees is appropriate, then some other structure needs to be implemented so as to provide that model of care. It is not realistic to simply hold out the hope of finding the necessarily skilled people to fill the existing roles – every unit in the country is searching for such people.

71. The review team recommends that the CDHB utilise the two people it currently has in post who would have the necessary skills to oversee behavioural management plans. But it would be impractical and unrealistic to expect those two persons to formulate those plans themselves given their other responsibilities.

72. What the review team suggests and envisages, is that nurses on the unit would become more empowered to formulate and write behavioural management plans for the patients. The review team did hear some nursing staff suggest that making such plans was outside of their scope and/or that they were not permitted to do this by the service. That same view was not held by management that the review team spoke with. Nonetheless there is clearly a perception held by nursing staff that they can't or shouldn't be doing this work.

73. The review team considers that it is well within a registered nurse's scope of practice working in mental healthcare to formulate behavioural management plans, particularly when there is oversight provided by other health practitioners that are specialised in this area.

74. If nurses were empowered and promoted to formulate behavioural management plans, it would also give them a greater degree of control over what is happening in the unit with the patients. That is likely to be useful in terms of reducing injury rates in more ways than simply through the direct management of the patient's behaviour as set out in the plan.

75. Certainly at the early stages, it would be prudent for the behavioural specialist and the psychologist that are in post, to have a role in overseeing and reviewing these plans. During that process, constructive feedback could be given so as to improve the quality of these plans. At any stage, those persons should be available to consult for any particular difficult issue encountered with the plan. Over time, the nursing staff will become more practised in this task, and will need lesser oversight.

Discordance between behavioural plans and treatment plans

76. The other similar recommendation that the review team makes, on having reviewed two patients' files while visiting the unit, is a greater concordance of the behavioural management plan with the treatment plan. On the files that were reviewed, which were limited in number, there was a behavioural plan in the file and also a treatment plan. The treatment plans did refer to the behavioural plans but there still appeared to be a discordance between the behavioural plans and the treatment plans. There is a need for a greater consistency between the behavioural plans and the treatment plans. The treatment plans should be implemented with particular reference to the points set out in the behavioural plan.

77. If the above recommendation of empowering nursing staff to take a greater role in drafting the behavioural plans was taken, this should assist in getting a greater degree of consistency between treatment plans and behavioural plans.

Arrange for nursing staff to visit other units

78. Another recommendation that the review team makes is that it would be useful for members of nursing staff in the unit to be able to visit other similar units elsewhere in the country to see how those units function. Many ideas could be taken from visiting those units and seeing how they function that could be usefully adopted at CDHB. This

would include seeing how nurses in other units are heavily involved in the behaviour management planning of patients. Ideally, the nurses who complete the visits would not only be the senior nurses on the unit.

SPEC effectiveness

79. A concern raised by some of the stakeholders was the utility and effectiveness of the SPEC process of restraint. This was viewed by some of the stakeholders as not being effective for the patients on the AT&R unit particularly when the patients are larger and stronger than the staff. The review team notes that utilisation of SPEC techniques is now uniform across the country, but in any situation it sometimes does need to be modified for the particular patient situation.

80. The review team recommends that the trainers in SPEC at CDHB specifically review the types of restraints used on patients in the AT&R unit whenever those restraints are used. Such a review can focus on whether injury occurred, or might have occurred, and whether the restraint was applied in the correct way. Even if it was applied correctly, it should also be considered whether there is a need to modify the restraint for that particular patient or in that unit. It is not clear to the review team that the SPEC trainers are in any way involved currently in reviewing the details of a restraint used. This would be a useful initiative to institute in the AT&R unit.

Staffing mix

81. The review team also recommends that specific attention is given to the staffing of each particular shift in the unit. The review team is conscious that staffing of the unit may be difficult at the current time with so many staff away due to injuries, but the situation is only going to get worse if further staff are injured.

82. What was apparent to the review team is that there was not sufficient attention being given to ensuring that there was an appropriate number of staff on any shift to conduct a safe restraint. Useful changes have been made around staffing including reducing the ratio of patients to staff, and adding senior nursing staff to the evening shift. But it was not apparent that sufficient consideration was given to whether a restraint could safely occur with the staff rostered. Consideration as to staffing for a safe restraint should give consideration to the gender mix of the staff on the shift. Similar consideration should be given to recruiting new staff.

83. The review team received comment that casual pool staff cannot be shift coordinators on the AT&R unit. Attention should be given to allowing this to occur as long as these staff are regularly on duty in the AT&R and have adequate experience.

84. Casual pool staffing also appears to be made via a central booking system. It may be useful for AT&R to be allowed to book its own casual pool staff for vacant shifts. This would allow regular staff to be booked more readily, and thus the skill mix to be managed more effectively.

Forensic aspects

85. A further recommendation that the review team makes is around the general practices in nature of the unit. The secure nature of the unit, and the patients that are resident there, is more akin to a forensic unit in terms of the level of risk posed. However, the unit due it is physical structure, is not ideal for that scenario as has been commented on above.

86. There are other issues with the unit that also do not fit well with a unit that has a forensic type of patient in terms of behavioural risk. In particular, the airlock entry to the unit involves a key system. What that allows for, and the review team understands that this has occurred on at least one occasion, is patients trying to obtain the keys off staff so as to be able to exit the unit. That obviously poses the risk to staff if an approach is made to obtain their keys.

87. Any forensic unit that was fit for purpose would usually involve an automatic control from a remote position of the doors into the unit. That allows a completely independent control of the area by somebody unable to be accessed by patients. Consideration should be given to whether such a change could be made in the unit, particularly if there is an additional build contemplated.

Duress alarms

88. Another feature of the unit in this regard is around the duress alarms that all staff have available. Currently, the alarms do not give any indication as to exactly what the nature of the alarm is for, or whereabouts on the unit the event is located. Staff would benefit in being able to quickly know through the activation of an alarm the nature of the alarm activation and whereabouts in the unit it would be. In particular, the event that occurred on the unit immediately prior to the review team's visit apparently involved staff responding to an alarm walking straight into the dangerous situation. That situation can, and should, be avoided with a better suited alarm system.

89. There also needs to be a clear procedure in place for non-AT&R staff coming onto the ward to assist when a duress alarm is activated. Staff responding from other areas need to use one entrance only, and if possible, an AT&R staff member (not involved in the restraint) should coordinate/direct responders to the appropriate area.

90. Additionally, as there is a functioning (linked) ward next door – PSAID, they could identify a duress response team/person on every shift to aid swift responding.

MEASURES TO EVALUATE THE SUCCESS OF THE REVIEW

91. The review team is optimistic that if the unit is able to implement the recommendations made above, that the risk to patients, and therefore the number of injuries will reduce. Even so, the review team is also realistic that it may take some time for these levels of injuries and assaults to reduce. That is particularly if institutionalised resident patients are having to be transitioned into a different way of behaving in the unit.

92. Even so, the review team would expect that within the next six months, if the recommendations were implemented promptly, there should be some changes evident.

93. The review team would be happy to reconvene to make a further assessment at such a time if the CDHB required that. Although, the DHB may equally be able to make its own assessment at that point.

Signed by:

Paul White

Dr David Bathgate

Murray Gordon

APPENDIX 1 – TERMS OF REFERENCE

TERMS OF REFERENCE FOR THE REVIEW OF THE AT&R SERVICE

1 Context

1.1 The Canterbury District Health Board [*CDHB*] is commissioning a review of the risks and risk management strategies associated with its Assessment Treatment and Rehabilitation [*AT&R*] services at the Hillmorton campus [the *Review*]. The CDHB is establishing an independent Review Group to carry out the Review. This document sets out the Terms of Reference for the Review Group.

1.2 The AT&R service provides specialist care to intellectually disabled consumers with behavioural problems. Services are delivered on a regional basis for consumers from Canterbury and beyond, and the delivery of care requires highly skilled staff and specialist facility design.

1.3 The AT&R service has a significantly higher staff incident rate compared with the rest of the CDHB.

1.4 In the context of the therapeutic nature of the services that are provided, the health outcomes that are sought for consumers, and the imperative to ensure consumer, staff and visitor safety, the Review is intended to assess current risk management practices and systems and to provide guidance on possible ways to improve the way in which risks are managed in order to reduce harm.

1.5 Following the identification of other stakeholders the CDHB will review these Terms of Reference with the Review Group to determine how best to collaborate with identified stakeholders through the course of the Review.

2 Accountability

2.1 The Review Group is accountable to Michael Frampton, General Manager People and Capability, Canterbury District Health Board.

3 Membership

3.1 The Review Group shall consist of the following members:

(a) Paul White [Lawyer].

(b) David Bathgate [Dr];

(c) Murray Gordon [nurse practitioner];

3.2 Support and oversight for the Review being provided by Mark Lewis, Manager – Wellbeing Health and Safety, People and Capability. Support on the Hillmorton campus with be provided by Warren Campbell-Trotter, Quality and Patient Safety on behalf of Toni Gutschlag, General Manager Specialist Mental Health Services. Additional contacts may be added or changed as the Review progresses.

4 Purpose

4.1 The purpose of the Review Group is to provide information, advice and guidance to the CDHB that will assist in the identification of risks present in the AT&R service and appropriate strategies to eliminate or reduce those risks. In particular, the Review Group is expected to:

(a) Identify all stakeholders involved in the provision of health care to consumers through AT&R.

(b) Identify the key risks to consumers and staff present at the AT&R service, including any legal requirements to take consumers or refuse access to the service based on the current model of care.

(c) Advise on and review the effectiveness of the current strategies stakeholders use to manage the identified risks.

(d) Review the model of care with reference to alternative models applied nationally or international including strategies to manage the identified risks.

(e) Advise on additional, or modification to, strategies for managing the identified risks with a view to:

(i) achieving the best outcomes for staff and consumers,

(ii) reducing the current injury rate of staff, and

(iii) taking into account any potential impact on other services provided by CDHB or other providers within Canterbury or across New Zealand.

4.2 Identify measures to evaluate the success of the Review.

5 Timeline

5.1 2 weeks to identify stakeholders in the Review and any alternative models of care.

5.2 6 weeks to complete the review once the stakeholders and alternative models of care have been identified.

6 Operating Principles

6.1 Review Group members agree to:

(a) Seek consensus in decision making to the extent possible;

(b) Work collaboratively and cooperatively with stakeholders;

(c) Provide early advice of any issues to avoid surprises;

(d) Share and receive information in good faith, and on a confidential basis where appropriate;

(e) Disclose any conflict of interest; and

(f) Abide by these Terms of Reference.

APPENDIX 2 – AT&R UPDATE APRIL 2017

AT&R UPDATE

Intellectually Disabled Persons Health Service
April 2017.

Dr Jane Hughes, Clinical Director; Claire Roelink, Nurse Consultant & Paul Kelly, Nursing Director.

AT&R Unit

- AT&R is a disability funded, secure 10 bed unit based at Hillmorton Hospital. Capped at 7 bed occupancy for safety
- Two consumer groups-Individuals with severe challenging behaviour (AT&R) and those under the IDCC&R Act (RIDSS).
- New model of care and alternative approaches to restraint and seclusion with a reduction in seclusion and assaults recognized in the 2016 DHB Quality awards.
- 2016- Onwards-model of care has been challenged by difficulty recruiting and retaining key staff-Behaviour Specialists.
- Continued challenges that culminate in periods of “crisis” in relation to peaks in risks particularly assault.

Clinical Challenges

- The unit has been unable to safely operate at full capacity of 10 beds
- Some AT&R consumers cared for in the PSAID Unit as a result
- Two consumers are cared for in the non ID Forensic unit due to risk of assault that can not be safely managed in the AT&R environment
- Additional at risk groups: under 18year olds and females

- There remain ongoing health & safety risks to consumers and staff- little reserve, such that at any time we are an admission away from crisis
- RIDSS admission pathway is external to service-courts/NIDCA and must be to a secure unit
- In Emergency situation –start escalation process within the RIDSS Contract-NIDCA-MOH when risks high++
- Major constraint-lack of RIDSS beds nationally.
- Hence most admissions are directed into the unit and there is no where else for a consumer to go, irrespective of risk

Resource Challenges

- Recruiting/retaining specialist staff
- Aged, small, re-purposed unit that despite modifications remains not fit for purpose
  - Peer interactions/dynamics frequent precipitant to assaults
  - Environment does not allow for physical separation of consumers
  - Limits observation
  - De-escalation area/seclusion poorly located
- 1:1 staff resource is utilised regularly to increase observations as a risk management strategy-$$, requires agency staff

Health & Safety Challenges

- Consistently high numbers of assaults occurring within this environment.

  AT&R has the highest rates of incidents and assaults of any unit in CDHB-40% of all incidents In SMHS (PSAID comprises 25% of all incidents in SMHS).

  2/3rds of all incident in SMHS occur in these two units despite the average occupancy of these until is 7 & 8 consumers respectively.

- Over 18 month period to 31st October 2016 – 339 assaults, 216 against staff and 123 against consumers/visitors/others.

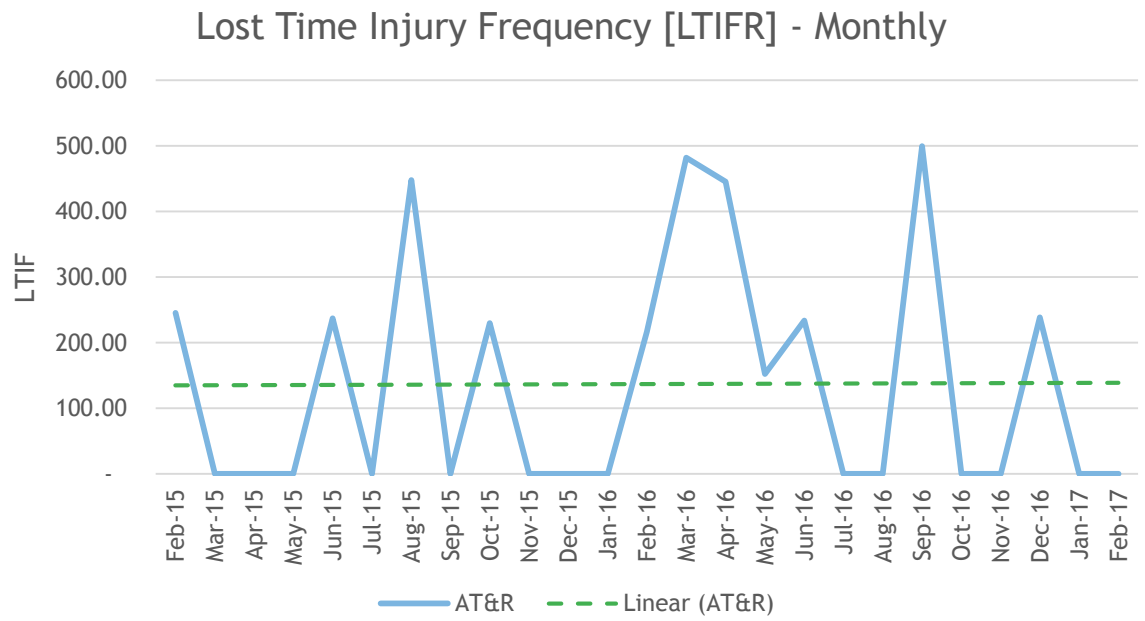
- Injury to staff or consumers occurs on average in half of these incidents.

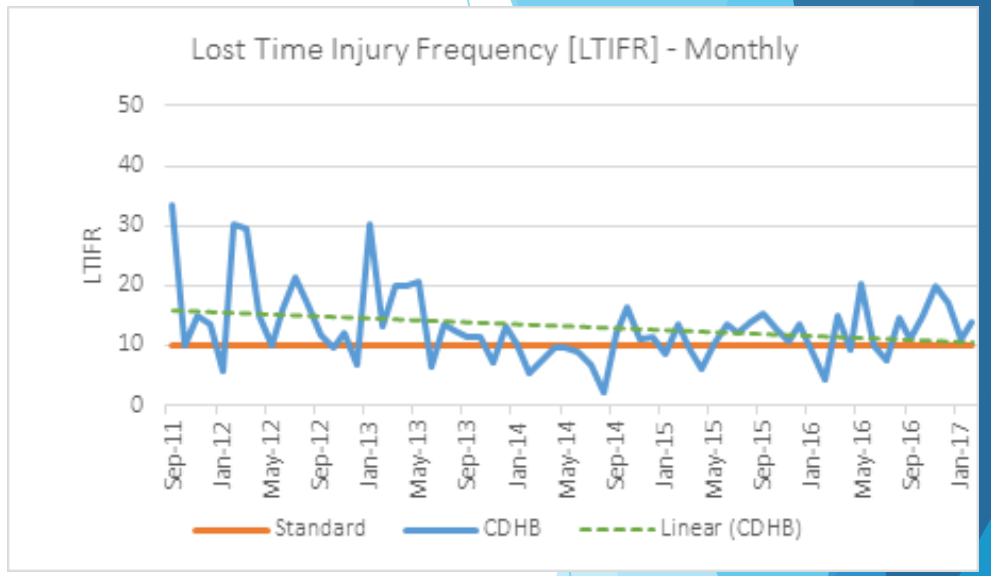
- For much of the last 18 months we have had at least one staff member off on work related ACC. The majority of those off were as a result of assault from this one patient and a number have involved head injuries

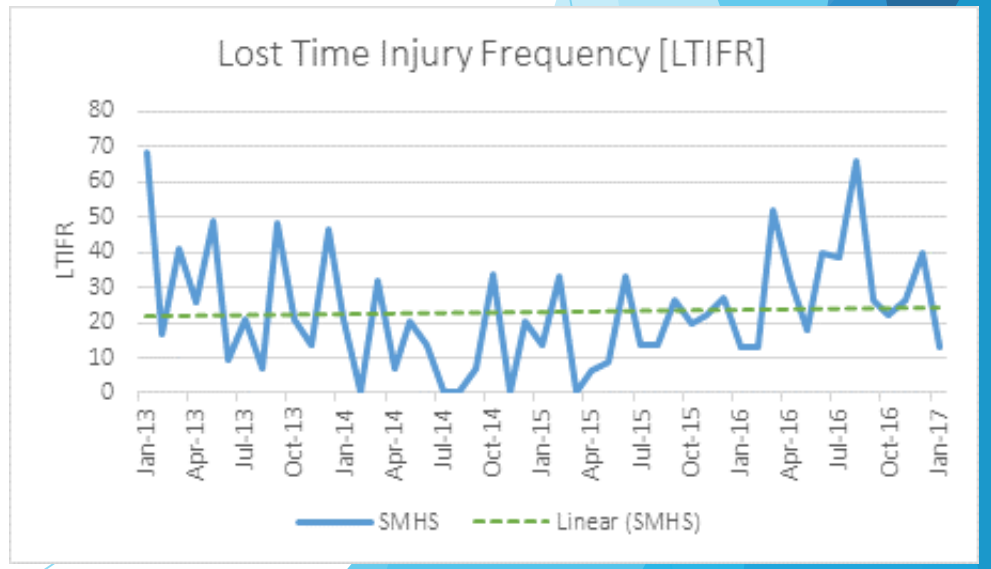
Lost Time Injury Frequency Rates

Lost time injury frequency rates [LTIFR] = number of loss time injuries per million hours worked. The loss time injury frequency average is ***10*** for the ACC Healthcare Levy Risk Group.

- For **CDHB the average is** ***10 staff lost time injuries per million hours worked*** [aligned to the current health industry standard].
- For **SMHS the LTIFR on average is** ***22 staff lost time injuries per million hours worked***.
- For **AT&R the LTIDR on average is** ***137 staff lost time injuries per million hours worked*** [over two year period].



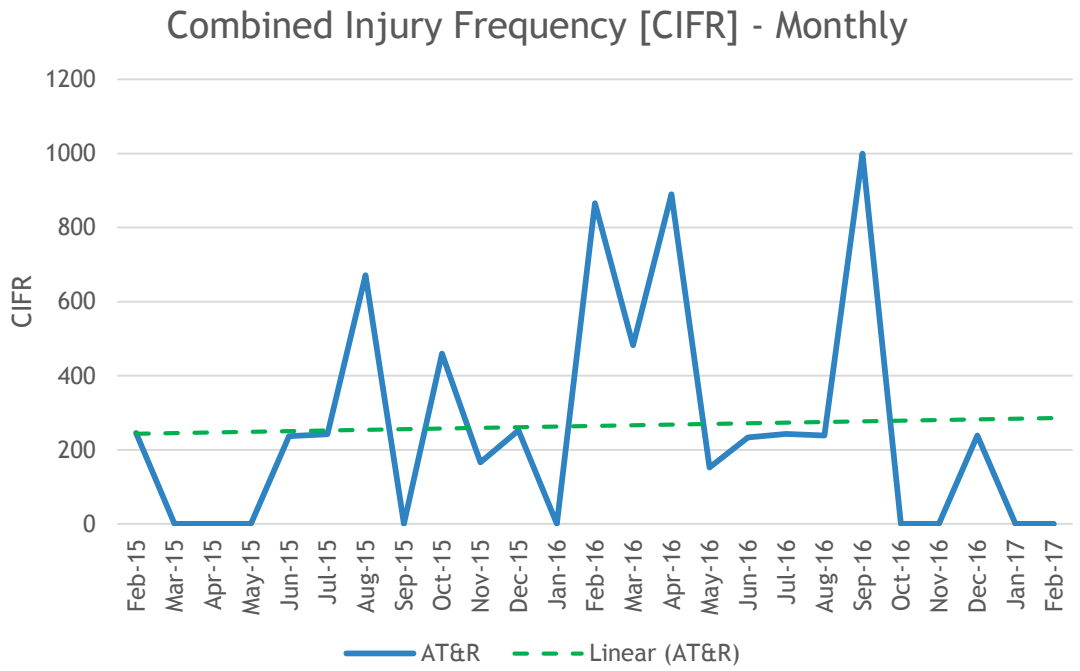


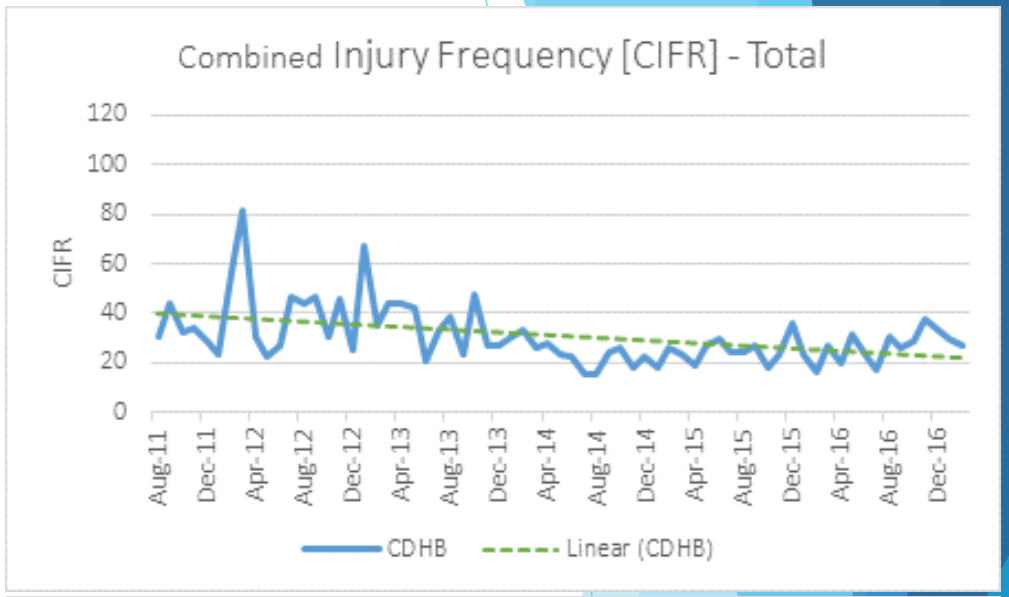


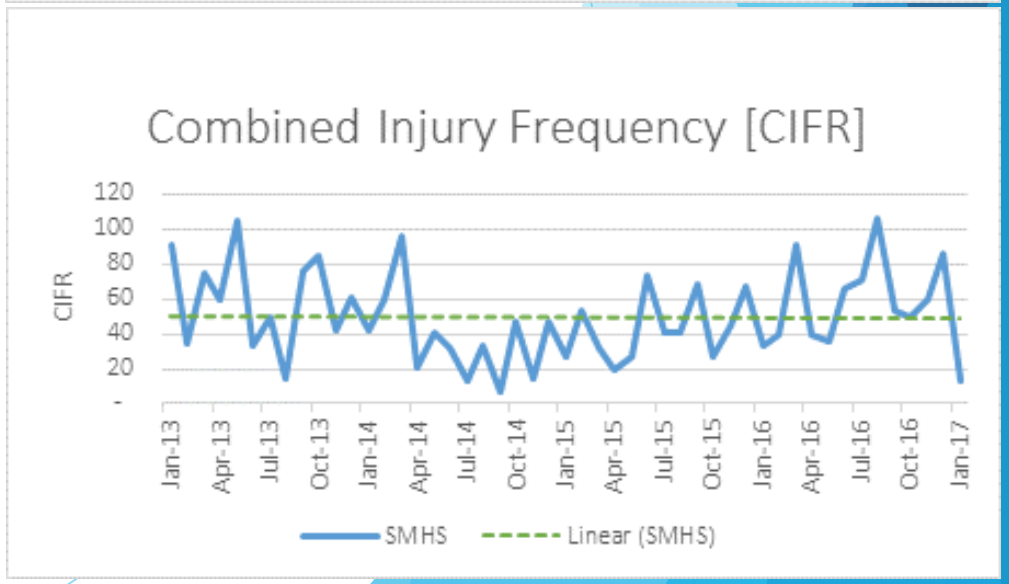
Combined Injury Frequency Rates

Combined injury frequency [CIFR] = number of all ACC accepted medical treatment claims per million hours worked.

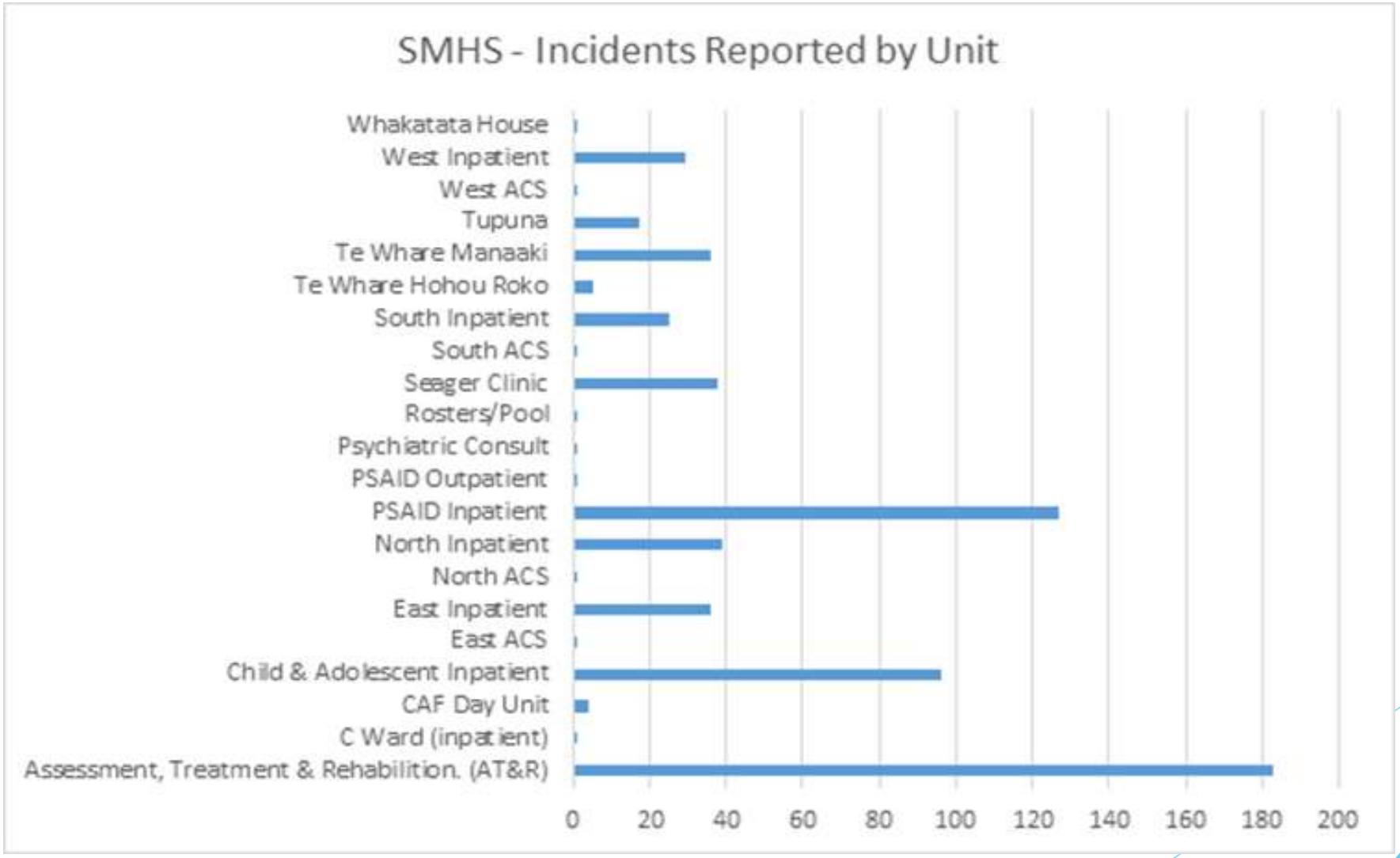
- For **CDHB the average is** ***22 staff injuries [total] per million hours worked***.
- For **SMHS the CIFR on average is** ***48 staff injuries [total] per million hours worked***.
- For **AT&R the CIFR on average is** ***264 staff injuries [total] per million hours worked*** [over two year period].

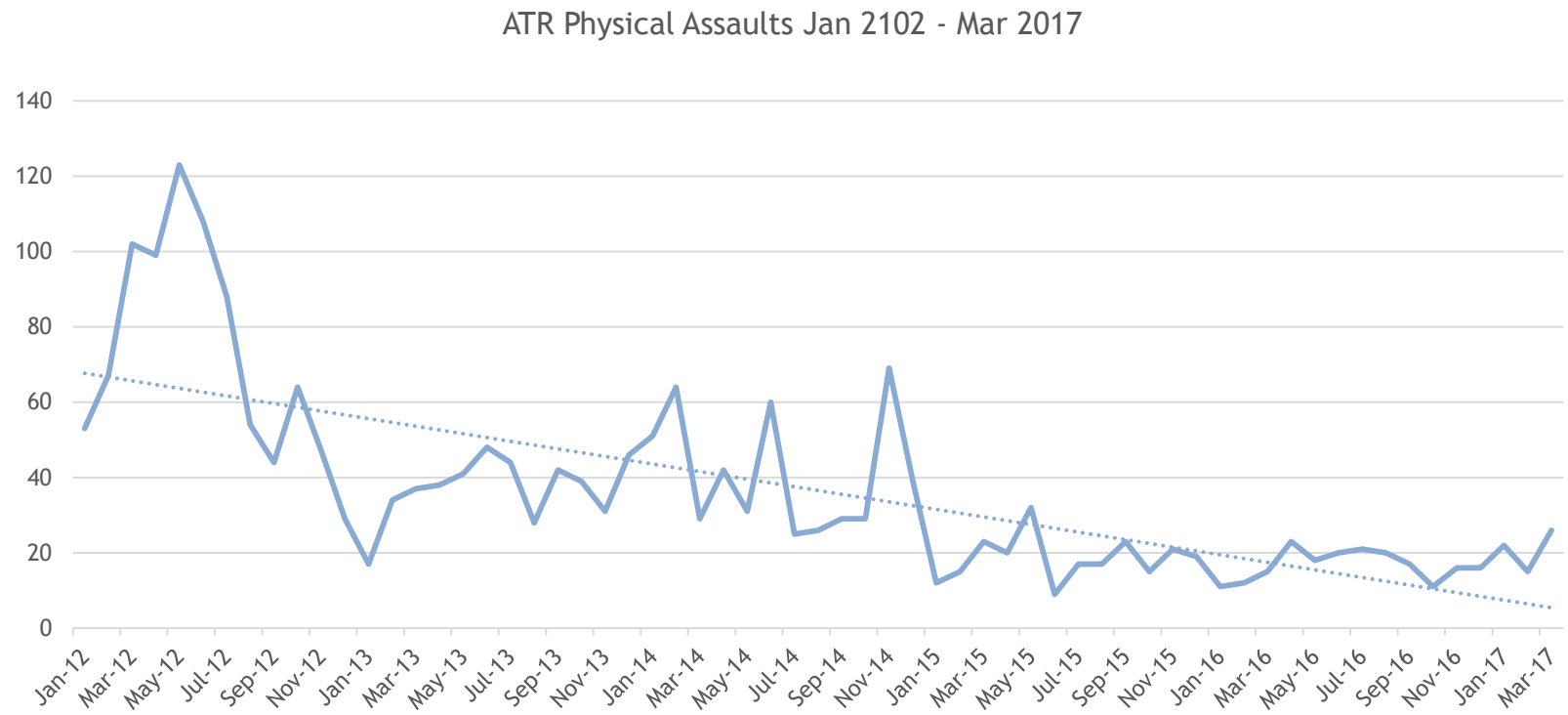






Incidents [all physical assaults] Reported by SMHS Unit




ATR Physical Assaults Jan 2102 - Mar 2017
140
120
100
80
60
40
20
0
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17

Risk Management Interventions

- Changes in model of care
- Use of 1-1 staffing observations, Allied Health Assistant resourcing for a consumer
- Minor alterations have been made to the building over the last few years
- ‘Crisis response’-escalation process and placement in forensic unit (now exhausted) and increase staff resource as able
- Regular H&S meetings involving staff, organisational support, unions
- Contingency planning for staff crisis
- Proposal for High Care Area as a priority action to mitigate risk of assault and injury

High Care Area

- HCA is a modification to the ward environment that is able to deliver:
  - an appropriately timely response-to commence as a priority
  - the provision of additional ward space, providing individual low stimulus robust areas for those posing the greatest risk (Pods)
  - the potential to be incorporated into a purpose built new facility when resources for this are made available
- There are currently four consumers within SMHS that would utilise this facility-capacity should be at least four.

Summary:-

- The AT&R service requires a greater ability to provide care for a diverse range of consumer needs including the management of violence and vulnerability risks
- The incident rates particularly of physical assault remain high and are of serious concern.
- The ability to manage this risk and other risks including gender and age related are unacceptably comprised by the current AT&R environment.
- National shortage of secure ID inpatient (and community) beds compounds the risk, as transferring to environment of greater security/resourcing is most often not possible