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2 June 2022

s 9(2)(a)

By email: s 9(2)(a)
Ref: H202206037

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to the Ministry of Health (the Ministry) on 6 May 2022. You asked:

> *"Please send me the 2003 audit undertaken by or for the Ministry of Health into the addiction residential programme run by the Hanmer Institute (otherwise known as Hanmer Clinic) at the Queen Mary Hospital site in Hanmer Springs. Also, any correspondence between the Ministry of Health and the Hurunui District Council in regard to the Queen Mary Hospital between 2003 and 2008, and any correspondence between the Ministry of Health and Ngāi Tahu in regard to the Queen Mary Hospital between 2003 and 2019."*

Please find the document requested attached. This is being released to you in full.

The Ministry endeavoured to search for any correspondence between the Ministry and Hurunui DC or Ngāi Tahu in regard to Queen Mary Hospital, however nothing was identified. Therefore, this part of your request is refused under section 18(g)(i) of the Act, as the information requested is not held by the Ministry and there are no grounds for believing it is held by another agency subject to the Act.

Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Ministry website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

Philip Grady
Acting Deputy Director-General
Mental Health and Addiction

The Hanmer Institute Limited (Queen Mary Hospital and Related Services)

Review Audit for the 15 Months to 31 March 2003 against the MOH Transitional Contract

FINAL REPORT
V5 17 Oct 2003

Contents

Executive Summary

Terms of Reference

- Funding contract dated January 2001
- Review audit team Letter of agreement dated 13 June 2003

Timing of Audit and Period of Review

- Site visit to Queen Mary Hospital, Hanmer Springs 26/27th June 2003
- Visits to Christchurch and Tauranga Clinics 27th June and 10th July respectively
- Review of operations for the 15 months 1 January 2002 to 31 March 2003

Background

The contract between the Ministry of Health and Hanmer Institute Ltd, trading as Queen Mary Hospital, Community Alcohol and Drug Service includes a transition pathway in respect of service delivery by Queen Mary Hospital and the Hanmer Clinics. The Provider Specific Terms and Conditions of the contract include the Ministry's right to specifically audit progress against the transition requirements at any time during the course of the contract term, subject only to any notice requirements as may be specified elsewhere within the contract. The contract specifies at least two audits, at or about 15 and 30 months of the contract's duration (1January 2002 to 31 December 2004).

The Ministry and Hanmer Institute representatives met as a Transition Board on 4 April 2003. At that meeting the Ministry advised its intention to undertake the 15 month Audit before June 2003.

Scope

The Audit will be conducted independently of the Ministry of Health and specifically assess Hanmer Institute's performance at 15 months into the term of the contract (i.e. March/April 2003):

- against its obligations under the Contract No 250076/256847/00,
- in particular Provider Specific Terms and Conditions in respect of the transition pathway,
- against the requirements of the National Mental Health Sector Standard NZS 8143:2001.

Summary Response to Audit Requirements

In response to the audit requirements of the Letter of Agreement dated 13 June we note the following:

Financial performance and position

The trading activities of HIL, QML, and Instep remain unprofitable up to 31 March 2003. A consolidated profit in 2003 and beyond appears dependent on the current level of Ministry funding. We have made adjustments to the statement of financial position which indicate an estimated negative equity for the group of $1,763,000 at 31 March 2003.

Financial Management

Internal management accounting and reporting appears adequate and takes into account detailed financial forecasts contained within Business Plans. We recommend that the 2004 Business Plan (once finalised) be independently reviewed.

Application of "one-off" funding

There now appears to be common agreement that the three "one-off" payments to date totalling $625,000 were cash advances with no specific application stated by the Ministry. For this reason no further work was undertaken by the review team to ascertain the application of the "one-off" cash advances.
General funding has not been applied in accordance with the transitional plan. Residential services still dominate and community-based clinical FTE's are significantly understated relative to the transitional contract.

Recording of private income

There appear to be adequate accounting systems in place to provide reasonable control and assurance over the proper segregation of private revenue. Costs associated with private service delivery are not separately identified.

Group structure

The purpose of the change in group structure, as confirmed by HIL management, appears simply to be to capitalise on the advantages of charitable status. This appears reasonable and we are unaware of any other purpose.

Progress with the transfer of publicly funded resources

The Hanmer Clinics Ltd Strategic Plan identifies strategic objectives and timeframes up to December 2004 for completion of the transition. There was evidence of in a number of areas of progress towards the requirements of the transitional contract however as there was no document that identified the implementation plans for the strategic objectives and milestones it was not possible to confirm whether HIL is on track in terms of achieving full compliance with the transitional contract by December 2004

Delivery of youth services to the capacity specific in the Monitoring Framework table in the (transitional) contract

At a meeting between HIL and MOH (17 May 2002) a variation to the Transitional Contract was agreed. This included agreement that:

- Youth age range is agreed as 18 – 23 yrs
- Youth treatment responses may be included in adult treatment programmes.
- Youth FTE may be incorporated with adult FTE totals in the Minimal Distribution FTE's in the Transitional Contract.

The agreed variation supersedes the youth capacity set in the monitoring framework therefore this requirement could not be reviewed.

Completion of the transition of the Taha Maori programme within the first 12 months of the contract term, 1 January 2002 to 31 December 2002.

There was no evidence provided of completed Joint Ventures with Maori at the time of the audit.

Quality audit of Hanmer Institute and the Hanmer Clinics against the National Mental Health Sector Standards (NMHSS)

HIL is required to fully meet the National Mental Health Sector Standards (NMHSS) by December 2000 as part of its contractual requirements. Ref. Section F: Service Specifications, 6.0 Service Standards.

Audit of the Hanmer Institute (QMH, Christchurch and Tauranga sites) using a sub set of the National Mental Health Sector Standards (NMHSS) (68 criteria) identified a number of areas where HIL does not fully meet the requirements of the NMHSS. Of the 68 audit criteria used HIL met the requirements of 36; partially met the requirements of 23, did not meet the requirements of 6; and 2 criteria were not applicable to the services delivered.

Key Findings

Financial

- HIL are failing to comply with the transitional funding contract relative to the level of clinical FTE's (refer Appendix 4). QML have confirmed that, even at 1 January 2002, QML had less than contractually required 43.39 FTE in post. For the 9-month period to 31 March 2003 the average clinical FTE's in post (both residential and IOP clinics) were 22.54. Data is unavailable to calculate any under-supply of FTE's for 2002. The annual funding level as at 1 January 2002 of $3,284,416 was based on a contracted rate of $75,699 per clinical FTE. Based on the average FTE data provided for the 9 months to 31 March 2003 the Ministry of Health is paying $145,715 per clinical FTE provided. This equates to an overpayment, in accordance with the Transition Contract, of ([145,715-75,699] *22.54) = $1,578,160 p.a. at current clinical FTE levels.
- It is unclear if the slow migration of clinical FTE's from QML to IOP clinics is due to the low demand for IOP/community treatment or a reluctance to scale down the QML operation leading to understaffing of the clinics thus restricting supply.
- During our visit QMH management acknowledged that there was an under provision of clinical FTE's but emphasized that this was offset by an overprovision of residential bed days. Although there is no contractual basis for funding to take account of client volumes, we have noted the financial effect based on this argument and note that on this basis QMH appear to have received a transitional funding premium in the region of $450,000 for the 9 months to 31 March 2003
- Private income accounts for 17% of total income for the latest reporting period being the 9 months to 31 March 2003.
- The HIL group is technically insolvent and might have to be placed in receivership without Ministry funding.
- The present operating performance is close to break even and is likely to be achieved for the 2nd 15 month period with scheduled funding (no additional cash injections required). This is based on the planned redundancies at QML announced 2/7/03 and if a negotiated rent-free agreement is achieved with Canterbury DHB.
- The future viability of HIL without Ministry funding beyond 31 December 2004 is currently in doubt. Private income levels have not achieved projection and show no signs of doing so. There is a commitment to maintaining the QML site on a reduced scale and with programme rationalization. It is still doubtful if private income could sustain this given the running costs and diseconomies of scale that will arise. A Business Plan for 2004 is currently in draft and it is recommended that this be independently reviewed.

Service Delivery

- HIL has a Strategic Plan 2002 –2004 that defines strategic objectives related to the transitional contract and within this, the Government Health priorities.

There was no recorded evidence provided of progress with the Strategic Objectives although senior staff were able to provide information regarding the status of the objectives. Some strategic objective timeframes have not been met.

There was no recorded evidence provided of how HIL service planning and delivery aligns with DHB Funder Plans for A & D Service Delivery in each region.

There was no evidence provided of service and workforce planning for the distribution of community based A & D services for Maori and non Maori clients throughout New Zealand.

- The MOH Transitional Contract identified 43.39 FTE's to be deployed from QMH residential services to community based A & D services. Calculation based on information provided during the review identified 13.75 Residential FTEs and 10.73 Community based FTE's = a total of 24.48 FTE which leaves 18.91 FTE unaccounted.

- At a meeting between HIL and MOH (17 May 2002) a variation to the Transitional Contract was agreed. This included agreement that:
  - Youth age range is agreed as 18 – 23 yrs
  - Youth treatment responses may be included in adult treatment programmes.
  - Youth FTE may be incorporated with adult FTE totals in the Minimal Distribution FTE's in the Transitional Contract.

  There was no evidence provided that identified how service delivery related to the transition will ensure appropriate services for Maori youth 18 – 23yrs.

- The Transitional Contract required the development of at least one Joint Venture with Maori by December 2002. Senior management reported that discussions with Iwi have commenced in some regions but progress has been slow. There was no evidence provided of communications nor joint venture transitional plans or documents. In the Transitional Contract the MOH agreed to the maintenance of revenue at the current level, including the revenue attached to the Taha Maori component of the Hanmer Institute contract. There was no evidence provided of planning for the transition of Maori FTE's to the community based services or to contribute to Joint Venture agreements.

- HIL is required to fully meet the National Mental Health Sector Standards (NMHSS) by December 2000 as part of its contractual requirements. Ref. Section F: Service Specifications, 6.0 Service Standards.

  The Chief Operating Officer reported that an assigned DAA is to conduct a Gap Analysis against the NMHSS in late July 2003. This was also recorded in the Quality Plan and Audit Plan provided.

  Audit of the Hanmer Institute (QMH, Christchurch and Tauranga sites) using a sub set of the National Mental Health Sector Standards (NMHSS) identified a number of areas where HIL does not fully meet the requirements of the NMHSS.

  An NMHSS implementation plan and timeframes to achieve full compliance with the NMHSS is required.

Section 1

Financial Review of Operations

Hanmer Institute Limited (HIL)

HIL is the non-trading holding company for Instep Limited and Queen Mary Hospital Limited (QML).

Income is solely management fees from group companies and these fees ceased from October 2002. Costs comprise loan interest on external debt and minor administrative expenses. Results for the period to 31 March 2003 show a small profit of $6,000. The future result is likely to be a loss representing external loan interest.

The investments in QML & Instep are recorded at historic cost and total $1.03m. Based on the underlying negative equity and poor operating results of Instep and QML it is likely that these should be written down to nil, reflecting their present value in accordance with the Institute of Chartered Accountants of NZ "Statement of Concepts".

HIL holds the debt used to finance group activity, currently comprising bank debt of $149,000, internal/related party debt of $297,000, and a suspensory loan with the MOH of $300,000. Only the external debt is interest bearing.

The suspensory loan will be forgiven by the Ministry on 31 December 2004 if the transitional contract terms are met. In respect of the maintenance of 43.39 clinical FTE's and the transition of service delivery (particularly Maori programmes) referred to in this report, the contract terms do not appear to have been met so far (refer Appendix 4).

We understand that HIL debt is to be transferred to Hanmer Clinic Limited. However the directors of HIL may not be able to accept the loan if the adjustments to the statement of financial position referred to below are taken into account, giving rise to negative equity in HIL at 31 March 2003.

With no realisable assets there would be no means to repay the related party balances or the suspensory loan (should terms be breached). The remaining obligation to repay external debt of $149,000 cannot currently be met.

HANMER INSTITUTE LIMITED FINANCIAL PERFORMANCE	30/6/01 $000	30/6/02 $000	31/3/03 (9 Months) $000
Review - QML Management fee	240	120	30
- Other	-	3	-
	240	123	30
Operating expenses			
Interest	43	38	20
Youth co-ordinator	25	-	-
Other	125	40	4
	193	78	24
Net Profit	47	45	6

HANMER INSTITUTE LIMITED FINANCIAL POSITION	30/6/01 $000	30/6/02 $000	31/3/03 (9 Months) $000
Working capital	21	4	-
Loan account - due from Instep	-	-	23
Fixed assets	4	-	-
Investment in QML	466	816	816
Investment in Instep	217	217	217
	708	1,037	1,056
Bank debt	(152)	(148)	(149)
Loan account - due to QML	-	-	(87)
Shareholder loans and other debt	(277)	(285)	(210)
MOH suspensory loan	-	(300)	(300)
	(429)	(733)	(746)
Equity	279	304	310

Conclusion

Future trading losses are expected in HIL due to the payment of debt interest.
We have set out in **Appendix 1** possible adjustments to the statement of financial position based on the above commentary. If fully taken into account these adjustments would result in a negative equity of $449,000 at 31 March 2003. (If the carrying value of Instep Limited is retained there would still be negative equity of $232,000 on this basis).

Queen Mary Hospital Limited

Queen Mary Hospital Limited is the trading subsidiary of HIL that provides alcohol and drug services from its Hanmer Springs residential hospital and outpatient clinics based in Auckland, Christchurch, Wellington, and Tauranga.

QUEEN MARY HOSPITAL LIMITED FINANCIAL PERFORMANCE	30/6/01 $000	30/6/02 $000	31/3/03 (9 Months) $000
Revenue			
Ministry of Health	2,925	3,718	2,324
Private	849	672	514
CYFS	229	252	-
Management fee - Instep	-	-	18
Other	298	462	149
	4,301	5,104	3,005
Operating expenses			
Personnel	2,671	2,958	1,651
Programme costs	561	674	291
Redundancy	-	156	-
Management fees	259	120	30
Occupancy	308	342	281
Overheads	1,035	1,058	853
	4,834	5,308	3,106
	(533)	(204)	(101)

The trading loss for the 9 months to 31 March 2003 shows an improvement over 2001 and 2002. On an annualised basis 2003 payroll costs are 26% lower than 2002 and programme costs are 43% lower. The 2002 result includes $156,000 redundancy costs that have enabled the payroll savings. A further round of redundancies were announced in July 2003.

Operating costs include rental payments for Queen Mary Hospital of $240,000 p.a. payable to Canterbury DHB. There is a current proposal for the remaining lease period (to 2005 with an option for a further 7 year renewal) to all be rent-free. Management fees payable to HIL have ceased from October 2002.

Cash advances from MOH of $525,000 have been credited to revenue in 2002. The latest cash advance from MOH of $100,000 was in April 2003 and is therefore not shown in the 2003 result above. These cash advances out of the agreed total funding for the 3-year contract do not correspond to additional service delivery and should be recorded as income in advance to recognise the potential liability to repay (or the shortfall in final funding payments as a result of the advances).

If the potentially non-recurring income and expenditure items are excluded from these results (namely management fees, QMH rental and cash advances, as discussed above) QMH Limited would have made a loss of $369,000 in 2002 and an annual equivalent profit for 2003 of $135,000. Note however that we have interpreted on page14 that the present block funding includes a transition premium in the region of $450,000 for the 9 months, such that these restated results (excluding non-recurring items) may not be sustainable when this transition premium is no longer received.

QUEEN MARY HOSPITAL LIMITED FINANCIAL POSITION	30/6/01 $000	30/6/02 $000	31/3/03 (9 Months) $000
Current assets			
Loan account HIL	-	57	87
Other current assets	400	353	442
	400	410	529
Current Liabilities			
Bank	177	52	161
Other	537	484	344
Accrued holiday pay & redundancy	178	287	169
Loan account HIL	32	-	-
Loan Hanmer Foundation	-	-	-
	924	823	674
Net current liabilities	(524)	(413)	(145)
Fixed assets	276	341	294
Goodwill	215	203	195
Non-Current Loans			
Hanmer Foundation	(162)	(96)	(514)
Other	(120)	(104)	-
Net liabilities	(315)	(69)	(170)
Equity			
Accumulated losses	(827)	(1,032)	(1,133)
Share capital	512	963	963
	(315)	(69)	(170)

The statement of financial position at 31 March 2003 shows net negative equity of $170,000. The following possible accounting adjustments are noted from our review. These may be necessary to establish the present value of QML as at 31 March 2003, in accordance with the Institute of Chartered Accountants of NZ "Statement of Concepts". These represent a possible write down in net assets of $1,070,000 and are shown in the table at **Appendix 1.**

- The loan account due from HIL may not be collectable (see HIL above).
- The trade debtors ledger includes approximately $10,000 of private client debts that are of uncertain collectability and should be provided against. Credit control and collection is generally good.
- The Queen Mary Hospital site comprises old buildings and utilities in varying conditions. The lease agreement originally signed with Health Link South, now transferred to Canterbury DHB, specifically excludes the landlord from responsibility for property and grounds maintenance. QML management have confirmed that they have the liability for any deferred maintenance. An upgrade assessment was conducted in 1997 based on the assumption that the site would continue in use for the foreseeable future. Based on a general update to this review we estimate the need to make current provision for deferred maintenance of $500,000. This reduces to approximately $400,000 if the proposal to reduce the hospital site plan goes ahead.
- As indicated in the October 2001 report, goodwill arising on the purchase of the IOP clinics was valued based on the present value of the current assets and the earnings potential of the clinics. Given the history of operating losses to date by the clinics (see below) the present value of the goodwill may be nil and write of is suggested.
- QML management calculate the remaining potential severance costs for the Hanmer Springs site to be $382,000 (including those announced in July 2003). Only $4,000 remains in the provision for redundancy in the management accounts at 31 March 2003, therefore a further liability of $378,000 should be recognised.
- The carrying values of fixed assets may be excessive for the Queen Mary Hospital but any adjustment is unlikely to be material.

If adjustments were made for the above matters QML would currently have negative equity (net liabilities) of $1,220,000, based on a deferred maintenance provision of $400,000. The restated financial positions of QML and other group companies are summarised in **Appendix 1**.

Conclusion

Future trading profits are likely at current funding, and expenditure levels based on staff reductions to date and the exclusion of management fees and rent. Adjustments to the statement of financial position result in a negative equity of $1,220,000 at 31 March 2003. A summary of the adjusted financial position of all HIL group companies is included in Appendix 1.

QMH - Programme Performance

As part of this review we were requested to analyse the current operating performance of Queen Mary Hospital Limited according to the individual programmes and service delivery locations.

QUEEN MARY HOSPITAL LIMITED PROGRAMME PROFIT/(LOSS)	30/6/01 [1] $000	30/6/02 [2] $000	31/3/03 (9 Months) $000
Hanmer Programme	(98)	1,341	128
Taha Maori	(104)	572	70
Joint Programme costs	-	(1,039)	-
Youth	(153)	-	-
IOP Auckland	(63)	(97) [3]	(37)
IOP Tauranga	(26)	51 [3]	(23)
IOP Wellington	(9)	(53) [3]	16
Christchurch Clinic	(86)	(193) [3]	(70)
Continuing Care	(66)	-	-
Hostel	(43)	(12)	(43)
Corporate	43	(774)	(142)
Total	(473)	(204)	(101)

Notes to 2001 & 2002 data:

[1] The analysis of 2001 programme performance has been taken from the 2001 report resulting from a detailed allocation exercise. The analysis was not provided by QML management. In 2001 the clinics were in the early stages of set-up and the results as stated are unlikely to be representative of a normal operating period.

[2] In 2002 there was a separate cost centre for Hanmer Springs joint programme costs and income but no separation was made between the Hanmer and Taha Maori programmes. Corporate cost allocations were made to the clinics each at $5,000 per month but no allocations were made to the residential programmes.

[3] Public funded IOP revenue has been separately accounted for but not counselling or other clinic-based services.

Given the limitations of programme-specific financial data for 2002, both in respect of income and shared costs, the analysis of programme performance has concentrated on the current 9-month period to 31 March 2003. Following a 12-month period when management has had the opportunity to develop the clinics and rationalise the residential programme, the present reporting period is considered the best indicator of programme performance.

MOH block funding is internally allocated to clinics according to actual activity for the 2002/2003 year. The balance of Ministry funding, after clinic allocations, is credited as revenue to the Hanmer programme, with no separate credit to the Taha Maori programme.
In order to attribute the Taha Maori programme with an appropriate proportion of revenue and direct programme costs currently recorded under the Hanmer programme a net credit for the 9 months to 31 March 2003 of $414,000 has been reflected in the Taha Maori result above. This has been based on the proportion of residential (public) bed days for each programme and applied to both MOH funding general programme costs.

Corporate costs have been recharged on the following basis:

- Hanmer 50%
- Taha Maori 10%
- Auckland clinic 10%
- Tauranga clinic 10%
- Wellington clinic 10%
- Christchurch clinic 10%

If QMH corporate overheads were apportioned based on the proportion of budgeted total income the clinics would have attracted recharges between 7 and 11% for the current period. On this basis the 10% used by management appears to be a reasonable recharge for the clinics.
However the Taha Maori programme would attract 24% of corporate overheads on the same basis, using the estimated income of the programme calculated above. On this basis the 10% overhead allocation used by management appears to be insufficient. An adjustment for a further $88,000 allocation of corporate overheads has been made from Hanmer programme costs to Taha Maori in this summary.

Conclusion

Community based clinics appear to receive a fair allocation of corporate overheads and collectively continue to trade at a loss of $114,000 for the 9 months to 31 March 2003. Only Wellington has reported a profit for this period of $16,000.

The restated 2003 results for the Hanmer and Taha Maori programmes are enhanced by the premium (transition) funding calculated as $450,000 (see page 14). It appears unlikely that the residential programmes would run profitably without this transitional funding from the Ministry.

Instep Limited

Instep derives its revenue from Employee Assistance Programmes (EAP) and ACC supervision services relative to drug and alcohol abuse. It incurs a small management charge for corporate services provided by QML management and directors but otherwise it stands alone.

INSTEP LIMITED FINANCIAL PERFORMANCE	30/6/01 $000	30/6/02 $000	31/3/03 (9 Months) $000
Revenue	168	810	627
Operating Expenses			
Staff costs	95	569	464
Group management fee	-	-	12
Other	66	172	173
Net Profit/(Loss)	7	69	(22)

INSTEP LIMITED FINANCIAL POSITION	30/6/01 $000	30/6/02 $000	31/3/03 (9 Months) $000
Working capital	(20)	(2)	(162)
Fixed assets	12	73	93
HIL loan account	-	-	(21)
Shareholders loans and other debt	(2)	(18)	(5)
	(10)	53	(95)
Equity	(10)	53	(95)

The ACC contract commenced in 2002 and was invoiced according to expected volumes that did not actually occur. Instep refunded ACC approximately $80,000 in 2003, crediting their trade debtors balance. This contributes to the negative working capital as at 31 March 2003 and loss of $22,000 for the 9-month period to 31 March 2003.

With lower than expected income and a high indirect cost base, Instep appears unlikely to make a significant future profit but the loss for the 9-months to 2003 may be isolated due to the impact of the ACC contract adjustments noted above.

Contract Monitoring

Over-Provision of Residential Bed Days

On page 17 we indicate a possible over-funding for the 9 months to 31 March 2003 of $1,044,557 based on the contractual interpretation of the provision of clinical FTE's. During our audit visit QML management acknowledged the under provision of clinical FTE's but emphasised that this was offset by the over provision of residential bed days. The graphs on pages 15 & 16 were provided by management in support of this view. The transitional agreement is clear that performance for funding is to be measured against FTE's and not client volumes (refer Appendix 4). However we have noted below the quantification of the argument put forward by QMH management in order to illustrate the possible over funding on this basis as compared to that on page 17.

The original residential contract prior to 1 January 2002 was for 11,635 bed days (all regions). This is shown in the following graph, prepared by QML management, as approximately 1000 per month in January 2002 declining steadily to zero by December 2004. The cumulative over provision of bed days shows that the only notable decline was over the Christmas 2002 closure.

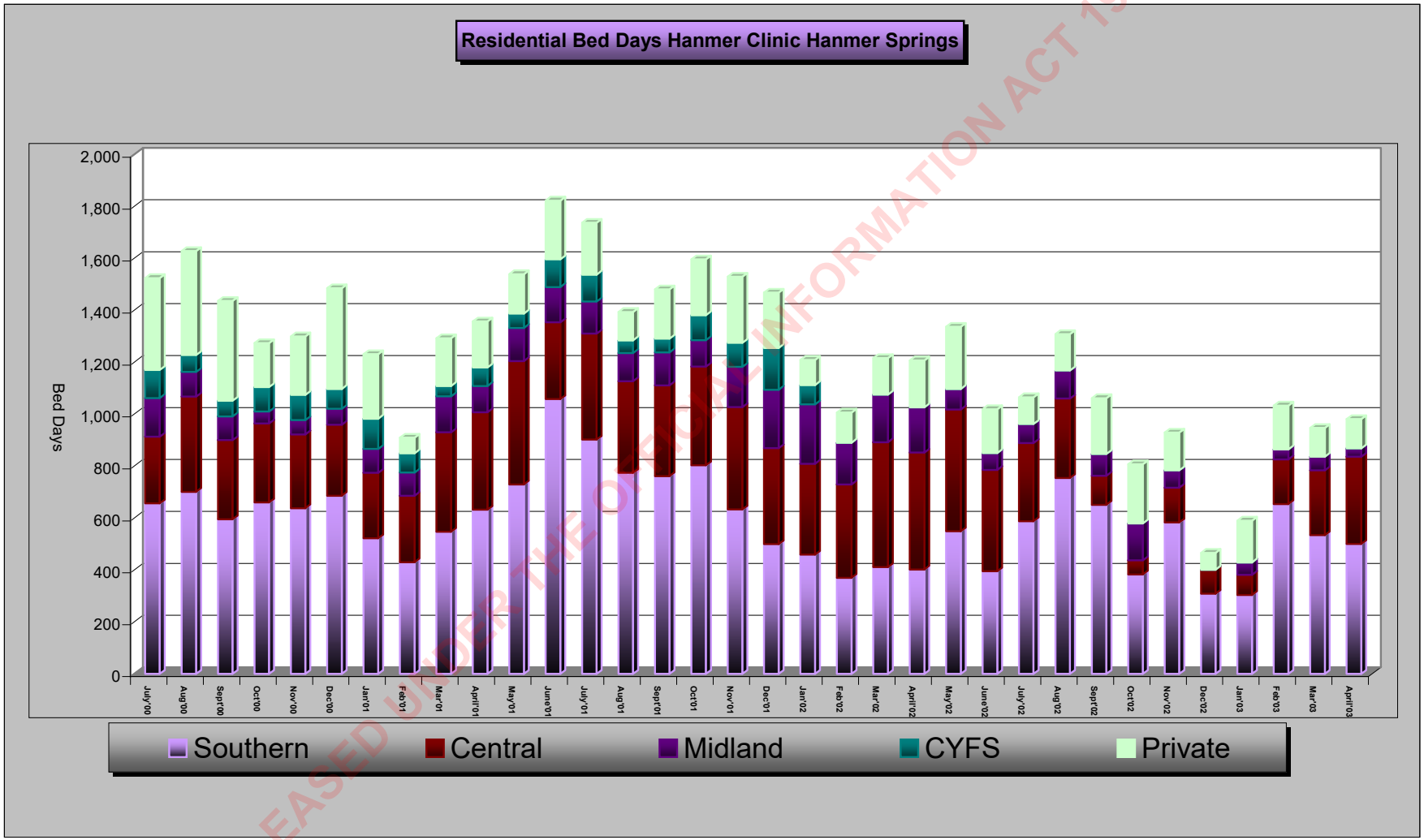
Although there is no contractual over-provision of residential bed days the graph on page 16 recognises the need for residential services to decline and for convenience have shown this to be linear. On this basis the over supply of bed days for the latest 9-month period is valued at $93,390 (at $165 per bed day) and $226,215 cumulatively from 1 January 2002 to 31 March 2003.

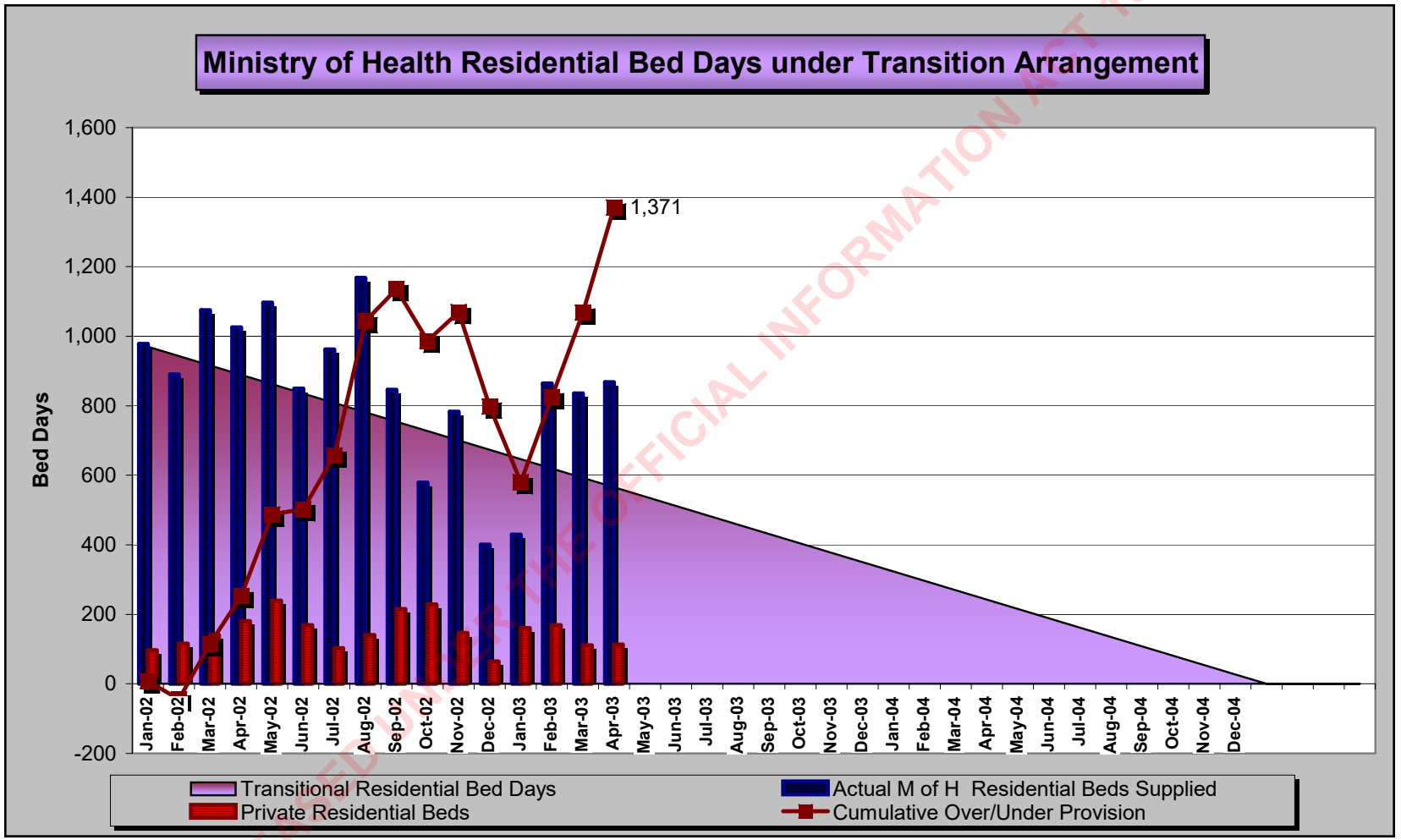
Based on an estimate for inflation to give a bed-day rate of $165 (prior contract for 2001/02 was $160) the value of actual bed days provided for the 9 months to 31/3/03 is **$1,133,220**.

The total residential income recorded in the management accounts to Hanmer/Taha Maori programmes out of the aggregate funding, after clinic allocations for the 9 months to 31/3/03 is **$1,578,660**.

The difference of ($1,578,660 - $1,133,220) = $445,440 arises due to the method of income allocation. Clinics are internally credited a portion of the block funding each month according to their activity. Set prices for IOP's, assessments etc. are based on an hourly rate of $90 for all clinical time and standard periods of time determined across all clinics. QML residential programme income is the residue of the block contract after clinic allocations. As the level of clinical activity is below projection residential income as allocated exceeds normal Ministry funding rates. If clinic volumes were to rise sufficiently then the reduction in attributed residential income might result in pressure to reduce residential bed days.

The $445,400 calculated above estimates the difference between capacity-based and block funding and **is effectively transition money that has not been applied to the transition process.** This overstates the sustainable financial performance of the residential programmes relative to the financial results for 2002 and 2003.





Under-Provision of Clinical FTE's

As noted in Appendix 4 the basis for the contract value was the rolled up value of all historical regional contracts, plus $350,000 for continuing care and IOP development. This gave an aggregate value to apply as at 1 January 2001 for the 3-year transition contract of $3,284,416 p.a. Although it contains development money and a blend of (envisaged) residential and outpatient services this ceases to be relevant for block funding from 1 January 2001. The national funding model for drug and alcohol services for 2002 determined that $75,699 was the rate per clinical FTE that should be paid to service providers, allowing for non-clinical support staff and all indirect costs. $3,284,416 divided by $75,699 gives rise to the 43.39 clinical FTE's in this contract.

The suitability of $75,699 per clinical FTE to specific providers depends on the size and structure of their organisation relative to the national model. Furthermore the model was developed for funding for stable A & D service delivery, rather than transitional.

As noted in Appendix 4 the transitional contract does not specify any requirement for QML to meet minimum or maximum clinical activity levels either at Hanmer Springs or the clinics. It is assumed that the migration of clinical FTE's will drive the transition of service delivery. In considering the suitability of the above funding model for QMH we note the following:

- QML advises that the composition of the Hanmer Springs residential programme is unique amongst NZ public service providers;
- The intention as set out in the contract is to introduce a clinic based service where the ratio of clinician to client is much lower than residential (group sessions being more common than one-on-one for the IOP).
- QML have confirmed that, even at 1 January 2002, QML had less than 43.39 clinical FTE in post.

Funding implications (9months to 31 March 2003 only)

The actual block funding for the 9 months to 31/3/03 (all services) was **$2,324,248**. This was paid on the assumption that QMH would provide 43.39 clinical FTE's p.a.

Based on the average clinical FTE's for the 9-month period of 22.54 (see table below) the contractual requirement upon the MOH of $75,699 per FTE would be funding for all services of only **$1,279,691** (75,699 * 22.54 * 9/12). This would require a **refund of $1,044,557.** Clearly given the financial performance of QMH summarised above this would be unsustainable.

Hanmer Clinics Ltd

Clinical FTE Summary

	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Feb-03	Mar-03	Apr-03
Hanmer Clinic - Hanmer Springs	13.41	12.99	14.31	15.80	13.58	13.35	14.51	12.12	15.17	13.75
Hanmer Clinic - Auckland	2.51	2.28	1.98	1.25	2.00	2.05	2.11	1.90	2.07	2.18
Hanmer Clinic - Tauranga	3.37	1.55	3.25	3.56	3.21	3.13	3.28	2.83	3.69	4.19
Hanmer Clinic - Wellington	2.05	2.11	1.67	1.89	1.94	2.06	1.94	1.95	2.26	2.30
Hanmer Clinic - Christchurch	1.54	1.55	1.35	1.36	2.16	1.32	1.41	1.27	1.77	2.07
Total	**22.88**	**20.48**	**22.57**	**23.85**	**22.89**	**21.92**	**23.25**	**20.07**	**24.97**	**24.48**

Financial Management

The review of financial management procedures was based on interviews with the Chief Financial Officer of HIL and the external auditors (Ashton Wheelans & Hegan), as well as a review of relevant financial material. Overall the standard of financial management appeared to have improved since the October 2001 review and is now considered satisfactory.

Accounting Team

Several staff support the Chief Financial Officer. There is a dedicated purchasing officer; a payroll clerk/cashier also responsible for client invoicing; an accounts/administrator who assists with monthly report production, general ledger asset management and control account reconciliations. The corporate office is also supported by a secretary whose duties include MOH data returns. Given the other duties of most of these staff the accounting resource is not excessive. The resource also appears adequate to ensure a segregation of duties as well as cover in times of absence. Roles and responsibilities for the support staff appear to be clear.

Accounting Controls and Audit Trail

Ashton Wheelans & Hegan have advised that their external audit for the year ended 30 June 2002 did not highlight any significant control weaknesses. They have indicated that they were satisfied in all material respects that accounting systems were reliable and audit trails adequate.
From our own observations the segregation of duties provided some level of comfort in regard to internal controls. We were advised that control account reconciliations were up to date with no backlog of reconciling items although we did not review current reconciliations in detail. Audit trails from management accounts (general ledger detail to supporting records) were clear and an extensive analysis of balances/costs was available. The general ledger account structure was very detailed enabling analysis and reporting of results to an appropriate course/programme level of operation as well as income source.

Accounts Production

We were advised that monthly reporting is completed by the 20th of the following month, which is considered a reasonable lead time and suggestive of adequate accounting procedures and systems.

Budgets and Planning

Monthly management accounts for 2002 and 2003 also show budget comparisons that agree to the financial forecasts contained within the Business Plan.

It was noted in the October 2001 review that there was an absence of detailed financial budgets and business plans to support the high-level strategic plan. This has been addressed. A detailed Business Plan and financial forecasts for the year ended 30 June 2003 is dated as prepared in October 2002. A detailed financial forecast for the year ended 30 June 2004 was also in draft form and made available to us shortly after our visit. Both documents were of an appropriate level of detail but were not audited as to their reasonableness.

We note that there has been a history to date of forecasts and income/profit projections being over-optimistic. We recommend that the 2004 Business Plan be reviewed to consider the reasonableness of its assumptions and profit/cash flow projections.

Conclusion

Internal management accounting and reporting appears adequate and takes into account detailed financial forecasts contained within Business Plans. We recommend that the 2004 Business Plan (once finalised) be independently reviewed.

Application of "one-off" Funding

The MOH funding contract with The Hanmer Institute detailed a payment schedule for the 36 months January 2002 to December 2004.

The schedule refers to two "one off" payments of $275,000 (January 2002) and $250,000 (May 2002) and a subsequent variation resulted in a payment of $100,000 in April 2003.

There has been some confusion between the contracting parties, reflected in correspondence, as to whether these sums were not only "one-offs" in their timing but also their intended purpose. This is relevant to the calculation of the required clinical FTE's that are the basis for the level of operational funding. HIL argue that the one-off payments are not relevant to the calculation and therefore the required clinical FTE's are lower than stated in the initial contract.

This review considers the application of one-off funding, ensuring that it has been used for the purpose intended and any unutilised portion is accounted for.

HIL management were asked by the audit team in a group interview to clarify the purpose(s) of the one-off payments that distinguished the funds from normal operating requirements. Contrary to earlier correspondence with the MOH, the Chief Financial Officer for HIL stated that the each of the three amounts had been cash advances to assist with potential operating cash deficits. Although part of the first advance had been applied to redundancy payments the advance had not been ring-fenced for this purpose. Rather it had been absorbed into the general operating funds. It was accepted that on this basis that no adjustment to the original 43.39 clinical FTE requirement was appropriate.

Conclusion

HIL management have acknowledged that the three "one-off" payments were cash advances with no specific application stated by the Ministry. For this reason no further work was undertaken by the review team to ascertain the application of the "one-off" cash advances.
We have noted on page 17 above, that general funding has not been applied in accordance with the transitional plan. This requires that a staffing level of 43.39 clinical FTE's be maintained with a transition in the location and nature of service delivery over the three year period to 31 December 2004. At the time of this review, residential services still dominate and community-based clinical FTE's are significantly understated relative to the transitional contract levels specified.

Recording of Private Income

The chart of accounts for financial reporting is extensive and reported private, public and sundry income sources by location and programme. The levels of income by source for each location/programme were discussed with the Chief Financial Officer and appear reasonable and consistent with our understanding and expectation.

Ministry funding for the period under review was agreed to the accounting records and had been correctly reported in the 2002 audited financial statements and 2003 management accounts.

Private clients are required to make payment in advance. All publicly funded outpatient clients are encouraged to make a contribution as it is considered more likely that they will complete treatment that they have personally paid for. Where there is a partial contribution the clinic receives this in addition to the QML internal allocation of Ministry block funding. If a client should make a contribution after their programme, once the Ministry funding has been received and credited to the clinic, QML advises that the donation is credited to the Hanmer Foundation. It is unlikely that such contributions are material and this was confirmed by the Chief Financial Officer.

The system for receiving and recording private income and donations was discussed with the Chief Financial Officer and appears to have adequate internal controls to ensure that initial data capture and then coding is complete and accurate. Clinic cash receipts are banked locally but cheques are forwarded to the corporate office where banking and all income accounting entries are made.
It would be possible for cash donations to be misappropriated *prior* to recording and this is a common weakness in any organisation. It would also be possible for private fee income to be diverted outside of QML and for equivalent public funds to be allocated to match the client activity returns when allocating the monthly block funding. This would be possible given that the block funding is at a level in excess of an equivalent capacity contract and so when the block funding is apportioned internally there is presently a premium that remains in the Hanmer programme. There was nothing identified in the review to suggest either practice has occurred.

The external auditors have advised that based on their audit work in respect of the year ended 30 June 2002 they found the accounting systems for the recording and classification of income to be satisfactory with no significant control weaknesses identified.

Conclusion

There appear to be adequate accounting systems in place to provide reasonable control and assurance over the proper segregation of private revenue. Costs associated with private service delivery are not separately identified.

Group Structure - Hanmer Foundation

Refer to the organisation chart on the following page.

The Hanmer Foundation (Charitable Trust) has been in existence for some time and pre-dates the current funding contract between The Hanmer Institute Limited (HIL) and the MOH. The new structure (over page) sees the Foundation form a new company called Hanmer Clinics Limited (HCL) which will take over all drug and alcohol services operations of Queen Mary Hospital Limited (QML).

As a charitable entity it is envisaged that HCL will attract, via the Foundation, much needed (tax-deductible) donations where the donor specifies drug and alcohol work is the purpose. This review has not determined the nature or extent of other activities and projects of the Hanmer Foundation as part of this review. These may compete with HCL to receive Foundation donations.

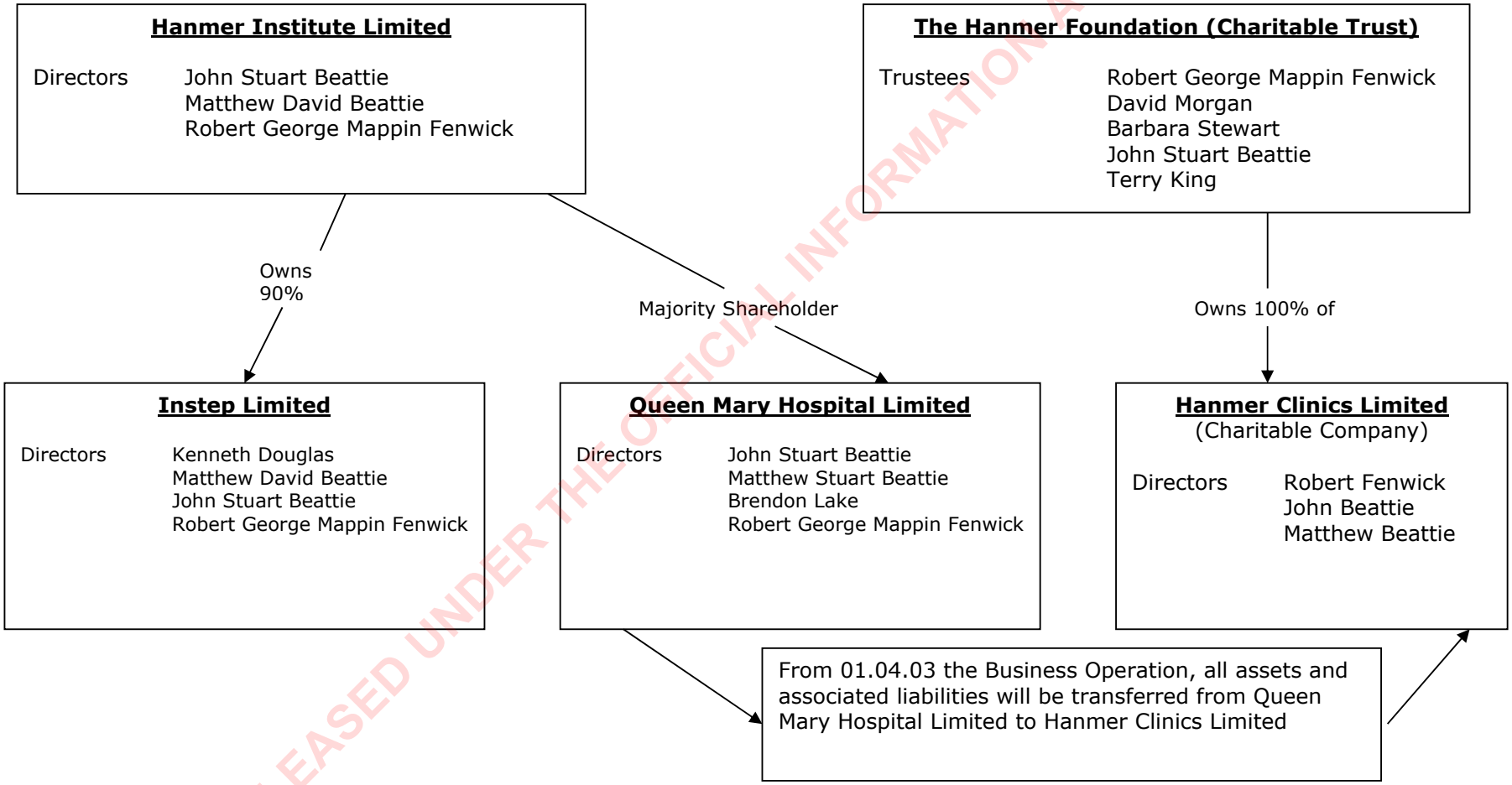
The change in name of the operating entity is consistent with the transition plan that sees the shift of emphasis in health services away from the Queen Mary hospital site towards the clinics as the primary delivery points for drug and alcohol services.

It is envisaged that Queen Mary Hospital Limited will become a dormant company and its parent, HIL will be non-trading, with its other subsidiary Instep Limited unaffected.

Conclusion

The purpose of the change in group structure, as confirmed by HIL management, appears simply to be to capitalise on the advantages of charitable status. This appears reasonable and we are unaware of any other purpose.

Proposed Change in Operating Structure 01 April 2003



Section 2

Transition Of Services From Residential To Community Based

Geographical Service Distribution

Transitional Contract Requirements

The Transition Contract allows for some flexibility in deployment of FTEs from QMH to different regions in order to service people in their local setting

It is required in the Contract that deployment would be consistent with the changes required to better meet the Mental Health Commission Blueprint and affected District Health Boards.

(All Health contracts are required to give consideration to Government Health Priorities including Alcohol and Other Drug and Maori Health and the links to service planning and delivery required by local DHB funders).

Conclusions

The MOH Transitional Contract identified 43.39 Other Clinical FTE's required to transition from QMH to community based services. The Chief Operating Officer and Chief Financial Officer disagree with this interpretation of the Transitional Contract.

At the time of the review the current FTE's for QMH of 13.75 and Hanmer Clinics of 10.73 = a total of 24.48 FTE leaving 18.91 FTE unaccounted. See Financial Section of this report for further analysis and comment regarding this.

***Minimal Distribution Requirements FTE's - Transitional Contract**
**** QMH – no minimum for level of reduction in FTE's given for Dec 2002**

	Northern FTE	**Midland FTE**	**Central FTE**	**South FTE**	**TOTAL**
Dec 2002	Adult 2.00 Youth 0.00	Adult 3.50 Youth .50	Adult 2.00 Youth 1.00	Adult 5.00 Youth 3.00	Adult 12.50 Youth 4.50 Total 17.00 FTE
As at April 03	Adult 2.18 (+.18 FTE)	Adult 4.19 (+.19 FTE)	Adult 2.30 (-.70FTE)	Adult 2.07 (-5.93FTE)	10.74 (-5.26FTE)

The Transition Contract Minimal Distribution of FTE's to community base services by December 2002 are under supplied by a total of 5.26 FTE.

HIL has a Strategic Plan 2002 –2004 that identifies strategic objectives related to the Transitional Contract and, within this, Government Health priorities. There was no recorded evidence provided of progress with the strategic objectives although senior staff were able to provide information regarding the status of most objectives. Some strategic objective timeframes have not been met for example the development of one Joint Venture with Maori by December 2002.

There was no evidence provided of how HIL service planning and delivery will align with DHB Funder Plans for A & D Service Delivery in each region.

The Strategic Plan and the Quality Plan goals identify workforce development goals. This included professional development and individual clinician accreditation with international bodies, and the intention to register with NZ clinical accrediting body in the near future. E.g. DAPAANZ.

The Chief Operating Officer reported that analysis of the referrals sources for MOH funded referrals could not be provided for outpatient Clinics without going through each file, but reported that referrals from DHB services was low in Auckland, Tauranga and Wellington and somewhat higher in Christchurch.

The auditors requested a print out of the total admissions to the IOP Clinics and residential programmes for the period July 02 – June 03. Eg. how many clients have entered the service over this period. The information received on the day of the audit, post audit from the Chief Operating Officer, and as part of the HIL response to the Draft Audit report vary considerably and cannot be verified without further audit/review of the client data/statistics. A focused review of actual individual client numbers and statistical reporting would need to occur (separate to this audit) to confirm standard interpretation and correct client statistical information.

At the time of the audit it was reported that there were no waiting lists at the Tauranga and Christchurch Outpatient Clinics. QMH – Hanmer Clinic reported (phone conversation with Admissions Officer July 15, 2003) a waiting list of approximately 40 MOH funded and 3 privately funded clients waiting for entry to the residential programme.

It is noted that MOH funded FTE clinicians work with both private and MOH funded clients and are also involved in delivering other contracted A & D related services within their communities (e.g. A & D education/training, ACC / EAP).

Population Service Distribution - Youth

Transitional Contract Requirements

The Transitional Contract noted that Hanmer Institute Ltd intended to close their Youth Residential Treatment (Maori and non Maori aged 14 – 17yrs) Programme as one of the first transition steps under the Contract
The Institute was required to use the funding released by the closure of the youth programme to enhance service delivery to youth through its community clinics. This included increasing the provision of services to youth in the community, reflecting the comparative under supply of youth drug and alcohol community services to those for adults. Meeting this requirement is a key element to determining the satisfactory delivery of the transitional Contract

Conclusions

At a meeting between HIL and MOH (17 May 2002) a variance to the Transitional Contract was agreed. This included agreement that:

- Youth age range is agreed as 18 – 23 yrs
- Youth treatment may be included in adult treatment programmes.
- Youth FTE may be incorporated with adult FTE totals in the Minimal Distribution FTE's in the Transitional Contract.

There was no evidence provided that identified how the transition of service delivery to community based settings and Joint ventures with Maori will ensure appropriate services for Maori youth 18 – 23yrs.

Population Service Distribution – Maori

Transitional Contract Requirements

The MOH Transitional Contract acknowledged that the delivery of programmes under a Maori kaupapa requires the active support and endorsement of Maori within whose geographical area or Rohe the service delivery takes place. Ngai Tahu have indicated an interest in delivering their own drug and alcohol treatment programmes, as have other Iwi throughout the regions. In the Transitional Contract the MOH and the Hanmer Institute agreed that the delivery of Taha Maori services by Hanmer will change on the following basis:

1. The MOH agrees to the maintenance of revenue at the current level attached to the Taha Maori component of the Hanmer Institute contract
2. The Hanmer Institute agrees to the development of one or more joint ventures to undertake the provision of all its Taha Maori services within the first 12 months of the Transitional Contract. Such joint ventures would be acceptable if between Hanmer and a suitable Maori partner, being either an Iwi authority having acknowledged Tangata Whenua status over the place(s) of service delivery or an Iwi provider with a mandate from such an Iwi authority
3. The Ministry of Health expects Hanmer Institute Ltd to cooperate fully in respect of timing of any joint venture arrangements, as the availability of future funding for any stand alone Iwi services will require careful planning on the Ministry's part
4. Hanmer Institute may in consultation with the Ministry of Health, seek to exit the provision of Taha Maori service entirely. The timing of such an exit, and the Ministry's agreement, would be dependent on the capability of the joint venture partner to deliver contracted services in their own right, as well as the Ministry's, or particular DHB's capacity to fund those services at the proposed time of exit
5. In the event that Hanmer Institute exits the provision of some or all of its Taha Maori services, the revenue associated with those services would be applied to the delivery of mainstream community clinic services. The locality and nature of mainstream services to be agreed with the Ministry of Health, and the affected DHB, if any.

Completion of this aspect of the transition within the agreed timeframe is a key element of determining the satisfactory delivery of this contract.

Conclusions

At the time of the audit Hanmer Institute had not indicated that it wished to exit from the provision of Taha Maori services therefore it is considered there is a need for a structured transitional plan for the distribution of resources to community based Taha Maori services/joint ventures in identified regions.

The transitional contract required the development of at least one Joint Venture with Maori by December 2002. This has not occurred. Senior management reported that discussions with Iwi have commenced in some regions but progress has been slow.

There was no evidence provided of communications nor joint venture transitional plans or documents. In the Transitional Contract the MOH agreed to the maintenance of revenue at the current level, including the revenue attached to the Taha Maori component of the Hanmer Institute contract.
There was no evidence provided of planning for the transition of Maori FTE's to the community based services or to contribute to Joint Venture agreements. Senior staff reported that one Maori staff member has transitioned to the Hanmer Clinic, Christchurch.

At the time of the audit the Chief Operating Officer, Chief Financial Officer and the Chief Clinical Officer reported difficulties in establishing a relationship with Ngai Tahu and reported having met with identified Maori health representatives in the Christchurch region regarding progressing discussions. Recorded evidence was not provided. (E.g. minutes of meetings, draft MOU.)

It was reported that discussions have occurred in the Tauranga and Auckland, Southland and Gisborne regions however recorded evidence was not provided. (E.g. minutes, draft MOU).

The Clinic Director, Hanmer Clinic, Tauranga has an MOU in place with Te Puna Hauora – a local Maori Health provider. This contract precedes the Transitional Contract requirements and is based on an agreement that a Te Puna Hauora staff member will provide 3.5 hours per week to facilitate a Maori A & D programme – the Hanmer Clinic provides the facility and resources for the programme (no FTE's). The Hanmer Clinic offers training and support to this position. The Clinic Director Tauranga reported that the MOU A & D programme has not run this year (2003) due to lack of clients and the Te Puna Hauora staff member is now planning to provide Anger Management groups. While this may be an appropriate allied service to refer clients to this activity does not meet the eligibility criteria for A & D service type specifications.

Evidence of the intent to develop relationships/services with Maori was evident in regional Business Plans for Tauranga and Christchurch Clinics.

The Clinic Director Tauranga reported there is a DRAFT MOU with the Board of Te Utahina Manaakitanga Trust – Rotorua. This was not viewed and it was not confirmed that this document reflects the requirements of the Transitional Contract.

Service Quality in Transitioning Services

Review Requirements

The auditors were asked to audit Hanmer Clinic's level of compliance with the National Mental Health Sector Standards. An audit tool was developed that included a sub set of Stds 1, Tangata Whenau; Std 2 Pacific Peoples; Std 3 Cultural Safety; Std 4 Children and Young People; Std 5 Rights of people receiving services; Std 6 Safety; Std 8 Privacy; Std 9 Consumer Participation; Std10 Family, Whanau participation; Std12 Leadership and Management; Std13 Access; Std14 Entry. The NMHSS (Subset) Audit Findings are reported in Appendix 2.

Clinical records were viewed and assessed against Std 7 Records and Confidentiality and criteria within Std 15 Assessment and Std16 Quality Treatment and Support. In the main the records viewed met the criteria however some areas identified the need for further development (Appendix 3).

Conclusions

The Hanmer Institute has developed and implemented a number of quality management systems and appropriate policies and procedures for the delivery of its services.

Management and staff interviewed are to be commended for their obvious commitment to tangata whaiora/consumers and continuous quality improvement related to service quality.

The Chief Operating Officer provided a DRAFT Hanmer Clinics Limited Operations Manual including Vision and Mission, Guiding Principles, Governance, Human Resource Management, Financial Management, Patient Information Management and Quality Management. A number of sections in this Manual are work in progress and not yet completed. The DRAFT Hanmer Clinics Limited Clinical Manual for the Intensive Outpatient Programme (IOP) was also provided. The IOP Manual is comprehensive and includes information related to the Hanmer Clinic philosophy, treatment approaches, levels of care, clinical screening, admission and orientation, assessment, treatment planning, therapy, discharge planning, programme content, programme and outcome evaluation, documentation and staffing – professional development.

An updated QMH Clinical Policy Manual was provided. Clinical policies have been developed in consultation with clinicians and Clinic Directors and in the main were relevant to that setting. However some generic policies viewed appeared relevant to QMH only and require review and amendment to appropriately reflect the Hanmer Clinic outpatient setting/perspective. E.g. Induction policy inlcuding specific Maori protocols related to induction (Mihimihi/Powhiri). This had not occurred in outpatient Clinics setting - Tauranga.

The Clinical Manual for QMH Residential programme was reported to be under development.

The auditors were provided with a DRAFT document "Hanmer Clinic Inpatient/Residential Care – Service Description Te Aroha O Te Hauangiangi – Taha Maori Programme as the framework for the Taha Maori programme. It was considered that this document is very limited in its reflection of Kaupapa Maori service provision and apart from the initial reference to Te Taha Tinana; TeTaha Wairua; Te Taha Hinengaro and Te Taha Whanau there were no descriptions of Maori models of treatment/care nor reference to cultural competency /roles for Maori staff. A considerable amount of the document appeared to be more appropriate to a mainstream rather than Kaupapa Maori service in its descriptions. The document went on to describe "Primary Components of Residential Treatment at Hanmer Clinic Hanmer Springs" in language and style that did not reflect the difference and importance of kaupapa Maori service provision. While the beginning of this document acknowledges local Rangatira and Maori staff at QMH developed the Taha Maori Programme there was no evidence of Maori contribution to the document provided (no sign off/authors etc).

There was evidence that past Taha Maori programme development has included consultation with Maori however Maori staff interviewed at the time of the audit reported they did had not had input at a programme development/transition level.

Staff professional development documents were comprehensive and addressed HR Procedures. However it was noted that Maori are not always involved in staff selection procedures (e.g. Tauranga). Induction /orientation procedures are thorough and sign off is gained for all phases of orientation. All staff interviewed reported having a current performance appraisal and identified goals.

Referrer and tangata whaiora/client information is well presented. The "We Value Your Comments" booklet includes information regarding the Hanmer Clinic Complaints procedure. This was evident in the Tauranga service but not visible in the Christchurch Clinic on the day of the audit.

The NMHSS (Subset) Audit Findings are reported in Appendix 2
NMHSS Summary – Audit Ratings Achieved
MR = Met Requirements
PMR = Partially Met Requirements
DMR = Did Not Meet Requirements
N/A = Not applicable

Standard	**MR**	**PMR**	**DMR**	**N/A**	**TOTAL** (Subset)
Std 1 Tangata Whenua		**3**			**3**
Std 2 Pacific Peoples			**2**		**2**
Std 3 Cultural Safety	**1**	**1**			**2**
Std 4 Children and Young People	**2**			**2**	**4**
Std 5 Rights of People receiving services	**2**	**2**			**4**
Std 6 Safety	**2**	**2**			**4**
Std 7 Records and Confidentiality	**6**				**6**
Std 8 Privacy	**2**				**2**
Std 9 Consumer Participation		**2**	**3**		**5**
Std10 Family, Whanau Participation	**1**	**-**	**2**		**3**
Std12 Leadership and Management	**8**	**7**			**15**
Std 13 Access	**3**				**3**
Std14 Entry	**1**	**1**			**2**
Std 15 Assessment	**2**	**1**			**3**

Std16 Quality Treatment and Support	**7**	**3**			**10**
Totals	**36**	**23**	**6**	**2**	**68**

There is a need for the organisation to complete its self assessment against the National Mental Health Sector Standards (NMHSS) and develop an organisation wide Action Plan that ensures compliance with the NMHSS including the findings of the NMHSS Audit Findings (Appendix 2 and Appendix 3). The NMHSS Action Plan is to identify responsibility, timeframes and progress reporting requirements for implementation.

The Chief Operating Officer reported that a gap analysis process is planned to take place in July 2003. This was also recorded in the Quality Plan goals and Audit Plan documents viewed.

Appendix 1

Summary of group financial position (unaudited)

	Management accounts $000	Proposed adjustments	$000	Restated at 31 March 2003 $000
Hanmer Institute Ltd	310	Write off investment on subsidiary companies	(1033)	(449)
		Write back (net) inter company loan accounts	64	
		Write back shareholder loans	210	
Queen Mary Hospital Ltd	(170)	HIL loan account not collectable	(87)	
		Provision for doubtful private debtors	(10)	
		Recognition of liability for deferred maintenance	(400)	
		Write off goodwill arising on purchase of clinics	(195)	
		Recognition of unrecorded liability for redundancy	(378)	
		Total adjustments	(1070)	(1,240)
Instep Ltd	(95)	Write back HIL loan account	21	(74)
Total	45		(1,808)	(1,763)

Appendix 2

NMHSS AUDIT FINDINGS
National Mental Health Sector Standards (NMHSS) Sub set) Audit Tool

Ratings used: MR = Met requirements; PMR = Partially met requirements: DMR = Did not Meet requirements; N/A = Not applicable

1: TANGATA WHENUA			
The mental health service provides appropriate services to meet the needs of Tangata whai ora, whanau, hapu and iwi. (NMHSS 1)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
1.1	**Mental health service staff demonstrate knowledge of, and practice in a manner that is consistent with the principles of the Treaty of Waitangi in the provision of treatment and support for tangata whai ora, whanau, hapu and iwi.** *This shall include and is not limited to:* *a) Maori participation at all levels;* *b) Active partnership in service delivery;* *c) Protection and improvement of Maori health status.*	PMR	Overall the QMH programme is supportive of the Taha Maori programme however there has been little or no input into service planning/delivery from Maori staff. There was no evidence of Maori participation in decision making at a senior staff level. Taha Maori programme staff reported that they have not been involved in the transition of services Some QMH Ltd Policy documents viewed at the Outpatient Clinics are QMH focused. For example, Induction including specific Maori protocols related to induction (Mihimihi/ Powhiri) are defined but this has not always occurred for new staff in the OP Clinic setting e.g. Maori have not been involved in the selection process in the OP Clinic setting in Tauranga

1.3	The mental health service delivers and facilitates culturally safe services for Maori. With the informed consent of tangata whai ora, these services include culturally accepted treatment options, which are inclusive of whanau, hapu and iwi. *This shall include and is not limited to:* *a) Cultural assessment;* *b) Cultural process/treatment;* c) *Cultural audit.*	PMR	It was reported that all staff (Maori and on Maori) have completed Treaty of Waitangi training. One QMH Taha Maori Programme Maori staff member reported that Treaty of Waitangi training had been provided and was well attended, informative and useful. QMH staff interviewed felt that such training was well supported by management. It was reported that non-Maori staff at QMH have access to QMH Kuia and the Chaplain who is available for consultation and advice. In QMH cultural assessments are carried out by Maori staff – however there are no standards /staff competencies related to this. (Who can do/skills/knowledge etc). In the Christchurch Clinic the Clinic Director reported that a Maori staff member provides cultural assessment for Maori clients. In Tauranga the Clinic Director reported that cultural assessment occurs during the Initial Assessment stage with the assigned (non Maori) staff member. Tauranga Clinic staff have a link to a member of a local Maori health service Te Puna Hauora and link and consult with this person regarding cultural protocol and issues. While the Taha Maori programme has separate sessions that focus on Taha Maori the programme combines with the mainstream QMH programme for a number of the sessions each day throughout the Programme duration.

1.5	The mental health service actively recruits and employs people with links to whanau and hapu, iwi who have relevant cultural knowledge and experience in mental health, or develops necessary links with other agencies such as Runanga. *This shall include and is not limited to:* *a) A Maori mental health worker or bilingual counsellor who has knowledge and understanding of Kaupapa Maori;* *b) Specific cultural training for staff;* *c) Cultural supervision for staff;* d) *Access to Kaumatua and Tohunga...*	PMR	There is no transition plan for the recruitment of Maori staff out to the Hanmer Clinics or to Joint ventures.. It is unclear how the Clinics will respond to the needs of Maori choosing to use mainstream services. Senior staff reported that one Maori staff member had transitioned to the Hanmer Clinic Christchurch. At the time of the audit two Maori clinical staff reported responsibility for facilitating the Taha Maori programme. A non Maori clinical staff member has been supporting their work together with QMH Kuia and Chaplain. Both staff are relatively new to the service, only one staff member has an A & D qualification (this is a non tertiary A & D qualification). Staff interviewed reported that Cultural supervision was a personally driven activity rather than included as a regular structured component of professional development for Maori staff. Clinical Supervision from a Maori perspective has not been provided to Maori Staff. There was no plan in place for Maori workforce development within the transition to the new structure. Cultural supervision for non-Maori staff is informal and relies linkages with either Maori staff/Kuia (QMH) or within the Clinics with identified local Maori.

2: PACIFIC PEOPLE			
The mental health service delivers and facilitates appropriate services for Pacific people and recognises the fundamental importance of the bond between Pacific people receiving the service, their families, religious groups and the community. (NMHSS 2)			
	NMHSS Criteria Being Assessed	***MR /PMR / DMR / NA***	***Findings / Comments***

2.3	The mental health service delivers and facilitates culturally safe services for Pacific people. With the informed consent of the person receiving the service, these services will include culturally accepted treatment options, which are inclusive of the person's family *This shall include and is not limited to:* *d) Cultural assessment;* *e) Cultural process/treatment;* f) *Cultural audit.*	DMR	Prior to their arrival at QMH, Pacific island people are offered the option of attending either the Taha Maori Programme or the mainstream programme There is no workforce development plan that identifies how staff in Clinics will respond appropriately to Pacific Island Peoples needs. Staff in Tauranga identified links to Pacific island MH staff in the DHB and reported they would consult with these staff if required. There was no evidence of consultation with Pacific Island people related to the transition of services to the community
2.5	The mental health service actively recruits and employs people with links to the Pacific with relevant cultural knowledge and experience in mental health, or develop necessary links with other Pacific agencies. *This shall include and is not limited to:* *a) Provision of suitable education/training of staff to respond to specific cultural requirements and preferences.*	DMR	Requires development of linkages (working protocols) in each region and appropriate recruitment strategies for Clinics in areas with high Pacific Island populations The Clinic Director in Tauranga reported having planned a workshop for staff in Working with Pacific Island people however this had unfortunately been cancelled and is to re booked.

3: CULTURAL SAFETY			
The mental health service delivers treatment and support in a manner that the person receiving the service, their family, whanau and community determines as being culturally safe. (NMHSS 3)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
3.1	Documented policies, protocols and procedures are implemented that ensure the mental health service delivers services in a culturally safe manner.	PMR	The policies for Cultural Safety and Maori Participation are in DRAFT – Maori staff reported they have not yet reviewed and commented on the policies.
3.4	The mental health service delivers and facilitates treatment and support in a manner that is sensitive to the cultural and social beliefs, values and practices of the person receiving the service. *This shall include and is not limited to:* *a) Consideration of the role of family and community;* *b) The recognition of the need for the person receiving the service to stay with family and community during treatment and support;* *c) Use of interpreters and advocates;* *d) Recognition of religious practices.* *e) Gender* *f) Gay / lesbian clients families* *g) Age*	MR	Staff interviewed at all sites (QMH, Christchurch and Tauranga) provided a range of examples of how they respect and work with tangata whaiora/clients culture and the specific needs of clients related to age, gender, religious practice and sexual orientation. QMH Staff reported that the last in-service training was related to working with people who are deaf. Gender matching occurs wherever possible. Maori clients are able to participate in the Taha Maori programme run by Maori staff. There is a staff member who identifies as Maori on the QMH mainstream programme – this is not a Maori position. Information about advocates was available at all sites and is provided to tangata whaiora/clients as they enter the programmes. There is one Maori staff member who has transitioned from Taha Maori to the Hanmer Clinic Christchurch.

4: CHILDREN AND YOUNG PEOPLE			
Mental Health Services providing this speciality service deliver developmental and environmentally appropriate assessment, treatment and support to children, young people and their families, who are affected by mental illness or mental health problems. (NMHSS 4)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
4.1	The mental health service provides services to children and young people in a developmental and environmentally appropriate manner.	MR	Young people >18yrs participate in the same programme as adults at QMH and in the Hanmer Clinics. QMH staff reported that they would match younger counsellors where possible.
4.3	Parents or guardians of children and young people are actively involved in the referral, assessment and treatment processes and are provided with relevant information in relation to this. The young person can also have a support person of their choice present.	N/A	
4.4	The mental health service has processes in place to manage the informed consent requirements for children and young people who are not living with their families, or who do not wish to have family involvement.	N/A	
4.6	Mental health services in this speciality area ensure staff have a thorough understanding of key legislation that impacts on children and young people. *This shall include and is not limited to:* *a) Children, Young Persons and Their Families Act 1989;* *b) Privacy Act 1993, the Health Information Privacy Code 1994;* *c) United Nations Convention on the Rights of the Child 1989.*	MR	Staff reported having training related to Privacy. Information regarding the Privacy Act and related requirements is contained in the Hanmer Clinics – Information for New Personnel Handbook

5: RIGHTS OF PEOPLE RECEIVING SERVICES			
The rights of the person receiving the service are understood, respected, and upheld. (NMHSS 5)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
5.2	The person receiving the service is provided with a written and verbal statement of consumer rights at the earliest opportunity. This should occur during the first face-to-face contact with the mental health service. The written and verbal statement of rights is communicated in a way that is easily understood by the person receiving the service, and repeated as necessary being mindful that explanations may be required on more than one occasion. Supportive written material is made available in a variety of languages, formats and media as appropriate to meet communication needs.	PMR	There is a Patients Handbook for Hanmer Clinic, Hanmer Springs. This provide to all new tangata whaiora/clients. QMH and Hanmer Clinic staff described how this information is given to tangata whaiora/clients on arrival and is also mailed to the referrer/client prior to arrival. Information was only available in English It is recommended that all Clinics ensure the H & D Rights posters in Maori language are visible and the H & D Rights Information Cards in Maori, English and five Pacific Island languages are available for tangata whaiora/clients
5.3	The person receiving the service is made aware of their rights to access and have present an advocate or support person of their choice at any time during their involvement with the mental health service.	MR	Information regarding advocates is included in initial information and is posted around the QMH site and was viewed at the Christchurch and Tauranga Clinics. There is a consumer representative – nominated with in the QMH programme There are Maori and non-Maori Advocates who visit Hanmer. The Maori Advocate visits Hanmer every two weeks and attends the Ward meetings. He passes on information, asks questions etc.

5.4	The mental health service has an easily accessed, responsive and fair complaint procedure. The person receiving the service, their family and whanau are fully informed of this.	PMR	The Hanmer Clinics Ltd Complaints policy and procedure was clear and easy to use. Staff reported they go over the complaints procedures at QMH programme at Ward meetings and information regarding complaints procedure is visible in the Main Building (Taha Maori tangata whaiora attend these). The information provided to tangata whaiora/clients at Clinics includes H & D Right to Complain but does not include written information regarding the Hanmer Clinic Complaints procedure e.g. How to make a complaint – time frames etc Staff are oriented to the policies and procedures during orientation. Sign off is recorded. A Client Feedback booklet (inviting Compliment, Complaint or suggestion) was visible in the waiting area at Tauranga Clinic but not in the Christchurch Clinic. This booklet is a Hanmer Clinic wide document.

5.6	Informed consent is obtained from the person receiving the service for all treatment and support, including changes in treatment and new treatments and complying with legislative requirements and practice guidelines.	MR	There is a system for gaining consent to release/collect health information. Tangata whaiora/clients sign a *Consent to Release Alcohol and Drug Abuse, Medical and /or Mental Health Patient records and Information* form on arrival/entry to Hanmer Clinics/QMH. In the auditors opinion (and in consultation with a consumer advisor MOH) it is considered that the document title used is over inclusive It is suggested that the title of document read – Consent to Release/Collect Health Information and then define within the document the specific information to be collected This Form includes a place for identification of the person/service to be contacted regarding the release/collection of information and also contains a number of tick boxes to identify the information to be collected or released. The form includes a statement that Hanmer Clinic may release or collect information for up to two years from the date signed but does not deal with how consent will either continue or cease should the client leave the programme. It is suggested that the consent to release or collect information records each event (not for up to two years) and where ongoing communication with an specific person is agreed then the contract must also include how the service will inform the tangata whaiora/client of each contact/communication with the identified person and the frequency that this agreement will be reviewed.

6: SAFETY			
The activities and environment of the mental health service are safe for the person receiving the service, their families, whanau, staff and the community. (NMHSS 6)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***

6.2	Mental health services shall have policies and procedures that promote the safety of the person receiving the service, their family, whanau, staff and the community.	PMR	There was evidence of OSH Manuals and reporting systems. Incident reporting policy and system viewed The Information for New Personnel Booklet March 03 provides information for staff to the QMH /Hanmer Clinic site. It was not clear what information is provided for staff in the Outpatient Clinics. This booklet does not include key information about safety /minimising risk procedures for Clinics There is a Crisis Management Policy and Ethical Guidelines for staff. Identified OSH staff at each site. At QMH (mainstream and Taha Maori) programme clinical risk is assessed through the Initial Nursing Interview sheet although this document only lists Suicidal Ideation – and does not include a category related to Harm to Others. The Health Questionnaire which is also completed at initial contact within QMH also addresses potential harm to self/others. Nursing staff reported that all tangata whaiora/clients are assessed by medical staff who also screen for risk. Staff were able to describe a process where they have taken a client whom they had concerns about through to Christchurch for psychiatric assessment and admission to MH service. Clinical staff at the outpatient Clinics reported that Initial Assessment includes risk assessment. Within the Hanmer Clinic IOP Manual no standard procedures/ documentation related to standard risk assessment and management were evident. Tauranga Clinic had a number of Clinic specific procedures that addresses clinical risk situation e.g. IOP Clients and Relapse, Management of Suicidal patients, Emergency procedures. Cultural Safety Policy is in the development stage. Maori staff have not been involve as yet.

6.3	Treatment and support offered by the mental health service will strive to protect the person receiving the service from all forms of neglect, abuse and exploitation.	MR	Appropriate policies and procedures in place Staff Code of Conduct provided to all staff. A Hanmer Clinic Policy of Care statement was viewed Complaints Policy and Incident reporting systems in place In the QMH Client Council meetings are held regular and feedback is given to staff re any issues.
6.4	The person receiving the service has the opportunity to access staff members of their own gender, wherever this is practicable	MR	MH staff reported that this occurs where ever possible – both gender staff available The two clinics visited have both male and female staff members available and tangata whaiora/client allocation takes gender into consideration
6.5	Staff are regularly trained to assess and respond appropriately to situations that may compromise the safety of the person receiving the service or others. *This shall include and is not limited to:* *a) Involvement of people receiving the service in this training;* *b) Use of recognised safety training courses;* *c) NZS 814:2001 Restraint Minimisation and Safe Practice.*	PMR	Not all staff have completed de-escalation training, however overall staff were conscious of risk and were able to describe how risk situations would be handled. There is a need for policy and procedures related to minimising risk /safety - e.g. related to staff travelling to outposts/working alone in community settings/procedures for office staff /alarms etc that are accessible for the office.

8: PRIVACY			
The mental health service respects the privacy of each person who receives the service including their family, whanau. (NMHSS 8)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
8.2	The mental health service has documented policies and procedures that ensure the protection of privacy for each person receiving the service and their families. The mental health service takes all reasonable steps taken to ensure they are aware of them.	MR	Staff are orientated to the requirements of Confidentiality Policy and Privacy and Sharing of Health Information. This is signed off. See 5.6 Suggestion re Consent to release/collection of Health information
8.3	The mental health service ensures that consultation and the provision of services occurs in an environment that provides for maximum visual and auditory privacy. *This shall include but is not limited to:* *a) Where telephone discussions or handovers between shifts occur that disclosures are not audible to the person receiving the service or visitors;* *b) Boards (such as a whiteboard in a ward setting or in a crisis team office), used to record information on the person who is receiving the service, are visible only by authorised persons;* *c) People receiving the service in counselling rooms cannot be seen or heard from outside;* *d) No personal information is elicited in waiting rooms;* *e) Signage only where appropriate;* *f) Discreet vehicle labelling.*	MR	The QMH programme, Taha Maori programme and the two community based Clinics visited had appropriate rooms for interview with sight and sound privacy. Clinical information is stored appropriately. Signage was appropriate to the services.

9: CONSUMER PARTICIPATION			
Consumers are involved in the planning, implementation and evaluation at every level of the mental health service to ensure services are responsive to the needs of individuals. (NMHSS 9)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
9.1	The mental health service has policies and procedures related to consumer participation, which are used to maximise their role and involvement in the service, and where practicable include their employment.	PMR	There is a QMH Consumer Participation policy however this does not fully address the requirements of NMHSS St 9. to promote and maximise tangata whaiora/consumer participation at every level of the services.
9.2	The mental health service includes participation from consumers in decisions relating to policies, protocols, planning, implementation and monitoring.	DMR	No evidence – Maori or non Maori
9.3	The mental health service assists with training and support for consumers and staff to maximise consumer participation in the service.	DMR	No evidence
9.4	Consumers and consumer groups who work in planning, implementation and evaluation of mental health services are appropriately reimbursed for expenses and/ or paid for their time and expertise.	DMR	No evidence

9.6	The mental health service establishes mechanisms and feedback processes that involve consumers in contributing to the collective view at service and team/unit levels.	PMR	EAS Evaluation Service gains feedback on client satisfaction with services. Examples of feedback were provided. Examples of how this has been used to improve services were provided (verbal). The EAS evaluation feedback had not been received in the Tauranga Clinic for approximately 18 months. Senior staff reported that this was due to the low return numbers and thus the unreliable validity of the data. Feedback from Advocates and clients in programme occurs through regular meetings in QMH. The auditors did not seek to interview tangata whaiora/clients at QMH, Taha Maori programme. This decision was made based on information provided to the auditors by HCL management regarding the pending changes in the QMH programme - it was considered that interview was not in the best interest of tangata whaiora/clients currently in the programme. Due to the timing of the visit to the Christchurch Clinic there were no clients available/present. In Tauranga one consumer at the site offered to meet with the auditors – this was unplanned. This person reported a high level of satisfaction with the services response to her needs and confirmed that support for her to return to the use of the 12 STEP programme (IOP and Continuing Care groups) had been considerable and appreciated. She felt that the staff involved were competent and able to offer appropriate services.

10: FAMILY, WHANAU PARTICIPATION			
Family, whanau are involved in the planning, implementation and evaluation of the mental health service. (NMHSS 10)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
10.1	The mental health service has policies and procedures relating to family/whanau participation, which encourage their appropriate involvement in the service.	DMR	No evidence
10.2	The mental health service includes appropriate family, whanau participation in decisions relating to policies, protocols, planning, implementation and feedback and monitoring. ***This may include but is not limited to:*** ***a) Strategic planning;*** ***b) Quality monitoring;*** ***c) Service development;*** ***d) Staff selection and training;*** ***e) Policies and procedures;*** ***f) Establishment of advisory groups, family, whanau networks;*** ***g) Focus groups.***	DMR	No evidence
10.3	The mental health service encourages family, whanau to provide feedback and contribute to the collective views. ***This may include but is not limited to:*** ***a) The mental health service assisting with education and support for families, whanau to maximise their participation in the service;*** ***b) Training for staff in working with families/whanau as advisors;*** ***c) The use of satisfaction surveys;*** ***d) Advisors liaising with family, whanau groups or networks.***	MR	Feedback received during family week at QMH and where the Clinics run Family groups family members are invited to comment on a regular basis.

12: LEADERSHIP AND MANAGEMENT			
The mental health service is lead and managed effectively and efficiently to facilitate the delivery of coordinated services. (NMHSS 12)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
12.1	The governing body provides leadership and has overall responsibility.	MR	The Financial Section in this Report describes the structure and identifies the current Charitable Trust Board members.
12.2	The mental health service has a documented organisational structure that identifies all lines of accountability and authority for allocating resources and planning.	MR	The organisation has a structure that defines key roles and responsibilities across the Hanmer Clinics /QMH. The Chief Operating Officer provided evidence of Reports to the Board although it is noted this has not occurred formally for approximately 6 months.
12.3	The governing body ensure there are effective communication systems and working relationships in order to facilitate the delivery of coordinated services. This should occur within and across the mental health service, and with other relevant organisations and individuals.	MR	Senior staff identified number of communication systems in place to allow information flow to staff at all levels and provided evidence of slide/presentation roadshows that have been presented to all staff in 2002 and 2003. Clinical communication appears to occur regularly through meetings at the sites visited. Staff interviewed reported they are not directly involved in Hanmer Clinic service planning and development. QMH Staff reported that they did not know a lot about the Transition and at times felt “ïn the dark” about what was happening. Senior staff reported that because of the sensitive nature of some transition plans some information has not been able to be shared with staff.

12.9	The mental health service documents and implements policies and procedures, which ensure the person who is receiving the service receives comprehensive, timely and accurate, assessment, treatment, support and review. *This shall include but is not limited to:* *a) The policies ensuring that people who are receiving the service and their families, whanau have access to safe, effective, empowering treatment and support;* *b) Policies ensuring that services are appropriate, comprehensive, effective, timely and safe, identify the person responsible for implementation and the date of the moist recent and next review;* *c) Ensuring that policies are reviewed regularly;* *d) Ensuring that policies are developed and reviewed in consultation, and with participation from consumers and staff.*	PMR	The Intensive Outpatient Programme (IOP) Clinical Manual provided comprehensive information regarding procedures and documentation related to all aspects of care for people entering the IOP at the Hanmer (outpatient) Clinics. The Chief Clinical Officer reported that all Hanmer Clinics are now required to work in accordance with this Manual – however this has only recently been implemented and not all Clinics are working in full accordance with this Manual. The QMH Ltd Policy and Procedure Manual has been provided to each site and senior staff hold responsibility for ensuring all staff are familiar with this. A number of policies and procedures pertain to QMH and do not appropriately reflect the outpatient Clinic perspective/setting The Hanmer Clinic Strategic Plan Objective 2 had a goal of implementation of standardised programmes/services by June 03 This has not been fully implemented as the Hanmer Clinic, Hanmer Springs Residential Programme Manual and Taha Maori programme have not been completed. The DRAFT documentation provided for the Taha Maori programme did not meet the comprehensive standard of the material in the IOP Manual. Clinic Directors have input into the development of policies and procedures.

12.12	The mental health service ensures sufficient qualified and experienced staff are available to assist each person receiving the service during each stage of service provision.	PMR	The organisation provided a list of all staff and their relevant qualifications. It is noted that one qualification (CAC) identified by a number of staff (12) was granted on completion of an 8 week American based training programme run in NZ by an American facilitator. However the facilitator of this training did not have authority (from the American organisation) to confer this qualification in NZ. It is not a recognised qualification by the parent body. A small number of staff have completed the NADAAC exam (American – internationally recognised A & D competency) (this involves completion of a written exam (multi choice) and the provision of evidence of 400 hours of supervised clinical work. (Obviously this qualification does not provide measures of NZ cultural requirements) Six staff are sitting the exam in July 2003 and another ten staff are preparing to sit in Nov 03. The Chief Clinical Officer reported that staff will be supported to join DAPAANZ (Drug and Alcohol Professionals Association Aotearoa New Zealand) and once the DAPAANZ Practitioner Accreditation body is under way staff will be supported to gain this NZ qualification. Currently there is not a workforce development or training plan. At the time of the audit there were only two staff facilitating the Taha Maori programme. These staff have limited A & D qualifications and rely on non-Maori clinical expertise/guidance from the QMH programme director.

12.13	The mental health service regularly identifies education, training and development needs of staff to ensure that the necessary skill mix is available to deliver the core functions of the service. *This may include but is not limited to:* *a) Performance appraisals, surveys and supervision, and with reference to industry-validated core competencies for mental health The Mental health Common Base Definitions, Ministry of Health, with reference to minimum skills and core functions;* *b) Employing appropriately trained staff with relevant knowledge and experience in working with children and young people.*	MR	Staff reported that the organisation is supportive of training Staff interviewed had all had performance appraisals within the past year and staff coming in to new positions have 3, 6 and 9 moth reviews as part of orientation in to new roles. All staff have Position Descriptions There is a comprehensive Performance Management Handbook. Supervision occurs for all staff - Peer Supervision occurs every week. Some senior staff have external supervision others are assigned an internal supervisor on a fortnightly or monthly basis. This is paid for by the organisation. A number of staff are CIT Certified Clinical Supervisors.
12.14	The mental health service ensures staff participate in education and professional development programmes.	PMR	Staff reported participating in training and education. The organisation does not have a Workforce Development (Training) Plan for transition to Clinics/community based services – i.e. identification of professional development - skills/qualification required to respond appropriately to A & D needs in a community setting, training needs for non Maori staff working with Maori, working with youth. There was no overall (summary) Training Record for staff.
12.15	Staff are provided with an orientation/induction to the service.	MR	There is a comprehensive Orientation /Induction Programme for staff at all sites. This includes General and Specific Induction Checklists, Professional Code of Ethics and Confidentiality Statement – signed off. There is also a Standard Terms of Employment, Information for new Personnel and Employee Information Booklet.

12.16	The mental health service ensures regular, formal, informal and professional supervision is available for all staff.	PMR	There was no evidence of Supervision Policy and procedures at QMH and Clinics Staff at the sites visited reported having access to clinical supervision and staff at QMH Hanmer Springs identified Maori staff whom they would consult with should they require cultural supervision. The Clinic Director Christchurch has links to QMH and the Maori staff member also links to local Maori services/groups in Christchurch – Ngai Tahu. Tauranga Clinic staff have links to local Maori and indicated that ongoing communication and consultation occurs. While the MOU with Te Puna Hauora does not recognise the provision of cultural supervision/consultation by the Maori staff member from Te Puna Hauora this does occur informally. Formalisation of linkages and recognition of access to cultural supervision is recommended. Maori staff reported not having Clinical Supervision and sought Cultural Supervision through their own effort
12.18	The mental health service keeps records of staff training, qualifications, and supervision received.	MR	QMH – records viewed OK Chch - OK Tauranga - Ok No summary training database – information contained in individual files
12.19	The mental health service routinely monitors the health outcomes of each person who receives the service.	PMR	The Chief Operating Officer provided copies of the outcome evaluation data provided by EAS – a contracted Evaluation and Audit Services The outcome evaluation results from EAS are not up to date - overdue and had not been received by Tauranga for approximately 18 months. Senior staff explained that this was related to the low number of surveys returned which affected the statistical validity of the outcomes measured.

12.22	**The mental health service has a documented quality improvement programme.**	PMR	The service has in it Operations Manual a section that describes the Quality Management principles, Quality Management System, Quality Plan Staff interviewed were not aware of a Quality Plan but were aware of the systems that ensure corrective actions are taken related to identified quality improvements. The Clinics visited did not have a Quality Plan/goals related to their specific service at the time of the audit. The lack of up to date returns from EAS limits the services ability to respond to identified issues/needs
12.23	The mental health service ensures implementation of the quality improvement plan and regularly monitors its performance against it, and the National Mental Health Sector Standard	PMR	There is no plan that demonstrates how the service identifies the gaps and monitors its compliance with the National Mental Health Sector Standards. QMH and the Hanmer Clinics has achieved accreditation with SGS Healthmark. A number of the SGS Healthmark Standards will cross reference to the National Mental Health Sector Standards however a gap analysis and evidence of how the service ensures compliance with the NMHSS for the organisation is required. Senior staff reported that this is to occur in July 2003.

12.24	The mental health service utilises quality related data to improve service performance.	MR	EAS provide client satisfaction /evaluation feedback however this was not up to date and in Tauranga had not been received for approximately 18 months. See explanation in 12.19. Senior staff reported that the Hanmer Programme and Family Programme reports are up to date and available. Some EAS data was viewed by the auditors. It was not evident how this data has been utilised to improved however Goal 4 in the Quality Plan refers to involvement of consumer/tangata whaiora, staff and other stakeholders in planning services. All complaints and incidents/hazards are reviewed and corrective actions taken to improve the identified issue.
12.25	All staff demonstrate commitment to, and are involved in quality improvement activities.	MR	Management and staff demonstrated knowledge and commitment to quality improvement however to date staff interviewed have in the main not been directly involved in quality improvement activities. Management and staff are aware of the National Mental Health Sector Standards and the Health and Disability standards and the need for compliance with these standards.

13: ACCESS			
The mental health service is accessible to the community. (NMHSS 13)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
13.1	The mental health service is accessible to the defined community, is conveniently located and operates at appropriate times.	MR	Standard brochures and information is available for all sites
13.2	The community is made aware of what services are available and at what times the services can be accessed.	MR	Hanmer Clinics has kept the national/ community informed of its programmes and services and the changes in service delivery during the transition
13.3	The mental health service promotes ease of physical access.	MR	All sites visited have access for people with disabilities.

14: ENTRY			
The process of entry for the person who receives the mental health service is facilitated in a timely manner. (NMHSS 14)			
	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
14.2	The mental health service has a system for prioritising referrals according to risk, urgency, distress, dysfunction and disability, and not excluding people with other disabilities or needs.	PMR	The QMH and Clinics have clearly defined pre admission criteria It was not clear how prioritisation of access to services MOH funded and private funded clients occurs if there is a wait list.
14.5	The mental health service provides each person who receives the service and where appropriate their family, whanau with an orientation to the service as soon as possible after entry.	MR	Comprehensive information is provided to potential tangata whaiora/clients and on entry to the service further orientation to the programme rights, rules etc occurs.

Appendix 3

CLINICAL RECORD AUDIT TOOL
SITE: A Sample of Clinical Records were viewed at QMH, Christchurch and Tauranga Clinics
Std 7: RECORDS AND CONFIDENTIALITY

An accurate and confidential record that promotes efficient and effective delivery of treatment and support is maintained for each person receiving the service. (NMHSS 7)

	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments***
	Meets eligibility criteria	MR	All files viewed had evidence that the client met the eligibility criteria for MOH funded services
7.1	People receiving the service have an individual record including relevant and necessary information about their treatment and support. The requirements for individuals' records shall be recorded in the organisation's policies and procedures.	MR	Individual records viewed. Included relevant information – the documentation for each file was standard and senior staff reported that Policy CL 405 Client Records is in place.
7.2	Individual records are comprehensive, objective, factual and accurate, and provide a sequential record of the involvement with the service. Each entry in the individual clinical record is dated, signed (including designation) and is legible.	MR	Clear recordings and documentation used for assessment and treatment planning clear
7.3	Each person who receives the service has access to his or her individual record inline with legislation.	MR	Information is provided to all tangata whaiora/clients regarding their right to access their files

7.4	A system exists by which the mental health service uses the appropriate information about the person who is receiving the service to ensure continuity of treatment and support for the individual. The record can be easily accessed for use in any contact with the service. *This shall include and is not limited to ensuring: A single record for each person who receives the service (this includes electronic records); Policies and procedures ensure that relevant and necessary information about the people who receive the service is shared between providers, and across all components of the service including inpatient and community.*	MR	There is a single record. – staff record progress/attendance at community based IOP programmes in one group record but record summary progress and any individual contact in the client's notes. QMH maintains appropriate progress notes
7.5	All steps are taken to maintain the confidentiality of information about each person who uses the service in compliance with the requirements of relevant legislation.	MR	Systems in place to lock and store clinical records

Std 15 ASSESSMENT

Treatment and support of each person who receives the service is based on a comprehensive assessment that is completed by a health team with appropriate knowledge and skills. (NMHSS 15)

	NMHSS Criteria Being Assessed	***MR / PMR / DMR / NA***	***Findings / Comments*** View files re cultural assessment etc Policy – who does this etc
15.2	The assessment is comprehensive, appropriate for the purpose and is conducted using accepted evidence based and culturally safe methods and tools.	PMR	Assessments viewed were comprehensive. The practice of non Maori staff carrying out cultural assessments requires review and the development of policy and procedures that assure appropriately staff conduct cultural assessments for Maori Staff complete a Financial assessment with all MOH funded clients to assess their ability to contribute financially to their treatment programme – where this is not possible access is accepted. However it is noted that this is not common practice for MOH funded treatment services. Where MOH funded clients do contribute to their treatment it was not clear how this dual income is recorded or managed.

15.4	Following assessment each person, and their family, whanau, with their informed consent, is provided with information on the diagnosis, options for treatment, support, or referral and possible prognosis.	MR	Tangata whaiora/clients are oriented to the assessment findings and the programme structure and content.
15.5	Each person who receives the service should be re-assessed regularly.	MR	Staff at all clinics visited reported that review occurs regularly with MDT staff meetings and with the client

STD 16 Quality TREATMENT AND SUPPORT			
Std 16.2	The mental health service promotes choice for each person who receives the service in regard to activities and environment.	MR	The QMH/Hanmer Clinics provided a clearly defined structured programme (residential and IOP) and tangata whaiora/clients are made aware of the programme and expectations prior to entry.
16.3	An individual plan is developed collaboratively with each person receiving the service and other persons nominated by them. A copy is provided to the person receiving the service.	MR	Assessment and treatment plans were evident. Staff reported that clients may have a copy of the plan if required.
16.4	The identification of early warning signs and relapse prevention is included in the individual plan. Risk Assessment/Mgmt Plan	PMR	Initial assessment includes consideration for risk of suicide – Risk to Others category was not included in the Nursing Assessment at QMH This procedure requires further development of procedure for recording/highlighting risk issues and related documentation in the Clinical Operations Manuals
16.5	Each person within the service has an individual plan that is based on the comprehensive assessment and identified needs, and is specific to that individual's stage in the recovery process.	MR	Standard goals of recovery through 12 step programme Other individual goals are set with the individual
16.6	The mental health service attempts to re-engage the recipient of the service who does not keep planned follow up arrangements and has protocols for action to be taken in the event of default of follow up by the recipient.	MR	Residential services will inform referrer and NOK if client leaves without notice Hanmer Clinics will follow up either by phone or letter where a tangata whaiora/client does not attend planned programmes
16.9	Mental health service staff review the outcomes of treatment and support for each person receiving the service.	PMR	Outcomes are evaluated through EAS contract however staff reported that the summary documentation evaluation feedback has not been received for approx 18 months. Individual goals are measured as the client progresses through planned programmes and at discharge.
16.13	Medication and other medical interventions are prescribed, stored, transported, administered, recorded and reviewed by authorised persons in a manner consistent with legislation, regulations and professional guidelines and reflect current best practice standards.	MR	QMH has appropriate policies and procedures in place

16.18	Each person's documented individual plan includes a Transfer, Exit or Discharge Plan which is commenced during entry to the mental health service, to ensure ongoing continuity of treatment and support once they have exited from the service. Copy to client	MR	Discharge record is kept in each file. Referrers are informed of discharge
16.21	The identification of early warning signs and relapse prevention is included in discharge planning. Each person receiving the service and their family, whanau receives assistance to develop a plan that identifies early detection or warning signs of a relapse and the appropriate action to take.	PMR	See 16.4
16.23	The mental service ensures that each person receiving the service has been referred to other services and has established contact and that discharge does not occur until arrangements for ongoing follow up are established and are satisfactory to the person, their family, whanau and other services.	MR	Tangata whaiora/clients are linked back to their region and referrer from QMH and the Hanmer Clinics provide Continuing Aftercare programmes for up to two years for people who have completed the 8 week Intensive Outpatient Programme

Appendix 4

Contractual requirement for clinical FTE

There has been debate between the contracting parties over the application of the 43.39 other-clinical FTE requirement. The transitional contract is clear in its requirement for QML to maintain 43.39 clinical FTE's throughout the 3-year transitional period with a gradual transition of these staff from residential to IOP clinic service delivery. The Ministry has confirmed that it believes there to be sufficient demand for community-based A&D services to justify such FTE's.

Within the service specification (part 3) are the following relevant definitions:

> **FTE:** "This is a full time equivalent employee (40 hours per week), and is calculated as the total number of hours employed per week (to a maximum of 40 hours per week), divided by 40."
>
> **Other Clinical FTE:** "This is a full time equivalent (see definition of FTE) clinical staff member with a health professional qualification (excluding senior medical staff, but including the non clinical training component of Registrar and House Surgeon time) involved in the direct delivery of services to Mental Health consumers. Exclude time that is formally devoted to administrative or management functions (e.g. half-time coordination of a community team)."

These definitions are generic to the health sector and are applied in contracting and contract monitoring throughout mental health services. The present provider has previously operated under the application of these definitions of FTE for public funding. These definitions were agreed to by both parties when the transitional contract commenced.

The transitional agreement (C2. Service Specifications) specifies that:

> ".. the contract is a capacity based contract, and is quantified on the basis of a number of other clinical full time equivalent staff (FTE"s). During the transition, these are the purchase units that will apply, as the exact nature of the service delivery at any period during the contract is at least partly a matter of description, rather than prescription in advance."
>
> "The price paid for FTE's in a capacity contract is inclusive of the full cost of overheads of those FTE's. As well as the non-clinical FTE's *[mentioned above]* it includes the cost of premises, facilities, etc, and the cost of all treatment overheads, including staff development and training, and such diagnostic testing as the provider determines is required for service users."

The specification of 43.39 FTE was determined and agreed upon between the parties based on a historic (rolled up) value of pre-transition service delivery contracts valued at $3,284,416 p.a. The national funding model for drug and alcohol services for 2002 determined that $75,699 was the rate per clinical FTE that should be paid to service providers, allowing for non-clinical support staff and indirect costs in this rate.