Ontario Health Team (OHT) Name:	Central West Ontario Health Team (formerly Brampton Etobicoke Ontario Health Team)
Key OHT Contact for Report: *Please indicate a contact for any questions pertaining to this report*	Saleem Chattergoon
Transfer Payment Recipient Name:	William Osler Health System
Reporting Period: ☐Q1 ☐Q2 ☑Q3 ☐Q4	October 1, 2021 to December 31, 2021
Due Date: *Once complete, please submit your templates to your Ministry of Health (ministry) point of contact*	January 31, 2022

This Report consists of three parts:

1) Narrative and Status Update
2) TPA Performance Indicator Reporting
3) Financial Expenditure Statement

PART ONE: NARRATIVE AND STATUS UPDATE

The Narrative and Status Update collects information about your OHT's progress against transfer payment agreement (TPA) outputs and milestones, as well as the overall advancement of the OHT model. There are no word limits to this part of the Report, but brevity is encouraged. Please submit this part of the Report as a Microsoft Word document. Please do not submit in PDF format.

As you complete this template, please consider and highlight in yellow up to three things that your team feels could be shared more broadly for other teams to adopt or learn from. These could be successes, achievements, activities, risks, and/or mitigation approaches.

Section A – Showcasing Successes To Date (Required for Q3)

Confirming OHT Membership

Your ministry point of contact has also shared with you the membership records we have on file for your team. Please validate the list per the instructions included in the provided spreadsheet.

What accomplishment is your OHT most proud of for this reporting period?
For our third quarter report, the Central West Ontario Health Team (CW OHT) is most proud of launching our digital media channels, including the website and social media. Though originally slated to be launched prior to our rebranding process, we identified the challenge in having to relaunch the website to partners with new branding. The website, https://centralwestoht.ca includes information about what an OHT is, how it helps key stakeholders, a list of all partners that comprise the OHT and information on navigating health and related services over the holiday period. Some patient content is also hosted on our website, including the CW OHT Patient Family Engagement Framework and the Patient, Family and Caregiver Declaration of Values for Ontario (PFCDOV). Along with the patient-facing resources, the CW OHT has also launched a digital platform (Slack) for physicians to engage with each other and share resources.

Is there a top patient-facing success that your OHT would like to share for this reporting period?
The top patient-facing success from the CW OHT, the PFCDOV, engaged with the larger community including patients/clients, family and caregivers to develop regional values. This was based on, and aligned with, the provincial patient declaration of values. From the strength of the provincial PDOV we were able to build and enhance our local PFCDOV (patient, family, caregiver declaration of values). Similar to other provincial patient materials, the PDOV provided a framework in order to have the conversations that highlights our regional values as an OHT.

Is there a top provider-oriented success that your OHT would like to share for this reporting period?
Building on the work from Q2, SCOPE (Seamless Care Optimizing the Patient Experience) continues to be a clear provider-oriented success for the CW OHT. SCOPE is a shared virtual interprofessional care team for primary care providers (PCPs), most beneficial to those who are unaffiliated with a Family Health Team or hospital. SCOPE creates equity among providers through better connection to services for PCPs. Services include internal medicine, mental health, medical imaging, a nurse navigator and home and community care. The Women's College Hospital and University Health Network first launched SCOPE in 2012 with funding from the Toronto Central LHIN, led by Dr. Pauline Pariser. Our SCOPE line launched as a pilot in October 2020 with 18 PCPs. As of December 31, 2021, the SCOPE line expanded to 97 PCPs, established, and maintained a 90 per cent satisfaction rate and an emergency department (ED) diversion rate of 60 per cent. For this reporting period, 15 additional PCPs (97 total) have joined SCOPE with the total number of calls reaching 425. Finally, as a result of SCOPE, Slack and our newsletter, our physician sign-ups to the OHT have increased from 121 to 136 as of this report.

Where applicable, describe any activities or planning your OHT has begun in relation to COVID-19 recovery.
In exploring how the CW OHT can best support COVID-19 recovery, we have begun supporting multiple COVID, Cold and Flu Care Clinics within our catchment area. Working closely with Ontario Health Central and Peel Public Health, we are supporting hubs that combine COVID-19 testing, COVID-19 vaccinations and assessment for patients and ensure a safe working space for primary care. This enables PCPs to focus on upstream health for screening and complex issues, reduce emergency department volumes, and provide increased access to these services for patients close to home. The COVID, Cold and Flu Care Clinics are a multi-organizational initiative. It involves guidance from Ontario Health Central, the CW OHT for additional development, planning and strategy and partners to operationalize. Developments for this quarter include working with Ontario Health Central to operationalize two COVID, Cold and Flu Care Clinics, including Snelgrove Community Centre in northwest Brampton and Four Corners Health in Malton, and working with the Region of Peel to increase vaccinations in the community.

Section B: Key Activities and Achievements (Required for Q3)

Progress related to specific TPA outputs and milestones are reported in section C; however, achieving these is dependent on advancements across key OHT model components (or building blocks) as described in the 2019 OHT Guidance Document and supported by eligible spending categories.

Whereas the Cohort 1 Year End Report 2020-2021 focused on notable highlights, the Cohort 1 quarterly reports (Q1-3) draw focus to specific objectives, activities, and results achieved by teams for each reporting period in alignment with the OHT building blocks and eligible TPA spending categories.

In situations where there were no relevant activities that took place during the reporting period because none were planned, please indicate this using N/A – Not Planned. Where activities were planned but did not take place due to COVID-19 capacity constraints, please indicate this using N/A – COVID-19.

Transforming Patient Care

Detail activities that your OHT has undertaken to re-design care for your target population(s), including the application of population health management approaches.		
Objectives	**Activities**	**Results Achieved** *(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)*
Implement and evaluate integrated care model for our priority population.	Developed a process to implement and evaluate an integrated care model for the CW OHT priority population.	The Priority Population Working Group has leveraged population demographics and care services data from its OHT Organizational Partners to better understand the needs and gaps of older adults experiencing frailty. The group has reviewed data pertaining to Emergency Department utilization rates in addition to data regarding homebound patients. Next steps include finalizing the population segments and leveraging the data to inform the co-design of a potential primary care program for homebound and at-risk older adults.

Patient, Family, and Caregiver Partnership and Community Engagement

Detail activities related to the inclusion of patients, families and caregivers as partners in OHT work. Where applicable, please include details about the work undertaken with your patient, family and caregiver partners.		
Objectives	**Activities**	**Results Achieved** *(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)*
Disseminate Patient Engagement Framework	Upon completion of the patient engagement framework, it was uploaded to our website.	Uploaded to our website, next step is to share through social media and extended network of partners.
Socialize Mission, Vision and Values among partners and on social media.	Upon completion of the mission, vision and values it was uploaded to our website.	Uploaded to our website and is currently being shared through social media and extended network of partners.

Develop the CW OHT Patient Declaration of Values (PDoV.)	Using the Ministry's PDoV, our own Mission, Vision and Values and working with the community to create a PDoV that is representative for the CW OHT.	Completed a PFCDoV aligned with the provincial PDoV that will be disseminated to the broader community for feedback.

Detail activities related to engagement with local communities to inform planning and build awareness of OHT work.		
Objectives	**Activities**	**Results Achieved** ***(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)***
Develop Patient Engagement Framework	Engaged with patients/clients, family and caregivers to create a patient engagement framework.	Launched patient engagement framework on our website and educated partners on the framework to guide the work of the OHT.
Develop the CW OHT Patient Family Caregiver Declaration of Values (PFCDoV.)	Engaged with patients/clients, family and caregivers to create a PFCDoV.	Completed PFCDoV, uploaded it to our website and educated partners on the values to guide the work of the OHT.

Detail activities related to addressing the needs of underserved populations and/or populations that face barriers to accessing services (including but not limited to engagement with First Nations, Inuit and Métis, racialized or marginalized communities, and Francophone populations).		
Objectives	**Activities**	**Results Achieved** ***(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)***
Embed equity into all aspects of the CW OHT work.	Created an equity framework and charter for the CW OHT.	The Equity Charter has been created for all partners to sign to solidify our commitment to equity, diversity and inclusion as an OHT. The charter also includes the use of an equity framework to be used in all of our OHT projects and for building accountabilities among all partners. It has been approved by our Collaboration Council. It has also been

		shared with partners to use as a guide to develop their own EDI values and framework where needed.
Better understand the CW OHT population from an equity perspective.	1. Worked with McMaster public health students to create an asset map for our priority population. 2. Used sociodemographic data to help understand the needs of the priority population from an equity perspective.	Asset map is currently in development. Initial sociodemographic data sources have been identified.
Determine how best to support francophone population.	Working with Entité 3 to best identify ways to work with target population.	Work with Entité 3 to recruit francophone PFAC member and exploring they can partner with our EDIAC committee. Commitment to schedule a learning session about active offer for our priority population to inform our working group, ensuring that they understand requirements for actively planning.

Leadership and Collaborative Decision-Making

Detail activities related to building a culture of trust, shared accountability, and unified direction across OHT members and OHT leadership.		
Objectives	**Activities**	**Results Achieved** ***(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)***
Improve CW OHT partner engagement.	The CW OHT's Governance Working Group is creating a board engagement plan and developed a survey to evaluate how best to integrate organizational boards into CW OHT activities to ensure they are engaged and informed.	Survey was completed and the results identified clear objectives going forward. The results of the survey will be brought to Collaboration Council to discuss implementation.

Detail activities related to primary care, clinical or specialist engagement and involvement, including the inclusion of clinical leaders in OHT work.		
Objectives	**Activities**	**Results Achieved** ***(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)***
Improve primary care provider engagement.	Created and maintained a bi-weekly primary care provider newsletter. Increased total subscribers from organic shares.	The open rate for the newsletter (average) is 53.17% opens. Increase from 51.4% in Q2. 335 total subscribers, increase from 224 in Q2.

Launch CW OHT Community for Physicians (Slack).	Develop groups and content to launch primary care communications protocol on Slack platform.	Launched the CW OHT Community of Physicians on Slack.
Expand knowledge of Community Medical Advisory Committee (CMAC) to more specialist perspectives.	Began the recruitment process to include more specialists that are familiar with our priority population.	Recruited a specialist with detailed knowledge of our priority population to CMAC.

Digital Health and Information Sharing

Detail activities related to the advancement of digital health/virtual care or advancing information sharing across the members of the OHT. Examples could include expanding access to patient-facing digital health solutions (e.g., virtual care, online appointment booking), supporting initiatives that enable access to integrated patient health information in a privacy protected manner, or other solutions which have supported integrated team-based care.		
Objectives	**Activities**	**Results Achieved** ***(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)***
Development of the Harmonization Information Management Plan (HIMP)	Created Privacy and Security for HIMP Charter Created HIMP Created HIMP Attestation response	Charter created and approved. The plan has been completed, revisions were noted from Collaboration Council ensuring alignment with priorities and our OHT's current capabilities. HIMP attestation approved and submitted to ministry prior to due date.
Build process for Privacy and Security Attestation of CW OHT Health Information Custodian (HIC) Organization	Created HIC Attestation form	Met with all participating pilot HIC organizations to examine their internal privacy and security policies for initial readiness (attestation) assessment.
Identify practical ways for the priority population to access virtual care and health records digitally	Deliver Surgical Transitions Lessons Learned to the Ministry	Ministry-funded Surgical Transition project supported by the CW OHT completed. Lessons learned document submitted to the ministry.

	Review early iterations of the High Intensity Senior's Continuum Program Joined the regional planning for Patient Portals to evaluate practical ways for allowing patients to access health records digitally.	High Intensity Senior's Continuum Program initial needs assessment completed. Due to HIMP, objective has been updated to: "Identify practical ways for the priority population to access virtual care and health records digitally." The goal of the HIMP has also been updated to understand our needs and flag opportunities from all integrated systems attempts during this fiscal year. In the process of submitting a proposal for funding to support 'IDENTOS' (a means of single sign on), in combination with 'Connect My Health' (a web-based application). These tools will connect patients to the OHT's inventory of patient portals and digital tools. If funding is approved, implementation will begin in FY2022/23 and will continue until FY2023/24.

Achieving the Quadruple Aim: Performance Measurement, Quality Improvement & Continuous Learning

Detail activities related to performance measurement and quality improvement, including the collection, sharing, or use of data to inform your OHT's work.		
Objectives	**Activities**	**Results Achieved** ***(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)***
Assess High Intensity Senior's Continuum Program to use key insights to inform future planning.	A framework has been created to assess and evaluate the High Intensity Senior's Continuum Program.	The closeout report for the HISH+ was completed and reviewed by the project sponsors in October 2021. The final draft was shared with the Executive Sponsors in Nov 2021.
Report on Ministry of Health OHT indicators.	Ongoing quarterly reporting on three chosen performance indicators. Establish targets for chosen performance indicators	The CW OHT Performance Indicator Working Group continues to follow its established process for quarterly reporting, with Q1 and Q2 results collected. Currently preparing Q3 submission with Q2 and Q3 results.

		Targets for each of the performance indicators have been identified and approved by the Collaboration Council.
Create a collaborative Quality Improvement Plan (cQIP)	Understand the requirements of the cQIP. Review materials to be provided by the MOH. Prepare plan of action.	cQIP lead has been assigned from the CW OHT Secretariat, and preliminary plan to engage patients, providers and partners in work streams corresponding to each cQIP indicator has been developed.

Section C: Status on Outputs and Milestones (Required for Q3)

Status of TPA Outputs

Schedule “C” of the TPA outlines “Outputs” that the Approved OHT is responsible for producing by a specified date. In the chart below, please identify the current status for each of these required Outputs. Where status is Yellow or Red please indicate associated risks in Section D - Risk Register. Any activities that teams have undertaken toward the development of these outputs may be considered when assessing status (regardless of whether ministry-issued guidance has been released).

Output	Due Date	Status Green – progressing well Yellow – some challenges Red – at risk N/A – not applicable/not yet started	Risk(s)/Barriers to Producing Output by Due Date (if applicable
Patient, Family and Caregiver Partnership and Engagement Strategy	September 30, 2021	**Green (completed)**	Please indicate associated risks in Section D
Primary Care Communication Protocol	September 30, 2021	**Green (completed)**	
Harmonized Information Management Plan	September 30, 2021	**Green (completed)**	
Patient Declaration of Values	November 30, 2021	**Green (completed)**	
OHT Expansion Plan	March 31, 2022	**Green**	
A Collaborative Quality Improvement Plan (cQIP)	March 31, 2022	**Green**	Due to Omicron response across the system, the level of engagement with patients, providers and partners may need to be less extensive to accommodate the March 31st due date. Extension of this deadline would allow for more robust engagement.

Progress To-Date on TPA Milestones

Schedule “C” of the Transfer Payment Agreement outlines Milestones that the OHT is expected to have progressed by the end of the funding agreement period. Appreciating that the advancement of these Milestones will take time, please categorize progress to-date for each as “green”, “yellow”, or “red”. For Milestones with “green” progress, identify key achievements. Where status is Yellow or Red please indicate associated risks in Section D - Risk Register.

TPA Milestone	Progress To-Date Green – progressing well Yellow – some challenges Red – at risk N/A – not applicable/not yet started	Upcoming Milestones & Associated Timelines Identify the next major project milestones associated with each TPA milestone and projected timing for completion.
Care has been re-designed for patients in the OHT's priority population(s)	**Green**	The Priority Population Working Group has leveraged population demographics and care services data from its OHT Organizational Partners to better understand the needs and gaps of older adults experiencing frailty. The group has reviewed data pertaining to Emergency Department utilization rates in addition to data regarding homebound patients. Next steps include finalizing the population segments and leveraging the data to inform the co-design of a potential primary care program for homebound and at-risk older adults.
Every patient in the OHT's priority population(s) experiences coordinated transitions between providers - there are no 'cold hand-offs'	**Green**	The Priority Population Working Group has leveraged population demographics and care services data from its OHT Organizational Partners to better understand the needs and gaps of older adults experiencing frailty. The group has reviewed data pertaining to Emergency Department utilization rates in addition to data regarding homebound patients. Next steps include finalizing the population segments and leveraging the data to inform the co-design of a potential primary care program for homebound and at-risk older adults.

Every patient in the OHT's priority population(s) has access to 24/7 coordination and system navigation services.	**Green**	The Priority Population Working Group has leveraged population demographics and care services data from its OHT Organizational Partners to better understand the needs and gaps of older adults experiencing frailty. The group has reviewed data pertaining to Emergency Department utilization rates in addition to data regarding homebound patients. Next steps include finalizing the population segments and leveraging the data to inform the co-design of a potential primary care program for homebound and at-risk older adults. The CW OHT website contains information on select areas for the population to go for care (available 24/7). The CW OHT is also working with Ontario Health Central Region to implement the 24/7 Patient Navigation Service project.
The majority of patients in the OHT's priority population(s) who receive a self-management plan understand the plan, and the majority who receive access to health literacy supports use those supports.	**Green**	Priority Population Working Group is working on the co-design, implementation and evaluation of an integrated care model for older adults experiencing frailty. This process is divided into 5 phases; defining the problem statement, segmentation, co-design, implementation and evaluation/spread of services. A working group has been created to lead the work pertaining to older adults experiencing frailty. Membership of the working group includes Community Agency partners, Patient and/or Caregiver partners, Physician partners and support from the Secretariat.

More patients in the OHT's priority population(s) are • accessing care virtually • accessing their health information digitally • booking appointments online	**Green**	The Priority Population Working Group has leveraged population demographics and care services data from its OHT Organizational Partners to better understand the needs and gaps of older adults experiencing frailty. The group has reviewed data pertaining to Emergency Department utilization rates in addition to data regarding homebound patients. Next steps include finalizing the population segments and leveraging the data to inform the co-design of a potential primary care program for homebound and at-risk older adults. Submitted proposal for funding to support online appointment booking for eight CW OHT organizations representing 100 primary care providers. Together these providers serve over 75,000 patients and it is anticipated that 60% of these patients will have new access to online appointment booking once implemented.
More providers in the OHT are accessing provincially-funded digital health solutions (e.g., provincial clinical viewers, Health Report Manager, eServices). *Note: Although not a listed milestone, the commitment to adopt core provincial digital health services is a pre-condition of using implementation funding on digital health, information management, and virtual care implementation activities) per page 23 of the TPA.*	**Green**	HRM adoption remains the same as previously reported in the End of Year report - greater than 80% among CW OHT Primary Care Providers. As in the previous report, the plan is that digital health expertise from the CW OHT will continue to provide more active guidance and support to CW OHT member organizations to adopt provincially funded digital health solutions throughout FY 21/22. The effort will include support for signing up for services as well as training and support. Dedicated resource(s) to support this will be available to all CW OHT members interested in increasing utilization of these tools as well as other informatics deemed beneficial in enhancing overall 'digital health tools' utilization and efficiencies for better care collaboration among our OHT. Tools to be reviewed: • HRM • ConnectingOntario • DI-r • Olis • Other products identified in the playbook This will commence when privacy and security work is launched.

Most primary care providers to the OHT's priority population(s) are members of, or partners with, the OHT.	Yellow	Developed engagement and onboarding strategy for physicians. Recruited onboarding specialist to assist.
Information about OHT member service offerings is readily available and accessible to the public, e.g. through a website.	Green	CW OHT website continues to evolve, includes holiday hours for partner services and will grow to include all services.
Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence.	Green	The Priority Population Working Group has leveraged population demographics and care services data from its OHT Organizational Partners to better understand the needs and gaps of older adults experiencing frailty. The group has reviewed data pertaining to Emergency Department utilization rates in addition to data regarding homebound patients. Next steps include finalizing the population segments and leveraging the data to inform the co-design of a potential primary care program for homebound and at-risk older adults.
The OHT's performance has improved on measures of access, transition, coordination of care, and integration.	Green	The Priority Population Working Group has leveraged population demographics and care services data from its OHT Organizational Partners to better understand the needs and gaps of older adults experiencing frailty. The group has reviewed data pertaining to Emergency Department utilization rates in addition to data regarding homebound patients. Next steps include finalizing the population segments and leveraging the data to inform the co-design of a potential primary care program for homebound and at-risk older adults.

Section D: Risk Register (Required for Q3)

Categorize and describe any current risks or challenges to achieving outputs or milestones. General risks to the OHT's implementation plans should also be identified. Describe any mitigation strategies put in place to address the identified risks.

Risk Category	Description of Risk (please indicate any risks added or removed since last reporting period)	Mitigation
Partnership Risk – Other [Engagement]	Achieving the milestone, "*Most primary care providers to the OHT's priority population(s) are members of, or partners with, the OHT"* as physicians are still expressing hesitancy about joining the OHT.	• Work with the OMA to address hesitancy about partnering with the OHT. • Leverage list of all physicians attributed to the CW OHT. • Created a physician engagement lead role as an extension of the CMAC. • Hired an outreach lead to facilitate physician onboarding • Use physician peer network to recruit physicians to the CW OHT. • Use the SCOPE program to recruit physicians to the CW OHT.
Resource Risk – Human Resource	Resourcing and expertise to develop the collaborative Quality Improvement Plan (cQIP).	• Identified a lead to support the development of the Collaborative QIP (cQIP). • Create a plan of action early on to establish the cQIP.
Partnership Risks - Other	Ability to maintain relationship with SPOs/private vendors despite lack of formal OHT partnership at this time.	• Coordinate with Home and Community Care Support Services (HCCSS) to work with and engage with SPOs/private vendors. • Utilize the findings from the CW OHT Retreat facilitated by Santis to facilitate better communication with SPO/private vendor partners.

		• Work with other OHTs and/or the Ministry to receive guidance on how to proceed with partnership.
Resource Risks - Financial	Ability of ongoing funding for physician engagement, patient engagement and backbone support. Ability to continue offering services that received one-time funding (e.g. Mobile Enhancement Support Team, HISH+ Program).	• Work with the Ministry to advocate for ongoing funding and address regional underfunding inequities. • Work with partners to pool funding where possible. • Establish a resource management committee to explore financial sustainability.
Compliance Risks - Legislative	Extent of privacy requirements to facilitate information sharing across partners.	• Work with the Ministry to understand the best solution to implement Data Sharing Agreements (DSAs) across OHT partner organizations and physicians. • Acquire resources to support to review privacy needs and develop DSAs.
Patient Care Risks- Other	Ability to provide equity in care across all aspects of the CW OHT catchment area.	• Create partnerships with additional organizations/providers in the different geographies to support equity in care for the various communities.

Risk Categories

Patient Care Risks	**Resource Risks**
• Scope of practice/professional regulation • Quality/patient safety • Other	• Human resources • Financial • Information & technology • Other
Compliance Risks • Legislative (including privacy) • Regulatory • Other	**Partnership Risks** • Governance • Community support • Patient engagement • Other

<u>Section E: Planned Activities for Next Fiscal Quarter (Required for Q3)</u>

Please provide a brief description of your team's top priorities for the next quarter and list key planned activities.

Priorities for the CW OHT for the next quarter include:

- Planning and Design
  - Launch an integrated care model, implementing CW OHT priority population approach
  - Leverage OHT mission, vision and values to build brand identity and organizational trust with partners
  - Finalize CDMA refresh and commence resign process
- Engagement:
  - Work with HCCSS to engage with SPOs and private vendors
  - Recruit more physicians to the CW OHT
  - Creating Stakeholder Matrix for CW OHT Expansion Plan
  - Implement Primary Care Communications Protocol
  - Recruit additional PFAC members to support expanded engagement role patients/clients, family and caregivers will play in the CW OHT
  - Develop board engagement plan following partner survey feedback
  - Revise partner engagement based on partner engagement evaluation
- Care Delivery:
  - Evaluate High Intensity Supports at Home (HISH)+ Program
- COVID-19 Response:
  - Support additional development of COVID, Cold and Flu Care Clinics as required
  - Continue to support COVID-19 testing and vaccination efforts as required
- Work Towards Completing TPA Milestones:
  - Complete Ministry of Health quarterly report.
  - Complete Ministry of Health EOY Report
  - Develop and Complete CW OHT Expansion Plan
  - Develop Collaborative Quality Improvement Plan (cQIP)

PART TWO: TPA PERFORMANCE INDICATOR REPORTING (Required for Q3)

Please complete and attach the 'TPA Performance Indicator Reporting' template to your submission.

PART THREE: FINANCIAL EXPENDITURE STATEMENT (Required for Q3)

Please complete and attach the 'Financial Expenditure Statement' template to your submission. Please do not submit in PDF format.