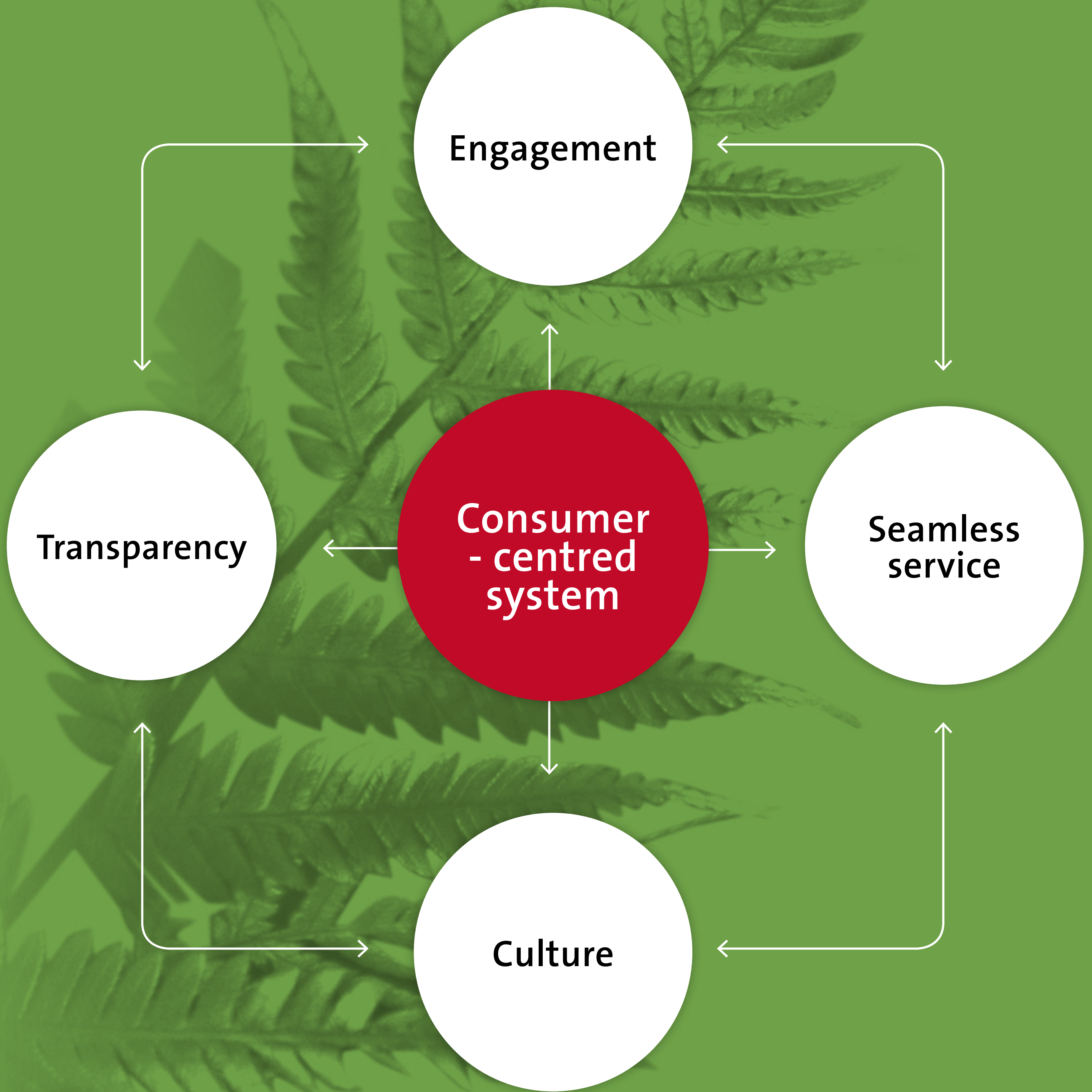
HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

ANNUAL REPORT
for the year ended
30 June 2014


Engagement
Transparency
Consumer - centred system
Seamless service
Culture

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Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004

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Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

31 October 2014

The Minister of Health
Parliament Buildings
WELLINGTON

Dear Minister

In accordance with the requirements of section 150 of the Crown Entities Act 2004, I enclose the Annual Report of the Health and Disability Commissioner for the year ended 30 June 2014.

Yours faithfully

Anthony Hill

Health and Disability Commissioner

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1.0 Commissioner's Foreword

Anthony Hill
Health and Disability Commissioner

I didn't get a glass of water. My baby died. From the apparently straightforward to the profoundly tragic, these complaints reflect two of the 1,901 complaints resolved by the Health and Disability Commissioner's office in the 2013/14 year.

HDC stands in a privileged and unique place in New Zealand's medico-legal environment. New Zealand has a health and disability system of which it can be rightly proud. It is HDC's role to stand in the margins where things do not go well — a fraction of the performance of the system as a whole, but enormously powerful and meaningful for those whose lives are affected. It is important that the system responds, reflects, changes and learns when things do not go well.

Our vision is "Consumers at the centre of services". We pursue this with the mission of independently upholding consumer rights by promotion and protection, complaints resolution, service monitoring, advocacy and education. Our unique role in the sector provides a unique perspective. A consumer centred system means engagement, seamless service, transparency, and a culture that focuses on the consumer. It is about doing the basics well. Read the notes, ask the questions, talk with the consumer. Culture is about the way we do things around here. When two clinicians are in the room and one is making a mistake and the patient is in peril, the other clinician must speak up. It's about a team environment where people will ask questions and raise concerns.

Complaint numbers are growing

HDC has seen a rapid and sustained growth in complaints in the last three years.

HDC has invested to increase output significantly in response to this growth. This has allowed us to improve timeliness, which came under pressure as the growth in complaint numbers accelerated. This year HDC has once again closed more cases than ever in its history, with 1,901 complaints resolved. This included 115 investigations. This, however, is only part of the picture. The Advocacy Service received over 27,000 calls and 3,500 complaints this year.

Every complaint requires careful analysis. In the Mid-Staffordshire report produced in the United Kingdom in 2013, patients were so thirsty they were drinking from flower vases. In that case, "I didn't get a glass of water" was a warning of a much wider problem. Sometimes, however, the glass of water is just a glass of water.

As we have significantly increased output, HDC has rigorously focused on quality improvement. I am very pleased that we have maintained and improved quality while increasing output over 37% in three years. This could not have been achieved without the work of extremely able, dedicated and passionate staff who are committed to achieving fair resolutions and ensuring our processes are thorough and just. I am indebted to them. I am grateful, too, for the work of the many clinical experts whose advice is critical to HDC's success.

It is my intention to position the HDC to sustainably deliver at the new level of output. I am grateful to the Ministry of Health for its support, and am pleased to be able to commit HDC to a break-even budget, at this increased level of output, in the 2014/15 year.

Our unique role in the sector provides a unique perspective.

Why are complaint numbers growing?

There are a number of possible explanations for increasing complaint numbers — the increasing profile of the HDC itself, increasing awareness and accessibility of the complaints process (many complaints are made through our website), and increasing awareness of consumer rights.

The pattern of complaints however has remained relatively consistent across four main areas over time: treatment, communication, professional conduct, and consent/information. Two conclusions may be drawn: one is that increasing complaints does not necessarily mean that quality is decreasing. The consistency of the pattern of complaints is one reassuring feature in this analysis. A second conclusion is that the rate of growth is unlikely to slow across the system. To assist providers to better manage and respond to complaints at the front line, HDC has worked with the hospital sector and with the primary care sector to provide guidance on effective complaints systems. Here and internationally attention on complaints systems is increasing. Organisations that run effective complaints systems will be more responsive to concerns that are raised with them, quicker to adapt and change should that be necessary, and more likely to be sharing learning across their organisation.

Effecting change

A key feature of resolving complaints is ensuring that learning occurs. Every complaint tells a real person's story and represents an opportunity to learn and to improve the system. Learning takes place locally, nationally, and by influencing ideas.

Local change

An 82-year-old man presented at a hospital having had a stroke. He was given the wrong drug and passed away. The reason for the wrong drug being given was a poorly drafted protocol, compounded by a failure to communicate in the right way with the right people.

The district health board was breached for its system failures, and recommendations included clarifying the protocol for stroke thrombolysis and clarifying communication requirements.

Sector change

Last year I became thoughtful about variance in practice between obstetricians and midwives, and nationally, relating to monitoring of the fetal heart in labour. I wrote to stakeholders inviting them to progress the matter. Early in 2014 I was pleased to be advised that agreement had been reached, and guidelines issued by the relevant colleges.

Influencing ideology

Some complaints raise wider questions for consideration in the relevant sectors. In one case, a young man was having brain surgery. Surgery can be complex and risky, and involves high degrees of teamwork from highly trained people. That case raised the question: Does the patient have the right to know that the person performing the patient's major surgery is a registrar?

A key feature of resolving complaints is ensuring that learning occurs.

What's it like at your place?

A question I ask providers when presenting at Grand Rounds is: "What's it like at your place?" As one organisation said, it reviews HDC cases and asks the question: "Could this happen here?"

At board level the question is: "Can you be confident today that what you expect to happen tomorrow at your place will happen?" For the individual it's about personal professionalism, about critical thinking, about engagement with consumers, their families/whānau and colleagues. The strongest environments are those where the consumer is at the centre of care.

It is not enough to have the rules, the protocols, the guidelines and the checklists. These need to be mindfully applied. For this reason, HDC commonly makes recommendations for change, gives time to effect the change, and then later requires an audit to test the reality of those changes.

Mental Health

The Mental Health Commissioner and her team have been very active in the mental health and addictions sector this year. Examples include collaborative work on monitoring, reducing the use of restraint, and a project to develop and pilot an information system to enable real-time feedback from consumers to providers. Pilot site uptake and experience on this project has provided valuable learning for providers, and excellent engagement with consumers.

Disability

Deputy Commissioner Rose Wall commenced her role in July 2013. In this area, we are focusing on increasing the volume of the unheard voice — both with a view to facilitating greater access to complaints resolution processes and expression by those receiving services, and also working with the sector to ensure that those charged with listening are hearing the messages. Strengthening provider complaints mechanisms in this area is another dimension of the work.

Conclusion

HDC continues to do more than ever before.

We continue to focus on behaviour — culture — that reliably and sustainably puts consumers at the centre of care. Learning from complaints leads to improvement in services — we see local and national change as a result.

Every complaint matters, and from pathos and tragedy can still come hope and healing. If we do better tomorrow, today's pain will not have been in vain.

Learning from complaints leads to improvement in services — we see local and national change as a result.

Complaints statistics at a glance — 2011–2014

	2011 – 2012	2012 – 2013	2013 – 2014
Complaints Closed	1,380	1,551	1,901
Investigations	44	60	115
Breach Opinions	29	42	79
Referrals to Director of Proceedings	8	16	23

1.1 2013/14 priorities

In line with HDC's vision and Statement of Intent for 2013–16, the key priorities for HDC for the 2013/14 year were to:

- resolve complaints at the appropriate level in a timely and effective way;
- maintain and improve high quality and timely complaints resolution processes;
- advocate for systemic improvements to mental health and addiction services;
- monitor mental health and addiction services;
- focus on organisational capability;
- maintain professional standards through proceedings in appropriate cases;
- continue to fund the Nationwide Health and Disability Advocacy Service (Advocacy Service);
- continue to work in partnership with other relevant agencies in the health and disability sectors;
- communicate with key stakeholders to ensure that our educational initiatives are effective;
- offer services and processes that are accessible to disability/mental health and addiction service consumers, Māori, Pacific peoples, refugee and other ethnic communities; and
- maintain HDC's high profile in both the health and disability sectors.

1.2 Entity performance: Highlights

HDC is committed to the promotion and protection of the rights of health and disability service consumers across New Zealand. This is achieved primarily through complaints resolution, quality improvement, and appropriate accountability. HDC had a very productive year in 2013/14, and we met our key priorities in a number of ways.

The 2013/14 year saw us receive and close our highest ever number of complaints:

- 1,784 complaints were received (10% increase from 2012/13);
- 1,901 complaints were closed (23% increase from 2012/13);
- 115 formal investigations were completed (92% increase from 2012/13);
- 79 formal investigations resulted in breach opinions (86% increase from 2012/13); and
- 23 providers were referred to the Director of Proceedings (44% increase from 2012/13).

Wide-reaching recommendations were also made across the sector for real and lasting improvements to health and disability services and systems.

HDC continues to provide six-monthly reports to district health boards (DHBs) on the numbers and types of complaints received that relate to DHB services. This year, we updated the reports to include more detail, increasing their usefulness as a quality improvement tool for DHBs.

As in previous years, HDC continued to deliver presentations to various provider and consumer groups about relevant topics including complaints management, HDC's role, and the Health and Disability Commissioner Act 1994 (the Act) and the Code of Health and Disability Services Consumers' Rights (the Code). We held a successful National Disability Conference, with the theme "How do we raise the volume of the unheard voice?" We also held the national advocacy conference, with a focus on mental health and addictions.

As required by the Act, HDC also completed its regular review of the Act and Code in the 2013/14 year. This involved issuing a public consultation document, receiving and reviewing submissions, and reporting to the Minister of Health.

2.0 Role of the Health and Disability Commissioner

2.1 Purpose and role

HDC was established under the Health and Disability Commissioner Act 1994 to promote and protect the rights of health and disability services consumers. The rights of consumers are set out in the Code of Health and Disability Services Consumers' Rights 1996 (the Code). The Code places corresponding obligations on all providers of health and disability services, including both registered and unregistered providers, in respect of those consumer rights.

There are 10 rights in the Code, which cover the following key aspects of service provision:

1. respect;
2. fair treatment;
3. dignity and independence;
4. appropriate standard of care;
5. effective communication;
6. full information;
7. informed choice and consent;
8. support;
9. teaching and research; and
10. right to complain.

Vision *Tā mātou matakite*

Consumers at the centre of services

Ko ngā kiritaki te mauri o ngā ratonga

Mission *Te Whāinga*

Independently upholding consumer rights by:

He whakatairanga motuhake i ngā tika o ngā kiritaki mā te:

- Promotion and protection

  Whakatairanga me te whakahaumaru

- Resolving complaints

  Te whakatau whakapae

- Service monitoring and advocacy

  Te arotake ratonga me te tautoko i te tangata

- Education

  Te mā tauranga

HDC promotes and protects the rights of consumers in two key ways: by resolving complaints about infringements of those rights, and through education of both consumers and providers.

HDC approaches its complaints resolution role with a focus on learning and quality improvement. HDC uses complaints as a means of promoting system improvements that support the vision of a consumer-centred system.

Many complaints are resolved directly between the consumer and the provider, with independent advocates available at no cost to assist consumers with this process. More serious complaints may be formally investigated by HDC. In only a small number of serious cases this may result in a prosecution being taken against a provider by the independent Director of Proceedings in the Health Practitioners Disciplinary Tribunal (HPDT) and/or the Human Rights Review Tribunal (HRRT).

What HDC does

Code of Health and Disability Services Consumers' Rights

Health and Disability sector

Supports learning and improvements in safety and quality

Advocates for a consumer-centred health and disability system

Upholds the Code of Rights

Health and Disability consumers

Resolves complaints and educates

Receives complaints

Health and Disability Commissioner

Output 1: Complaints resolution: Assesses and resolves complaints through a range of processes including referral to provider, referral to advocacy and investigation.

Output 2: Advocacy: Resolves complaints through advocacy, provides information and promotes consumer rights.

Output 3: Proceedings: Takes proceedings in serious cases to publicly redress breaches of the Code of Rights, practitioner standards and human rights.

Output 4: Education: HDC educates the sector and consumers on consumer rights and consumer-centred services, and encourages quality improvements based on learnings from complaints resolution.

Output 5: Systemic monitoring and advocacy – mental health and addiction services:
Monitors the quality of mental health and addiction services and advocates for improvements.

Figure 1: Overview of the role of HDC and how its purpose and role are reflected in its interaction with consumers and the Health and Disability system, and through the five output classes of: Complaints resolution; Advocacy; Proceedings; Education; and Systemic monitoring and advocacy — mental health and addiction services.

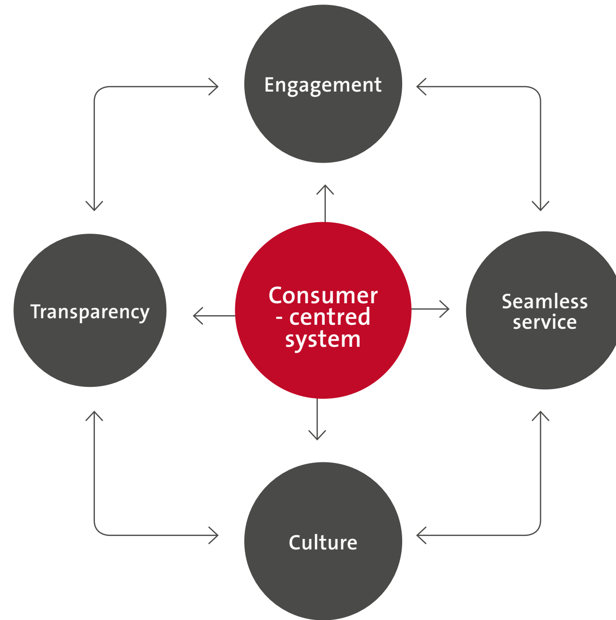
2.2 Impact and outcomes

HDC and the Advocacy Service work with the Health and Disability sector to support a culture where complaints are seen as an opportunity for learning and quality improvement.

The number of providers who implement changes to systems, policies and procedures as a result of a consumer's complaint and feedback continues to be encouraging.

HDC's role to achieve safe, high quality and consumer-centred Health and Disability services (see Figure 2) is reflected in its outcomes framework (see Figure 3).

Figure 2: The consumer-centred system



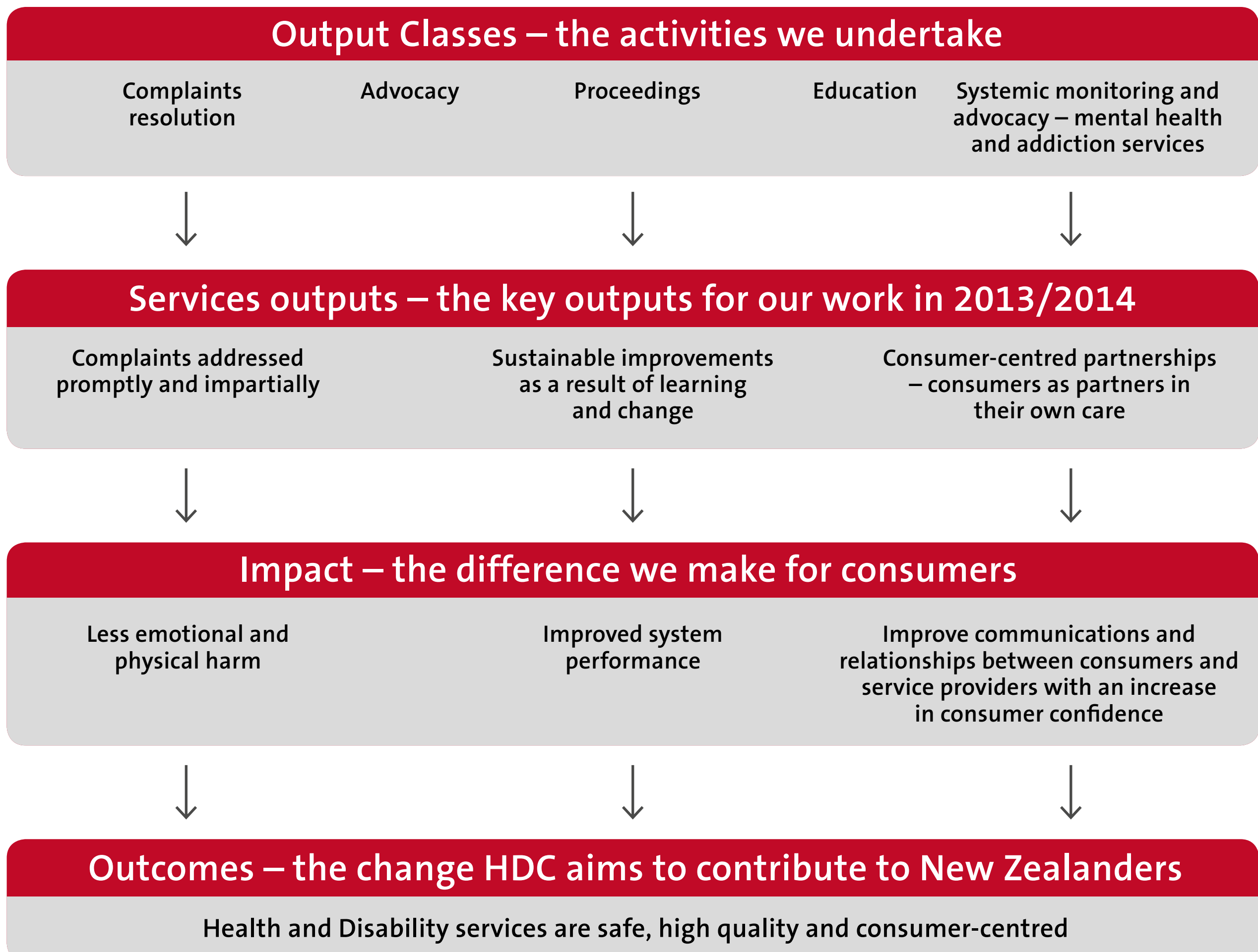


Figure 3: HDC's outcomes framework

Changes made by providers as a result of complaints

HDC's activities of complaints resolution, advocacy, proceedings and education are achieved by working with consumers, the health and disability sector and its wider government sector, and other stakeholders. By learning, preventing unacceptable behaviours and avoiding repetition of errors, the system improves experiences and outcomes for consumers, reduces preventable harm and, in the long run, reduces system costs.

A significant number of providers made changes to their systems, policies and procedures as a result of a consumer's complaint. Below is a small selection of the changes made:

1. Following an investigation of a complaint about a reused needle, a medical centre reviewed and updated its policy regarding administration of the Depo-Provera injection. It also updated its policy on the actions to be taken following a needle-stick injury.
2. As a result of a complaint about a dispensing error, a pharmacy purchased a software programme that provides an efficient and auditable way of managing its standard operating procedures (SOPs). In addition, the pharmacy reviewed its 73 SOPs and audited compliance with those SOPs related to consumer safety. The pharmacy now also ensures that all look-alike and/or sound-alike medications are associated with specific measures to prevent dispensing errors.
3. A disability support service provider that failed to arrange adequate staff coverage, leaving a consumer (who was paralysed from the chest down) without care over the holiday period was found in breach of the Code and referred to the Director of Proceedings. As a result of HDC's investigation, the provider reviewed its policies and procedures for arranging cover for clients when support workers take leave, and provided education to its coordinators and senior staff on how to communicate effectively and respectfully with clients, and how to engage consumers as active participants in their care.
4. As a result of an HDC investigation that found a public hospital had failed to detect the deterioration of an elderly patient prior to discharge, a DHB implemented its own process and documentation tools to govern and clarify the discharge and transfer arrangements of patients from the public hospital to a residential aged care facility, and the communication between hospital staff.
5. Following a complaint, a DHB reviewed its policies, information sheets and practice with regard to discussions of infertility with patients undergoing chemotherapy.
6. In a case where a woman taking a contraceptive pill died as a result of a blood clot following surgery, both the relevant policy at the medical practice and the preoperative questionnaire at the hospital were updated.
7. The Commissioner completed an investigation into a DHB and a psychiatrist who had treated 11 patients suffering treatment-resistant depression with intramuscular injections of ketamine. The Commissioner recommended that the relevant DHB, and all New Zealand DHBs, ensure they had in place appropriate policies on off-label prescribing, and policies and protocols that set out what is required of staff members in relation to clinical and research activities. As a result, the National DHB Chief Medical Officers Forum formulated and submitted a national blueprint policy for off-label use to the Ministry of Health for review.

2.3 The key differences to the health system

The key differences HDC makes for consumers are to:

- increase the focus on consumers with increasing transparency, integration and engagement of consumers with the system;
- reduce the incidence of preventable harm and death caused by unsafe, poor quality systems and practices;
- reduce the stress experienced by consumers and increase their confidence in health and disability services including provider complaint processes;
- increase the quality of communication and improve relationships between consumers and health and disability service providers; and
- improve the quality and performance of systems.

HDC's objectives are consistent with the Government's intermediate and long-term health and disability systems outcomes that:

- New Zealanders live longer, healthier, more independent lives;
- the health system is cost effective and supports a productive economy;
- health services are delivered better, closer, sooner and more conveniently; and
- future sustainability of the health system is assured.

The key ways in which HDC contributes to the Government's outcomes are through our own objectives of:

- resolving complaints about health and disability services (resolution of complaints);
- using the learning from complaints to improve the safety and quality of health and disability practices and systems, and to promote best practice and consumer-centred care to providers (quality improvement); and
- ensuring providers are held accountable for their actions (provider accountability).

Organisation structure

(as at 1 July 2014)

- **Health and Disability Commissioner** — Anthony Hill
  - EA to Commissioner — Kerry Norman
  - Deputy Commissioner, Complaints Resolution — Theodora Baker
  - Deputy Commissioner, Disability — Rose Wall
  - Mental Health Commissioner — Dr Lynne Lane
  - Director of Proceedings — Aaron Martin (until 5 August 2014); Nicola Wills (from 11 August 2014)
  - Director of Advocacy — Judi Strid
  - Associate Commissioner Legal and Strategic Relations — Dr Katie Elkin
  - Associate Commissioner Investigations — Dr Cordelia Thomas
  - Chief Operating Officer — John Stribrny

3.0 HDC Key Activities 2013/14

HDC assesses its own performance through its statutory responsibility and formal performance agreements, but it also takes a very holistic view of the difference it makes in the lives of New Zealanders and in the real improvements made to individual health and disability services.

The sections below report back formally on HDC's performance in its five output categories, including a focus on disability, and also show the impact these outputs have on health consumers.

3.1 Complaints resolution

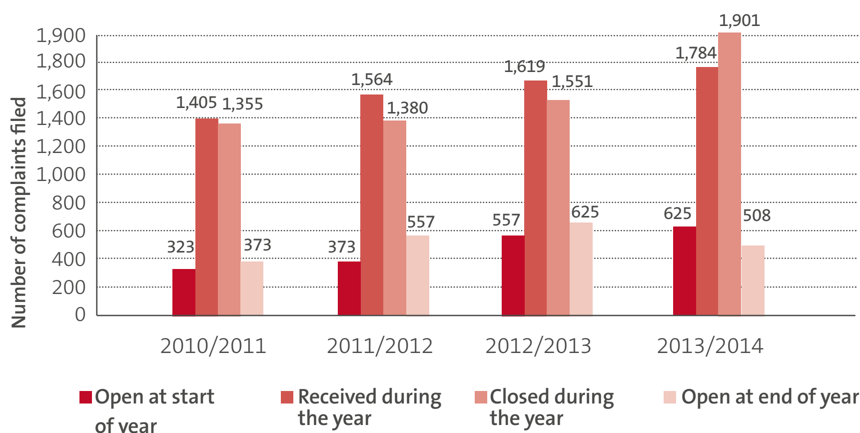
The purpose of the Health and Disability Commissioner Act 1994 (the Act) is "to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringement of those rights". It is not surprising, therefore, that a significant amount of HDC's time and resources is spent in the assessment of complaints.

Anyone can complain to HDC about a health or disability service in New Zealand. For HDC to have jurisdiction, there must be a provider of such a service, the provision of the service to a health or disability services consumer, and a possible infringement of the consumer's rights under the Code. It is not uncommon to receive a complaint from a third party, often a family member, and, where possible, HDC confirms that the consumer or his or her legal representative supports the complaint. The Commissioner may also initiate an investigation without a complaint.

Complaints received

The Complaints Assessment Team comprises over 30 staff members (25 FTE), including two part-time in-house clinical advisors. In addition, there are a further 10 investigators. Together they manage an increasing number of complaints each year. As Figure 4 shows, in 2013/14, 1,784 new complaints were received, a 10% increase on last year, and a 27% increase on the number received three years ago. The challenge has been met with a 22.5% increase in the number of complaints closed, the figure of 1,901 representing a 40% increase in output since 2010/11.

Figure 4: Complaint files open and closed



With the number of incoming complaints about health and disability services increasing year on year, it is easy to speculate that we should be concerned about the standard of care in the sector. However, there is no evidence that this is the case; rather, more people are choosing to complain to HDC. Increasing complaint numbers is a trend that is also being observed internationally.

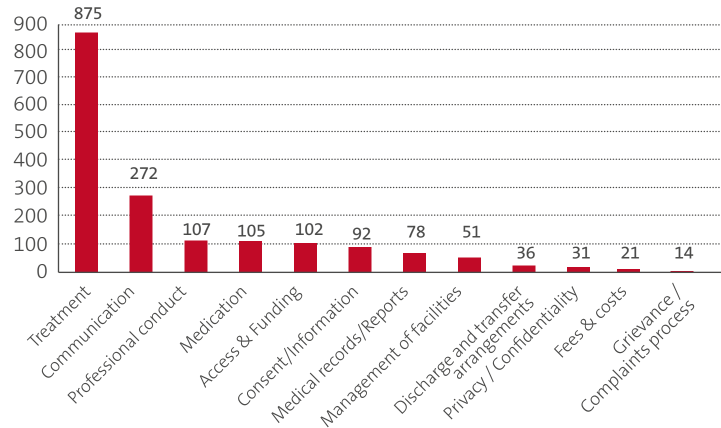
It is important to remember that not all of the 1,784 complaints received in the year end to 30 June 2014 related to events that occurred in that time period. More than 10% of all complaints received covered events or a period of care that had ceased more than 12 months before the complaint was lodged. There is no statutory time limit for lodging a complaint, but when considering whether to take any further action on a complaint, one of the matters that may be taken into account is the length of time that has elapsed between the date when the subject matter of the complaint arose and the date when the complaint was made. Each complaint is considered carefully and, in most cases, further information is obtained before deciding how to progress the complaint. It is recognised that in many instances the reason for the delay is understandable.

In 2013/14, 1,784 new complaints were received, a 10% increase on last year, and a 27% increase on the number received three years ago.

Primary issue complained about

Figure 5 shows the primary issue complained about. As in previous years, the most common complaint is treatment, followed by communication. Treatment covers a wide range of issues with varying consequences. For example, in the aged sector, treatment includes issues such as pain assessment, falls prevention, and pressure wound management; in dentistry a complaint about treatment may concern an unsuccessful root canal, or an unsatisfactory result from treatment; and, in surgery, it may cover an unexpected adverse outcome or poor postoperative monitoring.

Figure 5: Primary issue complained about in complaints received in the 2013/14 year



Providers complained about

Figures 6 and 7 show a breakdown of providers complained about by individual categories and group categories respectively. One complaint may involve more than one provider. Sometimes it is only as further information is gathered that it becomes apparent that our inquiry should be extended to other individuals or organisations. The spread of both individual providers and group providers across categories forms a similar pattern to previous years. The purpose of this table is not to make comparisons between providers, but to provide a picture of the complaints landscape from HDC's perspective.

Figure 6: Individual providers complained about in the 2013/14 year

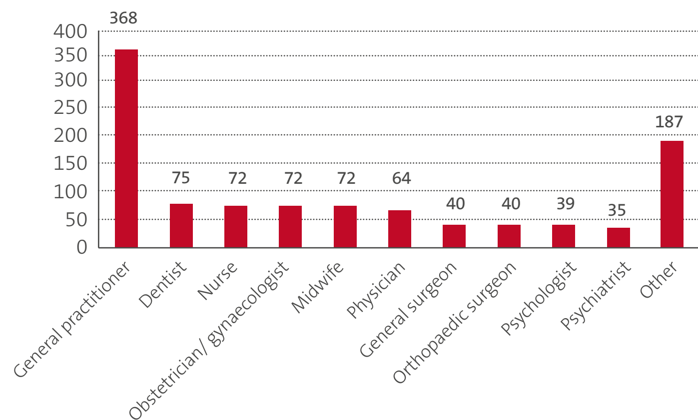
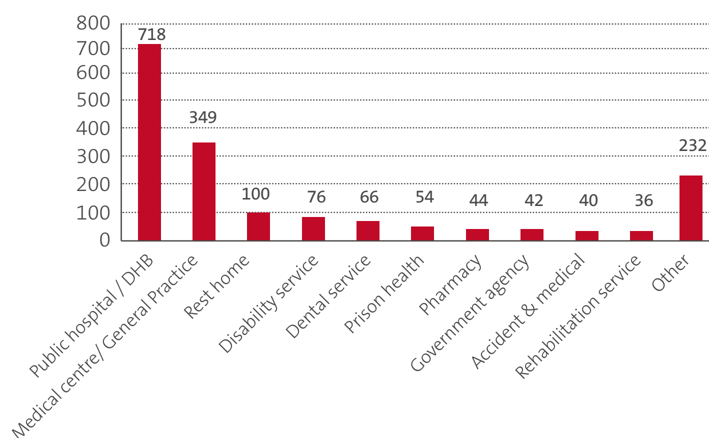


Figure 7: Group providers complained about in the 2013/14 year



Outcomes

The Commissioner's role under the Act is to secure the fair, simple, speedy, and efficient resolution of complaints. A range of resolution options is open to the Commissioner on receipt of a complaint. Some of the broad options for complaints resolution include: referral to another agency, referral to the provider, referral to the Advocacy Service, or commencement of a formal investigation.

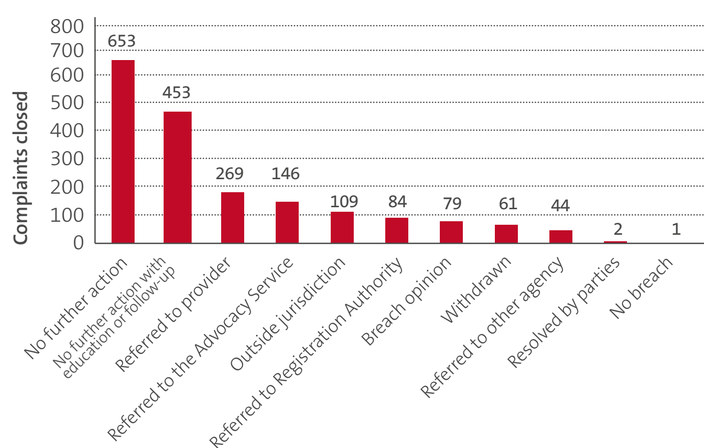
The Commissioner may also decide, after having regard to all the circumstances of a case, that any action or further action is unnecessary or inappropriate. There may be a number of reasons for deciding to take no further action on a complaint, such as: the independent expert opinion is that the care provided was of a reasonable standard; it is recognised that further inquiry will not resolve evidential issues; the allegation is not serious and the provider has apologised; the conduct departed from accepted practice only to a mild degree and the provider recognises the need for specific improvement; and/or the provider has made significant changes to their systems to avoid future administrative or systemic errors. When deciding to take no further action, the Commissioner may still make recommendations to the provider. Some examples of cases where no further action has been taken are highlighted in the case studies.

Figure 8: Outcomes of complaints closed since 2011

Complaint Statistics at a glance — 2011-2014

	2011-2012	2012-2013	2013-2014
Complaints Closed	1,380	1,551	1,901
Investigations	44	60	115
Breach Opinions	29	42	79
Referrals to Director of Proceedings	8	16	23

Figure 9: Outcomes of complaints closed 2013/14



Assisted resolution in dental care

A man complained about the care provided by an oral surgeon in the course of extraction of teeth. A dental plan to remove 10 abscessed teeth was prepared and discussed with the consumer, and it was agreed that given the patient's discomfort with dentists, he would have the teeth extracted in day surgery under general anaesthetic. Unfortunately, he awoke to discover that all of his teeth had been removed.

The oral surgeon provided a very full response to the complaint. At the initial consultation he found that as well as the 10 abscessed teeth, many of the other teeth had decay. The patient acknowledged that it had been some time since he had sought treatment because of a fear of dentists. The 10 abscessed teeth were specified as part of the estimate for approval by his insurance company, as some policies cover extractions where there are abscesses in the bone to be treated.

There was then a two-month interval to the day of the surgery. On the day of the procedure, the oral surgeon reviewed the dental plan, which detailed a "Dental clearance", including removal of 10 abscessed teeth, which he interpreted as a "Full Clearance", meaning that all teeth were to be extracted. Dental clearance was then entered on to the consent form and, when staff asked the patient if he was having a full clearance, he agreed, not appreciating that the term meant that all of his teeth were to be removed. The form was then signed in the presence of the oral surgeon.

In his mind, the plan to extract all the teeth was not inconsistent with the general state of the patient's mouth, and the dentist's knowledge of the patient's lack of comfort with dentists.

The Deputy Commissioner accepted that on the day of the procedure, the consumer did not understand that he was agreeing to the removal of all of his teeth, and also accepted that the surgeon believed that he had consent. The Deputy Commissioner was therefore concerned at the standard of communication and documentation of the patient's consent, and it seemed that ambiguous documentation led to the error on the day of surgery. While staff may have asked the patient if he was having a "full clearance", the Deputy Commissioner considered that the term would not be familiar to a layperson, and the patient would not necessarily have understood what was meant. With English not being his first language, along with feelings of anxiety, it is not surprising that he simply agreed. Had staff confirmed with him that he was having "all" of his teeth removed, it would have been more likely to have alerted him to the misunderstanding.

In replying to the complaint, the oral surgeon fully acknowledged and apologised for his error in the communication and consent process, and reiterated the offer he had made to the consumer to assist with a remedy. The consumer advised HDC staff that his primary concern was the cost of getting full dentures. The Deputy Commissioner spoke to each of the parties, and it was agreed that the dentist would pay for the consumer to have a full set of dentures made and fitted.

The consumer was happy to work directly with the dentist, who kept HDC informed of progress. In order to avoid a similar communication error occurring, the dentist implemented the following changes to his practice:

(a) routinely taking the patient's full medical record through to the ward to ensure he has all the up-to-date detailed information at the time of obtaining consent;

(b) clearly explaining to the patient in lay terms the details of the surgery;

(c) asking the patient to repeat back what he or she understands is the exact procedure to be performed; and

(d) writing on the consent document in lay terms the exact details of the specific teeth to be extracted, and then asking the patient to read through the document and confirm his or her understanding of the exact nature of the surgery to be performed.

On the basis of the provider's response, and the consumer's satisfaction with the resolution, the Deputy Commissioner decided that further action was not necessary.

HDC

Complaint withdrawn as a result of provider response

A woman consented to a trainee doctor being present to observe her smear test. After she had prepared for the procedure, the nurse and trainee doctor came in, and the trainee doctor proceeded to undertake the test with some apparent difficulty. The woman considered the trainee doctor to be very inexperienced in the procedure, and experienced considerable discomfort. Her physical and emotional distress was against a known history of sexual violation, and this incident caused her considerable anxiety, making it difficult to address the issue in person with her usual doctor. She therefore complained to HDC and clearly set out what she wanted to achieve from her complaint. This included an apology from the trainee doctor, as well as an assurance of the lessons learned from the incident.

HDC requested a response from the medical centre, which wrote to the woman with apologies from her usual doctor, the trainee doctor, and the Head of Department of her training faculty. While the trainee doctor had undertaken some training in the area, it was acknowledged that there was a need for further supervision and increased skill. The nurse had understood that she had obtained the woman's consent for the trainee doctor to perform the test, but accepted that communication must have been lacking.

The practice instituted changes, including ensuring that a trainee directly obtains consent before undertaking any procedure, and explicitly asks the patient to report any pain. In addition, trainees will not work with patients who have a history of sexual abuse.

The woman wrote to the practice thanking them for the response, and told HDC that she wished to withdraw her complaint. She said that the steps taken had restored her faith in the health system, and she felt that she could let go of the experience.

Complaint resolved through provider referral

A couple was advised (in error) by a fertility service that when the time came for treatment they would be eligible for a publicly funded cycle of treatment. Several months later, on the day they were to attend to collect the products, they were telephoned and advised that they did not qualify, and not to come in for the scheduled appointment. Their complaint was referred to the provider to resolve. The service provided apologies for the initial error and for the manner of communication on the day of the appointment, explaining that they had been unsure of the best way of informing the couple. An offer of a cycle of treatment was accepted.

HDC

Complaint closed with no further action taken

A man complained about the delay in diagnosis of his friend's bowel cancer. His friend was living in a rest home at the time of the events. A series of questions were raised in relation to the GP's care in reading and actioning a colonography report; what processes were in place in the rest home to ensure relevant information was communicated to GPs, and abnormal results were acted upon; and communication between the district health board and the GP. Responses obtained from all parties identified a series of individually minor process deficiencies, the combined effect of which led to a significant delay in following up on a potentially abnormal colonography report.

An outpatient colonography had been requested by a general surgeon. In the meantime, the patient was admitted to hospital for a gerontology assessment, and a delay in delivering preparatory fluids to the ward meant that his scheduled colonography could not proceed, and the appointment was cancelled. The gerontologist initiated a new referral for him. The consumer was then discharged back to his rest home. The colonography that then took place revealed some abnormalities, and a colonoscopy was recommended. A paper report was sent to the GP care of the rest home, and was purportedly sent to the gerontologist, but he did not receive it. No electronic copies were sent. The discharge summary was unclear as to where responsibility of following up the result lay, implying that the DHB would be doing so. It seemed that the rest home had filed the colonography report (which had not been ordered by the GP) without bringing it to the GP's attention; the GP was, however, aware that the colonography had been undertaken and, as the patient's primary clinician, he had a responsibility to follow up on the result. Breakdowns in the DHB's internal notification system meant that neither of the relevant clinicians reviewed the result.

The DHB acknowledged that had the new request that was generated by the gerontologist been treated as a rescheduled appointment, then the initial requester would have been notified. The DHB had been unable to send an electronic record to the rest home because it is not part of the same network. It now sends electronic records to the GP at his or her practice, and radiologists email unexpected findings to the requester. The GP advised that letters for all patients are red flagged on alert, and nurses are to follow up all correspondence with the hospital concerning referral letters and subsequent actions.

The complainant felt reassured by the assessment of his complaint, observing, "Your conclusions and actions that have been triggered by my complaint appear to have been thoughtful and useful in that deficiencies have been uncovered and appropriate actions taken to minimise similar problems arising in the future."

Investigations

As noted above, one of the options open to the Commissioner upon receiving a complaint is to conduct a formal investigation to establish whether the Code has been breached. This year 115 formal investigations were completed, and it was found in 79 cases that the consumer's rights under the Code had been breached. As a result of those breach decisions, 23 providers were referred to the Director of Proceedings for consideration of whether to bring tribunal proceedings. Figure 9 shows the manner in which complaints have been resolved in the past year.

Recommendations

HDC makes recommendations for change in many cases, and then monitors the implementation of those recommendations. As many complainants indicate that their desired outcome is to ensure that quality and safety is improved, recommendations play a key role in HDC's complaint resolution. HDC recommendations are complied with in the overwhelming majority of cases.

Care provided during high-risk labour (12HDC00846)

In 2011 a woman, aged 46 years, was pregnant with her fourth child. She had an uncomplicated pregnancy. When she was 37+5 weeks' gestation she experienced a spontaneous rupture of membranes and went into hospital. A decision was made to await spontaneous onset of labour. Syntocinon was commenced two days later because of the woman's failure to progress into spontaneous labour.

The hospital midwife caring for the woman noted a series of decelerations on the cardiotocograph (CTG). The on-call obstetrician was called. Following an assessment, the obstetrician decided to obtain a fetal blood sample to establish the fetal condition, but opted to await the arrival of the obstetric registrar who would collect the sample. The woman said that the obstetrician did not explain the assessment or his proposed management plan, and the assessment was distressing because of the obstetrician's manner.

When the registrar arrived she reviewed the CTG trace and noted that the woman was experiencing pain between contractions. The registrar asked the obstetrician to perform an emergency Caesarean section.

However, the obstetrician requested that fetal blood sampling be done first. The fetal blood sample showed severe acidosis, and the obstetrician decided to proceed with a Caesarean section. The baby was born pale and unresponsive, and resuscitation attempts were unsuccessful. A concealed placental abruption was diagnosed.

It was found that the obstetrician breached the Code in several respects. He failed to respond appropriately to the abnormalities on the CTG, and delayed the emergency Caesarean section. The obstetrician's manner was unprofessional, and he did not treat the woman with respect. In addition, he failed to inform the woman fully about her condition and his management plan. The obstetrician also did not heed the concerns raised by the obstetric registrar, and therefore failed to cooperate with the registrar to ensure quality of services.

Consideration was given as to whether the midwives and the registrar should have taken any further steps to raise their concerns about the obstetrician's decision to obtain a fetal blood sample and delay the Caesarean section. It was concluded that their actions taken to voice their concerns were reasonable in the circumstances.

The obstetrician provided a written apology to the family, and it was recommended that he undertake further training with regard to shared decision-making, fetal surveillance, and communication with patients. The Medical Council was asked to report to the Commissioner on its processes involving the obstetrician. The obstetrician was also referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

The DHB has now amended its training and induction for all staff to include information that the DHB's practice is that asking of questions and reporting of concerns is expected and accepted from all members of the multidisciplinary team. The DHB also introduced a clinical communication handover tool (ISBAR) to improve safety in the transfer/handover of clinical information, and proposed changes to its maternity orientation package to include information about the DHB's expectation with regard to escalating clinical concerns.

HDC

Refusal of blood and blood products (11HDC00531)

A woman was diagnosed with gallstones and placed on the waiting list for an elective laparoscopic cholecystectomy. Four days prior to her surgery, the woman attended a pre-admission clinic and confirmed at this time that she did not consent to the use of blood and blood products. The woman's views were recorded in her clinical notes.

The woman was admitted to hospital for surgery. The surgeon and the anaesthetist met with the woman to discuss the operation and obtained her informed consent. When surgery commenced a short time later, the surgeon was unaware of the woman's views in relation to blood and blood products. The anaesthetist was aware of the woman's views, but the matter was not raised during the surgical "Time Out", when any issues of concern are brought to the attention of the theatre team.

During the woman's surgery, there were difficulties with access and visibility, and it was decided to convert to open surgery. The woman's gallbladder was removed and the operation ended. About 40 minutes after her surgery, there were concerns about her condition. Initial measures taken to address these were unsuccessful, and it was thought that the woman was probably bleeding internally. The surgeon instructed that the woman be given blood, at which point he was advised of her treatment refusal.

The surgeon determined that further surgery was needed to identify and address the cause of the bleeding. The woman, still partially sedated, confirmed that she would not accept blood. The woman was returned to theatre, but no obvious bleeding point was identified. The surgeon determined that the best course of action was to transfer the woman to a facility better equipped and staffed to manage the situation. Arrangements were made to transfer the woman by helicopter but by the time the helicopter crew arrived it was decided that transfer was inappropriate. The woman died a short time later.

The DHB was found to have breached the Code, as the arrangements and systems in place at the hospital did not support the timely communication of the woman's refusal of blood and blood products, which was information that the anaesthetist and surgeon needed to know prior to surgery and in time for other plans and preparations to be made, should these be necessary.

The surgeon did not know about the woman's refusal of blood and blood products until her condition began to deteriorate following the first operation. The surgeon was found in breach of the Code for not reading the woman's notes sufficiently to obtain this information before commencing her surgery. It was also held that the anaesthetist failed to take reasonable steps to co-operate with his colleagues to ensure quality and continuity of services.

It was recommended that the DHB apologise to the woman's family, provide HDC with a copy of its revised informed consent policy and consent form, review its pre-admission process to ensure that patients who refuse blood and blood products are brought to the attention of the surgeon and anaesthetist prior to the day of surgery, and undertake an audit of its surgical safety checklist at the hospital.

The surgeon and the anaesthetist also provided an apology to the woman's family. It was noted that the Medical Council's processes were ongoing in relation to the surgeon, and the anaesthetist was required to review his practice in relation to the provision of anaesthetic services to patients who refuse blood and blood products.

Inadequate anaesthesia during Caesarean section (13HDC00515)

A woman was admitted to hospital in labour. Progress was slow, and the decision was made that it would be safest to deliver the baby by an emergency lower segment Caesarean section (LSCS). The woman was transferred to the operating theatre, where she met her anaesthetist. The anaesthetist conducted an "ice test" to check the woman's sensation, and she said she could feel that the ice was quite cold. However, he advised the obstetrician that she could begin the surgery in two minutes' time. Initially, the woman could not feel anything; however, when the obstetrician entered the peritoneal cavity, the woman complained of pain. The anaesthetist assured the obstetrician that she could continue with the surgery.

When the obstetrician attempted to deliver the baby, the woman complained of pain and began lifting both her knees. The obstetrician asked the nurses to hold down the woman's legs. The woman again voiced her pain, and the anaesthetist told her that she was feeling pressure rather than pain. He said that she could not have any more pain relief unless they "put her under", which would not be good for the baby. After the delivery, the woman continued to complain of pain while the obstetrician sutured the incision. The anaesthetist declined to administer extra pain relief.

The anaesthetist was found to be in breach of the Code for failing to ensure that the anaesthesia/analgesia was adequate during the operation, and because the information provided to the woman fell seriously short of accepted standards. It was also noted that the anaesthetist's communications with the woman displayed a lack of sensitivity, and he treated her with a striking lack of empathy.

The obstetrician was found in breach of the Code for not ensuring that appropriate analgesia was administered once she became aware of the woman's pain. The Commissioner said that he had "previously commented on the need for clinicians to advocate on behalf of patients, and for institutional providers to normalise a culture where such actions are accepted and expected".

It was recommended that the Medical Council review the anaesthetist's competence, and the anaesthetist was referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken. Comment was made on staff training, orientation and policies at DHBs, and it was recommended that the DHB review the orientation of locum staff and audit the implementation and effectiveness of its policies and protocols for epidural anaesthesia. It was also recommended that the DHB include information in its training that the practice of asking questions and the reporting of concerns is expected and accepted from all members of the multidisciplinary team.

HDC

Off-label prescription of ketamine for treatment-resistant depression (11HDC01072)

In 2010 and 2011, a psychiatrist treated 11 patients with intramuscular injections of ketamine. Each patient had treatment-resistant depression (TRD). The psychiatrist was employed by a university and held a clinical position with a district health board.

Ketamine is approved for use in New Zealand only as an anaesthetic. The unapproved use of an approved medicine is termed “off label” and is subject to practice guidelines.

Six patients gave only verbal consent to the treatment following some discussion about the use of ketamine. Those patients also received written information. Later an information/consent sheet on the use of ketamine in treating depression was created. The five patients who were subsequently treated with ketamine for TRD signed that information/consent sheet. The information/consent sheet was subsequently modified to include a sentence to the effect that the use of ketamine in this way was off label.

No individual patient complained about either the informed consent process or the provision of ketamine. It was accepted that the patients involved in this case were provided with the information they needed, and their decisions were made on an informed basis. Nonetheless, a more explicit discussion of the fact that this was off-label prescribing, and the anticipated end point of the treatment, and careful recording of that discussion, should have occurred for all patients. It is important that innovation is able to flourish in the health and disability sectors. However, it is even more important that consumers are fully engaged in their treatment and fully informed as to their options and choices, and properly consent to their treatment course.

The Code requires informed consent in writing if the consumer is to participate in research or if the procedure is experimental. Consideration of this matter centred on whether the prescription of ketamine in these circumstances could be categorised as clinical research or as an experimental procedure and, in addition, whether the relevant practice guidelines were complied with.

The controversy surrounding these events demonstrates that different minds may form different views as to whether or not a particular treatment amounts to research, or is experimental. The psychiatrist formed the view that the extant research provided a sufficient base on which to treat patients with ketamine. It was accepted that this position was not unreasonable, and was thus open to the psychiatrist.

The evidence did not, on the balance of probabilities, support a finding that research was being undertaken, or that the treatment, although uncommon, was experimental. The Commissioner said that he accepted that the integration of treatment, teaching and research can be ultimately beneficial to patients and to the public generally. Furthermore, many clinicians will at some point develop research interests that they wish to pursue. The essential issue is that they be clear when these activities overlap, both in their own thinking and in their communications with patients.

The Commissioner recommended that all DHBs ensure that they have in place appropriate policies on off-label prescribing that assist staff to determine whether or not proposed prescribing falls in the “grey area” of uncertainty between common off-label use and experimental treatment. These policies and protocols should set out what is required of staff members in relation to their clinical and research activities and the related reporting and review requirements, and copies of these policies should be provided to the National Health Board (Ministry of Health).

HDC

3.2 Advocacy

HDC, through the Director of Advocacy, contracts with the National Advocacy Trust to provide a Nationwide Health and Disability Advocacy Service for the benefit of consumers. The legal separation between HDC and the Advocacy Service allows advocates to act for consumers, while protecting HDC's impartiality in dealing with complaints.

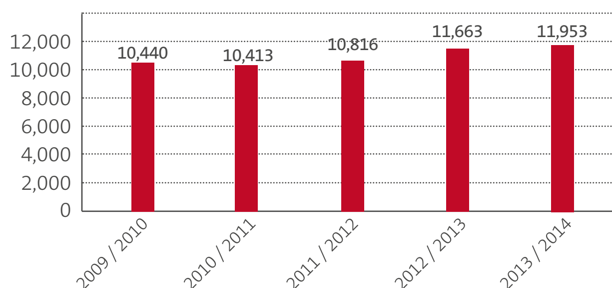
The Advocacy Service is a confidential service, available at no cost to any person in New Zealand who wants to know about their rights when using a health or disability service. This includes how to make and resolve a complaint, as well as how to achieve improvements in the quality of services provided.

There are 48 advocates in 24 community-based offices around the country. Over half of the core advocates are Māori. There are also three specialist advocates working with the Deaf community, and another three specialist advocates working with the refugee/migrant communities.

Enquiries

The Advocacy Service managed 11,953 enquiries during 2013/14. Figure 10 shows how the number of enquiries has increased over time. It is pleasing to note that 98% of enquiries were closed within two days, and 99% within five days.

Figure 10: Enquiries closed by year



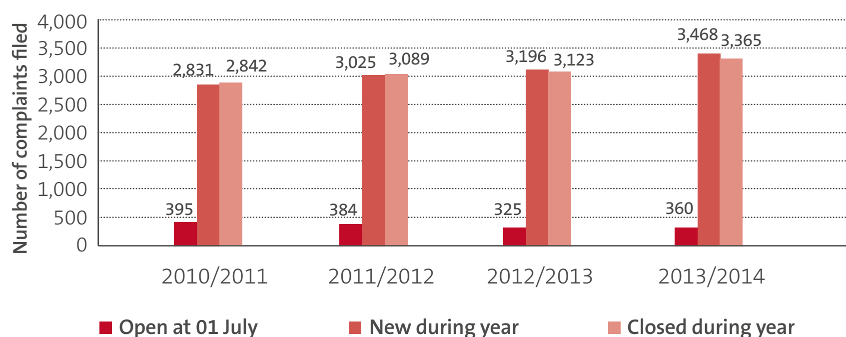
Focus of enquiries

Of the enquiries received, 22% were requests for information about advocacy and the role of advocates, 15% were about how to make a complaint, 9% were requests for education, and 5.1% were requests for information on mental health issues. ACC and prison health enquiries remained constant at 5.3% and 2% respectively. Other enquiries related to topics such as disability resources, access and funding, fees/treatment costs, privacy of information, and rest home standards. Over 8% of enquiries were escalated to a complaint.

Complaints

As seen in Figure 11, the number of new complaints rose this year to 3,468. However, with 360 complaints carried forward from last year, the total number of complaints managed during 2013/14 was 3,828. Of these, 3,365 complaints were closed, an increase of 7.7% from the 2012/13 year. In 2013/14, the Advocacy Service closed 89% of complaints within three months, 99.6% within six months, and all complaints within nine months.

Figure 11: Complaints by year



The high rate of resolution (94%) reflects the strong consumer-centred process used by advocates, as well as a high level of provider goodwill and commitment to resolving complaints at an early stage.

Complaint comparisons

Of the complaints to advocacy, 73% were about health services, 15% related to disability services, and 12% related to mental health services.

Mental health services and general practice each accounted for 12.9% of closed complaints. The number of prison health complaints closed rose from 282 in the previous 12 months to 398, and accounted for 11.6% of complaints closed. Residential homes accounted for 10.7% of the closed complaints.

Changes made by providers as a result of complaints to the Advocacy Service

1. A consumer who had no postal address and often did not have money on his phone to receive texts about appointments requested that the DHB implement an email communication system with patients. This was done and, until the system was up and running, it was agreed that the consumer's keyworker would arrange with the consumer's pharmacist that key communications for the consumer could be faxed there.
2. As a result of a Serious Event Review, a DHB made the following changes: paediatric and adult ENT consumers who have breathing obstructions will be monitored in the High Dependency Unit, using a new monitoring system of white board flagging for the collection and dissemination of information.
3. As a result of a complaint about a fall while in hospital care resulting in the death of a consumer, a DHB hosted a talk by the complainant, who spoke about the consumer's experience. The DHB also implemented a falls champion on the ward, aimed at preventing falls. The champion's role is to undertake regular checks to ensure that consumers have the things they need within easy reach. The DHB is also exploring the option of softer floor coverings in selected rooms, and offered to display in the ward a photo/poem written by the complainant in memory of the consumer.
4. As a result of complaints and an investigation by a DHB, a rest home decided to make the following changes: registered nurses and healthcare assistants who are administering medication are to undergo a competency test, including how to complete the documentation; training for staff is to be formally recorded; in-service training for staff is to be provided on the following topics: short- and long-term care planning, medication management, pain assessment procedures, and documentation standards; and a review of the cleaning schedule is to be undertaken.

Demographics

Of complaints brought to the Advocacy Service, 38.5% were from people aged between 41–60 years, 27.6% were from those aged between 26–40 years, and 24.7% were from those aged between 61–90 years.

Of the total complaints closed, 65.2% were from people who identified as New Zealand European/Pākehā, 13.8% were from New Zealand Māori, and 3.2% were from people of the Pacific.

Of the complainants, 55.8% identified as female and 39.5% as male, while 4.7% either declined to answer or described themselves as "other".

Residential visits

Advocates have been visiting rest homes for eight years, and disabled people who live in residential services for seven years. The purpose of the visits is to make it easy for residents to speak with an advocate; to provide free education sessions for residents, whānau/family members, and providers; and to assist with making complaints. This was also the fourth year of making a planned second visit to rest homes and residential services. The number of second visits was increased to 60% of homes. This second visit is designed to assist vulnerable consumers who would otherwise find it impossible or extremely difficult to seek the assistance of an advocate.

All but one of the 670 rest homes had at least one contact with an advocate, and 427 homes had at least two contacts. All but one of the 1,021 residential services catering to disabled people had at least one contact with an advocate, and 620 had at least two contacts. Over the 2013/14 year, there were a total of 3,096 rest home and 3,239 residential visits by advocates.

Advocates delivered Health Passports to every residential facility, and provided education sessions on how to use them.

Networking

Networking is an important way for advocates to establish a profile in their local communities so that they are well positioned to inform consumers of their rights, and providers of their duties. Networking also helps advocates to be well linked to their community and to stay up to date on where to refer callers if a matter is outside HDC's jurisdiction. These contacts are especially important as part of the role of the six specialist advocates.

Over the past year, advocates developed and maintained contact with 4,505 networks, 69% of which had a disability focus, 3% of which were Māori networks, 5% of which were refugee and migrant communities from non-English-speaking countries, and 1% of which were Pacific communities.

Having a national focus each year on Code of Rights Day (1 July) to celebrate the anniversary of the launch of the Code of Rights continues to provide a very real opportunity to attract the attention of the public to the unique features of the Code and how it can be used to improve the quality of services for consumers. The theme for 2014 day was aged care and older people.

Education and training

Like enquiries and complaints, the number of education sessions provided by the Advocacy Service has continued to increase. In the 2013/14 year, advocates presented a total of 2,407 education and training sessions to a range of consumers, providers and organisations. Among those who responded to surveys, 93% of consumers and 96% of providers gave high satisfaction ratings to advocacy education and training.

The greatest numbers of requests were once again for basic information on advocacy, the Code and HDC. Sessions also covered other topics such as self-advocacy, informed consent, effective communication, open disclosure, and effective complaint processes.

Staff education and training

The national advocacy conference is a key part of the advocacy education and training programme. This year the conference was opened up to external participants for the first time. The focus was on mental health and addictions, and the feedback was very positive.

A key part of the role of the specialist advocates is to up-skill the core advocates to build capacity within the service when working with the Deaf community, as well as the many different refugee/migrant communities.

Almost half of the advocacy workforce has completed, or is in the process of completing, the health and disability advocacy qualification. This new national certificate is included in the NZQA framework, and will form part of a career pathway for advocates.

Satisfaction survey results

Each month 33% of consumers and providers who have worked with an advocate are asked to comment on their level of satisfaction with the service. Survey results showed that 92% of consumers and 87% of providers were very satisfied with their dealings with the advocacy service. The following are a few of the unsolicited comments that demonstrate the commitment and dedication of the advocates.

"[H]e could not speak highly enough of her. He said she was extremely caring, and her support at what was a very difficult time was hugely appreciated."

"We would like to extend our warm thanks for your support in this matter ... You provide an essential service for those seeking advice and resolution in a health matter, and when people feel like they have nowhere else to turn."

"You people do a wonderful job — I have nothing but accolades for the support the advocate gave me and my family."

Acknowledgements from the Director of Advocacy

Once again, the Director of Advocacy would like to acknowledge the dedication and commitment of all those involved with the provision of the advocacy service. The combined efforts of the advocates, managers and support staff, members of the National Advocacy Trust Board and the Puna Mātauranga Group have all contributed to the provision of an excellent service for health and disability consumers throughout the country.

"You people do a wonderful job — I have nothing but accolades for the support the advocate gave me and my family."

Education session leads to help for a Deaf consumer in prison

Prison health staff sought the advice of one of the Deaf advocates following an education session. They had concerns about a Deaf consumer with a mental illness with whom they were struggling to communicate. They had attempted to access support for him through another agency, but this had been unsuccessful.

Prison staff had made a sincere attempt to support the consumer and, in the absence of other support, had tried putting him with a buddy. Unfortunately, due to communication difficulties, this strategy was not working very well.

An advocate offered to speak with the consumer. The advocate found the consumer to be quite unwell. He had difficulty with communication, and drifted off several times during their meeting. The consumer acknowledged the limited support available to him, and was happy for the advocate to provide suggestions to the Health Manager about how to access support for him.

Following the discussion with the consumer, the advocate suggested that the prison service contact Deaf Mental Health Services (DMHS), and provided the contact details. She recommended that the prison service organise for the consumer to be reassessed using a qualified interpreter and a DMHS support worker. In addition, the advocate suggested that the service contact Deaf Aotearoa to organise a tutor to teach the staff basic NZ Sign Language, and that staff develop some visual resources to help with communication.

The consumer was very pleased to have spoken with the advocate, and the staff were grateful for the suggestions on how to improve communication with the consumer.

When fear immobilises

A man with a needle phobia contacted advocacy after he attended a pre-anaesthetic clinic where the specialist nurse and anaesthetist did not take his phobia seriously, even though the DHB had been advised of the phobia by his GP. They tried to joke and jolly him through the appointment, and insisted he watch a video on anaesthetics, saying it would be beneficial for him. He was traumatised by the pre-anaesthetic procedure.

This experience left the consumer in extreme distress and unable to go ahead with the scheduled operation two days later.

As he was so traumatised, he asked the advocate to contact the DHB and raise his complaint. The DHB wrote a letter of apology, but the man did not think this fully addressed his problem, so he wrote another letter to his consultant and the manager of surgical services reiterating his concerns.

This resulted in a very positive and professional pre-anaesthetic appointment, and his operation was scheduled for the following week. The man was very pleased with the outcome and thanked the Advocacy Service for its assistance.

Obtaining a new case manager

A mental health consumer contacted the Advocacy Service with serious concerns about the relationship with her case manager. The consumer said that her case manager had made some very inappropriate and unprofessional comments about her as a person and her mental health status. The consumer said that she felt very disrespected and doubted whether their relationship could be restored to a point that would continue to meet her needs.

The consumer considered the options available and decided that she would like a meeting with the manager of the service.

At the meeting, with the advocate supporting, the consumer had the opportunity to express her concerns, and felt she was listened to.

A new case manager was appointed, and the consumer said she was very relieved, as the situation had caused her a lot of undue stress. The consumer said that she was very grateful for the support of the advocate.

3.3 Proceedings

The Director of Proceedings brings disciplinary charges and compensation claims to publicly redress serious breaches of the Code. These cases are heard by the Health Practitioners Disciplinary Tribunal (HPDT) and the Human Rights Review Tribunal (HRRT). Safety, public accountability, and consumer confidence are enhanced through proceedings. Health practitioners play a central part in these processes, as tribunal members or expert witnesses.

Aaron Martin, Director of Proceedings during the 2013/14 year, took up a new role in August 2014. The new Director of Proceedings is Nicola Wills.

As the statistics and case notes in this section illustrate, 2013/14 saw a significant volume of cases taken, with a good success rate. Highlights were several significant disciplinary hearings and a number of very meaningful settlements for consumers. Themes in cases included serious failures to maintain appropriate sexual boundaries, and responsibility of organisational providers for neglect and abuse by caregivers.

Statistics

The Director of Proceedings received 23 referrals, arising from 19 complaints, during the year. There were eight disciplinary hearings in the HPDT, six of which were successful. There was one defended hearing before the HRRT (only partially successful, with the Tribunal declining to award damages). Eight other HRRT proceedings were resolved by negotiated agreement on terms that either provided for consent order declarations by the Tribunal (in two cases), or (in one case) provided for a letter to be sent to a number of other disability services providers, as well as a payment of compensation. These cases are included as outcomes in Table 2. In addition, two other cases were settled without the Tribunal being asked to make formal orders. (These two cases are not included in the outcomes in Table 2.)

Table 1: Action taken in respect of referrals to Director of Proceedings in 2013/14

Provider	No. of providers	No further action	DP decision in progress	Proceedings pending	Proceedings concluded	No. of consumers involved
Dentist	1			1		1
Disability services provider	1		1			1
Medical practitioner:						
– General practitioner	4		1	1	2	4
– Other	3		2	1		3*
Midwife	6		3	3		6*
Nurse	6	1	1	3	1	6*
Rest home	1				1	1*
Sports therapist	1				1	1
TOTALS	23	1	8	9	5	23

*One consumer was the subject of a referral in relation to a rest home and two registered nurses. Another consumer was the subject of a referral in relation to a midwife and an obstetrician.

Psychiatrist's registration cancelled for relationship with patient

A charge was brought by the Director of Proceedings concerning a psychiatrist entering into a sexual relationship with a vulnerable patient.

The psychiatrist actively took advantage of his patient's vulnerability and dependence on him, abusing his position of trust and power to begin a sexual relationship with her. At the time of the events, the patient had longstanding anxiety and depression, and a significant past history of treatment for that, including counselling and medication.

After discharging the patient, the psychiatrist continued his sexual relationship with his patient in a clandestine manner, continuing to have regular sexual relations with her in New Zealand and in Tasmania. The psychiatrist took her to a seminar he was presenting, wrote intimate notes to her, encouraged her to study in Tasmania, booked their Trans-Tasman flight so that they could sit in adjacent seats, spent time sight-seeing with her, and on one occasion took video footage of the two of them having sex.

After the psychiatrist's wife found out about the psychiatrist's relationship with his patient, the psychiatrist made a number of improper attempts to interfere with his patient's right to complain about the serious professional breaches that had occurred. The Tribunal found that the psychiatrist put his own interests ahead of those of his former patient. This included inappropriate communication with his former patient and her father, and the payment of significant sums of money to her.

The Tribunal had regard to the manner in which the psychiatrist took advantage of a young, vulnerable and sexually inexperienced woman for his own sexual gratification, such being a complete abrogation of his professional responsibilities as a psychiatrist and of the trust inherent in a professional relationship.

Although he defended the charge, the Tribunal found that the psychiatrist had acted dishonestly to avoid serious professional consequences. An order was made cancelling his registration and censuring him. The psychiatrist was also ordered to pay costs of the Tribunal and prosecution (totalling $73,000). The Tribunal's decision is available at: **http://www.hpdt.org.nz/Default.aspx?tabid=379**.

HDC

DHB found responsible for caregiver's failures

In a case concerning a young man (Mr S) with Down syndrome and autism, the Director of Proceedings filed a claim in the Human Rights Review Tribunal (HRRT) against a DHB for failing to ensure the young man's safety. The HRRT issued a declaration that the DHB had breached the Code, and compensation for Mr S was resolved between the parties by negotiated agreement.

Mr S lived in a community home operated by the DHB. Mr S was the only client in the home, and he had two carers with him for 24 hours a day, seven days a week. The carers were managed by a team leader. Within three months of Mr S moving into the community home, some of the carers in the home brought to the attention of Mr S's parents concerns about the care he was being provided. The carers were concerned that the team leader was physically and verbally abusive towards Mr S. The carers met with the DHB in December 2009 and raised their concerns. There is no evidence that the concerns about the team leader's behaviour were formally investigated by the DHB, and the parents of Mr S were not informed by the DHB of the carer's complaints and actions taken at the time.

Throughout 2010, the parents of Mr S remained concerned about the care Mr S was receiving in the home. They were informed by one of Mr S's carers that he had witnessed physical and verbal abuse of Mr S. Based on that information, the parents made a complaint to the Police and to the National Health Board. In response to the complaint to the National Health Board, the DHB conducted a paper-based investigation into the parents' complaint, but did not interview staff and did not involve the parents in the investigation process. The review concluded that the complaints were not substantiated, and that a full investigation was not necessary. A subsequent review conducted between August 2011 and April 2012, which did involve staff interviews, found that there was a high probability that the team leader had verbally and physically abused Mr S. The team leader is no longer employed by the DHB.

The DHB accepted that its response to concerns raised about the care provided to Mr S in the community home fell well short of the expected standard, and its failures in that regard put Mr S's safety at risk. The HRRT found that the DHB breached the Code by failing to respond adequately to concerns about Mr S's care, and by failing to supply Mr S's parents with adequate information. In particular, the DHB accepted that its response to the serious concerns that were brought to its attention in December 2009 was inadequate. The DHB also accepted that its investigation in September 2010 was inadequate, including the decision to conduct only a paper-based review in response to serious allegations of abuse of a vulnerable consumer. The Tribunal's full decision can be found at **http://www.nzlii.org/nz/cases/NZHRRT/2014/4.html**.

HDC

Table 2: Outcomes in 2013/14

Note: Two other cases (**not** shown in the table below) were concluded by negotiated agreement without the Tribunal being asked to make orders.

Provider	Successful	Unsuccessful	Outcome pending	No. of providers	No. of consumers
HPDT					
Medical Practitioner:					
- General practitioner	3 [1]	2 [2]		5	5
- Psychiatrist	1			1	1
Nurse	2			2	2
HRRT					
Audiologist	1 [3]			1	1
DHB	2 [4]			2	2
Disability services provider	2 [5]			2	2
Midwife	1			1	1
Natural therapist	1 [6]			1	1
Rest home	1			1	1
Sports therapist	1			1	1
Totals	**15**	**2**		**17**	**17**

[1] One of these outcomes is subject to appeal.

[2] Outcomes recorded in HPDT minutes dated 19 June 2014 with full written reasons to follow in each case.

[3] One case involving an audiologist and a DHB has been resolved by negotiated agreement, as at 19 June 2014. As part of that agreement formal consent orders were sought from the HRRT.

[4] Ibid.

[5] The outcome of one case was that the proposed proceeding was settled by negotiated agreement without a claim being filed with the Tribunal. Although no orders were sought from the HRRT, the agreed resolution involved the provider writing to a list of organisations in the disability services sector outlining the incident, providing a copy of the anonymised HDC opinion, explaining changes implemented by the provider since the incident, and noting that compensation had been paid to the clients.

[6] Partially successful: HRRT made a declaration that the provider breached the Code in relation to one of the alleged breaches.

3.4 Education

HDC has an important leadership role in ensuring that there are ongoing systemic improvements in safety and quality in the health and disability sectors, with a particular emphasis on vulnerable consumers. Through education, HDC aims to give providers a clear understanding of their responsibilities, so that they comply willingly with the requirements of the Code and ensure that consumers know and are able to exercise their rights under the Code.

Education for providers, consumers, and the wider health and disability sectors

HDC delivered 71 education and training initiatives pitched at national service organisations and group providers, professional bodies, and consumer-based organisations. Community-based independent health and disability advocates, contracted by the Director of Advocacy, on the other hand, provide more community-level education. Thus the work of the Advocacy Service greatly complements HDC's educational initiatives.

Throughout the course of the 2013/14 year, HDC delivered a number of such educational initiatives, including: education sessions to staff in general practices around the country in line with the requirements of the Cornerstone Accreditation Programme; and presentations to regulatory bodies, other professional bodies, DHBs, and to disability services providers. Presentations were given at a number of conferences, including the Elder Law for the Health Sector Conference, the New Zealand Rural General Practitioners Network Conference, the Medical Health Law Conference, the New Zealand Nurses Organisation Conference, and the NZ College of Psychologists Conference. HDC continued to provide lectures on the Act and Code to students in various undergraduate, postgraduate, and professional courses — including to those studying pharmacy, medicine, Chinese medicine, health science, diversional therapy, and public health.

HDC also responds to many enquiries from consumers, providers, and other agencies about the Act and Code, and consumer rights under the Code. In the 2013/14 year, HDC also developed fact sheets providing information about topics such as informed consent for consumers who are not competent, the age of consent and informed consent for children, and "Do Not Resuscitate" orders. These fact sheets are available on HDC's website.

Promoting learning through DHB reports

HDC continues to provide six-monthly reports to DHBs outlining complaint trend information, nationally and for individual DHBs. The purpose of these reports is to assist DHBs to identify areas of service and aspects of care that are most commonly at issue in complaints to HDC. This year we made some changes to the information contained within these reports in order to improve their usefulness as a quality improvement tool for DHBs. These changes included providing DHBs with a much more nuanced description of issues raised in complaints to this Office. We also provided more detailed information about which services were involved in complaints and the outcomes of complaints received. When asked to rate the usefulness of these reports, 95% of DHBs indicated that they found the reports useful for improving services. HDC will continue to consult with DHBs about how these reports can best be developed to assist them to improve the quality and safety of their services.

Submissions

Chiefly through making submissions, HDC advises on the need for, or desirability of, legislative, administrative, or other action to give protection or better protection to the rights of health consumers and/or disability services consumers.

In 2013/14 HDC made 23 submissions. These included comments on policies, procedures, codes of conduct and guidelines from the Medical Council of New Zealand, the Dental Council, Ministry of Social Development, Department of Corrections, PHARMAC, Ministry of Justice, Psychologists Board, Productivity Commission, MedicAlert, New Zealand Medical Association, National Ethics Advisory Committee, Standards New Zealand, Dieticians Board, New Zealand Nurses Organisation, and Health Quality & Safety Commission.

Review of the Act and Code

HDC is required to review the Act and the Code regularly. In 2013/14 we completed the fourth such review. This included issuing a consultation document, receiving and reviewing submissions, and producing a report for the Minister of Health detailing issues and recommendations arising from the review. We received a total of 44 submissions. The report is available on HDC's website.

3.5 Systemic monitoring and advocacy – Mental Health and Addiction Services

The Health and Disability Commissioner has a statutory role in the monitoring and advocating for systemic improvements in mental health and addiction services following the disestablishment of the Mental Health Commission in 2012. It is the Mental Health Commissioner who is largely responsible for the performance of those functions under delegation from the Health and Disability Commissioner.

Mandate for change

The Government recognises that mental well-being is a fundamental component of health. Good mental health enables people to realise their potential, cope with the normal stresses of life, work productively, and contribute to their communities. Over the past two decades, progress has been made in addressing inadequate mental health services and social support, discrimination against people with severe and complex mental disorders and psychosocial disabilities and abuses of their human rights. However, internationally there is now growing concern that the impact of mental illness and addictions on the total population in the developed world (in terms of disability adjusted life years lost owing to mental illness) is increasing and is now greater than the impact from cardiovascular disease or cancer.

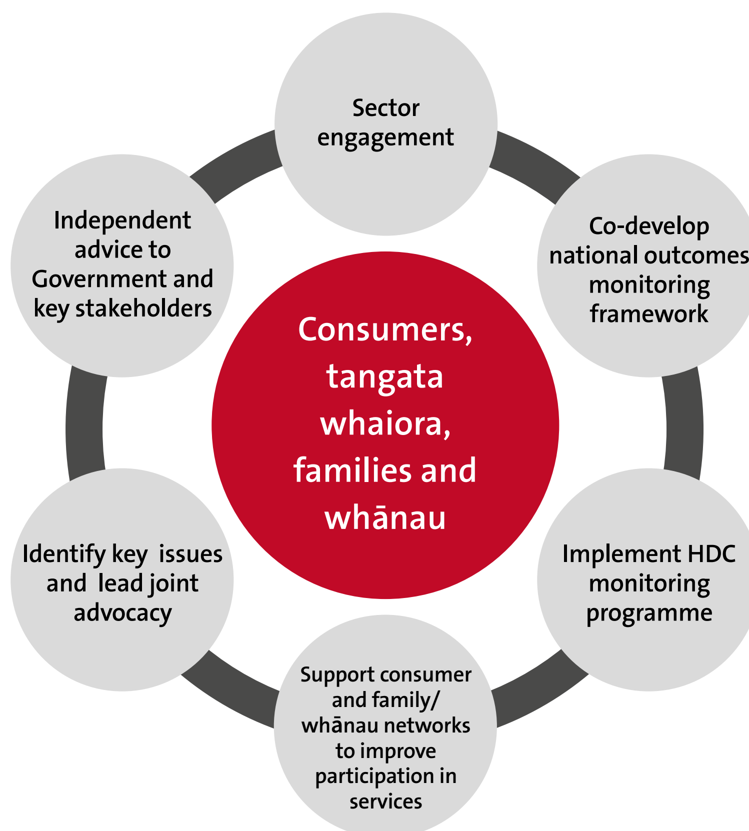
Monitoring mental health and addiction services and advocating for systemic improvements is undertaken to support the implementation of the Government's priorities to achieve mental health and well-being for all as set out in "Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012–17"[7] and informed by research and expert advice as set out in "Blueprint II"[8].

Work plan to support implementation

The Mental Health Commissioner has developed a three-year work plan that sets out how HDC will undertake its monitoring and advocacy functions in relation to mental health and addiction services. In order to monitor and support the programme of service transformation, HDC has established a programme of engagement with sector key stakeholder groups and collaborative projects with a range of external partners (see diagram below). This approach to co-develop monitoring tools and service improvement advice provides HDC with access to the best expertise in the sector, and supports the development of sector capability and capacity to lead change.

HDC has established a programme of engagement with sector key stakeholder groups and collaborative projects with a range of external partners

Figure 12: Mental Health Commissioner's Plan 2014–2017



[7] Ministry of Health (December 2012) Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012–17.

[8] Mental Health Commission (June 2012) Blueprint II: Improving mental health and wellbeing for all New Zealanders.

Consumers, tangata whaiora, families and whānau at the centre of services

HDC places high priority on advocating for systemic change to support consumers and their families/whānau as partners when using mental health and addiction services that are recovery focused. This approach reflects HDC's vision of consumers at the centre of services.

Sector engagement

The Mental Health Commissioner engages with the sector at a national, regional and local level through clinical leaders and service managers, provider groups, and consumers and family/whānau groups. Working relationships have also been established with national workforce agencies, and national professional and specialist sector interest groups. International engagement has led to HDC being a signatory to a Memorandum of Understanding with the Mental Health Commissioners in Australia and other countries to collaborate on agreed priorities to monitor and advocate for service improvement.

Outcome-based monitoring framework

There are over 100 specific actions set out in "Rising to the Challenge", of which about half are to be implemented by DHBs. The Mental Health Commissioner, in partnership with the National DHB KPI Group, developed a new outcomes framework to monitor its implementation. The three Auckland metro DHBs actively participated in this initiative to ensure that data collection was efficient, the information was readily available, and the reports were meaningful. The purpose of the framework is to provide DHBs with a "dashboard of indicators" in an electronic report that provides comprehensive information on progress towards achieving goals and for planning service improvements. It also provides HDC with information required to inform systemic advocacy. While the framework was not designed for accountability purposes, the underlying principles and rationale is available to inform the development of the Ministry of Health's (MOH) approach to monitoring DHBs.

"Real-time feedback" of consumer and family/whānau experience

HDC contracted CBG Limited to co-develop and pilot an information system to collect and report feedback on consumer and family/whānau experiences using mental health and addiction services "in real time" to inform service improvement.

The electronic feedback system is based on the findings of a review of international best practice, action research within the sector, and the views of an Expert Advisory Group. It was co-developed and tested in seven pilot sites, including four DHBs, two NGOs, and a whānau ora based Primary Health Organisation. The initial feedback from service users and providers testing the system confirms its ability to make an important contribution to service improvement. To see the live reporting of results across the pilot sites, go to **www.patientexperiencesurvey.co.nz.**

In September 2014, the pilot phase will be complete following six months of live data collection. CBG will provide recommendations from the internal evaluation for future development of the system. HDC, with the support of additional funding from the MOH, contracted Malatest International to undertake an independent evaluation of the system. The findings of the independent evaluation will be available in October 2014, and will inform decisions on the further development of the "real-time system" to be made following consultation with the sector. To inform decisions on future use of this live reporting system, HDC also analysed the past five years of data from the Ministry of Health consumer satisfaction survey to assess its ability to determine statistically significant trends in service quality.

Identify key issues and lead joint advocacy

During the year, a range of issues were identified that were considered a priority for co-developing advice or resources to guide advocacy in order to support implementation of "Rising to the Challenge" and to improve service outcomes. On the next two pages is a brief summary of the issues, the collaborative partnerships formed, and the outcomes achieved.

Key Issue	HDC Partnership/Joint process	Outcome
Improving outcomes for Māori youth/ Rangatahi	Agreed MOU with Te Rau Matatini Seconded Waitemata DHB Consumer Advisor	Reviewed 21 youth mental health and addiction services supporting Rangitahi to identify their common strengths and the challenges that need to be addressed. Launch planned post election. Interim findings used to inform development of services for Rangitahi. Draft report provided to MOH, sought and gained confirmation of actions to address recommendations.
Improving access to youth AOD services	Contracted National Drug Foundation National Council for Addiction Treatment	Developed advice on effective models of care for supporting recovery of youth with addiction problems and guidance for future service development. Produced a printed resource and disseminated it through national networks and electronically to inform service development.
Reducing the use of seclusion and restraint	Expert Working Group nominated by the National DHB Mental Health and Addictions Services Clinical Directors and Service Managers Group, and the National Directors of Mental Health Nursing Contracted Ko Awatea Advice sought from Te Pou	Completed a report outlining international evidence of best practice and progress in New Zealand. Recommendations included forming a collaborative initiative to support shared learning on implementing best practice.
Supporting increased sector productivity	Expert Working Group nominated by National DHB CDs and GMs Contracted Ko Awatea/ Artemis Consulting MOH additional funding	Completed an international literature review on best practice productivity improvement industry and sector wide, with exemplars of transformational practice. Used to inform priorities and approaches to transformational service changes to support better outcomes within available resources.
Clozapine use and concerns about premature sudden death	Centre for Adverse Reactions Monitoring, PHARMAC, Sector Experts	Analysed information on prescribing of clozapine and other medications, reporting of deaths associated with clozapine, and systems and processes to ensure safe use of this medicine. Provided data and reported concerns to MOH regarding systemic changes required to reduce avoidable deaths on clozapine, which have been acted on.

Key Issue	HDC Partnership/Joint process	Outcome
Support capability in DHB funding and planning	Synergia Ltd Auckland and Waitemata DHBs Whanganui DHB Capital Coast DHB	Developed an electronic tool and user guide for "Needs Assessment and Gap Analysis" based on preliminary work undertaken while developing *Blueprint II*. Presented the tool to DHB Planners and Funders and supported the use of the tool in 4 DHBs to inform service planning and funding.
Improving health literacy of consumers	Waitemata DHB Hospital MH&A Pharmacists PHARMAC The National Pharmaceutical Formulary	Identified need for nationally consistent relevant information on psycho-active medications to answer commonly asked questions about using these medications. Advocated for a national subscription to "Choice and Medicines" an international database suitable for this purpose. Agreement reached on the value of this service; however, it will not be provided from existing resources.
Improving access to social housing	Participated in meetings with National DHB Funders and Planners National KPI Group MSD	Reviewed changes in policy to improve access to social housing in light of increasing difficulty accessing social housing for people awaiting discharge for acute MH&A services resulting in • increasing average length of stay and occupancy rates • higher thresholds for admission to acute units • increased homelessness. DHBs are collating data to quantify the impact and cost to the sector. Noted the MSD criteria for urgent access to social housing excluded mental health and addictions inpatients. Advised the Minister and the MOH that MSD policy is having a negative impact on MH&A.

Support consumer and family/whānau advisor networks

The participation of advisors in service development and provision who have "lived experience" as consumers and family/whānau is essential in ensuring recovery-based services. The Mental Health Commissioner actively supports leadership development through regional and national networks, including:

- Nga Hau e Wha — National Consumer Network;
- NAMHSCA — National Association of Mental Health Service Consumer Advisors;
- National Family/Whānau Network; and
- NCAT — The National Council of Addiction Treatment.

Initiatives are agreed each year with the national leaders to support key activities to assist them to advance the Government's priorities for service improvement.

Feedback was sought from relevant key stakeholders to determine whether they were satisfied that HDC's initiatives would contribute to service improvement.

Table 3: Performance measures

Performance Measure	% Satisfaction	Comments
Develop and trial performance indicators to monitor implementation of "Rising to the Challenge"	89%	Co-developed and piloted the "Rising to the Challenge Outcomes Framework" with the National KPI Group and Auckland, Waitemata and Counties Manukau DHBs electronic dashboard of indicators (N=9)
Develop and pilot consumer and family/whānau experience electronic real-time feedback system	100%	Pilot not yet completed owing to delays in commencing. Feedback from pilot site workshop. (N=12)
Collaborative initiatives with consumer and family/whānau networks, Te Rau Matatini and other stakeholder groups	100%	Feedback was requested from network and organisational leads on collaborative initiatives (N=20)
Regular reporting to the MOH and the Minister	100%	Feedback from the Associate Minister of Health and Senior Management (N=2)

4.0 Supporting Disabled Consumers

HDC investigated a number of disability related complaints during the 2013/14 financial year. The investigations highlighted the need for disability services providers to provide responsive, high quality services in a manner consistent with disabled consumers' needs. Equally, investigations pointed to the need for health service providers to ensure that their services to disabled consumers meet the same standards of high quality and appropriate care. The investigations also revealed instances where providers showed a lack of respect, reasonable care and skill, and effective communication in the provision of services. These complaints are particularly concerning when considering the vulnerabilities of many disabled consumers, whose voices often go unheard.

HDC believes that health and disability services providers need to actively facilitate a culture where all consumers are heard, even those who are considered non-verbal. In keeping with this emphasis on speaking up, HDC held an extremely successful disability conference in 2014, titled "How do we all raise the volume of the unheard voice?" The conference raised some vital questions about whose voices in the sector are unheard, and the ways service providers are listening to their clients.

New resources have been created and posted on HDC's website to raise awareness about the Code among disabled consumers, and to make the complaints process more accessible for everyone. Two New Zealand Sign Language videos were developed and posted. The videos provide information in New Zealand Sign Language on a person's rights when using a health or disability service in New Zealand, and on how to make a complaint to HDC.

HDC has recorded a reduction in the number of disability related complaints in 2013/14, after an increase in 2012/13. This reduction in disability related complaints contrasts with an overall increase in all HDC complaints; however, this may be due in part to changes in the way HDC has recorded disability complaints. HDC received a total of 117 disability related complaints in 2013/14 and closed 121 complaints, including seven investigations. The types of complaints were consistent with previous years.

The five most common issues complained about were treatment, communication, professional conduct, consent/information, and management of facilities. The complaints continue to highlight the importance of health and disability services providers responding to the specific needs of disabled people.

Learning from complaints

Disability related complaints have led to a number of positive outcomes in disability service provision. Complainants' concerns have been acknowledged and actions have been taken to resolve their complaints. Providers have:

- formally apologised for not meeting consumer service expectations;
- undertaken additional education and training for their staff to increase their capability and skill levels;
- taken corrective measures by developing additional resources to guide service delivery; and
- made changes to systems and processes to better support service delivery.

Disability related complaints have led to a number of positive outcomes in disability service provision.

National Disability Conference

The Deputy Commissioner, Disability hosted a successful national conference in Auckland on 2 July 2014. The theme of the conference was: "How do we all raise the volume of the unheard voice?" The Honorable Tariana Turia, the then Minister for Disability Issues, opened the conference, and the Commissioner introduced the key issues around the "unheard voices" and HDC's role in raising the volume of those voices. The conference included speakers from a wide range of backgrounds, including representatives from disabled people's organisations, disability services providers, human rights experts, a clinician-academic, self-advocates, parents, family organisations, and the Mental Health Commissioner. A consumer panel made up of three people from a range of consumer groups gave their reflections on the day's speakers and the theme of the conference. A key theme from the conference was the need for people to support one another to speak up — and listen carefully — when things go wrong. Over 230 people attended the conference, including consumers, family members and carers, representatives from consumer organisations, disability services providers, and government agencies.

Consumer seminars

Consumer seminars were held in Wellington for the Ministry of Health's Consumer Consortium, in Auckland for the Home and Community Health Association, in Dunedin for the Otago Deaf Centre, in Lower Hutt for the Community Connections consumers, and via teleconference for consumers in the Disabled Person's Assembly's Kaituitui network from across the country. The evaluations of the seminars were very positive, with an average of 88% of attendees finding the seminars "met" or "exceeded" their expectations.

Health Passport

In 2011, HDC created Health Passports to give consumers an opportunity to simplify their interactions with healthcare providers, and an ability to take control of explaining their care and communication needs or preferences. There is growing awareness of the Health Passport among disabled consumers, with particularly high uptake in the lower North Island.

Consumer Advisory Group

HDC's Consumer Advisory Group (CAG) was dealt a sad blow this year with the sudden passing of long-time member and Co-chair Beverly Grammer. Bev was an incisive, passionate and committed leader who had already, at a young age, made huge contributions to the disability community.

CAG provided constructive input to HDC's work in 2013/14, including in relation to the planning of the National Disability Conference, the promotion of the Health Passport, and providing feedback on the "real-time feedback" pilot for mental health and addiction services.

Throughout the year, CAG also continued to provide advice to the Medical Council of New Zealand (MCNZ) on matters relevant to its work. The MCNZ have been appreciative of the feedback received.

Health and disability services providers need to actively facilitate a culture where all consumers are heard.

Woman's expressed wishes ignored

A woman was admitted to hospital because of a sudden onset of chest pain. She was unable to speak, and communicated via an iPad. She had difficulty swallowing, which was documented numerous times in her clinical records and the handover note. Her clinical records also noted her preference for intravenous (IV) rather than oral paracetamol.

Overnight, an agency registered nurse provided care for the woman. The clinical notes, including a written handover sheet, noted that the woman had "MND" (motor neurone disease). The registered nurse did not recognise the abbreviation "MND", and did not take steps to find out what it meant. However, the nurse said that she read the clinical notes during the shift. The notes clearly stated that the woman had motor neurone disease.

When the woman asked for pain relief, the nurse offered her liquid paracetamol. The woman wrote on her iPad that she required IV paracetamol and could not swallow the liquid. The nurse administered IV paracetamol.

Later the woman requested more pain relief, and the nurse again brought liquid paracetamol. The woman indicated that she could not take it, but the nurse administered some of the liquid into the woman's mouth. During administration of the liquid paracetamol, the woman felt as though she was choking. Later the nurse returned with IV paracetamol, but did not flush the drip and, after administering the paracetamol, threw the syringe on the woman's bed and walked away.

It was held that the nurse's conduct and manner towards the woman were unkind and unprofessional. Her behaviour demonstrated a lack of respect. The nurse should have been aware of the woman's diagnosis of motor neurone disease and familiarised herself with the woman's needs and preferences in order to provide safe care to her. The nurse's failure to take those steps meant that she failed to provide services in a manner consistent with the woman's needs.

In addition, by failing to flush the woman's drip prior to administering IV paracetamol the second time, the nurse failed to provide services with appropriate care and skill. In disregarding the woman's refusal to take paracetamol elixir, the nurse showed a disregard for the woman's right to make an informed choice about her care and treatment. The nurse was referred to the Director of Proceedings, who decided not to issue a proceeding.

Following HDC recommendations, the nurse sent a letter of apology to the family of the complainant.[9] It was also recommended that if she chose to return to practice, the nurse first undertake a communication course focused on interacting with disabled patients, and undergo a competence review by the Nursing Council.

This case highlights the need for mainstream health services to be provided to disabled people according to the same standards and with the same rights to respect, dignity, high quality care and informed consent as are afforded to all other consumers. It also highlights the importance of all health professionals involved with a disabled person in a mainstream health service being aware of any unique support needs that person might have, and of ensuring they respond appropriately.

HDC

[9] Unfortunately, the complainant passed away before the conclusion of HDC's investigation into her complaint.

No support services for paralysed woman over holiday period

A woman who was paralysed from the chest down and lived alone complained about the lack of care provided to her by her regular disability services provider over the Christmas/New Year period. The woman had been assessed as requiring approximately eight and a half hours of in-home care per day, and seven eight-hour sleepover shifts per week from the provider, although she elected to have only three sleepover shifts per week.

In June, the woman's usual weekday support worker advised the provider that she would be taking annual leave over the Christmas/New Year period. The provider did not arrange alternative support for the woman during this leave period. The provider also did not arrange alternative care for the woman following the resignation of one of her evening support workers in November, or following an injury sustained by her weekend day support worker in December, which left that worker unable to care for the woman.

As a result, the woman did not receive her scheduled support services during two days and one evening prior to Christmas. In addition, she did not receive her usual day cares on nine days, or four of her regular evening cares, over the Christmas/New Year period.

The lack of care provided to the woman over the Christmas/New Year period had a significant effect on her emotional and physical well-being. The woman emailed the provider several times over that period outlining the impact the lack of care was having on her, but she received no responses to her concerns from the provider.

It was held that by failing to arrange appropriate care for the woman over the Christmas/New Year period, the provider failed to provide services to the woman that were consistent with her needs. The provider's failure to respond to the woman over the Christmas/New Year period placed her at increased risk of harm. Additionally, the provider's poor communication with the woman, including the failure to respond to her emails, showed a complete lack of empathy or regard for her situation, or respect for her requirements.

Following HDC recommendations, the service provider apologised to the complainant, and is undertaking a review of its policies and procedures for arranging cover when employees take leave. Additionally, the provider will undertake training with senior staff and coordinators on how to communicate effectively and respectfully with clients, in a way that acknowledges clients' active participation in their own care. The service provider was referred to the Director of Proceedings.

An increasing number of disabled people are being supported to live independently in the community. They are reliant on their support services working effectively. This case highlights the need for the implementation and management of appropriate organisational systems, particularly when providing services to vulnerable people. It is also a reminder of the need for providers to facilitate open and responsive lines of communication with consumers, and their families and whānau.

5.0 Organisational Performance, Development and Capability

5.1 Leadership

HDC continues to be a leader in medical law, and health and disability services complaints resolution. Through complaints resolution, HDC strengthens New Zealand's health care system by making recommendations for change and by encouraging providers to learn from complaints and to use them as a tool to drive quality improvements. Through education, HDC champions system-wide quality improvements and encourages working towards a health care system where providers and consumers are fully engaged as part of a consumer-centred culture.

The Commissioner leads the organisation with the Executive Leadership Team of two Deputy Commissioners, two Associate Commissioners, the Mental Health Commissioner, the Director of Proceedings, the Director of Advocacy, and the Chief Operating Officer.

5.2 Staff

At HDC our people are our greatest resource. The majority of HDC's staff possess professional qualifications and predominantly come from health, disability or legal backgrounds. Together they bring to the organisation a wide range of skills in management, training, investigation, litigation, clinical practice, research and development, information technology, and financial management.

5.3 Equal Employment Opportunities

HDC is dedicated to respecting the rights of others, regardless of background, and this extends to its employment policy. Its Human Resources Manual recognises the need to provide equal opportunities for employment, promotion and training, both within the office and through its recruitment processes. All staff involved in recruitment are made aware of the requirements of HDC's Equal Employment Opportunities (EEO) policy, and it is part of new staff induction.

HDC's EEO policy states that HDC will ensure compliance with the New Zealand Disability Strategy.

HDC is a member of the Equal Employment Opportunities Trust.

HDC has organised programmes throughout the year to celebrate Māori Language Week, New Zealand Sign Language Week, and Matariki.

5.4 Workplace profile

As at 30 June 2014, the Health and Disability Commissioner has 62.58 Full Time Equivalents (FTE) staff, as follows:

- 83% females and 17% males; and
- 51 full-time positions and 11.58 FTE part-time positions.

HDC currently employs five disabled people, covering a range of different impairments. These staff members provide valuable insight into the challenges faced by those in our communities who live with impairments.

The Office benefits from a diverse workforce. For example, HDC has staff that are Māori, Samoan, Asian, and English, among other ethnicities, and aged between 20 to over 60 years.

5.5 Good employer obligations

1. Leadership, accountability and culture

Staff fora are held in both offices each month for divisions to talk about their work and current issues, and to recognise staff and team successes, both personal and work related. All staff are expected to attend these fora.

2. Recruitment, selection and induction

HDC's recruitment policy and practices ensure the recruitment of the best qualified employees at all levels using the principles of EEO, while taking into account the career development of existing employees. Vacancies are advertised throughout the Office as well as externally, and employees are encouraged to apply for positions commensurate with their abilities. The human resources policies are part of induction for new staff.

3. Employee development, promotion and exit

HDC policies support professional development and promotion, and HDC identifies training and development needs and career development needs as a formal part of the annual performance appraisal process. HDC has developed a new appraisal system where each staff member receives a performance management agreement tailored to his or her role and development requirements.

Professional development by employees is encouraged, and financial assistance or assistance in the form of time off during normal working hours may be granted by the Commissioner. Several staff have been given the opportunity to cover vacant senior management roles and thereby further develop their management skills.

4. Flexibility and work design

HDC continues to offer secondments across divisions, working from home options, and flexible work start and finish times. A number of staff work hours that enable them to study as well as gain valuable work experience.

5. Remuneration, recognition and conditions

HDC provides fair remuneration based on Equal Employment Opportunities principles. HDC recognises staff achievements in its internal newsletter "Highlights" and at monthly staff fora.

6. Harassment and bullying prevention

HDC has a "Non harassment" policy and has zero tolerance for all forms of harassment and bullying. In addition, HDC promotes and expects staff to comply with the State Services Standards of Integrity and Conduct.

7. Safe and healthy environment

HDC has an environment that supports and encourages employee participation in health and safety through its Health and Safety Employee Participation System and its Health and Safety Committee, which meets regularly. Health and safety is a regular agenda item at monthly staff fora, and hazards are actively managed in the office. Support is given to those staff with acknowledged impairments by way of sign language interpreters, special equipment, and assistance to get to and from work. In addition, HDC has a number of initiatives in place to promote a healthy and safe working environment, including sponsorship for health and wellness activities, use of VITAE, which offers confidential counselling, provision of fruit in each office, and flexible hours.

5.6 Process and technology

Sustainability

HDC works to reduce its impact on the environment and to save money. It makes use of recycling for its waste, endeavours to buy as much as possible locally, keeps a close eye on travel, encourages staff use of public transport where appropriate, and purchases environmentally-friendly products and services where possible.

Technology

HDC continues to improve its information management systems in order to achieve compliance with the Public Records Act 2005 standards. HDC is exploring database enhancements and other options for improving data mining capability.

5.7 Physical assets and structures

HDC continues to manage its assets cost-effectively. Our governance policies and practices are strong and our buildings and office space modern and well equipped. Office equipment is well maintained and in good working order.

6.0 Statement of Service Performance

6.1 Outcomes (the change HDC aims to achieve for New Zealanders) and outputs (HDC's key activities)

The outcomes HDC seeks are consistent with the Government's intermediate and long-term health and disability systems outcomes:

- New Zealanders live longer, healthier, more independent lives;
- the health system is cost effective and supports a productive economy;
- health services are delivered better, closer, sooner and more conveniently; and
- future sustainability of the health system is assured.

The role of HDC is to resolve complaints and through this, promote safe, high quality, consumer-centred health and disability services. Achieving safe, high quality services is a shared responsibility with other agencies, providers and professional bodies.

HDC has a range of resolution options available to it under the Health and Disability Commissioner Act 1994. These include referring the complaint back to the provider, to a professional body, to another agency, or to the Advocacy Service. The Commissioner may also decide to take no further action on a complaint. Often a decision to take no further action will be accompanied by an educational comment designed to assist the provider in improving future services. Where appropriate, the Commissioner may formally investigate a complaint. One of the possible outcomes of a formal investigation is that the provider may be found to have breached the Code of Health and Disability Services Consumers' Rights. Such findings, along with reasons, are usually set out in a formal report that is published on HDC's website for educational purposes. Relevant regulatory authorities, other agencies, and the consumer/complainant are also advised of the breach finding, thus holding the provider to account for the failure. The Commissioner may also decide to refer the provider to the Director of Proceedings who may elect to bring proceedings against the provider. Such proceedings provide an additional mechanism for holding a provider to account, either in a professional disciplinary context (where proceedings are brought in the Health Practitioners Disciplinary Tribunal) or in the Human Rights Review Tribunal (a forum in which damages may be awarded against the provider).

The key ways in which HDC contributes to the Government's outcomes, and the principal ways those contributions are measured (as reported in the statement of service performance), include:

- Resolving complaints about health and disability services

  Measured by:

  - *Number of complaints received and resolved by HDC;*
  - *Timeliness of complaints resolution by HDC;*
  - *Number of complaints received and resolved by the Advocacy Service;*
  - *Timeliness of complaints resolution by the Advocacy Service;*
  - *Degree of resolution achieved by the Advocacy Service; and*
  - *Level of stakeholder satisfaction with the Advocacy Service and the professionalism of the advocate.*

- Using the learning from complaints to improve the safety and quality of health and disability practices and systems

  Measured by:

  - *Improvements made by providers based on HDC recommendations;*
  - *Provision of HDC complaint trend reports to District Health Boards;*
  - *Number of, and satisfaction with, education sessions provided by HDC; and*
  - *Provision of, and satisfaction with, intensive provider education programmes.*

- Promoting best practice and consumer-centred care to providers

  Measured by:

  - *Number of, and satisfaction with, education sessions provided by HDC;*
  - *Number of, and satisfaction with, education sessions provided by the Advocacy Service;*
  - *Provision of, and satisfaction with, intensive provider education programmes;*
  - *Publication of Great Care Stories;*
  - *Provision of up-to-date, accessible and informative educational material;*
  - *Success of implementation of the Health Passport within DHBs;*
  - *Success of National Disability Conference;*
  - *Provision of high quality submissions addressing matters that affect the rights of consumers;*
  - *Success in developing and implementing key projects in the mental health and addictions sector to support best practice, through advocacy and monitoring; and*
  - *Provision of, and satisfaction with, expert advice on issues relating to mental health and addiction services.*

- Ensuring providers and their employees are held accountable for their actions.

  Measured by:

  - *Number of complaints received and resolved by HDC;*
  - *Proportion of disciplinary proceedings in which professional misconduct found;*
  - *Proportion of Human Rights Review Tribunal proceedings in which breach of the Code found; and*
  - *Proportion of cases in which awards of damages made.*

6.2 Output Class 1: Complaints resolution

Performance and measures	Achievement

Output 1 – Every complaint is addressed promptly and impartially using the most appropriate option under the HDC Act 1994

Performance and measures	Achievement
Complaints are closed within reasonable timeframes: Estimated 1,600 complaints received.	**Targets achieved** 1,784 complaints were received during the year; this represents 111.4% of the estimated volume. (2013: 1,619)
Estimated 1,650 complaints closed.	1,901 complaints were closed during the year; this represents 115.2% of the target. (2013: 1,551) This includes 115 investigations (2013: 60).
New measure for 2013/14 Age of open complaints to be managed so that: • No more than 20% of open complaints to be 6–12 months old; • No more than 5% of open complaints to be 1–2 years old; and • No more than 1% of open complaints to be 2+ years old.	**Target partially achieved** Total open files at year end was 508 compared with 625 at the end of last year. Age of open complaints at end of 2013/14: 6–12 months old, 93/508 — 18.3%; 12–24 months old, 68/508 — 13.4%[10]; and Over 24 months old, 9/508 — 1.8%. The number of open files has been reduced in total and in each age category as per table below:
Providers make service improvements based on HDC recommendations A random sample of providers who report that they have complied with HDC recommendations between 1 July 2013 and 30 June 2014 will be audited to verify compliance. That 99% of the random sample will be found to have complied.	**Targets achieved** 100% of a random sample of providers who reported that they complied with HDC recommendations were found to have complied (2013: 100%).

	Total open files	6 to 12 months	12 to 24 months	Over 24 months
30 June 2013	**625**	145	76	16
30 June 2014	**508**	**93**	**68**	**9**
# reduced	**117**	52	8	7
% reduced	**18.7%**	**35.9%**	**10.5%**	**43.8%**

[10] These results are partly due to the intentional drive to significantly increase closures. This reduced the number of open files at the end of the period and, consequently, the open investigation files form a larger proportion of overall open files. Complex investigations take 12–24 months. In the next financial year, HDC is looking to close 90% of investigations within 18 months.

6.3 Output Class 2: Advocacy

Performance and measures	Achievement
Output 1 – Complaints to advocates are addressed promptly and resolved in a timely manner	
Complaints are closed within reasonable timeframes An estimated 3,800 complaints received.	**Targets achieved** 3,468 new complaints were received by advocates in this reporting year. This represented 91% of the estimated total complaints expected (2013: 3,194, 84%). During the year 2013/14, 3,365 of these complaints were closed (2013: 3,126).
1. 85% closed within 3 months.	1. 89% (2,998) were closed within 3 months (2013: 88%, 2,739).
2. 95% closed within 6 months.	2. 99.5% (3,351) were closed within 6 months (2013: 99%, 3,111).
3. 100% closed within 9 months.	3. 100% (3,365) were closed within 9 months (2013: 100%, 3,126).
Complaints managed reach resolution 90% of complaints managed by the Advocacy Service are partially or fully resolved. Resolution is when the consumer is satisfied and happy to move on.	**Target achieved** 94% (3,160) of complaints managed by the Advocacy Service were partially or fully resolved (2013: 94%, 2,950).
Consumers and providers are satisfied with the service and the professionalism of the advocate Surveys of consumers and providers who have used/dealt with the Advocacy Service will report that 80% of the respondents are satisfied with the service and the professionalism of the advocate.	**Target achieved** 92% of consumers surveyed and 87% of providers surveyed who have dealt with the Advocacy Service said they were satisfied with the service and the professionalism of the advocate (2013: 81% of consumers and providers).
Output 2 – Advocacy will establish and maintain contact with consumers and providers within the community	
Vulnerable consumers (in rest homes and disability homes) have access to advocacy through regular contact	**Targets achieved**
1. Advocates to have two contacts with 60% of rest homes by 30 June 2014.	100% (670 of 670) of rest homes have had one contact by an advocate and 64% (427 of 670) have had two contacts. The total number of rest home contacts for the year is 3,096 (2013: 100% had one contact and 71% had two contacts. The total number of contacts was 3,096).
2. Advocates to have two contacts with 60% of disability homes by 30 June 2014.	100% (1,020 of 1,021) of disability homes have had one contact by an advocate and 61% (620 of 1,021) have had two contacts. The total number of disability homes visited for the year is 3,239 (2013: 100% had one contact and 66% had two contacts. The total number of visits was 3,145).
Consumer and provider networks have regular contacts from the advocates 3,500 network contacts with consumers and providers by June 2014.	**Target achieved** 4,505 network contacts with consumers and providers were made by the advocates over the reporting year. This represents 129% of the annual target (2013: 3,932, 112%).

6.3 Output Class 2: Advocacy - Continued

Performance and measures	Achievement
Output 3 — Advocacy will provide education and training sessions to consumers and providers on the Code of Rights and encourage providers to view complaints as opportunities for learning	
Consumers and providers are satisfied with education sessions 1. 2,000 education sessions provided by 30 June 2014. 2. 80% of the consumer and provider respondents report satisfaction with the education session.	**Targets achieved** 2,407 education sessions have been provided, which represents 120% of the annual target (2013: 2,225, 111%). 93% of consumers and 95% of providers who attended an advocacy education session said they were satisfied with the session (2013: 89% of consumers and 90% of providers).
Ongoing education is provided through Great Care Stories 180 case studies/stories of Great Care published by 30 June 2014.	**Target achieved** 180 case studies/stories of Great Care were collected and published. This represents 100% of the annual target (2013: 180, 100%).

6.4 Output Class 3: Proceedings

Performance and measures	Achievement
Output 1 – Proceedings are taken in appropriate cases	
Professional misconduct is found in disciplinary proceedings Professional misconduct is found in 75% of disciplinary proceedings.	**Target achieved** Decisions in eight disciplinary proceedings were received. Professional misconduct was found in 75% (6 of 8) of proceedings (2013: 75%, 3 of 4).
Breach of the Code is found in Human Rights Review Tribunal (HRRT) proceedings A breach of the Code is found in 75% of HRRT proceedings.	**Targets achieved** Breach of the Code was found in 100% (6 of 6) of the HRRT proceedings during 2013/14 (2013: nil).
An award is made where damages sought An award of damages is made in 75% of cases where damages are sought.	**Targets achieved** An award of damages was made in 83% of cases (5 of 6) where damages were sought (2013: nil).

6.5 Output Class 4: Education

Performance and measures	Achievement
Output 1 – Provide up-to date, accessible and informative educational materials for consumers and providers	
New informative resources for consumers and providers are added to the Education section of the HDC's website Development of two educational resources targeting vulnerable consumer groups and disability sector providers.	**Target achieved** Two new sign language videos were developed and posted on HDC's website. The videos provide information in sign language on a person's rights when using a health or disability service in NZ and how to make a complaint (2013: Two educational resources were produced).
Material on the HDC's education section of the website is accessible to people who use "accessible" software 80% of educational materials are available in HTML and/or Word formats on HDC's website by June 2014.	**Target achieved** 90% of educational materials are available in HTML and/or Word formats on HDC's website (2013: 78%).
Material on the HDC's education section of the website is available in "plain English" 20% of educational materials published in the last 5 years are available in "plain English" format by 30 June 2014.	**Target achieved** 39% of educational materials published in the last five years are available in "plain English" format (2013: 34%).
Output 2 – Provide informative reports on the work of the Commissioner to keep provider groups	
DHBs find complaints trend reports useful for improving services 1. Six-monthly HDC complaint trend reports are sent to all DHBs. 2. 95% of DHBs responding to the reports rate them as useful for improving the safety and quality of their services.	**Targets achieved** 100% of six-monthly reports to DHBs were issued in the year. 100% (20/20) of the DHBs rated the first half-year report as useful. 95% (19/20) of the DHBs rated the second half-year report as useful. (2013: 97.5%, 38 of 39).
Output 3 – Disability education	
National Disability Conference programme meets participants' expectations 1. A National Disability Conference will be held before 30 June 2014. All conference participants will be invited to complete an evaluation. 2. 80% of the respondents report that the information received during the conference met their expectations.	**Targets not achieved** HDC hosted its 4th National Disability Conference in Auckland on 2 July 2014. The conference, titled "How do we all raise the volume of the unheard voice?", was well represented by consumers, family and whānau, health service providers, and government agencies, with over 230 registrants attending the event. Feedback received showed that 60% of respondents indicated that the conference either met or exceeded their expectations (2013: 91%).
Consumer seminars meet participants' expectations 1. Two regional consumer seminars for people with high and complex needs and their families are to be held by June 2014. 2. 80% of respondents report that they are satisfied that the seminar met their expectations.	**Targets achieved** Seven regional consumer seminars were held in 2013/14 with the majority of respondents satisfied and reporting it met their expectations (2013: Two consumer seminars were conducted). Feedback received showed that 88% of respondents indicated that the seminar either met or exceeded their expectations (2013: 73%).

6.5 Output Class 4: Education - Continued

Performance and measures	Achievement
Output 4 – Education for providers	
Educational presentations meet requesters' expectations 1. Provide 25 educational presentations by 30 June 2014 and seek evaluations on those presentations. 2. 96% of respondents are satisfied that presentations met their expectations.	**Targets achieved** 63 educational presentations were made — this represents 252% of the annual estimated volume (2013: 67 presentations were made). 98% of people (55 of 56) who provided feedback reported that the presentation met or exceeded their expectations (2013: 100%, 61 of 61).
Intensive training programmes meet participants' expectations 1. Provide two intensive provider education programmes by 30 June 2014. 2. 90% of participants reporting that they are satisfied with the content and delivery of the programme.	**Targets achieved** Two intensive provider education programmes were provided (2013: Two). 97% reported that they were satisfied with the content and delivery of the programme (2013: 97%). 42 people responded (2013: 51).
Output 5 — Provide high quality submissions addressing matters that affect the rights of HDC consumers	
Recipient agencies are satisfied with the quality of HDC's submissions A survey of people receiving submissions from HDC will be undertaken. 95% of respondents rate that they are satisfied with the quality of HDC's submissions.	**Targets achieved** Year to date, 23 submissions were made (2013: 25). Feedback forms were received in relation to 12 of 23 submissions. 100% (12 of 12) of respondents rated that they were satisfied with the quality of HDC's submissions (2013: 100%).

6.6 Output Class 5: Systemic monitoring and advocacy — mental health and addiction services

Performance and measures	Achievement
Output 1 – Systemic monitoring and advocacy	
Key relationships are fostered and maintained nationally and internationally, to support best practice, innovation, and continual improvement Develop and implement engagement strategy to guide communication and networking with key stakeholders. Engagement plan completed including recommendations on optimal communication channels and eight key fora (national/international) to attend to develop collaborative relationships, and to share information on service improvement.	**Targets achieved** Engagement Plan completed and implementation underway. Attended, on request, international and multiple national and regional fora to present and seek feedback on key projects, and gain information on sector issues. The Mental Health Commissioner published articles on rangatahi mental health in the Mental Health Foundation newsletter. In June while in the UK the Mental Health Commissioner: • presented at the IIMHL Population Health/Public Health Exchange; • attended the IIMHL Conference; • participated in the Dublin Dialogues, the second international meeting of the Mental Health Commissioners in Dublin to debate the future of mental health and addictions services; and • attended the launch of the UK Mental Health network in London. Responded to a high degree of interest in Real Time feedback on consumer and family/whānau experiences using services as per the Communications Plan including printing leaflets for pilot sites and prepared information to be uploaded on HDC website to link people to the "live results" internet page at www.patientexperiencesurvey.co.nz
Implementation of Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 is monitored to provide useful information to support service improvement Develop, trial, and evaluate the collection of service performance indicators as per the joint national monitoring framework agreed with the Ministry of Health.	**Targets achieved** Completed the development and pilot of an Outcomes Framework with the three Auckland metro DHB mental health and addiction services to enable them to assess their progress in implementing "Rising to the Challenge: the Mental Health and Addictions Service Development Plan" (MOH 2012) ("RTTC"). A set of 21 indicators were agreed and tested with the information presented in an electronic dashboard format. The project steering group recommended further development and implementation in smaller DHBs in 2014/15 subject to agreement with the Northern Regional Alliance (NRA). Requests from the MOH and DHBs wanting to use the framework to inform their monitoring processes have been met. A communication plan to disseminate the outcome of the project will be developed.
80% of key stakeholders in the trial are satisfied that the HDC monitoring information is helpful in planning service improvements.	The evaluation (N=9) indicated 89% agreement by pilot sites that the outcome monitoring framework was useful for informing service improvement (2013: 90%).

6.6 Output Class 5: Systemic monitoring and advocacy — Continued

Performance and measures	Achievement
Design, pilot and evaluate a sustainable programme of local site based monitoring and advocacy for systemic mental health and addiction services improvements, that maximises involvement of consumers/tangata whaiora, families and whānau Develop and pilot a programme of local site visits that builds on the Mental Health Commission's District Sector Visit process to support service improvement locally. New site visit process evaluation completed, with recommendations to maximise its value for supporting service improvement and to ensure sustainability.	**Targets achieved** HDC participation in the regional consumer and family/whānau network meetings was trialled and evaluated as a sustainable option to replace district sector visits. Information from DHBs using the Outcome Framework for RTTC in the project above significantly informed the discussions at these meetings. A meeting schedule for 2014/15 is being finalised. All known regional and national network key personnel have been contacted requesting their network meeting dates for 2014/15.
Consumer/tangata whaiora and family/whānau experience is measured and informs continuous service improvement Pilot and evaluate an electronic real-time feedback system to measure public experience of interaction with mental health and addictions services.	**Targets achieved** The pilot of an electronic survey of consumer and family/whānau experience of mental health and addiction services across seven pilot sites using 40 devices (tablets) continues to be progressed. • 16 weeks of testing the survey was completed, with over 1,000 surveys submitted and analysed electronically. Results can be viewed at www.patientexperiencesurvey.co.nz. • The survey tool has been co-developed with consumers, their family and whānau, and staff from the pilot sites with oversight from the Expert Advisory Group to ensure its relevance to providers and service users and their family/whānau to inform service improvement. • The next update of the survey tool occurred in July and was translated into six languages. • Following testing and refining of the analytics and reporting functions, updated reporting functions were completed in July 2014. • The independent evaluation was completed in October 2014. • The Mental Health Commissioner presented the pilot and its interim results at multiple fora.
Evaluation of pilot sites indicate that 80% of the participants are satisfied that the information collected is useful to guide service improvement.	Interim evaluation from the pilot site workshop indicated that 100% of participants (N=12) are satisfied that the system is useful to guide service improvement.

6.6 Output Class 5: Systemic monitoring and advocacy — Continued

Performance and measures	Achievement
The role of consumers, families and whānau in mental health and addictions services is supported and strengthened Collaborate with consumer and family/whānau networks on these initiatives to support leadership development and capacity to influence change.	**Targets achieved** **Family/Whānau Advisors Competency Development Framework** The National Family/Whānau Advisors Group was supported to develop a competencies based generic position description, which forms the basis of a framework for training. The national group is in discussion with HDC to support it to develop a website promoting family/whānau participation both in the network and mental health and addiction services. The June Northern Region Family/Whānau network meeting was supported by the MHC at which HDC staff presented. **Update Mental Health Commission publications for family/whānau and service users** Consumer and family/whānau leaders participated in a review of the two most popular publications developed by the Mental Health Commission: "Oranga Ngakau" and "When someone you care about has a mental health or addiction issue". These resources were updated and rebranded for printing and distribution. **Review of services to improve outcomes for rangatahi**
Collaborate with Te Rau Matatini to advocate for responsiveness to the needs of Māori.	The joint review of 21 youth mental health services known to be achieving positive outcomes for rangatahi was completed with Te Rau Matatini. Interim results identifying the strengths and challenges facing these services were presented at multiple national and international fora. The final report was approved for printing and a joint launch plan will be agreed.
Feedback from consumer and family/whānau networks and collaborative partners indicate that 90% are satisfied that the HDC support will contribute to service improvement.	Feedback to date confirms that 100% of respondents (N=20) are satisfied that the HDC support will contribute to service improvement.

6.6 Output Class 5: Systemic monitoring and advocacy — Continued

Performance and measures	Achievement
The HDC's systemic advocacy activities make a positive contribution to mental health and addiction services Develop a programme of advocacy activities, informed by the HDC's independent monitoring and engagement activities. Emerging issues are identified and actions taken to advocate for service improvement on eight issues.	**Targets achieved** HDC has responded to issues arising from sector engagement and monitoring by developing advice and advocating for service improvement on the following issues: 1. **Reducing the use of seclusion and restraint:** A report was completed with national DHB clinical directors and general managers of mental health and addiction services to provide a sector resource on current and best practice with recommendations on service improvement. Sector engagement was commenced to gain DHB commitment to establish a learning collaborative with expert leadership from the relevant professional networks, Ko Awatea, Te Pou, and the National KPI Group. 2. **Increasing Sector Productivity:** HDC, as per the Memorandum of Understanding with the Ministry of Health, contracted with Counties Manukau DHB for Ko Awatea to lead the development of a sector resource to provide guidance on how to improve the productivity of services based on an international literature review of tools for increasing productivity, exemplars of best practice in mental health and addiction services, and measures that could be appropriate for demonstrating productivity. The national DHB clinical directors and general managers group and the adult KPI group agreed the project scope. The Project Lead is Dr Margaret Aimer, supported by independent consultant Sue Johnston and an Expert Advisory Group. The first draft of an international literature review of approaches to improve productivity in health and other sectors that are relevant for use in New Zealand mental health and addiction services was completed and sent to the advisory group for their feedback in July, and distributed to sector leaders as a final draft. 3. **Increasing access to effective youth AOD services:** The National Drug Foundation (NDF) was contracted to enable the National Council for Addiction Treatment (NCAT) to develop and disseminate two resources to support service development. The first resource summarises "the evidence and collective wisdom" of national experts on effective practice for supporting recovery of youth with AOD problems, and the second describes a vision for how services will evolve in the future to maximise the resilience and mental health of youth. The resources were disseminated on the NDF website and at the National Addictions Leadership day in July 2014, to inform discussion and service development.

6.6 Output Class 5: Systemic monitoring and advocacy — Continued

<table>
<tr><th>Performance and measures</th><th>Achievement</th></tr>
<tr><td>

The HDC's systemic advocacy activities make a positive contribution to mental health and addiction services

Develop a programme of advocacy activities, informed by the HDC's independent monitoring and engagement activities.

Emerging issues are identified and actions taken to advocate for service improvement on eight issues.

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Targets achieved - Continued

4. **Improving access to information on medicines:** HDC jointly advocated with DHB hospital pharmacists to improve consumer access to nationally consistent, relevant information on medicines used to support recovery of people with mental health and addiction problems. HDC advocated to PHARMAC, the MOH and the New Zealand Formulary to subscribe to the UK based "Choice and Medicines" service, to improve consumer literacy regarding the use of medicines in mental health.
5. **Safe use of clozapine:** An analysis of the use of clozapine and the risk of premature mortality for people taking clozapine and other antipsychotic medication has been shared with key stakeholders for their feedback and consideration.
The draft report was peer reviewed by Professor Graham Mellsop (Professor of Psychiatry Auckland University — Waikato Clinical School). Preliminary findings were shared with the MOH and HQSC to consider the report's recommendations.
6. **Supporting locality planning:** Synergia was contracted to develop and trial an electronic tool to support planners and funders to use empirical information to inform service development decisions. The tool was tested by four DHBs: Capital Coast, Waitemata, Auckland, and Whanganui DHB. The tool has been presented to the National Planners and Funders Group and other key stakeholders for their use.
7. **Improving access to social housing:** The Mental Health Commissioner reviewed the strategies and changes in national policy to provide social housing in response to concerns raised by DHBs. Reduced access to social housing is leading to delays in discharging consumers from acute wards and increasing levels of homelessness in people with high and complex needs. DHBs are collecting national information to quantify the impact of the problem. HDC identified concerns with changes in eligibility criteria as a barrier to access to social housing for inpatients, and raised concerns with key agencies and the Minister.
8. **Sector funding:** HDC engaged with NGO sector leaders on the "fair funding campaign" and advocated for the development of a new funding framework to ensure sustainable levels of investment in mental health and addictions across the whole sector including NGOs from prevention to tertiary specialist services. The MOH agreed this work is now a priority. HDC will continue to advocate for a process that involves relevant key stakeholders and appropriate expertise in this critical piece of work.

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Government and key stakeholders are provided with independent expert advice

Establish a programme of regular reporting to provide independent advice to the Minister and other key stakeholders on mental health and addiction services.

90% of recipients indicate they find the reports useful.

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Targets achieved

MHC met with Minister Dunne and provided a briefing on the HDC Mental Health Commissioner's work programme.

The MOU with the MOH will be implemented over the next 4 years to coincide with implementation of "Rising to the Challenge". HDC will continue to brief senior Ministry officials regularly on progress against planned work and any emerging issues.

Feedback from 100% of recipients was positive.

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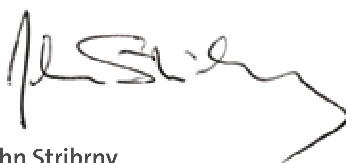
7.0 Statement of Responsibility

In terms of the Crown Entities Act 2004, the Health and Disability Commissioner is responsible for the preparation of the Health and Disability Commissioner's financial statements and statement of service performance, and for the judgements made in them.

The Health and Disability Commissioner has the responsibility for establishing, and has established, a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and performance reporting.

In the Health and Disability Commissioner's opinion, these financial statements and statement of service performance fairly reflect the financial position and operation of the Health and Disability Commissioner for the year ended 30 June 2014.



Anthony Hill
Health and Disability Commissioner

John Stribrny
Chief Operating Officer

31 October 2014

8.0 Audit report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of
The Health and Disability Commissioner's
financial statements and non-financial performance information
for the year ended 30 June 2014

The Auditor-General is the auditor of The Health and Disability Commissioner. The Auditor-General has appointed me, Leon Pieterse, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and non-financial performance information of The Health and Disability Commissioner on her behalf.

We have audited:

- the financial statements of The Health and Disability Commissioner on pages 56 to 77, that comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and notes to the financial statements that include accounting policies and other explanatory information; and
- the non-financial performance information of The Health and Disability Commissioner that comprises the statement of service performance on pages 43 to 52 and the report about outcomes on page 42.

Opinion

In our opinion:

- the financial statements of The Health and Disability Commissioner on pages 56 to 77:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect The Health and Disability Commissioner's:
    - financial position as at 30 June 2014; and
    - financial performance and cash flows for the year ended on that date;
- the non-financial performance information of The Health and Disability Commissioner on pages 42 to 52:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects The Health and Disability Commissioner's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2014. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of The Health and Disability Commissioner and our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and non-financial performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and non-financial performance information. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and non-financial performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and non-financial performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of The Health and Disability Commissioner's financial statements and non-financial performance information that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are

appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of The Health and Disability Commissioner's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by The Health and Disability Commissioner;
- the appropriateness of the reported non-financial performance information within The Health and Disability Commissioner's framework for reporting performance;
- the adequacy of all disclosures in the financial statements and non-financial performance information; and
- the overall presentation of the financial statements and non-financial performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and non-financial performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and non-financial performance information.

We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of The Health and Disability Commissioner

The Health and Disability Commissioner is responsible for preparing financial statements and non-financial performance information that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect The Health and Disability Commissioner's financial position, financial performance and cash flows; and
- fairly reflect its service performance and outcomes.

The Health and Disability Commissioner is also responsible for such internal control as is determined necessary to enable the preparation of financial statements and non-financial performance information that are free from material misstatement, whether due to fraud or error. The Health and Disability Commissioner is also responsible for the publication of the financial statements and non-financial performance information, whether in printed or electronic form.

The Health and Disability Commissioner's responsibilities arise from the Crown Entities Act 2004 and Health and Disability Commissioner Act 1994.

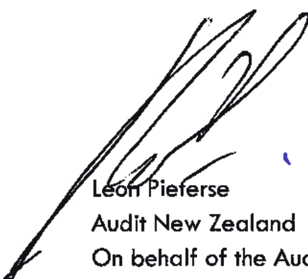
Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and non-financial performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

Other than the audit, we have no relationship with or interests in The Health and Disability Commissioner.



Leon Pieterse
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

9.0 Financial statements

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE

for the year ended 30 June 2014

	Actual 2014 $	Budget 2014 $	Actual 2013 $
OUTPUT 1: (Complaints Resolution)			
Resources employed			
Revenue	4,210,021	4,150,020	4,193,100
Expenditure	4,357,101	4,253,168	4,311,752
Net Surplus(Deficit)	(147,080)	(103,148)	(118,652)
OUTPUT 2: (Advocacy)			
Resources employed			
Revenue	4,720,790	4,656,120	4,300,552
Expenditure	4,935,902	4,852,268	4,512,681
Net Surplus(Deficit)	(215,112)	(196,148)	(212,129)
OUTPUT 3: (Proceedings)			
Resources employed			
Revenue	807,238	809,760	637,922
Expenditure	733,884	829,884	656,762
Net Surplus(Deficit)	73,354	(20,124)	(18,840)
OUTPUT 4: (Education)			
Resources employed			
Revenue	506,645	506,100	573,134
Expenditure	561,481	518,680	495,285
Net Surplus(Deficit)	(54,836)	(12,580)	77,849
OUTPUT 5: (Monitoring and Systemic Advocacy)			
Resources employed			
Revenue	1,065,000	1,000,000	1,000,000
Expenditure	1,066,897	1,000,000	987,213
Net Surplus(Deficit)	(1,897)	0	12,787
TOTALS:			
Resources employed			
Revenue	**11,309,694**	**11,122,000**	**10,704,708**
Expenditure	**11,655,265**	**11,454,000**	**10,963,693**
Net Surplus(Deficit)	**(345,571)**	**(332,000)**	**(258,985)**

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 30 June 2014

	Notes	Actual 2014 $	Budget 2014 $	Actual 2013 $
Income				
Revenue from Crown	2	10,920,000	10,920,000	10,420,000
Interest income		63,233	66,000	71,454
Other income	3	326,461	136,000	213,254
Total income		11,309,694	11,122,000	10,704,708
Expenditure				
Personnel costs	4	5,847,848	5,695,000	5,104,013
Depreciation and amortisation expense	9, 10	41,847	82,000	69,250
Advocacy services		3,539,998	3,596,000	3,546,580
Other expenses	5	2,225,572	2,081,000	2,243,850
Total expenditure		11,655,265	11,454,000	10,963,693
Surplus/(deficit) for the year		**(345,571)**	**(332,000)**	**(258,985)**
Total comprehensive income for the year		**(345,571)**	**(332,000)**	**(258,985)**

The accompanying notes form part of these financial statements

STATEMENT OF FINANCIAL POSITION
as at 30 June 2014

	Notes	Actual 2014 $	Budget 2014 $	Actual 2013 $
Assets				
Current assets				
Cash and cash equivalents	6	1,004,781	946,000	1,378,000
Debtors and other receivables	7	60,073	52,000	326,480
Prepayments		96,580	48,000	91,136
Inventories	8	19,885	25,000	53,502
Total current assets		1,181,319	1,071,000	1,849,118
Non-current assets				
Non-current receivables	7	36,000	0	0
Property, plant and equipment	9	344,987	80,000	81,921
Intangible assets	10	142,296	200,000	2,929
Total non-current assets		523,283	280,000	84,850
Total assets		**1,704,602**	**1,351,000**	**1,933,968**
Liabilities				
Current liabilities				
Creditors and other payables	11	624,652	462,000	511,302
Employee entitlements	12	268,565	190,000	228,497
Total current liabilities		893,217	652,000	739,799
Non-current liabilities				
Lease incentive	13	74,428	90,000	111,641
Total non-current liabilities		74,428	90,000	111,641
Total liabilities		**967,645**	**742,000**	**851,440**
Net assets		**736,957**	**609,000**	**1,082,528**
Equity				
General funds	14	736,957	609,000	1,082,528
Total Equity		**736,957**	**609,000**	**1,082,528**

The accompanying notes form part of these financial statements

STATEMENT OF CHANGES IN EQUITY
for the year ended 30 June 2014

	Actual	Budget	Actual
	2014	2014	2013
	$	$	$
Balance at 1 July	1,082,528	941,000	1,341,513
Capital contribution	0	0	0
Surplus/(Deficit) for the year	(345,571)	(332,000)	(258,985)
Total net movement in equity	736,957	609,000	1,082,528
Balance at 30 June	**736,957**	**609,000**	**1,082,528**

The accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS
for the year ended 30 June 2014

	Notes	Actual 2014 $	Budget 2014 $	Actual 2013 $
Cash Flow from Operating Activities				
Receipts from Crown revenue		11,170,000	10,920,000	10,170,000
Interest received		68,125	66,000	63,173
Receipts from other revenue		267,957	136,000	151,314
Payments to suppliers		(5,612,339)	(5,584,000)	(5,606,962)
Payments to employees		(5,807,780)	(5,695,000)	(5,021,183)
Goods and services tax (net)		(2,155)	0	36,492
Net cash from operating activities	**15**	**83,808**	**(157,000)**	**(207,166)**
Cash Flows from Financing Activities				
Receipts from Capital Contribution		0	0	0
Net cash from financing activities		**0**	**0**	**0**
Cash Flows from Investing Activities				
Receipts from sale of property, plant and equipment		74	0	78
Purchase of property, plant and equipment		(317,129)	(60,000)	(51,139)
Purchase of intangible assets		(139,972)	(150,000)	0
Net Cash from Investing Activities		**(457,027)**	**(210,000)**	**(51,061)**
Net increase/(decrease) in cash and cash equivalents		(373,219)	(367,000)	(258,227)
Cash and cash equivalents at beginning of year		1,378,000	1,313,000	1,636,227
Cash and cash equivalents at end of year	**6**	**1,004,781**	**946,000**	**1,378,000**

The accompanying notes form part of these financial statements

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 30 June 2014

1. Statement of accounting policies

Reporting Entity

The Health and Disability Commissioner is a Crown Entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. As such, the Health and Disability Commissioner's ultimate parent is the New Zealand Crown.

The Health and Disability Commissioner's primary objective is to provide public services to the New Zealand public, as opposed to making a financial return. The role of the Commissioner is to promote and protect the rights of health consumers and disability service consumers.

Accordingly, the Health and Disability Commissioner has designated itself as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

The financial statements for the Health and Disability Commissioner are for the year ended 30 June 2014, and were approved by the Commissioner on 31 October 2014.

Basis of Preparation

Statement of compliance

The financial statements of the Health and Disability Commissioner have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirements to comply with New Zealand generally accepted accounting practice (NZ GAAP).

The financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement base

The financial statements have been prepared on a historical cost basis.

Functional and presentation currency

The financial statements are presented in New Zealand dollars, and all values are rounded to the nearest dollar ($). The functional currency of the Health and Disability Commissioner is New Zealand dollars.

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

Standards, amendments and interpretations that are not yet effective and have not been early adopted

The XRB has now released the full suite of standards that will apply to public sector PBEs (tiers 1 to 4). They are effective for annual financial statements covering periods beginning on or after 1 July 2014. Early adoption is not permitted. All new IFRS and amendments to existing NZ IFRS are not applicable to public benefit entities. Under this framework, the Health and Disability Commissioner is classified as tier 2 and will be able to apply the PBE Accounting Standards Reduced Disclosure Regime. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Significant Accounting Policies

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Revenue from the Crown

The Health and Disability Commissioner is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of the Health and Disability Commissioner meeting his objectives as specified in the statement of intent.

Revenue from the Crown is recognised as revenue when earned and is reported in the financial period to which it relates.

Interest

Interest income is recognised using the effective interest method. Interest income on an impaired financial asset is recognised using the original effective interest rate.

Sale of publications

Sales of publications are recognised when the product is sold to the customer.

Sundry income

Sundry income is recognised when services are provided to external parties by HDC based on mutual agreements.

Leases

Operating leases

Leases that do not transfer substantially all the risks and rewards incidental to ownership of an asset to the Health and Disability Commissioner are classified as operating leases. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the term of the lease in surplus/deficit. Lease incentives received are recognised in surplus/deficit over the lease term as an integral part of the total lease expense.

Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at call with banks both domestic and international, other short-term, highly liquid investments, with original maturities of three months or less and bank overdrafts.

Debtors and other receivables

Debtors and other receivables are initially measured at face value, less any provision for impairment.

Investments

At each balance sheet date the Health and Disability Commissioner assesses whether there is any objective evidence that an investment is impaired.

Bank deposits

Investments in bank deposits are initially measured at fair value plus transaction costs.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method.

For bank deposits, impairment is established when there is objective evidence that the Health and Disability Commissioner will not be able to collect amounts due according to the original terms of the deposit. Significant financial difficulties of the bank, probability that the bank will enter into bankruptcy, and default in payments are considered indicators that the deposit is impaired.

Inventories

Inventories (such as publications) held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. The loss of service potential of inventory held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost (using the FIFO method) and net realisable value.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

Property, plant and equipment

Property, plant and equipment asset classes consist of leasehold improvements, furniture and fittings, office equipment, computer hardware, communication equipment and motor vehicles.

Property, plant and equipment are shown at cost or valuation, less any accumulated depreciation and impairment losses.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the Health and Disability Commissioner and the cost of the item can be measured reliably.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are included in surplus/deficit.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the Health and Disability Commissioner and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in surplus/deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Leasehold improvements
3 years (33%)

Furniture and fittings
5 years (20%)

Office equipment
5 years (20%)

Motor vehicles
5 years (20%)

Computer hardware
4 years (25%)

Communication equipment
4 years (25%)

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year-end.

Intangible assets

Software acquisition and development
Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of the Health and Disability Commissioner's website are recognised as an expense when incurred.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is de recognised. The amortisation charge for each period is recognised in the surplus/deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Acquired computer software
2 years 50%

Capitalisation threshold
Individual assets, or groups of assets, are capitalised if their cost is greater than $1,000. The value of an individual asset that is less than $1,000 and is part of a group of similar assets is capitalised.

Impairment of non-financial assets
Property, plant and equipment and intangible assets that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the Health and Disability Commissioner would, if deprived of the asset, replace its remaining future economic benefits or service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

Creditors and other payables
Creditors and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of creditors and other payables approximates their face value.

Employee entitlements

Short-term employee entitlements
Employee entitlements that the Health and Disability Commissioner expects to be settled within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned, but not yet taken at balance date, retiring and long-service leave entitlements expected to be settled within 12 months, and sick leave.

Superannuation schemes

Defined contribution schemes
Obligations for contributions to Kiwisaver and the Government Superannuation Fund are accounted for as defined contribution superannuation schemes and are recognised as an expense in surplus/deficit as incurred.

Goods and Service Tax (GST)
All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax
The Health and Disability Commissioner is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

Budget figures
The budget figures are derived from the statement of intent as approved by the Health and Disability Commissioner at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Health and Disability Commissioner for the preparation of the financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements the Health and Disability Commissioner has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Property, plant and equipment useful lives and residual value

At each balance date the Health and Disability Commissioner reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires the Health and Disability Commissioner to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by the Health and Disability Commissioner, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in surplus/deficit, and carrying amount of the asset in the statement of financial position. The Health and Disability Commissioner minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programmes.

The Health and Disability Commissioner has not made significant changes to past assumptions concerning useful lives and residual values. The carrying amounts of property, plant and equipment are disclosed in note 9.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying the Health and Disability Commissioner's accounting policies for the period ended 30 June 2014:

Lease classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the Health and Disability Commissioner.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

The Health and Disability Commissioner has exercised its judgement on the appropriate classification of equipment leases, and has determined that no lease arrangements are finance leases.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the lease expense.

2. Revenue from Crown

The Health and Disability Commissioner has been provided with funding from the Crown for the specific purposes of the Health and Disability Commissioner as set out in its founding legislation and the scope of the relevant government appropriations. Apart from these general restrictions there are no unfulfilled conditions or contingencies attached to government funding (2013 nil).

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 30 June 2014

3. Other Income

	Actual 2014 $	Actual 2013 $
Sale of Publications	114,247	107,570
Sundry Income	212,214	105,684
Total other revenue	**326,461**	**213,254**

4. Personnel costs

	Actual 2014 $	Actual 2013 $
Salaries and wages	5,635,477	4,918,540
Employer contributions to defined contribution plans	172,303	102,643
Increase/(decrease) in employee entitlements (note 12)	40,068	82,830
Total Personnel costs	**5,847,848**	**5,104,013**

Employee contributions to defined contribution plans include contributions to Kiwisaver and the Government Superannuation Fund.

5. Other expenses

	Actual 2014 $	Actual 2013 $
Fees to auditor:		
Audit fees for financial statement audit	42,030	40,704
Staff travel and accommodation	238,368	220,794
Operating lease expense	398,313	430,027
Advertising	21,448	22,873
Consultancy	575,122	478,360
Inventories consumed	138,466	134,225
Net loss on property, plant and equipment	12,746	0
Communications & computer	579,355	598,612
Other	219,724	318,255
Total other expenses	**2,225,572**	**2,243,850**

6. Cash and cash equivalents

	Actual 2014 $	Actual 2013 $
Cash on hand and at bank	1,004,781	378,000
Cash equivalents — term deposits	0	1,000,000
Total cash and cash equivalents	**1,004,781**	**1,378,000**

The carrying value of short-term deposits with maturity dates of three months or less approximates their fair value. The weighted average effective interest rate for term deposits is not applicable for 2014 (2013 3.62%).

7. Debtors and other receivables

	Actual	Actual
	2014	2013
	$	$
Trade receivables	52,250	63,765
Other receivables	7,823	12,715
Less provision for impairment	0	0
Accrued Revenue	0	250,000
Non-current receivables	36,000	0
Total debtors and other receivables	**96,073**	**326,480**

The ageing profile of receivables at year end is detailed below. All receivables greater than 30 days in age are considered to be past due. As at June 2014 and 2013, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2014	2013
	$	$
Not past due	45,407	307,691
Past due 1–30 days	3,887	4,747
Past due 31–60 days	990	412
Past due 61–90 days	1,921	811
Past due > 91 days	45	104
Total	**52,250**	**313,765**

8. Inventories

	Actual	Actual
	2014	2013
	$	$
Publications held for sale	19,885	53,502
Inventories	**19,885**	**53,502**

The carrying amount of inventories held for distribution that is measured at current replacement costs as at 30 June 2014 amounted to $19,885 (2013 $53,502).

9. Property, plant and equipment

Movements for each class of property, plant and equipment as at 30 June 2014 are as follows:

2014 Cost	Comp hardware	Comms equip	Furn and fittings	Leasehold improvements	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 2013	782,979	27,765	195,645	697,602	40,889	179,485	1,924,365
Additions during year	253,040	1,181	4,307	55,673	0	0	314,201
Disposals during year	(17,816)	(26,723)	(11,594)	(104,757)	0	(32,958)	(193,848)
Balance at 30 June 2014	1,018,203	2,223	188,358	648,518	40,889	146,527	2,044,718
Accumulated depreciation							
Balance at 1 July 2013	742,300	26,766	190,482	678,430	34,075	170,391	1,842,444
Charge for year	21,608	1,294	2,674	7,167	6,814	1,686	41,243
Disposals	(17,816)	(26,723)	(11,594)	(104,757)	0	(32,958)	(193,848)
Loss/(gain) on sale	0	0	0	7,428	0	2,464	9,892
Balance at 30 June 2014	746,092	1,337	181,562	588,268	40,889	141,583	1,699,731
Net book value 30 June 2014	**272,111**	**886**	**6,796**	**60,250**	**0**	**4,944**	**344,987**

HDC is contracting Gen-i to conduct an IT infrastructure refreshment which is work in progress under the computer hardware category with an amount of $211,921 as at 30 June 2014 (2013 $nil).

Movements for each class of property, plant and equipment as at 30 June 2013 are as follows:

2013 Cost	Comp hardware	Comms equip	Furn and fittings	Leasehold improvements	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 2012	751,839	26,723	194,725	691,146	40,889	173,186	1,878,508
Additions during year	36,421	1,042	920	6,456	0	6,299	51,138
Disposals during year	(5,281)	0	0	0	0	0	(5,281)
Balance at 30 June 2013	782,979	27,765	195,645	697,602	40,889	179,485	1,924,365
Accumulated depreciation							
Balance at 1 July 2012	723,826	26,723	189,574	671,135	25,897	167,161	1,804,316
Charge for year	23,755	43	908	7,295	8,178	3,230	43,409
Disposals	(5,281)	0	0	0	0	0	(5,281)
Loss/(gain) on sale	0	0	0	0	0	0	0
Balance at 30 June 2013	742,300	26,766	190,482	678,430	34,075	170,391	1,842,444
Net book value 30 June 2013	**40,679**	**999**	**5,163**	**19,172**	**6,814**	**9,094**	**81,921**

In the year ended 30 June 2014, HDC maintains its capitalisation threshold as $1,000. Health and Disability Commissioner has no restrictions or pledged security over the total of Health and Disability Commissioner's tangible assets.

10. Intangible assets

Movements in intangibles as at 30 June 2014 are as follows:

	Actual 2014 $	Actual 2013 $
Computer software		
Balance at 1 July	1,059,431	1,059,431
Additions during the year	142,900	0
Disposals during the year	(442,380)	0
Balance at 30 June	**759,951**	**1,059,431**
Accumulated amortisation		
Balance at 1 July	1,056,502	1,030,661
Charge for the year	604	25,841
Disposals	(442,379)	0
Loss/(gain) on sale	2,928	0
Balance at 30 June	617,655	1,056,502
Net book value at 30 June	**142,296**	**2,929**

All intangibles are acquired software.

HDC has two capital projects which are work in progress. They are Real-time Feedback programme with an amount of $100,000 and an IT infrastructure refreshment with software portion amount of $41,875 as at 30 June 2014 (2013 $nil).

There are no restrictions over the title of the Health and Disability Commissioner's intangible assets, nor are any intangible assets pledged as security for liabilities.

11. Creditors and other payables

	Actual 2014 $	Actual 2013 $
Creditors	381,655	294,521
Income in advance	39,780	0
Accrued expenses	51,844	49,600
Provisions	0	0
Lease incentive	37,213	37,213
Other payables	114,160	129,968
Total creditors and other payables	**624,652**	**511,302**

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms, therefore carrying value of creditors and other payables approximates their face value.

12. Employee entitlements

	Actual	Actual
	2014	2013
	$	$
Current employee entitlements are represented by:		
Annual leave	268,565	227,305
Retirement and long service leave	0	1,192
Total current portion	268,565	228,497
Total employee entitlements	**268,565**	**228,497**

13. Non-current liabilities

	Actual	Actual
	2014	2013
	$	$
Lease Incentive Liabilities	74,428	111,641
Total Non-current liabilities at 30 June	**74,428**	**111,641**

Lease incentive relating to Auckland office at Level 10, 45 Queen Street for period 1 July 2014 to 9 June 2017.

14. Equity

	Actual	Actual
	2014	2013
	$	$
General funds		
Balance at 1 July	1,082,528	1,341,513
Total comprehensive income for the year	(345,571)	(258,985)
Total equity at 30 June	**736,957**	**1,082,528**

15. Reconciliation of net surplus/(deficit) to net cash from operating activities

	Actual 2014 $	Actual 2013 $
Net Surplus/ (Deficit)	(345,571)	(258,984)
Add/(less) non-cash items		
Depreciation and amortisation expense	41,847	69,250
Total non-cash items	*41,847*	*69,250*
Add/(less) items classified as investing or financing activities		
Disposal of property, plant and equipment	12,746	(78)
Total items classified as investing or financing activities	*12,746*	*(78)*
Add/(less) movements in working capital items		
Debtors and other receivables	190,944	(60,476)
Inventories	33,617	(29,208)
Creditors and other payables	110,157	(10,500)
Employee entitlements	40,068	82,830
Net movements in working capital items	374,786	(17,354)
Net cash flow from operating activities	**83,808**	**(207,166)**

16. Commitments and operating leases

Advocacy service contracts

The maximum commitment for the 12 months from 1 July 2014 is $3,539,998 (2013: $3,595,998).

Operating leases as lessee

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	Actual 2014 $	Actual 2013 $
Not later than one year	353,419	389,694
Later than one year and not later than five years	534,310	860,925
Later than five years	0	0
Total non-cancellable operating leases	**887,729**	**1,250,619**

The Health and Disability Commissioner leases two properties, one in Auckland and one in Wellington.

A portion of the total non-cancellable operating lease expense relates to the lease of these two offices and a telephone system. The Auckland office lease has been renewed with a new lease expiry date in June 2017 and the Wellington lease expires in April 2015.

HDC has two capital commitments as at 30 June 2014. There are $158,000 related to the Real-time Feedback Programme which is completed in September 2014, and $5,307 related to an IT infrastructure refreshment which is completed in July 2014.

17. Contingencies

Contingent liabilities

As at 30 June 2014 there were no contingent liabilities (2013 $nil).

Contingent assets

The Health and Disability Commissioner has a contingent asset of a court case which was appealed and the decision will follow 30 July 2014 (2013 $nil).

18. Related party transactions and key management personnel

Related party transactions

All related party transactions have been entered into on an arm's length basis.

The Health and Disability Commissioner is a wholly owned entity of the Crown.

The Health and Disability Commissioner has been provided with funding from the Crown of deemed $10,920m (2013 $10,420m) for specific purposes as set out in its founding legislation and the scope of the relevant government appropriations.

In conducting its activities, The Health and Disability Commissioner is required to pay various taxes and levies (such as GST, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The Health and Disability Commissioner is exempt from paying income tax.

The Health and Disability Commissioner also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2014 totalled $0.1 million (2013 $0.1 million). These purchases included the purchase of electricity from Meridian, air travel from Air New Zealand, and postal services from New Zealand Post.

Key management personnel compensation

	Actual 2014 $	Actual 2013 $
Salaries and other short-term employee benefits	1,626,648	1,486,909
Post-employment benefits	68,037	37,949
Total key management personnel compensation	**1,694,685**	**1,524,858**

Key management personnel include the nine Executive Leadership Team members.

19. Employee remuneration

Total remuneration paid or payable

	Actual 2014	Actual 2013
100,000–109,999	2	1
110,000–119,999	1	2
120,000–129,999	0	0
130,000–139,999	3	1
150,000–159,999	0	1
160,000–169,999	0	1
170,000–179,999	3	0
180,000–189,999	0	0
190,000–199,999	1	1
250,000–259,999	1	1
270,000–279,999	0	1
320,000–329,999	1	0
Total employees	**12**	**9**

During the year ended 30 June 2014, there is one employee received compensation and other benefits in relation to cessation totalling $32,306 (2013: $nil).

19a. Commissioner's total remuneration

In accordance with the disclosure requirements of sections 152(1)(a) of the Crown Entities Act 2004, the total remuneration includes all benefits paid during the period 1 July 2013 to 30 June 2014.

	2014	2013
Commissioner	$322,851	$277,915

The current Commissioner took office on 19 July 2010.

20. Significant Events after the Balance Date

There were no other significant events after the balance date.

21. Categories of Financial Assets and Liabilities

The carrying amount of financial assets and liabilities in each of the NZ IAS 39 categories are as follows:

	Actual 2014 $	Actual 2013 $
Loans and receivables:		
Cash and cash equivalents	1,004,781	1,378,000
Debtors and other receivables	96,073	326,480
Total loans and receivables	**1,100,854**	**1,704,480**
Financial liabilities measured at amortised cost:		
Creditors and other payables	624,652	511,302
Total financial liabilities measured at amortised cost	**624,652**	**511,302**

22. Financial Instrument Risks

The Health and Disability Commissioner's activities expose it to a variety of financial instrument risks, including market risk, credit risk and liquidity risk. The Health and Disability Commissioner has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Market risk

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate owing to changes in market interest rates. The Health and Disability Commissioner's exposure to fair value interest rate risk is limited to its bank deposits which are held at fixed rates of interest. The Health and Disability Commissioner does not actively manage its exposure to fair value interest rate risk

The average interest rate on the Health and Disability Commissioner's term deposits is not applicable (2013: 3.62%).

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Investments and borrowings issued at variable interest rates expose the Health and Disability Commissioner to cash flow interest rate risk.

Credit risk

Credit risk is the risk that a third party will default on its obligation to the Health and Disability Commissioner, causing the Health and Disability Commissioner to incur a loss.

Due to the timing of its cash inflows and outflows, the Health and Disability Commissioner invests surplus cash with registered banks.

The Health and Disability Commissioner's maximum credit exposure for each class of financial instrument is represented by the total carrying amount of cash and cash equivalents (note 6), net debtors (note 7). There is no collateral held as security against these financial instruments, including those instruments that are overdue or impaired.

The Health and Disability Commissioner has no significant concentrations of credit risk, as it has a small number of credit customers and only invests funds with registered banks with specified Standard and Poor's credit ratings of AA- or better.

Liquidity risk

Liquidity risk is the risk that the Health and Disability Commissioner will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities and the ability to close out market positions. The Health and Disability Commissioner aims to maintain flexibility in funding by keeping committed credit lines available.

In meeting its liquidity requirements, the Health and Disability Commissioner maintains a target level of investments that must mature within specified time frames.

Sensitivity analysis

As at 30 June 2014, if the deposit rate had been 50 basis points higher or lower, with all other variables held constant, the surplus/deficit for the year would have been $5,000 (2013: $5,000) higher/lower. This movement is attributable to increased or decreased interest expense on the cash deposits.

The table below analyses the Health and Disability Commissioner's financial liabilities into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date. Future interest payments on floating rate debt are based on the floating rate at the balance sheet date. The amounts disclosed are the contractual undiscounted cash flows. The contractual undiscounted amounts equal the carrying amounts.

	Less than 6 months	Between 6 months and 1 year	Between 1 and 5 years
	$	$	$
2014			
Creditors & other payables – carrying amount (note 11)	624,652	0	0
Creditors & other payables – contracted cashflows (note 11)	624,652	0	0
2013			
Creditors & other payables – carrying amount (note 11)	511,302	0	0
Creditors & other payables – contracted cashflows (note 11)	511,302	0	0

23. Capital management

The Health and Disability Commissioner's capital is its equity, which comprises accumulated funds. Equity is represented by net assets.

The Health and Disability Commissioner is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

The Health and Disability Commissioner manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure the Health and Disability Commissioner effectively achieves its objectives and purpose, whilst remaining a going concern.

24. Explanation of significant variances

Statement of comprehensive income

HDC hired more staff, including a night team, to help process the increased volume of the closures during 2013/14, which increased by 15.2% (1,901 vs. 1,650).

To enhance efficiencies and prevent business disruption, HDC conducted an IT infrastructure refresh in the 2nd half of the 2013/14 year, and replaced its IT hardware which had reached its depreciated life. The total cost of this project was shared with the National Advocacy Trust.

Overall, HDC managed its net result within less than 5% variance of the SOI budget.

Statement of financial position

HDC had higher capital expenditures and creditor balance than budgeted. This is because that the IT infrastructure project was unbudgeted and in the year end creditors.

HDC staff endeavoured to deliver high quality work and exceeded the target for the year. This directly resulted in a higher employee entitlement liability at the balance date because of the strong work commitment.

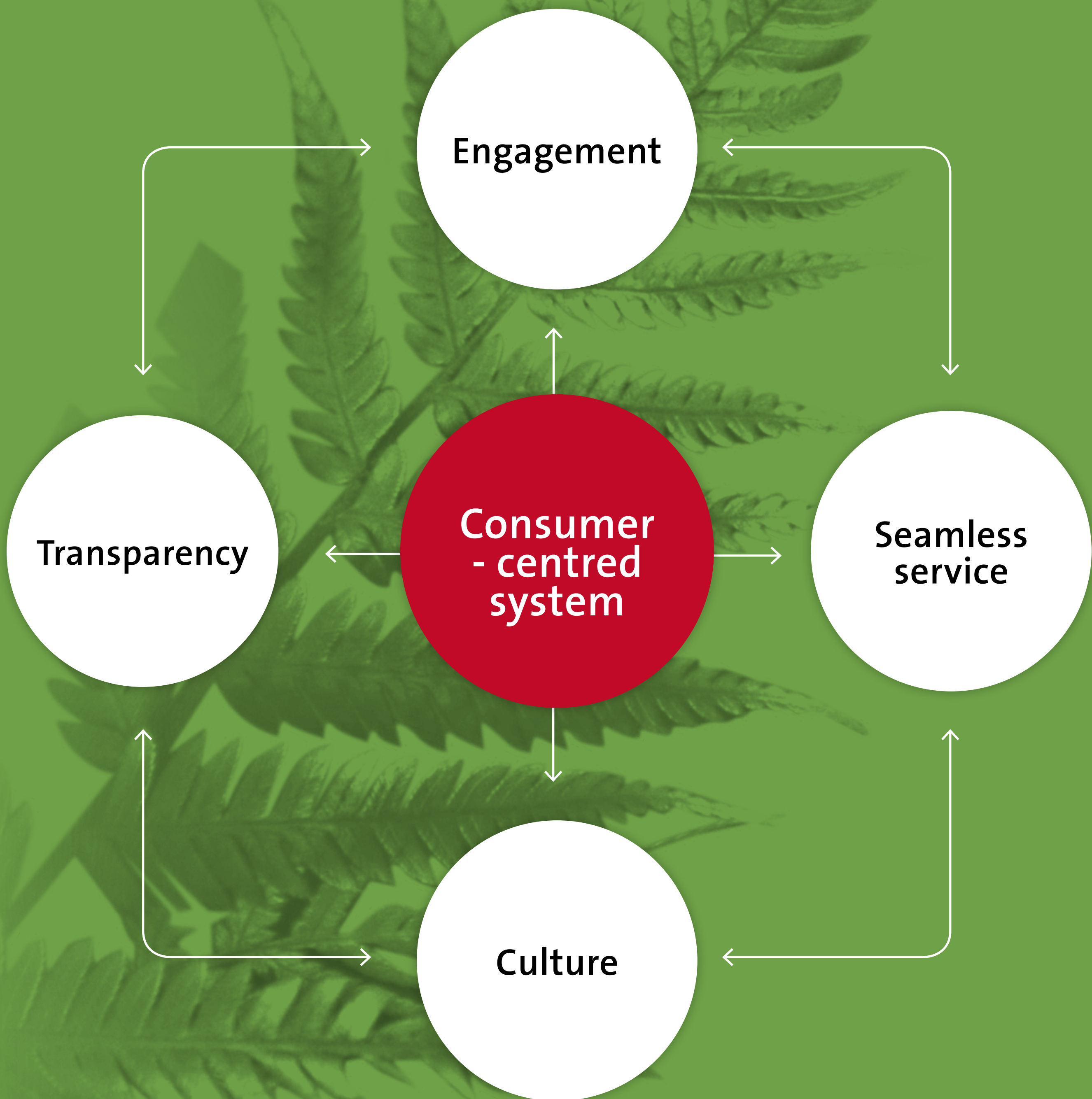
Statement of changes in equity

HDC finished at a better equity position than the budget as at 30 June 2014. This is mainly attributed to unbudgeted funding accrued for in June 2013.

Statement of cash flows

"Cash from operating activities" was improved by the IT cost contribution received from the National Advocacy Trust.

"Cash from investing activities" was higher than budgeted due to the IT infrastructure procurement.


Engagement
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