HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

E.17

Learning from complaints

Annual Report
for the year ended 30 June 2009

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

HEALTH and DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

4 September 2009

The Minister of Health
Parliament Buildings
WELLINGTON

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 2009.

Yours faithfully

Ron Paterson
Health and Disability Commissioner

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Vision

Champions of consumers' rights.

Wawata

Kai kōkiri i nga tika kai hokohoko.

Mission

Resolution, protection, and learning.

Whainga

Whakataunga, whakamaru me te akoranga.

Cover photograph

A well-informed patient receives expert advice from a general practitioner at HDC's Auckland office, 13 August 2009.

COMMISSIONER'S REPORT

Introduction

Key features of 2008/09 were:

- No backlog of files
- 98.5% compliance with HDC recommendations
- North Shore Hospital inquiry
- Continued spotlight on patient safety
- 3rd Review of the HDC Act and Code

In the face of a 5% increase in complaints to HDC, we increased our productivity (complaints resolved) by 6.5%. We ended the year with the tally of open files at an all-time low of 274, with 87% of complaints resolved within six months. We maintained our focus on early resolution, with only 112 complaints leading to a formal investigation. We achieved 98.5% compliance with our recommendations of changes in a provider's practice; 39% of group providers reported significant systems changes made as a result of HDC recommendations.

Ron Paterson
Commissioner

Advocacy and Proceedings

Advocacy continues to be a highly effective means of resolution, with 91% of complaints received by the Advocacy Service partly or fully resolved with advocacy support. At the other end of the complaints spectrum, the Director of Proceedings received 22 referrals during the year (in relation to 15 providers) because of major shortcomings in care or unethical practice. In 2008/09 the Director was successful in 9 of 12 substantive hearings.

North Shore Hospital Inquiry

This inquiry, ably led by Deputy Commissioner Rae Lamb, focused on the plight of five sick, elderly patients in the emergency department and on medical wards at North Shore Hospital in mid-2007. Waitemata DHB was found to have breached the Code by failing to treat patients with respect, lapses in nursing care, and poor communication. The report highlighted the need for concerted action nationally to tackle the widespread problem of hospital overcrowding, staff shortages and overwhelmed acute care services. The report held the DHB board and senior management accountable for the failings in care, but noted the need for support from central government for district health boards facing intractable pressures.

Patient Safety in Public Hospitals

The risk of patients being lost in hospital referral systems, with dire consequences, was vividly illustrated in three HDC investigation reports released in October 2008 (07HDC20199, 08HDC06165, 07HDC19869). Four reports released in December 2008 emphasised the need for robust systems in overcrowded emergency departments, effective supervision of junior staff, and electronic, integrated patient records (07HDC17769, 07HDC14539, 07HDC10767, 08HDC00248).

Patient safety featured in several other HDC reports, highlighting the need to credential surgeons and ensure good support services in provincial hospitals (07HDC17438), and the importance of public hospital on-call arrangements not being compromised by consultants' private work (07HDC15291). DHBs have been reminded of their statutory responsibility to monitor the quality of care delivered by contracted providers in rural hospitals (07HDC11548).

Aged Care

Aged care has been in the public eye this year, with a notable increase in complaints to HDC. Poor documentation, issues related to falls and the use of hoists to move residents, and inadequate care were common themes. Wound care was a particular issue (see 07HDC17744 and 07HDC12520) and a number of cases examined the responsibilities of nurse managers

and rest home owners, especially during periods of transition such as a change of ownership (eg, 08HDC04291).

Mental Health Services

In three cases released in January and February 2009, HDC highlighted the importance of the involvement of family in a mental health consumer's care. Privacy should not be put above safety — even where a consumer has expressed a wish that their family not be involved in their care, providers should not be afraid to notify family of the risk of self-harm (08HDC08140). The involvement of family can be valuable for the provision of ongoing support and crisis management (07HDC16607), and to assist providers to identify warning signs of relapse and to access all available information in assessing and treating the consumer (07HDC14286).

Review of HDC Act and Code

As required by the Health and Disability Commissioner Act 1994 (the Act), HDC undertook a review of the Act and Code and reported the findings to the Minister of Health on 30 June 2009. The report was tabled in Parliament by the Minister on 6 August 2009.

A consultation document was released on 1 December 2008, two forums were held in Auckland in early 2009 focusing on the possible changes in relation to disability consumers' rights, and a meeting was held in Wellington in June to discuss the possibility of a "right to compassion". 122 submissions were received, with general agreement that the Act and Code are working well.

There was, however, significant support for some changes. I have recommended that the Act and Code be amended to strengthen the rights of disability service consumers' rights, to change the current contractual model for delivering advocacy services so that the advocates can become employees of HDC (while maintaining their statutory independence), and to permit HDC to handle complaints about privacy of health information. Changes will ensue only if the Government decides to adopt my recommendations.

Educational Initiatives

This year again saw a broad array of educational initiatives undertaken by HDC staff and advocates, including numerous conference presentations and talks to health professionals and students around the country. We helped Deaf Aotearoa, New Zealand produce a DVD for health professionals working with hearing impaired and Deaf people, and provided continuing medical education for a large Waikato PHO (Pinnacle), workshops to nurses in 11 prisons, and six-monthly complaint trend information for DHBs. We organised a very successful medico-legal seminar in Wellington, attracting over 200 attendees.

Our website continues to be frequently accessed by consumers, providers, and the media. Recent cases are usually reported by daily newspapers within 24 hours of posting on the website. A monthly "Health ethics, law and policy" column in *New Zealand Doctor* highlights current issues for the general practice community. Regular interviews on Radio New Zealand, and television, radio and print media coverage ensured a continued high media profile for HDC.

Acknowledgements

In this my 10th Annual Report to the Minister of Health, I wish to record my gratitude for the privilege of serving the public of New Zealand as Health and Disability Commissioner since 2000. I acknowledge the dedicated service of Theo Baker, who joined the Proceedings team as legal counsel in 2000 and was an outstanding Director of Proceedings for five years from 2004. I thank all the staff at HDC, in particular Deputy Commissioners Tania Thomas (reappointed in March 2009 for a second five-year term, as Deputy Commissioner — Disability) and Rae Lamb, and everyone involved in the Nationwide Health and Disability Advocacy Service, for their commitment to our important work.

COMPLAINTS RESOLUTION

It's been seven years since we last saw so many complaints to HDC about health and disability services. There were 1,360 new complaints received this year — the highest number since 2001/02, and a sizeable increase from last year. Nonetheless we concluded more complaint files than ever before, using all the available options for "fair, simple, speedy, and efficient" resolution.

Also keeping complaints resolution staff busy were 4,579 enquiries about a range of matters, including consumers' rights and requests for information. Most of these (4,295) were telephone enquiries. In February we appointed two dedicated helpline staff to assist consumers calling our 0800 telephone service, and to release other staff to work on complaints files. This initiative has worked well.

Rae Lamb
Deputy Commissioner,
Complaints Resolution

Table 1: **Number of open complaint files**

	2008/09	2007/08	2006/07
Open at year start	292	295	279
New during year	1,360	1,292	1,289
Closed during year	1,378	1,295	1,273
Open at year end	**274**	292	295

Each complaint was carefully assessed to determine the most appropriate way to fairly and promptly resolve it. Eighty-seven percent of complaints were closed in six months. Ninety-six percent were closed within a year. Complaints were addressed in the following ways:

Table 2: **Complaints closed**

	2008/09	2007/08	2006/07
Outside jurisdiction (OJ)	132	113	154
Advocacy referrals	149	180	149
Formal investigation	109[1]	100	89
Referrals other agencies[2]	184	138	126
Resolved by referral to providers	158	33	18
Resolved by mediation	4[3]	5	11
Section 38(1)	584	661	617
Withdrawn/Resolved by parties or Commissioner	58	65	109
Total complaints closed	**1,378**	**1,295**	**1,273**

1 Excludes 3 investigations resolved by mediation.
2 Registration boards, agencies such as ACC and Ministry of Health, and officers such as District Inspectors and the Privacy Commissioner.
3 Includes 3 investigations resolved by mediation.

Outside Jurisdiction

Once again a significant number of complaints were unable to be considered by the Commissioner. This was because they did not relate to a health or disability service, they raised issues of funding or access, or there was, from the outset, clearly no apparent breach of the Code of Health and Disability Services Consumers' Rights (the Code). Wherever possible, people were informed about alternative sources of assistance.

Advocacy

Advocacy continued to be a good option for resolving complaints promptly, directly, and at the local level. It is particularly effective when communication is the main issue; where there are ongoing relationships to restore or maintain; where consumers need immediate help; or where organising a face-to-face meeting seems sensible. Ninety-four of the complaints referred to the Nationwide Health and Disability Advocacy Service last year were formal referrals requiring a report back from the advocate. A further 55 consumers were given information and contact details for the service and encouraged to use it. (A significant number of other complaints were also dealt with directly by the advocacy service, as can be seen elsewhere in this report.)

Referrals to Providers

As seen in Table 2, there was a big jump in the number of complaints referred to providers for resolution. This reflects two things. First, in our experience, the earlier and more directly a complaint is dealt with, the greater the chance of successful resolution. Many complaints come straight to HDC without being raised with the provider and therefore, depending on the circumstances, it may be appropriate to refer them to the provider in the first instance. Secondly, most of these referrals are to District Health Boards which, in line with their obligations under the Code, have increasingly developed good systems to address complaints in a timely and appropriate way.

REFERRAL TO PROVIDER — AN EXEMPLARY RESPONSE

A mother complained about her daughter's nursing and medical care during an initial visit to a hospital emergency department (ED) after a car accident. The young woman had, as it turned out, been prematurely discharged and serious injuries had been missed. Fortunately, thanks to the vigilance of her family, these were subsequently diagnosed and successfully treated.

The woman's mother first complained to the DHB but came to HDC because she was unhappy with the time the DHB was taking to respond, and she felt that there were outstanding, unresolved issues. She wanted changes to be made to ensure no one else had the same experience.

The Commissioner formally referred the complaint back to the DHB. A written explanation and apology were sent to the complainant, and senior medical and nursing staff met with her and fully acknowledged the failings in the care. Plans to set up an ED Consumer Group were discussed.

The mother was also invited to talk to ED staff during a formal teaching session, and staff feedback confirmed that this was a powerful presentation — so much so, that the DHB suggested to the local Polytechnic that the mother should speak to undergraduate nurses about caring and communication.

It was clear from the DHB's report that there had been professional reflection and learning, and changes in practice, as a result of this complaint.

With each referral, providers are required to report back on how they resolved the matter, and the Commissioner has the discretion to reassess the complaint if it is not appropriately addressed. Additionally, consumers are offered advocacy support during the process.

Referrals to Other Agencies

Most of the complaints referred to other agencies (119 of 184) related to competence or professional conduct issues needing review by a registration board (such as the Medical Council of New Zealand). The others included rest homes that were referred to the Ministry of Health and/or local District Health Boards for audits and other action to ensure appropriate changes had been made.

Mediation

It is disappointing to have had only four successful mediations this year. Although this is a very effective way of resolving difficult and complex matters, and it gives the parties an opportunity to influence the outcome of a complaint, it continues to be difficult to get people to agree to mediation. We are now trying a new approach whereby consumers are asked to speak to a professional mediator about the process before indicating their views on being referred to mediation. It remains to be seen what difference this makes.

SECTION 38 CLOSURE — LESSONS FOR AN INEXPERIENCED DOCTOR

An after-hours doctor misdiagnosed tonsillitis and failed to listen to the parents' concerns that their baby might have swallowed something. The child subsequently had surgery to remove a small padlock from his throat. The parents complained. They wanted an apology and reassurance that the doctor would pay more attention to parents in future.

In response, the doctor openly acknowledged the misdiagnosis and apologised. She advised that she should have recognised the parents' dissatisfaction with her diagnosis, offered an X-ray, and considered a second opinion.

The Commissioner's clinical advisor, an experienced GP, reviewed all the information and advised that the relatively inexperienced doctor's notes suggested a good standard of clinical examination, but that she had missed some clues and would have been wise to listen to the parents.

The clinical advice was sent to the doctor, who again apologised and offered to meet the parents. It was clear that she had learned a great deal from this event. She had made many changes, including making a more conscious effort to listen to parents, and researching the best practice for dealing with children suspected of ingesting foreign bodies. She had seen two more such cases and had sent them for X-rays. She advised that if she had any doubts in future she would seek a more senior, second opinion, and she had changed her method for testing a child's ability to swallow. She outlined planned further formal training.

The Commissioner advised the family of these changes, the apology, and the offer to meet. No further action was considered necessary.

Section 38(1)

There was a drop in number of complaints closed under this section of the Act, although large numbers of complaints are still addressed this way. Most are those where the Commissioner considers that an educational approach is appropriate. This includes complaints where matters don't meet the threshold for a formal investigation, or where an appropriate outcome

can be achieved without it, in a more flexible and timely way. Before any decision is made, considerable information is gathered and carefully assessed, and preliminary expert clinical advice is sought when needed. Before the complaint is closed, "education letters" are sent to providers, highlighting any issues and aspects of care needing review. An apology or other follow-up action is frequently requested.

Section 38 is also used to close complaints when no further action is required because, after careful assessment, there is no apparent breach of the Code, or because matters are already being addressed through other appropriate processes or agencies. Occasionally complaints are closed because so much time has elapsed since the events occurred that it is not really possible to address the complaint.

Investigations

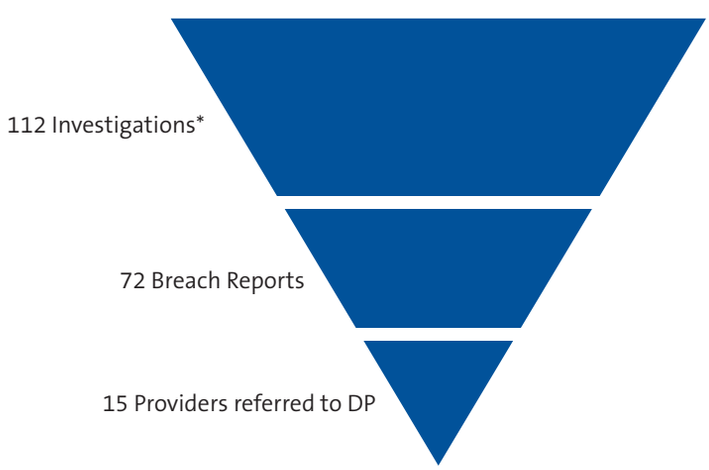
Proportionately the number of complaints formally investigated remains similar to other recent years. Formal investigations have increasingly been used for complaints involving potentially significant breaches of ethical and professional boundaries, and major lapses in standards of care that have resulted in death or severe disability.

Public safety concerns, the need for accountability, and the potential for the findings to lead to significant improvement in health and disability services, are also reasons why a complaint may be formally investigated.

Once again, a significant number of investigations (72 out of 112) have found breaches of the Code. This confirms that while the number of investigations has dropped in recent years, this option is being used for the most serious matters. Seventeen investigations resulted in 22 referrals (involving 15 providers) to the Director of Proceedings for disciplinary action to be considered.

An investigation may be discontinued if it becomes clear that the issues have been identified and the concerns addressed appropriately, or because expert clinical advice indicates the care was, in fact, generally reasonable. Last year 32 investigations were discontinued; four were closed when providers were referred to their registration boards; one was closed after being referred to the provider for follow-up action; and three were resolved by mediation. All investigations were concluded within two years, with 64 (57%) completed in 12 months.

Figure 1: **Outcome of investigations 2008/09**



*32 discontinued, 3 resolved by mediation, 4 referred to registration board, 1 referred to provider

Other Reasons for Closure

Some complaints are simply withdrawn, and others are closed because they have been resolved by the parties or as a result of some brief, informal involvement by the Commissioner.

Recommendations

Another feature of the year has been further significant growth in the number of recommendations made by HDC. It reflects the ongoing focus on looking for the learning from every complaint and seeking improvement, regardless of whether the matter has been formally investigated. There were 346 recommendations made this year, compared with 222 in 2007/08.

Recommendations generally include changes in individual and organisational practice, and specific initiatives to address identified failings. An apology is commonly requested. Compliance with recommendations is closely monitored and in only five cases has there been a failure to act on the Commissioner's recommendations (98.5% compliance). In these cases, individual practitioners have been referred to their registration boards.

Satisfaction Survey

For the first time in two years, we surveyed a random sample of complainants and providers to assess levels of satisfaction with our complaints resolution process and identify areas for improvement. In total, 229 complainants, 188 individual providers, and 13 DHBs were surveyed (n=430), with an overall response rate of 47% (n=200).

As with earlier surveys, more providers (53%) than complainants (47%) responded, and providers reported slightly higher levels of overall satisfaction with the process. Not surprisingly, complainants reported lower levels of satisfaction in response to the questions relating to HDC decisions — a result likely to reflect outcomes that have not met their expectations. HDC is required to make decisions that are fair and impartial. This can conflict with consumers' expectations that there should be a formal investigation (regardless of the issues), and that blame should be found.

Providers and complainants made both positive and negative comments, reflecting very mixed views regardless of which side of the complaints process they were on. The comments included:

"Having a complaint made against one is hugely stressful. I found the HDC staff to be as helpful and professional as possible — minimising the distress associated with the process. The promptness of response was particularly helpful. May I suggest you send out any future surveys in a different envelope though, as the sight of the envelope was enough to bring it all back!"

"Processes were clear and staff professional in their dealings with me. Final outcome was somewhat disappointing."

"I did feel that the length of time was excessive but in retrospect it was ok."

"I found HDC incredibly good with their information about how to best lay out my complaint, areas of help available, and their regular follow up contact to check how things were going."

"I felt my concerns and complaints were dismissed and I felt invalidated that because the facility concerned could not find anything written in my notes to substantiate my complaints, no further action was taken."

"I approve of levels of seriousness attributed to different complaints — this seems appropriate. My perception is that the burden falls on the practitioner to prove innocence which is at variance with our societal system of justice."

Table 3: **HDC survey results**

	Complainants	Providers	DHBs
Staff were polite to deal with	90%	94%	100%
Staff were professional	87%	95%	89%
Communications were promptly responded to	78%	83%	89%
Complaints process was clearly explained	80%	77%	75%
HDC role was clearly explained	77%	75%	75%
Information was easy to understand	85%	95%	100%
Letters were clearly laid out	88%	96%	100%
Letters were easy to understand	88%	95%	100%
Complaint was taken seriously	67%	97%	100%
Kept informed of progress	69%	76%	89%
Complaint dealt with fairly	62%	85%	87%
Complaint dealt with impartially	64%	86%	87%
Clear reasons were given for decision	64%	92%	100%
Understood reasons for decision	57%	92%	89%
Satisfied with management of complaint	54%	84%	100%

"I was annoyed that an obviously spurious complaint from a clearly psychotic patient triggered a further letter to notify the Medical Council."

"This was very much a new experience for me and I was quite amazed at the thorough and professional approach to my complaint when you consider it was a very minor issue compared to the high profile ones seen on TV and in the newspaper."

"The HDC acted at all times as an advocate for the subject [of] the complaint and made no attempt to act in the interests of the complainant. The HDC needs to be impartial not biased and to consider all material presented to it."

"We are appreciative that there is an organisation, which is independent from providers, that is able to do an investigation that is impartial. This is beneficial for providers as there is then an opinion as to whether the health service was acceptable and not a breach. Likewise if we are wrong HDC can endorse our improvement plans and suggest others we may not have thought of."

"Sometimes the complaint appraisal seems weighted in favour of the complaint. Sometimes they are overly pedantic about what, from a DHB perspective, are relatively minor issues. Sometimes DHB resource limitations do not seem to be appreciated and there are unrealistic expectations about what could be provided."

"Going to HDC really made a difference and not only benefited us, but others who had encountered similar problems to us as the agency seemed to change their strategy after the complaint — thank you!"

Survey Follow-up

The survey results and comments have been fed back directly to complaints resolution staff and the senior management team. Particular attention will be paid to continuing to try to improve response times, and improving understanding of the outcome of complaints.

RECOMMENDATIONS — MAKING A DIFFERENCE

Safer practices by beauty therapists

The Association of Beauty Therapists advised that it was revising its Code of Practice to require members using IPL (Intense Pulsed Light) and ELOS (Electrical Light Optical Synergy) machines to hold current Safety Certificates. It would inform members of this, and publish an article to highlight the risks when untrained operators use these machines.

This followed recommendations from an investigation into a complaint from a woman who was burned after ELOS treatment for acne scars and a skin pigmentation disorder. The investigation found the beauty therapist breached the Code of HDC Rights relating to the standard of care and informed consent, and the clinic owner was vicariously liable for these breaches. The investigation highlighted the absence of adequate guidelines for therapists and the unregulated nature of the industry. The findings were sent to all relevant agencies. (Case 07HDC09713)

Better hospital discharges and access to records

A DHB has now successfully implemented electronic patient discharge summaries, following an HDC investigation that highlighted slow progress with this. The investigation found that the absence of notes from an earlier ED presentation compromised the care of a woman who died after a rare complication from previous neurosurgery was misdiagnosed as a migraine.

The DHB advised that discharge summaries are now sent electronically by a secure link to patients' GPs after patients are discharged from its wards and the emergency department. Additionally a new system for specialists' letters and other correspondence to be securely sent electronically to GPs and linked to the patient record has been piloted, and is being rolled out. This is part of a wider project to introduce fully electronic patient records. (Case 08HDC00248)

GP systems changes

A general practice has implemented a suggestion by the Commissioner that an alert be placed on a patient's file if the record needs to be taken off site for any reason. In addition, all prescriptions prepared by nursing staff are now reviewed by the signing doctor before being released to patients.

This follows a complaint from a patient who was prescribed the wrong dose of an anti-epilepsy drug and took a lower than usual amount for some weeks before the error was discovered.

The patient was new to the practice and the clinical notes had been taken home to be reviewed by the doctor overnight. The repeat prescription was prepared according to information from the patient and not checked against the notes. The Commissioner took an educational approach to the complaint and the practice fully complied with his recommendations. (Case 08HDC06608)

ORGANISATION CHART as at 30 JUNE 2009

SENIOR MANAGEMENT TEAM

Commissioner
Ron Paterson

Deputy Commissioner, Disability
Tania Thomas

Chief Legal Advisor
Nicola Sladden

Deputy Commissioner, Complaints Resolution
Rae Lamb

Director of Advocacy
Judi Strid

Director of Proceedings
Aaron Martin

Health and Disability Commissioner
Ron Paterson
AK/WN

Executive Assistant
Ta'a Punivalu
AK

Executive Assistant
Julia Phillips
WN

Chief Legal Advisor
Nicola Sladden
WN (P/T)

Deputy Commissioner, Complaints Resolution
Rae Lamb
AK

Executive Assistant
Erina Mako
AK

Director of Advocacy
Judi Strid
AK

Director of Proceedings
Aaron Martin
WN

Personal Assistant
Mauryse Dix
AK

Deputy Commissioner, Disability
Tania Thomas
AK

Disability Initiatives Manager
Hemant Thakkar
AK

Investigations Manager
Mark Evans
AK

Clinical Advisor
David Maplesden
AK (P/T)

Complaints Assessment Manager
Warrick Hickman
AK

Personal Assistant
(Vacant)
AK (P/T)

Legal Counsel
Jason Tamm
WN

Alison Mills
WN

Proceedings Secretary
Elizabeth Sorenson
WN

Nationwide Health and Disability Consumer Advocacy Service

Finance Manager
Trudy Bennett
AK

Education Manager
Elizabeth Finn
AK

Information Manager
Anne Russell
AK

Projects Co-ordinator/ Office Manager
Julie Ruthe
WN

Receptionist/ Secretary
Elaine Lian
WN

Receptionist/ Secretary
(vacant)
AK

Senior Legal Advisors
Sarah Parker
WN

Cordelia Thomas
WN

Legal Advisors
Elizabeth Browne
WN

Julian Sakarai
WN

Helen Sims
WN

Legal Administration Assistant
Jane Balogh
WN

Senior Investigator
Jeane Mackay AK

Investigators
Wendy Vonlanthen AK
Kanny Ooi AK
Vanessa White AK
Anna Down AK
Emily McGowan AK
Marc Smith AK

Recommendations Liaison Co-ordinator
Wendy Sheehan AK

Investigations Secretary
(vacant) AK

Senior Complaints Assessors
Simon Latimer AK
Amanda James AK

Complaints Assessors
Jacqui Bozoky AK
Philippa McIver AK
Nidar Gailani AK
Stuart McLennan AK
Rosemary Pohio AK
Rebekah Mitchell AK

Helpline Complaints Assessors
Lyndon Stone AK
Kay McCall AK

Complaints Administrator
Michelle Smith AK (P/T)

Education Assistant
(vacant)
AK

Website Administrator
Helen Crompton
AK (P/T)

Systems Administrator
Martin Good
AK (P/T)

Publications Administrator
Christine Ley
AK (P/T)

Publications Despatch Co-ordinator
Tony Cavanagh
AK (P/T)

Ngā mihi mahana ki a koutou katoa.
Warm greetings to you all.

In March 2009 I was re-appointed for a further term of five years in my new role of Deputy Health and Disability Commissioner — Disability. This changed role will enable me to take greater responsibility for disability issues within the sector. It also means that I have delegations to manage all disability-related investigations. I will also have greater input into the resolution of complaints from the disability sector that do not meet the threshold for an investigation. The new role gives greater emphasis to education in the disability sector about complaints resolution.

Hemant Thakkar joined HDC as the Disability Initiatives Manager in February 2009. Hemant's key role is to identify and develop educational resources and initiatives for consumers and providers in the disability sector. Hemant will also be responsible for the implementation of the New Zealand Disability Strategy, including improving accessibility of HDC services for people with impairments.

Tania Thomas
Deputy Commissioner
— Disability

What's New?

HDC has been working on a new look website. It will have a number of additional features making the website more accessible for people with different types of impairment. There will also be a Disability section containing useful information for disabled consumers as well as other interested stakeholders.

Educational Resources

An educational resource entitled "Are you Committed to the Code?" has been designed to support caregivers in the disability sector and aged-care sector to implement the Code of Rights in daily practice. Two other resources entitled "Are you Committed to the Convention?" have also been designed to assist service providers in the disability sector and government agencies in implementing the United Nations Convention on the Rights of People with Disabilities at an organisational level.

DVD in New Zealand Sign Language

In association with Deaf Aotearoa, New Zealand, HDC had input into and jointly funded the production of a DVD aimed at assisting health professionals to work with hearing impaired and Deaf people.

Communication Strategy

HDC has developed and implemented an extensive strategy to communicate on an ongoing basis with the disability sector. It includes sending regular updates from our office to newsletters of various consumer organisations, regular community radio interviews, and extensive advertising in the community via community notice boards.

We are also using "Kiwi Way" on the Planet FM website. It is designed to educate new migrants and other people with English as a second language on key services that help them settle in New Zealand. HDC and the Advocacy Service have published a message about our services in 24 different languages on Kiwi Way. If you want to know more about Kiwi Way, go to: http://www.planetaudio.org.nz/kiwiway.php.

Student Placement

HDC now provides work experience placements for students with impairments. Our first student placement was from Kelston Deaf Education Centre in June 2009.

Plain Language Format

We converted the Review of the HDC Act and Code Consultation document into plain language format and continue to increase the accessibility of its planning and reporting information. HDC's Statement of Intent 2009–2012 and our Report on the Review of the HDC Act and Code has also been formatted into plain language.

Activities During the Year

Consumer forum — Māori with impairments

Listed below are some of the key issues arising from the participants of a forum held in South Auckland:

- Disability services are not well coordinated, which results in increased cost (time and money) for people wanting to access those services.
- Māori feel that they will be disadvantaged if they complain.
- There is a need for more Kaupapa Māori services as opposed to Pākehā services delivered in a Māori way.
- Whānau need to be involved in any decisions concerning disabled members of the family.
- Whānau need to be recognised as key caregivers and need to be paid.
- Required documentation (for funding application/needs assessment, etc) should be simple enough (in non-technical language) for whānau to understand — processes need to meet the needs of whānau.

Important Tribunal ruling

The Human Rights Review Tribunal delivered an important decision upholding the rights of disabled consumers. The case involved serious boundary violations committed by a caregiver working with a young man who experiences intellectual and developmental impairments. The Tribunal upheld the Director of Proceedings' claim that the defendant's actions breached the Code of Rights and awarded $30,000 damages (see case study, p 21).

Education

Educational needs of providers have been the focus of the major initiatives in the 2008/09 year. These have taken diverse forms — interactive workshops, presentations on request to conferences, meetings, and to students in the health professions, accredited professional development, articles for general publication, and specialised reports. Highlights were:

DHB complaints information

HDC provides six-monthly reports to DHBs covering the number and types of complaints received, and outcomes of closed complaints. In 2008/09, two further reports (covering January–June, and July–December 2008) were disseminated, making a total of six reports over the last three years. In response to feedback from DHBs that rates of complaints for DHBs would be more meaningful than numbers of complaints made to HDC, discharge data obtained from the Ministry of Health was used to calculate the frequency of complaints per 100,000 hospital discharges, enabling comparison of complaints data across DHBs. Inclusion of frequency information in future reports will allow more meaningful comparisons over time, both within and between DHBs. Case study material, which contains lessons from complaints and recommendations for improved practice, continues to be provided. All DHBs reported a high level of satisfaction with the reports, especially with the case studies.

Working with Corrections Health Services

This HDC Workshop for prison nurses is designed to enhance the awareness and skills of nurses in prisons, to enable them to deliver care appropriately (in line with the Code) despite the challenges of their work environment. The programme was first delivered in 2006 at

Waikeria prison, and this year has been updated and extended nationwide. It has been delivered in 11 more prisons and reached more than 115 nurses. Feedback and evaluations confirm the value of the workshop as an opportunity to focus on the team as a whole, and the importance of good leadership, mutual respect, cooperation and teamwork in maintaining safety and quality in the health care that nurses deliver.

Continuing medical education

A new opportunity this year was HDC's participation in professional development sessions for Pinnacle Incorporated, a general practice network representing approximately 300 GPs through the Midland region of the North Island. The sessions, accredited for RNZCGP MOPS (Maintenance of Professional Standards) points, focused on the importance of the clinical record for patient safety and best practice, and were held at five regional centres, reaching GPs, practice nurses and administrative staff who serve about 420,000 patients in the area. In addition, the presentation was recorded on video and is accessible to members on the Pinnacle website.

Wellington Office Move

On 31 March 2009 tenancy in the Vogel Building in Wellington came to an end after 12 years because of site redevelopment, and we moved to Te Renco House near the public library. The new office was opened with a blessing ceremony, and is proving to be an excellent move.

Consumer Advisory Group (CAG) Members

Disability Consumer Advisors

- Pati Umaga, Evan McKenzie, Kim Robinson, Dr Huhana Hickey, Martine Able, Beverley Grammer, David Corner

Health Consumer Advisors

- Barbara Robson, Ana Socratov, Suzy Stevens, Neil Hatcher, George Tripp

Pacific Consumer Advisors

- David Talitu, Molly Pihigia, Frances Hartnell

Iwi Consumer Advisors

- Naida Glavish, Ramari Maipi, Fiona Pimm

Thanks and acknowledgment is given to the members of the Health and Disability Consumer Advisory Group for their contribution to the work of HDC during the year. CAG met three times during the year. The work of this group has been very helpful in identifying and developing areas of focus for working with Māori, Pacific peoples, and the health and disability sectors.

Joint Inter-Agency Work

HDC actively worked as part of an inter-agency group with the Human Rights Commission, Mental Health Foundation, Office for Disability Issues, and the Mental Health Commission on a Multi Agency Plan. This is a collaborative action to benefit mental health services consumers by eliminating discrimination and promoting social inclusion.

The Interpreter Project is another collaborative project HDC was involved in to achieve equitable access to interpreting services for people who need to use other languages, including Te Reo Māori and New Zealand Sign Language.

HDC signed a Memorandum of Understanding with the Office of the Chief Coroner in 2009. The Memorandum is intended to improve information sharing between Coroners and HDC, and to facilitate the coordination of investigations where a person has died in circumstances involving a health or disability service. This should avoid unnecessary

duplication and expedite investigations, reduce stress on the families and health practitioners involved, and better ensure the health and safety of members of the public.

HDC also belongs to a network of Australasian Healthcare Complaints Commissioners that works to establish best practice in complaints management and sharing of information about health practitioners who have worked in Australia and New Zealand.

Corporate Services

Information Systems

HDC's website was reviewed, and recommended improvements in accessibility and user-friendliness have been approved for implementation in the 2009 year.

Three new case management systems were implemented for the Advocacy, Complaints Resolution, and Proceedings divisions. The new systems will make it easier to retrieve data and to run reports. The complaints resolution database also has some fields comparable with the Australian Healthcare Complaint Commissions, which will enable benchmarking in the future.

A review was conducted to identify the steps required to comply with the Public Records Act. Work began on developing a file classification system, and all our access control and security protocols were reviewed as part of the preparation for meeting compliance. A pilot document management system was implemented for HDC's Legal division.

Most users have now been migrated to a thin-client environment (most of the data processing occurs on a server rather than on the user's pc) to facilitate support, in particular for remote users.

Human Resources

During the year HDC has:

- promoted the State Services Code of Conduct within HDC to support a culture of high achievement and learning, and a commitment to excellent service
- provided in-house and external training, Te Reo Māori and New Zealand Sign Language classes, career development opportunities, internal secondments, and career counselling to support professional development and skills enhancement of staff
- supported several staff with study leave options to support career and professional development
- convened monthly "Brown Bag Lunch" guest speaker programmes for staff on topical issues
- recognised staff for achievements and going the extra mile with "on the spot" recognition awards
- supported flexibility in work design, hours and working arrangements for staff to better meet the work–life balance needs of staff
- encouraged employee participation in identifying occupational health and safety concerns and initiatives to reduce risks
- held regular staff forums, produced an internal newsletter and provided staff with the opportunity to give feedback on working in HDC via a Gallup Employee Engagement Survey, and via "fresh eyes" interviews for newcomers to HDC.

EEO

HDC worked with Crossroads Clubhouse, a community organisation offering employment transition for disabled people, which has led to a successful full-time permanent placement.

Publications

HDC branding of its posters and brochures was refreshed during the year to make HDC information easier to recognise.

REPORT OF THE DIRECTOR OF ADVOCACY

The Nationwide Health and Disability Advocacy Service is a confidential service available, at no cost, to any person in New Zealand who wants to know about their rights when using a health or disability service, including how to make and resolve a complaint. Advocates are independent and on the side of the consumer. They can be easily contacted on an 0800 number as well as by free fax and email.

There are 43 advocates (34.5 full-time equivalents) located in 25 community-based offices around the country.

As a consumer-centred service, access for consumers and responsiveness to them is key. Particular efforts are made to improve access for people in rural and provincial areas as well as vulnerable consumers such as those in residential facilities.

A dedicated national call centre co-ordinator has been in place for two years to improve the responsiveness of the service when people call on the free 0800 number. Although people still contact advocates directly, the 0800 number processed 28,750 calls over the past year with 95% being answered in person. A significant proportion of those that weren't answered directly were out-of-hours calls, which were responded to on the next working day.

Judi Strid
Director of Advocacy

Advocates have now been visiting rest homes for three years, and disability homes for two years, to provide free education sessions for residents as well as providers and to make it easy for residents to speak with an advocate. The "Speaking Up" sessions have proved popular — advocates provide a session for residents as well as one for the providers to focus on a safe environment for people to speak up in.

Over the past year, advocates have made 2,584 contacts with 721 of the 728 rest homes across the country, which is 99% of all rest homes.

A total of 2,544 advocacy contacts have been made with 901 of the 931 individual disability homes residential facilities. This means that 97% of these facilities have had at least one visit from an advocate in this reporting year.

There will be an under-reporting of the level of use by people with impairments, as the data collected has a focus on the service type rather than whether the person contacting an advocate has an impairment. However, the increased focus on vulnerable consumers, particularly those in situations where they would find it difficult or impossible to contact an advocate themself, has significantly shifted the advocates' focus to the disability sector.

This increased focus on disability has also resulted in 64% of the 6,216 networking contacts along with 60% of the 1,990 education sessions, training and presentations taking place in the disability sector. One in five complaints to advocacy are about residential facilities.

Table 1: **Comparison between health and disability complaints 2008/09**

	Disability	Health		Disability	Health
Right 1: respect	6%	6%	Right 5: communication	15%	14%
Right 2: fairness	4%	4.5%	Right 6: information	9%	13%
Right 3: dignity and independence	8%	2%	Right 7: consent	4%	2%
			Right 8: support	10%	4%
Right 4: quality	36%	46%	Right 10: complaints	6%	5%

The Nationwide Health and Disability Advocacy Service (including members of the National Advocacy Trust and Kaumātua Network) at the March 2009 National Advocacy Conference in Hamilton.

(Photo: Tony Daly)

Thirty-four percent of complaints about mental health services relate to service quality (Right 4), and a total of 33% are about communication, information, and consent (Rights 5, 6, and 7).

Consumers made up 60% of those who made complaints to an advocate, 37% were made by a third party on behalf of the consumer, and 3% were referred from HDC. Of those making a complaint who provided their ethnicity, 17% were Māori.

Fifty percent of complaints related to consumers aged between 41–60 years, 25% related to 26- to 40-year-olds, and 17.5% related to consumers aged between 61–90 years.

A total of 6,547 complaints were managed during the past 12 months. Ninety-one percent of the 3,565 complaints that were closed during this time were fully or partially resolved so the consumer was able to move on.

A key aspect of the advocacy resolution process is the rebuilding of relationships, as this is particularly important for those consumers who need ongoing contact with the same provider. Consumers are often impressed during a face-to-face resolution meeting by the willingness

RESPONDING TO A COMPLAINT AS AN OPPORTUNITY FOR QUALITY IMPROVEMENT

A male prisoner complained to HDC that the prison had failed to accept the seriousness of his eye condition. Despite this being spelled out by the eye specialist in front of two Corrections Officers, there was a delay in the prison organising a return to hospital for an urgent follow-up appointment. The man received no explanation of why he hadn't been taken to his appointment, or reassurance that his condition could wait. He found health staff dismissive when he asked what was going on. This was very worrying and stressful for him.

The consumer was referred to advocacy. The advocate met with him to clarify the key issues and a resolution meeting was organised with the relevant prison staff. Ongoing actions were recorded on the "complaint resolution agreement". These consisted of a written apology and acknowledgement of the anxiety caused by the lack of communication and information, feedback to be provided to Health Unit staff about the incident, as well as the updating of the relevant protocol relating to communication between the hospital, health unit, and custodial staff. Finally, he was to receive feedback on the policy and process changes as a result of his complaint.

The consumer was pleased with the outcome of his complaint as significant changes have been put in place to make sure the process is clear to all parties, so there will not be a repeat of what happened to him.

A CONSUMER SPEAKS OUT ABOUT ADVOCATES

"Our local advocates have been fantastic. I truly don't know how we would have coped without them. We are still resolving some issues, with their assistance, so that ongoing care of my partner in particular is safe and helpful.

We have been consulted about everything, given choices, supported when we were both too unwell to cope with fighting to get proper care. The outcome is a great feeling of empowerment around collaborating with these people. It really works — being given choices, being consulted and supported fosters a feeling of 'containment' in a tricky situation and a feeling of not being alone.

I would thoroughly recommend an advocate if people are experiencing difficulty with services. They understand the meaning of working alongside people, are aware of 'power and control' issues and understand how important 'nothing about me, without me' is for consumers."

THE IMPORTANCE OF TIKANGA IN ACHIEVING RESOLUTION FOR MĀORI WHĀNAU

An advocate facilitated a successful resolution hui in partnership with a local Kaumātua to ensure:

- **the right protocols of the Marae were respected**
- **a safe process for all was maintained**
- **Te Reo Māori was used appropriately**
- **Kuia and Kaumātua were fully informed about the complaint and resolution process**
- **whānau of the deceased consumer were kept informed**
- **opportunities for other whānau and friends to express their concerns and grief in an environment they felt comfortable in**
- **opportunities for questions and answers.**

The outcome was very positive for the surviving partner, who now feels less anger and frustration. She realises that the provider did all he could to save her partner at the time and believes he is genuinely sorry for her loss and that of her whānau. This process provided a good example of how Tikanga Māori/cultural protocols can be particularly valuable when working to resolve issues for Māori whānau that include grief.

of the provider to do the right thing, and may change from not wanting any future contact to being pleased to have the relationship restored. As one consumer noted, "I was very angry with what my GP had done and wanted to find a new one. However, when I received his apology at the meeting and heard what he had learned from the incident and that he had never intended to cause harm, I was more than happy to stick with him."

Advocates use resolution agreements for any ongoing actions agreed to at a resolution meeting so there is a shared record all parties can take away with them. Advocates have used a total of 209 resolution agreements over the past year for actions agreed to beyond the resolution meeting. Only three providers have required follow-up by the advocate, which shows both the level of confidence in the advocacy process and just how much goodwill there is from providers to resolve complaints. The three providers had simply forgotten the agreed date and once reminded completed the outstanding actions. An increasing number of providers are now using these agreement forms (available from advocates) for complaints sent directly to them by a consumer. The use of the agreement form removes the focus on minutes from meetings, which can trigger further dispute and the risk of a misunderstanding about what has been agreed to. The form also provides a prompt for an agreed date for reporting back to the consumer.

Surveys of consumers who have used the advocacy service show an overall satisfaction rate of 86%. The survey measures consumer views on their experience of the advocacy process (88%) and resolution (80%) as well as the skill (90%) of the advocate.

THE VALUE OF USING CONSUMER EXPERIENCES TO HIGHLIGHT CONSUMER-CENTRED CARE

A woman sought advocacy support to address her concerns about the care she had received after a mastectomy followed by radiotherapy. Complications arose with a radiotherapy burn and then an infection. For 18 months she underwent dressings and plastic surgery to try to heal the wound. She found that some of the nurses had little empathy for her plight. This was despite each dressing change causing intolerable pain and having to go on for so long, as healing was slow and complications continued to arise. She also felt they didn't listen to her when she offered suggestions about the best way to do the dressing, so as to cause the least pain. Although some nurses did an excellent job, others didn't appear to follow instructions about giving the prescribed pain relief at the correct time prior to the dressings being done.

The consumer chose to have the advocate assist her to put her concerns in writing. She received a written response from the DHB acknowledging the difficulties with treating wounds like hers and the problems with managing pain relief. They sought her permission to use her experience as training for nursing staff in wound care. The consumer was very happy that her very painful experience would be used to make it better for others. She felt it had been worth the effort of making the complaint.

Although advocates are on the side of consumers, it is important for providers to have confidence in the advocacy process. Providers who have had contact with the service and responded to the survey gave an overall satisfaction rate of 77.5%. The survey measures provider views on the advocacy approach (74%), the professionalism of the advocate (82%), resolution (70%), and whether they would recommend the service and work with an advocate in the future (84%). Survey results show a 92% overall level of satisfaction amongst consumers and providers with education sessions and training provided by advocates.

In conclusion, I would like to once again acknowledge the dedication and commitment of all those involved with the provision of the advocacy service, including the advocates, managers and support staff, members of the National Advocacy Trust, and the Kaumātua Advisory Group, and to thank them for their combined efforts in providing an excellent service for health and disability services consumers throughout the country.

KEEPING THE FOCUS ON THE CONSUMER

A woman approached advocacy for assistance so that her 29-year-old daughter who was 38 weeks pregnant with her second child could have a natural delivery. She had legal guardianship for her daughter, who was mentally unwell and residing in a secure Mental Health Unit, and supported her daughter's wish to have a vaginal delivery. Despite being even more unwell mentally during her first pregnancy, she had successfully given birth vaginally and was keen to do the same with this baby.

A misunderstanding about whether the daughter was in labour resulted in a significant reaction from her because she felt she wasn't being listened to. The midwife withdrew her services and the obstetrician insisted the birth would have to be by Caesarean section because of fears about what the woman might do in labour.

The advocate spoke with key DHB personnel about the situation and an urgent meeting was organised to discuss the matter and prepare a birthing and postnatal plan.

Once all the points had been fully debated the plan was approved by the consumer's mother and the multidisciplinary team. A new midwife and obstetrician were appointed and the mother left the meeting feeling confident that everything was in place to cover any eventuality.

The advocate made a follow-up phone call to the family a week later and was told that it was a beautiful natural birth with no difficulties. The mother said that her daughter and baby were now at home with her and she thanked the advocate for the immediate response to her complaint.

REPORT OF THE DIRECTOR OF PROCEEDINGS

Theo Baker, the previous Director of Proceedings, left the office to work overseas after five years in the role. I have been in the role of Director of Proceedings since 14 April 2009.

I am fortunate to enjoy the support of a dedicated team of professionals, and our work complements other approaches to complaint resolution within HDC.

A range of challenging issues have already arisen, from considering whether a surgeon's clinical care of a patient requires a disciplinary sanction, to deciding whether to bring a civil claim to obtain compensation for a vulnerable consumer. The role involves being both an independent prosecutor and providing "access to justice" for consumers, in what are often very sad cases. Supporting consumers or their families through the litigation process is a key aspect of this team's work.

Aaron Martin
Director of Proceedings

Statistics

There continues to be a steady flow of referrals by the Commissioner of providers found in breach of the Code following an investigation, for consideration by the Director whether to take disciplinary and/or Human Rights Review Tribunal (HRRT) proceedings. The Director of Proceedings team received 22 referrals during the year (in relation to 15 providers). Eight complaints about rest home care (relating to four rest homes) led to referrals to the DP. There were 12 substantive hearings, as compared to 11 in the previous year. Nine of this year's hearings resulted in successful outcomes, notably the first successful case against a disability services provider (O'Malley, discussed on page 21).

Table 1: **Action taken in respect of referrals to Director of Proceedings in 2008/09**

Provider	No. of providers	No further action	DP decision in progress	Proceedings pending	Proceedings concluded	Total No. of consumers involved (referrals)
Counsellor	1			1		1
Medical practitioner						
General surgeon	2		1	1		2
Obstetrics	1				1	1
Massage therapist	1			2		2
Natural healer	1		2			2
Nurse	6		2	4	2	8
Psychologist	1			1		1
Rest home	1			2		2
Chiropractor	1	1		2		3
Total	**15**	**1**	**5**	**13**	**3**	**22**

Table 2: **Outcomes in 2008/09**

Provider	Successful	Unsuccessful	Outcome Pending	Total
Discipline				
Substantive hearings				
Medical practitioner				
General practitioner	1[1]	1		2
Obstetrics		1		1
Midwife	1			1
Nurse	2	1		3
Physiotherapist	1			1
Psychologist	1			1
Appeals				
Medical practitioner				
General Surgeon	1			1
Nurse	1			1
HRRT				
Substantive hearings				
Carer	3[2]			3
Interlocutory/Appeal				
Psychiatrist		1		1
General Practitioner	1[3]			1
Total	**12**	**4**	**0**	**16**

1 Case subject to appeal.
2 One of these was heard "on the papers".
3 Judicial review.

SEXUAL EXPLOITATION OF VULNERABLE CONSUMER

This case concerned a caregiver's sexual exploitation of a vulnerable disabled consumer.

On 2 February 2009 the Human Rights Review Tribunal awarded a total of $40,000 against Mr David O'Malley: compensatory damages ($20,000), exemplary damages ($10,000), and costs ($10,000). The Tribunal found Mr O'Malley breached Code Right 1(1), the right to be treated with respect, Right 2, the right to freedom from discrimination, coercion, harassment and exploitation, Right 3, the right to dignity and independence, and Right 4(3), the right to services of an appropriate standard. These breaches related to Mr O'Malley's role as a caregiver for Mr A, a young man with significant disabilities.

The Director's claim centred on a period of time when Mr A had a girlfriend, Ms B, who was staying with him. Mr A and Ms B were not in a sexual relationship.

Mr O'Malley spent time with both Mr A and Ms B at Mr A's flat, and indulged in sexualised behaviours with Mr A and and Ms B when he (Mr O'Malley) was supposed to have been providing Mr A with disability services.

There was evidence from another caregiver and from Mr A's mother of the effect of these events on Mr A. He became suicidal and his behaviour regressed. He became very depressed. As the Tribunal held: "There is no doubt that [Mr A] was amongst the most vulnerable of people. One significant result of the events was that his first attempt at independent living failed in the most regrettable of circumstances."

The Director brought this case in order to vindicate the consumer's rights and recover compensation for him. These objectives were achieved without the consumer himself having to give evidence. The case should send a strong deterrent message against sexual exploitation of vulnerable consumers.

See: www.nzlii.org/nz/cases/NZHRRT/2009/2.html

UNSUCCESSFUL APPEAL BY SURGEON IN INFORMED CONSENT CASE

The Director of Proceedings was largely successful in resisting an appeal by a surgeon against a finding of professional misconduct. The case may be noted for its interesting discussion of "informed consent" in New Zealand. It confirms that a surgeon must "enable" but cannot "ensure" patient understanding of information provided, and suggests that a patient cannot waive the requirement that the surgeon disclose sufficient detail about the risk of major surgery.

Mr John Harman is a surgeon to whom Ms A was referred for breast reduction. An abdominoplasty and liposuction were also discussed, but only briefly. After surgery, Ms A's condition deteriorated and infection damaged her tissue. ACC raised significant concerns about Mr Harman's care of Ms A, and there were also concerns about the records kept. Ms A lost her right nipple, lost sensation in her left nipple, and had permanent scarring on her breasts.

The Health Practitioners Disciplinary Tribunal found that Mr Harman had failed to gain informed consent from Ms A, maintain adequate records, and provide adequate postoperative information. Mr Harman appealed the Tribunal's finding of professional misconduct. (See www.hpdt.org.nz/Default.aspx?tabid=142.)

The appeal against the Tribunal's substantive decision was allowed, but only to a limited extent — one finding in relation to a sub-particular of the charge being set aside. Otherwise, the Tribunal's substantive findings stand.

The High Court substituted a fine of $5,000 for the $7,500 fine imposed by the Tribunal. Other penalites imposed by the Tribunal, including a recommendation of a competence review, were not disturbed on appeal. The Director was entitled to costs on the appeal, it having been largely unsuccessful.

John Edgar Harman v Director of Proceedings (High Court Auckland, CIV 2007-404-003732, 12 March 2009, Wild J)

MIDWIFE FOUND GUILTY OF PROFESSIONAL MISCONDUCT

This case concerned the care provided by a midwife, Ms Monique Kapua, to a first-time pregnant woman (Ms C). Ms C gave birth to a stillborn baby boy, following a prolonged pregnancy of 43 weeks.

On 22 June 2009 the Health Practitioners Disciplinary Tribunal found that Ms Kapua's conduct amounted to malpractice and negligence and in many instances her conduct amounted to acts or omissions that would bring discredit to the midwifery profession.

Ms Kapua failed to:

- provide Ms C with relevant information about standard midwifery tests and examinations
- undertake sufficient standard midwifery tests and examinations
- provide Ms C with relevant information about the risks involved in prolonged pregnancy or the induction process and the reasons for induction
- provide Ms C with information about access to, and choices of, obstetric and secondary care
- recommend to Ms C that a consultation with a specialist was warranted and/or make adequate arrangements to ensure that this was done
- provide adequate handover of care of Ms C in that she spoke to another midwife but failed to arrange for her to see Ms C in her absence; and/or provide her with her client's records
- arrange for appropriate assessments for a prolonged pregnancy to be undertaken
- adequately and/or accurately document the care she provided to her client between 1 January 2006 and 5 October 2006.

The Tribunal stated:

> "A lot of the emphasis in this case was placed by Ms Kapua on the fact that Ms Kapua had, in addition to her midwifery practice, an emphasis on traditional Māori aspects of birthing. There was some suggestion that this Tribunal hearing might be a challenge to those practices. It is certainly not a challenge of those practices. Ms Kapua appears before the Tribunal in her role as a registered midwife and in that role has the obligations of a reasonably competent midwife to carry out all of the tests and analysis required by midwifery standard and to gather and document that information which is regarded as being standard care for midwives. Ms Kapua's Māori Tikanga should be an additional (and desirable) part of her practice, influencing her care but never allowing it to mean that any women receives a substandard level of care. Tikanga Māori is an enhancement to safe practice, not a detriment to it."

The Tribunal further stated that Ms Kapua would not be guilty of professional misconduct simply because she had adopted the practice of traditional Māori midwifery. The Tribunal confirmed that what was being judged was the practitioner's level of conduct against the level of other reasonably competent midwives whether they be Māori midwives practising Tikanga Māori in addition to their midwifery practice or Pākehā midwives or midwives from other ethnicities. What was not being judged here was traditional Māori birthing practice.

See: www.hpdt.org.nz/portals/0/mid08103ddecdp070anon.pdf

Statement of Responsibility for the year ended 30 June 2009

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

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

In the Health and Disability Commissioner's opinion, these financial statements and statement of service performance fairly reflect the financial position and operation of the Health and Disability Commissioner for the year ended 30 June 2009.

Signed on behalf of the Health and Disability Commissioner.

Ron Paterson
Health and Disability Commissioner

Tania Thomas
Deputy Health and Disability Commissioner — Disability

4 September 2009

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Audit Report

To the readers of
Health and Disability Commissioner's
financial statements and statement of service performance
for the year ended 30 June 2009

The Auditor-General is the auditor of the Health & Disability Commissioner. The Auditor-General has appointed me, John Scott, using the staff and resources of Audit New Zealand, to carry out the audit. The audit covers the financial statements and statement of service performance included in the annual report of the Health & Disability Commissioner for the year ended 30 June 2009.

Unqualified Opinion

In our opinion:

- The financial statements of the Health & Disability Commissioner on pages 26 to 45:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health & Disability Commissioner's financial position as at 30 June 2009; and
    - the results of its operations and cash flows for the year ended on that date.
- The statement of service performance of the Health & Disability Commissioner on pages 46 to 50:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards outlined in the statement of forecast service performance adopted at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses outlined in the statement of forecast service performance adopted at the start of the financial year.

The audit was completed on 4 September 2009, and 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 the Auditor, and explain our independence.

Basis of Opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and statement of service performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Health and Disability Commissioner;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement and statement of service performance disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Health and Disability Commissioner and the Auditor

The Health and Disability Commissioner is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health & Disability Commissioner as at 30 June 2009 and the results of its operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health & Disability Commissioner's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses adopted at the start of the financial year. The Health and Disability Commissioner's responsibilities arise from the Crown Entities Act 2004 and the Health and Disability Commissioner Act 1994.

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

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

John Scott
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

STATEMENT OF FINANCIAL PERFORMANCE for the year ended 30 June 2009

	Note	Actual 2009 $	Budget 2009 $	Actual 2008 $
Income				
Revenue from Crown	2	8,990,000	8,989,000	8,331,000
Interest Income		152,438	173,000	211,587
Other revenue	3	85,637	80,000	84,435
Total income		9,228,075	9,242,000	8,627,022
Expenditure				
Personnel costs	4	3,788,066	3,889,165	3,653,072
Depreciation and amortisation expense	9, 10	296,670	283,454	312,195
Advocacy Services		3,229,230	3,320,998	3,085,750
Other expenses	5	1,956,257	2,183,293	1,823,227
Total expenditure		9,270,223	9,677,001	8,874,244
Net deficit for the year		**(42,148)**	**(435,001)**	**(247,222)**

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION as at 30 June 2009

	Note	Actual 2009 $	Budget 2009 $	Actual 2008 $
Assets				
Current Assets				
Cash and cash equivalents	6	1,296,657	1,110,420	1,479,900
Debtors and other receivables	7	87,900	30,000	29,471
Prepayments		85,329	34,000	62,971
Inventories	8	31,798	18,000	10,336
Total current assets		1,501,684	1,192,420	1,582,678
Non-current assets				
Property, plant and equipment	9	365,316	361,521	341,930
Intangible assets	10	98,971	83,692	127,983
Total non-current assets		464,287	445,213	469,913
Total assets		**1,965,971**	**1,637,633**	**2,052,591**
Liabilities				
Current Liabilities				
Creditors and other payables	11	436,448	430,858	469,636
Employee entitlements	12	148,117	170,000	159,401
Total current liabilities		584,565	600,858	629,037
Total liabilities		584,565	600,858	629,037
Net Assets		**1,381,406**	**1,036,775**	**1,423,554**
Equity				
General funds	13	1,381,406	1,036,775	1,423,554
Total Equity		**1,381,406**	**1,036,775**	**1,423,554**

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY for the year ended 30 June 2009

	Actual 2009	Budget 2009	Actual 2008
	$	$	$
Balance at 1 July	1,423,554	1,471,776	1,670,776
Amounts recognised directly in equity:			
Net deficit for the year	(42,148)	(435,001)	(247,222)
Total Net Recognised Revenues and Expenses	1,381,406	1,036,775	1,423,554
Balance at 30 June	**1,381,406**	**1,036,775**	**1,423,554**

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS for the year ended 30 June 2009

	Note	Actual 2009 $	Budget 2009 $	Actual 2008 $
Cash Flow from Operating Activities				
Receipts from Crown revenue		8,990,000	8,989,000	8,331,000
Interest received		156,910	173,000	223,032
Receipts from other revenue		29,725	80,000	82,047
Payments to suppliers		(5,280,248)	(3,899,165)	(4,878,462)
Payments to employees		(3,799,350)	(5,494,290)	(3,639,290)
Goods and services tax (net)		7,072	–	241
Net cash from operating activities	**14**	**104,109**	**(151,455)**	**118,568**
Cash Flows from Investing Activities				
Receipts from sale of property, plant and equipment		4,019	0	0
Purchase of property, plant and equipment		(175,703)	(110,000)	(202,256)
Purchase of intangible assets		(115,668)	(223,000)	(121,280)
Net Cash from Investing Activities		**(287,352)**	**(333,000)**	**(323,536)**
Net decrease in cash and cash equivalents		**(183,243)**	**(484,455)**	**(204,968)**
Cash and cash equivalents at beginning of year		1,479,900	1,594,875	1,684,868
Cash and cash equivalents at end of year	**6**	**1,296,657**	**1,110,420**	**1,479,900**

The accompanying notes form part of these financial statements.

1 Statement of accounting policies for the year ended 30 June 2009

Reporting Entity

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

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

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

The financial statements for the Health and Disability Commissioner are for the year ended 30 June 2009, and were approved by the Commissioner on 4 September 2009.

Basis of Preparation

Statement of Compliance

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

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

Measurement base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of certain items of property, plant and equipment, and the measurement of equity investments and derivative financial instruments at fair value.

Functional and presentation currency

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

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

Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the HDC include:

- NZ IAS 1 Presentation of Financial Statements (revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (issued 2004) and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. The revised standard gives the HDC the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). The HDC intends to adopt this standard for the

year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income statement followed by a statement of comprehensive income.

Significant Accounting Policies

Revenue

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

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

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

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

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

Leases

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

Cash and cash equivalents

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

Debtors and other receivables

Debtors and other receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

Investments

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

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

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

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

Inventories

Inventories (such as spare parts and other items) held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at the lower of cost and net realisable value, adjusted when applicable, for any loss of service potential. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

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

Property, plant and equipment

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

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

Additions

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

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

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are included in the statement of financial performance.

Subsequent costs

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

The costs of day-to-day servicing of property, plant and equipment are recognised in the statement of financial performance as they are incurred.

Depreciation

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

Leasehold improvements	3 years	(33%)
Fixtures and fittings	5 years	(20%)
Office equipment	5 years	(20%)
Motor vehicles	5 years	(20%)
Computer hardware	4 years	(25%)
Communication equipment	4 years	(25%)

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

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

Intangible Assets

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

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

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

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

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

Acquired computer software	2 years	50%

Impairment of non-financial assets

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

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

If an asset's carrying amount exceeds its recoverable amount the asset is impaired and the carrying amount is written down to the recoverable amount.

Creditors and other payables

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

Employee Entitlements

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

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

Superannuation Schemes

Defined contribution schemes
Obligations for contributions to Kiwisaver and the Government Superannuation Fund are accounted for as defined contribution superannuation schemes and are recognised as an expense in the statement of financial performance as incurred.

Goods and Service Tax (GST)

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income Tax

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

Budget Figures

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

Cost Allocation

The Health and Disability Commissioner has determined the cost of outputs 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/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Other direct costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

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

Property, plant and equipment useful lives and residual value

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

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

- physical inspection of assets;
- asset replacement programmes.

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

Critical judgements in applying the Health and Disability Commissioner's accounting policies

Management has exercised the following critical judgements in applying the Health and Disability Commissioner's accounting policies for the period ended 30 June 2009:

Lease classification

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

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

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

2 Revenue from Crown

The Health and Disability Commissioner has been provided with funding from the Crown for the specific purposes of the Health and Disability Commissioner as set out in its founding legislation and the scope of the relevant government appropriations. Apart from these general restrictions there are no unfulfilled conditions or contingencies attached to government funding (2008 nil).

3 Other Revenue

	Actual 2009 $	Actual 2008 $
Sale of Publications	85,637	84,435
Total Other Revenue	**85,637**	**84,435**

4 Personnel Costs

	Actual 2009 $	Actual 2008 $
Salaries and wages	3,780,246	3,622,729
Employer contributions to defined contribution plans	19,104	16,562
Increase/(decrease) in employee entitlements (note 12)	(11,284)	13,781
Total Personnel Costs	**3,788,066**	**3,653,072**

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

5 Other Expenses

	Actual 2009 $	Actual 2008 $
Fees to auditor:		
Audit fees for financial statement audit	29,400	30,000
Audit fees for NZ IFRS transition	0	3,500
Staff travel and acommodation	124,858	123,534
Operating lease expense	486,974	379,990
Advertising	31,218	34,779
Consultancy	391,530	401,660
Inventories consumed	160,164	138,818
Net loss on sale of property, plant and equipment	(3,692)	498
Other	735,805	710,448
Total other expenses	**1,956,257**	**1,823,227**

6 Cash and cash equivalents

	Actual 2009 $	Actual 2008 $
Cash on hand and at bank	36,657	59,900
Cash equivalents — term deposits	1,260,000	1,420,000
Total cash and cash equivalents	**1,296,657**	**1,479,900**

The carrying value of short-term deposits with maturity dates of three months or less approximates their fair value.

The weighted average effective interest rate for term deposits is 4.2% (2008 8.8%).

7 Debtors and other receivables

	Actual 2009 $	Actual 2008 $
Trade receivables	75,485	12,584
Other receivables	12,415	16,887
Less provision for impairment	0	0
Total debtors and other receivables	**87,900**	**29,471**

The carrying value of receivables approximates their fair value.

As at June 2009 and 2008, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2009 $	2008 $
Not past due	87,374	27,659
Past due 1–30 days	526	1,669
Past due 31–60 days	0	0
Past due 61–90 days	0	143
Past due > 91 days	0	0
Total	**87,900**	**29,471**

8 Inventories

	Actual 2009 $	Actual 2008 $
Publications held for sale	31,798	10,336
Total inventories	**31,798**	**10,336**

The carrying amount of inventories held for distribution that are measured at current replacement costs as at 30 June 2009 amounted to $31,798 (2008 $10,336).

9 Property, Plant and Equipment

Movements for each class of property, plant and equipment as at 30 June 2009 are as follows:

Cost	Comp hardware	Comms equip	Furn and fittings	Leasehold improve-ments	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 08	844,359	26,723	197,209	650,875	42,280	185,408	1,946,854
Additions during year	109,630	0	5,098	19,657	40,889	429	175,703
Disposals during year	(171,400)	0	(5,337)	0	(42,280)	(0)	(219,017)
Balance at 30 June 2009	782,589	26,723	196,970	670,532	40,889	185,837	1,903,540
Accumulated Depreciation							
Balance at 1 July 08	626,111	26,723	185,951	588,417	42,280	135,442	1,604,924
Charge for year	82,056	0	5,052	48,024	1,363	15,495	151,990
Disposals	(171,073)	0	(5,337)	0	(42,280)	(0)	(218,690)
Balance at 30 June 2009	537,094	26,723	185,666	636,441	1,363	150,937	1,538,224
Net book value 30 June 2009	**245,495**	**0**	**11,304**	**34,091**	**39,526**	**34,900**	**365,316**

Cost	Comp hardware	Comms equip	Furn and fittings	Leasehold improve-ments	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 07	722,905	26,723	215,555	618,621	42,280	178,557	1,804,641
Additions during year	149,199	0	1,494	32,254	0	20,305	203,252
Disposals during year	(27,745)	0	(19,840)	0	0	(13,454)	(61,039)
Balance at 30 June 2008	844,359	26,723	197,209	650,875	42,280	185,408	1,946,854
Accumulated Depreciation							
Balance at 1 July 07	602,306	26,723	198,696	491,909	42,280	131,556	1,493,470
Charge for year	51,550	0	7,095	96,508	0	16,842	171,995
Disposals	(27,745)	0	(19,840)	0	0	(12,956)	(60,541)
Balance at 30 June 2009	626,111	26,723	185,951	588,417	42,280	135,442	1,604,924
Net book value 30 June 2009	**218,248**	**0**	**11,258**	**62,458**	**0**	**49,966**	**341,930**

10 Intangible Assets

Movements for each class of property, plant and equipment as at 30 June 2009 are as follows:

	Actual 2009 $	Actual 2008 $
Computer Software		
Balance at 1 July	761,622	640,342
Additions during the year	115,668	121,280
Disposals during the year	0	0
Balance at 30 June	877,290	761,622
Accumulated Amortisation		
Balance at 1 July	633,639	493,439
Charge for the year	144,680	140,200
Disposals	0	0
Balance at 30 June	778,319	633,639
Net book value at 30 June	**98,971**	**127,983**

All software is acquired software.

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

11 Creditors and other payables

	Actual 2009 $	Actual 2008 $
Creditors	249,596	320,984
Accrued expenses	40,083	19,751
Other payables	146,769	128,901
Total creditors and other payables	**436,448**	**469,636**

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

12 Employee entitlements

	Actual 2009 $	Actual 2008 $
Current employee entitlements are represented by:		
Annual leave	147,117	158,363
Retirement and long service leave	1,000	1,038
Total current portion	148,117	159,401
Total employee entitlements	**148,117**	**159,401**

13 Equity

	Actual 2009 $	Actual 2008 $
General funds		
Balance at 1 July	1,423,554	1,670,776
Deficit for the year	(42,148)	(247,222)
Total equity at 30 June	**1,381,406**	**1,423,554**

14 Reconciliation of net deficit to net cash from operating activities

	Actual 2009 $	Actual 2008 $
Net deficit after tax	(42,148)	(247,222)
Add/(less) non-cash items:		
Depreciation and amortisation expense	296,670	312,195
Total non-cash items	296,670	312,195
Add/(less) items classified as investing or financing activities		
(Gain) on disposal of property, plant and equipment	(3,692)	(498)
Total items classified as investing or financing activities	(3,692)	(498)
Add/(less) movements in working capital items		
Debtors and other receivables	(73,798)	(19,323)
Inventories	(21,462)	11,382
Creditors and other payables	(40,177)	48,252
Employee entitlements	(11,284)	13,782
Net movements in working capital items	(146,721)	54,093
Net cash from operating activities	**104,109**	**118,568**

15 Commitments and operating leases

Advocacy Service contracts

The maximum commitment for the 12 months from 1 July 2009 is $3,595,998 (2008: $3,320,998).

Operating leases as lessee

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

	Actual 2009 $	Actual 2008 $
Not later than one year	537,412	363,367
Later than one year and not later than five years	942,463	561,287
Later than five years	94,071	0
Total non-cancellable operating leases	**1,573,946**	**924,654**

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

A portion of the total non-cancellable operating lease expense relates to the lease of these two offices. The Auckland lease expires in May 2011 and the Wellington lease expires in April 2015.

16 Contingencies

Contingent liabilities

As at 30 June 2009 there were no contingent liabilities (2008 $nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2008 $nil).

17 Related party transactions and key management personnel

Related party transactions

The Health and Disability Commissioner is a wholly owned entity of the Crown. The government significantly influences the role of the Health and Disability Commissioner in addition to being its major source of revenue.

The Health and Disability Commissioner enters into transactions with government departments, state-owned Commissioners and other Crown entities. Those transactions that occur within a normal supplier or client relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the Health and Disability Commissioner would have adopted if dealing with that entity at arm's length in the same circumstances have not been disclosed as related party transactions.

Key management personnel compensation

	Actual 2009 $	Actual 2008 $
Salaries and other short-term employee benefits	967,000	901,000
Post-employment benefits	14,750	13,560
Other long-term benefits	0	0
Termination benefits	0	0
Total key management personnel compensation	**981,750**	**914,560**

Key management personnel include the six Senior Management team members.

18 Employee remuneration

Total remuneration paid or payable

	Actual 2009 $	Actual 2008 $
110,000–119,999	1	1
120,000–129,999	1	1
130,000–139,999	0	1
150,000–159,999	1	2
170,000–179,999	2	0
220,000–229,999	0	0
230,000–239,999	0	1
240,000–249,999	1	0
Total employees	**6**	**6**

During the year ended 30 June 2009, no employees received compensation and other benefits in relation to cessation (2008: $nil).

19 Events after the balance sheet date

There were no significant events after the balance sheet date.

20 Categories of financial assets and liabilities

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

	Actual 2009 $	Actual 2008 $
Loans and receivables:		
Cash and cash equivalents	1,296,657	1,479,900
Debtors and other receivables	87,900	29,471
Total loans and receivables	**1,384,557**	**1,509,371**
Financial liabilities measured at amortised cost:		
Creditors and other payables	436,448	469,636
Total financial liabilities measured at amortised cost	**436,448**	**469,636**

21 Financial instrument risks

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

Market risk

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate owing to changes in market interest rates. The Health and Disability Commissioner's exposure to fair value interest rate risk is limited to its bank deposits which are held at fixed rates of interest.

The average interest rate on the Health and Disability Commissioner's term deposits is 4.2% (2008: 8.8%).

Cash flow interest rate risk

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

Credit risk

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

Due to the timing of its cash inflows and outflows, the Health and Disability Commissioner invests surplus cash with registered banks. The Health and Disability Commissioner's Investment Policy limits the amount of credit exposure to any one institution.

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

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

Liquidity risk

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

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

Sensitivity analysis

As at 30 June 2009, if the deposit rate had been 50 basis points higher or lower, with all other variables held constant, the surplus/deficit for the year would have been $6,238 (2008: $7,100) higher/lower. This movement is attributable to increased or decreased interest expense on the cash deposits.

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

	Less than 6 months $	Between 6 months and 1 year $	Between 1 and 5 years $
2009			
Creditors and other payables (note 11)	436,448	0	0
2008			
Creditors and other payables (note 11)	469,636	0	0

22 Capital Management

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

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

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

23 Explanation of significant variances against budget

There were favourable variances in property costs where lesser rents were negotiated than had been budgeted and considerable savings in travel costs. Prudent cost control also saw a favourable variance in personnel costs. Advocacy service contracts were underspent to offset higher than anticipated information technology support, training and educational costs to assist the implementation of the existing advocacy service contracts.

Output Class 1: Service Delivery

HDC carries out several key activities in relation to its responsibilities under the Act:

- A nationwide, independent advocacy service promotes and educates consumers about their rights, and providers about their responsibilities, and assists consumers unhappy with health or disability services to resolve complaints about alleged breaches of the Code of Health and Disability Services Consumers' Rights, at the lowest appropriate level.
- The Commissioner responds to enquiries.
- The Commissioner assesses and resolves complaints.
- The independent Director of Proceedings initiates proceedings against providers.
- The Commissioner promotes and educates consumers, providers, professional bodies and funders about the provisions of the Code of Health and Disability Services Consumers' Rights.
- The Commissioner provides policy advice on matters related to the Code of Health and Disability Services Consumers' Rights and legislation that affects the rights of health and disability services consumers.

Output 1: Complaints Resolution

	Performance Measure	Target Date	Actual
	Complaints		
1.	80% of all complaints closed within 6 months of receipt, and 95% closed within 12 months of receipt; no files aged over 2 years.	30 June 2009	**Target achieved. 87% of all complaints (1196 of 1378) closed within 6 months of receipt; 96% of all complaints (1325 of 1378) closed within 12 months of receipt. No file over 2 years.**
2.	Fewer than 1% of complaints files reopened after a closed file review to determine fairness and appropriateness of original decision.	30 June 2009	**Target achieved. Fewer than 1% (1 of 1378) of complaints files reopened after a closed file review (139 closed files reviewed).**
3.	A random sample of consumers and providers surveyed and feedback sought regarding timeliness and fairness of HDC complaints processes.	30 June 2009	**Target achieved. 430 complainants and providers (of cases closed between July and December 2009) surveyed. Response rate 47% (200). 82% felt complaint taken seriously, 76% felt complaint treated impartially, 79% felt clear reasons given for decision, 76% understood reason for decision, and 70% satisfied overall with management of complaint.**
4.	Follow-up of recommendations confirms 100% compliance by providers.	30 June 2009	**Target partially achieved. 346 recommendations made from 1 July 2008 required compliance by 30 June 2009. 98.5% complied with: 66% (229) full compliance, 32% (112) partial compliance, 1.5% (5) non-compliant and referred to registration boards where appropriate.**

Output 1: Complaints Resolution (continued)

	Performance Measure	Target Date	Actual
5.	10% of group providers (organisations) subject to recommendations from HDC report systems changes to improve quality and safety of their service.	30 June 2009	**Target achieved. 72% (188 of 260) of group providers subject to recommendations as a result of a complaint have made systems changes. 39% (101 of 260) have made significant systems changes.**
6.	Review of Act and Code completed with findings and recommendations reported to Minister of Health.	30 June 2009	**Target achieved. Report submitted to Minister by 30 June 2009.**

Output 2: Education and Promotion

	Performance Measure	Target Date	Actual
1.	80% of DHBs report that they find trend reports useful and describe how they have used trend information.	30 June 2009	**Target achieved. Responses to September 2008 and March 2009 trend reports show 81% and 100% respectively of DHBs found the information useful. The information was used for:** **• review by clinical governance structures** **• benchmarking against national averages** **• systems review** **• staff education** **• incorporation into quality improvement programmes** **• discussion with consumer feedback committee.**
2.	Educational initiatives implemented.	30 June 2009	**Target achieved. Two initiatives developed and implemented:** **• Rehabilitation in Partnership with Consumers: educational initiative with a range of rehabilitation workers from Foundation of the Blind (national service provider).**

Output 2: Education and Promotion (continued)

	Performance Measure	Target Date	Actual
			• Inter-DHB Referral System initiative: mandatory and good practice recommendations, supported by Quality Improvement Committee, adopted by all DHBs — actions based on release of 3 HDC reports with recommendations relating to inter-DHB referrals and need to improve outpatient processes.
3.	DVD produced on Code of Rights in NZ Sign Language in association with Deaf Aotearoa NZ.	30 June 2009	Target achieved. DVD produced.
4.	Produce and deliver 300,000 units of educational material and increase the percentage of new orders from 3% to 5% per month.	30 June 2009	Target achieved. 475,279 units delivered and 2,450 orders placed in 2008/09; 559 were new orders — an overall increase of 28%.
5.	Facilitate 2 consumer seminars and have 80% of participants who respond to evaluation rate that they were satisfied or very satisfied with usefulness of seminar.	30 June 2009	Target partially achieved. 2 consumer seminars held — 1 in Christchurch and 1 in Auckland; response rate too low to be useful.
6.	Provide 20 education presentations to health and disability sector organisations and have 100% of organisations requesting presentation rate that it met expectation.	30 June 2009	Target achieved. 25 education presentations provided. 95% (24) of organisations requesting presentation responded; all rated that the presentation met expectation.
7.	Provide 2 intensive provider training programmes for providers who work in isolation or with little or no input from consumers of service.	30 June 2009	Target achieved. 31 team development workshops for prison nurses presented at 11 prisons.
8.	80% of participants who respond to an evaluation of the intensive training programme rate they were satisfied or very satisfied with content and delivery of programme.	30 June 2009	Target achieved. On average 89% of participants who responded to evaluation rated they were satisfied or very satisfied with content and delivery of programme.
9.	Provide annual report on impact of policy advice given and submissions made, with quarterly updates on percentage of satisfaction with quality of policy advice and submissions.	30 June 2009	Target achieved. 22 submissions made; 100% of those surveyed responded and were 100% satisfied with quality of policy advice given or the submission. Submissions made have had positive impact and resulted in HDC's suggestions being adopted or included in final decision.

Output 3: Advocacy Services

Performance Measure	Target Date	Actual
Advocacy Agreement		
1. Administer compliance with Advocacy Services Agreements:		
• 7,640 enquiries managed.	30 June 2009	• **Target achieved. 9,500 enquiries managed: 124% of annual target.**
• 4,680 complaints closed.	30 June 2009	• **Target not achieved: 3,565 of 6,547 complaints closed (76% of target). An independent audit confirmed anecdotal reports that target for complaints closed is not being met because of increasing complexity of complaints, resulting in longer time to close.**
• 75% of closed complaints either fully or partially resolved.	30 June 2009	• **Target achieved. On average 91% of closed complaints were partially or fully resolved.**
Promotion and Education		
2. Monitor compliance with Advocacy Services education targets:		
• 180 case studies or stories of great care provided.	30 June 2009	• **Target achieved. 180 case studies or great care stories provided (100% of target).**
• 1,500 education sessions provided.	30 June 2009	• **Target achieved. 1,990 education sessions provided (133% of target).**
• 2,000 networking contacts provided.	30 June 2009	• **Target achieved. 6,216 networking contacts provided (311% of target.)**

Output 4: Proceedings

	Performance Measure	Target Date	Actual
	Decision to prosecute		
1.	80% of decisions are made within 2 months of referral.	30 June 2009	Target not achieved. 64% (14 out of 22 decisions) were made within 2 months of referral. In each instance where a decision was not made within the two-month timeframe this was due to an extension being granted to the respective provider so that further information could be provided prior to a decision being made, or because the DP required further information and/or expert advice before a decision could be made.
	Compliance with directions		
2.	100% compliance with Tribunal/ Court directions.	30 June 2009	Target achieved. 100% (36 out of 36) compliance with Tribunal/Court directions.
	Successful proceedings		
3.	A finding of professional misconduct is made in 75% of disciplinary proceedings.	30 June 2009	Target not achieved. A finding of professional misconduct was made in 66% (6 of 9) of disciplinary proceedings.
4.	A breach of the Code is found in 90% of HRRT proceedings.	30 June 2009	Target achieved. A breach finding was made in 100% (1 of 1) HRRT proceedings.
5.	An award of damages is made in 80% of cases where damages are sought.	30 June 2009	Target achieved. Award of damages achieved in 100% (1 of 1) of cases where sought.
6.	75% of costs awarded are recovered.	30 June 2009	Target not achieved. Despite reasonable efforts to recover costs where appropriate, 28% (2 of 7) of costs awarded were recovered. Since recovery is largely dependent on means of debtor, and given the additional costs involved in protracted enforcement, this is an area where variance in results from year to year is to be expected.

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Commissioner

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