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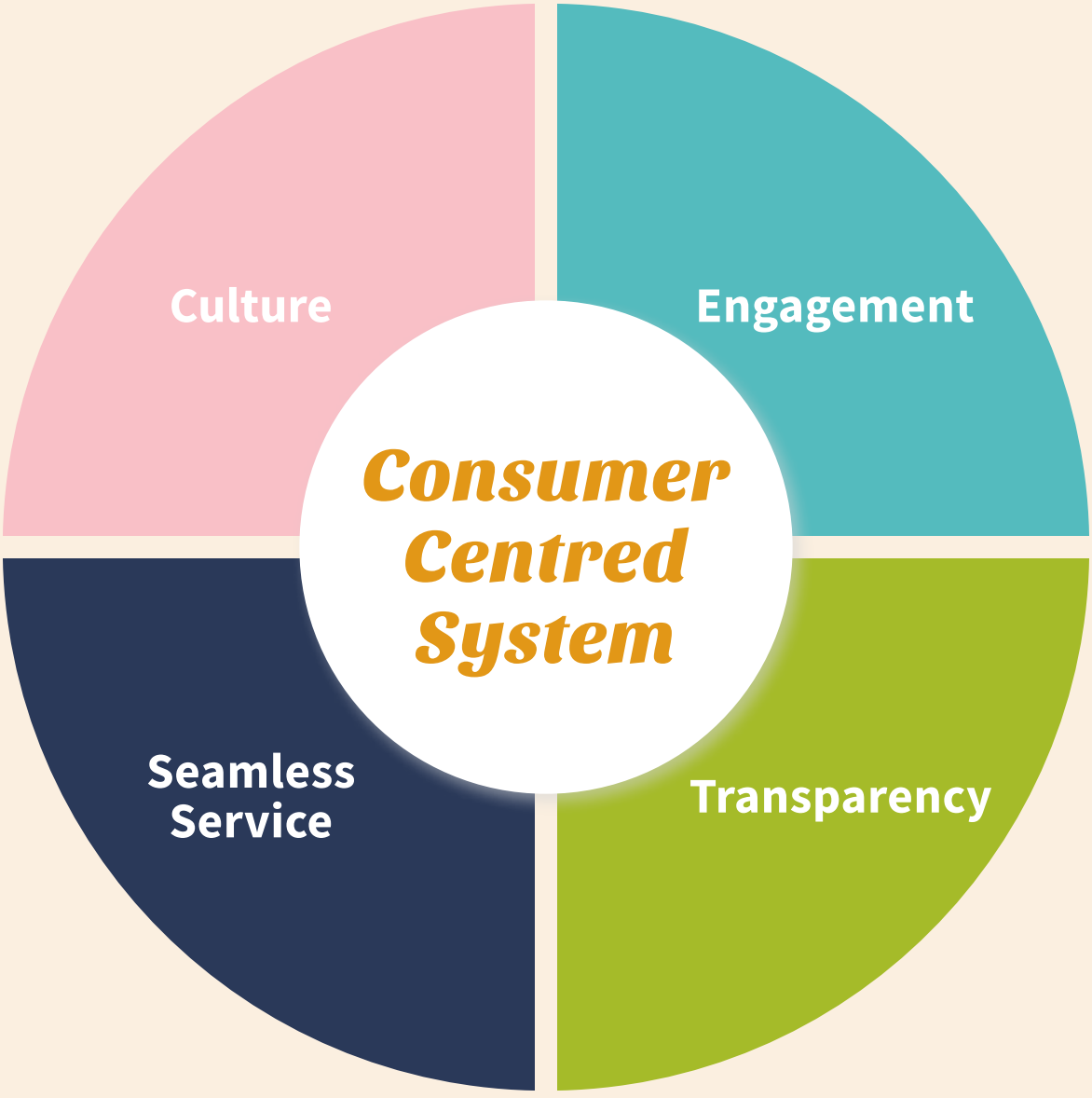
HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

ANNUAL REPORT FOR THE YEAR ENDED 30 JUNE 2019


Culture
Engagement
Consumer Centred System
Seamless Service
Transparency

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

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PO Box 1791, Auckland 1140

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

30 October 2019

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 2019.

Yours faithfully

Anthony Hill
Health and Disability Commissioner

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Commissioner's foreword

Anthony Hill

Health and Disability Commissioner

This has been a busy, successful year for the HDC. We have closed more complaints than ever before — almost 2,400 — and in doing so, we have helped to ensure the promotion and protection of the rights of people who use health and disability services in New Zealand.

Through the resolution of each individual complaint, HDC enables the people involved to understand and learn from what happened, and reduces the likelihood of the same thing happening to someone else. In 2018/19 HDC made recommendations for change and/or educational comment on 448 complaints, and 99% of our recommendations were complied with, ensuring that providers are held accountable for making change.

Learning from complaints also goes beyond those directly involved. Every complaint is an opportunity to learn, and by looking at what we see across complaints, HDC has a unique perspective on New Zealand's health and disability sector. To make the sector stronger for all of us we share that information and encourage providers to learn from it. For example, in 2018/19 HDC published a report on the contributing factors commonly seen in complaints about medication errors and the lessons that can be learnt from these events.

HDC is independent — of complainants, providers, and of government policy. When assessing a complaint we listen to every side of the argument, seek clinical advice if required, weigh up the evidence, and make an impartial decision. That independence and impartiality is critical to allow us to be an effective watchdog. Notwithstanding the necessary distance we need to maintain from the people involved in a complaint, I would like to thank everyone who contacted us with their concerns this year. It takes courage to complain, but by contributing to a stronger sector overall, each individual complaint is part of making a wider positive impact. I would also like to acknowledge those providers of services who have responded to complaints with an open and willing attitude to listen and a commitment to improving their services.

HDC is under pressure. There is an overall trend of rising complaint numbers. Between 2015/16 and 2017/18 we received an unprecedented 28% increase in the number of complaints received, and during 2018/19 we have continued to feel the impact of this. We have adapted and become even more efficient, and I am incredibly proud of the work of our team. The average time to closure for complaints is four months, and nine out of ten are closed within nine months. In light of this pressure and changing societal expectations of watchdog agencies, we have been looking at our processes and how we can make the best impact with the work we do. I look forward to seeing those projects come to fruition in the year ahead.

HDC stands in the margins where things do not go well. However, it is important to acknowledge that much has changed for the better since the Cartwright Inquiry, which prompted the establishment of the HDC in 1994, and over the past 25 years New Zealand has moved toward a health and disability system that has consumers of services firmly at its centre.

That said, we continue to see common themes recurring in complaints, which is both a concern and a reminder that we must stay ever vigilant in ensuring people's rights are upheld. The issue

> "Each individual complaint is part of making a wider positive impact."

of informed consent, which lay at the heart of the Cartwright Inquiry and is the cornerstone of the Code of Health and Disability Services Consumers' Rights (the Code), continues to be raised in complaints to HDC. In one case I considered this year, a midwife pretended to give a woman in labour pain relief when in fact the midwife was giving only saline. She told her colleagues that she believed in the placebo effect. In undertaking such an action, the midwife ignored the fundamental importance of consent. The midwife's conduct was dishonest, and displayed a concerning degree of paternalism. I found the midwife in breach of the Code and referred her to the Director of Proceedings, who decided to take proceedings in the Health Practitioners Disciplinary Tribunal.

Maternity

Looking at maternity services more broadly, some recurring issues appear in the complaints we assess. The most common of these are the failure by lead maternity carer midwives to follow Ministry of Health guidelines for when a woman should be referred to a specialist, and inadequate fetal heart rate monitoring and interpretation by both obstetricians and midwives. The referral guidelines provide an essential safety net for pregnant women and their babies, and support and guide midwives in the primary to secondary care interface. Used consistently, these guidelines ensure that every woman receives specialist input when necessary, and the information she requires to make an informed choice about her care. I have raised both these issues with the sector and liaised with relevant professional bodies, including the Midwifery Council, the College of Midwives, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Ministry of Health in regard to the quality improvement work that is being undertaken in these areas.

Diagnosis of cancer in primary care

Another issue that continues to appear in the complaints we receive is the delayed diagnosis of cancer in primary care. Cancer can be difficult to diagnose, but our data shows that there is an opportunity for GPs to focus, in particular, on making appropriate referrals and communicating effectively with specialists when they do; ensuring that all relevant patient history is taken, reviewed and considered; conducting clinically indicated examinations and tests; providing appropriate safety-netting advice; and considering all relevant differential diagnoses. In a case I closed this year, I found a GP in breach of the Code for inadequate care provided to a woman who was later diagnosed with bowel cancer. The GP failed to order the appropriate tests, failed to carry out the appropriate examinations, and did not refer the patient in a timely manner. Often these cases can reflect a failure to get the basics right — to read the notes, ask the questions, and talk to the patient. While these things may not be difficult to do, they can be easily overlooked in the context of a busy practice. However, patients rely on healthcare providers to do these things right, every time.

While I am aware of the stress time-poor GPs can face, it is vital to remember that pressure on the health system does not relieve providers of their duties under the Code. This is true both in primary and secondary care.

Prioritisation

This exact issue is reflected in an investigation into urology services at a district health board (DHB) that I considered this year. I initiated an inquiry into the service, which resulted in a finding that the DHB had breached the Code after it became apparent that there were lengthy delays in the assessment and treatment of patients, and consequently a substantial clinical risk. It is important — and particularly so when services are under pressure — that DHBs have effective mechanisms in place to monitor waiting times and prioritise patients appropriately. The investigation also highlighted the critical impact an organisation's culture and leadership can have. In this case, individual relationships had become so strained that it was affecting the delivery of services, and delays had become accepted as normal. At all times it is vital that leadership is integrated. Collaborative and mutually accountable relationships between clinicians and executive management have a central role to play in the effective delivery of services.

Mental health and addictions

This year has had a significant focus on mental health and addiction services, especially with the announcement of *He Ara Oranga*, the report of the Government Inquiry into Mental Health and Addiction. In his monitoring and advocacy role, Mental Health Commissioner Kevin Allan supported the Inquiry and provided information from the findings and recommendations in his 2018 monitoring and advocacy report. Both he and I have gone on to provide advice to the Minister and the Ministry on areas we see as key to ensuring a strong and long lasting transformation in New Zealand's mental health and addiction sector.

Advocacy

Throughout the year the independent Advocacy Service has continued to play an important role in helping people to resolve complaints directly with their provider, and HDC entered into a new contract with the National Advocacy Trust for a further five years, commencing on 1 July 2018. While not all complaints are suitable to be resolved with the help of the Advocacy Service, for the many thousands that are, this is often an excellent way for both sides to hear and understand what happened, how it affected the complainant, and what the provider can change as a result. This is an especially helpful method of resolving complaints when the relationship between the complainant and provider will be ongoing. I would like to thank and acknowledge the advocates who work throughout the country helping New Zealanders.

I would also like to acknowledge our Consumer Advisory Group for the invaluable perspective it brings to our work. And finally, thank you to the staff of the Office of the HDC. You bring great diligence to the work you do, with a focus on wanting to make things better for your fellow New Zealanders.

1.0 The year in review

2,392 Complaints closed

3,733 Enquiries responded to

2,350 Complaints received

102 Investigations completed

77% Closed within 6 months

99% Full compliance with HDC's quality improvement recommendations

32 Educational sessions

4 Complaints resolution workshops delivered

56 Decisions published

2,720 Complaints to Advocacy

2,644 Complaints closed

3,803 Networking visits and meetings

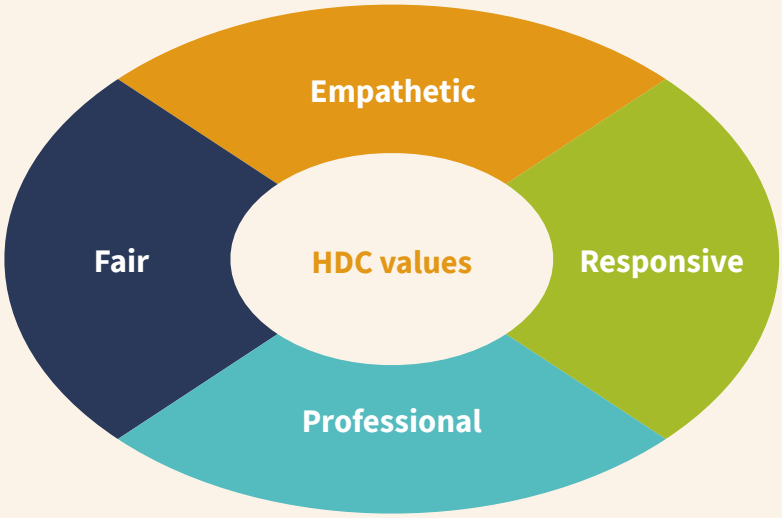
1,681 Education sessions provided

100% of HRRT proceedings found a breach of the Code

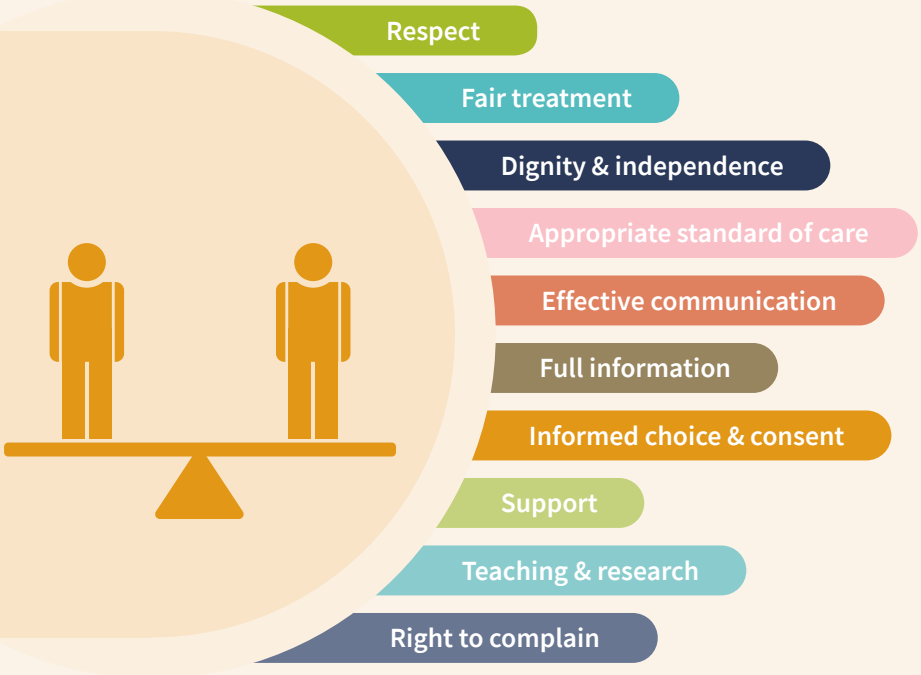
128 stakeholder events attended by the Mental Health Commissioner

2.0 Who we are

The Health and Disability Commissioner promotes and protects the rights of people who use health and disability services. HDC's independence — from providers, from consumers, and from government policy — is critical to enable us to be an effective watchdog.



10 Consumers' rights



The code

People's rights are set out in the Code of Health and Disability Services Consumers' Rights, which applies to all health and disability service providers.

HDC resolves complaints about those rights, holds providers of services to account, and uses the findings from complaints for quality improvement, both at the individual level and for the wider health and disability system.

What we do

Complaints Resolution

HDC's central function is to assess and resolve complaints. There are a number of options for resolving complaints, focusing on a fair and early resolution.

Advocacy

The Advocacy Service plays an important role in supporting people to resolve their complaints directly with the provider, and promotes the Code through local networking and community-based education.

Proceedings

HDC can refer a provider found in breach of the Code to the Director of Proceedings (an independent statutory role), who will decide whether or not to take proceedings against that provider.

Mental Health Monitoring and Advocacy

The Mental Health Commissioner monitors and advocates for improvements to mental health and addiction services.

Education

HDC delivers education and training initiatives to improve providers' knowledge of their responsibilities under the Code.

Disability

The Deputy Commissioner, Disability has a particular focus on promoting awareness of, respect for, and observance of, the rights of disability services consumers.

HDC's funding

HDC is funded under the Monitoring and Protecting Health and Disability Consumer Interests Appropriation in Vote Health. This appropriation is intended to protect the rights of people who use health and disability services. This includes addressing the concerns of whānau and appropriately investigating alleged breaches of consumers' rights. HDC received $13,370,000 from this appropriation in the year ended 30 June 2019 to fund six output classes as set out in the Statement of Performance. Despite the high demand for HDC's services, and HDC's record output for complaints resolution, a surplus was still delivered. This was due to a focus on continuing to achieve more with our limited resources, and an additional one-off $500,000 of funding received from the Ministry of Health at the end of the financial year.

HDC's Executive Leadership

Anthony Hill
Health and Disability Commissioner

Kevin Allan
Mental Health Commissioner & Deputy Commissioner

Meenal Duggal
Deputy Commissioner, Complaints Resolution

Rose Wall
Deputy Commissioner, Disability

Jessica Mills
Director of Advocacy
(Independent statutory role, reports to the Deputy Commissioner, Disability)

Kerrin Eckersley
Director of Proceedings

Jane King
Associate Commissioner, Legal

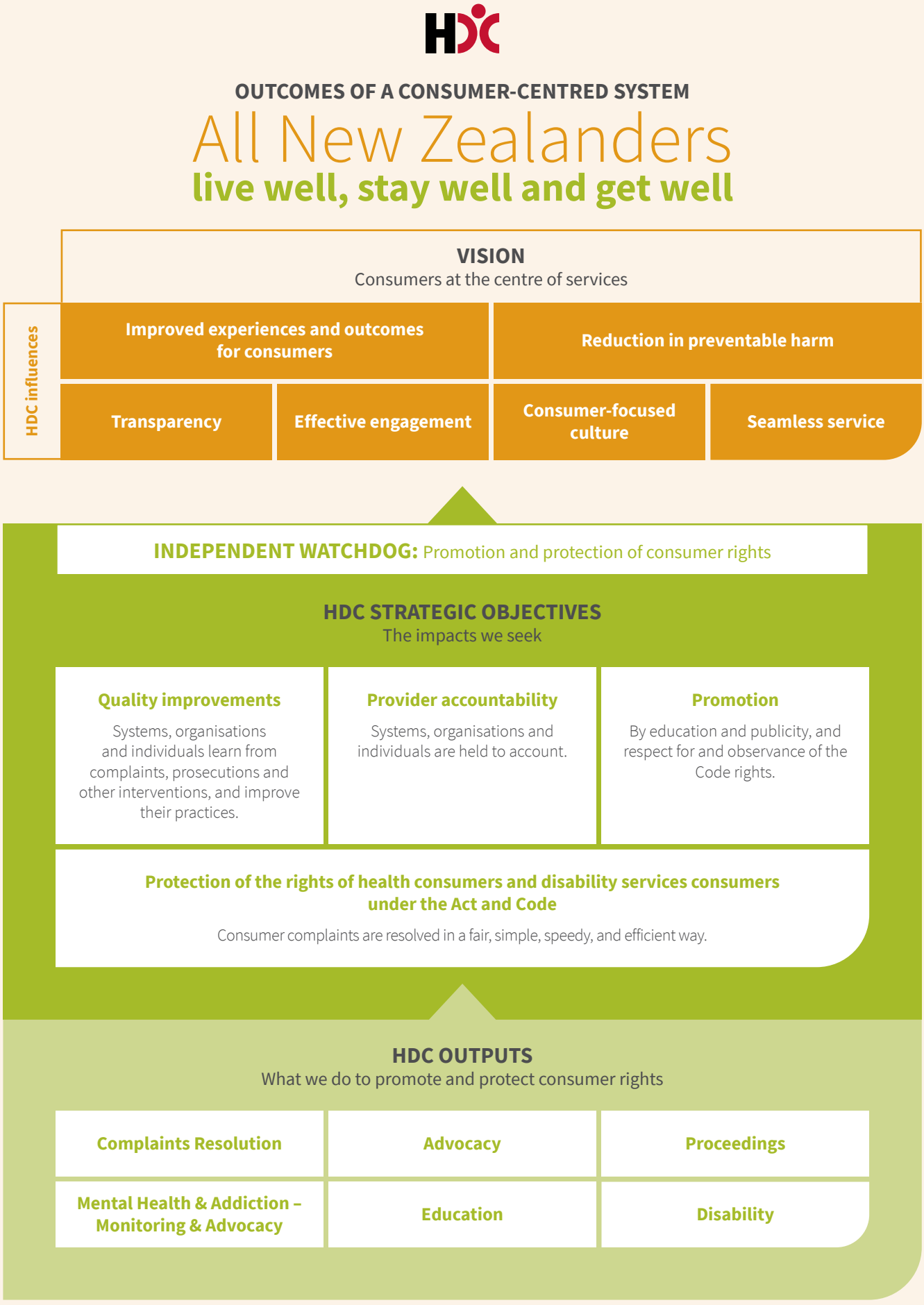
Dr Cordelia Thomas
Associate Commissioner

Mark Treleaven
Associate Commissioner, Investigations

Jason Zhang
Corporate Services Manager

3.0 Delivering HDC's strategy

Figure 1: HDC's strategic objectives and vision



HDC's strategic objectives

HDC's vision is that consumers are at the centre of services. Consumer-centred services are characterised by transparency, engagement, seamless service, and a culture that supports the consumer-centred vision. In this model, people are fully engaged in their own care, they and their families are listened to, providers and services work effectively and respectfully together at all levels, and information is shared freely. In a consumer-centred system the Code is upheld.

HDC's strategic intent is to promote and protect the rights of consumers as set out in the Code. By doing this, we aim to maximise the well-being that people experience when they use health and disability services, and to reduce preventable harm. Four strategic objectives underpin our strategic intent:

1. **Protection of the rights of consumers of health and disability services**
   HDC is New Zealand's independent watchdog for the rights of people who use healthcare and disability services. HDC's primary vehicle for protecting those rights is by resolving complaints about those services. Resolving complaints holds providers to account, encourages quality improvement, and promotes the rights set out in the Code. HDC has a number of options for resolving complaints, focusing on fair and timely resolution. In addition to resolving complaints, HDC can take action in response to issues of concern that arise out of individual complaints, complaint trends, or at the Commissioner's initiative.

   In 2018/19:

   - HDC received 2,350 complaints
   - HDC closed 2,392 complaints — more than ever before
   - The Advocacy Service closed 2,644 complaints
   - HDC closed 62% of complaints within 3 months, 77% within 6 months, and 92% within 9 months
   - The Advocacy Service closed 83% of complaints within 3 months, 99% within 6 months, and 100% within 9 months
   - 91% of consumers and 93% of providers who responded to surveys were satisfied or very satisfied with the Advocacy Service's complaints management process

2. **Quality improvement**
   Every complaint is an opportunity to learn, and the motivation for many complainants is change to services, so that what happened to them does not happen to someone else. In response to complaints, HDC makes numerous educational comments and recommendations for change. In this way, people and the systems in which they work are held to account — individuals learn, systems are improved, preventative action is taken, and the rights set out in the Code are protected. To ensure that what is learnt from complaints is disseminated widely, HDC publishes anonymised reports of the investigations that find a breach of the Code, and holds education sessions for providers. HDC also produces research reports to help the health and disability sector to learn from the patterns that emerge across complaints.

   In 2018/19:

   - HDC made recommendations for change or educational comment on 448 complaints
   - Providers complied with 99% of HDC recommendations that were due
   - HDC provided DHBs with two six-monthly complaint trend reports, which DHBs said were useful for improving services
   - HDC published a research report into medication error

> "Resolving complaints holds providers to account, encourages quality improvement, and promotes the rights set out in the Code."

3. **Provider accountability**
Holding providers to account, through resolving complaints, is an essential protection in a country where medico-legal litigation is largely unavailable. Providers can be held to account in various ways — the simple fact that accountability mechanisms exist helps to drive change and quality improvement at an individual and wider system level. The hundreds of recommendations HDC makes hold providers to account and encourage change. For the most serious breaches of the Code, HDC will refer providers to the Director of Proceedings to consider disciplinary or other legal action.

In 2018/19:

- HDC completed 102 investigations
- HDC made 77 breach findings
- HDC referred 9 providers to the Director of Proceedings
- 100% of Human Rights Review Tribunal proceedings (3 of 3) found a breach of the Code
- Resolution by negotiated agreement was achieved in 100% (3 of 3) of proceedings

4. **Promotion, by education and publicity, and respect for, and observance of, the Code rights**
Understanding their rights helps people to advocate for themselves and to seek support when they need it. Understanding their duties encourages providers to design and deliver consumer-centred services.

In 2018/19:

- HDC responded to 3,733 enquiries, and the Advocacy Service responded to over 12,000 enquiries, helping people to understand their rights under the Code
- HDC delivered 32 education sessions; 100% of respondents reported that they were satisfied or very satisfied with each session
- HDC facilitated 3 regional seminars for people who use disability services, with an average respondent satisfaction rate of 98%
- The Advocacy Service provided 1,681 education sessions; 88% of respondents were satisfied with the session they attended

“Understanding their rights helps people to advocate for themselves and to seek support when they need it.”

4.0 Performance on key functions

HDC achieves its strategic objectives through six key functions

4.1 Complaints resolution

Resolving complaints is central to HDC's role in promoting and protecting the rights of people who use health and disability services. HDC aims to resolve each complaint in a fair and timely manner, and a number of options are available to help us to achieve this.

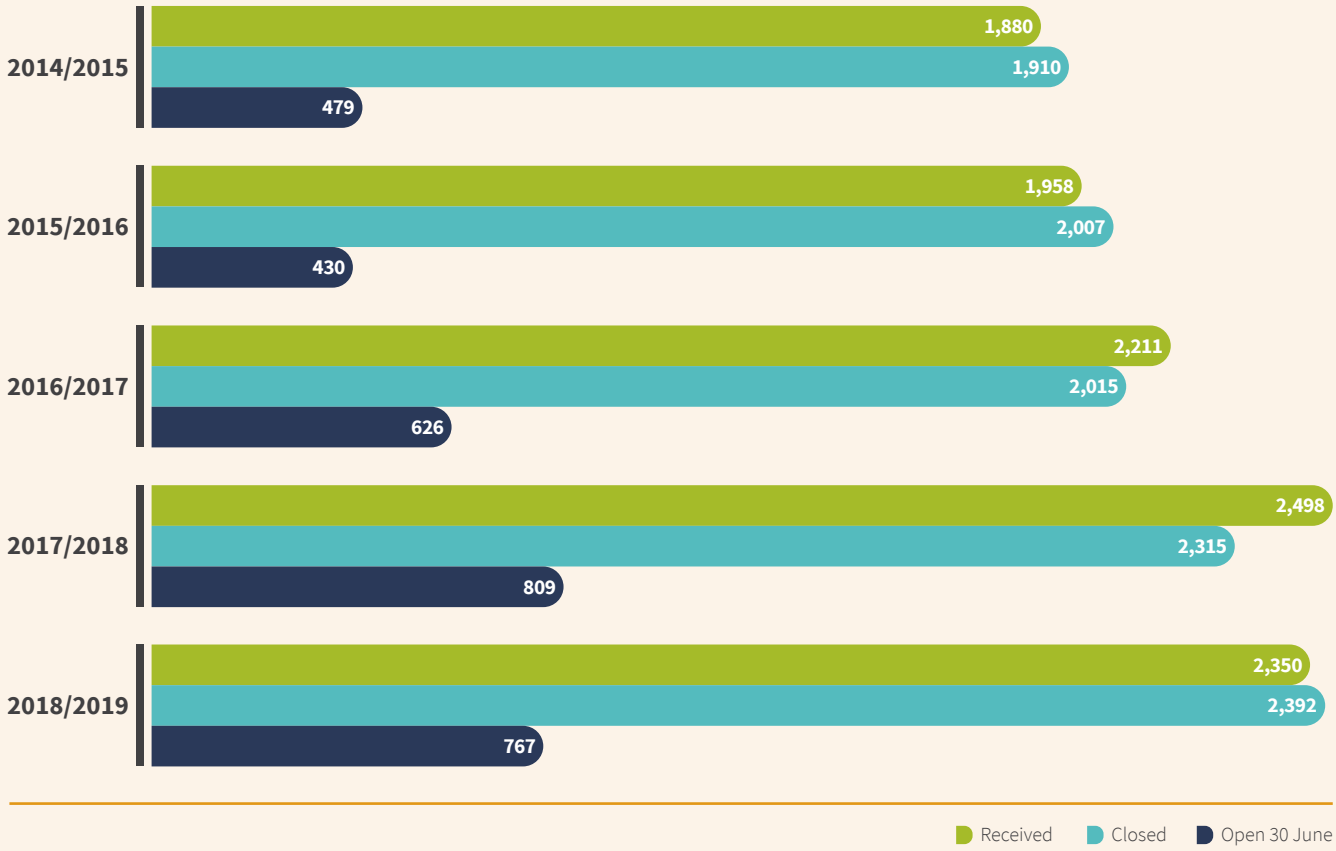
Complaints received and closed

In 2018/19, HDC received 2,350 complaints. Although this was a slight decrease on the number received in the previous year, the overall trend is increasing. Between 2015/16 and 2017/18 HDC received an unprecedented 28% increase in the number of complaints.

This increase could be due to a number of factors, including the improved accessibility of the complaints process, increasing public knowledge of consumer rights, and increasing health service activity. Similar agencies overseas are also experiencing an increase in complaint numbers. HDC closed 2,392 complaints in 2018/19 — more than in any previous year.

Complaints received and closed

Figure 2: Complaints received and closed from 1 July 2014 to 30 June 2019



Issues complained about

Issues complained about have remained consistent over the last four years. Misdiagnosis and inadequate treatment are the most commonly complained about primary issues, with around 9% of complaints each year being primarily about these issues. Primary issues are those that were of most concern to the complainant, and do not represent all issues complained about, and will not necessarily have been substantiated subsequently, factually or clinically.

Complaints received by HDC can raise a number of issues. When all issues raised in complaints are considered — not just primary issues — the most common complaint issue categories in 2018/19 were:

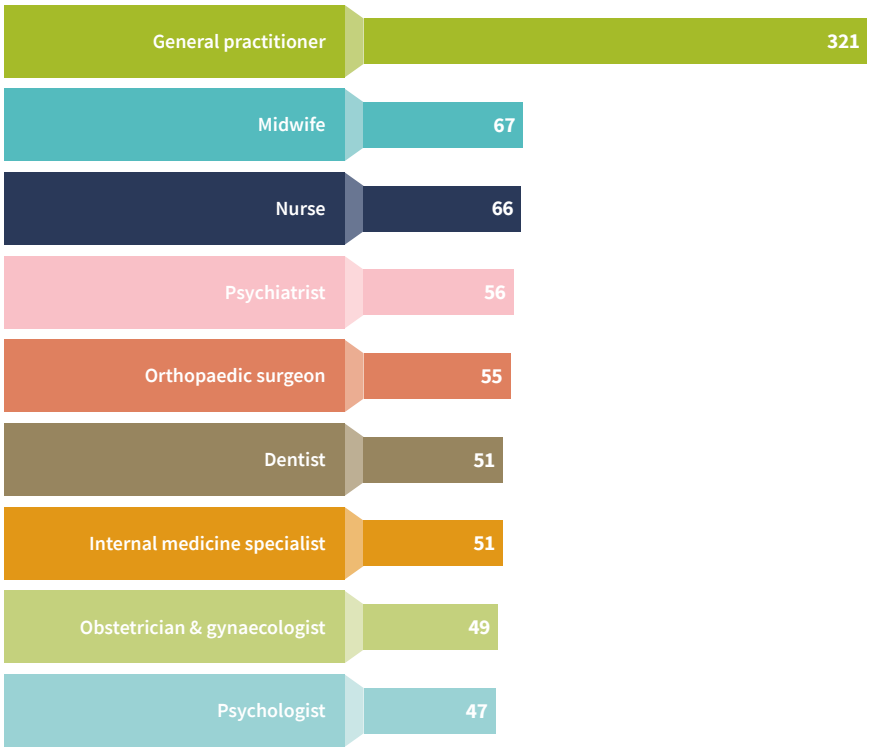
- Care/treatment (64%)
- Communication (54%)
- Access/funding (16%)
- Consent/information (15%)

This is similar to what has been seen in previous years. The fact that communication continues to appear as an issue in 54% of complaints to HDC indicates that although people may be complaining about a care or treatment issue, they also feel that the manner of communication with them about that issue was lacking. This highlights the importance of clear and compassionate communication with people and their families.

Figure 3: Complaints received — commonly complained about primary issues in 2018/19

> “Communication continues to appear as an issue in 54% of complaints to HDC... This highlights the importance of clear and compassionate communication with people and their families.”

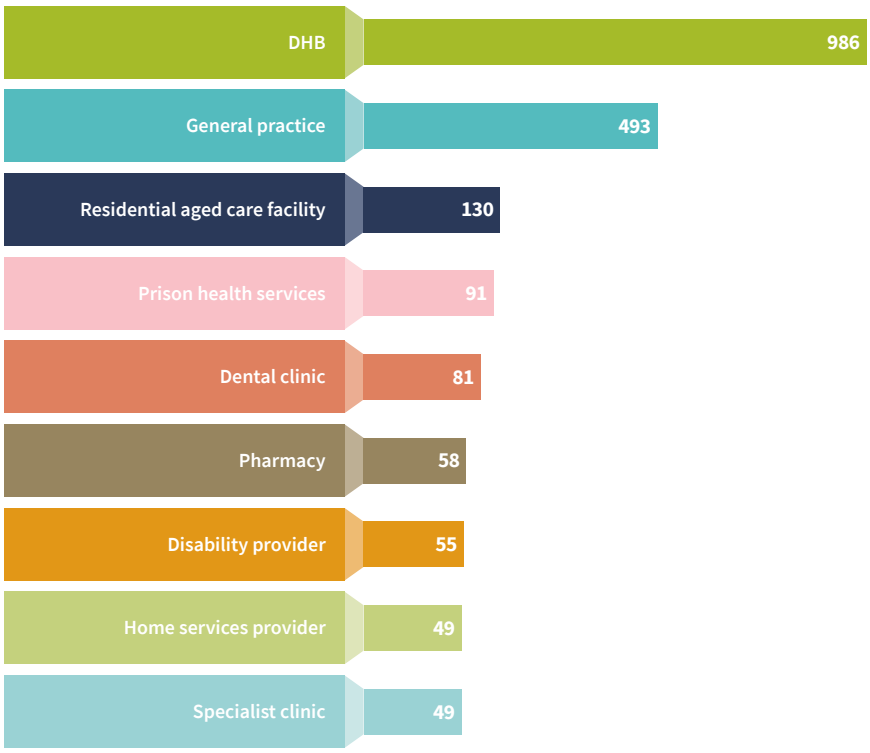
Figure 4: Complaints received — commonly complained about individual providers in 2018/19



Providers complained about

Complaints can be about individuals and group providers, and it is not uncommon for more than one provider to be named in a single complaint. GPs and DHBs provide the majority of health care in New Zealand, and this is reflected in complaints to HDC, with GPs being the most commonly complained about individual provider, and DHBs the most commonly complained about group provider.

Figure 5: Complaints received — commonly complained about group providers in 2018/19



How HDC resolves complaints

Each complaint received by HDC is assessed and resolved in the most appropriate manner, bearing in mind the issues raised and the evidence available. The preliminary assessment process is thorough and can involve a number of steps, including obtaining a response from the provider, seeking independent clinical advice, and asking for information from the complainant or other people.

HDC has a wide discretion as to what action is taken after the preliminary assessment process is complete. This includes referring the complaint to the Advocacy Service or to the provider for direct resolution between the parties. Both the Advocacy Service and providers are required to report back to HDC on the outcome of these referrals, ensuring that people's concerns have been addressed appropriately.

In other situations the initial assessment may indicate that a provider's actions were reasonable in the circumstances, or that the matters at issue in the complaint have been addressed appropriately by HDC making an educational comment or recommendations for change to a provider's systems or procedures to reduce preventable harm. In these cases, the complaints are closed under s38(1) of the Health and Disability Commissioner Act 1994 (the Act), which gives HDC broad discretion to take no action or no further action on a complaint.

As well as often including educational comments or recommendations for change, these decisions can also include recommendations that a provider apologise to a complainant and, in some cases, encourage the parties to meet.

In this way, the HDC complaints process enables people to receive an explanation of the care provided, an apology, and assurances that what happened to them will not happen to someone else. This reflects the motivation for many of the people who lay a complaint.

In some cases, HDC carries out a further formal investigation of a complaint, which may result in a provider being found in breach of the Code. The general focus of investigations continues to be on more serious departures from accepted standards of care, allegations of breaches of ethical boundaries, public safety concerns, and where there is potential for significant positive change as a result. HDC's powers to investigate are used where they can have greatest effect.

Table 1: Outcome of complaints closed in 2018/19

Outcome	Number of complaints
Investigation	**102**
Breach finding	77
Referred to registration authority	2
No breach finding with adverse comment and recommendations	22
No breach finding	1
Other resolution following assessment	**2,176**
No further action with recommendations or educational comment	349
Referred to registration authority	83
Referred to other agency	68
Referred to provider to resolve	525
Referred to Advocacy Service	273
No action/no further action	784
Withdrawn	94
Outside jurisdiction	**114**
TOTAL	**2,392**

EXAMPLES OF CASES CLOSED UNDER S38(1)

Improving communication from fertility service

A woman undergoing fertility treatment complained to HDC about the quality of communication by her provider.

In particular, she was concerned that she was given incorrect advice via text message about the dosage and timing of her medication. HDC assessed her complaint and found that although the information in the text message had been incorrect, she was given the correct advice in person and on paper. The Deputy Commissioner recommended that the provider develop additional measures to reduce the risk of such an error happening again.

As a result, the provider changed its process so that its text message template prompts staff to consider various options, and is reviewed by an embryologist before it is sent out.

Improving triaging of children and advice to patients at a medical centre

A father complained to HDC about the care an after-hours medical centre provided to his son for a fractured arm.

In particular, he was concerned that it had taken nearly two hours to see a doctor. Having obtained clinical advice, HDC determined that the medical centre had used a pain scale that was inappropriate for children, and that this resulted in the boy not being triaged appropriately. HDC also had concerns about the follow-up advice.

The Deputy Commissioner recommended that the medical centre provide further education to nurses on the triaging of children, and develop guidelines for staff regarding the provision of safety-netting advice and follow-up of patients who leave the clinic before being seen by a doctor. The medical centre promptly complied with the recommendations.

Referral for resolution between the parties

Many of the complaints HDC receives involve communication issues, and can best be resolved by the service provider and the person who complained communicating directly with each other, so that what happened can be explained and the impact on the person understood. It helps for people to hear an explanation about what happened to them, and sometimes it can be very helpful if the service provider directly acknowledges how the experience affected the person and their family, and explains any changes being made. This may be a suitable resolution option when the complaint does not raise serious clinical or conduct issues, the health and safety of the public is not at question, and the provider has the processes in place to respond to and address the complainant's concerns. This option can help to rebuild relationships where ongoing services will be provided.

In these circumstances, HDC may refer the complaint to the provider to resolve it directly with the complainant, or to the Advocacy Service. An advocate can guide a person to clarify the issues and the outcomes he or she is seeking, and give the provider the opportunity to respond openly and directly to the person's concerns. The advocacy process has a high satisfaction rate.

The Advocacy Service reports back to HDC on the outcome of any referral, and HDC retains oversight of complaints referred to the provider by reviewing the actions the provider took in response.

New protocol for deaf clients

A deaf man contacted HDC via the NZ Relay Service after a private radiology service declined his request to arrange a sign language interpreter for him.

When HDC asked the service provider to respond to the complaint, the provider said that it intended to create a protocol for deaf clients, and HDC referred the complaint to the Advocacy Service to help the man to resolve his concerns.

An advocate contacted the man via Skype, with the assistance of a New Zealand sign language interpreter. The man said that he wanted the radiology service to confirm that it had created a protocol, or to provide a clear timeframe in which a protocol would be created.

The provider sent the man a copy of the new protocol, and indicated that it would be happy for the man to make amendments if necessary. The provider apologised and said that the complaint had provided a learning experience for them, and thanked the man for that. The man accepted the protocol, acknowledgement, and apology, and considered the complaint to have been resolved.

Clearer instructions to plan for appointments

A woman complained to HDC about having to pay for a taxi to and from an eye appointment.

She thought that she would not be able to drive after the appointment, based on the information she had from the DHB. However, as it transpired, she could have driven herself. As the woman wanted her costs reimbursed, HDC decided to refer the complaint to the DHB for a response.

The DHB paid the cost of the taxis and reviewed its template letter so that instructions would be clearer for people in future.

Information from GP clinic

A woman visited her GP clinic after she miscarried early in her pregnancy.

She was told that she would need regular blood tests, and to call the clinic to check her results, but was given no explanation about why this was necessary. In subsequent interactions she had with the clinic, it was apparent that some staff did not know that the woman had miscarried. Given her ongoing relationship with her general practice, HDC decided to refer the matter to the practice for resolution.

As a result, the provider met with the woman to apologise for the poor quality of care she received. The nurses involved were reminded about the importance of effective communication and empathy for patients in distress. The clinic also reviewed its processes to ensure that sufficient information about the reason for tests is given to patients who have suffered a miscarriage.

Other ways to resolve complaints

In some instances, HDC will refer complaints to a regulatory authority, such as the Medical Council. HDC may also refer complaints to other agencies, such as the Office of the Ombudsman or the Office of the Privacy Commissioner, when those agencies are better placed to consider the concerns raised in the complaint.

EXAMPLE OF CASE REFERRED TO ANOTHER AGENCY

Referral to the District Inspector

A man complained about having been placed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

HDC referred the complaint to a District Inspector, as this was considered more appropriate for the man's concerns. District Inspectors are lawyers appointed by the Minister of Health under the MHA to receive and investigate complaints by people subject to compulsory assessment and treatment about alleged breaches of their rights under the Act, and other matters relating to their care and treatment under the Act.

Recommendations to providers

In 2018/19, HDC made recommendations and/or educational comment on 448 complaints. Recommendations are a way of strengthening the health and disability system for all New Zealanders, and helping providers to learn from complaints and reduce preventable harm in future.

Recommendations can include clinical audits, changes to policies or processes, additional education or training, and ensuring that recommendations from other reviews such as a DHB's own adverse event review are implemented. Often HDC will also ask providers to report back on the effectiveness of any changes made.

HDC actively monitors compliance with its recommendations. In 2018/19, recommendations were fully complied with in 99.3% of cases. In the two cases of non-compliance, one provider was referred to the appropriate regulatory body, and the other to its parent organisation.

EXAMPLES OF RECOMMENDATIONS FOR CHANGE

Improving access to prison health services

A prisoner complained to HDC regarding the lack of a timely assessment for his injured foot.

After obtaining clinical advice, HDC recommended that staff be trained on the assessment and treatment of soft tissue injuries. The prison was also asked to report back to HDC on any other quality improvement work being undertaken as a result of the complaint, and on any initiatives to enhance prisoners' access to healthcare services, one of which was a decision to increase Medical Office hours in the prison by 30%.

Monitoring fluid balance and nutrition

The family of an elderly woman living in a rest home complained to HDC after she was admitted to hospital with dehydration.

During assessment of the complaint, HDC obtained clinical advice from a nurse, who advised that the woman's fluid balance had not been monitored adequately. The Deputy Commissioner recommended that the rest home review its processes for monitoring at-risk residents. HDC also notified the Ministry of Health and the appropriate DHB about the complaint.

As a result, the rest home developed a new policy to ensure that residents who do not consume the required amount of food and fluids are referred to the appropriate clinician. Furthermore, the rest home changed its clinical governance model, provided new training to staff, and conducted an audit to ensure that nutritional intake is being reported by all staff.

Consistent information for parents of babies with tongue tie

The mother of an eight-day-old baby was finding breastfeeding difficult.

A lactation consultant visited the family at home, identified a tongue tie, and offered to perform a frenotomy, which involves cutting the thin piece of skin under the tongue. She explained the procedure but did not discuss alternatives or have any information leaflets with her. After the frenotomy was carried out, bleeding from the wound could not be stopped, and the baby underwent surgery to repair it. While a simple frenotomy is within the scope of practice for midwives who have completed specific training, the question of whether frenotomies should be performed at all on newborn babies has been debated widely, with no consensus on whether frenotomies should be carried out by specialists or other health professionals. Following an investigation, the Deputy Commissioner made a number of recommendations in regard to the lactation consultant, and also recommended that the Ministry of Health consider formulating a consensus position on the efficacy of frenotomies, and consider developing guidelines for the diagnosis and performance of frenotomies by midwives — work that is now underway.

Use of restraint in aged care

HDC found that the care provided to an 80-year-old man in the psychogeriatric unit of an aged care facility was deficient.

One aspect of the poor care was that the man was restrained with a lap belt for several hours on ten occasions over nine days by different staff. Documentation of the restraint and consent was not completed adequately or in accordance with the facility's policy. Following an investigation, the Deputy Commissioner recommended that the facility provide further training for all staff on the NZS 8134.2.2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards. The facility was also required to undertake an audit of the restraint use consent forms that were completed within the previous six months, to see whether the forms had been completed in line with the facility's policy.

Treatment of tetraplegic patient with lumbar pain

A woman who had partial tetraplegia as a result of an accident suffered many years previously sought treatment from an osteopath for a lumbar sprain and a lower back injury.

The woman explained that she had a spinal cord stimulator and a baclofen pump in situ. Within an hour of the fifth treatment, she developed severe pain in her right sacroiliac joint and lumbar spine. The osteopath did not

EXAMPLES OF RECOMMENDATIONS FOR CHANGE (CONTINUED)

undertake research to remedy his gap in clinical knowledge regarding treatment of people with tetraplegia, and recommended acupuncture treatment and for the woman to apply ice to the affected area. Following an investigation, the Deputy Commissioner recommended that the Osteopathic Council consider whether a review of the osteopath's competence was required, and that he write an apology to the woman. In response to recommendations from HDC, the osteopath arranged for an independent peer to audit his documentation to ensure that it is sufficiently comprehensive in relation to case histories and examination findings, and he provided the results of the audit to HDC. The osteopath also arranged for regular mentoring from a senior colleague.

Co-ordination between mental health and addiction services

Following an investigation, the Mental Health Commissioner found that a DHB had focused on addressing a woman's alcohol and addiction issues, but that the same level of attention was not given to her mental health issues or to integrated, ongoing risk assessment.

It was recommended that the DHB review and update its Service Provision Framework to ensure that it explicitly clarifies and documents the transfer processes between services; the Community Alcohol and Drug Service (CADS) criteria for acceptance; and the CADS telephone screening process.

Evidence of changes made was requested, and details of any other improvements to the interaction between Crisis Resolution (formerly Psychiatric Emergency Service), CADS, and the Alcohol and Other Drug Co-ordination Services.

Improving documentation of care plans

A DHB did not fully complete a Patient Admission to Discharge Plan (PADP) on the day of a woman's admission for ongoing treatment and management of lymphoma, which meant that there was inadequate baseline information.

Subsequently, the plan was not updated accurately. Following a fall, full assessments of the woman's condition were not completed adequately, her changing condition was not monitored accurately, and there was an unacceptable delay in communicating with her family regarding the fall. In response to recommendations made by the Commissioner following an investigation, the DHB advised that it had conducted regular audits of staff compliance with PADP documentation, and that significant improvements had been made to staff training on the completion of PADPs. The DHB also advised that it will review the way in which the use of PADP documentation can support staff to assess an individual patient's needs and recognise deterioration. The Commissioner recommended that the DHB provide HDC with the outcome of the review, and send a letter of apology to the woman's family.

Paediatric observations in Emergency Department

A woman took her six-month-old son to the Emergency Department of a hospital on multiple occasions and was seen by a number of staff.

The Child Emergency Assessment Chart was not used appropriately, and staff did not consult with the Paediatric Service of a second hospital until the fourth presentation. Following an investigation, the Commissioner recommended that the first DHB undertake an audit of staff compliance with the Child Emergency Assessment Chart, and provide staff with training on making referrals to the Paediatric Service at the second hospital, and on taking and documenting observations for paediatric patients.

EXAMPLES OF RECOMMENDATIONS FOR CHANGE (CONTINUED)

Importance of clear communication between hospital teams

A man did not receive quality and continuity of services because of failures in communication and a lack of clear planning between the Orthopaedics and Plastic Surgery teams of a hospital.

The Commissioner recommended that the DHB update its policy on clinical documentation; consider implementing policies outlining when a patient should become a Plastic Surgery patient and when to undertake patient transfers between teams via the teams' consultants; reiterate to its Plastic Surgery and Orthopaedics staff the need to document communication pathways accurately; provide HDC with an update on the efficacy of its venous thromboembolism prevention pathway; and provide a written apology to the man's family.

Investigations

One option for resolving a complaint is to carry out an investigation, which may result in a provider being found in breach of the Code. During an investigation, relevant evidence is collected from the consumer, the provider or providers being investigated, and third parties. Often HDC will ask for independent clinical advice from a peer of the provider with experience in the matters under investigation. In some cases, clinical advice may be needed from several different fields or speciality areas.

After all the evidence has been assessed, the Commissioner or Deputy Commissioner forms a provisional opinion on whether or not the provider breached the Code. At that point, the complainant is given the opportunity to comment on the information gathered as part of the investigation, and the provider is given an opportunity to respond to any proposed adverse findings. After considering the responses, the Commissioner or Deputy Commissioner forms a final opinion.

This year, 102 investigations were completed, and in 77 of these it was found that a person's rights had been breached. Recommendations for change were made in all of these cases and, in another 22 cases, although the provider was not found in breach of the Code, the Commissioner was critical of the care provided and made recommendations for change. Two investigations were referred to the provider's registration authority, and one resulted in a no breach decision. As a result of the breach decisions this year, nine providers were referred to the Director of Proceedings to decide whether any further legal action should be taken.

“This year, 102 investigations were completed and in 77 of these it was found that a person's rights had been breached.”

CASE STUDY

Informed consent during labour

HDC investigated a midwife who gave a woman in labour intravenous saline as a placebo instead of pethidine. The midwife was the woman's lead maternity carer (LMC), and recorded in the birth plan that the woman would use pethidine for pain relief in labour if needed.

When the woman was in labour in hospital and requested the pethidine, the midwife instead drew up a syringe of saline. She told a student midwife and another hospital-employed midwife that she believed in the placebo effect, and was going to administer the fluid to the woman and tell her that it was pethidine. Over approximately two and a half hours, 10ml of saline was administered to the woman intravenously. The labour progressed slowly, and when the woman continued to be in pain she was given pethidine. After the woman left hospital, the midwife advised her that pethidine had not been given because of concerns about the safety of the baby.

The Commissioner found that by not providing the woman with the medication she had requested and agreed to receive, the midwife ignored the fundamental importance of consent, and breached Right 7(1) of the Code. It was the woman's right to make an informed choice about the pain relief she was to receive, and her right not to receive IV normal saline when she had not consented to this.

The principle of informed consent is at the heart of the Code. Services may be provided to someone only if that person makes an informed choice and gives informed consent. It is the person's right to decide, and in the absence of an emergency or certain other legal requirements, clinical judgement regarding best interests does not apply.

The midwife's conduct in misleading her client during labour by administering saline and telling her that it was pethidine was not only dishonest, but also showed a concerning degree of paternalism. This was demonstrated by comments she made to the student midwife about her relationship with her clients as being one of a parent and child.

Such behaviour by a midwife is an abrogation of the essential partnership between the midwife and her client, which lies at the centre of the midwifery model in New Zealand. The midwife contravened the standards set out in the Midwifery Council's code of conduct, which states that midwives are expected to work in partnership with women, to act with integrity, and to be open and honest. Accordingly, the midwife breached Right 4(2) of the Code.

The Commissioner recommended that the midwife undergo further training in the Code of Rights, informed consent, and communication with clients, and that the Midwifery Council of New Zealand consider whether she should undergo a competency review. He also recommended that she provide a written apology to the woman.

The midwife was referred to the Director of Proceedings for the purpose of deciding whether any further legal action should be taken.

(Case 18HDC01578)

CASE STUDY

Poor pattern of care across DHB services

A woman with severe abdominal pain was assessed at a hospital Emergency Department. She was admitted and had surgery for a perforated bowel, but did not survive. An HDC investigation found there had been a pattern of poor care by the DHB between the time of the woman's admission and her surgery.

At 4.46am, nearly three hours after the woman's presentation to the Emergency Department, the results of a CT scan suggested enteritis of the bowel with perforation, which indicated that surgery was necessary. However, on assessment it was considered that the woman was stable clinically.

The Early Warning Score (EWS) chart, used to alert staff of deterioration, was not filled in during the early hours of the morning. When observations were taken at 5.15am, the woman's EWS was two, and although this should have triggered half-hourly vital sign observations and escalation to the doctor, this did not occur, and no further observations were recorded until 10.15am.

No beds were available in the surgical ward, so the woman was admitted to a medical ward — the Acute Assessment Unit. No observations were recorded on arrival.

Observations were taken at 10.15am, 10.39am, and 11.10am, at which point the woman was noted to be very unwell, and her health status was escalated to the anaesthetic registrar. Her EWS continued to rise, and she was taken to theatre at approximately 12.30pm.

During surgery, it was found that a part of the woman's bowel had slipped under a band adhesion that had formed during her tubal ligation some years ago. The bowel had become strangulated, and had perforated. The dead bowel was removed, but the woman's condition deteriorated further and she died the following day.

The HDC investigation found that during the time the woman was in hospital:

- There were poor staffing levels in the Acute Assessment Unit and lapses in communication between services.
- The handover policy was not followed; this meant that critical information about the woman was not transferred and staff were not aware of her potential to deteriorate rapidly.
- The Early Warning Score chart was not filled in and observations did not trigger the escalation in care that should have occurred.
- Documentation was poor.

These factors hindered the co-ordination and delivery of care. While individual staff held some responsibility for their failings, overall the deficiencies indicated a pattern of poor care across services. DHBs are responsible for the operation of the clinical services they provide, and can be held responsible for any service failures. They have a responsibility for the actions of their staff, and an organisational duty to facilitate continuity of care. This includes providing adequate support to staff in respect of the application of relevant policies, and ensuring that staff work together and communicate effectively.

The DHB was found in breach of Right 4(1) of the Code for failing to provide services with reasonable care and skill.

The Commissioner recommended that the DHB apologise to the woman's family. He also recommended that the DHB audit its services to ensure that its clinical handover tool is being used to transfer patient information between the Emergency Department and the Acute Assessment Unit. He further recommended that the DHB audit staff compliance with the Early Warning Score Policy in both the Emergency Department and the Acute Assessment Unit. He also asked the DHB to provide evidence that better education would be provided for junior doctors about when to contact an on-call consultant, and evidence that a dedicated surgical registrar would be available at night.

(Case 17HDC00419)

CASE STUDY

Inadequate health care for prisoner

A woman was diagnosed with irritable bowel syndrome before she went to prison. A few months after she arrived, she reported symptoms that included a burning throat, a sore right ear, an inability to hold down food, light-headedness, weakness, too much gas in her stomach, and acid in her mouth on waking.

Over approximately two months the woman continued to report health concerns relating to nausea, reflux, and vomiting by submitting health chits or attending the prison's nursing clinic. She was seen by nurses on a number of occasions. She was also seen by two different doctors and prescribed medications to decrease stomach acid production and to relieve nausea and vomiting.

The second doctor saw the woman after she had been in prison for around seven weeks, and he queried a diagnosis of inner ear inflammation. The next day, the woman reported black matter in her vomit, and a nurse scheduled her for review the following morning, at which point she was transferred to hospital. Investigations revealed advanced gastric cancer, and she died the following year.

A number of deficiencies were identified in the care provided to the woman, including a lack of appropriate assessment and physical examination, inconsistent documentation, and poor co-ordination of care. This indicated an environment that did not support staff adequately to do what was required of them. Staff individually and as a group failed to act on the woman's continued discomfort and escalating symptoms. The Department of Corrections failed in its responsibility to ensure that the woman received services of an appropriate standard, and, accordingly, was found to have breached Right 4(1) of the Code.

The Department of Corrections was referred to the Director of Proceedings.

The Deputy Commissioner found that the second doctor also breached Right 4(1) by not taking adequate account of the woman's symptom history, and by not performing an appropriate clinical examination. The nurse who responded to the woman's report of black matter in her vomit was also found to have breached Right 4(1), as the lack of urgency was considered to be seriously deficient care.

The Deputy Commissioner recommended that the nurse and the Department of Corrections provide a written apology to the woman's family. The second doctor had provided an apology in response to a recommendation in the provisional opinion.

In response to recommendations made in the provisional opinion, the Department of Corrections provided evidence of staff training on history taking, physical examination, and health assessment, and undertook to arrange staff education on commonly presenting health conditions. The Deputy Commissioner also recommended that the Department of Corrections conduct an audit of its documentation.

(Case 16HDC01703)

CASE STUDY

Inquiry into urology services

This year the Commissioner carried out an investigation he initiated into the urology services at a DHB, after it became apparent that there were lengthy delays in the assessment and treatment of patients, and consequently a substantial clinical risk.

In the investigation, HDC addressed four separate complaints, and in all cases found the DHB to have breached the Code for failing to provide services with reasonable care and skill.

For one man, the time taken for him to receive treatment was almost double the target timeframe, which was compounded by a failure to keep him informed about a likely date for his surgery.

Another man had an unacceptable delay in receiving treatment. He was graded as priority 3 (expected to be seen within six weeks), but he was not seen until over five months after his initial referral. It was then a further seven weeks until his biopsy was performed, even though the booking form was marked urgent, with multiple circles and a star to emphasise the urgency.

A third patient, who was triaged "to be seen within 6 weeks", was offered a first specialist appointment more than four months after he was referred by a GP. Subsequently, the appointment was brought forward after his GP made a further referral noting the "high suspicion of cancer". In this case the Commissioner was also concerned about the DHB's communication with the man, in particular regarding information about managing his anticoagulation medication.

The fourth patient was booked for a flexible cystoscopy, an examination of the bladder using a fibre-optic tube. This was not performed until after a gynaecologist made an "urgent referral" six months later. In this case, the DHB was also found in breach of the Code for failures relating to its response when the woman complained.

There had been little planning for urology services in light of changing demographics, and referrals exceeded the DHB's capacity. The DHB did not have an effective system for managing patients who were waiting for urology services, and clinicians and the public came to expect delays, which became normalised.

In this environment, relationships within the DHB became strained, and there was a lack of willingness to work together to find solutions.

It is essential that DHBs assess, plan, adapt, and respond effectively to the foreseeable effects that changing demographics will have on systems and demand. In the context of constrained resources, appropriate waiting list and appointment management systems are vital. Having mechanisms to monitor wait times and make these transparent to both the public and to referrers is critical. Organisations also need to consider initiatives such as different models of care to reduce the gap between capacity and demand.

This investigation also highlighted the importance of collaborative and mutually accountable relationships for effective delivery of services. These are issues of central importance for all DHBS, and can have severe consequences for patients if not recognised and acted on.

(Case 17HDC02066)

CASE STUDY

Delayed diagnosis of cancer

A woman visited a medical centre with concerns about her high blood pressure and bowel issues, including rectal bleeding. She was seen by a GP, who arranged a follow-up consultation to review the bowel issues further, but did not record the bowel issues in the woman's clinical notes.

The GP ordered a faecal occult blood test, but did not prepare appropriate paperwork for the test, and the faeces sample was discarded by the laboratory. Subsequently, the GP realised that the test is not recommended for patients with the woman's symptoms, but neglected to advise the woman of this.

The following week, the woman had her follow-up consultation with the GP. However, the GP did not perform a digital rectal examination when clinically this was indicated. The GP did decide to refer the woman for a colonoscopy, but omitted to set up the referral in the electronic patient management system, and did not advise the woman of the estimated wait time for an appointment.

Advice about estimated wait times is important when making referrals, as it enables patients to take an active role in their care, particularly in terms of knowing when to follow up if an appointment has not been received within the expected timeframe.

The woman called the medical centre several months later to ask about her colonoscopy referral. At this point the GP made the referral, but did not inform the medical centre management team of her original omission, and did not complete a Learning Event form. In addition, the woman was not informed of the omission until she telephoned the practice again a few days later to follow up on her previous call.

The Commissioner found that the GP failed to provide services to the woman with reasonable care and skill and breached Right 4(1). The GP failed to order a complete blood count, and ordered a faecal occult blood test when it was not recommended practice. She did not perform a digital rectal examination at the second consultation, did not process the referral for a colonoscopy in a timely manner, and did not advise the woman of the estimated wait time for an appointment. When eventually the GP made the referral, she failed to do so appropriately.

The Commissioner found that the GP breached Right 6(1) of the Code by not promptly informing the woman of the delay in making the referral, which was information that a reasonable person in her circumstances would expect to receive. Effective communication and open disclosure are vital in ensuring and maintaining a good relationship between a patient and a healthcare provider.

The Commissioner recommended that the GP arrange an independent audit of referrals she had instigated, enter into a mentoring relationship with another GP, and apologise to the woman.

(Case 18HDC00740)

4.2 Advocacy

The Director of Advocacy at HDC contracts with the National Advocacy Trust to provide and operate the independent Nationwide Health and Disability Advocacy Service.

Advocates promote the rights set out in the Code and support people to resolve their concerns directly with providers of health and disability services.

Advocates have a sound understanding of the health and disability sector, and substantial knowledge about their local community.

36
Advocates

22 Community-based offices from Kaitaia to Invercargill

Responded to more than **12,000** enquiries

Guided and supported people to close **2,644** complaints

Provided 1,681 education sessions

Made **3,803** networking visits

Nationwide Health & Disability Advocacy Service
Ngā Kaitautoko

The Advocacy Service complaints resolution process

The Advocacy Service is critical to achieving HDC's strategic objective of fair, effective, and timely resolution of complaints, by facilitating early resolution between the parties. Nearly 90% of the complaints managed by the Advocacy Service are considered by the complainant to have been resolved or are withdrawn, and the majority are closed within three months.

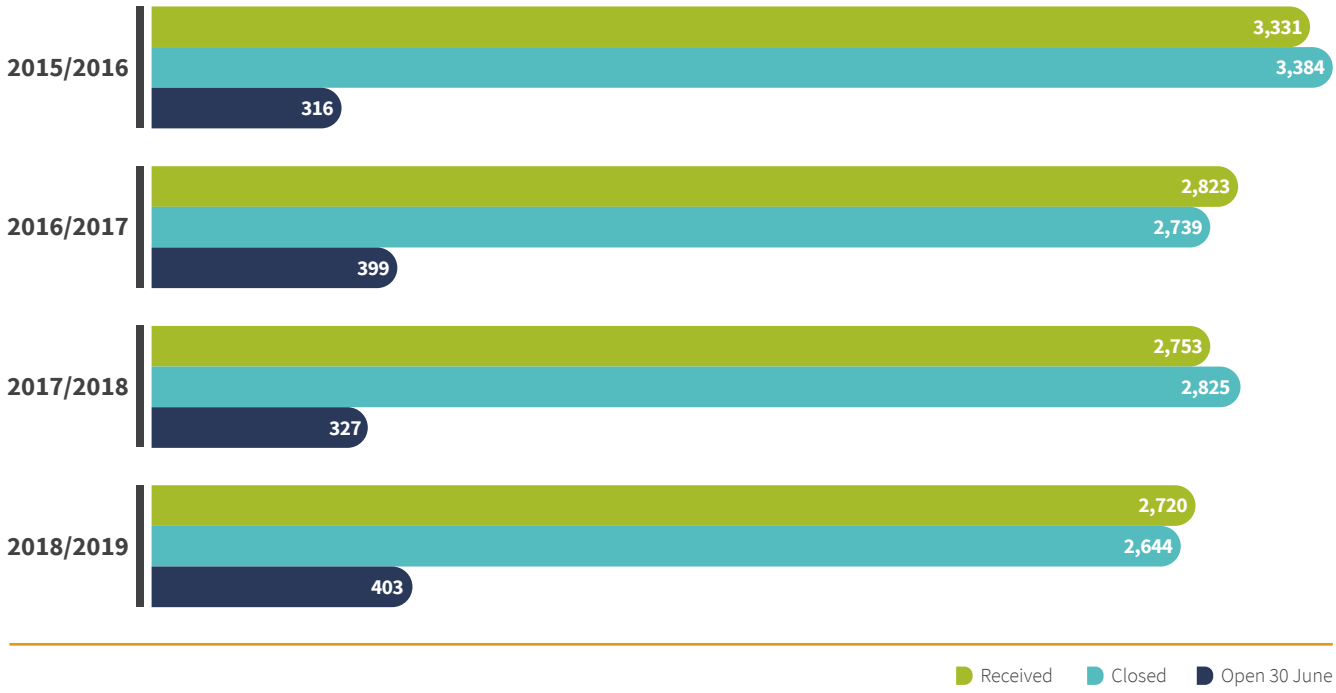
Consumers are always at the centre of the Advocacy Service's complaints resolution process, with advocates guiding and supporting complainants to clarify their concerns and the outcomes they seek. This clarity enables the provider to write or speak effectively and directly to the complainant. Hearing each other's stories is an essential part of the advocacy process.

Often the advocacy process can support people to rebuild relationships, which is particularly important when the relationship will be ongoing, such as with a GP or a rest home. In some instances, just having the opportunity to talk through the events and to draft a complaint letter with an advocate enables someone to achieve a degree of personal reconciliation, and they may no longer need to make a formal complaint.

The high resolution rate achieved by the Advocacy Service reflects its consumer-focused approach and the commitment of providers to achieving early and effective resolution.

Complaints received and closed

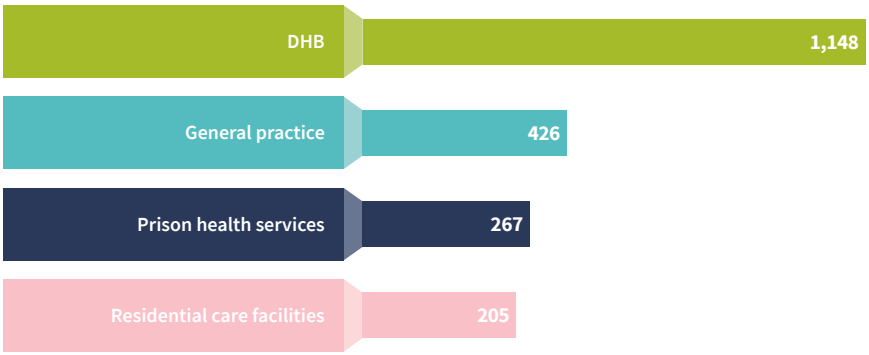
Figure 6: Complaints received and closed by the Advocacy Service from 1 July 2015 to 30 June 2019



This year, the Advocacy Service received 2,720 complaints and guided and supported people to close 2,644. Of these, 83% were closed within three months, and 99% were closed within six months.

In 2018/19, 93% of all complaints received by the Advocacy Service related to healthcare services, while 7% of complaints related to disability services. Eleven per cent of all complaints to the Advocacy Service related to mental health services. This is generally in line with what was seen for complaints to HDC.

Figure 7: Providers commonly complained about to the Advocacy Service in 2018/19



Reaching people and promoting the Code

Advocates work to ensure that they are accessible and familiar by networking with people, consumer focused groups, and providers; by providing education sessions; and by distributing promotional materials in their communities.

Over the past year, advocates made 3,803 networking visits in their local communities, with a special focus on ensuring that the hard-to-reach and the most vulnerable consumers, along with their whānau and carers, were made aware of the Advocacy Service and the Code. Networking helps advocates to build community knowledge and provide practical, up-to-date information, and referrals to other services when necessary.

Networking includes visiting services that provide support to those consumers who are least able to self-advocate and whose welfare may be most at risk. In particular, visits to aged-care and disability residential facilities, and to day-care centres, enables contact with those residents who may otherwise find it impossible or extremely difficult to seek the assistance of an advocate. Advocates also use these visits to provide information and arrange education sessions for residents, whānau/family members, and providers. During the year, advocates made 1,239 visits to residential services and 85 visits to facilities/services that provide day programmes and care.

Accessing the Advocacy Service

The Advocacy Service operates an 0800 national call centre and a website with online complaint forms and information on how to contact a local advocate. Promotional leaflets, posters, and other resources are distributed by advocates.

During the 2018/19 year, staff managed over 12,000 public enquiries, covering a broad range of topics. In addition, the Advocacy Service website — www.advocacy.org.nz — was improved substantially to facilitate contacting an advocate. All promotional items, including the website, continue to present advocacy information in a clear and accessible format.

Promoting the Code through education sessions

Advocates provide face-to-face education sessions to groups of consumers about their rights under the Code, and to groups of providers about their responsibilities and effective complaints management. These sessions are a great opportunity to discuss the Code within the context of the specific circumstances of the attendees, and also for advocates to explain successful complaints management processes and the advocate's role.

In the 2018/19 year, advocates presented 1,681 education sessions.

Education sessions are very well received, with 87% of attendees who responded to a survey reporting that they were satisfied or very satisfied with the session.

Complaint classification and demographics

Figure 8: Ethnicity of complainants to the Advocacy Service 2018/19

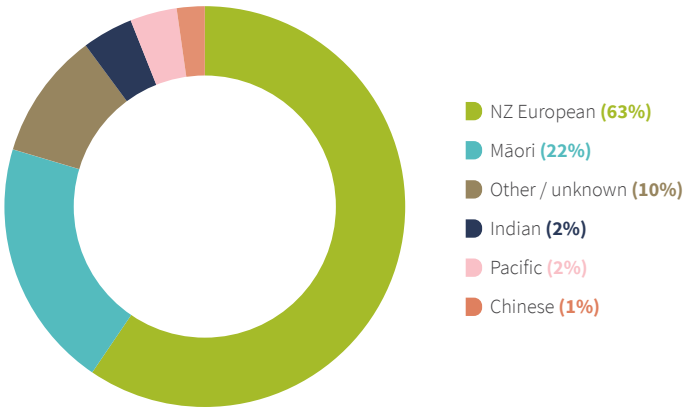
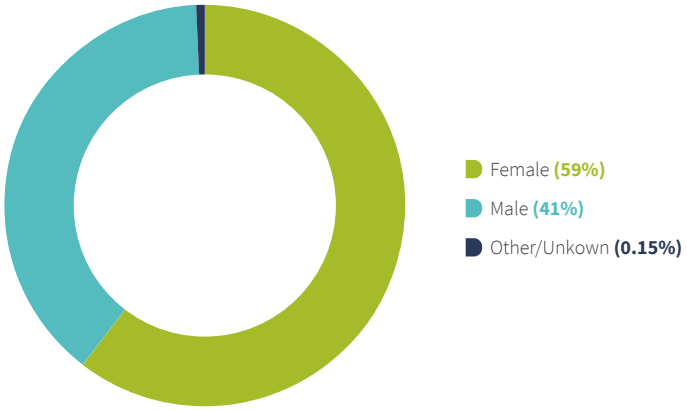


Figure 9: Gender of complainants to the Advocacy Service in 2018/19



Satisfaction with the Advocacy Service

Complainants who contact the service often express frustration and anger about a situation. In some instances, being able to express their feelings to an advocate who listens, and to talk through the options available to them, may be enough to resolve their concerns. In other circumstances, the advocate will take an active role in supporting complainants to resolve their complaint with the person or organisation who provided the service. Active advocacy can be by way of mentoring a person who wants to address their complaint directly with the provider, or by writing letters and supporting complainants at meetings.

Both complainants and providers have talked about the clarity advocates bring to the process, not only identifying issues but also providing guidance about what complainants need to help them to resolve their concerns. In 2018/19, 91% of consumers and 93% of providers who responded to satisfaction surveys said that they were satisfied or very satisfied with the Advocacy Service.

> “I was hesitant to seek advocacy at first because I wasn’t sure it was for me, but found that the complaint process was so much easier when I had support and that going through the process helped me to get back my sense of self-efficacy that I had lost during the incident.”
>
> — Complainant

Planning for independent living

A woman wanted to move from a residential home to independent living. She had tried to discuss this with her service provider, but felt that she was not being listened to, as no plan had been put in place.

A support worker, who had attended an Advocacy Service session, advised the woman to speak with an advocate.

After discussing the options available, the woman agreed for the advocate to write to the service provider outlining the woman's concerns and asking for information about the support available to help the woman to achieve her goals. A meeting was then arranged with the woman and her advocate, the Needs Assessment and Service Coordination (NASC) representative, and the Service Manager. As a result, a plan was developed to help the woman with independent living skills, including budgeting, personal care, and household skills, so that she could move towards independent living.

Disrespectful attitude

A woman contacted the Advocacy Service concerned about the way she had been treated at a hospital Emergency Department.

The woman felt that she had been discriminated against and treated disrespectfully because she had disclosed that prior to sustaining her injury she had drunk two glasses of wine. As a result, she did not feel that she could go back to the service for help.

After discussion about the options available, the woman asked the advocate to write a complaint letter to the DHB on her behalf. In response to the letter, the DHB apologised and requested permission to use the woman's complaint as a learning tool for staff around respect, dignity, and effective communication.

The woman felt that the apology was sincere, and said that the process and response had made her feel empowered and confident in herself again. She was also happy to return to the hospital in the future as her trust had been restored.

Information about additional charges for tests

A woman complained to the Advocacy Service that she had not been told about an extra charge for a recommended test at her GP practice, and that when she queried the charge she was upset by the receptionist's response.

The woman was advised by her GP that she should have an electrocardiogram (ECG) carried out by a nurse before she left the clinic. There was no mention of a charge for the test. A few days later the woman received a bill for the ECG and contacted the practice. She was told by the receptionist that it was her responsibility to ask about additional charges, and that as the test had already been done, she would have to pay.

After discussing her options with an advocate, the woman asked the advocate to help her to write a letter to the practice outlining the issues and what she felt would resolve them. In response, the GP practice apologised for the lack of communication about the extra fee, and for the way she had been dealt with by the receptionist, and it waived the charge. The practice advised the woman of the steps it had taken to address her concerns, including meeting with medical and nursing staff and reminding them of their responsibility to inform people and seek their consent when tests will attract additional fees. The woman was very satisfied with the outcome, and felt that all her concerns had been resolved.

4.3 Proceedings

The Director of Proceedings has an independent statutory role. The Director takes proceedings against health and disability services practitioners in the Health Practitioners Disciplinary Tribunal (HPDT) and/or the Human Rights Review Tribunal (HRRT).

The overall objective is to protect the public interest through holding practitioners to account, determining and upholding appropriate standards for healthcare providers, and promoting consumer confidence.

The HPDT considers cases of professional misconduct by a registered health practitioner, and has a range of penalties available, including a fine, conditions on practice, and suspension or cancellation of the practitioner's registration as a health practitioner. The HRRT considers allegations of a breach of the Code, against both registered and unregistered providers. Remedies include formal declarations of a breach of the Code, and in limited circumstances compensation is available.

The Health and Disability Commissioner refers providers to the Director — a step reserved for the most serious of breaches of the Code. The Director decides whether or not to take proceedings independently of the Commissioner.

Proceedings taken by the Director

This year the Director negotiated a number of outcomes, which included consent for the HRRT to issue a declaration that providers had breached the Code. In addition, the Director successfully defended three practitioner appeals in the High Court. In two cases the practitioner had appealed a penalty order made in the HPDT. The Director defended the penalty outcomes and was successful in having the orders of the HPDT upheld. In the third case, the practitioner appealed against a finding by the HPDT of professional misconduct. The High Court accepted the Director's submission that the HPDT was correct to find professional misconduct established and, in doing so, the High Court followed an earlier appellate decision involving the Director, which had confirmed the correct test for professional misconduct under the Health Practitioners Competence Assurance Act 2003.

Referral statistics

During 2018/19, the Director of Proceedings had 28 referrals from HDC in progress, including nine referrals received in the course of the year.

Table 2: Referrals received in the 2018/19 year by provider type

Provider	No. of referrals received in 2018/19
Midwife	2
DHB	2
Rest Home	1
Nurse	1
Disability Services	1
Prison Health Services	1
Other	1
TOTAL	**9**

CASE STUDY

GP held accountable for failure to refer patient for further investigation to rule out possible cancer

The Director of Proceedings filed a charge against a GP in the HPDT alleging failure to refer a patient for endoscopy, or to a medical specialist, despite the patient's red flag symptoms, and failure to communicate adequately with the patient to clarify his symptoms. The GP defended the charge.

The charge related to four consultations, over a four and a half month period, with a 57-year-old man who presented with difficulty swallowing (dysphagia), a sore throat, pain around his chest and stomach (dyspepsia), and unexplained weight loss. At the first consultation, the GP failed to identify her patient's presentation as red flag symptoms warranting referral to a specialist or referral for an endoscopy, and proceeded on the basis of her working diagnosis of gastritis. The GP prescribed medication to suppress gastric acid production, to promote effective stomach emptying, and to ease the man's discomfort, and referred him for blood tests, which were all normal except for the CRP (an inflammation marker), which was raised slightly. At his second consultation, the patient had the same problem with swallowing and was continuing to lose weight unintentionally. The GP advised him to continue taking the gastric acid suppressant medication, but made no referral for further testing. At his third visit, the patient was still having difficulty swallowing with associated pain, he was feeling tired all the time, and he was still losing weight. The GP referred him for a chest X-ray and blood tests, including a test for carcinoembryonic antigen (CEA), which can indicate the presence of cancer. His CEA result was slightly raised, but the GP considered that his blood results were all within normal range. The chest X-ray was reported as normal. She advised her patient to continue taking the prescribed medication regularly. Her patient returned nine days later because his condition had deteriorated, and he was still losing weight and having trouble swallowing. It was not until the patient saw his usual GP four and a half months after his last consultation with the first GP that he was finally referred urgently for a gastroscopy and diagnosed with oesophageal cancer. Subsequently, the patient underwent surgery to remove the cancer, and treatment with radiation and chemotherapy.

The HPDT accepted expert evidence that there were red flag symptoms in the patient's presentation at each consultation. The expert advice was that pain or discomfort in the upper abdomen may indicate disease of the upper gastrointestinal tract. Further, losing weight without trying is an abnormal symptom that indicates that disease is present, and is a red flag for a GP. The expert considered it to be a basic clinical competency for a GP to know that dysphagia is a red flag symptom that requires urgent investigation. The expert considered that the working diagnosis of gastritis ignored the red flag symptoms, and that the two diagnoses a GP should be particularly concerned about are cancer causing an obstruction, or acid reflux causing scarring (stricture) in the oesophagus. The expert advised that the blood test and X-ray results did not definitely support a diagnosis of gastritis or rule out possible cancer. However, the key written guidelines for GPs are clear that these red flags should prompt an immediate referral for an endoscopy or specialist review to exclude cancer. The HPDT noted the expert's advice that the seriousness of the departures was such that a

fifth-year medical student would fail a clinical competency exam for not knowing the significance of dysphagia and for not making the appropriate referral.

The GP accepted in hindsight her failures to refer her patient. She said that she had become blinkered by her initial diagnosis of gastritis. She also submitted that she believed she had to undertake a basic work-up before a specialist referral would be accepted. However, the HPDT accepted the expert advice that a basic work-up for referral was completed on receipt of the blood results.

The HPDT was satisfied that, cumulatively, the failure to refer amounted to professional misconduct (both as negligence and bringing discredit to the profession), and that the failure to refer at the fourth consultation also amounted separately to professional misconduct. The HPDT was satisfied that the failure to refer was negligent from the outset at the first consultation, and remained so at each successive consultation. However, the HPDT was not satisfied that the first three failures to refer in isolation were significant enough to warrant disciplinary sanction. The HPDT was satisfied that by the fourth consultation the persistent failure to refer in these circumstances was grossly negligent and inevitably had an impact on the reputation of the profession as a whole. The HPDT was not satisfied that the allegation that the GP had failed to communicate adequately to clarify her patient's symptoms was established; rather, her failure was in interpreting the symptoms obtained from her patient.

A link to the Tribunal's decision can be found at:
https://www.hpdt.org.nz/portals/0/946Med17378D.pdf

The GP unsuccessfully appealed the HPDT's finding of professional misconduct to the High Court (H v Director of Proceedings [2018] NZHC 2175). The High Court confirmed that a finding of gross negligence constituting professional misconduct is a serious matter and should be reserved for the most serious misconduct, and that the level of conduct required is more than a departure from accepted professional standards or a failure to follow guidelines. The High Court agreed that the GP's omissions amounted to negligence of such a degree as to constitute serious misconduct.

The High Court decision can be found at:
http://www.nzlii.org/nz/cases/NZHC/2018/2175.html

CASE STUDY

Residential aged care facility held accountable for failing to provide services with reasonable care and skill

The Director filed proceedings by consent in the HRRT against a company that owns and operates a residential aged care facility. The proceedings concerned the care of an 80-year-old man with multiple health problems, including type II diabetes and Alzheimer's dementia with delirium.

At the time of events, the man was receiving two weeks of respite care in the company's psychogeriatric facility. The man was admitted on 21 December 2015 and discharged on 4 January 2016. During his stay, staff failed to follow the company's policies and procedures, including the use of restraint; failed to review the man's medication regimen in light of his deteriorating condition; failed to monitor his diabetes appropriately; failed to evaluate the reasons he was not eating or taking fluids; failed to clarify his legal status; and provided him with suboptimal personal cares.

The company's restraint policy in place at the time of events was consistent with The New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2.2008), which state that restraint should be used only in the context of good clinical practice and after all less restrictive interventions have been attempted and found to be inadequate. In addition, the family and the client must be consulted at each step in the process and agree to the use of restraint. On 23 December, a registered nurse recorded in the man's progress notes that his wife had agreed to the use of a lap belt, as required, for his safety, and that she might visit the facility to sign a consent form on 26 December. On 26 December, a Restraint Discussion and Consent form was partially filled out. A handwritten entry on the form recorded that restraint had been discussed with "family & RN on duty", and that everyone was in agreement that a restraint trial period should commence and had agreed to a lap belt being used when "client in agitated/aggressive/ elevated mood", for a maximum time period of 30 minutes. The wife never signed the restraint consent form, which was signed only by the Restraint Coordinator (a registered nurse) on 26 December. There is no indication that the man was ever consulted about restraint, or his consent gained. Contrary to the company's own policy and the recorded plan for the lap belt, it was subsequently recorded that the man was restrained by a lap belt for several hours on ten occasions over a period of nine days. There is no record that alternatives to restraint were considered, or attempted, and no evidence that a doctor was consulted at any stage.

Prior to his admission, the facility was provided with information about the man's medications. However, the medication order sheet sent by the facility GP on 23 December incorrectly recorded the dosage for the man's medications, and when the medication was dispensed by the pharmacy it further incorrectly recorded the required dosage. The inconsistencies in the medication prescription and doses were not reconciled on admission to the facility, and neither the man's GP nor the pharmacy was contacted to query the dosages. Further, the man's wife was not contacted to query whether the prescribed and dispensed medications were consistent with the medication regimen he had been following at home. A comment in his discharge form indicated a concern that he was unsteady on his feet and sleepy, and that this might be linked to

overmedication. This concern was not raised with the man's family or GP during the time he resided at the facility.

On 22 December, a nutrition assessment was completed for the man, and it was noted that he required a diabetic diet. However, the dietary requirement form and the respite/short-term care plan both stated that he ate a "normal diet". The form also noted a recent history of weight loss (with the man experiencing further weight loss during his stay). The food and fluid intake forms recorded that he ate ice cream, cake, and other foods that did not form part of a diabetic diet. While records initially indicated that the man was eating well, later recording (after a period of no recording) showed that he either refused meals, or ate and drank very little. The staff at the facility did not evaluate the reasons why the man was refusing food or fluids, and his family or GP were not advised that his intake had decreased. There is no evidence that his blood sugar level was monitored at any time during his stay, despite his fluctuating levels of confusion and observations that he was not eating and drinking adequately.

"Daily Personal Cares" charts recorded the cares provided to the man during his stay at the facility. One chart was kept for December 2015. Two charts were kept for January 2016, which were a combined but in some instances inconsistent record of the cares provided during that time. The December 2015 "Daily Personal Cares" chart recorded that the man was showered on three out of eleven days, and had his teeth cleaned once daily over five days. One "Daily Personal Cares" chart kept for January 2016 recorded that he was showered on three days, and had his teeth cleaned once daily over three days, and a second chart recorded a fourth day of showering, but that his teeth were cleaned only once. On 5 January 2016, the day after the man was discharged from the facility, he was diagnosed with oral thrush.

While in their care, the staff at the facility acted on the basis that the man had an activated Enduring Power of Attorney (EPOA) for personal care and welfare, and that his wife was the appointed attorney and had the power to make decisions on his behalf. In fact the EPOA had not been activated, and his wife did not have that authority. For example, on 21 December 2015, staff at the facility inappropriately organised for the man's wife to sign a non-resuscitation order on his behalf. The man was not consulted as to his wishes about resuscitation, and did not have the opportunity to discuss this order with a doctor.

Despite observing a decline in the man's cognitive status, mobility, and eating and drinking ability, staff at the facility failed to respond appropriately to these changes in his overall health. The company accepted the shortcomings in the care and documentation during the man's stay in its facility, and acknowledged the failures by senior staff to fulfil key functions of their respective roles. The company accepted that it had overall responsibility for the actions of its staff and had an organisational duty to ensure the provision of timely, appropriate, and safe services to the man, and to facilitate continuity of his care.

The company accepted that its failures in care amounted to a breach of the Code, and the matter proceeded before the HRRT by way of an agreed summary of facts. The HRRT was satisfied that the company failed to provide services to the man with reasonable care and skill, and issued a declaration that the defendant breached Right 4(1) of the Code.

The decision can be found at: **http://www.nzlii.org/nz/cases/NZHRRT/2019/24.html**

4.4 Monitoring and advocacy — mental health and addiction services

There has been a significant focus on mental health and addiction services in 2018/19.

The Mental Health Commissioner is responsible for monitoring mental health and addiction services and advocating for improvements to those services. He uses four information sources for this work: HDC's complaints data, service performance information, consumer feedback, and insights gained from sector engagement. Using a framework developed in collaboration with consumers, family and whānau, and mental health and addiction sector representatives, the Mental Health Commissioner focuses on how well the system is working overall, whether services are meeting people's needs, and, where there are opportunities for improvement, advocating for that improvement.

To support his monitoring and advocacy role, the Mental Health Commissioner engages widely with the sector. In 2018/19 he attended 128 stakeholder meetings and sector events, including consumers' hui, site visits, and conferences.

Achieving transformation and ensuring success of new Mental Health and Wellbeing Commission

The Government Inquiry into Mental Health and Addiction was set up in January 2018 to identify unmet needs and develop recommendations for a better mental health and addiction system. Its final report, *He Ara Oranga*, was released in December 2018. HDC supported the work of the Inquiry by providing information and submissions with a focus on the findings and recommendations of our **2018 Monitoring and Advocacy Report**.

The Mental Health Commissioner publicly welcomed the overall direction proposed in *He Ara Oranga* and has provided advice to the Minister and Ministry of Health in response to its 40 recommendations. The advice focused on the critical components for achieving the required transformation in the mental health and addiction sector, in particular:

- **Leadership and clear accountability:** The need for integrated, collaborative leadership to bring about transformative change in the mental health sector, and the importance of clarity about who is going to be responsible for performing key functions, including setting, implementing, and monitoring an action plan to deliver the level of change required.
- **Dedicated support for transformation:** Two critical decisions are needed to support transformation: where to place national transformation support, and what level of resource will be required to support it. New, dedicated support will be required in either a new or existing organisation. Simply adding these critical components to the existing workloads of providers and others will, most likely, result in failure. Additional resources for agencies — including service providers — will also be required to enable them to transform the way they work at a local level while continuing to deliver business-as-usual services. These services are currently under significant pressure owing to growing demand, expectations, and workforce pressures.
- **The right focus for the Mental Health and Wellbeing Commission:** HDC's support for the proposed establishment of a Mental Health and Wellbeing Commission with a broad focus on promoting mental well-being and a whole-of-government approach, and ensuring that mental health and addiction services contribute to that. While the new Commission should make a critical contribution to system leadership, it should not be expected to solve all issues. It should add value rather than merely duplicate effort.
- **An independent watchdog properly empowered:** The overarching purpose of the new Commission should be to act as an independent watchdog — an authoritative, independent monitoring and advocacy agency. In order to perform that role, and maintain public confidence, it is critical that the new Commission be established with sufficient powers and resources, and the independence required to be able to report publicly without fear or favour. Given these requirements, the new Commission should be established as an independent Crown entity.
- **Ensuring an enduring commitment to mental health:** The need for a statutory requirement for an all-of-government mental health strategy to ensure an enduring commitment to addressing mental illness and addiction and improving the mental well-being of New Zealanders. While the spotlight is on mental well-being now, that will not always be the case. Underpinning these changes with a statutory requirement for a mental health and addiction strategy would leave a lasting legacy, and ensure that New Zealand's future efforts are aimed at building on progress rather than responding to crisis.

In 2018/19, HDC also provided advice to the Ministry of Health as it progressed specific recommendations, including the Suicide Prevention Plan and the repeal and reform of the Mental Health Act. To support consultation on the Act, we drew on information from complaints and sector engagement to develop scenarios that could help people to think through potential changes.

Resolving complaints about mental health and addiction services

As part of monitoring mental health and addiction services and advocating for their improvement, the Mental Health Commissioner has responsibility for making decisions in relation to complaints to HDC about mental health and addiction services. In doing so, the Mental Health Commissioner has the opportunity to make recommendations for service improvement in relation to individual complaints. Each complaint provides a valuable opportunity to identify key learnings and promote best practice within the sector.

In 2018/19, HDC received 301 complaints about mental health and addiction services. This is a 15% increase on the number of complaints received about these services in 2017/18. Complaints about mental health services made up around 13% of all complaints received by HDC. While the overall proportion change is small, this is a slight increase on the previous three years, when complaints about mental health services made up around 10% of all complaints.

There are a number of factors that could be contributing to this small increase. These include a mental health workforce under significant pressure, and greater public awareness of mental health and addiction issues and service challenges — with significant attention generated by the Inquiry into Mental Health and Addiction.

When all issues complained about in relation to mental health services are considered, in 2018/19 the most common categories were:

- Care/treatment (62%)
- Communication (60%)
- Consent/information (23%)
- Medication (20%)
- Professional conduct (20%)
- Access/prioritisation (16%)
- Facility issues (14%)

This is largely in line with what was seen in 2017/18, although there have been small increases in the percentage of complaints about care/treatment and medication.

The most common issues complained about within these broad categories in 2018/19 were:

- Failure to communicate effectively with consumer (32%)
- Inadequate/inappropriate clinical treatment (23%)
- Failure to communicate effectively with family (23%)
- Inadequate/inappropriate examination/assessment (20%)
- Issues with involuntary admission/ treatment (14%)
- Disrespectful manner/attitude (12%)
- Lack of access to services (12%)
- Inappropriate prescribing (12%)
- Inadequate co-ordination of care/ treatment (11%)

Again, this is largely consistent with what was seen in 2017/18. It should be noted that these reflect the issues as they are described by the consumer, and were not necessarily substantiated by HDC.

Promoting service improvement

In 2018/19, providers fully complied with all 35 quality improvement recommendations made by the Mental Health Commissioner helping to improve mental health and addiction services.

Recommendations to DHBs placed a strong emphasis on discharge planning, the co-ordination of care between services, and engagement with family/whānau. For example, it was recommended that a DHB formalise the handover process between its Addictions Service and other services and undertake an audit to ensure that the changes had been embedded into practice.

In another case, the Mental Health Commissioner's findings prompted a DHB to introduce measures to improve family/whānau engagement, such as routine family meetings to discuss care, and a focus on identifying shared goals. Other examples include the development of a "mental health telephone triage scale" for emergency team staff to refer to when taking calls; the introduction of regular formal meetings between the Emergency Department and acute mental health team at a major hospital to improve response times; and the adoption by one DHB of an automated email reminder to prompt follow-up by clinicians.

Recommendations to non-DHB providers focused on improving the quality of assessments through training and education. Following an investigation in one case, the Mental Health Commissioner recommended that a provider develop specific policies relating to issues of sexual and social contact with clients.

CASE STUDY

Cultural care plan and psychiatric review of at-risk patient

A number of issues raised in complaints to HDC about mental health and addition services are seen in this case, including concerns about communication and care and treatment.

A woman had been a consumer of mental health services since the mid-1990s. She had been diagnosed with bipolar affective disorder and admitted to mental health services a number of times, including a previous admission under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA).

The woman's mother contacted the local DHB's Mental Health Emergency Team (MHET) with concerns about her daughter's mental health, and requested her admission under the MHA. An assessment was carried out by a psychiatrist, who concluded that the woman could be managed by the community mental health team. The MHET and members of the community mental health team were in regular contact with the woman and her mother following this assessment.

The following month, the woman's mother told MHET that she had confiscated hunting knives found in her daughter's possession, and that her daughter's highs and lows were more extreme. A short time later, the woman was taken into Police custody after harming a woman unknown to her.

The Mental Health Commissioner found that the DHB breached Right 4(1) of the Code for failing to provide services to the woman with reasonable care and skill. He considered that the DHB did not have an adequate care plan in place for the woman, which was contributed to by a lack of psychiatric review over a protracted time. This issue was compounded by the absence of a cultural care plan, and the lack of elementary factors of Māori communication and care in the DHB's engagement with the woman. This meant that opportunities to foster engagement and create an appropriate plan based on the woman's strengths — including progress already made and a very strong cultural identity — were missed. In addition, reliance was largely placed on the woman's mother to monitor and evaluate her daughter's mental health, with very little support provided to her by the DHB.

The Mental Health Commissioner recommended that the DHB assess how its cultural and clinical care can be best co-ordinated and integrated, in collaboration with local Māori communities, and with input from consumer and family/whānau advisors. He acknowledged the work the DHB had already done in this regard, and recommended that it provide a further update to HDC in relation to the changes made since this complaint, and in relation to the outstanding recommendations made following its own Serious Adverse Event Review.

The DHB apologised to the woman and her family.

It should be noted that mental health consumers are significantly more likely to be victims of violence than perpetrators.

(Case 16HDC00195)

4.5 Education

Education is one of the ways in which HDC promotes respect for, and observance of, the Code. HDC carries out educational activities to share what can be learnt from complaints, and to advocate for improvements to the health and disability sectors.

Education sessions

HDC conducted 32 education sessions in 2018/19, setting out the common issues that appear across complaints for a particular group, such as district health boards or primary care, and the recommendations HDC has made in these areas to improve quality of care. These sessions also aim to equip attendees with a clear understanding of, and respect for, the Code. In this way, HDC's educational activities are greatly complemented by the community-level educational initiatives of the Advocacy Service.

This year education sessions included presentations to professional colleges and organisations, universities, primary care organisations, private hospitals, and aged care providers, as well as presentations at a number of health and disability sector conferences. Feedback from these sessions was positive, with 100% of respondents reporting that they were very satisfied or extremely satisfied.

Education about the Act and Code and the work of HDC is also delivered directly to consumers and providers through responses to individual enquiries. In 2018/19, HDC provided formal responses to 53 enquiries, in addition to the thousands of informal enquiries and telephone calls responded to by HDC.

To support HDC's strategic priority to work with providers to improve their complaints management processes, we provide complaints management workshops to equip people with the confidence and capability to resolve and learn from complaints at the provider level. In 2018/19, HDC conducted four of these workshops for two DHBs and two primary health organisations. Feedback continues to be positive, with the majority of attendees reporting that they were satisfied or very satisfied.

Complaint reports

Every complaint is an opportunity to learn. HDC ensures that what is learnt from individual complaints is reported back to the sector and general public by publishing reports on many of the decisions where there has been a breach of the Code. In 2018/19, HDC published 56 such decisions.

There is also much to be learnt from the trends and patterns that emerge across complaints, and HDC shares this by analysing its complaints data and publishing complaint trend reports.

HDC provided all DHBs with two six-monthly complaint trend reports in 2018/19. The reports detail the issues and services complained about for all DHBs nationally, and for each individual DHB, allowing them to identify aspects of their care commonly at issue in complaints to HDC. Because the reports are produced regularly, they allow DHBs to compare data about their individual DHB to all DHBs nationally and to themselves over time. These reports continue to be received positively, with 100% of DHBs who responded to a feedback survey reporting that the reports were useful for improving services.

The analysis of complaints data about a selected type of adverse event can be particularly valuable for providing insights into the common contributing factors to those events. With this in mind, in December 2018 HDC published a report analysing complaints where it was found that a medication error had occurred. This report was widely disseminated to the sector, including to relevant providers, regulatory authorities, the Health Quality & Safety Commission, the Ministry of Health, and professional colleges.

CASE STUDY

Medication error report

Medication is the most common intervention in health care, and most New Zealanders will receive safe and effective care. However, when medication errors do occur they have the potential to cause significant harm. To ensure that such errors do not occur again, it is vital that we understand what contributed to them, learn from them, and take preventative action, including strengthening systems.

HDC analysed complaints where a medication error was found to have occurred to shed light on possible patterns regarding contributing factors that led to the error. The resulting report also collated the lessons from the findings and from case examples, to help providers and organisations to recognise and address issues that contribute to medication errors.

The factors differed depending on the stage of the medication process at which the error happened (ie, prescribing, dispensing, administering). The majority of errors were due to a complex mix of human and organisational issues. Many were slips or lapses, whereby providers made inadvertent errors often due to factors in the organisational environment.

Common contributing factors included:

- A failure by providers to follow medication policies and procedures — often this issue could reflect a culture of tolerance within an organisation, where not following policies/procedures had become normalised.
- Inadequate communication between providers and inadequate documentation contributing to errors during transfers of care.
- A failure to do the basic checks — is this the right drug, for the right patient, for the right reasons, in the right dose, at the right time?
- Lack of communication with the consumer — often representing a missed opportunity to provide consumers with the information they required to identify the medication error themselves.

HDC identified a number of areas where additional focus would help to reduce medication errors, including:

- Placing priority on completing the nationwide rollout of electronic medication management systems. In order to reduce error it is important that these systems are well planned, well designed, and subject to close scrutiny, and that providers are trained appropriately on the use of these tools to ensure that they make the best use of the safety features.
- Organisational leaders fostering a culture and systems that support staff to do what is required of them, and ensure compliance with policies/procedures.
- Individuals ensuring that they are doing the basics well. Prescribers, dispensers, and those who administer medication must think critically each time they deliver a medication — considering the drug, the patient, and the context in which the medication is being delivered — to ensure that the medication is being delivered safely. Providers must also conduct the necessary checks to ensure that they are undertaking their role safely.

Submissions and recommendations

Through making submissions, HDC advises on the need for, or benefit of, legislative, administrative, or other action to give protection or better protection to the rights of health services consumers or disability services consumers or both.

In 2018/19, HDC made 24 submissions. These included comments on proposed legislation, policies, procedures, codes of conduct or ethics, guidelines, and practice standards for health practitioners.

HDC has been considering whether changes are needed to the current rules regarding health and disability research involving adult consumers who are unable to give informed consent to their participation in the research. At present, the effect of Right 7(4) of the Code is that a consumer who cannot give informed consent can be enrolled in a research project only if the research is in the consumer's "best interests". It has been argued that the effect of Right 7(4) may be to prevent some potentially valuable ethical research from proceeding. People who are unable to give informed consent are vulnerable to exploitation, yet they or others with their impairing condition may be disadvantaged if they are excluded from involvement in research.

HDC carried out public consultation on the matter, and has drafted a report that sets out the conclusions the Commissioner has reached regarding this complex and contentious issue, and his recommendations for next steps. The report, including an easy-read version, will be published in November 2019.

> "There is also much to be learnt from the trends and patterns that emerge across complaints."

4.6 Disability

Supporting disabled consumers

A key focus of the Deputy Commissioner, Disability is on increasing the awareness of disabled consumers about their rights under the Code, and ensuring that HDC is accessible and responsive to all people. Providing education sessions to disabled people is one way to do this. In 2018/19, this included presenting to disabled youth and their family/whānau at the Christchurch Next Steps Transition Exposition, to parents/family members and people with disabilities in Palmerston North, to disabled people in the Waikato, and at a NZ Down Syndrome Association Youth Development forum in Auckland.

HDC produced three easy-read resources in te reo Māori, which are available on the HDC website. In line with HDC's efforts to reduce inequities to access of information, this helps to engage with disabled Māori more effectively.

HDC acknowledges the launch of "Mana Whaikaha", the new prototype for disability support in the mid-central region, on 1 October 2018. This model aligns with HDC's vision of consumers being at the centre of health and disability services. In 2018/19, HDC continued work on updating the Health Passport, a tool for communicating with providers about consumers' individual needs. HDC has been working with the Ministry of Health and Capital and Coast DHB in preparing for the implementation of an online version, to make this helpful tool more easily accessible.

Complaints received about disability services

The Deputy Commissioner, Disability recognises the importance of continuing to strengthen the safeguards in place for consumers of disability services, and promoting quality improvement. To that end, data from complaints is reviewed regularly to identify common issues and areas of concern, and information is shared with other agencies. Opportunities are also taken to increase public awareness of people's experiences, and bring about systems improvement where this is warranted.

In 2018/19, HDC received 92 complaints about disability services — a decrease from the 111 complaints received in the 2017/18 year. Some of the most common issues identified by HDC on assessment of these complaints were:

- A lack of access to funding and services
- Individual support needs not being met
- A lack of effective communication with the consumer and their family/whānau, particularly regarding changes to support staff
- Inadequate service co-ordination, particularly in regard to staff rostering and staff attendance to shifts
- Ensuring adequate training and skills of staff to carry out necessary support

These issues are broadly consistent with what was seen in the previous year.

Complaints received about residential aged-care facilities

People who receive residential aged-care services have particular vulnerabilities, and HDC pays close attention to the information received in complaints about those services. In 2018/19, HDC received 122 complaints about residential aged-care facilities — a small decrease on the 137 complaints received in 2017/18. Some of the most common issues identified by HDC on assessment of these complaints were:

- Inadequate recognition, assessment, monitoring, and management of deteriorating conditions
- Inadequate falls risk assessment and management, including inadequate post-falls assessment
- Inadequate pain management
- Inadequate wound care, including inadequate assessment and monitoring
- A delay in escalating care for further medical review with other providers such as GPs
- Inadequate management of challenging behaviours
- Communication with consumers and family/whānau
- Inadequate care plans and documentation.

These issues remain similar to those found in the previous year, and highlight the complex nature of the support that is required to ensure that people's rights are complied with while maintaining their safety and well-being.

CASE STUDY

Inadequate risk management

This case demonstrates a common issue seen in disability complaints regarding individual support needs not being met by providers.

When a 21-year-old man moved from his family home into a supported living arrangement, his family informed the disability service provider supporting him that he had a history of behaviour and safety concerns. Despite this, the disability service did not have a formal risk management or safeguarding plan in place.

The initial transition into the assisted living arrangement went smoothly. The young man was free to come and go from his residence and received regular support from the disability service provider in this home. However, after some time issues arose. Staff were concerned that the man engaged in lying, stealing, manipulating, and bullying behaviours, he stopped taking his medication consistently, and he had called suicide helpline services.

The situation intensified to the point where the man was involved in two serious incidents, which resulted in him being charged by the Police.

This case demonstrates the important balance between recognising and supporting a person's autonomy to make choices about his or her life, and ensuring that any identified risks are managed appropriately. As a provider there is a responsibility to explore any potential risks and put in place mitigation strategies.

The Deputy Commissioner found that by failing to have a risk management plan in place, the disability provider did not provide services to the man with reasonable care and skill, and therefore breached Right 4(1) of the Code.

On HDC's recommendation, the provider updated its risk management tool in line with expected standards, and apologised to the man's family.

(Case 17HDC00689)

> "A key focus ... is on increasing the awareness of disabled consumers about their rights under the Code, and ensuring that HDC is accessible and responsive to all people."

CASE STUDY

Assessment and care following fall

This case demonstrates a common issue seen in aged-care complaints regarding a failure to recognise deteriorating conditions and document them accordingly, as well as a delay by staff to escalate care.

An elderly woman living in a rest home suffered a number of falls. Despite a general assessment identifying her as being at a high risk of falls, her specific falls risk assessment and care plan were not updated to reflect the new risk rating. Furthermore, no multi-disciplinary review was organised following any of the falls, which was inconsistent with the rest home's policy. The elderly woman then suffered an unwitnessed fall.

Following that fall, the woman was assessed by a registered nurse and remained in the rest home, where she received pain relief and nursing care. On the second day, a doctor was contacted for advice. The doctor suggested an X-ray and prescribed stronger pain medication, but did not go to the rest home to assess the woman in person. On the third day, when the woman's symptoms had worsened and she was unable to weight bear, she was taken to hospital and found to have a pelvic fracture.

The Deputy Commissioner considered that the care provided to the woman by the rest home was inadequate, and that it did not provide services with reasonable care and skill, breaching Right 4(1) of the Code. Multiple staff failed to follow appropriate procedures in light of the woman's increasing number of falls, putting her at risk of harm from future falls. Furthermore, following the unwitnessed fall there was a delay in providing the woman with adequate regular pain medication, and its effectiveness was not monitored consistently. Additionally, the woman was not assessed by a doctor until three days after her fall.

It was recommended that the rest home develop an assessment tool for follow-up reassessment of a resident who has had a fall; amend its falls policy to clarify who is responsible for assessing a resident after a fall; review its moving and handling policy and consider amending it to cover situations when a resident declines the use of a hoist; provide evidence to HDC that it has implemented the changes to its policy; and provide HDC with evidence of further training and education for staff on falls prevention and post-falls care.

The Deputy Commissioner also recommended that the rest home apologise to the woman and her family.

(Case 17HDC01304)

5.0 Organisational health and capacity

Leadership

In 2018/19, the Commissioner led the organisation with the Executive Leadership Team of three Deputy Commissioners (one of whom is the Mental Health Commissioner), the Director of Proceedings, three Associate Commissioners, and a Corporate Services Manager.

Staff

HDC's people are its greatest resource. Most staff hold professional qualifications and predominantly come from health, disability, or legal backgrounds. Together they bring a wide range of skills in management, training, investigation, litigation, clinical practice, research, information technology, and financial management.

Equal employment opportunities

HDC is committed to being a good employer, promoting and maintaining equal employment opportunities. It has a "Good Employer and Equal Employment Opportunities Policy" that clearly outlines this commitment and the need to provide equal opportunities for employment, promotion, and training. The policy provides guidance to managers and staff, and ensures that these commitments are integrated throughout the business operation, including the recruitment process.

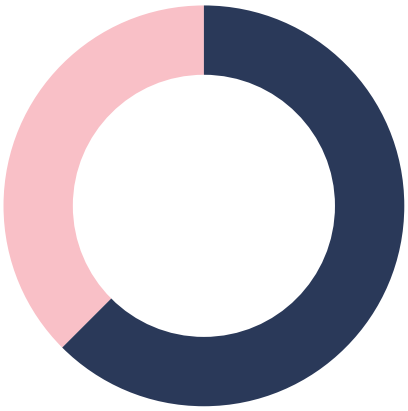
HDC's policies require all employees and other workers at HDC to take responsibility to ensure that the objectives in the New Zealand Disability Strategy are put into practice.

Workplace profile

As at 30 June 2019, HDC had 88 staff members (76 full-time equivalents), as follows:

Figure 10: Gender of HDC staff

Figure 11: HDC staff in full-time and part-time positions



HDC employs staff with disabilities, who in addition to their primary role, provide valuable insight into the challenges faced by people in our communities who live with disabilities. Staff who disclose their disabilities are supported by HDC to ensure their needs are met, including providing sign language interpreters and special equipment.

HDC benefits from a diverse workforce with different ethnic backgrounds, including New Zealand European, Māori, Pacific, Asian, and other ethnicities, and aged between 20 to over 60 years.

Throughout the year, HDC organised programmes to enhance Mental Health Awareness and to celebrate Māori Language Week, International Day of Persons with Disabilities, and Matariki.

Good employer obligations

Leadership, accountability, and culture

The Executive Leadership Team is dedicated to working collaboratively to achieve the organisation's strategic objectives. Managers are accountable for leading a performance culture that is supportive and equitable. Staff forums are held regularly in both the Auckland and Wellington offices to discuss and share current issues, and to recognise staff and team successes.

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. When vacancies are advertised throughout the office, employees are encouraged to apply for positions commensurate with their abilities. HDC has a comprehensive induction programme and orientation plan for new staff. The induction programme provides an introduction to the team; an oversight of the organisation's activities; information on policies, procedures and tools; and training as required. HDC also carries out a "Fresh Eyes" survey to obtain feedback from new staff members. The feedback received via these surveys supports continuous improvements to the organisation, to support staff and improve work practices.

Employee development, promotion, and exit

HDC's policies support professional development and promotion. Training and development needs and career development needs are formally identified as part of the performance appraisal process. Staff members jointly develop with their manager a performance agreement tailored to their role, with clearly defined objectives and a supporting development plan.

HDC provides a structured training programme to support staff as they develop and progress in their roles.

Professional development by employees is encouraged, and financial assistance and/or study leave may be granted by the Commissioner.

Flexibility and work design

HDC continues to offer occupational development across the organisation, 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.

Remuneration, recognition, and conditions

HDC provides fair remuneration that is linked to position accountability and market movement, and is based on EEO principles. HDC recognises staff achievements at staff forums.

HDC offers long service leave in addition to standard leave under the Holidays Act 2003, to acknowledge the commitment, dedication, and valuable contribution of staff.

Harassment and bullying prevention

HDC has an "anti-harassment" policy and does not tolerate any forms of harassment or bullying. In addition, HDC promotes, and expects staff to comply with, the State Services Standards of Integrity and Conduct.

Safe and healthy environment

HDC 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 staff forums and Executive Leadership Team meetings, and hazards are managed actively. During the year, HDC reviewed and updated its Health and Safety policy and organised the corresponding training for staff.

HDC has a number of initiatives in place to promote a healthy and safe working environment, including the use of VITAE (which offers confidential counselling services), providing fresh fruit, and offering influenza vaccinations, sit/stand desks, and a wellness programme.

Process and technology

Sustainability: HDC works to reduce its impact on the environment and to save money. HDC encourages the efficient use of resources and recycling by staff; endeavours to buy as much as possible locally; monitors travel and encourages staff use of public transport where appropriate; and purchases environmentally friendly products and services where possible.

Technology: HDC continues to seek initiatives to bring positive changes to the organisation. In 2018/19, HDC developed an intranet to improve document accessibility and internal communication. In addition, HDC has continued to make a series of improvements to its main database systems and has refreshed the printing facility. These initiatives will help to enhance capability and efficiency, as well as to maintain associated costs at an economical level.

Physical assets and structures: HDC manages its assets cost-effectively. In 2018/19, HDC undertook a security review of its premises and implemented recommendations to further enhance security to improve staff safety. Our assets are maintained and cared for to ensure that they provide an appropriate useful life.

6.0 Statement of performance

6.1 Output Class 1: Complaints resolution

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 1: Complaints resolution	Actual 2019 $	Budget 2019 $	Actual 2018 $
Revenue	7,307,281	6,952,000	7,000,562
Expenditure	7,150,890	7,158,000	6,985,858
Net surplus/(deficit)	**156,391**	**(206,000)**	**14,704**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 1.1 — COMPLAINTS MANAGEMENT		
		Targets achieved
Efficiently and appropriately resolve complaints (which contributes to achievement of Strategic Objectives 1 and 3: see Section 3).		2,350 complaints were received during the year. This represents a 6% decrease on the previous year's volume (2018: 2,498).
Assume 2,750–2,950 complaints will be received.	Close an estimated 2,350–2,420 complaints. This includes an estimated 120 investigations.	2,392 complaints were closed during the year (a year-on-year increase of 3.3%), which includes closing 102 investigations (2018: 2,315 total complaints closed including 102 investigations).
		Targets partially achieved*
		Total open files at year end were 767 (2018: 809).
	Manage complaints so that:	Age of open complaints at 30 June 2019:
	• No more than 18–20% of open complaints are 6–12 months old.	• 6–12 months old, 160 out of 767 — 20.8% (2018: 16.4%)
	• No more than 16–18% of open complaints are 12–24 months old.	• 12–24 months old, 129 out of 767 — 16.8% (2018: 14.5%)
	• No more than 2–3% of open complaints are over 24 months old.	• Over 24 months old, 36 out of 767 — 4.7% (2018: 2.6%)

* HDC actively manages the prioritisation between closing aged files and maintaining the required level of throughput.

6.1 Output Class 1: Complaints resolution (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 1.2 — QUALITY IMPROVEMENT		
		Targets achieved
Use HDC complaints management processes to facilitate quality improvement (which contributes to achievement of Strategic Objective 2).	Make recommendations and educational comments to providers to improve quality of services and monitor compliance with the implementation of recommendations and encourage better management of complaints by providers.	Between 1 July 2018 and 30 June 2019, compliance with quality improvement recommendations on 310 complaints were due to be reported to HDC by 167 providers. Recommendations in relation to 308 of those complaints (99.3%) were fully complied with, and recommendations in relation to two were not fully complied with.
	Providers make quality improvements as a result of HDC recommendations and/or educational comments.	In the two cases of non-compliance, one provider was referred to the appropriate regulatory body, and the other to its parent organisation. HDC will continue to monitor and follow up the providers who received HDC's recommendations to ensure their compliance.
	• HDC audit a sample of providers to verify their compliance with HDC quality improvement recommendations: 97% compliance.	• 99.3% compliance (2018: 98.9%)

6.2 Output Class 2: Advocacy

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 2: Advocacy	Actual 2019 $	Budget 2019 $	Actual 2018 $
Revenue	4,097,816	3,940,000	4,046,272
Expenditure	4,010,114	4,058,000	4,037,773
Net surplus/(deficit)	**87,702**	**(118,000)**	**8,499**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 2.1 — COMPLAINTS MANAGEMENT		
Efficiently and appropriately resolve complaints (which contributes to achievement of Strategic Objective 1).		**Targets substantially achieved** 2,720 new complaints were received by the Advocacy Service in the year ended 30 June 2019 (2018: 2,753).
Assume 2,800 to 3,300 complaints will be received.	Close an estimated 2,800 to 3,300 complaints.	For the year ended 30 June 2019, 2,644 complaints were closed.
		Targets achieved
	Manage complaints so that:	Complaints were managed so that:
	• 80% are closed within 3 months	• 83% were closed within 3 months (2018: 84%)
	• 95% are closed within 6 months	• 99% were closed within 6 months (2018: 99%)
	• 100% are closed within 9 months	• 100% were closed within 9 months (2018: 100%)
		Targets achieved
Consumers and providers are satisfied with Advocacy's complaints management processes (which contributes to achievement of Strategic Objective 1).	Undertake consumer satisfaction surveys, with 80% of respondents satisfied with Advocacy's complaints management processes. Undertake provider satisfaction surveys, with 80% of respondents satisfied with Advocacy's complaints management processes.	91% of consumers and 93% of providers who responded to satisfaction surveys were satisfied or very satisfied with the Advocacy Service's complaints management process (2018: 90% of consumers and 87% of providers).

6.2 Output Class 2: Advocacy (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 2.2 — ACCESS TO ADVOCACY		
		Targets achieved
Network to promote awareness of the Code and access to the Advocacy Service in local communities (which contributes to achievement of Strategic Objective 4)**.**	Advocates carry out 3,000 scheduled visits or meetings with community groups and provider organisations for the purpose of providing information about the Code, HDC, and the Advocacy Service.[1] Such visits/meetings include aged care facilities and residential disability services, with the emphasis on reaching vulnerable consumers and the family/whānau members who support them.	**Certified aged-care facilities** For the year ended 30 June 2019, 3,803 scheduled visits or meetings with community groups and provider organisations were carried out. 1,239 of these visits were to aged care and residential disability facilities. (2018: 3,917 visits or meetings, including 1,799 aged care and residential disability facilities visits.)
OUTPUT 2.3 — EDUCATION AND TRAINING		
		Targets achieved
Promote awareness of, respect for, and observance of, the rights of consumers and how they may be enforced (which contributes to achievement of Strategic Objective 4)**.**	Advocates provide 1,600 education sessions.	A total of 1,681 education sessions were provided (2018: 1,499).
		Targets achieved
	Consumers and providers are satisfied with the education sessions: ● Seek evaluations on sessions with 80% of respondents satisfied.	88% of consumers and providers who responded to a survey were satisfied with the Advocacy Service education session they attended (2018: 87% of consumers and providers).

[1] A more prioritised approach is being adopted to residential home visits and networking.

6.3 Output Class 3: Proceedings

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 3: Proceedings	Actual 2019 $	Budget 2019 $	Actual 2018 $
Revenue	570,318	640,000	508,529
Expenditure	558,112	659,000	507,461
Net surplus/(deficit)	**12,206**	**(19,000)**	**1,068**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 3.1 — PROCEEDINGS		
Professional misconduct is found in disciplinary proceedings (which contributes to achievement of Strategic Objective 3).	Professional misconduct is found in 75% of disciplinary proceedings.	**Not measurable** For the year ended 30 June 2019, the Director of Proceedings had no professional misconduct proceedings heard by the HPDT (2018: misconduct found in 100%, 3 of 3 proceedings).
Breach of the Code is found in Human Rights Review Tribunal (HRRT) proceedings (which contributes to achievement of Strategic Objective 3).	A breach of the Code is found in 75% of HRRT proceedings.	**Target achieved** For the year ended 30 June 2019, a breach of the Code was found in 100% (3 of 3) of HRRT proceedings (2018: 100%, 1 of 1 proceedings).
An award is made where damages are sought (which contributes to achievement of Strategic Objective 3).	An award of damages is made in 75% of cases where damages are sought.	**Target achieved** Resolution by negotiated agreement was achieved in 100% (3 of 3) of proceedings (2018: 100%, 1 of 1 proceedings).
Where a restorative approach is adopted, agreement is reached between the relevant parties (which contributes to achievement of Strategic Objective 3).	An agreed outcome is reached in 75% of cases in which a restorative approach is adopted.	**Not measurable** For the year ended 30 June 2019, no restorative approach was adopted in a case (2018: nil).

6.4 Output Class 4: Education

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 4: Education	Actual 2019 $	Budget 2019 $	Actual 2018 $
Revenue	430,406	362,000	438,941
Expenditure	421,195	372,000	438,019
Net surplus/(deficit)	**9,211**	**(10,000)**	**922**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.1 — INFORMATION AND EDUCATION FOR PROVIDERS		
		Targets achieved
Monitor DHB complaints and provide complaint information to DHBs (which contributes to achievement of Strategic Objectives 2 and 4).	Produce six-monthly DHB complaint trend reports and provide to all DHBs.	Two six-monthly DHB complaint trend reports for each DHB were produced and provided to all DHBs.
	80% of DHBs who respond to an annual feedback form find complaint trend reports useful for improving services.	100% (17/17) of the DHBs who responded to an annual feedback form rated the complaint trend reports as useful for improving services (2018: 100%, 17 of 17).
		Targets achieved
Assist DHBs to improve their complaints systems (which contributes to achievement of Strategic Objectives 2 and 4).	Provide two complaints resolution workshops for DHBs.	Two complaints resolution workshops for DHBs were held.
	Seek evaluations on the workshops, with 80% of respondents satisfied with the session.	96% of respondents reported that they were satisfied or very satisfied with each session respectively (2018: 97%).

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.1 — INFORMATION AND EDUCATION FOR PROVIDERS (continued)		
		Targets achieved
Assist non-DHB group providers to improve their complaints systems (which contributes to achievement of Strategic Objectives 2 and 4)**.**	Provide two complaints resolution workshops for non-DHB group providers.	For the year ended 30 June 2019, two complaints resolution workshops for non-DHB group providers were held (2018: two).
	Seek evaluations on workshops, with 80% of respondents satisfied with the session.	92% of respondents reported that they were satisfied with each session (2018: 100%).
		Targets achieved
Promote awareness of, respect for, and observance of, the rights of consumers and how they may be enforced (which contributes to achievement of Strategic Objective 4)**.**	Provide 30 educational presentations. Consumers and health and disability service providers are satisfied with the educational presentations.	For the year ended 30 June 2019, 32 educational presentations were made (2018: 33).
	Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	For the year ended 30 June 2019, 100% of respondents who provided feedback (28 of 28) reported that they were satisfied with the presentations (2018: 100%, 28 of 28).
		Target achieved
	Make public statements and publish reports in relation to matters affecting the rights of consumers: • Produce and publish on the HDC website key Commissioner decision reports and related articles. Report on total number.	For the year ended 30 June 2019, 56 decisions relating to matters affecting the rights of consumers were published at www.hdc.org.nz (2018: 76).

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.2 — OTHER EDUCATION		
		Target achieved
HDC engages in sector education through making submissions on relevant policies, standards, professional codes, and legislation (which contributes to achievement of Strategic Objective 4)**.**	HDC makes at least 10 submissions.	For the year ended 30 June 2019, 24 submissions were made (2018: 32).
		Target achieved
HDC responds formally to queries from consumers, providers and other agencies about the Act, the Code, and consumer rights under the Code (which contributes to achievement of Strategic Objective 4)**.**	At least 40 formal responses to enquiries provided.	For the year ended 30 June 2019, 53 formal responses to enquiries were provided (2018: 76).

6.5 Output Class 5: Disability

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 5: Disability	Actual 2019 $	Budget 2019 $	Actual 2018 $
Revenue	573,597	586,000	588,388
Expenditure	561,321	603,000	587,152
Net surplus/(deficit)	**12,276**	**(17,000)**	**1,236**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 5.1 — DISABILITY EDUCATION		
Promote awareness of, respect for, and observance of, the rights of disability services consumers (which contributes to achievement of Strategic Objective 4)**.**	Publish on the HDC website (and make accessible to people who use "accessible software") educational resources for disability services consumers and disability services providers. At least two new educational resources will be available in plain English.	**Targets achieved** During the year ended 30 June 2019, two new educational resources were developed and posted on HDC's website: 1. Ka aha i muri i tō tuku amuamu ki Te Toihau Hauora, Hauātanga? (What happens after you make a complaint to the Health and Disability Commissioner?) — Easy Read format translated into te reo Māori. 2. Ka aha ina tūhuratia ai tō amuamu e Te Toihau Hauora, Hauātanga? (What happens when the Health and Disability Commissioner investigates your complaint?) — Easy Read format translated into te reo Māori. The Code of Rights poster in Easy Read format has also been translated into te reo Māori and made available on HDC's website.

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 5.1 — DISABILITY EDUCATION (continued)		
		The decision to translate these Easy Read documents into te reo Māori was made in response to HDC's interest in reducing inequities to access of information and to more effectively engage with Māori with disabilities. In addition, three seminars to promote awareness of the rights of disability services consumers were planned and presented in three regions in New Zealand: Hamilton, Christchurch and Palmerston North. ● The Hamilton seminar targeted people with disabilities who were under the Enabling Good Lives model but was attended by consumers under other services as well. This seminar had an overall satisfaction rate of 93%. ● The Christchurch seminar was given at a Transition Exposition for disabled youth transitioning from school into the community. This seminar had an overall satisfaction rate of 100%. ● The Palmerston North seminar targeted parents/family members and people with disabilities. This seminar had an overall satisfaction rate of 100%.

6.6 Output Class 6: Mental health and addiction services — monitoring and advocacy

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 6: Monitoring and Advocacy	Actual 2019 $	Budget 2019 $	Actual 2018 $
Revenue	671,398	670,000	618,375
Expenditure	657,028	691,000	617,076
Net surplus/(deficit)	**14,370**	**(21,000)**	**1,299**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 6.1 — MONITORING AND ADVOCACY		
Monitoring		
		Targets achieved
Monitor mental health and addiction services to identify potential improvements to services (which contributes to achievement of Strategic Objective 2)**.**	Monitor and analyse issues and trends identified by HDC complaints and the Advocacy Service.	In 2018/19, HDC prepared an analysis of 2017/18 complaint trends about mental health and addiction services.
	Maintain engagement with key sector stakeholders and monitor sector performance information to keep informed about service issues and trends.	In 2018/19, HDC attended 128 stakeholder meetings and events, including consumers' hui, site visits, and conferences.
	Provide briefings to the Minister as required.	In 2018/19, the Mental Health Commissioner publicly welcomed the overall direction proposed in He Ara Oranga and provided advice to the Minister of Health and the Ministry of Health on critical components for achieving the transformation required in the mental health and addiction sector.

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 6.1 — MONITORING AND ADVOCACY (continued)		
Advocacy		
		Targets achieved
Advocate for improvements to mental health and addiction services (which contributes to achievement of Strategic Objective 2)**.**	Make recommendations and educational comments to providers (and other organisations or individuals) when resolving complaints, to improve the quality of mental health and addiction services and complaints resolution processes.	HDC monitors providers' compliance with recommendations throughout the follow-up process by seeking evidence of the changes made. There were 35 quality improvement recommendations due in 2018/19.
	Monitor compliance with the implementation of recommendations: • 97% compliance.	For the year ended 30 June 2019, providers were: • Fully compliant with 100% of recommendations due this financial year.
	Provide briefings or make recommendations or suggestions to any person or organisation in relation to issues or trends identified in HDC's monitoring of mental health and addiction services.	In 2018/19, HDC wrote to the Minister of Health with advice regarding the form, function, and powers of the new Mental Health and Wellbeing Commission. HDC also met regularly with Ministry of Health officials to discuss implementation of recommendations from *He Ara Oranga*.

7.0 Financial statements

Statement of comprehensive revenue and expense for the year ended 30 June 2019

	Notes	Actual 2019 $	Budget 2019 $	Actual 2018 $
Revenue				
Funding from the Crown		13,370,000	12,870,000	12,870,000
Interest revenue		59,840	50,000	56,218
Other revenue	2	220,976	230,000	274,849
Total revenue		**13,650,816**	**13,150,000**	**13,201,067**
Expenditure				
Personnel costs	3	7,560,879	7,440,000	7,154,685
Depreciation and amortisation expense	8, 9	89,457	122,000	124,774
Advocacy services		3,485,310	3,485,000	3,487,781
Other expenses	4	2,215,819	2,494,000	2,406,099
Total expenditure		**13,351,465**	**13,541,000**	**13,173,339**
Surplus/(deficit)		**299,351**	**(391,000)**	**27,728**
Total comprehensive revenue and expense		**299,351**	**(391,000)**	**27,728**

Explanations of major variances against budget are provided in Note 18.

The accompanying notes form part of these financial statements

Statement of financial position as at 30 June 2019

	Notes	Actual 2019 $	Budget 2019 $	Actual 2018 $
ASSETS				
Current assets				
Cash and cash equivalents	5	2,110,648	1,276,000	1,750,732
Receivables	6	18,902	30,000	24,173
Prepayments		39,166	100,000	97,003
Inventories	7	27,971	20,000	24,094
Total current assets		**2,196,687**	**1,426,000**	**1,896,002**
Non-current assets				
Property, plant, and equipment	8	153,795	151,000	111,632
Intangible assets	9	154,512	137,000	165,282
Total non-current assets		**308,307**	**288,000**	**276,914**
Total assets		**2,504,994**	**1,714,000**	**2,172,916**
LIABILITIES				
Current liabilities				
Payables	10	410,861	328,000	391,503
Employee entitlements	11	439,448	450,000	408,292
Total current liabilities		**850,309**	**778,000**	**799,795**
Non-current liabilities				
Payables	10	31,779	20,000	42,371
Total non-current liabilities		**31,779**	**20,000**	**42,371**
Total liabilities		**882,088**	**798,000**	**842,166**
Net assets		**1,622,906**	**916,000**	**1,330,750**

Statement of financial position as at 30 June 2019 (continued)

	Notes	Actual 2019 $	Budget 2019 $	Actual 2018 $
EQUITY				
Contributed capital	13	788,000	788,000	788,000
Accumulated surplus/(deficit)	13	834,906	128,000	542,750
Total equity		**1,622,906**	**916,000**	**1,330,750**

Explanations of major variances against budget are provided in Note 18.

The accompanying notes form part of these financial statements

Statement of changes in equity for the year ended 30 June 2019

	Notes	Actual 2019 $	Budget 2019 $	Actual 2018 $
Balance at 1 July		1,330,750	1,307,000	1,303,022
Adjustment to accumulated surplus from the adoption of PBE IFRS 9		(7,195)	-	-
Adjusted balance at 1 July		1,323,555	1,307,000	1,303,022
Total comprehensive revenue and expense for the year		299,351	(391,000)	27,728
Balance at 30 June	13	**1,622,906**	**916,000**	**1,330,750**

Explanations of major variances against budget are provided in Note 18.

The accompanying notes form part of these financial statements

Statement of cash flows for the year ended 30 June 2019

	Notes	Actual 2019 $	Budget 2019 $	Actual 2018 $
Cash flows from operating activities				
Receipts from the Crown		13,370,000	12,870,000	12,870,000
Interest received		60,439	50,000	55,254
Receipts from other revenue		77,980	70,000	110,843
Payments to suppliers		(5,486,610)	(5,906,000)	(5,787,907)
Payments to employees		(7,529,723)	(7,440,000)	(7,107,483)
GST (net)		(11,319)	-	29,298
Net cash from operating activities		**480,767**	**(356,000)**	**170,005**
Cash flows from investing activities				
Purchase of property, plant, and equipment		(114,351)	(91,000)	(85,004)
Purchase of intangible assets		(6,500)	(45,000)	(68,100)
Net cash from investing activities		**(120,851)**	**(136,000)**	**(153,104)**
Cash flows from financing activities				
Receipts from capital contribution		-	-	-
Net cash from financing activities		**-**	**-**	**-**
Net increase/(decrease) in cash and cash equivalents		**359,916**	**(492,000)**	**16,901**
Cash and cash equivalents at beginning of the year		**1,750,732**	**1,768,000**	**1,733,831**
Cash and cash equivalents at end of the year	5	**2,110,648**	**1,276,000**	**1,750,732**

Explanations of major variances against budget are provided in Note 18.

The accompanying notes form part of these financial statements

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1. Statement of accounting policies

Reporting entity

The Health and Disability Commissioner (HDC) has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for the Health and Disability Commissioner are for the year ended 30 June 2019, and were approved by the Commissioner on **30 October 2019**.

Basis of preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the year.

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 have been prepared in accordance with PBE Standards Reduced Disclosure Regime (RDR). The criteria under which HDC is eligible to report in accordance with PBE Standards RDR is that its total expenses are less than NZD30m.

PRESENTATION CURRENCY AND ROUNDING

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest dollar ($).

STANDARD EARLY ADOPTED

The Crown, and therefore HDC, have early adopted all of the requirements of PBE IFRS 9 Financial Instruments (PBE IFRS 9) as of 1 July 2018, replacing PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Under the transition options of PBE IFRS 9, HDC is not restating financial instrument comparatives for classification, measurement, and impairment.

Summary of significant accounting policies

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below.

GOODS AND SERVICE TAX (GST)

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, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the 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 a net 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 provision has been made for income tax.

BUDGET FIGURES

The budget figures are derived from the statement of performance expectations 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.

COST ALLOCATION

HDC has determined the cost of outputs using the following cost allocation system:

Direct costs are costs directly attributed to an output. Indirect costs are costs that cannot be attributed to a specific output in an economically feasible manner.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited 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:

- Useful lives and residual values of property, plant, and equipment — refer to Note 8.
- Useful lives of software assets — refer to Note 9

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

Management has exercised the following critical judgements in applying accounting policies:

- Leases classification — refer to Note 4.

2. Revenue

Accounting policy

The specific accounting policies for significant revenue items are explained below:

FUNDING FROM THE CROWN (NON-EXCHANGE REVENUE)

The Health and Disability Commissioner is primarily funded from the Crown. This funding is restricted in its use for the purpose of the Health and Disability Commissioner meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

The Health and Disability Commissioner considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

The fair value of revenue from the Crown has been determined to be equivalent to the amounts due in the funding arrangements.

INTEREST REVENUE

Interest revenue is recognised using the effective interest method.

SALE OF PUBLICATIONS

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

SUNDRY REVENUE

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date.

Breakdown of other revenue and further information

	Actual 2019 $	Actual 2018 $
Sale of publications	65,162	69,677
Advocacy Trust contribution to IT costs	140,514	145,245
Sundry revenue	15,300	59,927
Total other revenue	**220,976**	**274,849**

3. Personnel costs

Accounting policy

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 the surplus or deficit as incurred.

Breakdown of personnel costs and further information

	Actual 2019 $	Actual 2018 $
Salaries and wages	7,309,447	6,902,628
Defined contribution plan employer contributions	220,276	204,855
Increase/(decrease) in employee entitlements	31,156	47,202
Total personnel costs	**7,560,879**	**7,154,685**

Employer contributions to defined contribution plans include contributions to KiwiSaver and the Government Superannuation Fund.

Employee Remuneration

	Actual 2019 $	Actual 2018 $
Total remuneration paid or payable:		
100,000–109,999	1	1
110,000–119,999	1	3
120,000–129,999	3	2
130,000–139,999	1	1
140,000–149,999	-	1
150,000–159,999	1	-
160,000–169,999	1	1
170,000–179,999	1	1
180,000–189,999	1	-
230,000–239,999	-	1
240,000–249,999	-	2
250,000–259,999	3	-
370,000–379,999	-	1
380,000–389,999	1	-
Total Employees	**14**	**14**

During the year ended 30 June 2019, one employee received compensation and other benefits in relation to cessation totalling $4,660 (2018: $6,231).

COMMISSIONER'S TOTAL REMUNERATION

In accordance with the disclosure requirements of sections 152(1)(a) of the Crown Entities Act 2004, the total remuneration including all benefits paid to the Commissioner during the period 1 July 2018 to 30 June 2019 is $386,024 (2018: $377,807).

4. Other expenses

Breakdown of other expenses

	Actual 2019 $	Actual 2018 $
Advertising	20,293	21,974
Audit fees	46,786	45,340
Clinical and legal advice	527,480	607,281
Communications & IT	484,186	571,197
Inventories consumed	39,269	47,051
Net loss on property, plant, and equipment	1,460	-
Operating lease expense	471,880	466,121
Policy and operational consultancy	99,700	174,873
Staff travel and accommodation	171,636	180,439
Other expenses	353,129	291,823
Total other expenses	**2,215,819**	**2,406,099**

Accounting policy

OPERATING LEASES

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

OPERATING LEASES AS LESSEE

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

	Actual 2019 $	Actual 2018 $
Not later than one year	491,351	427,859
Later than one year and not later than five years	1,200,244	1,003,318
Later than five years	-	-
Total non-cancellable operating leases	**1,691,595**	**1,431,177**

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

A significant portion of the total non-cancellable operating lease expense relates to the lease of these two offices and office equipment (2018: two office leases and office equipment). The Auckland office lease expires in June 2023 and the Wellington lease expires in June 2022.

5. Cash and cash equivalents

Accounting policy

Cash and cash equivalents includes cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

	Actual 2019 $	Actual 2018 $
Cash on hand and at bank	1,110,648	750,732
Term deposits with maturities less than 3 months	1,000,000	1,000,000
Total cash and cash equivalents	**2,110,648**	**1,750,732**

While cash and cash equivalents at 30 June 2019 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

As at 30 June 2019, the Health and Disability Commissioner holds no unspent grant funding received that is subject to restrictions (2018: nil).

6. Receivables

Accounting policy

Short-term receivables are recorded at their face value, less any allowance for credit loss.

In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

There have been no changes during the reporting in the estimation techniques or significant assumptions used in measuring the loss allowance.

The receivable allowance for credit loss in 2019 is $4,980 (2018: nil).

	Actual 2019 $	Actual 2018 $
Trade receivables	16,452	16,145
Less: allowance for credit loss	(4,980)	-
Other receivables	7,430	8,028
Total receivables	**18,902**	**24,173**
Total receivables comprises:		
Receivables from the sale of goods and services (exchange transactions)	18,902	24,173
Receivables from the lease incentive payment (exchange transactions)	-	-

7. Inventories

Accounting policy

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 the surplus or deficit in the period of the write-down.

	Actual 2019 $	Actual 2018 $
Commercial inventories		
Publications held for sale	27,971	24,094
Total inventories	**27,971**	**24,094**

The write-down of inventories in 2019 amounted to $836 (2018: nil). There were no net write-down reversals in 2019 (2018: $310). No inventories are pledged as security for liabilities (2018: nil).

8. Property, plant, and equipment

Accounting policy

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

Property, plant, and equipment are measured at cost, less 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 HDC and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

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 the surplus or 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 HDC 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 the surplus or 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 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.

ESTIMATING USEFUL LIVES AND RESIDUAL VALUES OF PROPERTY, PLANT, AND EQUIPMENT

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 the surplus or deficit, and the 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; and
- asset replacement programmes.

The Health and Disability Commissioner has not made significant changes to past assumptions concerning useful lives and residual values.

Movements for each class of property, plant, and equipment are as follows:

	Computer hardware $	Comm-unications equipment $	Furniture & fittings $	Leasehold improve-ments $	Motor vehicles $	Office equipment $	Total $
Cost or valuation							
Balance at 1 July 2017	466,443	3,650	161,145	656,393	40,889	60,129	1,388,649
Balance at 30 June 2018	537,089	7,145	169,099	656,393	40,889	61,520	1,472,135
Additions	90,775	2,466	12,884	7,941	-	1,745	115,811
Disposals	(54,842)	(3,345)	(5,314)	-	-	(12,633)	(76,134)
Transfer to assets held for sale	-	(1,106)	-	-	-	-	(1,106)
Balance at 30 June 2019	**573,022**	**5,160**	**176,669**	**664,334**	**40,889**	**50,632**	**1,510,706**
Accumulated depreciation and impairment losses							
Balance at 1 July 2017	343,280	2,692	158,699	650,264	40,889	55,447	1,251,271
Balance at 30 June 2018	443,387	4,536	160,719	652,563	40,889	58,409	1,360,503
Depreciation expense	48,740	2,743	15,244	2,954	-	2,505	72,186
Disposals	(53,825)	(2,902)	(5,314)	-	-	(12,631)	(74,672)
Transfer to assets held for sale	-	(1,106)	-	-	-	-	(1,106)
Balance at 30 June 2019	**438,302**	**3,271**	**170,649**	**655,517**	**40,889**	**48,283**	**1,356,911**
Carrying amounts							
At 1 July 2017	**123,163**	**958**	**2,446**	**6,129**	**-**	**4,682**	**137,378**
At 30 June 2018/ 1 July 2018	**93,702**	**2,609**	**8,380**	**3,830**	**-**	**3,111**	**111,632**
At 30 June 2019	**134,720**	**1,889**	**6,020**	**8,817**	**-**	**2,349**	**153,795**

There are no restrictions on the Health and Disability Commissioner's property, plant, and equipment.

During the year, HDC disposed of some computer hardware, communications equipment, furniture, and office equipment that had reached the end of its useful life.

The net loss on all disposals was 1,460 (2018: nil).

There are no capital commitments at balance date (2018: nil).

9. Intangible assets

Accounting policy

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 that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development employee costs and relevant overheads.

Staff training costs are recognised as an expense when incurred.

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

Costs associated with the maintenance of HDC'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 derecognised. The amortisation charge for each period is recognised in the surplus or deficit.

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

Acquired computer software
3 years (33%)

Developed computer software
3 years (33%)

Movements for each class of intangible asset are as follows:

	Acquired software $	Internally generated software $	Total $
Cost			
Balance at 1 July 2017	632,647	248,516	881,163
Balance at 30 June 2018/1 July 2018	700,747	248,516	949,263
Additions	6,501	-	6,501
Transfer	1,106	-	1,106
Balance at 30 June 2019	**708,354**	**248,516**	**956,870**
Accumulated amortisation and impairment losses			
Balance at 1 July 2017	521,441	248,516	769,957
Balance at 30 June 2018/1 July 2018	535,465	248,516	783,981
Amortisation expense	17,271	-	17,271
Transfer	1,106	-	1,106
Balance at 30 June 2019	**553,842**	**248,516**	**802,358**
Carrying amounts			
At 1 July 2017	**111,206**	**-**	**111,206**
At 30 June 2018/1 July 2018	**165,282**	**-**	**165,282**
At 30 June 2019	**154,512**	**-**	**154,512**

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.

There are no capital commitments at balance date (2018: nil).

10. Payables

Accounting policy

Short-term payables are recorded at their face value.

Breakdown of payables and deferred revenue

	Actual 2019 $	Actual 2018 $
Payables under exchange transactions		
Creditors	135,622	139,751
Accrued expenses	105,293	59,010
Lease incentive	10,593	17,514
Total payables under exchange transactions	251,508	216,275
Payable under non-exchange transactions		
Taxes payable (GST, PAYE, and rates)	159,353	175,228
Total payables under non-exchange transactions	159,353	175,228
Total current payables	**410,861**	**391,503**
Lease incentives	31,779	42,371
Total non-current payables	31,779	42,371
Total payables	**442,640**	**433,874**

11. Employee entitlements

Accounting policy

SHORT-TERM EMPLOYEE ENTITLEMENTS

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, and paid sick leave.

Employee entitlements

	Actual 2019 $	Actual 2018 $
Current portion		
Annual leave	439,448	408,292
Total employee entitlements	**439,448**	**408,292**

12. Contingencies

Contingent liabilities

As at 30 June 2019 there were no contingent liabilities (2018: nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2018: nil).

13. Equity

Accounting policy

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- contributed capital; and
- accumulated surplus or deficit.

	Actual 2019 $	Actual 2018 $
Contributed capital		
Balance at 1 July	788,000	788,000
Capital contribution	-	-
Balance at 30 June	788,000	788,000
Accumulated surplus/(deficit)		
Balance at 1 July	542,750	515,022
Adjustment from the adoption of PBE IFRS 9	(7,195)	-
Adjusted balance at 1 July	535,555	515,022
Surplus/(deficit) for the year	299,351	27,728
Balance at 30 June	**834,906**	**542,750**
Total equity	**1,622,906**	**1,330,750**

14. Related party transactions

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

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect HDC would have received in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Ministry of Health, Ministry of Inland Revenue, ACC, and New Zealand Post) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel compensation

	Actual 2019 $	Actual 2018 $
Leadership Team		
Remuneration	1,993,745	1,973,597
Full-time equivalent members	8.87	8.95
Total key management personnel remuneration	**1,993,745**	**1,973,597**
Total full-time equivalent personnel	**8.87**	**8.95**

15. Financial instruments

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

	Actual 2019 $	Actual 2018 $
Financial assets measured at amortised cost		
Cash and cash equivalents	1,110,648	750,732
Receivables	18,902	24,173
Investments — term deposits	1,000,000	1,000,000
Total financial assets measured at amortised cost	**2,219,550**	**1,774,905**
Financial liabilities measured at amortised cost		
Payables (excluding income in advance, lease incentive, taxes payable and grants received subject to conditions)	240,916	198,761
Total financial liabilities measured at amortised cost	**240,916**	**198,761**

16. Events after the balance date

There were no significant events after the balance date.

17. Adoption of PBE IFRS 9 Financial Instruments

Accounting policies have been updated to comply with PBE IFRS 9. The main updates are:

- Note 6 Receivables: This policy has been updated to reflect that the short-term receivables are now measured at the amount due, less any allowance for credit loss — determined by applying an expected credit loss model.

On the date of initial application of PBE IFRS 9, being 1 July 2018, the classification of financial instruments under PBE IPSAS29 and PBE IFRS 9 is as follows:

	Measurement category		Carrying amounts		
	Original PBE IPSAS 29 category (PBE IPSAS 29)	New PBE IFRS 9 category (PBE IPSAS 9)	Closing balance 30 June 2018 $	Adoption of PBE IFRS 9 adjustment	Opening balance 1 July 2018 $
Cost or valuation					
Cash and cash equivalents	Loans and receivables	Amortised cost	750,732	-	750,732
Receivables	Loans and receivables	Amortised cost	24,173	(7,195)	16,978
Investments — term deposits	Loans and receivables	Amortised cost	1,000,000	-	1,000,000
Total financial assets			**1,774,905**	**(7,195)**	**1,767,710**

18. Explanation of major variances against budget

Explanations for major variances from HDC's budgeted figures in the statement of performance expectation are as follows:

Statement of comprehensive revenue and expense

TOTAL REVENUE

Ministry of Health provided a one-off funding increase of $500,000 in June 2019 to help address the back-log caused by the significant increase of complaints in the previous two years.

TOTAL EXPENDITURE

Personnel costs were higher than budget by $120,879, mainly due to more staff being hired in response to the increased volume of complaints received.

Other expenses were $278,181 lower than budget, as a result of prudent financial management and the benefit of unbudgeted court cost recoveries.

Overall, HDC managed its total expenditure under the budget by $189,535.

Statement of financial position

Cash and cash equivalents were higher than budgeted as the one-off funding increase was received from the Ministry of Health in June 2019.

Payables were higher than budgeted owing to more costs incurred towards the year end.

Statement of equity

The closing equity balance was $706,906 higher than budgeted owing to a higher opening balance and the surplus for the year.

Statement of cash flows

The higher net cash movement was mainly a result of the one-off funding increase from Ministry of Health and the unbudgeted court cost recovery received.

8.0 Statement of responsibility

Statement of Responsibility

We are responsible for the preparation of the Health and Disability Commissioner's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Health and Disability Commissioner under section 19A of the Public Finance Act 1989.

We have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Health and Disability Commissioner for the year ended 30 June 2019.

Anthony Hill
Health and Disability Commissioner

Jason Zhang
Corporate Services Manager

30 October 2019

9.0 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 performance information for the year ended 30 June 2019

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, David Walker, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health and Disability Commissioner on his behalf.

Opinion

We have audited:

- the financial statements of the Health and Disability Commissioner on pages 65 to 86, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of the Health and Disability Commissioner on pages 51 to 63.

In our opinion:

- the financial statements of the Health and Disability Commissioner on pages 65 to 86:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards Reduced Disclosure Regime; and
- the performance information on pages 51 to 63:
    - presents fairly, in all material respects, the Health and Disability Commissioner's performance for the year ended 30 June 2019, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 30 October 2019. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Commissioner and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of the Commissioner for the financial statements and the performance information

The Commissioner is responsible on behalf of the Health and Disability Commissioner for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Commissioner is responsible for such internal control as it is necessary to enable the Health and Disability Commissioner to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Commissioner is responsible on behalf of the Health and Disability Commissioner for assessing the Health and Disability Commissioner's ability to continue as a going concern. The Commissioner is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the Health and Disability Commissioner, or there is no realistic alternative but to do so.

The Commissioner's responsibilities arise from the Crown Entities Act 2004 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health and Disability Commissioner's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit 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.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Commissioner.
- We evaluate the appropriateness of the reported performance information within the Health and Disability Commissioner's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Commissioner and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Health and Disability Commissioner's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the

audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health and Disability Commissioner to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Commissioner regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Commissioner is responsible for the other information. The other information comprises the information included on pages 1 to 50, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

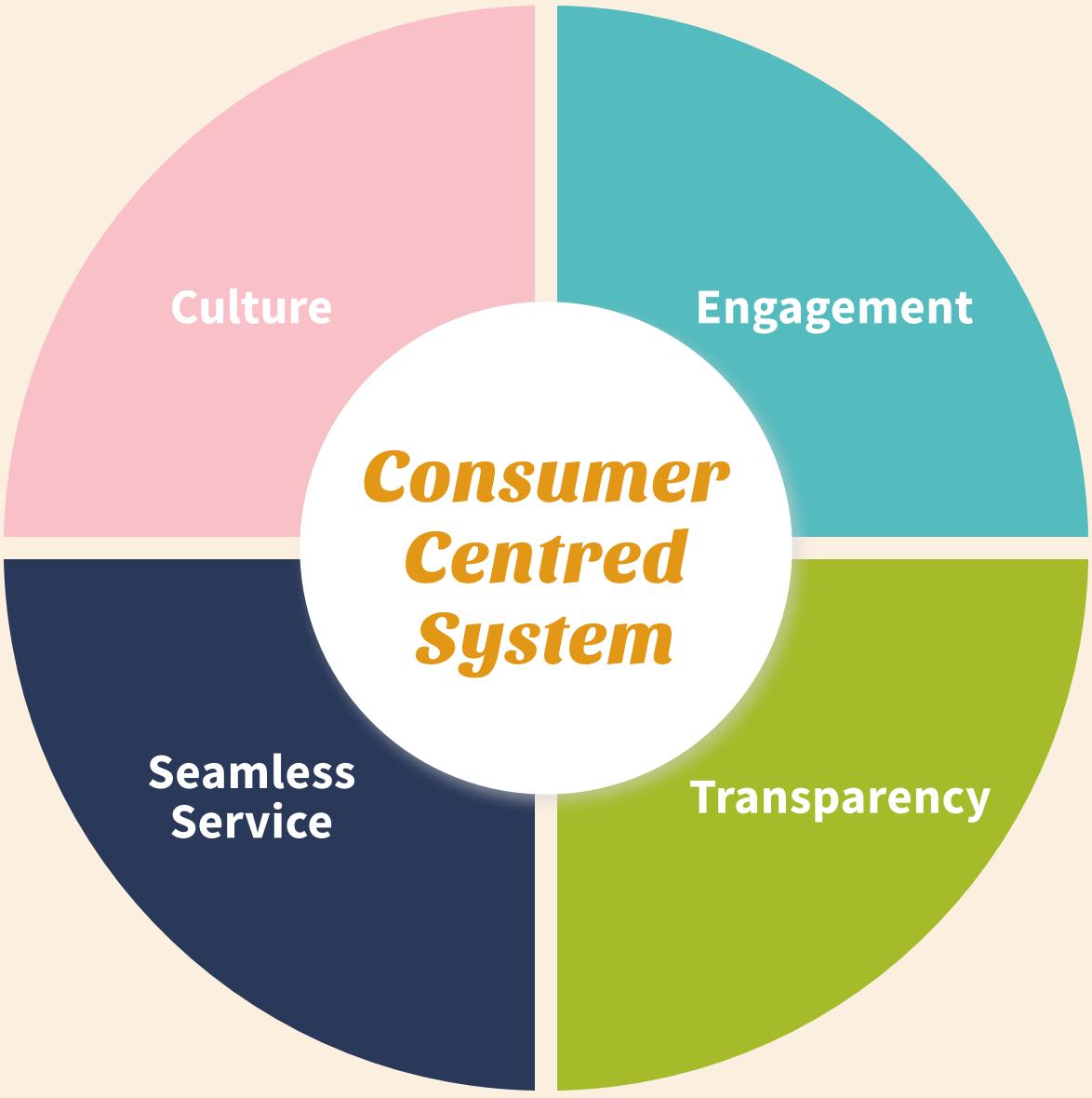
In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health and Disability Commissioner in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 (Revised): *Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

Other than in our capacity as auditor, we have no relationship with, or interests, in the Health and Disability Commissioner.

David Walker
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand


Culture
Engagement
Consumer Centred System
Seamless Service
Transparency

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