



**2008 NGO-DHB Contracting
Environment**

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- David Bradley for his advice and guidance on survey design
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Preface

Platform's Trust Board welcomes the third in Platform's NgOIT series of publications. The first NgOIT survey described the mental health and addictions sector and the second provided details on the characteristics of the workforce. The third in this series provides a snapshot of the contracting environment in which non government organisations (NGOs) are operating. The focus was on the contracting relationship between District Health Boards (DHBs) and NGOs.

In many ways the report contains nothing new and echoes what Platform members have been telling us for several years; now, pulled together as a single snapshot, it paints a disturbing picture.

The practice described by respondents falls short of The Treasury Guidelines for the contracting relationship between the Crown and NGOs. There are some shining examples of good practice, where relationships have been built on trust and a good understanding of the contribution NGOs have to make to a well-functioning integrated mental health and addiction service system. These are the exception. For most NGOs, the contracting environment and their contracting relationship with DHBs present immense frustrations.

A disproportionate amount of energy is expended administering a clumsy, highly specified, over-engineered system diverting precious resource away from the real work. The dictates of the system have dominated the discussions between DHBs and NGOs, rather than how to improve the lives of people with addiction and mental health issues. NGOs have been expected to survive year to year with no contracting certainty, inadequate adjustments to price to reflect increasing costs, and a pricing framework that means they fail to compete with DHB provider services.

The NGO sector is robust and immensely skilled in the management of community enterprises. It has a successful track record over a long period of responding to changing demands and has made significant investment in its capacity to meet the needs of people with mental health and addiction issues and their families.

The sector understands that times are difficult and welcomes greater discussion across the whole sector about value for money and how that might be demonstrated. If we are to get the best value from the NGO sector we have to address some of the contracting obstacles that compromise the delivery of efficient, effective and sustainable services.

Jan Dowland
Chair
Platform Trust

Executive Summary

This report reflects the experiences, issues and views from a range of community sector organisations that contract with DHBs to provide mental health and addiction services.

Feedback has highlighted that the present environment stifles service growth, development and innovation in this sector. The costs to community organisations tendering for new work are significant. Contractual processes are unsatisfactory, with significant delays in contract completions, ambiguities in documentation, and cumbersome reporting regimes. This also frustrates community organisations' abilities to do what they do best.

In some regions the split between the provider and purchaser is no longer visible, and DHB provider-arm health professionals and managers are influencing funding and planning processes. The general lack of transparency in many aspects of the contractual environment is concerning to community organisations. Particular note was made about the failure to pass on to NGOs increases provided by the Government which means that increasing costs are having to be met without adequate adjustment for price increases.

Reports of wide variations in some specific contract prices, the difference between the lowest and highest full-time equivalent (FTE) rate paid for a community support worker was \$31,676 per annum. The findings support the need to further investigate a regionalised or nationalised contracting system with benchmarked pricing to ensure equity and fairness.

The crucial role of DHB funding personnel is highlighted in terms of relationship and contract management and service knowledge. There are pockets of excellence characterised by consistent and knowledgeable funding and planning managers, but overwhelmingly it is a picture of high turnover, lack of experience, and concern that the loss of institutional knowledge about the nature and purpose of contracts makes NGOs extremely vulnerable.

The most significant recurring issue in the report is the fundamental need for mutually respectful relationships between funding and planning managers and community organisations and increased understanding of what each has to offer.

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Introduction



NgOIT is the brand used to identify information collection projects that are commissioned by Platform Trust on behalf of the community non government organisations (NGOs) providing mental health and addiction services in New Zealand. The information collected is shared and used in ways that increase understanding about the critical role community organisations take in the health and wellbeing of our nation.

NgOIT Projects to Date

The initial **NgOIT2005 Landscape Survey** represented a national collection of data that provided a snapshot in time about the community organisations contracted by the Crown to provide mental health and addiction services.

The **NgOIT2007 Workforce Survey** further developed the information provided in the Landscape Survey and concentrated on the workforce. It described qualifications, age, gender and the types of work people did within their organisations.

This report **NgOIT 2008 NGO-DHB Contracting Environment** has been produced at the request of community mental health and addiction service providers to draw attention to the current contracting environment.

Background

'As a market driven ethos began to shape the relationship between the government and the non profit sector in the late 1980s purchase of services through contracts become the preferred mechanism for transferring resources from the state to non-profit organisations and for delivery of services by these organisations'

(Tennant, O'Brien and Saunders 2008)

Core mental health and addiction support needs of people in New Zealand are provided by hundreds of community organisations.

There is a long-standing historical relationship between community organisations and the Crown that has been influenced by New Zealand's history, culture, politics and geography. Tennant, O'Brien and Saunders (2008) have described this history and Tennant (2007) has written extensively on the drivers that have shaped the current relationship, including the sectors' concerns about the contractual environment within which they operate.

Government Guidance about Contracting

Government agencies have developed a number of tools, advice and good practice guidelines for contracting with non-government organisations including a dedicated website www.goodpracticefunding.govt.nz.

Possibly the most influential of these have been:

- *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown The Treasury (2003)*. The current District Health Board Operational Policy Framework 2008/2009 (Ministry of Health 2007) refers readers to the Treasury Guidelines.
- Principles to underpin Management by Public Entities of funding to Non-government Organisations (Office of the Auditor General, 2006).

Strategic Operating Environment for all Mental Health and Addiction Services

Te Tāhuhu Improving Mental Health 2005-2015 was the second New Zealand Mental Health and Addiction Plan (Ministry of Health 2005). This reflected the complex nature of the sector by introducing '10 leading challenges' for the mental health and addiction sector.

Te Kōkiri the Mental Health and Addiction Action Plan 2006-2015 (Ministry of Health 2006) was produced the following year and set out a programme of actions to implement the policy.

Mental health and addictions NGOs' experience

Over the last decade the responsibility for contracting and purchasing a wide range of mental health and addictions services from NGOs has been located within local DHBs. During this period the challenges of the contracting environment have been conveyed to Platform by members, established NGO networks and at general sector meetings.

The issues associated with contracting with the Crown (through DHBs) as described by the sector have included:

- Use of multiple funding models and short-term contracts
- Perceived lack of service growth
- Resource intensive tendering processes
- Issues of transparency in the contracting practices
- Similar services purchased at different contract rates
- Difficulties in relationship management
- Inconsistencies in application of future funding track (FFT) payments

The **NgOIT 2008 NGO-DHB Contracting Environment** survey was commissioned by Platform in order to understand current contracting practices, to describe the sector's experience of contracting with the Crown and to consider the impact of this experience on the sector's ability to deliver services.

Methodology

Platform contracted an independent consultant to gather information about a range of contractual issues and to carry out the **NgOIT 2008 NGO-DHB Contracting Environment**.

The project targeted NGOs that contract with District Health Boards for the delivery of mental health and addiction services. Information was gathered using a survey template, interviews (some by telephone) and attending a regional NGO network meeting.

The sample size of participating respondents reflected the diversity, organisational size and geographic spread of the sector. All 21 DHBs had contracts with one or more of the respondents.

Survey questions were developed to explore the issues described above, they were trialled and modified based on feedback. The survey questions, along with information and instructions, are attached as Appendix 1.

The survey sought to gather data that was comparable across organisations. Any organisational data and comments provided were visible only to the researcher and information has been collated and analysed to be unidentifiable.

Interviews were conducted to allow respondents to provide additional information and insights that would assist with an understanding of the contracting environment.

The researcher also attended a group meeting of organisations from the wider Auckland region (which has a large concentration of NGO providers) and followed up with individual interviews.

Survey Results

The following results are based on the survey information from the 20 organisational respondents that completed the 2008 NgOit Prices and Contracts Survey and is supplemented by additional information sourced from face to face and telephone interviews and attendance at sector meetings. What has been reported is a mix of quantitative information from the survey, commentary from the independent researcher based on discussions with respondents and direct quotes from the respondent's interviews.

Part I

Describing the organisation's mental health and addiction contracts and the contract environment

Numbers of contracts with DHBs

To understand the volume of contract activity respondents were asked about how many separate mental health and/or addictions contracts the organisation was currently delivering and to which DHB they contracted.

Results

A total of 87 contracts were held between the 19 respondents to this question and these were across all 21 DHBs, ranging from respondents having one contract to one having in excess of 32 contracts. Some respondents contracted with more than one DHB.

Organisation Size

There is a wide range of organisations that provide services and in order to capture this range respondents were asked to identify how many full time equivalent (FTE) staff they employed in their mental health/addiction services.

Results

Table 1: Organisation size

Total FTE employed in mental health & addictions services	Percentage	Size of organisation	No of organisation
More than 2, less than 5	15%	Small	3
More than 5, less than 10	25%	Medium	5
More than 10, less than 50	20%	Large	4
More than 50	40%	Very large	8
Totals			20

Table 1 shows that the survey respondents covered a range of different-sized organisations.

Funding models

DHBs use a range of different contract models and frameworks to purchase community services. To clarify the extent of these variations respondents were asked to provide information on the funding models used by the DHBs for the contracts they held.

Table 2: Description of funding models

Term	Definition
FTE funding	The service is funded on the basis of a set number of FTE staff per annum.
Fee for Service Funding Client Claim Processing System (CCPS)	The service is funded on the basis of the number of people that are supported each 'bed night' within the specified limit. For example, the contract may specify funding for 5 people at level 3. If there are only 4 people being supported at level 3, the service claims for 4 people.
Capacity Funding Contract Management System (CMS)	The service is funded 'at capacity.' For example, the contract may specify funding for 8 people at level 4. If there are 7 people being supported at level 4, the service is still reimbursed for the 8 people.
Packages of Care Funding	<p>Packages of care funding offer a range of possibilities;</p> <ul style="list-style-type: none"> • The service is funded to provide a package of care to an individual, and the organisation may claim up to a set number of hours per month, if these hours have been utilised. • The service is funded to deliver 'packages of support' to a specified number of people within a given timeframe. • Another option includes funding within a range. For example, the provider is to deliver packages of care to not less than 20, and not more than 23 people. If the provider drops below 20, the funding is reduced as specified in the contract. If the provider exceeds 23 people, the funding may increase as specified in the contract (up to a set maximum).
Programme Funding	The service is funded to deliver a particular programme, usually a set number of times per annum. For example, the contract may specify funding for a six-week 'return to employment programme' that is offered three times each year.

Results

Table 3: Funding models utilised

Funding Model	Number of Contracts
FTE Funded	17
Fee for Service	15
Capacity Funded	12
Packages of Care	8
Programme Funding	2
Total Organisations	20

Twenty respondents provided information and the table demonstrates that a wide range of funding models is applied to contracts; furthermore, similar services provided by NGOs are subject to different funding models. Twelve respondents are funded through FTE and fee for service contracts.

The overall picture painted by respondents is one of an environment with inconsistent application of purchasing models, and models that are not always conducive to sustainable service delivery.

Respondents' comments

One respondent commented that they believe capacity funding is the best method for a NGO because it provides funding security. Others, however, viewed FTE funding as providing the same income security as capacity funding.

Another respondent talked about the difficulties of sustaining a service on fee for service funding. An example was cited by one NGO holding a bed 'as an extension to a hospital ward' and not receiving payment for the vacant bed. In other words, the provider was required to maintain the capacity but was not funded on a capacity basis.

One respondent said that they used to provide services on the basis of 'packages of care' for children and young people but stopped because it became unmanageable. The packages of care funding were set up around young people with high needs. The individuals required high levels of staff and had changeable needs, meaning a service could be established one day, and the next day they may have moved out 'and the whole thing would fall to bits.' Personnel were employed on temporary contracts because of the changing nature of the situation and this was unsatisfactory.

DHB Personnel and Contract Relationships

NGOs have for some years been reporting that having to deal with constantly changing personnel who manage their DHB contracts is a major impediment to building good contract relationships. To understand the extent of the issue respondents were asked to identify the number of funding and planning personnel the organisation have worked with over the past two financial years across all mental health contracts.

Results

Comments paint a picture of some pockets of excellence characterised by consistent and knowledgeable funding and planning managers but, overwhelmingly, it is a picture of high turnover, lack of experience, and concerns that the loss of institutional knowledge about the nature and purpose of contracts makes NGOs extremely vulnerable.

Respondents Comments

A number of respondents said they were fortunate to have had only one DHB contract manager to deal with. Another said their organisation had contact with over 30 DHB contract personnel over the past two years. This organisation relates to 10 DHBs across the country and has multiple contracts.

A respondent spoke about the turnover in DHB contract personnel as being one of the most difficult elements of contracting, particularly where individuals are appointed who have no mental health system knowledge. Despite excellent relations with this DHB's funding and planning team, much of the respondent's contact time with them has been spent orienting new DHB contract managers to the community sector.

One respondent commented on an 'excellent mental health portfolio leader' who they credited with enabling the survival of the region's mental health portfolio; another spoke of a funder who was extraordinarily good and recognised that the NGO had been chronically under-funded:

Until a year ago, we had a DHB contract manager who was visionary, consistent, knew the sector and had a long-term view. (This person) created a contracting environment where capacity and capability was appropriately used. Since then there have been two new contract managers, both of whom have been new to the sector.

In some smaller DHBs respondents experienced contract managers being prescriptive and rigid while others named a power dynamic that negatively impacts on the contractual relationship where there is a 'take it or leave it' approach to the contract.

Some commented that the high turnover of DHB contract personnel resulted in constantly working through change, with a lack of capacity to be responsive to current community issues. One respondent noted that every contract issue and discussion has to be documented, as DHB contract personnel leave and there is usually little or no 'hand over' or briefing to the new contract manager.

A respondent who was a new manager said they had to learn extremely quickly about how to interpret the contracts. There had been no information provided by the DHB contracting personnel (or others) about the contracting process or the DHB infrastructure as it related to contracts, and there was no benchmarking data available to enable comparison to ensure that what was negotiated was in fact reasonable.

Service growth

Previous NgOIT reports have identified the growth of community organisations during the late 1990s and it has been suggested that this has now slowed considerably. Respondents were asked to comment on whether the organisation had expanded, remained the same, or reconfigured.

Results

Results suggest that while the last few years are characterised by reasonable growth, signs are that we are entering a period of considerable readjustment and consolidation.

Respondents Comments

A respondent said their organisation had grown rapidly in 10 years but in the last two years it has virtually stayed the same. While they had responded to some Requests for Proposals (RFPs), they felt the DHB was encouraging other organisations into the region at the same time as expressing concern about there being 'too many mental health and addictions NGOs.' 'They [the DHB] are contracting with them all and taking on new ones, including rest homes doing long term care...taking on three or four clients... [This creates] a lot of services with no particular shape, size, or speciality.'

Another respondent commented that their organisation had doubled in size over the previous five years, but in the last two years there had only been very small growth. They had reconfigured one service significantly, and rewritten the service specifications with the previous funding and planning manager, despite provider-arm opposition to the resulting reduction in beds. The reconfiguration has been exceptionally successful, with a lot more client independence, and it has become much easier to attract and keep staff.

One provider commented that their organisation has remained the same size, but that they reconfigured the service to suit what they now deliver and that the growth in their service came from an internal restructure rather than a change in the contract. Another talked about how they had been delivering an advocate programme for six years. Each year it is renewed but is still called a 'pilot' advocate programme, despite good feedback from the DHB and others.

Respondents told of DHBs that had no new money available for service development and that substantial work and negotiation was required to get an increase of just one FTE.

The process, outcome and estimated cost of tendering for new work

The tendering process used by DHBs for changed, additional or new work for community organisations has been described by the sector as an area for improvement. Respondents were asked to describe the type, process, outcome and estimated preparation costs for proposals they had developed in response to RFPs over the past two years.

Results

Respondents completing this question reported that 111 RFPs were submitted and nine were successful. Respondents estimated that the actual cost to complete all RFPs totalled \$294,000. The main issues raised included: the cost and time taken to develop a response: the time delays from acceptance to formal agreement to service delivery; the stop-start nature of the services for which a RFP is sought; and the perception of bias in the selection process where DHB provider personnel are involved.

Respondents' comments

Several respondents commented on the significant cost and time it takes to develop a response to a RFP, with many indicating up to two (or sometimes three) weeks of work, as DHBs want significant detail, much of which they already have. In one example given, the RFP format changed three times within a short timeframe, resulting in additional work just to comply with the RFP specifications. One respondent responded to RFPs for the same services across several DHBs and was faced with different service specifications for each one.

A respondent told of a RFP that was awarded and verbal agreement reached; it then took five months to get an agreement in writing. When the agreement finally came it was for half of the verbally agreed staffing, with dates for implementation of the full FTE quota for the second half of 2009 making roll-out of the contract very complex.

A number of respondents commented that the RFP process is very competitive, which works against the collaboration that DHBs have said they want to encourage.

The contracts that emerge from DHB RFP processes 'are often rigid and barely viable.' While we appreciate the challenges of rationing and prioritising health budgets, the rigidity of contracts does not allow for flexibility that can assist with viability as well as improving the quality of service provision. 'There is a sense sometimes of merely covering off a service gap, with a service specification that mitigates risk.'

About 15 months ago a DHB put out several RFPs for expansion to their mental health and addiction services. One NGO put in seven proposals, was short-listed for five and was subsequently notified they were the preferred provider for four of these. However, due to funding restraints, the funder has not proceeded any further on any of these. The respondent was irritated by the waste of time and money.

While for some years we have been concerned about a gradual erosion of a funder/provider separation, this has become a clear reality when panels dominated by staff from the provider arm consider RFP proposals.

Negotiations for a service to be delivered broke down when the DHB provider arm and a respondent could not get to a shared solution around funding. The service therefore continued with a range of providers on a fee for service basis but without a contract.

This example is important as there are issues where a contract is seen to be a subcontract of the provider arm and there is significant confusion over who can dictate the terms of the contract. It's just another symptom of the lack of real purchaser provider split.

In another proposal the same respondent was interviewed by a DHB funding and planning selection panel was made up of 10–12 provider arm staff,

none of whom had any real experience of this kind of contract. The panels' questions were mostly about clinical issues...In the past I have felt that a key funder role is the overall development of the NGO sector, and I don't think that this is the way that they would have chosen to have the development, but I believe the provider arm has influenced it to be the best solution from their point of view.

On a more positive note one respondent identified that they were fortunate to have received 'good responses from the DHB for solicited and unsolicited proposals...and we have some innovative programmes funded. Our experience of the RFP process is very positive...' This respondent outlined their belief that their success may have been due to their staff members' previous experience of the development of full proposals for the provider arm.

Significant contractual issues impacting on the organisation

Respondents were asked what they thought were the main impacts of the current contracting environment.

Results

The main issues related to the high level of specificity and variation in contracts, the lack of transparency as to how prices are set, the low volumes of service for which contracts are sought, the failure of DHBs to pass on to the NGOs the FFT to which they are entitled, the onerous and often irrelevant reporting requirements, and the growing issues associated with a perceived blurring of DHB funding and provider roles.

Respondents' comments follow these main themes, as detailed below.

Service and contract details

- 'Provider specific terms and conditions (are) generally very poorly drafted; contain ambiguities, repetition and irrelevant content.'
- Some DHBs have been slow in including the new service specifications in NGOs' contracts. This has resulted in ongoing costs in particular at level 4 as NGOs are still required to employ on-site clinical staff despite the changed specifications and difficulty in recruiting and retaining clinicians
- There are significant variations in contracts for the same kinds of services, and organisations with multiple contracts report that there are different reporting requirements for each contract. One respondent commented they had one service with six contracts, and in another case one contract that covered three services.
- Delays in receiving contract and contract variation documentation, '...three or more months after contract/variation commencement date.'
- One-year contracts and two-year contracts are expensive to administer. A five-year contract would be more appropriate with a built-in pricing adjustment mechanism.

Contract pricing

- It is not clear and transparent how prices are set.
- Contract reporting and administration has grown significantly with no recognition in the contract price. Compliance costs, (for example there is additional paper work with Inland Revenue Department requirements and Kiwi Saver) have increased.
- The size of some contracts (two FTE in two cases noted by one respondent) makes it difficult to build sustainable services and meet the needs of the population. Low-funded FTE rates make it difficult to compete with DHB provider-arm services for clinical staff and have an effect on NGO staff retention and morale.
- 'Because of the low volume contracts, we have a high proportion of part time workers which has a financial impact on the organisation and on staff.'

Future Funding Track (FFT)

- 'Our wage costs have risen sharply over the last two years but with only a 2% increase from the main contractor.'
- 'The DHB would not shift on its offer of a 2% (FFT) increase to us, with a take it or leave it approach. Given the rising costs of service provision and general living costs, it is hard to understand how the DHB can think organisations can exist on less than inflation adjustments in their contracts.'
- There are 'inadequate contractual price adjustments based on CPI that (are) nowhere near the actual organisational costs – (and are) not assisted by poor baseline rates that are probably never going to be addressed.'

Inequity and competition with the Crown

- There is a significant and unfair differential between DHB funding and NGO funding. For example
 - ...our FTE rate is expected to meet all costs of service delivery, development, infrastructure and capital expenditure. (This is) not so for DHBs who are increasingly our competitors. We have lost a number of our top staff to DHBs and the statutory sector where significantly higher salaries have been the principle attraction.
 -our FTE contracts prohibit us from invoicing on FTEs where, vacancies exist, and yet it is not uncommon practice of DHBs to hold vacancies.
- Examples of conflicts of interest were described where some new services started by the DHB provider openly compete with services already available in the community.
- With erosion of the split between the provider arm and the funder, some respondents are experiencing the introduction of increased expectations and requirements (often not detailed on the contract). For example, one respondent reported that their contract requires monthly reporting, but the DHB provider wants them to report fortnightly.
- One respondent described how a DHB funder has apportioned NGO 'contact' and 'non contact' time. 'It is overly simplistic with no serious analysis of the time it takes to actually deliver the service as it does not recognise coordination roles, or staff leave obligations.' The respondent felt it signalled the DHB having a lack of confidence in the organisation (or sector) to determine these needs.
- In some DHBs, clinicians have access to an NGOs contract and the monetary value of that contract; respondents thought this inappropriate and a breach of confidentiality.

Reporting processes and templates

- The reports are 'onerous and time intensive to administer.'
- 'Contract reports are not relevant and do not reflect the services provided', the templates focused on activities carried out by DHB services and were not specific to community activity.
- The reports contain reference to outdated legislation.
- There is little outcome information reported.

Strengths and positive attributes of the current contractual environment

Respondents were asked to describe the positive attributes of the present environment.

Results

Positive comments focused on the benefits of a mutually respectful relationship based on trust and an understanding of what each had to offer.

Respondents' comments

- We have a 'good relationship with a generally supportive and collegial contracts manager this is down to personalities rather than the contract environment.'
- As the only DHB-contracted mental health provider in this area we are somewhat removed from the competitive nature of contracting.
- Relationships between the community and DHB sectors have improved enormously over recent years. The contracting environment has led to significant development and growth and skill sets within NGOs and this has contributed to the level of effectiveness, efficiency, sophistication and focus on process.
- Generally I would say there is good will and a collaborative 'greater good' theme. We are able to take frustrations to the funder and provider arm and be heard.

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- The NGO sector is gaining recognition as valid and viable in mental health provision.
 - The NGO sector is very diverse and this is its strength, but also weakness by trying to meet all that is desired.
 - There is a guaranteed cash flow.
 - In contrast to our experience of other DHBs, there is one that 'has been transparent and reliable in its dealings with providers and operates with a consistent partnership approach.'

Strategies to improve the contractual environment

Respondents were asked what in their view could improve the environment.

Results

Respondent's comments are self-explanatory and outline a range of strategies which would improve the current contracting environment.

Respondents' comments

Service specifications

- The service specifications need to be simple, and the contract not more than 14 pages long.
- The new service specifications should be applied as early as possible in contract negotiations and new contracts.

Contracts

- A national review of the current contracting environment needs to happen and it should consider whether to develop standard processes and templates.
- Greater standardisation of contracts nationally would be advantageous.
- Single contracts would be best with the same rates for similar services by all DHBs that contract with a single provider.
- There needs to be more logical arrangements of contracts – one service one contract.
- The contract should be easy to understand and have more clarity.
- A five-year contract would be more appropriate with a built-in pricing adjustment mechanism.
- Contracts need to be less prescriptive and more flexible, allowing services to focus on current needs and be innovative rather than be constrained by detailed specifications. There needs to be greater use of packages of care as a method of contracting, and outcomes reporting.
- Longer-term contracts would reduce the administrative impact and create a better strategic environment for planning, innovation and growth. (One respondent suggested three-year contracts for all core activities).
- Occupancy levels provide incentives to keep people rather than support them to move this needs to change.

Pricing

- National pricing is a bone of contention. It may be useful to look first at regional pricing before determining the possibilities of national pricing
- There should be national prices for work contracted under national service specifications. South Island prices should be comparable with North Island prices
- Consistent national pricing is appealing but demographics/deprivation indices can throw out the real price of services. There is no simple answer. There needs to be room for specialised services. Mergers are risky, especially for Pacific and Maori providers
- There also needs to be flexibility on price negotiations

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- Annual cost of living adjustments are essential to long term sustainability
 - A rural weighting on all contracts would be beneficial
 - There needs to be genuine commitment from DHBs to address funding disparities
 - Financial acknowledgement of the actual cost of compliance is required
 - NGOs need equitable funding with DHBs to be able to employ staff and remunerate at the same level

The number of NGOs

- Funders need to stop splitting contracts [in] to smaller pieces and spreading them among more providers.
- It may be more proactive to combine providers, so that clients don't lose the range of options available.

The funder/provider split

- The blurring of DHB funder and provider roles creates a conflict of interest
- There needs to be a clear separation of DHB funding and provision functions and transparency over funding levels. We need independent funders and planners to work regionally to enable objective, fair contracting processes.
- Funders and planners need to use evidence in decision-making, such as what is best practice for service delivery models (not just what the DHB clinicians want).

Relationships

- Trust is at the heart of the issue. The greatest gains will be made where there is a high degree of trust. Providers and funders need to make time for building and maintaining these relationships.
- Communications from DHB contract personnel needed to be proactive, particularly when changes occur.
- Contract personnel need to understand the nature of the provider's business, and the realities of the NGO environment.
- Relationships need to be respectful; we (NGOs) are talented and run successful small businesses in the current environment.

Planning

- [We need] a joint planning approach that engages the sector in finding solutions to problems.
- There needs to be regional planning and funding as the locality model has created silos which limit knowledge-sharing and innovation, especially in developing specialist services.

Reporting

- There needs to be greater standardisation of reporting requirements, recognising multiplicity of reporting to Programme for the Integration of Mental Health Data (PRIMHD), HealthPAC and individual DHBs.
- There should be a computer programme for NGO data recording – one set for DHBs and one set for NGOs rather than try to force NGOs into an incorrect data set.
- I'd like to see an annual publication of all providers' contract amounts and what they were for. Crown monies should not be secret squirrel stuff.
- The consolidation of audits would help larger providers who hold a number of contracts across various DHBs. This could be done through the identification of expert auditors, and a system for sharing the audit results with all of the DHBs.
- A centralised audit process would be so much better; there are huge compliance and contractual transaction costs for example a large organisation has had over 100 audits over the last three years.
- The current environment and contract need to be transparent with relatively simple reporting

requirements.

NGO behaviour

- NGOs need creative leadership to break us out of our mind set and get out of the current paradigm (and to) encourage us to determine what we do – we can't be responsible for everything that goes wrong in the community. We criticise silo mentality but we also help to maintain it!
- NGOs need to deliver what they are contracted for –...our worst enemies are ourselves when other providers let down the NGO sector through poor performance; we are all tarred with the fallout from that.

Part 2

Describing a specific mental health and addiction contract

In order to seek comparisons for like services across the country, respondents were asked to select one of the current contracts they held with a DHB that included either a community support work FTE and or level 3 or 4 bed night rates. The intention was to try to gather information that could enable national comparisons related to contracts for similar activity.

Contract Rates

Contracts for community support workers (CSWs), level 3 and level 4 bed rates, are applied all across New Zealand and respondents were asked about the current contract price paid by the funder for these contracts in order to seek national comparison.

Results

The minimum level 3 bed night rate paid was \$94.46 and the maximum was \$139.04, a difference of \$44.58.

The minimum level 4 bed night rate was \$121.06 and the maximum was \$213.27, a difference of \$92.21.

Community support worker FTE contract rates are often used as one of the most consistently reported comparable contracts that are purchased from the community sector. The difference between the lowest and highest values was \$31,676 per annum.

- Nationally the minimum FTE rate paid for a CSW contract was \$61,200 and the maximum \$92,876.
- The North Island minimum rate paid for a CSW contract was \$76,000 and the maximum was \$92,876.
- The South Island minimum rate paid for a CSW contract was \$61,200 and the maximum was \$72,988.

Hourly pay rates

There are no national or standardised role or job descriptions, workforce data definitions or code sets for occupations in the NGO sector. Respondents were asked to provide information about hourly rates to illustrate the national variations.

Results

The minimum average hourly rate paid to community support workers was \$12 per hour and the maximum was \$22.00 making the variance between the lowest and highest rates \$10.00 per hour. The

mean average hourly rate paid to a community support worker was \$17.60 per hour.

Annual DHB percentage increases to community organisations

Respondents were asked to provide the details of the annual percentage increase (FFT) for the specific mental health and addictions contract selected for their comparative review.

Results

It has always proved quite difficult to understand what DHBs get in the way of FFT funding to cover price increases, and even more difficult to get a coherent picture of what is passed on to NGOs. But comments from respondents suggest DHBs are failing to pass on the full component of FFT to their NGO providers. In the final analysis, the process is not explicit or transparent and NGOs have to meet increasing costs without adequate adjustment for price increases.

Respondent's comments

- My understanding was the DHB received an FFT of 3.5%. They then took a top slice off for other DHB requirements and projects, before giving us a lower percentage.
- (In 2006 there was no cost of living adjustment). In 2007 the contract was renegotiated and the residential programme changed from CMS to care packages and for the first time an annual increase was incorporated. In 2008 this was referred to as FFT and translated into increased FTE rates, increased volumes (.2FTE) for rural outreach services and an additional \$5,000 for accreditation costs.

Discussion

This report reflects the experiences, issues and views of a range of people from organisations that currently contract with DHBs to provide a range of mental health and addiction services to communities across New Zealand.

It is a small study of a very broad area; however, the consistency of the feedback from respondents has confirmed that there are some serious issues to be addressed in the way the Crown, via its agents DHBs, is engaging, contracting and relating to community NGOs.

The Treasury (2003) identified three areas that influence the contracting capability of Government agencies.

1. The quality of the systems employed. This includes having clear policies and processes for contracting, ethical standards, and record keeping systems (p21).
2. Management capability. Of particular importance here is mention of the organisational culture being committed to 'high quality contract management', as well as aligning organisational objectives with budgets, good relationship management and negotiation skills, tested by reference to results achieved in contracts and relationships', and 'Clear assignment of role and responsibility' to those responsible for contracting (p21).
3. Human resource capability. This includes 'suitably qualified and experienced staff', and access to specialist legal, financial, contracting, policy and cultural expertise (p22).

Respondents have raised concerns about all of the areas above as influencing the DHBs' contracting capabilities.

Strategic Direction

The framework described in *Te Tāhuhu* (2005) and the 10 leading challenges of *Te Kōkiri* (2006) set a new national strategic direction for mental health and addiction policy, with an emphasis on outcomes. With respondents making little mention of outcomes, evidence-based purchasing or contracting for change it could be assumed that both community organisations and DHB funding and planning managers have yet to integrate these features into the contractual environment.

Building and broadening the range, type and effectiveness of services and supports for people severely affected by mental illness is one of *Te Kōkiri* challenges. It is difficult to accurately determine or quantify expansion and growth in services provided by community organisations; however, respondents were in agreement that in their view there has been little growth in community based services over the past two years. What growth they have seen has been minimal and usually means small increases in services such as peer support, respite and advocacy services.

Funding mechanisms that support recovery, advance best practice and enable collaboration is another challenge of *Te Kōkiri* 'with an immediate emphasis on establishing funding models, contracting processes and service frameworks that:

- foster learning and evaluation
- promote the seamless delivery of services between providers and across boundaries
- remove incentives that can keep some service users tied to certain services and enable providers to adapt the services they provide to better meet the needs of service users
- enable the development of provider capability.'

Knowing what is the best possible mental health and addictions service for the people who need to use it while making best use of Vote Health dollars is at the heart of any debate on the funding and planning

process. DHB funding and planning arms are accountable for the spending of public money, and as the responsible government agency, have to give 'reasonable assurance that the expenditure is value for money' (Treasury 2003).

The most common process used by most DHBs for developing new services and growing options available to mental health and addiction consumers is the RFP process. Organisations report that taking part in this organisations report that taking part in this cumbersome process is a significant cost of time and effort and sometimes requires additional personnel.. Our survey respondents estimated that the actual cost for RFPs that were not successful totalled over \$208,000. This uses resources that do not directly enhance the mental health system. The widespread use of such a blunt tool for tiny allocations of funding such as .5 of a salary does pose questions about the efficacy and efficiency of this mechanism to gather proposals for the provision of new or additional services.

Based on the feedback from respondents, the funding and contracting environment that supports recovery as described in *Te Kōkiri* remains aspirational.

Relationship and Trust

Significant issues that have emerged through the survey about the contractual environment could be summarised in terms of relationships and trust.

There was clear feedback that when the parties have developed sound, respectful relationships positive results and wider impacts than just contract efficiency have been created.

The high turnover of funding and planning contract managers has made it difficult to build the relationships that are at the base of every contract negotiation and future contract interpretation.

Despite the long experience of community mental health and addiction services delivering in New Zealand communities, it appears there are still are some DHB funders with limited confidence, trust, understanding or experience in relation to community organisations. They may rely more heavily on health professionals for advice, without realising that many health professionals also have limited perspective and experience in community service delivery.

A number of respondents referred to the DHB in ways that show they too have limited trust in the DHB, both as a clinical service provider or as planning and funding personnel.

Planning, funding services to improve the health of the population

A duty of funding and planning personnel is to effectively plan, fund and manage health and disability services to improve the health of populations that are being served (Ministry of Health, 2006). They are responsible for managing each region's service development processes in an equitable and objective manner. The Government recognises that NGOs make a significant contribution to the mental health and addictions sector, provide leadership, 'and are often at the forefront of innovation in service delivery, workforce culture change, effective partnerships with service users, tangata whaiora, whanau, families and communities and putting recovery into action' (*Te Kōkiri* 2006).

Examples were given by respondents of suggestions and improvements ignored by funders resulting in continuation of prescriptive contracts and limited innovative purchasing.

Comments were made about the lack of development, progress and growth of community services that support people to get and stay well and become independent of the mental health system. The lack of strategic future planning about the how the community sector will support mental health in the future is seen by the sector as a major gap.

As one respondent put it, 'the risk is that short term priorities dominate consideration, while the notion of strategic development, investment in the future, capacity and capability building are "optional" elements. Innovative practice and developments are smothered in a wet quilt of risk management.'

Contract Issues

While respondents identified many areas of concern with regards to contractual issues, themes that emerged included highly-specified contracts with a focus on inputs, poor quality contract documentation and lack of transparency and objectivity in the contractual environment.

The contractual documentation forms the basis upon which services are delivered and with contracts with 'specific terms and conditions (are) generally very poorly drafted, contain ambiguities, repetition and irrelevant content.'

With regularly-changing funding and planning personnel, these documents are particularly important as they form the basis of the relationship between the DHB and the community organisation. If the quality of such documents is of a poor standard, there is greater potential for challenge and misinterpretation.

Respondents expressed a strong desire for greater transparency in and across contracts and contract pricing mechanisms. At the moment there is little understanding about how funding and planning managers arrive at contract prices.

Lack of information about price increases and the way the FFT funding is applied frustrates future planning and budgeting for community organisations and risks ongoing sustainability.

Many respondents had been providing services when the purchaser/provider split was first introduced in health contracting in the early 1990s, a time when investment in the community sector was encouraged and supported. The erosion, and in some cases removal, of the clear demarcations and boundaries between the DHB as a purchaser and as a provider of services was commented on by respondents, who also believed this was a factor that had slowed growth of the community sector.

While there were varying views expressed about whether a regionalised or nationalised contracting and pricing system may assist in improving the contractual environment, all respondents were interested in the system being more equitable.

The price variance paid by different DHBs for similar contracts (eg, support worker FTE a difference of \$31,676 per annum) lacks any clear justification. This is the sort of practice that possibly prompted respondents to call for an investigation of national pricing and or benchmarking.

Conclusion

This survey has provided a sample of information and perspectives from community organisations delivering mental health and addictions services from all DHBs using a variety of contractual frameworks.

This report is based on the survey information from the 20 organisational respondents that completed the 2008 NgOIT Prices and Contracts Snapshot Survey and supplemented by additional information sourced from face-to-face and telephone interviews and attendance at sector meetings. What has been reported is a mix of quantitative information from the survey, commentary from the independent researcher based on discussions with respondents, and direct quotes from the respondents' interviews.

Summary of Results

- Feedback has highlighted that the present environment stifles service growth, development and innovation in the mental health and addictions sector. The costs to community organisations tendering for new work are significant. Contractual processes are unsatisfactory, with significant delays in contract completions, ambiguities in documentation, and cumbersome reporting regimes. This also frustrates community organisations' abilities to do what they do best.
- In some regions the split between the provider and purchaser is no longer visible, and provider-arm health professionals and managers are influencing funding and planning processes. The general lack of transparency in many aspects of the contractual environment is concerning to community organisations, including the failure to pass on increases provided by the Government.
- Reports of wide variations in some specific contract prices support the need to further investigate a regionalised or nationalised contracting system with benchmarked pricing to ensure equity and fairness.
- In some places community providers identify ongoing problems with the quality of the systems, management of the contracts, service knowledge and relationship skills of DHB funding personnel. The most significant of these issues has been identified as the lack of relationship and trust between funding and planning managers, and community organisations. As one respondent said 'the issue isn't the contract, it is all about the relationship.'

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Appendix I



2008 Prices and Contracts Snapshot Survey

ABOUT THIS SURVEY

Platform has commissioned Wendy Becker to conduct this survey to help us get an up to date picture of current contracting practices that are impacting on mental health and addictions community organisations in New Zealand.

We need the participation and support of community organisations that contract with District Health Boards for the delivery of mental health and addiction services. The information gathered will be used to assist Platform to understand the inconsistencies and issues at local, regional and national levels, as described by the sector and reported to Platform by individual members and networks. This will assist us to act from an informed position and raise these issues with the incoming Government on your behalf. A findings report will be available for the use of individual organisations and local networks.

This survey is being carried out by **email and post** and there will also be a number of phone and face to face interviews undertaken by Wendy to ensure representation from across the sector. We would be grateful if you could please assist this national NGO information collection project by participating in the survey. **Please complete the survey by 3 December 2008.**

Be assured that organisational data and comment that you provide will be visible only to the researcher, any information provided will be collated and analysed so that it will be not be identifiable. When the project is completed, all data provided by organisations will be destroyed.

A summary of the findings and report will be provided to NGOs via the Platform Newsletter and available on the Platform website www.platform.org.nz



SURVEY INSTRUCTIONS

When completing the survey, please tick one or more boxes as required.

If you are completing the survey by email, please send it to;

wendysbecker@clear.net.nz

If you are completing the survey by post, please complete the attached survey document and return in the self addressed envelope to;

Wendy Becker
538 North Road
North East Valley
DUNEDIN

Please attach any extra pages at the back of this survey if you need to provide further information. Please document the question number that relates to the extra information.

If you need any help or would prefer to talk to Wendy please do not hesitate to phone.

If you require any more information about the way Platform will use the material phone Marion Blake CEO 04 3850385 or 021790587.

Please return this survey to Wendy by 3rd December 2008.

Describing the Organisation's mental health and addictions contracts and contract environment:

1	Name of Organisation: Contact Number: Person Completing the survey: Survey Completion Date: Position in the Organisation:	
2	Which DHB is the main contract holder for the organisation? What is the total number of the DHB mental health and/or addiction contracts the organisation is currently delivering on? Total number of DHB contracts: Please tick the DHB regions that the organisation provides mental health and or addiction services in: (please tick all that apply) <input type="checkbox"/> Auckland <input type="checkbox"/> Bay of Plenty <input type="checkbox"/> Canterbury <input type="checkbox"/> Capital & Coast <input type="checkbox"/> Counties Manukau <input type="checkbox"/> Hawkes Bay <input type="checkbox"/> Hutt Valley <input type="checkbox"/> Lakes <input type="checkbox"/> Mid Central <input type="checkbox"/> Nelson/Marlborough <input type="checkbox"/> Northland <input type="checkbox"/> Otago <input type="checkbox"/> Southland <input type="checkbox"/> Sth Canterbury <input type="checkbox"/> Tairāwhiti <input type="checkbox"/> Taranaki <input type="checkbox"/> Waikato <input type="checkbox"/> Wairarapa <input type="checkbox"/> Waitemata <input type="checkbox"/> West Coast <input type="checkbox"/> Whanganui Comments:	
3	What is the total number of staff employed by the organisation as at the 31st October 2008? (Include staff from management, admin and service delivery) (no. of staff)
	How many Full Time Equivalents does the organisation employ? (no. of FTE'S)
	How many of these Full Time Equivalents does the organisation employ for the delivery of mental health and/or addiction services? (Include staff from management, admin and service delivery) (no. of mental health and or addiction FTE'S)
4	District Health Boards use many different models of contracting with community providers. We would like to understand the size and scope of this issue. What funding models are used by the DHB(s) that you mainly deal with? (Please refer to Appendix 1 for examples. Please tick all that apply) <input type="checkbox"/> FTE Funding <input type="checkbox"/> Fee for Service (CCPS) <input type="checkbox"/> Capacity Funding (CMS) <input type="checkbox"/> Packages of Care <input type="checkbox"/> Programmed Funding Comments:	

5	<p>Community organisations have advised Platform that they have to deal with constantly changing personnel who manage their DHB contracts and this has been described as a major problem for building good contract relationships.</p> <p>What has been the total number of DHB contract personnel (ie associated with funding and planning) the organisation has worked with over the last two financial years across all of its mental health and addictions contracts?.....(Total no. of DHB Personnel)</p> <p>Comments:</p> <p>.....</p> <p>.....</p>
6	<p>Community organisations have advised Platform that there has been little service growth in the last few years, therefore over the last two financial years has the organisation experienced any of the following with the DHB(s) mental health and/or addiction contracts?(Please tick only one)</p> <p><input type="checkbox"/> Expanded <input type="checkbox"/> Remained the same <input type="checkbox"/> Reduced <input type="checkbox"/> Reconfigured</p> <p>Comments:</p> <p>.....</p> <p>.....</p>
7	<p>Community organisations have advised Platform that the process of tendering for new work is an area for improvement. Briefly describe any proposals that the organisation has developed in response to DHB Mental Health and Addictions Request for Proposals (RFP) over the past two years?</p> <p>(Please copy this section or add additional pages if there have been more than 3 RFPs).</p> <p>(a) Type of Proposal?</p> <p>.....</p> <p>(a) Process and Outcome? (i.e. is the organization now delivering this service?)</p> <p>.....</p> <p>(a) Development Cost? (i.e. estimation in dollar terms, time taken)</p> <p>.....</p> <p>(b) Type of Proposal?</p> <p>.....</p> <p>(b) Process and Outcome? (i.e. is the organization now delivering this service?)</p> <p>.....</p> <p>(b) Development Cost? (i.e. estimation in dollar terms, time taken)</p> <p>.....</p>

7	<p>(c) Type of Proposal?</p> <p>.....</p> <p>(c) Process and Outcome? (i.e. is the organisation now delivering this service?)</p> <p>.....</p> <p>(c) Development Cost? (i.e. estimation in dollar terms, time taken)</p> <p>.....</p> <p>Comments:</p> <p>.....</p>
8	<p>Please comment on any other significant contractual issues that are impacting on the organisation.</p> <p>.....</p> <p>.....</p> <p>.....</p>
9	<p>Please comment on the strengths and positive attributes of the current contractual environment.</p> <p>.....</p> <p>.....</p> <p>.....</p>
10	<p>Please make suggestions on how mental health and addictions contracts, contract environment, and contractual relationships may be enhanced to benefit the organisation and/or the DHB.</p> <p>.....</p> <p>.....</p>

Describing a Specific DHB/Organisation Mental Health and Addiction Contract:

To complete this section, please select one of the current DHB mental health and/or addiction contracts that include community support worker FTE rates and/or Level 3 & 4 bed night rates. Please answer the following questions as they relate **to this specific** contract. The information provided will enable comparisons across the sector to be made.

11	<p>Which DHB is the contract holder for this specific mental health and/or addiction contract with the organization?</p> <p>What is the current expiry date for this specific DHB mental health and/or addiction contract? (Contract expiry date)</p> <p>What is the full length of this specific DHB mental health and/or addiction contract?</p> <p><input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Year <input type="checkbox"/> 3 Year <input type="checkbox"/> Other (please specify)</p> <p>How many variations have there been for this specific DHB mental health and/or additions contract? Comments:</p>
12	<p>DHB Contract Rates for this specific mental health and/or addiction contract:</p> <p>What is the current price paid for a Community Support Worker FTE \$ (FTE price excl GST)</p> <p>What is the current bed night rate paid for Level 3? \$ (Level 3 bed night excl GST)</p> <p>What is the current bed night rate paid for level 4? \$ (Level 4 bed night excl GST)</p> <p>Are these Level 3 and 4 bed night rates inclusive or exclusive of the client contribution (ie the WINZ residential support subsidy)?</p> <p><input type="checkbox"/> Inclusive of client contribution <input type="checkbox"/> Exclusive of client contribution</p> <p>Comments:</p> <p>.....</p> <p>.....</p>

13	<p>What is the organisation's average hourly rate paid to a Community Support Worker?.....(Average hourly rate) (This information will used when comparing the contract price paid for Community Support Worker FTE)</p> <p>Comments:</p> <p>.....</p>																				
14	<p>What funding models are utilized by the DHB for this specific mental health and/or addiction contract? (Please tick all that apply)</p> <p> <input type="checkbox"/> FTE Funding <input type="checkbox"/> Fee for Service (CCPS) <input type="checkbox"/> Capacity Funding (CMS) <input type="checkbox"/> Packages of Care <input type="checkbox"/> Programmed Funding </p> <p>Comments:</p> <p>.....</p>																				
15	<p>What has been the total number of DHB personnel (ie funding and planning) the organisation has worked with over the last two financial years for this specific mental health and addictions contract? (Total no. of DHB Personnel)</p> <p>Comments:</p> <p>.....</p>																				
16	<p>Please provide the annual DHB percentage increase for this specific mental health and or addiction contract for the following areas of the contract for the three financial years noted.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 20%; text-align: center;">06 to 07</th> <th style="width: 20%; text-align: center;">07 to 08</th> <th style="width: 20%; text-align: center;">08 to 09</th> </tr> </thead> <tbody> <tr> <td>Over the entire contract?</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> </tr> <tr> <td>Community Support Worker FTE?</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> </tr> <tr> <td>Level 3 Bed Night Rate?</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> </tr> <tr> <td>Level 4 Bed Night Rate?</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> </tr> </tbody> </table> <p>What was the explanation provided from the DHB for the annual contract percentage increase? (i.e. Future Funding Track, Consumer Price index, Labour Cost Index Change, Cost of Living Adjustment)</p> <p>Comments:</p> <p>.....</p>		06 to 07	07 to 08	08 to 09	Over the entire contract?	Community Support Worker FTE?	Level 3 Bed Night Rate?	Level 4 Bed Night Rate?
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PLATFORM

