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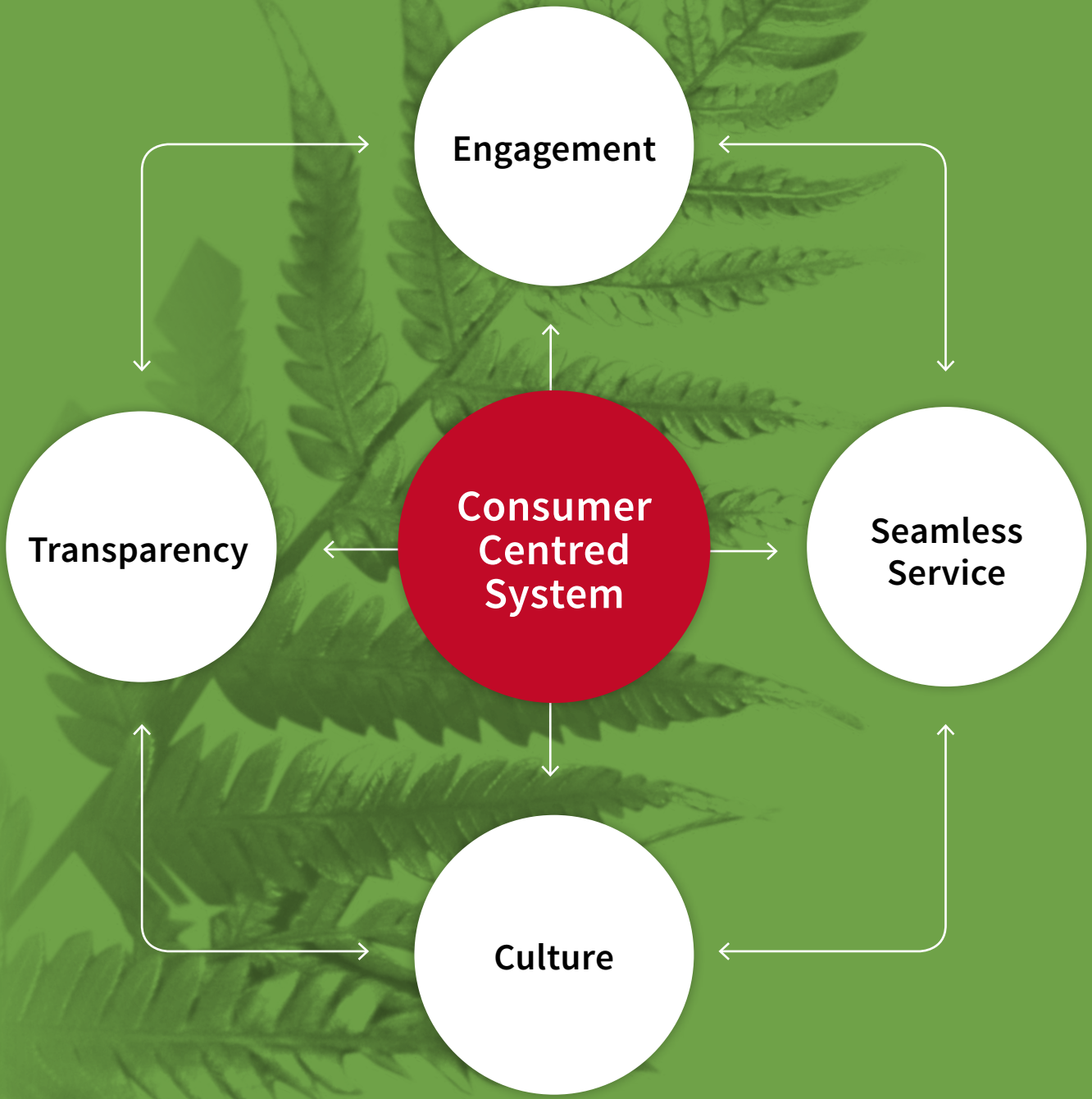
HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

ANNUAL REPORT FOR THE YEAR ENDED 30 JUNE 2015


Engagement
Transparency
Consumer Centred System
Seamless Service
Culture

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

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Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

30 October 2015

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 2015.

Yours faithfully,

Anthony Hill

Health and Disability Commissioner

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Commissioner's Foreword

Anthony Hill
Health and Disability Commissioner

New Zealand's health and disability sector is a sector we can be proud of, with an impressive workforce delivering services with exceptional dedication, skill and passion. However, as with any system, there is always room for improvement. As in previous years, in 2014/15, HDC received complaints that ranged from the comparatively minor to the devastating. What these complaints had in common was their ability to shine a light on areas where improvements could be made.

The value that a robust complaints process adds to improving the provision of services cannot be overstated, and HDC's privileged role of promoting and protecting consumer rights is not one that is taken lightly. To that end, I am always cognisant of the profound effect that a resolved complaint can have on both individuals and on the sector itself, and am continually encouraged by the positive changes we see. Whether it is an apology, amended policies, further training, or sector-wide changes, steps are frequently being taken across New Zealand to make health and disability services more consumer-centred. HDC plays an integral role in that journey.

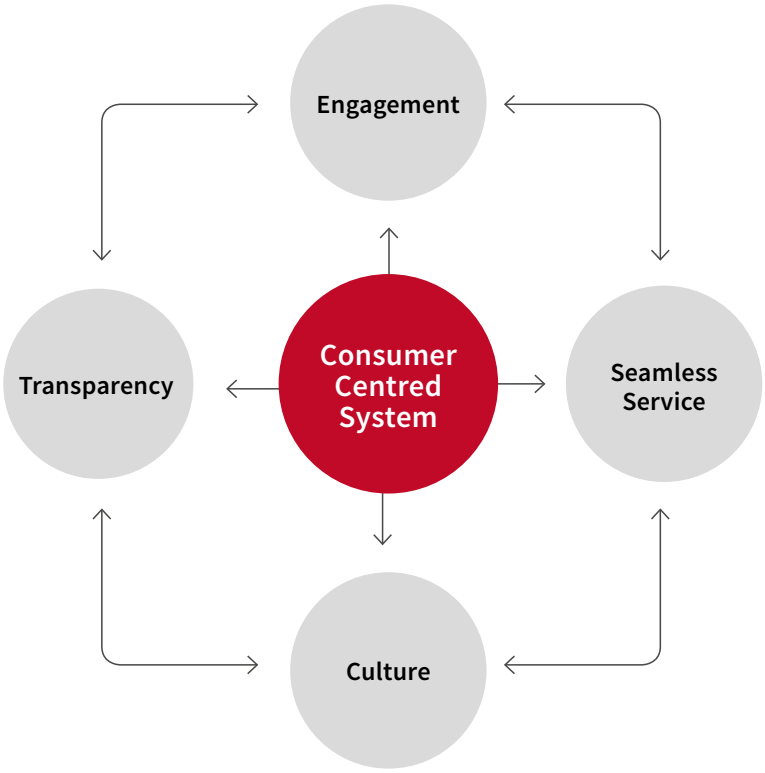
Consumer-centred care

HDC's vision is of a consumer-centred system. A health and disability system where consumers are at the centre of services is one characterised by transparency, by engagement, by seamless service, and by a culture that is consumer-centred in its focus and operation. These concepts sit alongside the Code of Health and Disability Services Consumers' Rights (the Code) and, operating together, promote an environment in which the Code can and will be upheld.

Where a consumer-centred culture is not upheld, the rights of consumers often fall through the cracks. This is often seen in complaints to HDC. In a complaint closed this year, an elderly man in a psychiatric hospital was found lying, mostly naked, on the floor of his room with the water running. Over the next 14 hours, the man was seen by eight different nurses at the psychiatric hospital. Some of these nurses raised concerns about the man's presentation; however, no specific action was taken in response to these concerns. The man was left lying on the floor until the following afternoon. At afternoon handover the next day, the registered nurse in charge noted that the man was cold and that he looked pale. Following review, the man was transferred to a public hospital, where it was found that he had a large subdural bleed that was too extensive to treat. Sadly, the man died that evening. Three of the nurses and the DHB were found to have breached the Code for the care provided to the man. HDC's report was also critical of the DHB regarding its environment, culture, and the failure to ensure that staff were familiar with policies and protocols. It was noted that there appeared to be a culture at the psychiatric hospital where less experienced staff felt disempowered and unable to advocate for the man, despite having concerns. It is complaints like this that highlight the important part that culture plays in providing consumer-centred care.

When consumer rights are promoted and protected, we create an environment in which the activities and attitudes of individual providers, and the culture of their workplaces, is encouraged, in fact required, to become more consumer-centred. Everything that HDC does is done with this vision in mind.

Where a consumer-centred culture is not upheld, the rights of consumers often fall through the cracks.



Resolving complaints

The 2014/15 year saw HDC both receive and resolve a record number of complaints. This is off the back of a record-breaking year in 2013/14.

The challenge that this increase in complaints presents to the organisation has been met head on, with a dedicated and talented team of staff working tirelessly to resolve complaints fairly, through a robust and just process. HDC would not be able to make the difference that it does without their work, and that of the experts who advise us in our decision-making process. I am forever grateful to all of the individuals who together enable HDC to do what it does, so well.

As I often note, although complaint numbers are growing, this does not necessarily reflect a change in the quality of care being provided throughout the health and disability sector. HDC's profile has continued to grow and, as a result, consumers are more aware of their own rights and the role of HDC's complaints process. This increase in complaint numbers should be viewed as an increased opportunity to effect changes in the sector, influencing positive change for both consumers and providers.

Effecting change

Each complaint that HDC receives tells a story. The 1,880 stories told to HDC this year represent 1,880 potential opportunities to learn and to improve the system.

Positive change and system improvement at a local level occurs in the majority of complaints that come to HDC, either in response to direct recommendations made by HDC, or through providers taking proactive steps in response to issues raised. These changes result in safer, higher quality service delivery by individual providers, and in stronger local systems.

The opportunities for positive change are not limited to the local level, and the sector as a whole can also benefit from the learnings we are able to take from complaints. This year we took a further step in harnessing the data we collect from complaints, producing the first annual DHB report, a full-year analysis of complaints involving DHBs, and a report on ten years of complaints about delayed diagnosis of cancer in primary care. These reports present an opportunity for the sector to learn from the trends and themes that emerge in complaints to HDC, enabling providers to use those insights to support quality improvement.

HDC continues to be a strong voice in the health and disability sector. Promoting consumer rights remains at the heart of what HDC does, as we influence the ideology of the health and disability sector to become more consumer-centred.

Advocacy

Sadly, in February 2015, Judi Strid, the Director of Advocacy since 2004, passed away. Judi was a tireless advocate for the rights of consumers. She was a valued colleague and a remarkable human being, and it was a privilege to have shared part of her journey with her. She will be long remembered, and the principles she stood for — the rights of consumers — will endure.

Disability

The disability team has worked with dedication and passion to ensure that the rights of all consumers, including the most vulnerable, are known and upheld. A number of new resources to support disabled consumers have been created in the past year, supporting our focus on increasing the volume of the unheard voice.

Mental health and addictions

The mental health and addictions team has had an active year in the sector. In particular, an extensive range of projects has been completed to help services meet the needs of consumers, and to empower consumers and their families/whānau to be active participants in their care.

Conclusion

In July 2015, I completed my first term as Commissioner. Having been reappointed for a second three-year term, I look forward to continuing to lead the important work that HDC does, protecting and improving consumers' experience of New Zealand's health and disability system.

Promoting consumer rights remains at the heart of what HDC does.

1.0 The Year in Review

1.1 2014/15 priorities

In line with HDC's vision and Statement of Intent for 2014–18, HDC's strategic priorities for the 2014/15 year were to:

- resolve complaints in a timely and effective way while dealing with the sharply increasing volume and complexity;
- work with district health boards (DHBs), health providers and disability service providers to improve their complaints processes so that complaints are resolved at the lowest possible appropriate level;
- continue to work closely with the Health Quality and Safety Commission (HQSC) and other key stakeholders to effect change from complaint learnings;
- operate a financially sustainable organisation resourced appropriately for business size and complexity; and
- strive for continuous improvement in the way HDC operates.

Wide-reaching recommendations were made across the sector for real and lasting improvements.

1.2 2014/15 performance highlights

The purpose and overriding strategic intent of HDC is to promote and protect the rights of consumers as set out in the Code of Health and Disability Services Consumers' Rights (the Code). There are three main strategic objectives that feed into this priority:

- To resolve complaints.
- To improve quality within the health and disability sectors.
- To appropriately hold providers to account.

HDC had a very successful year in 2014/15, and met its strategic priorities in a number of ways.

The 2014/15 year saw HDC receive and close its highest ever number of complaints:

- 1,880 complaints were received.
- 1,910 complaints were closed.
- 100 formal investigations were completed.
- 70 formal investigations resulted in breach opinions.
- 14 providers were referred to the Director of Proceedings.

Timeliness targets were achieved in every category of complaints.

As a result of these complaints, wide-reaching recommendations were made across the sector for real and lasting improvements to health and disability services and systems.

HDC has continued to provide detailed six-monthly reports to DHBs on the numbers and types of complaints received in relation to DHB services. This year, HDC also published its first annual report of complaints about DHB services.

In 2014/15 HDC also published a report entitled: "Delayed Diagnosis of Cancer in Primary Care: Complaints to the Health and Disability Commissioner: 2004–2013". That report analysed the trends and themes in ten years of complaints and brought together key recommendations made, so as to inform quality improvement initiatives.

As in previous years, HDC has continued to deliver presentations to various provider and consumer groups about relevant topics including HDC's role, the Health and Disability Commissioner Act 1994 (the Act) and the Code. HDC's biennial conference was held in March, with more than 200 people from across the health and disability sectors attending.

HDC also continued its focus on empowering providers to better deal with complaints themselves, including by running complaints management workshops at DHBs, and by producing a complaints management guide for primary care, disseminated through Primary Health Organisations.

HDC has continued to work closely with key stakeholders in a range of areas. In particular, learnings from HDC complaints have been shared with HQSC, ACC and the Ministry of Health through involvement in a regular information sharing forum. HDC has also worked in collaboration with many other organisations in the mental health and addictions, and disability settings. In mental health and addictions, the real-time consumer feedback system has been a particular highlight. In the disability area, HDC has worked in partnership with others to produce a number of resources to assist disability service consumers to know and exercise their rights. Resources include an easy-read guide of HDC's Health Passport, a plain language peer-to-peer video on the Code for people with learning disabilities, and three new "Know Your Rights" resources for disabled people who receive individualised funding.

Despite the increase in demand for HDC's services, and HDC's record output, a surplus was still delivered. The surplus enabled HDC to recover from prior year deficits and restore equity to an appropriate amount. This was due to ongoing prudent financial management and an attitude of continuously looking to achieve more with less.

2.0 Role of the Health and Disability Commissioner

2.1 Purpose and role

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

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

1. Respect.
2. Fair treatment.
3. Dignity and independence.
4. Appropriate standard of care.
5. Effective communication.
6. Full information.
7. Informed choice and consent.
8. Support.
9. Teaching and research.
10. Right to complain.

Vision *Tā mātou matakite*

Consumers at the centre of services
Ko ngā kiritaki te mauri o ngā ratonga

Mission *Te Whāinga*

Independently upholding consumer rights by:
He whakatairanga motuhake i ngā tika o ngā kiritaki mā te:

- **Promotion and protection**
  Whakatairanga me te whakahaumaru
- **Resolving complaints**
  Te whakatau whakapae
- **Service monitoring and advocacy**
  Te arotake ratonga me te tautoko i te tangata
- **Education**
  Te mātauranga

HDC's Strategy

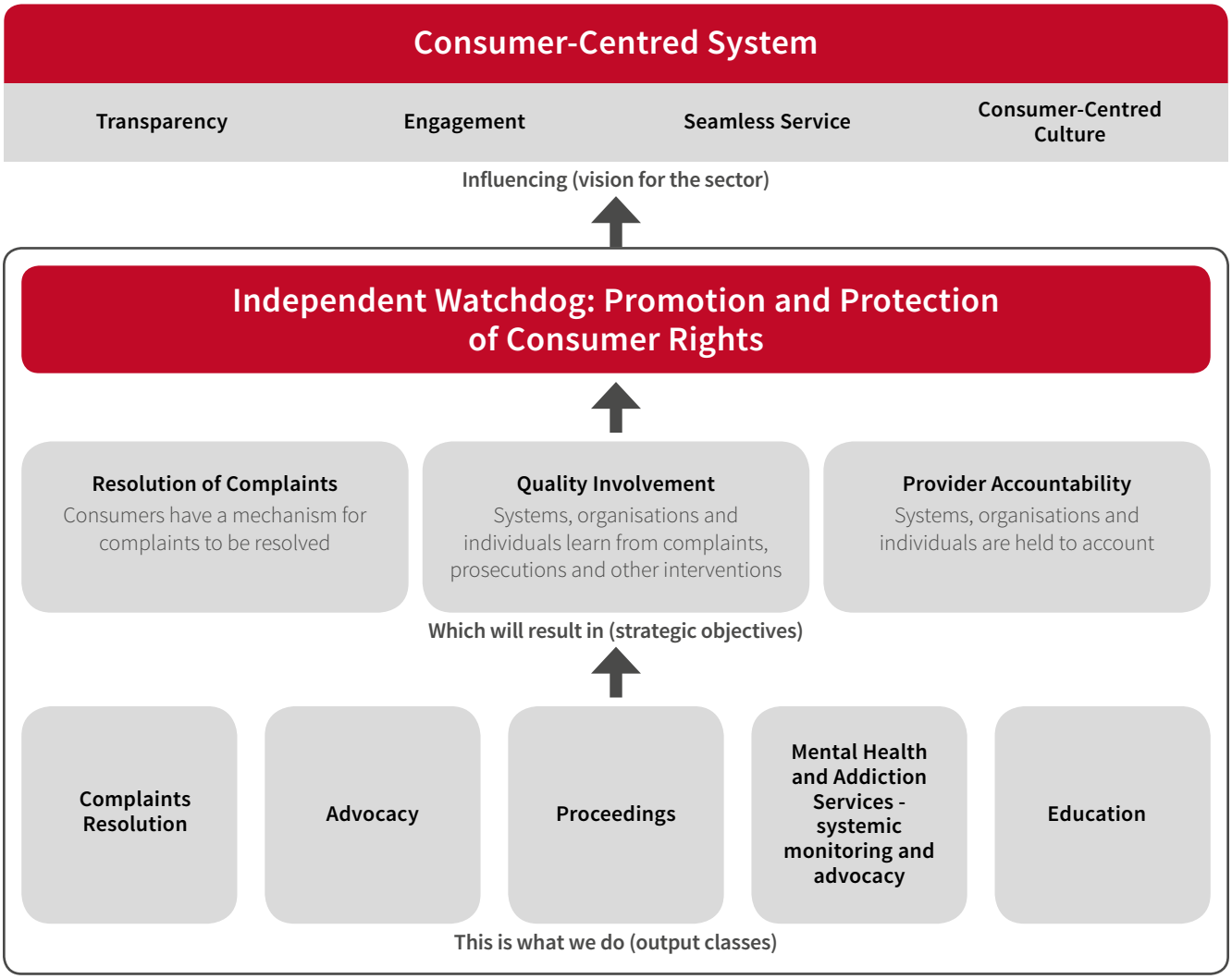


Figure 1: Overview of how HDC's output classes link to its strategic objectives in order to support the overriding strategic intention. The impact of HDC's outputs and objectives then flow through to HDC's consumer-centred vision for the sector.

2.2 HDC's strategic intent

As noted above, HDC's principal statutory mandate is to promote and protect consumers' rights as set out in the Code. The Commissioner is independent of providers, of consumers and of government policy, allowing him to be an effective watchdog in relation to those rights.

2.3 HDC's strategic objectives

HDC has three principal strategic objectives which together promote and protect consumer rights more effectively than any one of them could do alone. These are:

- Resolution of complaints.
- Quality improvement.
- Provider accountability.

The effective resolution of complaints is a legitimate and valuable outcome in and of itself in a country where medico-legal litigation is largely unavailable to consumers. However, it is also the route to provider accountability through the Commissioner's findings of non-compliance, and to quality improvement through the recommendations and educative comments that typically accompany such findings. Provider accountability is also important in the context of New Zealand's no fault treatment injury regime. The mere existence of accountability mechanisms is an important driver for change and thus quality improvement, both at an individual and systemic level. In addition, in some cases, it is only through appropriate accountability that true resolution can occur.

The outcome of quality improvement has self-evident intrinsic value, but it also plays a part in effective complaints resolution, as the express motivation of many complainants is to see change occur so that what happened to them does not happen to others. Providers are also held to account for their own quality improvement through HDC's monitoring and audit of the recommendations made.

These strategic objectives are important for the difference they make to consumers as well as the difference they make to the wider population.

2.4 The difference HDC makes

The difference HDC makes for consumers

Through resolution of complaints, quality improvement and provider accountability, HDC minimises the harm and maximises the well-being that consumers experience in their dealings with, and use of, health and disability services. By learning, addressing unacceptable behaviour and avoiding repetition of errors, the system improves experiences and outcomes for consumers, reduces preventable harm and, over time, reduces system costs.

The key difference HDC makes to consumers is to:

- resolve consumer complaints, assisting with the healing process;
- increase the focus on consumers with increasing transparency, integration and engagement of consumers with the system;
- reduce the incidence of preventable physical injury and death through unsafe, poor quality systems and practices;
- reduce the stress experienced by consumers and increase their confidence in health and disability services, including provider complaint processes;
- increase the quality of communication and improve relationships between consumers and health and disability service providers; and
- promote awareness of, respect for, and observance of, the rights of consumers, with particular emphasis on the rights of vulnerable consumers.

The difference HDC makes for New Zealand

HDC's strategic objectives are consistent with, and contribute to, the achievement of the Government's intermediate and long-term health and disability systems outcomes:

- New Zealanders live longer, healthier, more independent lives.
- The health system is cost effective and supports a productive economy.
- High-quality health and disability services are delivered in a timely and accessible manner.
- Future sustainability of the health and disability system is assured.

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

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

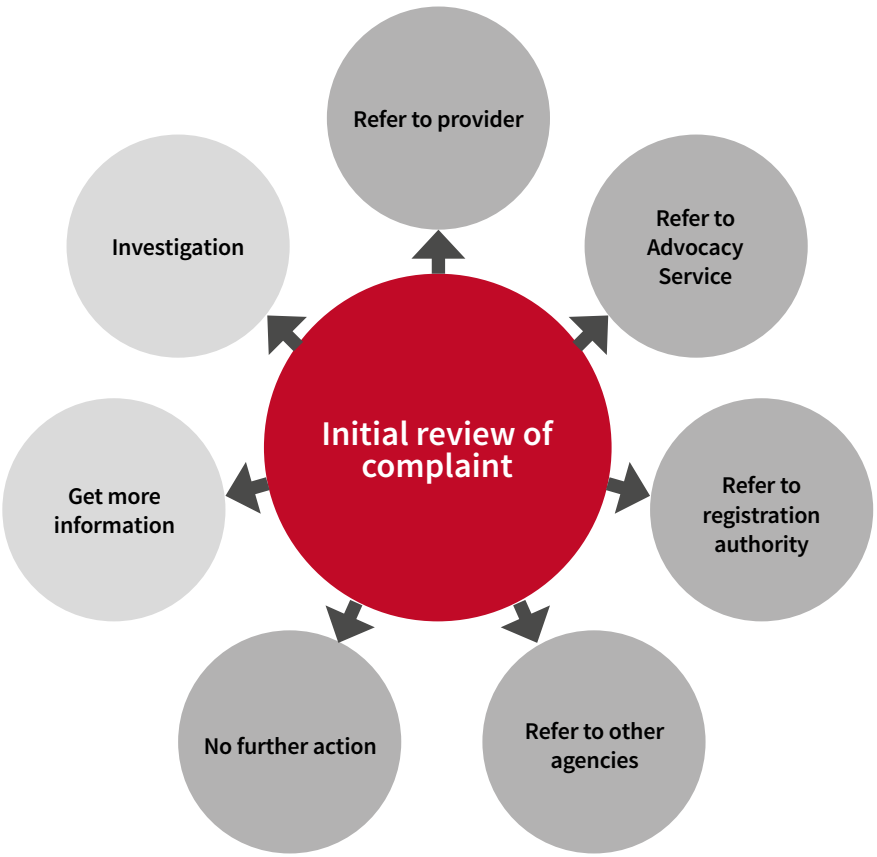
A significant number of providers made changes to their systems, policies and procedures as a result of a consumer's complaint.

Changes made by providers as a result of complaints in 2014/15

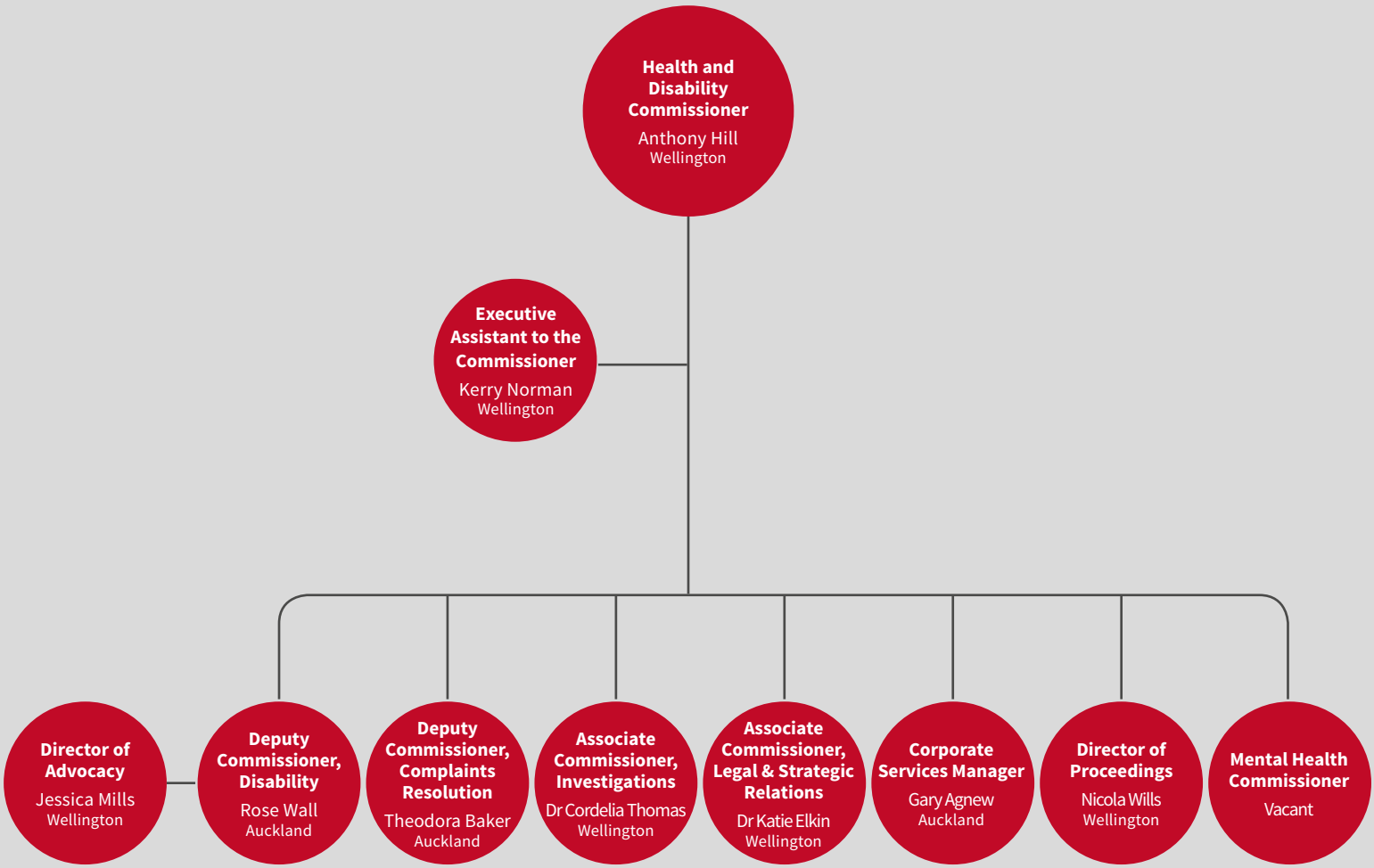
During the 2014/15 year, a significant number of providers made changes to their systems, policies and procedures as a result of a consumer's complaint. Below is a small selection of the changes made:

1. As part of an apology letter to a deceased man's family, a DHB accepted that it should have provided the man with a timeframe in which he would be seen in its services, and provided him with information about what he should do if he had not heard from the DHB and his condition changed. The DHB has changed the information it provides to patients and their general practitioners (GPs) as a result of this investigation.
2. In response to a complaint about inadequate pain relief, a large rest home facility provider updated its Pain Assessment Tool in all of its rest homes.
3. A woman had a contraceptive device inserted by her GP when she already had one in situ. The GP failed to remove the first device or adequately assess the woman's contraceptive history. The GP clinic made the following changes as a result of the investigation:
   i. An IUCD pre-insertion checklist was developed to prompt the treating doctor to check the patient's contraceptive history and other details to see if IUCDs are safe and appropriate to use. The screening template also provides a recall reminder for medical staff.
   ii. A guideline for doctors inserting contraceptive implants, IUCDs and intrauterine systems was developed.
   iii. There are now specific consent forms for IUCD and intrauterine system insertions, and these have been incorporated into the IUCD screening template.
4. It was recommended that a DHB develop a process to ensure that clinicians prescribing and administering medication are not interrupted or otherwise exposed to factors associated with increased errors. The DHB introduced MedChart, a computer program for electronic prescribing and administration, to replace paper medication charts.
5. As a result of a complaint about inadequate pain medication, policies and procedures for medication administration and documentation requirements were updated at a prison, and further training provided. An audit indicated a significant improvement in medication administration.
6. A mental health service consumer complained that her mental health service provider moved a flatmate into her flat (reserved for community based mental health patients) without adequate consultation. As a result, the mental health service provider developed a pathway for staff to follow for two or more service users sharing accommodation, to ensure that service users are part of the decision-making process.
7. A complaint about inadequate treatment and care of an older woman in hospital revealed that the handover process between two hospitals was deficient, and that there was poor communication with the family regarding the patient's clinical situation. Following the complaint, the provider developed a new handover form, using the ISBAR communication tool to ensure that vital clinical information is passed on, and a family meeting is now offered when there is an unexpected outcome or adverse event.

Figure 2: Available actions on assessment of a complaint



Organisation Structure



3.0 HDC Key Activities 2014/15

As seen in Figure 1, HDC achieves its strategic objectives through five principal output classes (key activities). These are:

1. Complaints resolution.
2. Advocacy.
3. Proceedings.
4. Education.
5. Mental health and addiction services — systemic monitoring and advocacy.

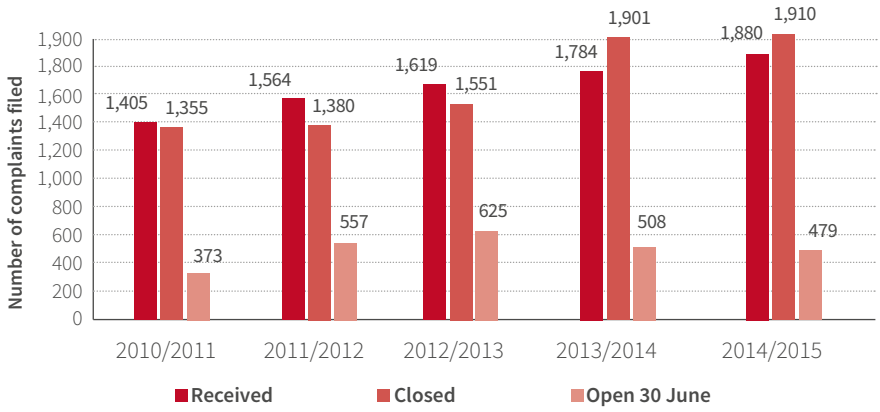
Perhaps the most significant of these is complaints resolution — a key output in the achievement of HDC's three strategic objectives. Complaints may be resolved in a number of ways but, consistent with legislative requirements, HDC's focus is on effective local and early resolution. HDC, through the Director of Advocacy, contracts with the National Advocacy Trust for the provision of advocacy services. This is critical in ensuring success in that space, with advocates around the country assisting consumers to work with providers to achieve resolution without the need for a formal complaint to HDC. At the other end of the spectrum, there are cases in which formal proceedings against a provider are necessary to promote and protect consumer rights.

Service monitoring is undertaken in a variety of ways, with the resulting systemic advocacy being informed by the results of that monitoring, along with the insight HDC gathers from its complaints resolution service. The education output class is both informed by the other output classes, which may identify the need for education on specific consumer rights, and is also an outcome of those output classes, particularly in relation to the specific providers engaged in those other processes.

The following sections report on each of HDC's five principal output classes, including a focus on disability, and also reflect how these outputs have effected change in the provision of services to health and disability service consumers. The following also reflects on the specific ways in which each output class has contributed to the delivery of HDC's strategic priorities for 2014–2018.

HDC's focus is on effective local and early resolution.

Figure 3: Complaints received and closed from 1 July 2010 to 30 June 2015



3.1 Complaints resolution

The rate of incoming complaints continues to rise. This year HDC received a total of 1,880 complaints. This represents a 5% increase on last year and a 33% increase in the four years since June 2011. Despite this increase in activity, HDC has successfully improved its timeliness in complaints resolution. HDC closed 1,910 complaints and ended the year with 479 open complaints, which is 29 fewer open complaints than at the end of last year (see Figure 3). The age of open files has also dropped, with the average age of a file across the organisation having reduced by over one month from 168 days to 136 days; and 77% of all open files are now less than six months old.

Anyone may complain to HDC. Approximately 49% of the 1,880 complaints received were from a consumer, with 29% being from a relative. There has been no significant change in the nature of the complaints, with the statistics showing a similar spread across primary issues, provider types and outcomes to previous years (see Figures 4, 5 and 6, and Table 1).

The Act provides the Commissioner with broad discretionary decision-making powers, which are used to ensure quality and fairness in complaints assessment processes and in the resulting decisions.

On receipt of a complaint, there is a range of options available (see Figure 2). Where "the complaint does not raise questions about the health or safety of members of the public and can, in the Commissioner's opinion, be appropriately resolved by the provider", HDC may decide to refer the matter back to the provider to deal with (section 34(1)(d)). As shown in Table 1, this occurred in 302 cases in the last year. In a further 96 cases, the matter was formally referred to the Advocacy Service. In many others, consumers were given information about the Advocacy Service so that they could use that service, if they wished to do so. In 75 cases, a referral was made to a registration authority, on the basis that it appeared "… from the complaint that the competence of a health practitioner or his or her fitness to practise or the appropriateness of his or her conduct may be in doubt". In each of the three referral situations, the person or agency to whom the referral is made is required to report back to HDC as to the steps taken and the outcome (either under section 35 or section 37 of the Act).

Figure 4: Complaints received — Primary issue

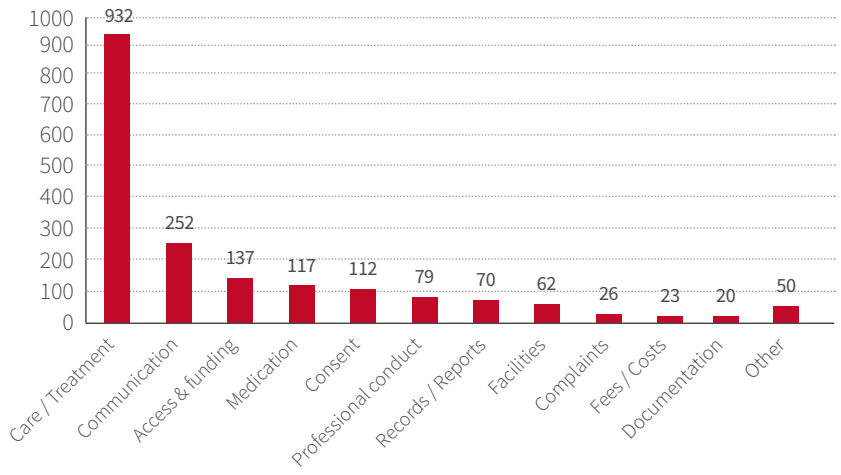
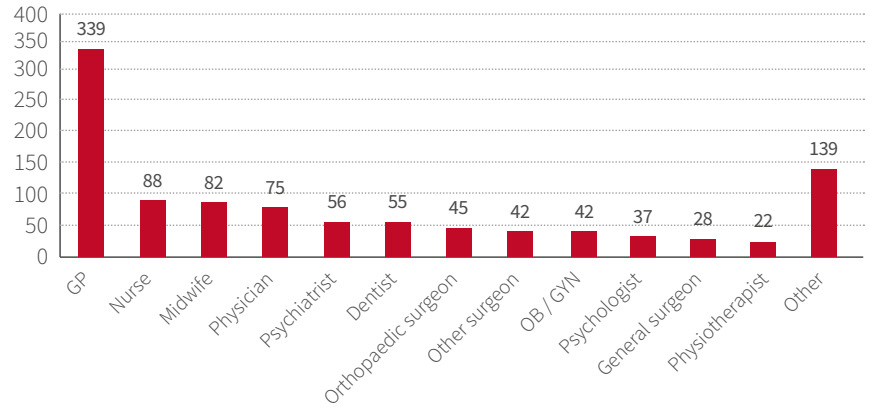


Figure 5: Complaints received — Individual provider[1]



[1] This graph relates to the number of individual providers complained about. Because some complaints will not have involved an individual provider, while other complaints will have involved more than one individual provider, the number of individual providers complained about in 2014/15 will not equal the total number of complaints received in 2014/15.

In most situations, further information is obtained to assist with the assessment of the complaint, and a response is requested from the provider complained about, along with copies of relevant clinical records and sometimes comments from other providers. Between them, HDC's in-house clinical and nursing advisors provided opinions on over 300 cases during the year. External expert advice was obtained on over 220 occasions. It is often not until a clinical opinion has been obtained that the Commissioner is able to decide whether he wishes to conduct a formal investigation.

The Commissioner may also decide, after having regard to all the circumstances of the case, that any further action is unnecessary or inappropriate (section 38 of the Act). This may be for a number of reasons, such as: the length of time that has elapsed since the events complained of; the provider has already provided a reasonable response directly to the complainant; the independent expert opinion is that the care provided was of a reasonable standard; it is recognised that further inquiry will not resolve evidential issues; and/or the provider has made significant changes to his or her systems to avoid future administrative or systemic errors. When deciding to take no further action, the Commissioner may still make recommendations to the provider.

Figure 6: Complaints received — Group provider[2]

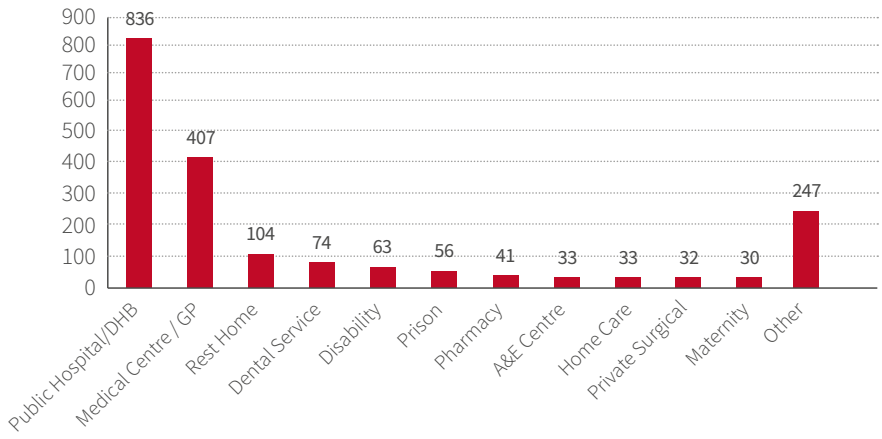


Table 1: Complaints closed — Outcomes[3]

Complaints closed — Outcomes[3]	2014/15
Breach	70
No breach (after investigation)	2
Section 38 no further action	713
Section 38 with follow-up/recommendations	401
Referred back to provider to resolve	302
Referred to Advocacy Service	96
Referred to registration authority	75
Outside jurisdiction	162
Withdrawn	47
Referred to other agency	36
Resolved/discontinued	6
TOTAL	**1910**

[2] This graph relates to the number of group providers complained about. Because some complaints will not have involved a group provider, while other complaints will have involved more than one group provider, the number of group providers complained about in 2014/2015 will not equal the total number of complaints received in 2014/2015.

[3] Outcomes are displayed in descending order. If there is more than one provider listed on a complaint and, therefore, more than one outcome upon resolution of a complaint, then only the outcome that is listed highest in the table is included.

Section 38(1) with recommendations and follow-up: Communication and manner of a GP

A woman complained that at a consultation with a GP, he asked her whether her pregnancy was wanted before she had even sat down, which she found insensitive and inappropriate. The GP then referred her for blood tests and prescribed her iodine and folic acid. Before she could ask him any questions, his cellphone rang, and he answered it. While speaking on the phone, he waved her out of his consultation room.

When she returned a week later, with concerns about bleeding, the GP scolded her for her food choices, and told her she had probably miscarried. The woman was referred for tests and scans without explanation about what they were for, and without being offered any words of comfort or reassurance. Fortunately, the woman had not miscarried.

In response, the GP acknowledged that his communication had been lacking, reflected on his consultations, and agreed that he could have shown more empathy and spent more time discussing any fears the woman may have had around the viability of her pregnancy.

The GP's response was acknowledged as appropriate. However, it was also suggested that he attend a communication course, and he was asked to provide his reflections on what he had learned from the complaint. The GP advised that he had enrolled for a workshop that included communication skills; he had discussed the case with his peers; and he had arranged to role play with one of the senior teachers of the Royal New Zealand College of General Practitioners. He acknowledged that he should have allowed the consumer more time, and should have ascertained whether she had any questions before she left the consultation. He also recognised that he should have refrained from discussing the possible effects of her food choices until after she had had the results of her tests.

Referral to advocacy: Care and facility issues

A resident in rest home care had a number of concerns about the care she was being provided by the rest home. These included: the poor response when she rang her call bell (either a delay in responding, or responding by turning it off but then not returning to assist her); that her chair was not being cleaned; the lack of ability among staff to use the transfer belt for transfer of residents; and the lack of suitable meals given her physical impairment, which made eating difficult. HDC referred the matter to the Advocacy Service. An advocate assisted the resident to write a letter outlining her concerns, and supported her at a meeting with the Facility Manager and Clinical Manager. A complaint resolution agreement was reached, which included that: a new lead and wall point would be put in place for the call bell, and further discussions had with the rest home owners regarding addressing the faulty connections throughout the facility; the cleaning roster would specify a weekly clean of the resident's chair; staff who have difficulty with the transfer belt would be identified and further training provided; the Facility Manager and cook would review all personal eating plans and ensure that needs were clearly identified. The complainant confirmed with the advocate that there had been improvement in the meals and call bell responses. She said she felt more confident that she would be able to raise any future issues with the rest home, and that she could access the Advocacy Service if required.

Referral to regulatory authority: Comments by psychologist during assessment

A mother complained about the comments of a psychologist during an assessment of her child for the purposes of a Family Court report. It was alleged that the psychologist questioned why it would be inappropriate for the child to be exposed to his father's illegal drug use or for the father to watch pornography in front of the child. The complaint was referred to the Psychologists Board to look into, as it raised issues of professional conduct and fitness to practise.

Section 38(1) with recommendations and follow-up: Fall and injury management in public hospital

A complaint was made to HDC after an elderly woman experienced a fall in a public hospital while she was being assisted to mobilise off her bed by a nurse. During the fall the woman hit her head on the floor causing a haematoma to form on the side of her head. A registrar reviewed the woman and noted that, as she had no neurological symptoms, a CT scan was not required. Neurological monitoring of the woman was undertaken every two hours. That night, the woman's level of consciousness dropped, her blood pressure increased, and she vomited. An urgent medical review of the woman was undertaken, and a CT scan showed an acute bilateral subdural haemorrhage. Following a discussion between the woman's family and the doctors involved, it was decided that providing comfort cares was the most appropriate action and, sadly, the woman passed away.

The DHB undertook a serious event review of the woman's fall and noted a number of learnings from the case regarding head injury imaging guidelines and post-fall medication management. HDC obtained advice from an expert physician, who advised that the management of the woman following her fall was appropriate. Additionally, HDC's in-house nursing advisor stated that the management of the woman's falls risk, and the events immediately prior to her fall, were consistent with accepted nursing standards. The nursing advisor also noted that the overall management of the woman's fall was appropriate and consistent with accepted standards in relation to assessment of injuries and clinical documentation.

Taking this expert advice into account and noting the actions undertaken by the DHB in its serious event review report, the Deputy Commissioner decided to take no further action on the complaint. However, the Deputy Commissioner asked the DHB to provide HDC with the details of a number of policy reviews and actions that had been undertaken by the DHB as a result of the learnings identified in the serious event review report. The Deputy Commissioner also asked the DHB to provide HDC with the results of an audit of compliance with the new imaging guidelines, and for confirmation that the learnings from the case had been shared at quality forums and ward meetings. The DHB has complied with all of these recommendations.

Investigations

As noted above, one of the options open to the Commissioner upon receiving a complaint is to conduct a formal investigation to establish whether the Code has been breached. This year, 100 formal investigations were completed, and it was found in 70 cases that the consumer's rights under the Code had been breached. As a result of those breach decisions, 14 providers were referred to the Director of Proceedings for consideration of whether to bring tribunal proceedings.

Recommendations

In many instances, providers themselves identify areas for improvement, and proactively make changes to their practice as a result of being subject to a complaint. HDC also makes recommendations for change in many cases, and then monitors the implementation of those recommendations. As many complainants indicate that their desired outcome is to ensure that quality and safety is improved, recommendations play a key role in HDC's complaint resolution. Between 1 July 2014 and 30 June 2015, HDC made recommendations or educational comments in relation to 470 complaints, including the 70 cases in which a breach of the Code was found. HDC recommendations are complied with in the overwhelming majority of cases.

Informed consent for use of haloperidol (13HDC01252)

An elderly woman was admitted to a public hospital after a review by her GP suggested a diagnosis of pneumonia. The woman had a complex medical history including dementia. At the time of her admission, the woman was noted to have had a recent fall, and was confused.

The woman had previously appointed her daughter to be her Enduring Power of Attorney (EPOA) for personal care and welfare. However, the EPOA was not activated via medical certification.

At admission, sections of the hospital admission forms were left incomplete. A general physician reviewed the woman. An X-ray showed no evidence of pneumonia, and the physician considered that the woman might have a urinary tract infection. He performed a neurological examination but did not document it.

The daughter was advised that her mother's behaviour was disrupting the ward. The woman was thought to have delirium in addition to cognitive impairment, and the medical team sought a review by Psychiatric Services.

The woman was prescribed low dose (0.5mg) haloperidol (an antipsychotic), to be administered two-hourly as required. She was not assessed to ascertain whether she was competent to consent to the proposed treatment, and there is no evidence of any discussion with her or her daughter about the options for treatment, or the risks, side effects, and benefits of treatment with haloperidol, or consent having been obtained for the administration of haloperidol.

The woman was discharged, and her GP stopped prescribing haloperidol. Prior to the hospital admission, the woman had been able to walk well without an aid, but following her discharge she shuffled, taking small steps, and was unable to get in and out of bed by herself. Her facial expression was blank. The daughter felt that the haloperidol was a major contributor to her mother's deterioration.

A short time later, the woman was readmitted to hospital, as she had not managed at home. A cognitive assessment was not fully completed at admission. The daughter requested that haloperidol not be administered to her mother. However, again it was administered on five occasions when the woman was agitated and non-compliant with cares. No consent was obtained for the administration of haloperidol. Haloperidol was ceased and, subsequently, the woman was administered low dose quetiapine (an alternative antipsychotic).

Hospital clinicians failed to be clear as to the legal basis on which haloperidol was being administered to the woman, either by consent from the woman or within the terms of Right 7(4). It was found that the DHB breached Right 7(1). It was also held that the use of haloperidol during the second admission was unwise, and the issue of cessation of the haloperidol should have been considered earlier during that admission. Furthermore, the overall standard of communication between DHB staff, the woman, and her daughter, could have been much improved.

The DHB had taken a number of steps to improve the quality of its services. In addition, the Deputy Commissioner recommended that the DHB review its admission procedures, audit compliance and completion of admission and cognitive assessment documentation of dementia patients, and update relevant policies. The DHB also apologised to the woman's daughter.

Investigations prior to discontinuing warfarin (13HDC01237)

A man was a patient of a GP at a medical clinic for a number of years, before transferring to a GP at another clinic. Five years later the man transferred his care back to the original GP.

The second clinic transferred an electronic and a paper copy of the man's medical records to the first clinic. The GP said that the electronic notes he received from the second clinic lacked clear identification of the long-term conditions and medications. The practice nurse at the first clinic received the paper copy, reviewed the transfer summary, and noted incorrectly that there had been no changes to the man's medication since 2003.

After his care was transferred, the man attended a consultation with the GP. A trainee intern was briefed by the GP to assess the man as a new patient, and to conduct a comprehensive medical history and thorough clinical examination. However, the intern did not elicit from the man that he had had cardiac surgery, and the man did not advise him that he was taking warfarin. During the physical examination, the intern did not detect a metallic "click", which is associated with a mechanical mitral valve, or record that the man had a sternotomy scar.

The next day, the man attended a further consultation. At this appointment, the GP was made aware by the man that he was taking warfarin. The GP said that when he asked the man why he was taking it, the man gave a vague reply about it being for his heart. The GP assumed that the man was taking warfarin for a rhythm disturbance. The GP did not investigate further, and advised the man to stop taking warfarin.

Four weeks later, the man consulted the GP with complaints of palpitations. The man advised that he had taken four warfarin tablets, which had made him feel better. The GP was concerned that the man was self-medicating with warfarin, and again advised him to stop taking it. Shortly afterwards, the man died in hospital after suffering several strokes.

It was held that the GP breached Right 4(1) by failing to review the man's medical records adequately, and for failing to investigate the reason why the man had been prescribed warfarin before advising him to stop taking it.

The GP also breached Right 6(1) by failing to provide the man with information about the risks and benefits of discontinuing warfarin therapy, and Right 7(1) as the man did not receive sufficient information about the risks and benefits of stopping warfarin, and so was not in a position to make an informed choice and give informed consent to the discontinuation of that treatment.

The Commissioner recommended that the GP review the relevant aspects of his practice and provide evidence to the Commissioner of this review and the subsequent changes he had made. The GP had already undergone a Medical Council of New Zealand competence review and, following that assessment, the Medical Council had ordered that the GP undertake a 12-month educational programme. The Commissioner recommended that on completion of the educational programme the Medical Council consider whether a further review of the GP's competence was warranted.

Interpretation of a CTG trace during labour (13HDC01430)

A woman who was pregnant with her first child went into labour at 40+4 weeks' gestation. The woman met her LMC midwife at the delivery unit of a hospital. Upon assessment, the LMC noted that the woman was experiencing contractions at a rate of three every ten minutes and that, on vaginal examination, the cervical opening could not be reached. A CTG was commenced to monitor the fetal heart rate (FHR).

The LMC noted non-reassuring features on the CTG recording and continued to monitor the FHR, but did not interpret the CTG as requiring consultation with the obstetric team. A second vaginal examination was carried out an hour later by the LMC, and the cervix was found to be 2cm dilated. The woman was then given 100mg of pethidine and 2.5mg of Droleptan to help her sleep.

Shortly afterwards, the LMC noted a prolonged deceleration of the FHR down to 60bpm. Five minutes later, she called the on-call locum obstetric consultant, as she was no longer able to detect a fetal heartbeat.

The consultant arrived 20 minutes later and carried out an assessment, which confirmed the absence of a fetal heartbeat. The consultant then made the decision to perform a Caesarean section, on the basis that a fetal heartbeat had been present within the previous 20 minutes. A Caesarean section was performed, and the baby was born floppy and not breathing. Resuscitation was commenced but, sadly, the baby was pronounced stillborn.

It was found that the CTG showed non-reassuring features that warranted earlier consultation with the on-call obstetrician, and that by failing to interpret the CTG trace correctly and, as a result, failing to contact the on-call obstetrician early enough, the LMC failed to provide services with reasonable care and skill and, accordingly, breached Right 4(1).

Adverse comment was made about the consultant's decision to proceed with a Caesarean section in the circumstances.

The midwife apologised to the woman for her breach of the Code, and provided confirmation of further training in CTG interpretation, as recommended by the Commissioner.

Provision of care to patient requiring ambulance transfer (13HDC01568)

A 72-year-old woman had spinal surgery without complication, and was discharged two days later. Two days following discharge, while the woman was at home, she vomited a large amount of blood. The woman's daughter took the woman to an accident and emergency clinic.

The woman's daughter told the receptionist that her mother had recently undergone spinal surgery and was vomiting blood. Having overheard the daughter, a registered nurse (RN) told the daughter to call an ambulance for her mother to be taken to hospital. The RN considered that the woman required hospital treatment, and that a personal call would achieve a priority response from the ambulance service, rather than if the clinic contacted the ambulance for her. The RN did not triage the woman, take a history, or undertake an initial assessment of her. The woman's daughter immediately telephoned 111 on her cellphone from inside the building. The woman waited for the ambulance with her daughter, while lying down in the back of her daughter's car in the car park.

An ambulance arrived and the woman was taken to hospital, where she was diagnosed with multiple stomach ulcers.

It was held that the RN failed to assess the woman when she presented to the clinic, failed to contact the ambulance service, and failed to offer any assistance to the woman while she waited for the ambulance, including monitoring her. Accordingly, the RN failed to provide services to the woman with reasonable care and skill, in breach of Right 4(1).

Adverse comment was made in relation to the RN's subsequent inability to provide handover to the ambulance service.

The RN apologised to the woman and her daughter. The Commissioner recommended that the RN undertake training on effective communication with consumers, and report back on the training and the changes made to her practice.

3.2 Advocacy

The Advocacy Service is a free and confidential service, which operates independently of health and disability service providers. Advocates use a consumer-centred empowerment model to support consumers to resolve their concerns about health or disability services.

HDC, through the Director of Advocacy, contracts with the National Advocacy Trust to provide the Advocacy Service, which includes advocates providing education sessions on the Code to consumers and providers. The legal separation between HDC and the Advocacy Service allows advocates to act in the interests of consumers, while protecting HDC's impartiality in dealing with complaints.

The National Advocacy Trust Board provides governance and oversight of the Advocacy Service and the 46 advocates around the country in 23 community-based offices from Kaitaia to Invercargill. Those advocates are supported by administrative staff, four regional team managers, a national education, training and resource manager, and the national service manager, who has overall responsibility for the day-to-day running of the service.

Complaints

The number of new complaints to the Advocacy Service rose this year to 3,635 from 3,468 in the 2013/14 year, an increase of 4.8%. Over the past five years the number of new complaints received by the Advocacy Service has increased by 28.4%. This year 3,679 complaints were closed, an increase of 9.3% from the 2013/2014 year (see Figure 7).

Advocates were able to assist consumers to resolve 92% of the complaints made, or referred, to the Advocacy Service. This high rate of resolution reflects the strong consumer-centred process used by advocates, and the quality of the process, as well as a high level of provider goodwill and commitment to resolving complaints at an early stage, at the lowest appropriate level. Eighty-seven percent of complaints were closed within three months, and over 99% were closed within six months.

Eighty-four percent of the complaints to the Advocacy Service were about health services, and 16% related to disability services.

Advocacy Service Organisation Structure

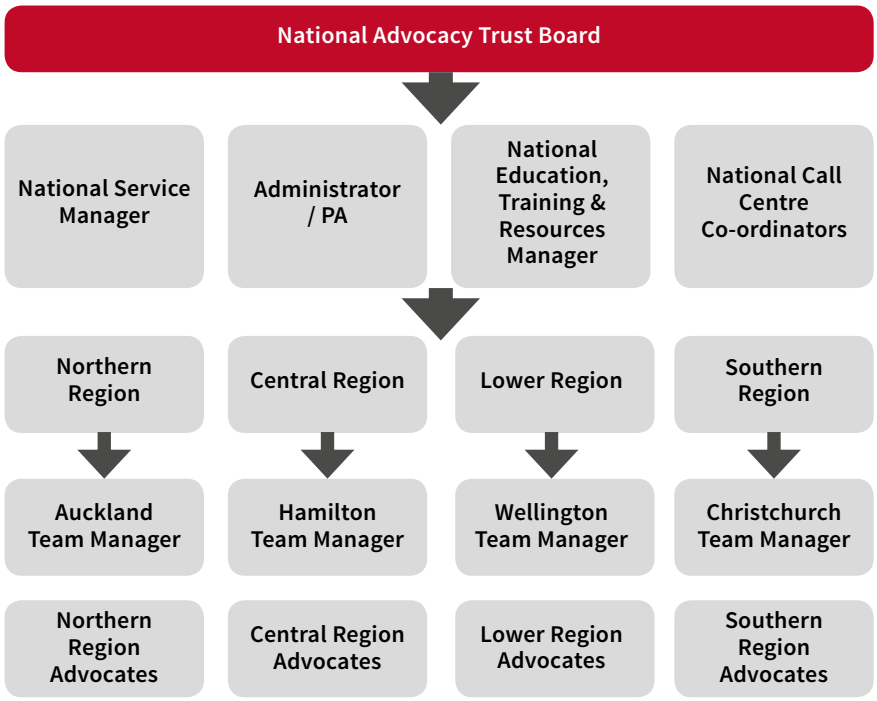


Figure 7: Complaints to the Advocacy Service by year

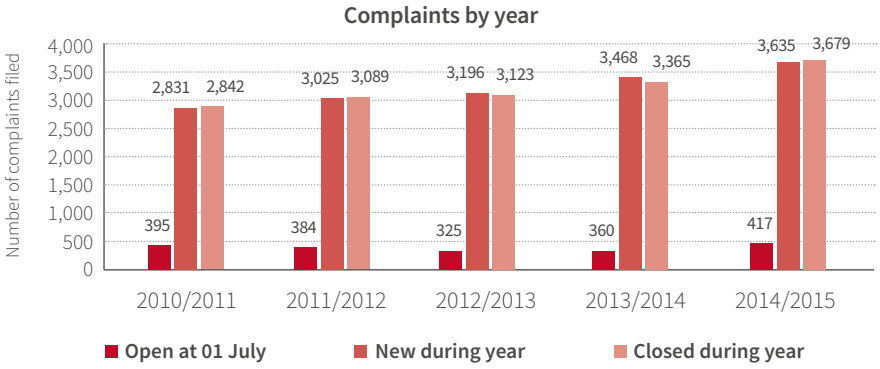
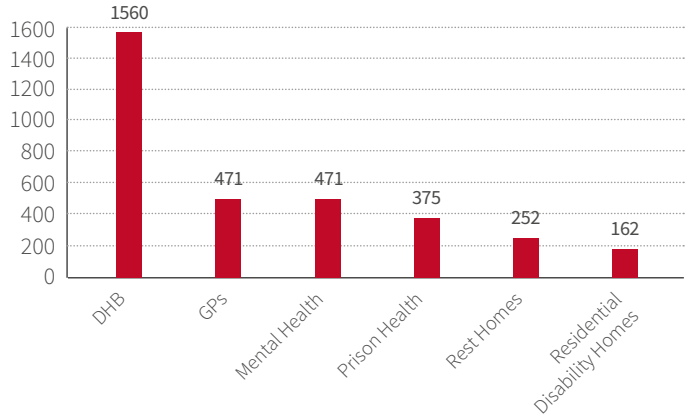


Figure 8: Types of service providers in complaints closed by the Advocacy Service



Education and training

Education is a key part of an advocate's role. Sessions are provided to consumers about their rights under the Code, and to providers about their responsibilities as providers of health and disability services. Advocates are keen to assist staff who work in areas where there are particularly vulnerable consumers to be proactive in making sure the rights of these consumers are respected.

The majority of education sessions provided related to information on advocacy, the Code and HDC. Advocates also provided focus sessions on topics such as self-advocacy, effective communication, open disclosure, health passports and effective complaint processes. Advocates aim to be influential in shifting the focus of health and disability services towards a more consumer-centred approach.

The number of education sessions provided by the Advocacy Service has continued to increase. In the 2014/15 year, advocates presented a total of 2,252 education and training sessions to a range of consumers, providers and organisations. Survey forms are left at each session for participants to complete, and this year 9,082 people provided feedback, with 91% of consumers and 96% of providers who responded expressing satisfaction with the sessions.

Reaching consumers

The Advocacy Service operates an 0800 national call centre and provides email and local office numbers in promotional material and on the HDC website.

Through phone and email enquiries

During the 2014/15 year, the Advocacy Service received 13,479 enquiries, a 12.8% increase on the preceding year. Ninety-eight percent of those enquiries were closed within two days. Enquiries covered a broad range of topics. In addition to requests for information about the role of advocates, information on how to make a complaint, and requests for education sessions, advocates received requests for disability resources, information on the role of HDC, mental health matters, funding, fees and treatment costs, information privacy, and rest home and residential disability home standards.

Through residential visits

Advocates visited all of the 658 certified rest homes nationwide, and 486 rest homes had at least two visits. All of the 994 certified residential services catering to disabled people had at least one visit from an advocate, and 630 had at least two.

These visits ensure contact with those residents of rest homes and residential disability services who might otherwise find it impossible or extremely difficult to speak with and, if necessary, seek the assistance of, an advocate. Advocates also utilise these visits to provide information and arrange free education sessions for residents, whānau/family members, and providers.

Through networking

Networking is an important way for advocates to establish a profile in their communities and to make contact with a wide range of consumers, including those consumers who are least able to self-advocate and whose welfare may be most at risk. Networking also assists advocates in understanding local issues, and enables them to keep up to date with local support services so they are able to provide practical information when necessary.

Over the past year, advocates developed and maintained contact with 3,927 network contacts. Thirty-one percent of non-residential network contacts had a disability focus, a figure that rises to 71% when the residential visits are included. Non-residential network contacts include public interest groups and community groups, including those involving older people, the Deaf community, and Māori and refugee/migrant communities. Advocates also maintain network contacts with key providers.

Advocates aim to be influential in shifting the focus of health and disability services towards a more consumer-centred approach.

Demographics

Figures 9-11 show some of the demographics of those who made complaints to the Advocacy Service this year.

Figure 9: Age of complainants to the Advocacy Service

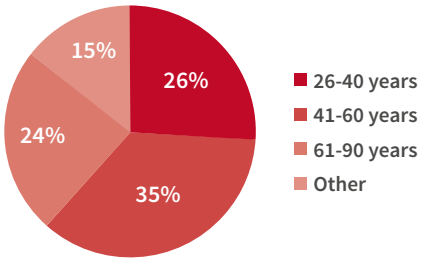


Figure 10: Ethnicity of complainants to the Advocacy Service

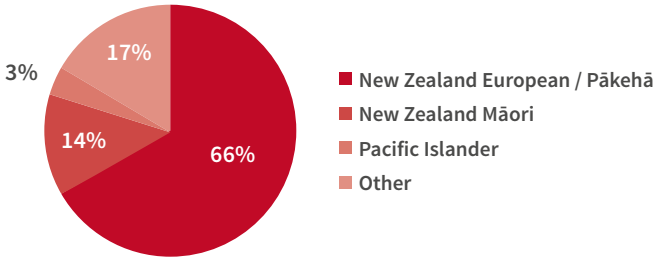
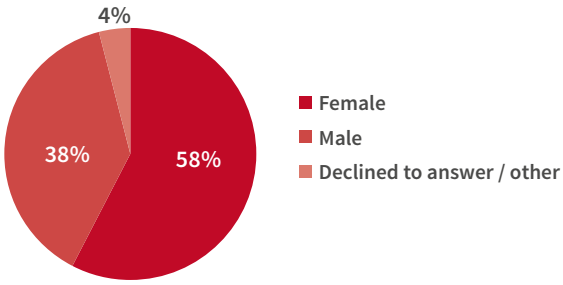


Figure 11: Gender of complainants to the Advocacy Service



Satisfaction with the Advocacy Service

Each month, 33% of consumers and providers who have worked with an advocate through the complaint resolution process are asked to comment on their level of satisfaction with the service. Survey results showed that 93.5% of consumers and 85.5% of providers were satisfied with their dealings with the Advocacy Service. The following are comments from two consumers and two providers, but can be considered reasonably typical of the comments that are provided by those who complete and return surveys.

"Just great … Knowledge, support and advice all given in a very caring supportive manner."

"… was absolutely wonderful. She understood everything I said and took all the stress from me completely dealing with my complaint."

"… is a professional always in her communication and discussions. She does not assume anything and treats … with respect and in a friendly non-confrontational manner."

"Fantastic advocate for the clients and culturally appropriate."

Acknowledgement from the Commissioner

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

"Knowledge, support and advice all given in a very caring supportive manner."

Improving communication between providers

A woman with a serious medical condition was transferred to a large tertiary hospital for stabilisation and insertion of an inferior vena cava filter. Prior to leaving the tertiary hospital the woman was told she would need to have the filter removed within four to six weeks of discharge, and have further tests carried out. It was impressed upon her that this was very important. She returned to her local hospital before being discharged home. Three weeks later she contacted her GP as she had not received the expected appointment. The outpatient appointment she then received meant that the timeframe for removing the filter would not be met. The woman attempted to self-advocate, but could not get the information she wanted, and so contacted the Advocacy Service for support.

With assistance from her local advocate, the consumer wrote to all three providers — her GP, the tertiary hospital and the local hospital — seeking to identify who was responsible for organising follow-up. All the providers acknowledged that there had been a breakdown in communication at many levels, and identified in their responses the changes they put in place to avoid this in the future. In addition, the local hospital's Quality and Risk Department took the issue to senior management, and an ongoing dialogue was initiated with the tertiary hospital on how to improve future exchanges of information. It was acknowledged that assumptions had been made about who was organising the tests and removing the filter, and all of the providers apologised to the woman.

Improving a provider's complaint resolution processes

An advocate became concerned over complaints from consumers about a local provider regularly not adhering to timeframes for responding to complaints. The advocate raised her concern directly with the person who received the complaints. The advocate was told that the difficulty was with clinical staff and senior managers not providing responses in a timely manner.

The advocate requested a meeting with a senior manager. As a result of that meeting the advocate was invited to attend a service managers meeting to discuss the provider's management of complaints. The service managers were interested in looking at ways to better monitor processes within their departments to improve their processes for consumers. As a result, it was agreed that there would be regular scheduled meetings with the Advocacy Service to receive feedback on what was working well for consumers and what, if anything, needed to change.

Empowering a consumer to question a disability service decision

A consumer with a physical disability and speech impairment living in residential care was told that he was to be moved to another residential facility until a permanent home in the community could be found for him. The consumer was distressed by the decision and the lack of consultation. While happy with the plan to live in the community with support, he wanted to be based in his current area to be near his family and church. He felt he was not being listened to, and contacted his local advocate.

The advocate and consumer met, and the consumer chose to meet with the provider and the needs assessment service coordinator (NASC) team. Prior to the meeting, the advocate and consumer met again to discuss the agenda for the meeting, and the advocate provided support and guidance to enable the consumer to speak for himself at the meeting. As a result of the advocate's support, the consumer felt he had the confidence to raise his concerns effectively. This resulted in an agreement that the consumer would be reassessed before any further decisions were made and, when he did move, it would be to a permanent home within the local area.

Empowering a consumer to question her prescribed medication

A distressed consumer contacted the Advocacy Service advising that she was under a community compulsory treatment order and had received a medication by injection. She said she was experiencing bad side effects including hearing and seeing things, and her family had also a noted a change in her behaviour, but her psychiatrist was not listening.

After talking through the assistance an advocate could offer, the consumer decided that the best option was to have support at her next appointment with the psychiatrist, when she would ask for the medication to be stopped, and enquire about alternatives to the medication. The consumer said she had good family support, so would take a family member. The advocate talked her through the preparation for the meeting/appointment, suggesting writing down the things she would like to raise and taking the list to the appointment.

A family member attended the appointment with the consumer, and the consumer said that because of the support and information provided by the advocate she was able to speak for herself. She said she felt really surprised when the psychiatrist listened to her and then discussed alternative medication. She is now back on medication she had taken previously, and is doing well.

3.3 Proceedings

The Director of Proceedings brings proceedings against providers on referral from HDC. The Director of Proceedings is an employee of HDC but performs that role independently of the Commissioner. Cases are heard before the Health Practitioners Disciplinary Tribunal (HPDT) and the Human Rights Review Tribunal (HRRT). Case outcomes provide accountability, determine and uphold appropriate standards for healthcare providers, and promote consumer confidence.

Significant outcomes included a number of successful disciplinary proceedings in the HPDT and declarations of breaches of the Code in the HRRT (as detailed in Tables 2 and 3, and case notes.)

Statistics

The Director of Proceedings had 35 referrals in progress during 2014/15 including 14 referrals received in the course of the year. Around half of referrals in progress are referrals involving issues of practitioner competency. Table 2 identifies 2014/15 referrals by provider type. Table 3 sets out the status of all referrals in progress during the year. During the course of the year there were five disciplinary hearings in the HPDT, three of which were successful.[4] Seven HRRT proceedings were resolved by negotiated agreement that provided for consent order declarations of a breach of the Code by the Tribunal.[5] A significant number of settlements were obtained for consumers. Three other matters were resolved without recourse to Tribunal proceedings. Two appeals from HPDT decisions were heard in the High Court — one relating to name suppression, the other to both decision and penalty.

Case outcomes provide accountability, determine and uphold appropriate standards for healthcare providers, and promote consumer confidence.

Table 2: Referrals received in the 2014/15 year by provider type

Provider	No. of referrals in 2014/15
Caregivers	2
Disability services provider	2
Private medical hospital	1
Midwife	1
Nurse	2
Anaesthetist	1
General surgeon	1
Counsellor	1
Pharmacist	1
Physiotherapist	1
Detention services healthcare provider	1
TOTAL	**14**

[4] One of these cases is listed in the Proceedings Pending column, as the result had not been received as at 30 June 2015

[5] Two of these cases are listed in the Proceedings Pending column as the results had not yet been received as at 30 June 2015.

Table 3: Status of referrals in progress during 2014/15

Provider	No. of referrals	DP decision in progress	No further action	Proceedings pending / Awaiting decision	Successful proceedings	Unsuccessful proceedings	Other resolution
Caregivers	3	1	1				1
Disability services provider	3	1		1***	1 (HRRT)		
Private medical hospital	1			1			
Midwife	7			3	2 (HRRT)		2
Nurse	6	1	2	1	2 (HPDT)		
Anaesthetist	1			1			
General surgeon	1	1					
Counsellor	1			1***			
Pharmacist	1	1					
Physiotherapist	1	1					
General practitioner	4		1	1****		2 (HPDT)	
Audiologist	1				1 (HRRT)		
Obstetrician	2			2			
Dentist	1			1**			
Detention services healthcare provider	1	1					
DHB	1				1 (HRRT)		
TOTALS	**35**	**7**	**4**	**12**	**7***	**2**	**3**

* Since 30 June 2015, three further proceedings have been successful (as identified in the Proceedings pending/awaiting decision column).

** A successful prosecution in the HPDT at the time of compiling this report (decision issued after 30 June 2015).

*** A successful prosecution in the HRRT at the time of compiling this report (decision issued after 30 June 2015).

**** A successful prosecution in the HPDT at the time of compiling this report (awaiting written decision).

Nurse's registration cancelled for relationship with patient

The Director of Proceedings laid a charge against a mental health nurse in the Health Practitioners Disciplinary Tribunal concerning an inappropriate personal relationship he commenced with a patient in 2012. The nurse did not attend the hearing. The Tribunal found that the charge of professional misconduct had been made out, and cancelled the nurse's registration.

The nurse was employed by the DHB in the Mental Health Inpatient Unit (MHIPU). He attended the discharge meeting for a young female inpatient and then drove her home. They exchanged mobile telephone numbers. Following her discharge, the patient continued to receive treatment as an outpatient from community mental health services. During this time the nurse exchanged text messages with the patient, met with her socially (including at a motel on four or five occasions), went camping with her, and had some physical contact by way of a hug or cuddle. The nurse denied having a sexual relationship with the patient.

About a month after her discharge, the patient was at home, upset and emotional. She exchanged text messages with the nurse, in which she indicated that she was suicidal and had self-harmed. The nurse did not take any steps to seek assistance for the patient or to ensure her safety during the exchange of text messages that evening. The patient's family found her and called an ambulance. She was taken to the Emergency Department having seriously self-harmed. Following the patient's readmission to the MHIPU, the DHB discovered the relationship and formally investigated the matter. The nurse admitted that he had formed an inappropriate relationship with the patient. As a result, the DHB dismissed the nurse from his employment. Following the dismissal, the nurse remained in contact with the patient despite being instructed not to do so.

The Tribunal found that the nurse's personal relationship with the patient compromised his objectivity and professional judgement, and was a stark reminder of the reason for professional boundaries. The Tribunal noted that it is an essential feature of the trust that is placed in nurses that they carry out their duties in a way that does not breach the ethical and clinical boundaries set for the profession. The Tribunal cancelled the nurse's registration, censured him, imposed conditions on his practice should he ever seek to resume practice, and imposed costs.

A link to the Tribunal's decision can be found at:
http://www.hpdt.org.nz/portals/0/nur14285Ddecisionweb.pdf

Midwife breached Code for failures in care

A declaration was made by consent between the parties that a midwife breached Right 4(1), 4(2) and 4(4) of the Code for midwifery care she provided to Ms B. Ms B was 16 years old and pregnant with her first child at the time. The midwife did not develop a sufficiently comprehensive birth plan with Ms B, and failed to provide her with adequate information about the labour process and caring for a newborn. The midwife failed to attend the birth of Ms B's child when requested to do so, and failed to provide on-going assistance with breastfeeding and management of Ms B's perineal tear.

On 15 January 2012, the midwife was telephoned five times between 5.29am and 6.27am by Ms B, Mr B and Mr B's mother, informing the midwife that Ms B was in established labour. The midwife did not come to Ms B's assistance until after the fifth telephone call, when Ms B could feel the baby's head. When the midwife arrived, Ms B had given birth to the baby on the bathroom floor.

Following the birth, the midwife assessed Ms B and informed her that she had a first degree perineal tear. Despite Ms B experiencing significant pain over the coming weeks and suffering dizziness and hot flushes, the midwife did not refer Ms B to a medical practitioner or hospital for examination and assessment of her tear. Ms B later self-referred to her GP and was found to have an infected second degree tear requiring intravenous antibiotics and surgery.

The midwife failed to respond adequately to Ms B's requests for assistance with breastfeeding, and did not discuss with Ms B how or how often to breastfeed after the birth. The midwife informed Ms B that breastfeeding pain was normal, and advised Ms B to watch the breastfeeding DVD she had provided earlier.

The midwife also failed to document her care of Ms B appropriately.

The Tribunal's full decision can be found at:
http://www.justice.govt.nz/tribunals/human-rights-review-tribunal/decisions-of-the-human-rights-review-tribunal/decisions-under-the-health-and-disability-commissioner-act-1994/2015/

3.4 Education

Through its education function, HDC continues to take a leadership role in ensuring that there are ongoing systematic improvements in safety and quality in the health and disability sector. HDC delivers education sessions to both provider and consumer groups which aim to give providers a clear understanding of their responsibilities, so that they comply willingly with the requirements of the Code, and ensure that consumers know and are able to exercise their rights under the Code. HDC also produces complaint trend reports in order to ensure that important learnings are reported back to the sector and to the general public in a way that supports quality improvement.

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

HDC delivered 59 education sessions in 2014/15. The sessions included presentations to regulatory bodies, DHBs, professional colleges, disability service providers, and other professional bodies. HDC also provided education sessions to staff in general practices in line with the requirements of the Cornerstone Accreditation Programme, and continued to provide regular sessions on the Code for those studying to become health and disability service providers at universities and other training institutions, such as to those studying medicine, pharmacy, natural medicine, midwifery, and diversional therapy. Presentations were also given at a number of conferences in 2014/15, including the Asia Pacific (APAC) Forum on Quality Improvement in Healthcare, the New Zealand Aged Care Association (NZACA) Conference, the Life Without Limits Neuromuscular Conference, the Elder Law for the Health Sector Conference, and the Osteopathic Council of New Zealand Conference.

HDC's biennial medico-legal conference was held in March 2015 in Wellington. The conference, "Improving the Consumer Experience", had a high calibre line-up of speakers and presentations from practitioners, consumer representatives, regulators, and HDC's in-house clinical advisors. The sold-out conference received an overwhelmingly positive response from attendees.

In 2014/15, HDC provided two complaint resolution workshops for DHBs. These three-hour interactive workshops aim to develop DHB staff confidence and capability in resolving and learning from complaints, in order to increase: the proportion of complaints effectively resolved by the DHB; complainant satisfaction with the DHB's response to complaints; and staff learning from complaints in order to improve service quality.

HDC has also begun extending this complaints resolution process focus to include primary care. This year, HDC produced a Complaints Management Guide for Primary Care, which was distributed to all Primary Health Organisations for dissemination to their practices.

HDC also provided formal written responses to 60 enquiries from consumers, providers, and other agencies about the Act and Code and consumer rights under the Code.

Promoting learning through complaint trend reports

Promoting learning from complaint trends is also an important facet of HDC's education function. To this end, HDC continues to provide six-monthly reports to DHBs outlining complaint information, both nationally and for individual DHBs. These reports allow DHBs to identify areas of service and aspects of care that are most commonly at issue in complaints to HDC. DHBs indicated that they found the reports useful for improving services. In 2014/15 HDC also produced a report detailing a national full-year analysis of complaints involving DHBs. That report outlined the type of complaints HDC receives about services run by DHBs, how HDC has resolved these complaints, and the positive changes that have been made to services as a result. The data and case studies within that report aimed to assist DHBs, and the individual providers who provide care within DHBs, to learn from complaints received about other DHBs, and to better understand how their complaint patterns compared nationally. The report also aimed to empower consumers to become stronger partners in their own health care.

In 2014/15, HDC also published a report entitled "Delayed Diagnosis of Cancer in Primary Care: Complaints to the Health and Disability Commissioner: 2004–2013". The report contains an analysis of all complaints made to HDC in the last ten years in which an expert clinical advisor considered that aspects of primary care management had contributed to a delay in cancer diagnosis. The analysis reported on the common factors that were identified by the clinical advisor as contributing to a delayed diagnosis of cancer, both overall and with reference to specific cancer types. The report brought together the recommendations made in the cases, with a view to making those recommendations more readily accessible to providers and consumers, thus improving quality of care. The report was picked up and endorsed by the Royal New Zealand College of General Practitioners, which produced a Policy Brief for its members, focusing on the recommendations made.

Submissions

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

In 2014/15, submissions made by HDC included comments on policies, procedures, codes of conduct and guidelines to the Medical Council of New Zealand, the Dental Council of New Zealand, the Ministry of Health, DHBs, the Nursing Council of New Zealand, Te Poi o te Whakaaro Nui, the Royal New Zealand College of General Practitioners, the National Ethics Advisory Committee Secretariat, the National Health Board, the Braille Authority of New Zealand, and the Physiotherapy Board of New Zealand.

Important learnings are reported back to the sector and to the general public in a way that supports quality improvement.

3.5 Systemic monitoring and advocacy – Mental Health and Addiction Services

HDC has a statutory role in the monitoring and advocating for systemic improvements in mental health and addiction services (MH&A Services). The Mental Health Commissioner (MHC) is responsible for the performance of those functions under delegation from the Commissioner.

Monitoring MH&A Services and advocating for systemic improvements is undertaken to support the implementation of the Government's priorities to achieve mental health and well-being for all, as set out in "Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2013–2017".

The MHC has developed a work plan that sets out how HDC will undertake its monitoring and advocacy functions in relation to MH&A Services' implementation of "Rising to the Challenge". This involves engagement with key sector stakeholder groups. Projects are undertaken in collaboration with appropriate external partners, including consumer and family/whānau networks. This approach to work in collaboration provides HDC with the best expertise in the sector and supports the development of sector capability and capacity to lead change.

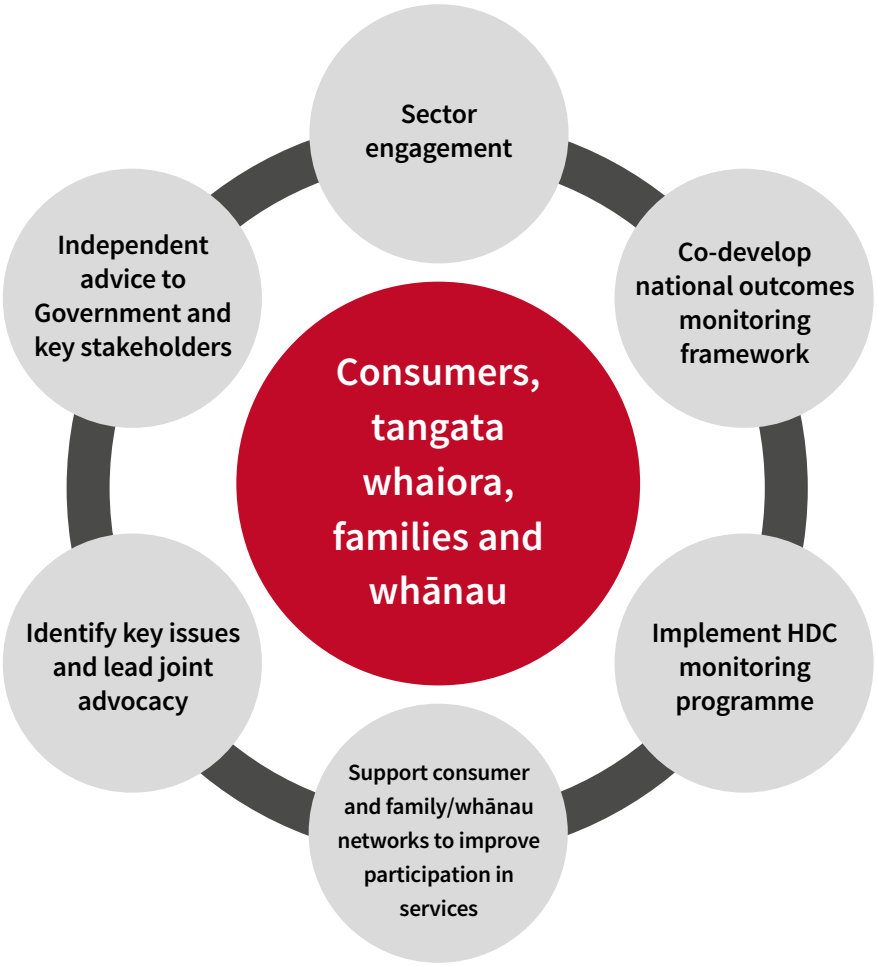
In June 2015, Mental Health Commissioner, Dr Lynne Lane, departed HDC having spent the last three years successfully embedding the mental health and addiction services functions within HDC.

Work plan to achieve targets

This year was a year of major progress and achievement. HDC made substantial progress against the 2014/15 Performance Measures. Alongside these performance results HDC achieved an increased level of engagement with consumers and family/whānau, through locality meetings held in Southern, Midland and Central DHB regions and through attendance and participation at over 240 meetings with sector leaders and key stakeholders.

The achievement of HDC's targets was accomplished by working collaboratively and with the support of national networks and sector leaders.

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



Projects are undertaken in collaboration with appropriate external partners, including consumer and family/whānau networks.

Major achievements for the year

Engagement

On behalf of HDC, the MHC extensively engages with the wider MH&A Services sector. This is done through participation both in key international forums, exchanging knowledge and facilitating international benchmarking, and by engaging at a national level, identifying and supporting key projects for collaborative learning.

Highlights from the 2014/15 year in this respect included attending and presenting at the annual Australia and New Zealand Mental Health Commission Leaders Forum, and attending several national forums for the purpose of shared learning and identification of emerging issues to inform policy advice. Feedback from the national forums indicated that they were satisfied that the HDC input has been useful in supporting quality improvement.

Monitoring and analysis

Monitoring MH&A Services and analysing national data on mental health and well-being is a fundamental part of the MHC's functions. 2014/15 saw the continuing development of the real-time consumer feedback system (RTF), with an independent evaluation completed in October 2014. Following this, a national roll-out of RTF to DHB and NGO services was commenced. Feedback from the services using RTF confirms that the data is useful in informing quality improvements. Information on RTF can be found at www.hdcrtf.co.nz.

Systemic advocacy

HDC is in a unique position to report on consumer and family/whānau experiences of interaction with MH&A Services. As part of this role, and in collaboration with others, several projects were completed as follows:

- Hīkaka te Manawa — Improving services for Rangatahi. HDC completed a review of 21 services providing access to Māori youth with mental health and addiction problems in collaboration with Te Rau Matatini. The review identified the strengths and collective challenges of the services, and made recommendations for changes to the funding of services in order to meet the needs of Māori youth.
- A trial of the Choice and Medication website is underway at Waitemata DHB. This website provides access to information on all medicines used in MH&A Services in New Zealand, across a range of literacy levels. An evaluation of the trial will be undertaken to assess the usefulness of the website in empowering consumers and their family/whānau to be active participants in their care.
- Ten thousand copies of the rebranded HDC publications "Oranga Ngākau" and "When someone you care about has mental health or addiction issues" were produced and distributed through national networks.
- During the year, HDC provided support to the National DHB Consumers and Family/whānau forums to strengthen their roles in decision-making within their services. Feedback from these groups indicated satisfaction with HDC's contribution in these sector groups.
- A report was produced on current initiatives and recommendations to address the priority action in "Rising to the Challenge", to "reduce and eliminate the use of seclusion and restraint". The report recognised the progress made in some DHBs towards achieving this goal. It identified the need for a collaborative learning initiative to support implementation of best practice amongst DHBs.
- HDC developed a resource that describes international best practice in increasing productivity in mental health services. The report recognises and describes features of what productive services look like in some DHBs. The report provides a summary of what best practice productivity improvement initiatives and underlying processes could be used in services.

4.0 Supporting Disabled Consumers

HDC received a total of 113 complaints about disability services in 2014/15. This number is consistent with the number received in the previous financial year, and represents a relatively small proportion of the total number of complaints referred to HDC over the 12-month period. HDC also closed 116 complaints about disability services in the same financial year. In the 2014/15 financial year, close to half of the complaints to HDC about disability services were made by consumers, while a third were made by family members, and less than 10% were made by staff and providers.

During 2014/15, the most common issues complained about in relation to disability services were when there were concerns:

- that inadequate or inappropriate disability support had been provided;
- that inadequate or inappropriate non-clinical care (such as feeding, bathing or dressing) had been provided; and
- over the safety or dignity of a disabled person.

Communication with consumers and their family/whānau was also a prominent issue in complaints about disability services, particularly where people felt they were not given enough information about what was happening to them or their family member. HDC also saw some examples of inadequate responses to complaints by providers, which caused frustration for consumers. In particular, receiving an inadequate or no response to a complaint from a provider often left consumers and their family/whānau dissatisfied.

The general ability of service providers to safely care for high and complex need consumers, with adequate training, policies and procedures, also featured in the disability services complaints to HDC. Having sufficient staff numbers and well-trained staff was very important to consumers and family/whānau. Safe, reliable and appropriate support was of particular concern to consumers and family/whānau. In the process of assessing complaints, HDC identified the following key factors in the provision of high quality disability support:

- recruiting and retaining respectful and reliable staff;
- communicating appropriate standards of care to staff, including those working remotely;
- having appropriate policies and procedures;
- having good care plans in place; and
- having appropriate training in place.

The types of concerns people raised in 2014/15 were broadly similar to the previous financial year.

HDC closed seven investigations relating to disability services over the 2014/15 financial year, and in four of the seven cases found providers in breach of the Code. Providers were referred to the Director of Proceedings in two of those cases.

A number of the complaints that HDC received in 2014/15 related to home-based support, which is important to the independence and functioning of disabled consumers in the community. The complaints highlight a few key aspects of the care that was crucial to home-based support working well, particularly:

- having support workers who were on time, reliable and did all tasks they were required to;
- having additional support workers and systems in place, so that there was continuity of care when support workers were sick, on leave, or left their jobs; and
- having staff who could communicate appropriately and respectfully with consumers.

Following on from HDC's national disability conference in 2014, which highlighted the need to "raise the volume of the unheard voice", the 2014/15 financial year has shown HDC's commitment to supporting disabled consumers and their family/whānau to understand and take ownership of their rights. HDC has focused on providing disabled consumers with information about what their rights look like in the context of disability service provision, how to identify when things go wrong, and what to do about it. HDC continued to work with the Consumer Advisory Group, receiving their input on promotional and educational initiatives.

Accessible education resources for all

HDC continues to invest resources in fostering understanding in the disability sector about the Code and what to do when things go wrong. As well as delivering seminars to disability consumers and community groups, over the past year HDC worked in partnership with People First NZ (a self-advocacy organisation led and directed by people with learning disabilities) to co-produce an easy-read guide to HDC's Health Passport (a resource for high users of health and disability services or those who may have barriers to communication) and a plain language peer-to-peer video on the Code for people with learning disabilities. The video features members of People First NZ describing and acting out easily recognisable situations that consumers may find themselves in when receiving disability services, and linking them to the Code. The video has been promoted by HDC and People First NZ, and is available on both websites.

Maintaining quality services in an evolving funding landscape

In 2014/15, HDC worked with the "Enabling Good Lives" pilot demonstration in Christchurch to produce three new "Know Your Rights" resources for disabled people who receive individualised (or enhanced individualised) funding to manage their disability support needs in the community. The resources arose from HDC's proactive work to maintain high levels of awareness and understanding of the Code and complaints processes. As an increasing number of disabled consumers are given the opportunity to coordinate their own support needs independently, it is important for disabled consumers to understand that they continue to have the same rights to high quality health and disability services as they would if they were receiving the services through a larger scale disability service provider.

The "Know Your Rights" resources are designed to remind disabled consumers of their rights when they receive disability support in their own home.

HDC continues to invest resources in fostering understanding in the disability sector about the Code and what to do when things go wrong.

Provision of services to intellectually disabled man (13HDC01204)

A 35-year-old man with a significant learning disability, who spoke English as a second language, was funded to receive "community engagement" by a disability services provider. The man lived at home with his mother, who was his primary caregiver, and was independent with his personal cares. The man had limited contact outside of the home.

The disability service provider was contracted to assist with the man's daily activities in the community for two days per week. The disability service provider arranged for the man's services to be provided by a caregiver who also spoke very limited English and did not speak any of the man's first language. The man and the caregiver communicated by way of signs, gestures and simple English words. The caregiver had not undertaken any disability-focused training.

On multiple occasions the caregiver took the man to his (the caregiver's) home, where the man watched television for lengthy periods. Once, the caregiver slept while the man watched television. The caregiver pinched the man's ears, hit him on the head, and engaged in rough play. The caregiver also left the man alone in a vehicle while he was fishing and shopping, and took the man with him while the caregiver did his son's paper round.

The man's sister complained to the disability service provider about the services provided to her brother. The disability service provider conducted an investigation, but did not interview the man, and a resolution meeting was unsuccessful.

The man was a vulnerable consumer who needed social contact through community engagement. The services provided appeared to be little more than "babysitting" and provided minimal community engagement for the man. HDC found that the caregiver breached the Code by not providing the man with adequate stimulation, by engaging in inappropriate physical contact with the man, and by leaving him unattended. In addition, the caregiver failed to comply with the man's care plan or the disability service provider's policies.

The disability service provider was found to have breached the Code by failing to have in place adequate systems and processes to provide safe and appropriate services for the man. HDC also found the provider in breach of the Code for failing to respond to the complaint in an appropriate manner, and failing to facilitate a resolution meeting that was consistent with acceptable standards.

HDC recommended that the caregiver and the disability service provider apologise directly to the man. A number of recommendations were also made to the disability service provider, with the aim of improving the quality and safety of the service it provides to its clients in the future. HDC also referred the disability services provider to the Director of Proceedings.

Care of disabled man receiving individualised funding (13HDC00854)

A woman complained about the care provided to her 20-year-old son, who had complex needs and required one-to-one care. Since 2003, the woman had chosen her son's support workers and had a longstanding professional relationship with one support worker and his family members who became the young man's support workers. Care was usually provided in the support worker's family home.

In 2011, the young man's needs assessment service coordinator (NASC) referred him to an individualised funding (IF) host provider. The mother became her son's IF agent. The IF host provider's role was to help the mother to understand IF, and how to organise, set up and manage the young man's support allocations and administer payments for support services, and to help the mother to manage her responsibilities. The IF host provider was required to carry out quality monitoring at six-monthly intervals.

The mother continued to use the support worker's family as the young man's main support workers, and privately engaged an agency to help manage the support package. There was no written contract between the agency and the mother.

In 2012, the main support worker went on leave. The support worker's son (the second support worker) became one of the young man's support workers at this time. He was an independent contractor of the agency and was also the support worker for another client. He gained his experience as a support worker for the young man when assisting his father to care for him for approximately one year several years prior to 2012. Before working with the young man in 2012, the only training provided to the second support worker by the agency was a first aid course.

On one particular day, the second support worker was rostered to care for the young man and another client on the same day. However, the agency understood that another family member of the main support worker would be looking after the young man, and that the second support worker would be looking after the other client only.

The second support worker proceeded to care for both clients at the same time, as well as his own young child. In the evening, he left both clients unsupervised and locked in his home while he went to collect food. A fire broke out, and the young man was unable to get out of the house and, sadly, died in the fire.

It was held that the second support worker did not provide services with reasonable care and skill and breached Right 4(1) by caring for three vulnerable people at one time when he knew the young man required one-to-one care, and by leaving the young man unsupervised and locked in his home with another client, despite knowing that the young man required supervision at all times.

The agency failed to provide services consistent with certain Home and Community Support Sector Standards and breached Right 4(1) of the Code by failing to adequately assess or monitor the quality of care being provided by the second support worker; failing to provide training or supervision to the second support worker in caring for clients with the young man's needs; and failing to have a formal written agreement in place with the mother, which resulted in uncertainty about the roles and responsibilities of those managing the young man's support. In addition, the process for rostering support workers created an environment where errors could occur, and the agency did not conduct the necessary checks to ensure that the young man would be receiving one-to-one care by a suitably qualified support worker when it realised that it had rostered one support worker to work with two clients on the same day. The agency's care planning and record-keeping was suboptimal.

The second support worker and the agency were referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

HDC recommended that the support worker, the care agency, and the IF host provider make written apologies to the young man's family. The care agency was also required to ensure it had written agreements in place for all clients; to ensure that its staff orientation and training programme included core disability focused training; to develop a policy for service provision in a support worker's home; and to implement robust procedures to monitor employee and contractor performance and compliance with policies and procedures.

In light of the findings in the investigation, HDC recommended that the Ministry of Health consider reviewing the management, monitoring, and reporting requirements for any clients receiving IF, and report back on the outcome of such a review and any changes made.

5.0 Organisational Performance, Development and Capability

5.1 Leadership

HDC continues to be a leader in the resolution of complaints about health and disability services, and in the medico-legal field. As the health and disability consumer watchdog, HDC encourages providers to alert it to issues as they arise, and supports providers to resolve complaints without the need for HDC's intervention. The Advocacy Service strives to empower consumers to resolve complaints and to manage on-going relationships with their health or disability service providers.

HDC provides leadership in systemic advocacy and the monitoring of mental health and addiction services, which leads to demonstrable systemic mental health and addiction service improvements. The work to improve the delivery of mental health and addiction services is part of HDC's role via promotion of the Code, the resolution of complaints, and educational initiatives. HDC encourages others in the sector to take a shared-responsibility role, as co-operation and collaboration from within the sector supports HDC's work in these functions.

In 2014/2015 the Commissioner led the organisation with the Executive Leadership Team of three Deputy Commissioners (one of whom is the Mental Health Commissioner), two Associate Commissioners, the Director of Proceedings, the Director of Advocacy, and a Corporate Services Manager.

5.2 Staff

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

5.3 Equal Employment Opportunities

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

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

5.4 Workplace profile

As at 30 June 2015, HDC had 59 full-time equivalent (FTE) employees made up of 48 full-time and 23 part-time positions.

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

The Office benefits from a diverse workforce, with a variety of ethnicities including Māori, Sāmoan, Asian, Brazilian, French, and English, among other ethnicities.

5.5 Good employer obligations

Leadership, accountability and culture

Managers are accountable for leading a performance culture that is supportive and equitable. Staff fora are held in both the Auckland and Wellington offices each month for divisions to talk about their work and current issues, and to recognise staff and team successes, both personal and work related.

Recruitment, selection and induction

HDC's recruitment policy and practices ensure the recruitment of the best qualified employees at all levels using the principles of EEO, while taking into account the career development of existing employees. Vacancies are advertised throughout the Office as well as externally, and employees are encouraged to apply for positions commensurate with their abilities.
The induction for all new staff members provides an introduction to the team; an oversight of the organisation's activities; information on policies, procedures and tools; and training as required.

Employee development, promotion and exit

HDC policies support professional development and promotion. Training and development needs and career development needs are formally identified as part of the annual performance appraisal process. Staff members jointly develop with their manager a performance management agreement tailored to their role and development requirements.

Professional development by employees is encouraged, and financial assistance and/or study leave may be granted by the Commissioner. Several staff have been given the opportunity to cover vacant senior management roles and thereby further develop their management and leadership skills.

Flexibility and work design

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

Remuneration, recognition and conditions

HDC provides fair remuneration that is linked to employee performance and based on Equal Employment Opportunities principles. HDC recognises staff achievements in its internal newsletter "Highlights" and at staff fora.

Harassment and bullying prevention

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

Safe and healthy environment

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

5.6 Process and technology

Sustainability

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

Technology

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

5.7 Physical assets and structures

HDC continues to manage its assets cost-effectively. Our governance policies and practices are strong. Our assets are maintained and cared for to ensure they provide an appropriate useful life.

6.0 Statement of Service Performance

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

HDC seeks to effect change to health and disability services, leading to significant improvements for both consumers and the wider New Zealand population. This change occurs through local change, through wider sector change and through influencing the ideology of providers.

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

- New Zealanders live longer, healthier, more independent lives.
- The health system is cost effective and supports a productive economy.
- High-quality health and disability services are delivered in a timely and accessible manner.
- The future sustainability of the health system is assured.

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

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

- Resolving complaints about health and disability services.

  Measured by:

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

- Using the learning from complaints to improve the safety and quality of health and disability services' practices and systems (quality improvement).

  Measured by:

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

- Promoting best practice and consumer-centred care to providers (quality improvement).

  Measured by:

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

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

  Measured by:

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

Monitoring and Protecting Health and Disability Consumer Interests Appropriation

HDC is funded under the Monitoring and Protecting Health and Disability Consumer Interests Appropriation. This appropriation is intended to achieve the following: the rights of people using health and disability services are protected. This includes addressing the concerns of whānau and appropriately investigating alleged breaches of patients' rights. HDC received funding of $11,670,000 from this appropriation in 2014/15. In addition, HDC earned other income of $513,870. This combined income was used to fund HDC's expenditure of $11,828,579.

6.2 Output Class 1: Complaints resolution

Financial Performance of Output Class

For the year ended 30 June

	Actual 2015	Budget 2015	Actual 2014
OUTPUT 1: Complaints resolution	**$**	**$**	**$**
Revenue	5,592,305	5,486,720	4,210,021
Expenditure	5,456,856	5,486,720	4,357,101
Net surplus/(deficit)	**135,449**	**-**	**(147,080)**

Performance and measures	Achievement
Output 1 — Complaints management	
Efficiently and appropriately resolve complaints	**Targets achieved**
Receive an estimated 1,800 complaints.	1,880 complaints were received during the year; this represents 104.4% of the estimated volume (2014: 1,784).
Close an estimated 1,900 complaints.	1,910 complaints were closed during the year; this represents 100.5% of the target (2014: 1,901).
Undertake an estimated 100 investigations.	100 investigations were undertaken and closed (2014: 115). Total open files at year end was 479[6] (2014: 508).
Manage complaints so that: • No more than 20% of open complaints are 6–12 months old. • No more than 10% of open complaints are 12–24 months old. • No more than 1% of open complaints are over 24 months old.	Age of open complaints at end of 2014/15: 6–12 months old, 65 out of 479 — 13.6% 12–24 months old, 41 out of 479 — 8.6% Over 24 months old, 5 out of 479 — 1% The number of open files has been reduced in total and in each age category as per the table below:
Consumers and providers are satisfied with HDC's complaints management processes	**Targets not achieved**
Undertake a two-yearly consumer and provider satisfaction survey. 80% of the respondents rate that they are "satisfied" or "highly satisfied" with the HDC complaints process.	65% of respondents agreed or strongly agreed that they were satisfied with HDC's complaints process.

	Total open files	6 to 12 months	12 to 24 months	Over 24 months
30 June 2014	508	93	68	9
30 June 2015	479	65	41	5
# reduced	29	28	27	4
% reduced	5.7%	30.1%	39.7%	44.4%

[6] This number includes one complaint file that was reopened.

6.2 Output Class 1: Complaints resolution - *Continued*

Performance and measures	Achievement
Output 2 — Quality improvement	
Use HDC complaints management processes to facilitate quality improvement Make recommendations and educational comments to providers to improve quality of services and monitor compliance with the implementation of recommendations: • Report on the number of HDC complaints leading to quality improvement recommendations and/ or educational comments. • Report on providers' self-reported level of compliance with HDC quality improvement recommendations: 95% compliance. • Providers make quality improvements as a result of HDC recommendations and/or educational comments. Audit a sample of providers to verify their compliance with HDC quality improvement recommendations: 100% compliance.	**Targets achieved** Between 1 July 2014 and 30 June 2015 HDC made recommendations or educational comments on 470 complaints, including 70 breach opinions (a breach opinion is where a provider has been found in breach of the Code following a formal investigation). Of these, 352 led to HDC making quality improvement recommendations or educational comments. Quality improvement recommendations exclude recommendations to apologise and other accountability recommendations. During the year, recommendations were due to be met by 312 providers. 303 (97%) were fully met. A further three are ongoing, with engagement from the providers. Four were partially met, and on only two has there been no compliance. One of these involved a non-regulated provider who had been found to have breached the Code for her failure to appreciate her professional responsibilities. **Target partially achieved** HDC monitors compliance on all files where we have made a recommendation by seeking evidence of the changes made. Where the level of compliance is not satisfactory, HDC does not record it as fully met. The target has been recognised as partially achieved because all but two providers have either fully or partially met the quality improvement recommendations (as per the details above). 99.4% compliance
Output 3 — Education	
Promote awareness amongst consumers and providers of the rights of consumers and how they may be enforced 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. • Release media statements in relation to key Commissioner decisions and other issues as appropriate. Report on total number.	**Targets achieved** 73 decisions were published at www.hdc.org.nz for the year. 71 of these decisions were sent to national media by way of media alert.

6.3 Output Class 2: Advocacy

Financial Performance of Output Class
For the year ended 30 June

	Actual 2015	Budget 2015	Actual 2014
OUTPUT 2: Advocacy	**$**	**$**	**$**
Revenue	4,215,006	4,135,683	4,720,790
Expenditure	4,140,190	4,135,683	4,935,902
Net surplus/(deficit)	**74,816**	**-**	**(215,112)**

Performance and measures	Achievement
Output 1 — Complaints to advocates are addressed promptly and resolved in a timely manner	
Complaints are closed within reasonable timeframes Receive an estimated 3,800 complaints. Close an estimated 3,800 complaints. Manage complaints so that: • 85% closed within 3 months • 95% closed within 6 months • 100% closed within 9 months	**Targets achieved** 3,635 new complaints were received by advocates in this reporting year. This represented 96% of the estimated total complaints expected (2014: 3,468, 91%). During the year 2014/15, 3,679 complaints were closed (2014: 3,365). • 87% were closed within 3 months (2014: 89%). • 99.3% were closed within 6 months (2014: 99.5%). • 100% were closed within 9 months (2014: 100%).
Complaints managed reach resolution 90% of complaints managed by the Advocacy Service are partially or fully resolved.[7]	**Target achieved** 92% of complaints managed by the Advocacy Service were partially or fully resolved (2014: 94%, 3,160).
Consumers and providers are satisfied with the service and the professionalism of the advocate Surveys of consumers and providers who have used/dealt with the Advocacy Service will report that 80% of the respondents are satisfied with the service and the professionalism of the advocate.	**Target achieved** 93.5% of consumers and 85.5% of providers who have dealt with the Advocacy Service said they were satisfied with the service and the professionalism of the advocate (2014: 92% of consumers and 87% of providers).

[7] A complaint is partially or fully resolved when the consumer's goals have been partially or fully met to a level where the consumer is happy to move on and there are no outstanding matters needing resolution.

6.3 Output Class 2: Advocacy — Continued

Performance and measures	Achievement
Output 2 — Advocacy will establish and maintain contact with consumers and providers within the community	
Vulnerable consumers (in rest homes, residential disability services and living independently in the community) have access to advocacy and regular visits from advocates	**Targets achieved**
Advocates to visit 100% of rest homes at least once, with 70% being visited twice.	***Rest Homes*** 100% (658) of rest homes received a visit from an advocate this year (2014: 100%, 670 of 670). Over 73% (486) of rest homes received a second visit from an advocate this year (2014: 64%, 427 of 670).
Advocates to visit 100% of residential disability services at least once, with 60% being visited twice.	***Residential Disability Services*** 100% (994) of residential disability services received a visit from an advocate this year (2014: 100%, 1,021 of 1,021). Over 63% (630) of residential disability services received a second visit from an advocate this year (2014: 61%, 620 of 1,021).
Consumer and provider networks have regular contacts from the advocates	**Targets achieved**
3,500 network contacts with consumers and providers by June 2015.	3,927 network contacts with consumers and providers were made by the advocates over the reporting year. This represents 112% of the annual target (2014: 129% 4,505). 31% of non-residential networks had a disability focus, 20% were with public interest groups and 17% with older people.

6.3 Output Class 2: Advocacy — *Continued*

Performance and measures	Achievement
Output 3 — Education and Training	
Promote awareness, respect for and observance of the rights of consumers and how they may be enforced	**Targets achieved**
Advocates provide 2,000 education and training sessions. Definition of a session is when an advocate delivers a training or educational presentation at a venue.	A total of 2,252 education and training sessions have been completed this year.
Consumers and providers are satisfied with the educational sessions: • Seek evaluations on sessions with 80% of respondents satisfied.	Satisfaction surveys showed 91% of consumers and 96% of providers were satisfied with the Advocacy Service's education or training sessions.
Surveys are provided to all consumers and providers who attend an advocacy education or training session.	All attendees at presentations and education sessions were provided with survey forms. From 2,252 sessions, 9,082 completed surveys were received.
Ongoing education is provided through Stories about Great Care	**Target achieved**
180 case studies/Stories about Great Care published by 30 June 2015.	180 case studies/Stories about Great Care were collected and published. This represents 100% of the annual target (2014:180, 100%).

HDC, through the Director of Advocacy, reviews the Advocacy Service source data within the Advocacy Trust to scrutinise performance results. The Director of Advocacy has not independently verified the accuracy or completeness of the source data this year, but will carry out such an audit in the coming year.

6.4 Output Class 3: Proceedings

Financial Performance of Output Class

For the year ended 30 June

	Actual 2015	Budget 2015	Actual 2014
OUTPUT 3: Proceedings	**$**	**$**	**$**
Revenue	579,406	568,502	807,238
Expenditure	575,714	568,502	733,884
Net surplus/(deficit)	**3,692**	**-**	**73,354**

Performance and measures	Achievement
Output 1 — Proceedings	
Professional misconduct is found in disciplinary proceedings Professional misconduct is found in 75% of disciplinary proceedings.	**Target not achieved** Professional misconduct was found in 60% (3 of 5) of proceedings during 2014/15 (2014: 75%, 6 of 8).
Breach of the Code is found in Human Rights Review Tribunal (HRRT) proceedings A breach of the Code is found in 75% of HRRT proceedings.	**Target achieved** A breach of the Code was found in 100% (5 of 5) of the HRRT proceedings during 2014/15 (2014: 6 of 6).
An award is made where damages sought An award of damages is made in 75% of cases where damages are sought.	**Target achieved** 80% (four proceedings involving five providers) have been resolved by negotiated agreement (2014: 5 of 6).

6.5 Output Class 4: Education

Financial Performance of Output Class

For the year ended 30 June

	Actual 2015	Budget 2015	Actual 2014
OUTPUT 4: Education	**$**	**$**	**$**
Revenue	777,622	647,095	506,645
Expenditure	672,410	647,095	561,481
Net surplus/(deficit)	**105,212**	**-**	**(54,836)**

Performance and measures	Achievement
Output 1 — Disability Education	
Promote awareness, respect for and observance of the rights of disability consumers	**Targets achieved**
Publish educational resources for disability consumers and disability service providers on the HDC website (and accessible to people who use "accessible software"). At least two new educational resources will be available in plain English.	In 2014/2015, HDC worked collaboratively with Enabling Good Lives Christchurch to publish three separate resources for young disabled people entering the pilot Enabling Good Lives (EGL) demonstration programme in Christchurch. The three resources were written in plain English (in particular avoiding technical language and jargon). The resources, which are posted on HDC's website, recognise the challenges disabled consumers face with community-based service delivery and include basic information and everyday examples on the following topics: • "Starting out Right — What you and your employees need to know about your rights". • "Personal space — Having service providers in your home". • "Sorting things out — Problems and complaints". It is anticipated that the resources will be taken up by disabled people nationally. In 2014/2015, HDC also worked in partnership with People First NZ to produce a peer-to-peer Code of Rights video education resource for people with a learning disability. The resource provides information on the Code of Rights and how to make a complaint, and is available on both HDC's and People First's website.
Facilitate four regional consumer seminars. Consumers are satisfied with the seminars: • Seek evaluations on seminars with 80% of respondents satisfied.	HDC facilitated four regional consumer seminars in 2014/2015 with respondents' satisfaction reported at 86–100% (2014: Two educational resources were produced).
Host a national HDC disability conference every two years. Attendees are satisfied with the conference: • Seek evaluation on conference with 80% of respondents satisfied.	HDC hosted its 4th National Disability conference on 2 July 2014. Feedback was generally positive with 83% of the respondents indicating that the conference mostly met, met or exceeded their expectations.

6.5 Output Class 4: Education — *Continued*

Performance and measures	Achievement
Output 2 — Information and Education for Providers	
DHBs find complaints trend reports useful for improving services Produce six-monthly DHB complaint trend reports and provide to all DHBs. 80% of DHBs who respond find complaint trend reports useful for improving services.	**Targets achieved** Produced two six-monthly DHB complaint trend reports for each DHB and provided these reports to all DHBs. 100% (19/19) of the DHBs who responded rated the first six-monthly report as useful. 100% (20/20) of the DHBs who responded rated the second six-monthly report as useful. (2014: 97.5%, 39 of 40)
Assist DHBs to improve their complaints systems Provide two complaint resolution workshops for DHBs. Seek evaluations on the workshops with 80% of respondents satisfied with the session.	**Targets achieved** Two complaint resolution workshops for DHBs were held. 95% and 97% of respondents reported that they were satisfied or very satisfied with each session.
Promote awareness, respect for and observance of the rights of consumers Provide 30 educational presentations. Consumers and health and disability service providers are satisfied with the educational presentations. Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	**Targets achieved** 59 educational presentations were made — this represents 197% of the annual estimated volume (2014: 63). 100% of respondents (59 of 59) who provided feedback reported that they were satisfied with the presentations (2014: 98%, 55 of 56).

6.5 Output Class 4: Education — *Continued*

Performance and measures	Achievement
Output 3 — Other Education	
HDC engages in sector education through making submissions on relevant policies, standards, professional codes, and legislation HDC makes at least 10 submissions.	**Target achieved** 11 submissions were made during the year (2014: 23).
HDC responds formally to queries from consumers, providers and other agencies about the Act, the Code and consumer rights under the Code At least 40 formal responses to enquiries provided.	**Target achieved** 60 formal responses to enquiries were provided during the year.

6.6 Output Class 5: Systemic monitoring and advocacy - Mental Health and Addiction Services

Financial Performance of Output Class

For the year ended 30 June

	Actual 2015	Budget 2015	Actual 2014
OUTPUT 5: Monitoring and systemic advocacy	**$**	**$**	**$**
Revenue	1,019,531	1,000,000	1,065,000
Expenditure	983,409	1,000,000	1,066,897
Net surplus/(deficit)	**36,122**	**-**	**(1,897)**

Performance and measures	Achievement
Output 1 — Systemic Monitoring and Advocacy	
Engagement	**Target achieved**
Participate in key international forums to exchange knowledge and facilitate international benchmarking Evidence of presenting at one international forum for mental health knowledge exchange.	The Mental Health Commissioner (MHC) attended and presented at a meeting with Australasian Commissioners in Brisbane in February 2015.
Engage with national sector forums to identify and support key projects for collaborative learning Attend at least four national forums. Feedback from the national forums chairs will indicate at least 75% are satisfied that the HDC input has been useful in supporting quality improvement.	During the year the MHC attended meetings of four National forums. These were: the National District Health Board (DHB) Mental Health & Addiction Service Clinical Directors and General Managers Group (National DHB CDs and GMs Group), the National Committee on Addictions Treatment (NCAT), the National DHB MH&A Service portfolio Managers forum and the National DHB Family/ Whānau Advisors Forum. Attendance at these meetings informed key issues for policy advice or resources for implementation. Feedback received during the year indicated that 100% of national forums chairs are satisfied that the HDC input has been useful in supporting quality improvement.

6.6 Output Class 5: Systemic monitoring and advocacy - *Continued*

Performance and measures	Achievement
Output 1 — Systemic Monitoring and Advocacy	
Monitoring and Analysis **Report on consumer and family/whānau experience of interacting with mental health and addiction services** Complete the evaluation of the Real Time Feedback system and develop recommendations for national roll-out. 90% of recipients of feedback reports will confirm usefulness of data in informing quality improvements.	**Real Time Feedback system (RTF) for collecting information on consumer and family/whānau experience** During the year the evaluation was completed. 100% of recipients of feedback reports confirmed usefulness of the data in informing quality improvements. A national roll-out commenced and Expressions of Interest from DHBs and NGOs are being followed up. At the end of June, seven (three DHBs and four NGOs) services are using RTF and a further 15 (11 DHBs and four NGOs) have committed to commence implementation or use of the system by December 2015. Proposed changes to the administration of RTF are being considered as part of the plan to move RTF from a project to business as usual. An RTF workshop was held in June. The purpose of the workshops are to bring current users of RTF and interested parties together for information sharing, feedback and discussion on the use of the system to inform service improvement.

6.6 Output Class 5: Systemic monitoring and advocacy - *Continued*

Performance and measures	Achievement
Output 1 — Systemic Monitoring and Advocacy	
Analysis of national data collections on mental health and well-being to report progress implementing "Rising to the Challenge" and to determine key challenges Implement a national monitoring program based on the National DHB KPI Group pilot of a monitoring framework in three DHBs to measure progress and inform their plans to implement "Rising to the Challenge". 90% of recipients find the reports useful.	HDC developed the Rising to the Challenge Outcomes Framework in 2013/14 in association with key stakeholders including DHBs and the Ministry of Health (MOH). In January 2015, DHBs were invited to participate in a national roll-out of the framework. This coincided with the MOH announcing the development of a similar project. The HDC and MOH personnel agreed to collaborate with the development of a single framework to ensure that DHBs were provided with reporting that met their needs and the MOH and HDC requirements.

6.6 Output Class 5: Systemic monitoring and advocacy - *Continued*

Performance and measures	Achievement
Output 1 — Systemic Monitoring and Advocacy	
Systemic Advocacy **Undertake projects on issues emerging from monitoring activities in collaboration with national sector groups to support leadership in service planning and development** Complete at least three projects to facilitate service improvement.	**Targets achieved** During the year, the MHC completed five projects to facilitate service improvement. They are: **Improving productivity:** This report was co-developed with the National DHB CDs and GMs Group and Ko Awatea. The main purpose of this report is to inform future actions by DHB clinical leaders and GMs pursuing productivity improvement. It provides a summary of research, learning and evaluation of productivity initiatives within the health sector and beyond, both internationally and in New Zealand. This report is available on the HDC website: http://www.hdc.org.nz/publications/other-publications-from-hdc/mental-health-resources/mental-health-services-productivity-improvement-best-practice-review **Reducing the Use of Seclusion and Restraint:** This report was co-developed between the MHC and National DHB clinical leaders and GMs Group. The main purpose of the report was to undertake a brief review of current initiatives and to make recommendations to address the priority action in "Rising to the Challenge" to "reduce and eliminate the use of seclusion and restraint". The review was undertaken by Ko Awatea. It recommended that DHBs work collaboratively to share insights on reducing the use of seclusion and restraint using best practice approaches. **Youth Alcohol and Other Drugs Services (AOD):** In 2014/15, the MHC supported a joint project in collaboration with the MOH and the National Committee of Addiction Treatment (NCAT) to establish a service development framework that leads to improved access to services by providing youth friendly AOD services. Implementation of the framework commenced in January this year and will continue in 2015/16. **Choice and Medication:** This year HDC contracted with Waitemata DHB to pilot and evaluate the use of a subscription to an online service providing consumers and professionals with relevant information to support treatment decisions on all psycho-active medicines available in New Zealand. The website went live on 8 June 2015. As at 21 June, 686 people had visited the site, downloaded 584 medication information sheets and viewed 1,675 pages. 79.2% of users identified themselves as new users to the site. 20.8% identified themselves as returning visitors. The trial and evaluation will be completed in 2016.

6.6 Output Class 5: Systemic monitoring and advocacy - *Continued*

Performance and measures	Achievement
Output 1 — Systemic Monitoring and Advocacy	
Systemic Advocacy — Continued	**Resources to provide information to support consumer and family/whānau participation in recovery:** This year 10,000 copies of the rebranded HDC publications "Oranga Ngākau" and "When someone you care about has mental health or addiction issues" were distributed to DHBs' consumer and family/whānau organisations, primary care and NGOs. Feedback received indicates that the resources are useful. A second print run was undertaken in June.
Advocate for increased partnership with mental health and addictions consumers and their families/whānau	
HDC support two national forums for the DHB Consumers Advisors and Family/ Whānau Advisors to strengthen their roles	HDC supported three national forums for the DHB consumers and family/whānau advisors during the year: • Matua Raki – National Addictions Consumer Leadership Group; • The National Association of Mental Health Services Consumer Advisors (NAMHSCAs); and • Ngā Hau e Whā. The purpose of supporting these forums is engagement with consumers and family/whānau on issues for improvement within services that they use, to share information on developments and to support initiatives to strengthen their role as partners in recovery and service delivery. The outcomes of these forums were used to inform projects mentioned in the section above.
80% satisfaction with HDC's contribution in these sector groups.	100% of feedback received indicates satisfaction with HDC's contribution in these sector groups.

6.6 Output Class 5: Systemic monitoring and advocacy - *Continued*

Performance and measures	Achievement
Output 1 — Systemic Monitoring and Advocacy	
Advocate for improved outcomes for Māori and Pacific peoples Ensure HDC has current agreements in place to work collaboratively with Māori and Pacific workforce development agencies on priority areas to improve outcomes for their population groups. Feedback from these agencies indicates that satisfactory progress is being made.	**Improving Outcomes in Rangatahi Mental Health:** This year our MOU partner, Te Rau Matatini, led the development and publication of the report "Hikaka te Manawa: Making a difference for rangatahi". This report summarises visits to 21 kaupapa Māori rangatahi mental health services. The review identified the strengths and challenges of rangatahi. The report advocates for future development of services that build on their strengths and provide solutions to the common challenges to maximise rangatahi development and whānau inclusion. The report was launched in March 2015 by Emeritus Professor Sir Mason Durie. **Māori and Pacific Workforce Development:** The MHC has a current MOU with Te Rau Matatini. The main output was the report referred to above. The MHC signed an MOU with Le Va in June 2015. A work programme of agreed actions will be developed in early 2015/16. A letter of feedback from Te Rau Matatini confirms that satisfactory progress is being made.
Reporting to Minister on progress in implementing "Rising to the Challenge" (ref: MoH 2012) Provide briefings to the Minister as requested.	**Ministerial Briefing:** The MHC contributed to briefings to the Minister as required throughout the year.

7.0 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 2015.

Anthony Hill
Health and Disability Commissioner

Gary Agnew
Corporate Services Manager

30 October 2015

8.0 Audit report

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 2015

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, Athol Graham, 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 her behalf.

Opinion on the financial statements and the performance information

We have audited:

- the financial statements of the Health and Disability Commissioner on pages 56 to 75, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health and Disability Commissioner on pages 37 to 52.

In our opinion:

- the financial statements of the Health and Disability Commissioner:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2015;
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards with reduced disclosure requirements.
- the performance information:
  - presents fairly, in all material respects, the Health and Disability Commissioner's performance for the year ended 30 June 2015, including:
    - for each class of reportable outputs:
      - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
      - 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;
    - 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 2015. This is the date at which our opinion is expressed. The basis of our opinion is explained below. In addition, we outline the responsibilities of the Health and Disability Commissioner and our responsibilities, and explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and the performance information are free from material misstatement. Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall

understanding of the financial statements and the performance information. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health and Disability Commissioner's financial statements and performance information in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health and Disability Commissioner's internal control.

An audit also involves evaluating:

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

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

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

Responsibilities of the Health and Disability Commissioner

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

- comply with generally accepted accounting practice in New Zealand;
- present fairly the Health and Disability Commissioner's financial position, financial performance and cash flows; and
- present fairly the Health and Disability Commissioner's performance.

The Health and Disability Commissioner's responsibilities arise from the Crown Entities Act 2004 and the Public Finance Act 1989. The Health and Disability Commissioner is responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Health and Disability Commissioner is also responsible for the publication of the financial statements and the performance information, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board. Other than the audit, we have no relationship with or interests in the Health and Disability Commissioner.

Athol Graham
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

9.0 Financial statements

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE
FOR THE YEAR ENDED 30 JUNE 2015

	Notes	Actual 2015 $	Budget 2015 $	Actual 2014 $
Revenue				
Funding from the Crown		11,670,000	11,670,000	10,920,000
Interest revenue		56,881	55,000	63,233
Other revenue	2	456,989	113,000	326,461
Total revenue		12,183,870	11,838,000	11,309,694
Expenditure				
Personnel costs	3	5,717,614	6,012,000	5,847,848
Depreciation and amortisation expense	8, 9	238,276	194,000	41,847
Advocacy services		3,546,298	3,540,000	3,539,998
Other expenses	4	2,326,391	2,092,000	2,225,572
Total expenditure		11,828,579	11,838,000	11,655,265
Surplus/ (deficit)		**355,291**	**0**	**(345,571)**
Total comprehensive revenue and expense		**355,291**	**0**	**(345,571)**

Explanations of major variances against budget are provided in note 20.
The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2015

	Notes	Actual 2015 $	Budget 2015 $	Actual 2014 $
Assets				
Current assets				
Cash and cash equivalents	5	1,343,988	555,000	1,004,781
Receivables	6	37,327	46,000	60,073
Prepayments		92,897	56,000	96,580
Inventories	7	21,487	55,000	19,885
Total current assets		1,495,699	712,000	1,181,319
Non-current assets				
Non-current receivables		0	0	36,000
Property, plant and equipment	8	316,120	190,000	344,987
Intangible assets	9	194,616	178,000	142,296
Total non-current assets		510,736	368,000	523,283
Total assets		**2,006,435**	**1,080,000**	**1,704,602**
Liabilities				
Current liabilities				
Payables	10	586,667	263,000	624,652
Employee entitlements	11	290,306	245,000	268,565
Total current liabilities		876,973	508,000	893,217
Non-current liabilities				
Payables	12	37,214	30,000	74,428
Total non-current liabilities		37,214	30,000	74,428
Total liabilities		**914,187**	**538,000**	**967,645**
Net assets		**1,092,248**	**542,000**	**736,957**
Equity				
Contributed capital	13	788,000	788,000	788,000
Accumulated surplus/(deficit)	13	304,248	(246,000)	(51,043)
Total equity		**1,092,248**	**542,000**	**736,957**

Explanations of major variances against budget are provided in note 20.
The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2015

	Notes	Actual 2015 $	Budget 2015 $	Actual 2014 $
Balance at 1 July		736,957	542,000	1,082,528
Total comprehensive revenue and expense for the year		355,291	0	(345,571)
Capital contribution		0	0	0
Balance at 30 June	**13**	**1,092,248**	**542,000**	**736,957**

Explanations of major variances against budget are provided in note 20.
The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2015

	Notes	Actual 2015 $	Budget 2015 $	Actual 2014 $
Cash flow from operating activities				
Receipts from the Crown		11,670,000	11,670,000	11,170,000
Interest received		51,900	55,000	68,125
Receipts from other revenue		475,191	113,000	267,957
Payments to suppliers		(5,933,461)	(5,593,000)	(5,612,339)
Payments to employees		(5,695,873)	(6,012,000)	(5,807,780)
GST (net)		34,534	0	(2,155)
Net cash from operating activities		602,291	233,000	83,808
Cash flows from financing activities				
Receipts from capital contribution	13	0	0	0
Net cash from financing activities		0	0	0
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		0	0	74
Purchase of property, plant and equipment		(90,139)	(80,000)	(317,129)
Purchase of intangible assets		(172,945)	(85,000)	(139,972)
Net cash from investing activities		(263,084)	(165,000)	(457,027)
Net increase/(decrease) in cash and cash equivalents		339,207	68,000	(373,219)
Cash and cash equivalents at beginning of the year		1,004,781	487,000	1,378,000
Cash and cash equivalents at end of the year	5	**1,343,988**	**555,000**	**1,004,781**

Explanations of major variances against budget are provided in note 20.
The accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

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 2015, and were approved by the Commissioner on 30 October 2015.

BASIS OF PREPARATION

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

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 Tier 2 PBE accounting standards and disclosure concessions have been applied. HDC can report in accordance with Tier 2 PBE Standards as HDC does not have public accountability and HDC's annual expenses are under $30 million.

These financial statements comply with PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There were no material adjustments arising on transition to the new PBE accounting standards as explained in note 21.

Presentation currency and rounding

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

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Revenue

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.

IT cost contribution
IT cost contribution is recognised when services are provided to the National Advocacy Trust by HDC based on mutual agreement.

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.

Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ$ (the functional currency) using the spot exchange rates at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Expenditure

Expenses are recognised when goods or services have been delivered, or when there is a present obligation that is expected to result in an outflow of economic benefits.

Leases

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.

Cash and cash equivalents

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.

Receivables

Short-term receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that the Health and Disability Commissioner will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Inventories

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

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

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

Property, plant and equipment

Property, plant and equipment consists 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.

Intangible assets

Software acquisition and development

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

Costs 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 an appropriate portion of 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 the 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	2 years	50%
Developed computer software	2 years	50%

Impairment of property, plant and equipment and intangible assets

The Health and Disability Commissioner does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

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

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

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

The reversal of an impairment loss is recognised in the surplus or deficit.

Payables

Short-term payables are recorded at their face value.

Employee entitlements

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 sick leave.

Superannuation schemes

Defined contribution schemes

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

Equity

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.

Goods and service tax (GST)

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, 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

The cost of outputs is determined using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output. Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Indirect personnel costs are charged on the basis of estimated time incurred. Other indirect costs are assigned to outputs based on the proportion of direct staff headcount 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 discussed below:

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 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. The carrying amounts of property, plant and equipment are disclosed in note 8.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies for the period ended 30 June 2015:

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

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

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

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

2. Other revenue

	Actual 2015 $	Actual 2014 $
Sale of publications	88,173	114,247
IT cost contribution	250,000	123,000
Sundry revenue	118,816	89,214
Total other revenue	**456,989**	**326,461**

3. Personnel costs

	Actual 2015 $	Actual 2014 $
Salaries and wages	5,528,385	5,635,477
Defined contribution plan employer contributions	167,489	172,303
Increase/(decrease) in employee entitlements (note11)	21,740	40,068
Total personnel costs	**5,717,614**	**5,847,848**

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

4. Other expenses

	Actual 2015 $	Actual 2014 $
Staff travel and accommodation	167,718	238,368
Operating lease expense	393,475	398,313
Advertising	21,377	21,448
Consultancy	610,504	575,122
Inventories consumed	98,197	138,466
Net loss on property, plant and equipment	1,354	12,746
Communications & computer	640,865	579,355
Other expenses	392,901	261,754
Total other expenses	**2,326,391**	**2,225,572**

5. Cash and cash equivalents

	Actual 2015 $	Actual 2014 $
Cash on hand and at bank	343,988	1,004,781
Term deposits with maturities less than 3 months	1,000,000	0
Total cash and cash equivalents	**1,343,988**	**1,004,781**

At 30 June 2015, the Health and Disability Commissioner holds no unspent grant funding received that is subject to restrictions (2014 $nil).

6. Receivables

	Actual 2015 $	Actual 2014 $
Trade receivables	24,524	52,250
Other receivables	12,803	7,823
Less provision for impairment	0	0
Non-current receivables	0	36,000
Total receivables	**37,327**	**96,073**
Total receivables comprises: Receivables from the sale of goods and services (exchange transactions)	37,327	45,323
Receivables from other (non-exchange transactions)	0	50,750

7. Inventories

	Actual 2015 $	Actual 2014 $
Commercial inventories		
Publications held for sale	21,487	19,885
Total inventories	**21,487**	**19,885**

The write-down of inventories amounted to $nil (2014: $nil). There have been no reversals of write-down.

No inventories are pledged as security for liabilities (2014: $nil).

8. Property, plant and equipment

Movements for each class of property, plant and equipment as at 30 June 2015 are as follows:

	Comp hardware	Comms equip	Furniture & fittings	Leasehold improvements	Motor vehicles	Office equip	Total
Cost or valuation	$	$	$	$	$	$	$
Balance at 1 July 2013	782,979	27,765	195,645	697,602	40,889	179,485	1,924,365
Balance at 30 June 2014	1,018,203	2,223	188,358	648,518	40,889	146,527	2,044,718
Balance at 1 July 2014	1,018,203	2,223	188,358	648,518	40,889	146,527	2,044,718
Additions	85,187	347	864	0	0	3,740	90,138
Disposals	(642,577)	(590)	(34,123)	(1,319)	0	(91,876)	(770,485)
Balance at 30 June 2015	460,813	1,980	155,099	647,199	40,889	58,391	1,364,371
Accumulated depreciation and impairment losses							
Balance at 1 July 2013	742,300	26,766	190,482	678,430	34,075	170,391	1,842,444
Balance at 30 June 2014	746,092	1,337	181,562	588,268	40,889	141,583	1,699,731
Balance at 1 July 2014	746,092	1,337	181,562	588,268	40,889	141,583	1,699,731
Depreciation expense	90,660	395	2,297	22,085	0	2,214	117,651
Elimination on disposal	(642,577)	(590)	(34,123)	(1,319)	0	(91,876)	(770,485)
Impairment losses	0	49	0	1,305	0	0	1,354
Reversal of impairment losses	0	0	0	0	0	0	0
Balance at 30 June 2015	194,175	1,191	149,736	610,339	40,889	51,921	1,048,251
Carrying amounts							
At 1 July 2013	40,679	999	5,163	19,172	6,814	9,094	81,921
At 30 June and 1 July 2014	272,111	886	6,796	60,250	0	4,944	344,987
Balance at 30 June 2015	266,638	789	5,363	36,860	0	6,470	316,120

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

During the year, a large amount of computer hardware that had reached predetermined useful lives were disposed of. The net loss on all disposals was $1,354 (2014: $9,892).

9. Intangible assets

Movements for each class of intangible asset are as follows:

	Acquired software	Internally generated software	Total
	$	$	$
Cost			
Balance at 1 July 2013	1,059,431	0	1,059,431
Balance at 30 June 2014/1 July 2014	659,951	100,000	759,951
Additions	24,429	148,516	172,945
Disposals	(166,033)	0	(166,033)
Balance at 30 June 2015	518,347	248,516	766,863
Accumulated amortisation and impairment losses			
Balance at 1 July 2013	1,056,502	0	1,056,502
Balance at 30 June 2014/1 July 2014	617,655	0	617,655
Amortisation expense	27,431	93,194	120,625
Disposals	(166,033)	0	(166,033)
Impairment losses	0	0	0
Balance at 30 June 2015	479,053	93,194	572,247
Carrying amounts			
At 1 July 2013	2,929	0	2,929
At 30 June 2014/1 July 2014	42,296	100,000	142,296
At 30 June 2015	39,294	155,322	194,616

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.

10. Payables - current

	Actual 2015 $	Actual 2014 $
Payables under exchange transactions		
Creditors	354,193	381,655
Income in advance	0	39,780
Accrued expenses	45,248	51,844
Lease incentive	37,213	37,213
Total payables under exchange transactions	436,654	510,492
Payables under non-exchange transactions		
Taxes payable (GST, PAYE and rates)	150,013	114,160
Other	0	0
Total payables under non-exchange transactions	150,013	114,160
Total payables	**586,667**	**624,652**

11. Employee entitlements

	Actual 2015 $	Actual 2014 $
Current portion		
Annual leave	290,306	268,565
Total employee entitlements	**290,306**	**268,565**

12. Non-current liabilities

	Actual 2015 $	Actual 2014 $
Payables	37,214	74,428
Total Non-current liabilities	**37,214**	**74,428**

The payables are the lease incentive relating to Auckland office at Level 10, 45 Queen Street for the period of from 1 July 2016 to 9 June 2017.

13. Equity

	Actual 2015 $	Actual 2014 $
Contributed capital		
Balance at 1 July	788,000	788,000
Capital contribution	0	0
Balance at 30 June	788,000	788,000
Accumulated surplus/(deficit)		
Balance at 1 July	(51,043)	294,528
Surplus/(deficit) for the year	355,291	(345,571)
Balance at 30 June	304,298	(51,043)
Total equity	**1,092,248**	**736,957**

14. Capital commitments and operating leases

	Actual 2015 $	Actual 2014 $
Capital commitments		
Computer hardware	0	5,307
Intangible assets	0	158,000
Total capital commitments	**0**	**163,307**

Advocacy Service contracts

The maximum commitment for the 12 months from 1 July 2015 is $3,339,998 (2014: $3,539,998).

Operating leases as lessee

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

	Actual 2015 $	Actual 2014 $
Not later than one year	267,273	353,419
Later than one year and not later than five years	279,178	534,310
Later than five years	0	0
Total non-cancellable operating leases	**546,451**	**887,729**

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

A significant portion of the total non-cancellable operating lease expense relates to the lease of these two offices and a telephone system (2014: two offices leases and a telephone system). The Auckland office lease expires in June 2017 and the Wellington lease has reached the end of the initial fixed term and is currently being renegotiated.

15. Contingencies

Contingent liabilities

As at 30 June 2015 there were no contingent liabilities (2014: $nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2014: one case).

16. 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 2015 $	Actual 2014 $
Leadership Team		
Remuneration	1,775,782	1,694,685
Full-time equivalent members	8.54	9
Total key management personnel compensation	**1,775,782**	**1,694,685**
Total full time equivalent personnel	**8.54**	**9**

17. Employee remuneration

	Actual 2015	Actual 2014
Total remuneration paid or payable:		
100,000–109,999	2	2
110,000–119,999	2	1
120,000–129,999	1	0
130,000–139,999	1	3
140,000–149,999	1	0
170,000–179,999	0	3
180,000–189,999	1	0
190,000–199,999	0	1
210,000–219,999	2	0
240,000–249,999	1	0
250,000–259,999	0	1
320,000–329,999	0	1
340,000–349,999	1	0
Total employees	**12**	**12**

During the year ended 30 June 2015, no (2014: 1) employee received compensation and other benefits in relation to cessation (2014: $32,306).

17a. Commissioner's total remuneration

In accordance with the disclosure requirements of sections 152(1)(a) of the Crown Entities Act 2004, the total remuneration includes all benefits paid during the period 1 July 2014 to 30 June 2015.

	2015 $	2014 $
Commissioner	346,986	322,851

The current Commissioner took office on 19 July 2010.

18. Events after the balance date

The reappointment of the current Commissioner takes effect on 19 July 2015

There were no other significant events after the balance date.

19. Financial instruments

19a. Financial instrument categories

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

	Actual 2015 $	Actual 2014 $
Loans and receivables:		
Cash and cash equivalents	343,988	1,004,781
Receivables	37,327	96,073
Investments – term deposits	1,000,000	0
Total loans and receivables	1,381,315	1,100,854
Financial liabilities measured at amortised cost:		
Payables (excluding income in advance, lease incentive, taxes payable and grants received subject to conditions)	399,441	433,499
Total financial liabilities measured at amortised cost	399,441	433,499

20. 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

Other revenue
More other revenue was received than budgeted, including a one-off IT cost contribution from the National Advocacy Trust and registration fees for two conferences which were held by HDC.

Total expenditure
HDC had a favourable staff variance due to position vacancies, some of which were filled by hiring external temporary contractors.

HDC incurred some doubtful debts related to the recovery of court costs and incurred additional IT testing costs for the new infrastructure.

Overall, HDC managed its total expenditure closely in line with the budget.

Statement of financial position

The closing cash balance was higher than budgeted largely because of the other revenue receipts and timing difference on creditor balances.

Property, plant and equipment capital expenditure was higher than budgeted because the new IT infrastructure was not anticipated as a self-funded project at the time when the 2014/15 Statement of Performance Expectation was prepared.

Statement of equity

The closing equity balance was higher than budgeted because of the surplus for the year and a higher opening balance.

Statement of cash flows

The higher net cash movement was mainly attributed to the one-off IT cost contribution from the National Advocacy Trust.

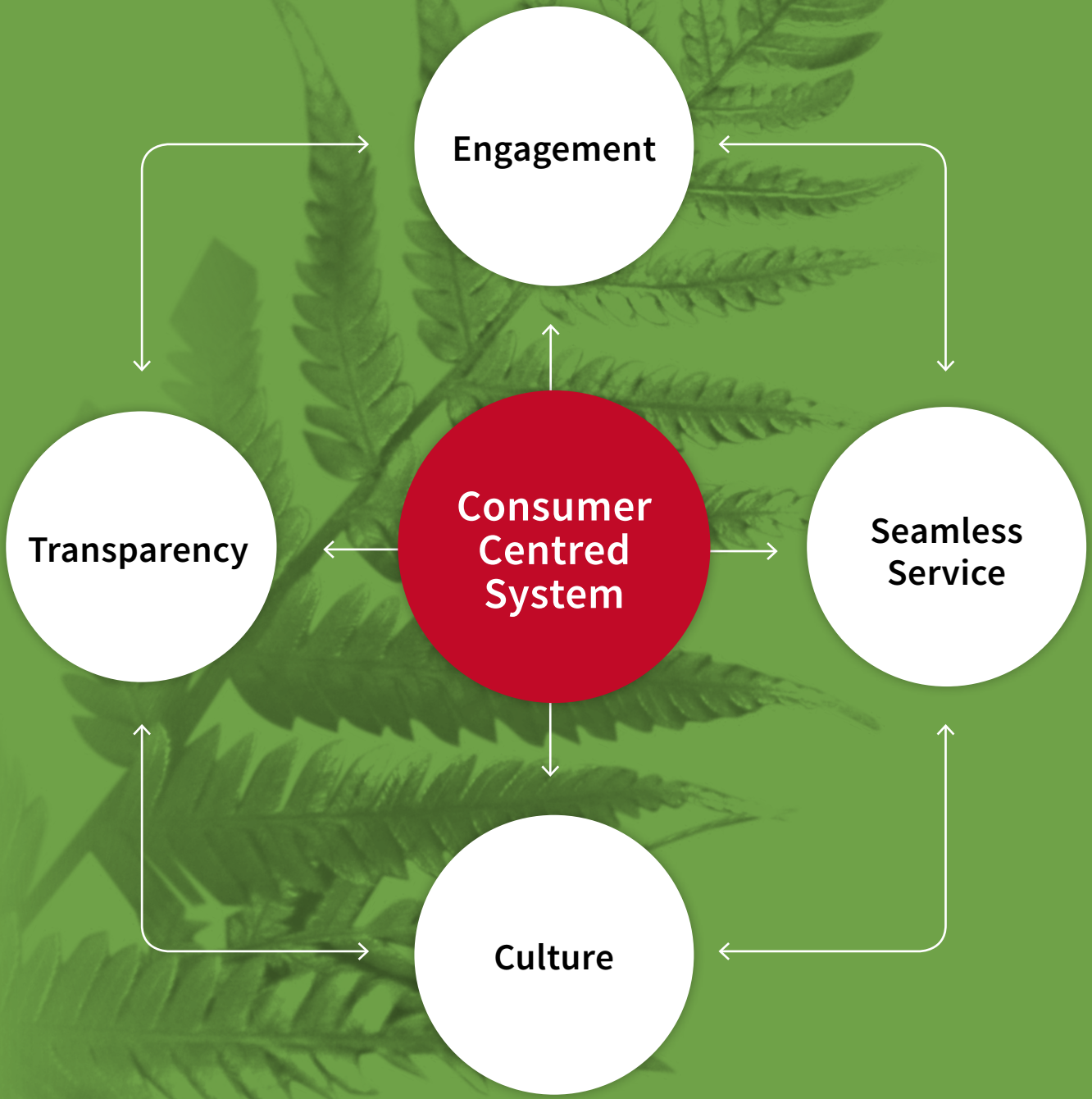
21. Adjustments arising on transition to the new PBE accounting standards

Reclassification adjustments

There have been no reclassifications on the face of the financial statements as a result of adopting the new PBE accounting standards.

Recognition and measurement adjustments

There have been no recognition or measurement adjustments on the face of the financial statements as a result of adopting the new PBE accounting standards.


Engagement
Transparency
Consumer Centred System
Seamless Service
Culture

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