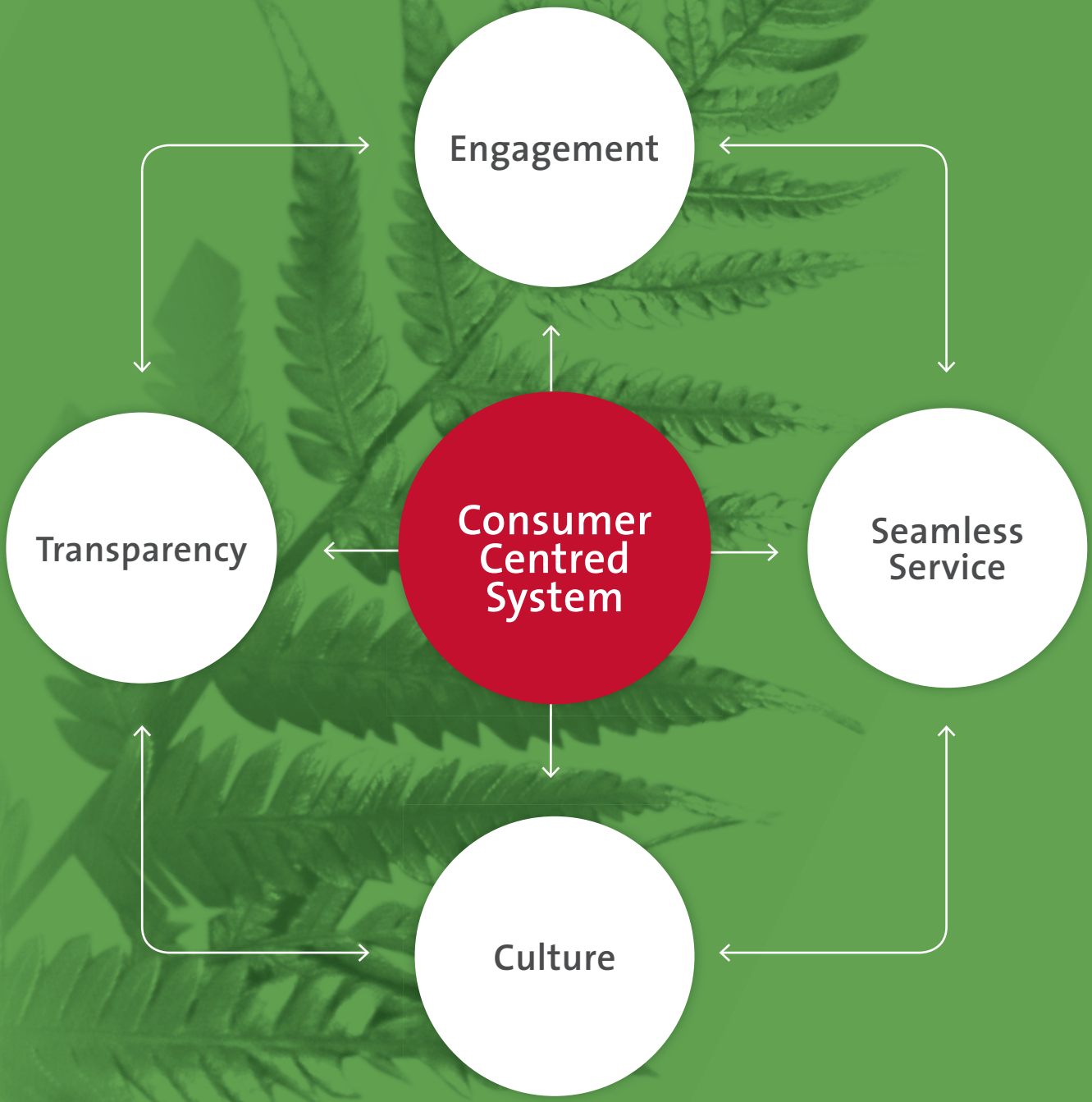
HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

ANNUAL REPORT
for the year ended 30 June 2012


Engagement
Transparency
Consumer Centred System
Seamless Service
Culture

CONTENTS

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

Published by the Health and Disability Commissioner

PO Box 1791, Auckland

Letter to Minister of Health

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

31 October 2012

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, 2012.

Yours faithfully

Anthony Hill
Health and Disability Commissioner

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1.0

Commissioner's Foreword

The majority of the time consumers in New Zealand experience good care. We can be proud of the health and disability system in New Zealand, but we can also do better.

Over the last year I have spoken at dozens of venues, addressed thousands of people and read hundreds of letters from people who have encountered the New Zealand health and disability system.

I am encouraged each day by the passion demonstrated by New Zealand's health and disability service providers, and their commitment to delivering safe and high quality services.

The HDC is a champion of consumers' rights, and our mission is to resolve consumer complaints, protect consumer rights, and to encourage providers to learn from complaints to improve the quality of the services they deliver. My vision for health and disability services in New Zealand is a consumer-centred system; a system that is built on the concepts of seamless service, engagement, transparency, and an empowering culture.

By seamless service I mean the services – people and systems – wrapped around a consumer are appropriately connected and communicating. It is about the woman with a history of breast cancer who presented to hospital with a sudden onset of back pain with no trauma, whose care was not adequately coordinated between the different services providing care to her, resulting in missed opportunities to diagnose her metastatic bone disease.

By engagement I mean engaging consumers by respecting, informing, involving, and listening to them, and I mean providers aspiring to excellence and advocating strongly for their consumers. It is about doctors listening to and examining patients and, consequently, not missing opportunities to diagnose. As one consumer aptly stated: "Yes I have cancer and [Dr B] did not pick it up, but what is more important is the way he treated me. I was never listened to, never sent for tests, never examined or blood pressures taken, no X-rays just prescribed my medication and told to give up smoking. I had to sit through comments from [Dr B] such as 'you depress me'. How would that make you feel?"

By transparency I mean sharing information when things do go wrong, talking about adverse events and learning from them. And by an empowering culture I mean the way all these elements come together to form a well-functioning system; what we do, how we do things and the reasons behind our actions (or omissions).

I mean that team members who strongly suspect that a consumer is at risk must advocate for that consumer. Providers must be supported to bring concerns about a consumer's welfare to the attention of an appropriate senior practitioner.

Health and Disability Commissioner
Anthony Hill

We can be proud of the health and disability system in New Zealand, but we can also do better.

These concepts are not new. Twenty five years ago Judge Cartwright, as she was then, advocated for a system in which the focus of attention is on the consumer, not the provider, and where a provider's paramount consideration must always be their duty to safeguard the consumer's health. The message internationally is the same. The consumer must come first; quality and safety is everybody's concern and is a commitment for 365 days of the year; and a culture that actively and reliably expresses that is foundational.

There is a clear correlation between the concepts that define consumer-centred care, and complaints to HDC. This year, HDC received 1,564 new complaints (an 11% increase from the previous year and a 21% increase over a five year period). The HDC dealt with 4,910 enquiries (and advocacy received 10,816 enquiries). Many of those 15,000 people were seeking help to have a conversation with the system that serves them. Recurring themes from these complaints include a failure to get the basics right – read the notes, ask the questions and talk with the consumer. Concerns about treatment represent 51% of complaints and communication represents 14.5% of complaints. We actively use these recurring themes to direct our efforts in improving our system. I continue to be pleased with the number of providers who implement changes to systems, policies and procedures as a result of a consumer's complaint and feedback. Every complaint is an opportunity to learn and improve.

The current performance of HDC is pleasing. We are handling greater volumes, and resolving as many complaints as ever. We continue to manage the pressures facing us by seeking innovation and efficiency.

Our staff are our greatest resource. I am fortunate to be surrounded by people of integrity, passion, commitment and talent, and I am indebted to them.

New Zealand should rightly be proud of the quality of its health and disability systems. The journey toward improvement is ongoing, and we at HDC are proud to be a part of that.

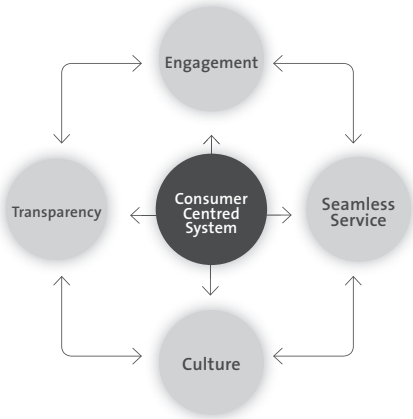


Figure 1: A consumer-centred system

1.1 2011/12 Priorities

In line with HDC's vision and Statement of Intent 2011/12–2013/14, the key priorities for the HDC for the 2011/12 year were to:

- maintain high quality and timely complaints resolution processes
- focus on organisational capability
- maintain professional standards through bringing proceedings in appropriate cases
- continue to support the work of the nationwide Health and Disability Advocacy Service
- continue to work in partnership with other relevant agencies in the health and disability sector
- communicate with key stakeholders to ensure that our educational initiatives are effective
- offer services and processes that are accessible to disability service consumers, Māori, Pacific peoples, refugee and other ethnic communities
- maintain HDC's high profile in both the health and disability sectors.

Vision
Champions of consumers' rights.

Wawata
Kai kōkiri i nga tika kai hokohoko.

Mission
Resolution, protection, and learning.

Whainga
Whakataunga, whakamaru me te akoranga.

We have also made recommendations for real and lasting improvements to health and disability services and systems.

1.2 Entity performance: Highlights

My Office is committed to promoting and protecting the rights of health and disability service consumers in New Zealand. This year, HDC has had many successes and we have met our key priorities in a number of ways.

We have successfully responded to an increased number of complaints, helping many consumers achieve resolution to concerns about the standard of care they received. We have also made recommendations for real and lasting improvements to health and disability services and systems. Of the 1,380 complaints closed during 2011/12, 44 were formal investigations, resulting in 29 breach opinions and 8 referrals to the Director of Proceedings. HDC continues to report a very high level of compliance with recommendations made following the complaints resolution process (99.2%). I have also appointed a new Deputy Commissioner responsible for complaints resolution.

HDC continues to provide six-monthly reports to District Health Boards (DHBs) on the numbers and types of complaints received about services provided by DHBs, and this year HDC staff also held complaints management workshops to facilitate efficient and effective complaints resolution processes. In addition, we organised a successful National Disability Conference, with the theme Fostering a Culture of Consumer Engagement.

One of the significant highlights for the year was the announcement that HDC would be taking on some of the functions of the former Mental Health Commission (MHC), effective 1 July 2012. In particular, the functions of systemic advocacy and monitoring of mental health and addictions services. This change has implications for organisational roles, capacity, skills, relationships and resourcing.

The HDC and the Mental Health Commissioner spent several months prior to 30 June 2012 preparing for the transfer of hard copy and electronic records, documentation and publications, including relevant information from the MHC's website. Office accommodation continues to be reconfigured to include the Mental Health Commissioner and members of her team. Key stakeholders in the mental health and addictions sector were kept informed of the transition progress. Preparation for the transition also included developing an interim work plan to include in the Health and Disability Commissioner's Statement of Intent for 2012–2015.

It is a privilege for the HDC to take on board the advocacy and monitoring roles of the former MHC. We are committed to the successful integration of the new functions, and to ensuring that the consumer voice is central in all of our work. We will continue to build on the gains already achieved in the mental health and addiction sector over the past decade. The former MHC and HDC share many common goals: both act as independent advocates for the rights of consumers of health, disability and mental health and addiction services and provide advice on how to improve services for consumers.

2.0

Role of the Health and Disability Commissioner

2.1 Purpose and role

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

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

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

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

Vision

Champions of consumers' rights.

Wawata

Kai kōkiri i nga tika kai hokohoko.

Mission

Resolution, protection, and learning.

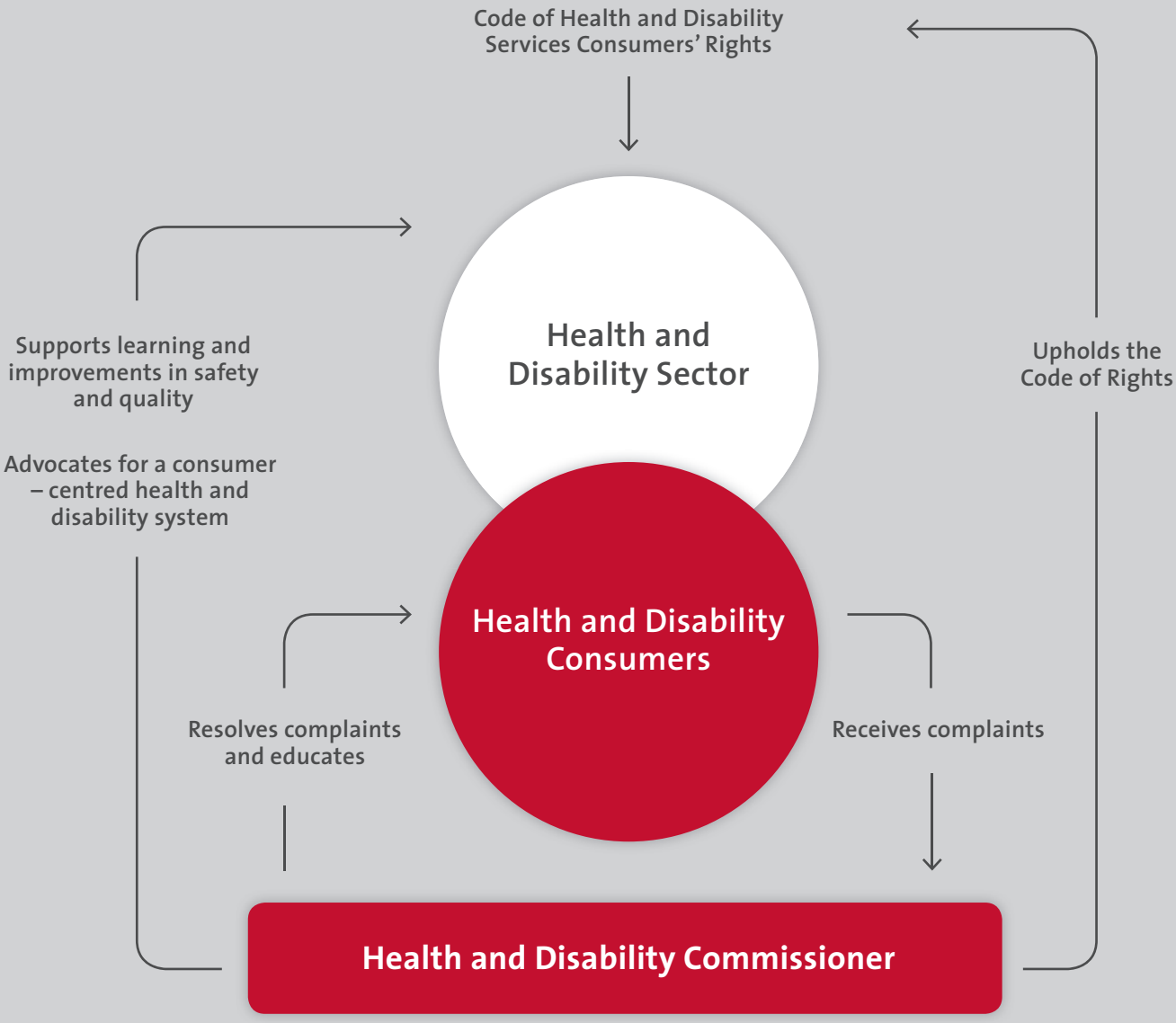
Whainga

Whakataunga, whakamaru me te akoranga.

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

Many complaints are resolved directly between the consumer and the provider, with free independent advocates available to assist consumers with this process. More serious complaints may be formally investigated by HDC and, in a small number of serious cases, may result in a prosecution being taken against a provider by the independent Director of Proceedings in the Health Practitioners Disciplinary Tribunal and/or the Human Rights Review Tribunal.

What the HDC does



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

Output 2: Advocacy: Resolves complaints early through advocacy

Output 3: Proceedings: Proceedings are taken in serious cases to publicly redress breaches of the Code of Rights practitioner standards and human rights

Output 4: Education: The HDC educates the sector and consumers on consumer rights and consumer-centred services and encourages quality improvements based on learning from complaints

Figure 2: Overview of the role of the HDC and how its purpose and role are reflected in its interaction with consumers and the health and disability system and through the four output classes of: Complaints resolution; Advocacy; Proceedings; Education

2.2 Impact and outcomes

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

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

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

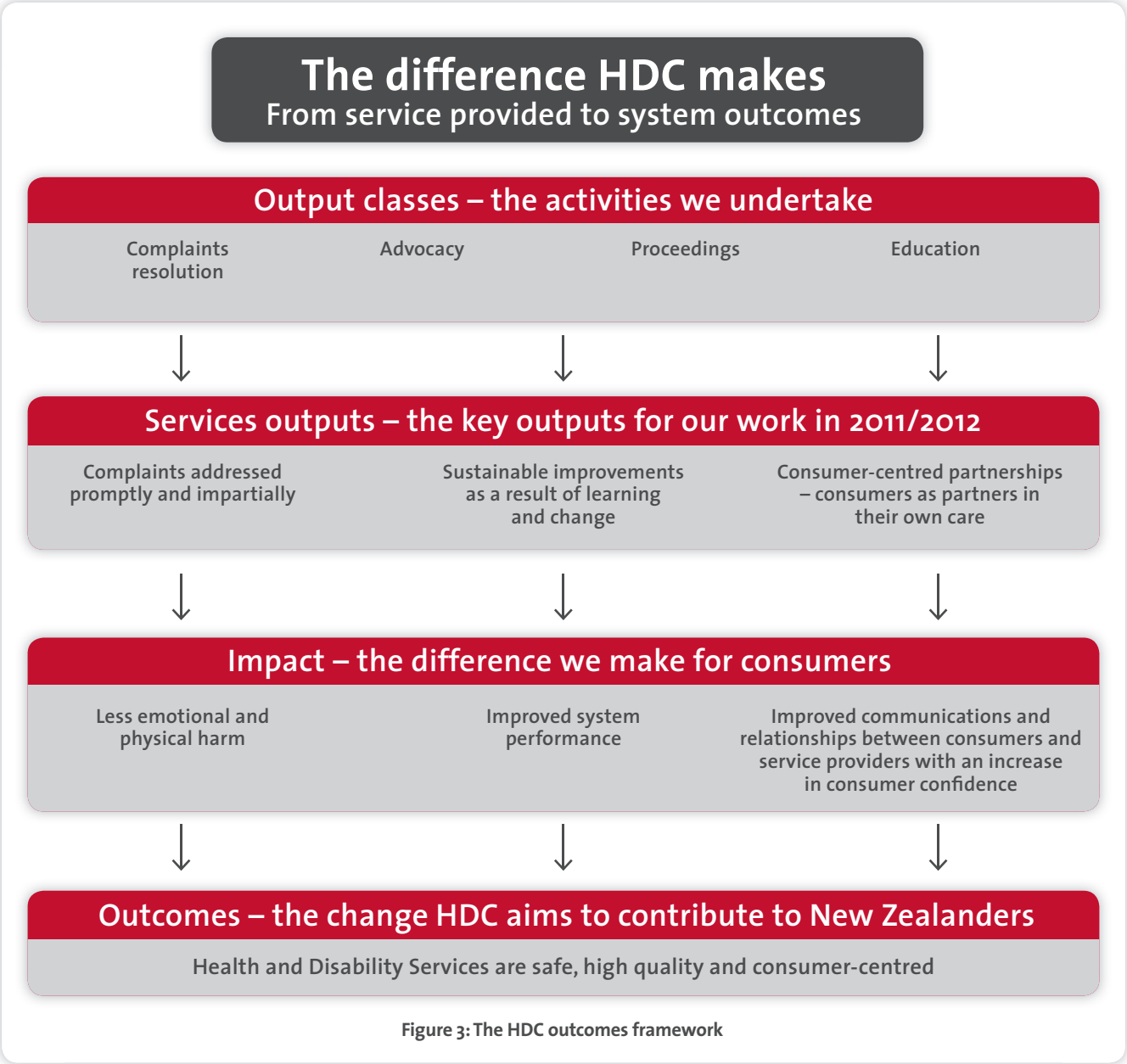


Figure 3: The HDC outcomes framework

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

Examples of the sorts of changes made as a result of complaint resolution processes include:

- A DHB was recommended to develop a culture where the asking of questions is expected to and from any point in the hierarchy – after a midwife contacted a registrar appropriately but failed to escalate her concerns when the registrar did not recognise the seriousness of the situation.
- A GP practice improved its referral and reminder processes after a patient's referral to a hospital for investigation was not actioned within the practice.
- A DHB undertook an audit of childhood brain cancers in the area and has now adopted overseas guidelines for diagnosis of brain tumours in young adults.
- A DHB pharmacist conducts group and individual medication education sessions at the inpatient unit.
- A private hospital and surgeon developed the following: a pamphlet on how to prevent blood clots, which is given at preadmission; a reminder sticker is now placed on information sent to consumers requesting they bring a printed list of current medication from their GP or pharmacist; discharge guidelines have been reviewed and now include specific advice for patients on anticoagulants; the surgeon now systematically communicates to consumers information about stopping their anticoagulant and also about restarting the medication.
- A medical centre provided training on the writing of full care plans for their consumers, so if their regular GP is unavailable a colleague will know exactly what is required to meet the needs of that consumer.
- A surgical clinic implemented a new system where tissue samples are labelled with red tape on which are written instructions about whether the tissue is to be returned to the consumer. In addition, they are also introducing a system of coloured paper for tissue samples.
- A hospital implemented a system of meeting with families following any significant event and requested the advocates provide open disclosure training for staff.
- Another hospital introduced a new pamphlet for consumers attending the renal unit.
- A consumer was nominated to be part of a consumer advisory group as a result of their complaint.
- A provider reviewed their policy and implemented a double-checking system for notifying consumers of cancelled appointments.
- An inpatient mental health service now ensures there is a designated person on each shift to coordinate the response to any medical emergencies.

The key differences HDC makes to the health system include:

- increasing consumer focus of providers, thereby increasing transparency, integration and engagement
- reducing the incidence of preventable injury and death through unsafe, poor quality systems and practices
- reducing the stress experienced by consumers and increasing their confidence in health and disability services
- increasing the quality of communication and improving relationships between consumers and health and disability service providers
- quality and performance of systems improved.

Achieving safe, high quality services is a shared responsibility with other agencies, providers and professional bodies. The outcomes HDC seeks are consistent with the Government's intermediate and long-term health and disability systems outcomes that:

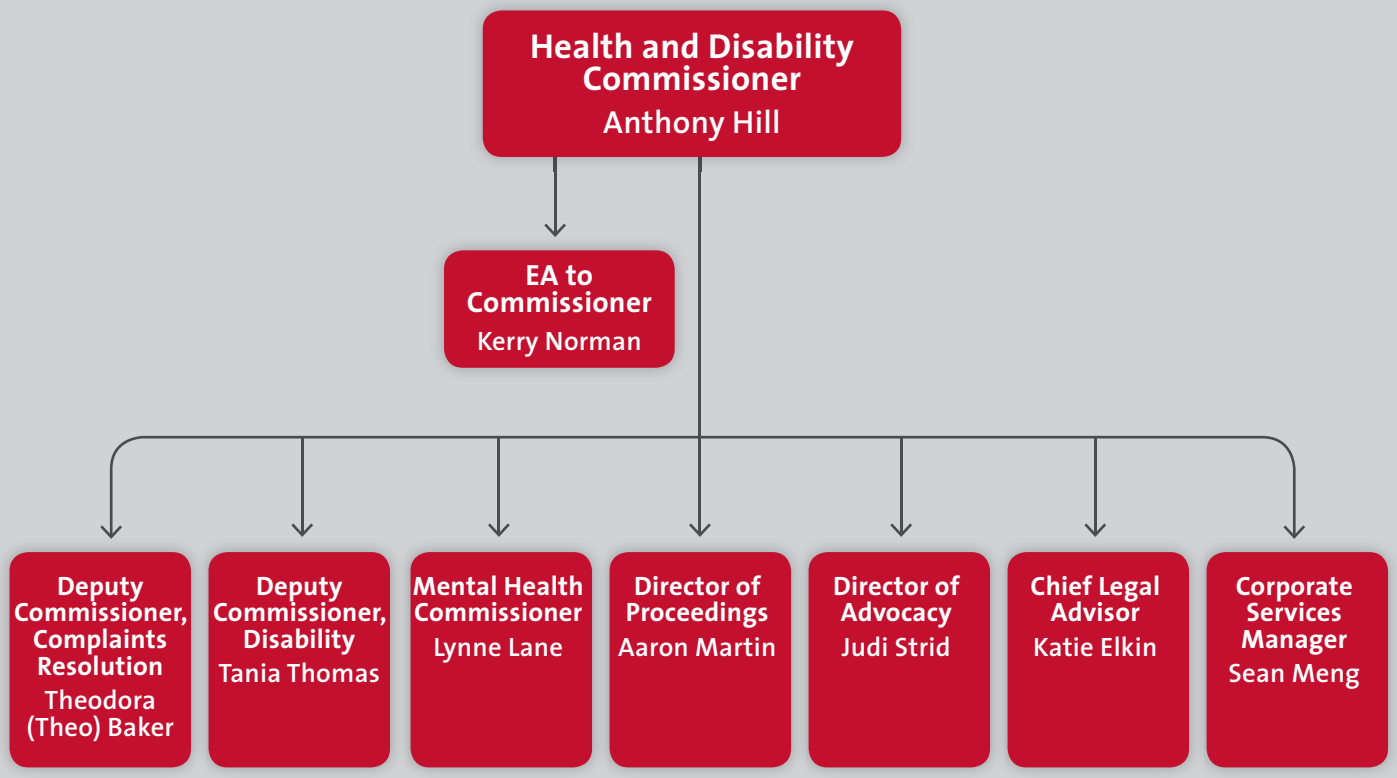
- New Zealanders live longer, healthier, more independent lives
- good health is protected and promoted
- people receive better health and disability services
- the health and disability system is improved and unified
- health and disability systems and services can be trusted and used with confidence.

The key ways in which HDC contributes to the Government's outcomes include:

- promoting best practice and consumer-centred care to providers
- ensuring providers and their employees are held appropriately accountable for their actions
- resolving complaints about health and disability services
- learning from complaints to improve the safety and quality of health and disability practices and systems.

Organisational structure

(as at 1 July 2012)



3.0

HDC Key Activities 2011/12

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

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

3.1 Complaints resolution

Anyone can complain to the HDC, orally or in writing – consumers, their families and support people, third parties such as concerned staff in provider organisations, or representatives of other organisations in the health and disability sector.

The HDC receives around 5,000 enquiries a year and received 1,564 new complaints during 2011/12, an 11% increase from the previous year and a 21% increase over a five-year period.

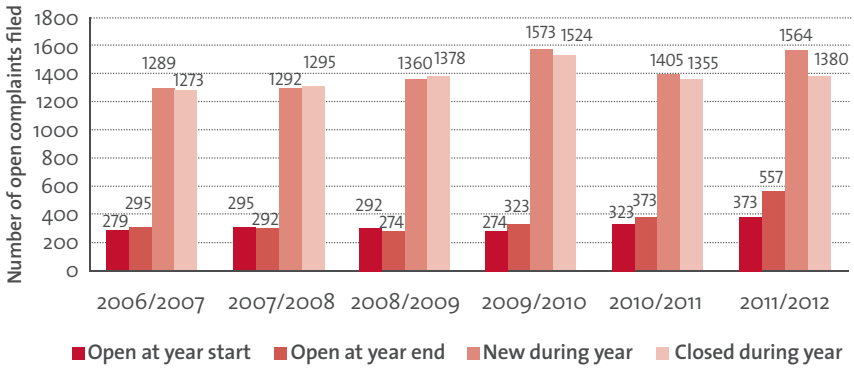


Figure 4: Number of open complaints filed

Note The 2009/2010 figures included the receipt and resolution of 161 complaints arising from the change to the laboratory service in Auckland.

CASE STUDY:
Lack of consistent approaches to prevention of thromboembolism

In 2011 at a private hospital, a 64-year-old man had a mini-laparotomy to remove his kidney, which had developed a malignant tumour. He was given anticoagulants after this procedure. A few days later he was admitted to a public hospital because of dehiscence of his surgical wound. Sadly and unexpectedly five days later, he died in hospital as a result of a pulmonary embolism (PE).

Senior staff met with the family to discuss the events and acknowledged some shortcomings, and proposed changes. The family complained to the HDC that despite numerous PE risk factors, the man was not given a further course of anticoagulants at the pubic hospital. The family want to ensure that all surgical wards in the hospital review their processes.

The Commissioner obtained the opinion of an independent surgeon, who observed that there was no evidence of formal risk stratification, but it was evident that the registrar did consider the man's risk of thrombosis. He explained that the registrar was mistaken in that thromboprophylaxis would lead to a significantly increased risk of bleeding (given the patient's abdominal bruising), but noted this is a commonly-held misperception.

The expert considered that, according to more modern practice, the man should have been on prophylaxis for one month following the procedure at the private hospital.

The expert commented that there is a large variation in thromboprophylactic practice amongst district health boards, and noted that all disciplines bring expertise to the question of prevention of thrombosis.

The Deputy Commissioner sent a copy of the expert opinion to the district health board and asked it to report back on the steps taken across all wards of its hospitals to involve all disciplines in the education and prevention of thrombosis. The DHB was also asked to report back on its own initiatives, which included use of a stamp to direct the post-operative management of thrombosis risk, amendment of the Admission to Discharge planning document to include a thrombosis risk assessment, and revision of the prescribing charts to include a separate thromboprophylaxis section.

Copies of the complaint and the expert opinion were sent to the Health Quality and Safety Commission, and the Commissioner provided endorsement for the venous thromboembolism (VTE) prevention quality improvement initiatives proposed by the VTE Prevention Group.

CASE STUDY:
Use of unapproved medication to perform dermal filling procedure

A woman consulted a medical practitioner, wanting a cosmetic procedure to help her achieve a healthier appearance. He recommended a procedure called the "mid-face volumisation", which involved the injection of a dermal filler into her cheeks. The product he used as the dermal filler (the product) was not an approved medicine in New Zealand under the Medicines Act 1981.

The medical practitioner informed the woman that the product included the same chemical compound that he had been using for the previous four years, and that he had considerable experience performing the procedure, but did not inform her that the product was not approved in New Zealand. The medical practitioner did not inform her about the possible side effect of granuloma formation.

Following the procedure, the woman developed granuloma formations, which the medical practitioner was unsuccessful in treating.

It was held that the medical practitioner failed to ensure that the product was safe and appropriate for use as a dermal filler and failed to provide adequate follow-up, breaching Right 4(1) of the Code. He did not provide the woman with information about the risk of granuloma formation or independent clinical literature about the product's safety, or tell her that the product was not an approved medicine in New Zealand, breaching Rights 6(1) and 7(1).

The medical practitioner was also found to have inadequate documentation and therefore breached Right 4(2) of the Code. He was referred to the Director of Proceedings.

(10HDC00986)

CASE STUDY:
Treatment of woman with cancer by natural therapist/iridologist

A woman consulted an iridologist and natural health practitioner about a lesion on her head, which the woman thought was a cyst. The provider recognised that the lesion "looked cancerous" and that it was beyond her ability to treat. However, the provider treated the woman over a period of 18 months. Treatment of the lesion included picking out dead skin, cleaning the lesion, and the use of topical and oral remedies. Although initially the lesion appeared to improve, it subsequently deteriorated. In order to treat the woman, the provider spent many hours at the woman's house each day, and the woman and provider went on holiday together. The lesion grew larger and was frequently infected. It bled frequently, and smelled unpleasant. The woman became weak and was in severe pain. No other health practitioner treated the woman's lesion during the 18 months.

By the time the woman sought hospital treatment, the lesion was 10 x 11 cm and some underlying bones were damaged. The woman was diagnosed with cancer and underwent major surgery but, sadly, she died a year later.

The provider was aware that the lesion was likely to be cancerous, but did not inform the woman of her opinions about the severity of the woman's condition or that the lesion was worsening during the course of the treatment. The provider knew that she had exceeded the limits of her expertise and that the woman required advice from another practitioner, but she did not appropriately communicate this or discontinue her treatment of the woman. In addition, the provider gave the woman information which accentuated the woman's fear of conventional treatment.

The provider did not maintain any records, misled the woman about her training, and developed a friendship which compromised the care she provided the woman.

The provider was found to have breached Rights 4(2), 4(4), 4(5), 6(1), 6(1)(a) and 7(1) of the Code, and was referred to the Director of Proceedings. The Director decided to issue an HRRT proceeding, which is pending.

This case highlights the need for health providers to seek another provider's advice when faced with a situation that is beyond their expertise, or where the relationship between practitioner and consumer goes beyond a professional one. It also highlights the need for careful documentation of the history and treatment, particularly if the consumer is alleged not to have accepted a recommendation made by the provider.

Consumers who seek alternative health care are entitled to be given information about their condition, its progression, and the safety of the proposed therapy. The fundamental ethical principle of health care – "primum non nocere" (first do no harm) – is no less applicable to alternative practitioners than to medical practitioners.

Where a treatment proves unsuccessful or a provider reaches the limits of his or her expertise, the provider should recognise this, advise the consumer of the alternatives available and involve other providers in the consumer's care.

(10HDC00970)

Nature of complaints

The HDC received 1,564 new complaints during 2011/12 and resolved 1,380[1]. While there has been an increase in complaints received, it should not be concluded that the increase in complaints indicates a decrease in the standard of care being delivered to consumers in New Zealand. It is likely that the increase indicates a heightened awareness among consumers and providers of the Code and improved complaints processes. Every complaint represents an opportunity to learn. For the year ending 2011, 679 (50.1%) of the complaints closed concerned Treatment as the primary issue, compared with 42.1% in the past year. As Figure 5 shows, many factors lead someone to complain to the HDC. For example, there has been an increase in the number of complaints about medical records and reports. The Commissioner does not have jurisdiction over issues of inaccuracies in medical records, so these issues are referred to the Privacy Commissioner. Communication remains a significant issue, and featured as the primary concern in 201 complaints closed last year. Poor communication includes a rude or unhelpful manner as well as issues of inadequacy. Every consumer has the right to "be treated with respect" as well as the right to "effective communication." Even where communication is not the primary issue complained of, ineffective communication is a common aspect of many complaints. Effective communication is at the heart of consumer-centred care.

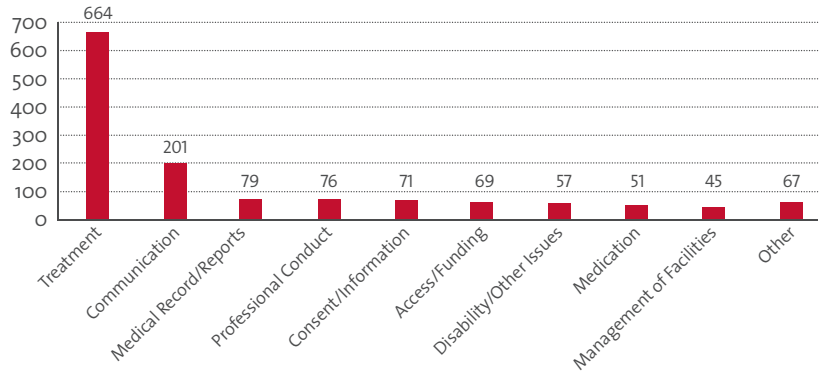


Figure 5: Complaints closed – nature of complaints

Providers complained about

Of the 1,564 complaints received during 2011/12, 1,037 individual providers and 1,217 group providers were identified.

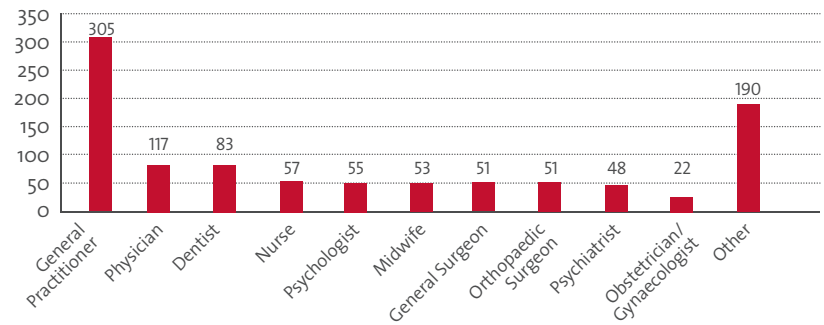


Figure 6: Complaints against individual providers

Note: The Physician category includes all specialities that are included in the Royal Australasian College of Physicians, such as dermatologists, haematologists, gastroenterologists.

1 Both of these totals are second only to 2010, when numbers were inflated by a large number of complaints arising from a change in the provision of Auckland laboratory tests.

Complaints were sometimes about identified individuals or a specific group of services. Sometimes complaints were more general, and it was only through the assessment process that the relevant providers could be specified. Figure 7 shows, in line with previous years, that public hospitals and DHBs make up for about half of all group providers identified in the complaints received. Figure 6 shows that about 30% of all individual providers complained about were general practitioners. A complaint may involve more than one provider.

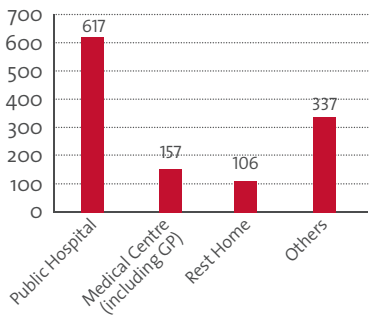


Figure 7: Complaints against groups of providers

Referrals to providers and to advocacy

Over 200 complaints were referred back to the provider to resolve. Suitable cases include complaints about a provider's manner, or less serious complaints about an institution. Where there is an ongoing relationship with the provider, the Commissioner often refers the complaint to Advocacy in order to enhance the communication between the parties, and empower the consumer to resolve complaints without external intervention. As Figure 9 shows, 140 complaints were referred to Advocacy.

Investigations

HDC closed 1,380 complaints.
The Commissioner continues to conduct formal investigations into the more significant departures from a reasonable standard of care. This year 44 investigations were completed, and it was found in 29 cases that the consumer's rights had been breached. Of the breach decisions, eight providers were referred to the Director of Proceedings for consideration of proceedings. Figure 8 shows the manner in which complaints have been resolved in the past year.

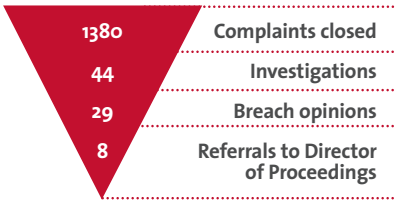


Figure 8: Number and manner in which complaints have been resolved during 2011/12

Recommendations

The ability to make and monitor the implementation of recommendations is a key complaint resolution tool. Many complainants indicate their desired outcome is to ensure that quality and safety is improved. There has been a high level of compliance with recommendations during 2011/12 (99.2%). An audit carried out on six group providers who were subject to recommendations following a formal investigation confirmed that there had been 100% compliance.

DHB reports

The HDC continues to provide six-monthly reports to DHBs covering the numbers and types of complaints and the outcomes of closed complaints. In an HDC survey of DHBs, all of the DHBs indicated they consider the reports useful. Complaints to the HDC citing concerns about DHB complaints processes for the period January–June 2012 were more than double that for the two preceding periods combined. In response to the concerns of one DHB regarding the adequacy of their complaints processes, HDC staff held complaints management workshops to facilitate efficient and effective complaints resolution processes. Feedback about these workshops was that they had a positive impact, with DHBs reporting a real difference in the approach of their staff to discussing and resolving complaints.

Section 38

The Commissioner may assess a complaint and decide to take no further action under section 38. This decision may be made at any point in the life of a complaint. Usually, as a minimum, the provider is asked to respond to the complaint. Sometimes no further action is taken at that point if the Commissioner or Deputy Commissioner considers that the provider has appropriately addressed the issues or further enquiry will not help resolve it. In many cases preliminary expert clinical advice is obtained and recommendations are made to the provider. Even after a formal investigation has been commenced, a decision is sometimes made not to continue. This may be on the basis of further information, including expert opinion, or actions the provider has taken to ensure that the shortcomings are not repeated.

Feedback about these workshops was that they had a positive impact, with DHBs reporting a real difference in the approach of their staff to discussing and resolving complaints.

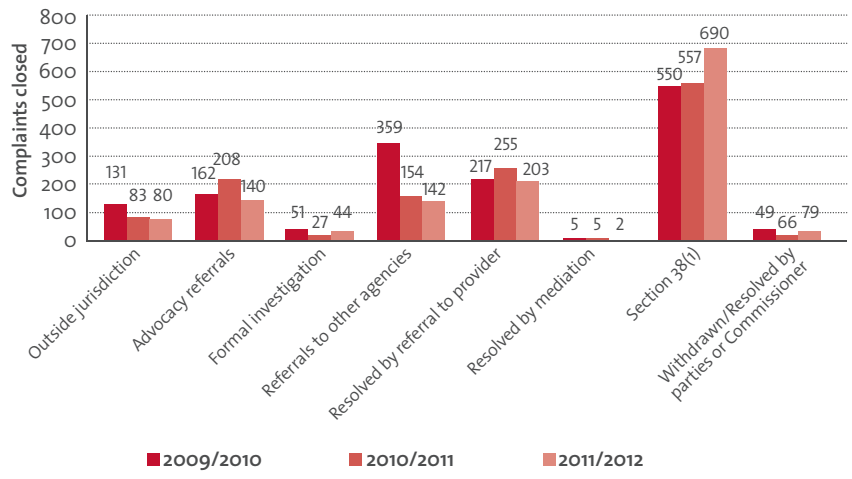


Figure 9: Complaints closed by category

The high level of public awareness of the advocacy service is reflected in the high number of calls to the 0800 number.

3.2 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. This includes how to make and resolve a complaint as well as how to achieve improvements to the quality of services provided. Advocates are independent. They can be easily contacted on an 0800 number as well as by free fax and email.

There are 48 advocates (41 FTEs) located in 25 community-based offices around the country. This means that 86% of the total advocacy workforce (56 people) are frontline advocates.

Over half the core advocates are Māori. Six are specialist advocates, with three working with the Deaf community and three working with refugee/migrant communities. Although they are based in Auckland, Wellington and Christchurch, the specialist advocates cover large geographical regions to improve access for consumers from these communities. The high level of public awareness of the advocacy service is reflected in the high number of calls to the 0800 number; of the 26,123 calls, 95% of those made during normal business hours were answered. This number does not include the calls made directly to the 48 advocates.

CASE STUDY:
Dental care – is this the right child?

A 5-year-old girl received dental treatment on two consecutive days without permission or even the knowledge of her grandparents who are her legal guardians. The child suffered lip trauma from the dental treatment. The grandmother's enquiries revealed the child had been treated in error and that they had initially been misled by the therapist.

They received a response advising that a full investigation would be undertaken and an offer to meet to discuss the matter. The grandmother sought advocacy help to prepare for and attend the meeting with them. At the meeting the provider apologised and advised a full investigation was being undertaken by the Quality Team. The complainant received full details of the treatment provided plus an acknowledgement that the child was mistaken for another and should not have received any treatment.

The grandmother requested a written apology from the therapist, and to have all future dental care provided by a private dentist. The meeting concluded with the provider saying they would send the results of the investigation to the grandparents.

Following receipt of the investigation report the grandmother asked the advocate to support them at another meeting with the provider. The outcome from that meeting confirmed that the provider will fund the child to have free dental care with a private dentist outside of the DHB's Oral Health Service until the end of year 8. It was also agreed that a letter of apology from the therapist would also be sent to the child.

To prevent this from happening again, protocols are being developed to ensure the correct child is treated. In the meantime a system has been put in place where the teacher must receive a note from the therapist requesting the child, and the teacher must tick a register to confirm the correct child has been sent for treatment.

The grandparents were happy with the outcome of the investigation and that systems had been put in place to ensure the right child received the right treatment in future.

CASE STUDY:
Loss of speech following multiple strokes

The son of a rest home resident who is unable to speak or write following multiple strokes contacted an advocate, as she appeared to him to be unhappy at the rest home. The advocate agreed to visit the resident. Through a combination of signs, writing and yes/no questions, she told the advocate that she is very unhappy that she can't live at home but knows that it is not practical for her to go back there. Although she was generally happy with the way the staff at the rest home treated her, she did find it distressing when they spoke to each other over her head as if she couldn't understand them. She asked the advocate if it would be possible to organise a meeting with the manager while the advocate was present.

The manager was happy to meet and the advocate assisted the resident to relay her concerns about how staff spoke about her rather than to her. The manager agreed to address these communication issues with the staff. The contact details for the advocate were placed on her notice board with a copy on her file in case she needed advocacy assistance in the future. The resident was very pleased with this outcome.

Rest home staff have contacted the advocate on two occasions after the consumer presented them with the card left by the advocate. At the second visit the resident introduced the advocate to a staff member who she can communicate well with. Her subsequent complaints have not related to communication, which she describes as working well since the meeting.

This response shows a high level of goodwill amongst providers, who are also keen to resolve complaints at an early stage.

Enquiries

The advocacy service managed 10,816 enquiries for the year, with 98% of the enquiries closed within two days and 99% within five days. Of the enquiries, 7,355 (68%) were about the Code of Consumers' Rights, the HDC, how to make a complaint or the role of an advocate. These callers were provided with verbal and/or written information. Close to 9% of enquiries (941) were escalated to complaints. Although advocates are unable to assist consumers with resolving complaints about matters outside the HDC's jurisdiction, they can provide self-advocacy training to consumers so they can deal with these matters themselves.

Complaints

The advocacy service received 3,025 new complaints and brought forward 384 from the previous year, giving an overall total of 3,409. Timeliness is a key aspect of achieving successful resolution of complaints. On average, 87% of complaints are closed within three months and 99% are closed within six months. Ninety percent of complaints managed by advocacy were partially or fully resolved.

In 109 of a total of 362 resolution meetings, providers agreed to take post-meeting actions, which were recorded on the resolution agreement form.

In all but two cases the provider completed the actions within the agreed timeframe. This response shows a high level of goodwill amongst providers, who are also keen to resolve complaints at an early stage. During the past year, 37.2% were simple complaints (up to 2 hours), 54% of complaints closed were classified as standard (2–8 hours) and 6.5% were complex (8–15 hours) and about 2% of complaints were classified as taking more than 15 hours.

An increasing number of providers continue to use these resolution agreement forms (available from advocates) for Right 10 complaints that go directly to them. The use of the agreement form removes the focus on minutes that can trigger further dispute as well as the risk of misunderstanding what has been agreed to. The form also provides a prompt for an agreed date for reporting back to the consumer.

Some consumers advise that the changes to DHB complaint processes from a centralised system to each department dealing with their own complaints continue to create difficulties for those consumers, particularly when more than one department is involved in a complaint. Advocates have reported significant delays in getting responses to complaints when this approach is being used. During the year the director wrote to the CEOs of each DHB about the distress experienced by some consumers when there are delays in dealing with their complaints.

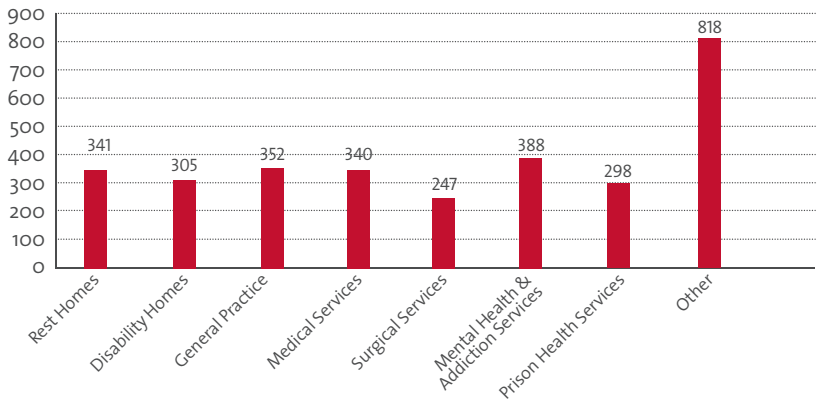


Figure 10: Number of complaints to advocacy, by provider category

Source of complaints

Of those who complained, 57% rang a local advocate directly; 20% used the 0800 number; 10% called in to the local advocacy office or discussed their complaint with the advocate during an education or networking session; 12% contacted the advocate by letter, text, fax or email and 4% were formal referrals from the Health and Disability Commissioner. Complaints received directly from consumers accounted for 66% of complaints, with a further 30% from a third party such as family members, friends and the HDC. This result reflects the proactive efforts of advocates to improve access to vulnerable consumers concerned about their care.

At 75%, the vast majority of complaints relate to health service providers, with a further 10% being complaints about mental health services. The 15% relating to disability service providers is not reflective of consumers with impairments as the statistics record the service used rather than the details about the consumer.

Complaint comparisons

It is interesting to observe the similarities and differences between the nature of complaints about health (75%), disability (15%) and mental health services (10%). It is common for complaints to cover more than one particular right (from the rights described in the Code of Rights).

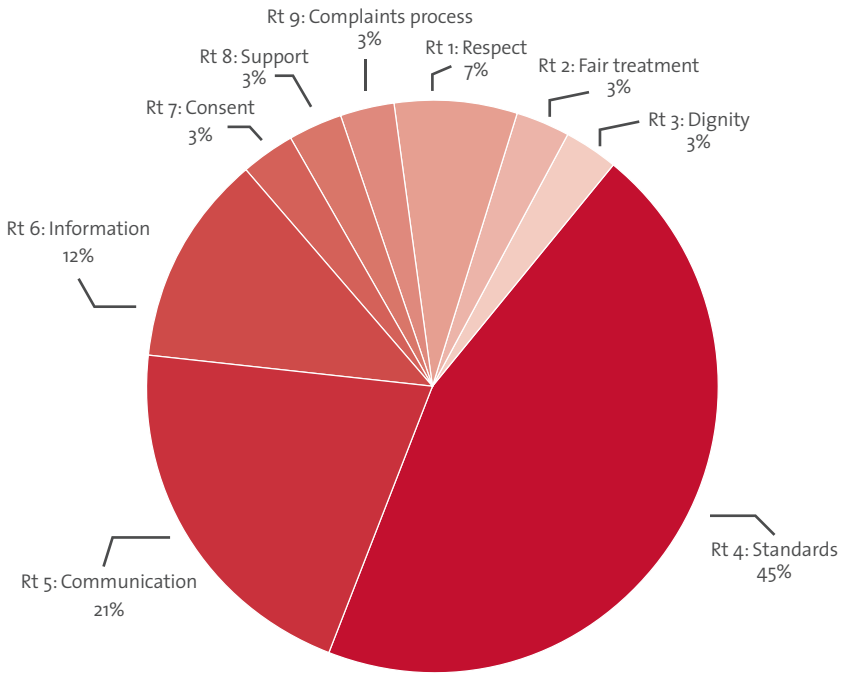


Figure 11: Advocacy complaints issues 2011/12

Right 4 is clearly a major factor for all sectors, with 43% of complaints about disability services, 53% of complaints about health services and 37% of those involving mental health providers relating to standards of care. The combined complaints about communication, information and consent (Rights 5, 6 and 7) featured in 39% of complaints about disability services (up from 36% in the previous year), 33% of complaints about health providers and 37% of complaints about mental health providers. The right to support (Right 8) continues to feature in just 2% of disability complaints, compared with 1% of health and 6% of mental health complaints. The complaint process (Right 10) featured in 4% of the complaints about both disability and mental health services, compared with 2% of complaints about health services.

Demographics

In 2011/12 more complaints came from female callers (56.7%) than male callers (38.3%). People who described their gender as "other" made up the remaining 5% of complainants. Consumers under the age of 15 years accounted for 4% of complaints. At 34%, the highest number of complaints was made by people in the 41–60 age group followed by 27% from the 26–40 age group and 23% being about consumers aged between 61 and 90 years of age. New Zealand Pakeha continued to make the largest number of complaints (67%) with New Zealand Māori making 13% of the complaints. Pacific people made 2% of complaints in 2011/12. The remainder of complaints were from a wide range of ethnic groups, including a small group of people who declined to provide their ethnicity.

Residential visits

Advocates have been visiting rest homes for six years and disability homes for five years. The purpose of the visits is to make it easy for residents to speak with an advocate and to provide free education sessions for residents and whānau/family members as well as providers. All but one of the 680 rest homes had at least one contact with an advocate, and 506 rest homes had at least two contacts. Advocates made at least one contact with 957 of 961 disability homes and 657 had at least two contacts. Over the reporting year, there have been a total of 3,069 rest home and 3,074 disability residential visits by advocates. Every residential home has been given a free copy of the Tell Someone DVD. The DVD is an educational tool to help people with learning or intellectual disabilities understand their rights. About 10% of the visits have been to assist residents and/or a third party acting on behalf of the resident to make a complaint.

Networking

Networking is an important way for advocates to establish a profile in their local communities so they are well positioned to inform consumers of their rights and providers of their duties. Networking helps advocates make effective referrals if the matter is outside the HDC's jurisdiction. Networking and education are the key features of the role of the six specialist advocates. These advocates respond to the needs of a range of Deaf, refugee and migrant communities. Over the past year advocates developed and maintained contact with 4,189 networks, of which 46% had a disability focus, 3% were with Māori networks and 6% were with refugee and migrant communities from non-English speaking countries.

Having a national focus each year on Code of Rights Day (1 July) to celebrate the anniversary of the launch of the Code of Rights provides an opportunity to attract the attention of the public to the unique features of the Code and how it can be used to improve the quality of services for consumers.

Satisfaction results

By its very nature, the advocacy service provides a consumer-centred approach. It is therefore very important that this is done well to set a great example for providers.

Providers who have had contact with the service and responded to the survey were satisfied with the professionalism of the advocate. A number commented on how well advocates facilitate communication between the parties and that they would happily recommend the services to others.

Surveys showed that 92% of consumers and 85% of providers are very satisfied with their dealings with the advocacy service. Ninety four percent of consumers were very satisfied with the advocacy process as well as the skill shown by the advocate, with 90% being satisfied with the resolution of the complaint; 92% of consumers and providers said they would recommend the service to others. Ninety percent of consumers and 91% of providers were very satisfied with the education sessions provided by advocates. Reported comments on the advocacy service included:

"Fantastic service," "friendly and made me feel comfortable," "easy to talk to," "she allowed us to take a lead role," "supported me and helped me to get through my terrible ordeal by walking alongside me," "I found the advocate sympathetic, understanding and thorough," "everything was exceptional," "simply the best," "conclusively, I could not have resolved the issue without your great role as an advocate."

Although advocates are on the side of consumers, it is important for providers to have confidence in the advocacy process.

Education and training

Advocates presented 2,117 education and training sessions to consumers, providers and organisations. The greatest number of requests were for basic information on advocacy, the Code and the HDC (63%). Advocates delivered 82 open disclosure training sessions (4%) with 101 sessions (5%) being given on informed consent. Including residential homes, 59% of education and training was provided to the disability sector. A role of the specialist advocates is to up-skill the core advocates in working with the Deaf community as well as the many different refugee/migrant communities.

A number of advocates are completing the new dedicated qualification for health and disability advocates. This national certificate was approved last year as part of the New Zealand Qualifications Authority framework and will form part of a career pathway for these advocates.

Acknowledgements from the Director of Advocacy

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

"I could not have resolved the issue without your great role as an advocate."

3.3 Proceedings

The Director of Proceedings brings disciplinary charges and compensation claims to publicly redress serious breaches of the Code of Health and Disability Services Consumers' Rights. These cases are heard by the Health Practitioners Disciplinary Tribunal (HPDT) and the Human Rights Review Tribunal (HRRT).

Departures by providers from generally accepted practice may be deliberate or come about through inattention. In some cases it is also appropriate that organisations are held publicly accountable for inadequate systems and processes, or for the failures of their staff.

Safety, public accountability and consumer confidence are enhanced through proceedings. Health practitioners play a central part in these processes, whether as tribunal members or expert witnesses.

Cases the Proceedings team worked on during 2011/12 raised a variety of significant issues, and meaningful outcomes were achieved for consumers. Where appropriate, attempts were made to reach agreement on facts and to negotiate settlements to achieve speedy and efficient resolution of cases.

Table 1: Action taken in respect of referrals to Director of Proceedings in 2011/12

Provider	No. of providers	No further action	DP decision in progress	Proceedings pending	Proceedings concluded	No. of consumers involved
Community support worker	1				1	1
General practitioner	2	1	1			2
Obstetrician	1				1*	1
General surgeon	1	1				1
Midwife	1			1		1
Iridologist	1		1			1
Medical practitioner†	1		1			1
Totals	**8**	**2**	**3**	**1**	**2**	**8**

*Concluded by negotiated agreement without the HRRT being asked to make orders. †General scope of practice, working in a collegial relationship (cosmetic).

CASE STUDY:
Achieving compensation and redress for breach of rights

Two health and disability service providers agreed to pay compensation to the estate of a 43-year-old female consumer unlawfully detained in a secure dementia unit for more than a year. The Human Rights Review Tribunal made declarations against the two providers for failures of care and breaches of the woman's rights.

The consumer (who has since died) had a complex history that included severe psychological trauma, depression and alcohol abuse. Admitted to hospital in May 2007 in a confused state, she was assessed as not having the capacity to make decisions about her own care. It was decided that an application should be made for a court order to place her in an appropriate residential facility. The application was prepared but never filed with the Court.

In August 2007 the consumer was discharged from hospital and placed by a needs assessment and service coordination service (NASC) in a secure dementia unit caring mostly for older people. She understood she was legally required to live there. She was assessed by the NASC three times over the following ten months, and on each occasion she expressed her wish to leave the dementia unit and to live somewhere more suitable.

At various times she clearly expressed her frustration at having to live in the dementia unit, and was recorded as being unhappy and increasingly depressed about her situation. In an email to another clinician in June 2008 one doctor wrote "I would agree with her perspective that where she is, is worse than a prison."

In August 2008 the Community Alcohol and Drug Service discovered there was no court order and therefore no legal requirement for the consumer to remain in the dementia unit if she did not wish to be there. Over the following two months arrangements were made for the consumer's transition and she left the dementia unit in October 2008.

The Director of Proceedings brought claims on behalf of the consumer's estate against the NASC and the operator of the dementia unit in the Human Rights Review Tribunal. The Tribunal made orders by consent of the parties that the NASC had breached the consumer's rights by failing to provide services in a manner that respected her dignity and independence, failing to provide services with reasonable care and skill, and failing to cooperate with other providers to ensure quality and continuity of services. The operator of the dementia unit was also found to have breached her rights by failing to provide services with reasonable care and skill.

The Human Rights Review Tribunal's decision is available at http://www.nzlii.org/nz/cases/NZHRRT/2012/

CASE STUDY:
GP disciplined for repeated failure to follow up signs of serious illness

On 21 December 2011 the Health Practitioners Disciplinary Tribunal issued a decision (428/Med10/170D) in relation to a general practitioner, finding the Director of Proceedings' charge of professional misconduct made out.

The charge arose out of the doctor's care of a patient who subsequently died of bowel cancer, and comprised six "particulars" covering the period from 15 November 2007 to 20 November 2008. Although only one of these particulars was upheld, it concerned the doctor's failure to adequately follow up signs of pathology in his patient. This was the central concern in the case. The expert called by the prosecution described a number of clear warnings which should have alerted the doctor to the need to identify the underlying cause of his patient's symptoms. The doctor failed to (among other things) adequately investigate a marked decrease in his patient's haemoglobin. This was a "red flag" that there was some infective or inflammatory disease process occurring in the body. The Tribunal found that the doctor should have requested an investigative procedure such as gastroscopy or colonoscopy.

For the doctor to have decided instead that what was required was an increase in his patient's intake of iron (he prescribed iron tablets) without seeking to identify the cause of the anaemia was a "significant error of judgment."

The Tribunal found the doctor guilty of professional misconduct, censured him and imposed significant conditions on him should he seek to resume practise. These conditions include: undergoing a psychological assessment before he resumes practice and then undergoing such clinical psychologist treatment and assistance and other rehabilitation steps as are required by the Medical Council; practising in a group practice that must include a vocationally registered medical practitioner; and practising under supervision approved by the Medical Council, with the doctor to meet all attendant costs.

The Tribunal also ordered the doctor to pay costs to the Director of Proceedings and to the Tribunal totalling $106,190.

Statistics

The Director of Proceedings received eight referrals during the year (in relation to eight providers). There was one substantive hearing before the HRRT and that decision is pending. Three HRRT cases were dealt with by the Tribunal "on the papers" with declarations being made without the need for a formal hearing. In each of those cases, other relief claimed by the Director was resolved by negotiated agreement.

One other case was concluded by negotiated agreement without the Tribunal being asked to make any formal orders and is therefore not included in Table 2 below.

Table 2: Outcomes in 2011/12

Provider	Successful	Unsuccessful	Outcome pending	No. of providers	No. of consumers
HPDT					
General practitioner	1			1	1
HRRT					
Massage practitioner			1	1	1
Community support worker	1			1	1
NASC	1			1	1†
Rest home	1			1	1†
Totals	**4**		**1**	**5**	**5**

† One consumer was the subject of a claim against a rest home and a NASC. **Note:** One other case concerning an obstetrician (not shown in the above table) was concluded by negotiated agreement without the HRRT being asked to make orders.

3.4 Education

The HDC and Health and Disability Advocacy Service have an important leadership role in ensuring that there are ongoing systemic improvements in safety and quality in the health and disability sectors. Through education, the HDC and Advocacy Service aim to give providers a clear understanding of their responsibilities, so that they comply willingly with the requirements of the Health and Disability Commissioner Act 1994 and the Code, and ensure that consumers know and are able to exercise their rights under the Act. HDC and the Advocacy Service deliver education and training for large providers, professional bodies and consumer-based organisations.

CASE STUDY:
Consumer complaint leads to positive action and service improvements

The mother of a severely disabled 13-year-old boy made a complaint about the communication processes of a Needs Assessment and Services Coordination (NASC) agency. The mother was primarily concerned about the lack of transparency in communication and also raised issues around:

- the lack of clear information on the types of supports available, and the eligibility criteria
- having to constantly chase the NASC staff for an update
- difficulties in contacting staff.

The desired outcome for the complainant was for the NASC agency to make necessary improvements to benefit all service users of that agency.

The NASC agency was asked to provide a detailed response to the complaint. The response from the agency was positive in the sense that it met with the complainant to get a better understanding of the issues, took necessary steps to resolve the complainants' specific concerns and identified quality improvement steps that would benefit all future service users of the agency. In light of the response, the complaint was closed but the agency was asked to provide an update to the HDC on the measures taken to improve the communication with the service users including:

- an update on the planned website improvements
- an update on the changes to improve "first point of contact" for service users
- details of action taken to address correspondence standards.

The agency provided a timely update on the improvements made in the above areas and also mentioned that, as a result of the improvements, their recent survey of consumer satisfaction with their communication process reported a higher satisfaction rate.

CASE STUDY:
Education for the Bhutanese community

At the invitation of the Bhutanese Refugee Community the local advocate presented an education session on the Code of Rights and the Advocacy Service. This particular group of people had recently arrived in the country after spending many years in refugee camps.

Using a qualified interpreter, the advocate provided the education session requested, paying particular attention to the consumer's right to effective communication, as this is an area that can be a major barrier for this specific category of vulnerable consumers who are new to the county, are not able to speak English and have a low level of self-confidence. The audience was interactive, engaging in discussions and reflections on the various aspects of the Code and Right 5 in particular.

Four consumers, who had previously faced difficulties with their primary healthcare providers, wished to share their experiences. They said that interpreters were not provided in spite of their explicit request when they booked their appointments. The lack of interpreters meant their consultations did not go as well as they could have.

The group was pleased with the information provided, particularly when they were given handouts in their own language. They were pleased to know there is a free independent organisation to support them to have their rights upheld.

Education for providers and the wider health and disability sectors

The HDC provided education sessions to staff in general practices, in line with the requirements of the Cornerstone accreditation programme. Medico-legal sessions were presented to a variety of audiences including as part of a Medical Law Conference, Health Law Intensive programme and Elder Law for the Health Sector Conference. Sessions on the Code for those studying to become health and disability services providers continue to be a regular occurrence in universities and other training institutions. Practitioners undertaking post-graduate study, including medical and nursing practitioners and health services managers and administrators, also requested and received HDC education sessions.

The HDC provides information for the disability community on its website through weekly updates, news and events. The information includes the use of New Zealand Sign Language, useful information for Asian, migrant and refugee communities, and the Māori Disability Action Plan. Numerous presentations are made to consumer groups including the Like Minds Provider Seminar, Wakefield Health GP Conference, New Zealand Home Health Association Conference, New Zealand Medical Students' Association annual conference, the Auckland Disability Providers Network, the Health Quality and Safety Commission inaugural quality forum and the Ngāti Kāpo Biennial Conference.

Consumer advisory group

Consumer Advisors have provided valuable, thought provoking advice and input during the year, which the Commissioner and his staff have been grateful to receive.

The HDC acknowledges the contributions of founding Consumer Advisory Group (CAG) member Barbara Robson (Co-convenor of CAG) as her term on the group came to an end.

Two meetings were held with HDC's CAG. CAG provided advice to the Commissioner on the planning of the 2nd National Disability Conference, an information resource for consumers and providers on the use of Enduring Powers of Attorney and Welfare Guardianship, the transition of new functions in systemic advocacy and monitoring of mental health and addictions services, following the disestablishment of the Mental Health Commission.

CAG also brought a range of issues to the HDC's attention, which included:

- Accessible information for medication around dosage and instructions for taking medication and instruction on how to use self-test kits.
- Changes in definitions to the Privacy Information Sharing Bill and the Health Information Privacy Code and how proposed changes might impact on mental health services consumers.
- Regionalisation of maternity services and its possible impact on the availability of emergency maternity services.
- Welfare reform and the advantages of streamlining assessment processes for supported living payments.
- Complaint processes for consumers who use a support person under an individualised funding model.
- The importance of providing culturally responsive assistance to Pacific peoples caring for family members so the support needs of both the consumer and the carer are addressed.

The HDC undertook follow up, where appropriate, on several of these issues.

The HDC's CAG also provided advice to the Medical Council of New Zealand on its Protocol for Decision-making Principles, its website information for consumers about conditions for practice and its review of Good Medical Practice information that outlines the Council's core expectations of doctors.

Educational resources

The You Have Rights booklet was first produced in 2004 to assist people with learning disabilities in understanding their rights in a format that is accessible to them. The booklet was updated during 2011/12 following feedback from the disability sector. The revised version of the booklet was developed in consultation with the HDC's CAG and People First New Zealand. It replaced the photographs with easy to follow illustrations and includes an additional section on making a complaint.

4.0

Supporting Disabled Consumers

A complaint can help change and improve services, it may help other consumers in similar situations, consumers are more likely to have their needs met.

A total of 105 disability-related complaints were received during 2011/12. The Disability Initiatives Team promotes learning from such complaints. There are important benefits in making a complaint about a health or disability support service. A complaint can help change and improve services, it may help other consumers in similar situations, consumers are more likely to have their needs met, and it can identify bigger issues, like poor systems and policies.

Complaints are about raising concerns, issues, problems or worries or something consumers or their friends or family are not happy with. Raising concerns offers an opportunity for people with disabilities to actively engage in decisions that affect their lives.

CASE STUDY

CASE STUDY:
Lack of honesty and trustworthiness of a disability worker

The police responded to a report from a neighbour that a disabled man, strapped into a wheelchair, had been left unattended in a van. The van, owned by a disability service provider, was parked in the driveway of the home of one of the disability service provider's Community Service Workers (CSW). The CSW was not authorised to use the van to go home, nor to leave a consumer unattended.

It was clear that despite the systems in place to monitor staff use of vehicles, it is difficult to check on staff once they leave the consumer's home. In many cases the consumers are unable to tell anyone if the outing was not conducted according to their personal choice and as written up in the log. The disability service provider had to rely on the honesty and trustworthiness of staff.

The Director of Proceedings decided to issue a proceeding in the Human Rights Review Tribunal. The disability services provider agreed to pay the man $5,000 compensation for humiliation, loss of dignity and injury to feelings, and forms part of orders made by the Human Rights Review Tribunal.

The service provider installed GPS systems in its fleet vehicles to better monitor staff.

(09HDC02149)

Disability related complaints received

The primary issues people complained about have remained similar to previous years. The most common issues are standard of care, communication and the management of facilities. These issues often consist of concerns about:

- Poor communication by providers with consumers and their families – people complained that they were not kept informed about health and care issues affecting themselves or their family member. Complaints were made about the way in which people were communicated with, including verbal abuse, lack of response to enquiries and non-returning of telephone calls.
- Inadequate care and treatment – people complained that personal cares were not performed properly: medication was not administered properly, there were allegations of assault, improper use of restraint, poor equipment assessments and dissatisfaction with assessment results.
- Poor attitude and manner – people complained that they were disrespected, that their personal privacy was not respected, that they experienced a lack of compassion or that they felt threatened.

There were also complaints about access to services and funding of services and several issues about accident compensation processes and decisions were raised and referred as appropriate.

National Disability Conference

The second National Disability Conference was held on 11 June 2012 in Auckland. In line with the HDC's vision of a consumer-centred system, the 2012 conference theme was "Succeeding Together: Fostering a Culture of Consumer Engagement". Successful service outcomes require the knowledge of both the disability provider and the consumer, enabling a collaborative approach. The conference encouraged consumers to be active participants in their care and to work with their providers to achieve shared decision making around their care. More than 350 people attended the conference, including consumers, family members and unpaid carers, representatives of consumer organisations, disability service providers, government agencies, suppliers of disability related products and services, speakers and presenters. Professor Ron McCallum, Chair, United Nations Committee on the Rights or Persons with Disabilities (UNCRPD) was the keynote speaker.

Health Passport

The evaluation phase of the HDC-led initiative of implementing the Health Passport in New Zealand hospitals has been completed. The Health Passport is a document designed to assist nursing, medical and support staff to understand the care, communication and support needs of people with disabilities.

The HDC has received numerous responses from consumers strongly in support of the Health Passport as they consider it will assist them in receiving safe and appropriate health care during a hospital visit. Responses from consumers who have used the passport indicated that:

- it assisted them in having a better overall care experience
- it helped their health care worker to understand their needs
- they were saved the frustration of having to continually explain their health problems, as all their relevant information was written in the Heath Passport
- communication with the health professional was made easier because relevant information had already been written in the Health Passport.

Multi Agency Group (MAG)

The HDC is a member of the MAG, a coalition of agencies that work together to reduce discrimination and promote social inclusion and the rights of people with experience of mental illness and addiction. The group works at a national level to lead change within a holistic view of mental health. In July 2011 MAG published Measuring Social Inclusion – A Baseline Report, which was produced by the Mental Health Commission. The report provides a high-level summary of social inclusion of people with experience of mental distress and/or addiction in New Zealand and provides the basis for the monitoring of social exclusion outcomes. The report has found people with symptoms of mental distress feel less included in society than other New Zealanders at major cost to them and their communities. The work plan for the year included the development of a resource to support and guide social inclusion for people with experience of mental illness and addiction.

Accessibility and responsiveness of HDC's services

HDC provides information for the disability community on its website through weekly updates from the sector. The information offered ranges from an inquiry into the use of New Zealand Sign Language, updates on the Convention Coalition monitoring report, useful information for Asian, migrant and refugee communities, to the Māori Disability Action Plan. Two of HDC's staff are learning New Zealand Sign Language. HDC employed two more disabled people during the last year. A student from Kelston School for the Deaf completed a work experience placement in the HDC office.

5.0

Organisational Performance, Development and Capability

5.1 Leadership

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

The Commissioner leads the organisation with the Executive Leadership Team of two Deputy Commissioners, the Mental Health Commissioner, the Chief Legal Advisor, the Director of Proceedings, the Director of Advocacy, and the Corporate Services Manager.

5.2 Staff

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

5.3 Equal Employment Opportunities

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

The HDC's EEO policy states that the HDC will ensure compliance with the New Zealand Disability Strategy by ensuring all disabled people employed by the Commissioner have the same employment conditions, rights and entitlements as everyone else, and that the Commissioner will give consideration to flexible work hours and the opportunity to work from home to ensure a suitable workplace for people with disabilities.

The HDC is a member of the EEO Trust.

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

5.4 Workplace profile

As at 30 June 2012, the Office of the Health and Disability Commissioner has 51.15 full time equivalent (FTE) staff, as follows:

- 78% females and 22% males
- 43 full-time and 8.15 part-time.

Of the seven senior management positions, four were occupied by females and three by males.

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

Although no data was collected this year on ethnicity or age, the Office benefits from a diverse workforce. For example, the HDC has staff who are Māori, Samoan, Asian, and English, among other ethnicities, and aged between 20 to over 60 years.

5.5 Good employer obligations

1. Leadership, accountability and culture

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

2. Recruitment, selection and induction

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

3. Employee development, promotion and exit

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

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

4. Flexibility and work design

The HDC continues to offer secondments across divisions, working from home options, and flexible work start and finish times.

5. Remuneration, recognition and conditions

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

6. Harassment and bullying prevention

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

7. Safe and healthy environment

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

5.6 Processes and technology

Sustainability

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

Technology

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

5.7 Physical assets and structures

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

6.0

Statement of service performance

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

- The Commissioner assesses and resolves complaints, including via formal investigations.
- The Commissioner responds to enquiries.
- 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.
- 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 independent Director of Proceedings initiates proceedings against providers.

HDC carries out the above activities through four output classes: Complaints Resolution; Advocacy; Proceedings; and Education.

6.1 Output Class 1: Complaints resolution

Performance and measures	Achievement
Output 1 – Every complaint is addressed promptly and impartially using the most appropriate option under the HDC Act 1994.	
Complaints are closed within reasonable timeframes Estimated Annual Volume: Estimated 1,400 complaints received. Estimated Resolution Times: 1. 80% closed within 6 months. 2. 95% closed within 12 months. 3. 99% closed within 2 years.	**Targets achieved** 1,564 complaints were received – this represents 112% of the annual estimated volume. **Targets substantially achieved** 1. 80% (1,102 of 1,380) closed within 6 months. 2. 93% (1,290 of 1,380) closed within 12 months. 3. 98% (1,350 of 1,380) closed within 2 years. HDC received 11.3% more complaints than the previous year.
Output 2 – Where quality and safety issues are identified, changes are recommended. Recommendations are followed up to ensure improvements have occurred.	
Providers made service improvements based on HDC recommendations A random sample of providers who have reported that they have complied with HDC recommendations between 1 July 2011 and 30 June 2012 will be audited to verify compliance. 99% of the random sample will be found to have complied.	**Target achieved** 100% (6 of 6) providers subject to recommendations at the conclusion of the investigation process had their compliance with HDC recommendations reviewed. The six providers were reviewed for compliance; five fully met the compliance and one still has to provide more information to fully meet the compliance (partial compliance to date).

6.2 Output Class 2: Advocacy

Performance and measures	Achievement
Output 1 – Complaints to advocates are addressed promptly and resolved in a timely manner.	
Complaints are closed within reasonable timeframes Estimated Annual Volume: Estimated 3,800 complaints received. Estimated Resolution Times: 1. 85% closed within 3 months. 2. 95% closed within 6 months. 3. 100% closed within 9 months.	**Targets achieved** 3,025 new complaints were received. When the 384 open complaints carried over from the last reporting year are added to this, the YTD complaints managed total is 3,409. The YTD total complaints closed is 3,089. **Targets substantially achieved** 1. 87% (2676 of 3089) closed within 3 months. 2. 99% (3061 of 3089) closed within 6 months. 3. 100% (3086 of 3089) closed within 9 months.
Complaints managed reach resolution 90% of complaints closed by advocacy are partially or fully resolved.	**Targets achieved** 90% (2780 of 3089) of complaints closed by advocacy are partially or fully resolved.
Consumers and providers are satisfied with the service and the skills of the advocate Surveys of consumers and providers who have used/dealt with the advocacy service will report that 80% of the respondents are satisfied with the service and the skills of the advocate.	**Targets achieved** Surveys are provided to consumers and providers on a monthly basis. The results for the first half of the year show that 85% of providers and 91% of consumers are satisfied with the advocacy service. The results for the second half of the year show that 85% of providers and 92% of consumers are satisfied with the advocacy service.
Complaints managed reach resolution 90% of complaints closed by advocacy are partially or fully resolved.	**Targets achieved** 90% (2780 of 3089) of complaints closed by advocacy are partially or fully resolved.
Output 2 – Advocacy will establish and maintain contact with consumers and providers within the local community.	
Vulnerable consumers (in rest homes and disability homes) have access to advocacy through regular contact 1. Advocates to have two contacts with 60% of rest homes by 30 June 2012. 2. Advocates to have two contacts with 60% of disability homes by 30 June 2012.	**Target achieved** 100% (679 of 680) of rest homes have had one contact by an advocate and 74% (506 of 680) have had two contacts. 100% (957 of 961) of disability homes have had one contact by an advocate and 68% (657 of 961) have had two contacts.
Consumer and provider networks have regular contacts from the advocates Advocates to have 3,000 network contacts with consumers and providers.	**Target achieved** 4,189 network contacts with consumers and providers were made by the advocates – this represents 139.6% of the annual target.

Performance and measures	Achievement
Output 3 – Advocacy will provide education and training sessions to consumers and providers on the Code of Rights and encourage providers to view complaints as opportunities for learning.	
Consumers and providers are satisfied with education sessions 1. 2,000 education sessions provided by 30 June 2012. 2. 80% of the "provider" respondents report satisfaction with the education session. 3. 80% of the "consumer" respondents report increased awareness of their rights.	**Targets achieved** 2,117 education sessions were provided – this represents 106% of the annual estimated volume. 90% of consumers and 91% of providers were satisfied with the education services provided by advocates during the second half of the year.
Ongoing education is provided through Great Care Stories 180 case studies/stories of Great Care published by 30 June 2012.	**Targets achieved** 180 case studies/stories of Great Care were collected and published – this represents 100% of the annual target.

6.3 Output Class 3: Proceedings

Performance and measures	Achievement
Output 1 – Proceedings are taken in appropriate cases.	
Professional misconduct is found in disciplinary proceedings Professional misconduct is found in 75% of disciplinary proceedings.	**Targets achieved** Professional misconduct was found in 100% (1 of 1) disciplinary proceedings.
Breach of the Code is found in HRRT proceedings A breach of the Code is found in 75% of HRRT proceedings.	**Targets achieved** A breach of the Code was found in 100% (3 of 3) HRRT proceedings. Comments: Awaiting decision in one other HRRT proceeding.
An award is made where damages sought An award of damages is made in 75% of cases where damages are sought.	**Targets achieved** An award of damages was made in 100% (1 of 1) cases where damages were sought. As mentioned above, awaiting decision in one other HRRT proceeding in which damages were sought. There were also confidential settlements in three other cases.

6.4 Output Class 4: Education

Performance and measures	Achievement
Output 1 – Provide up-to-date, accessible and informative educational materials for consumers and providers.	
New informative resources for consumers and providers are added to the Education section of the HDC's website Two new informative educational resources are produced by 30 June 2012.	**Targets achieved** Two new informative educational resources titled Getting the best from your doctor (a booklet for consumers) and You have rights (an easy-read version of the Code of Rights) were produced during 2011/12.
Material on the HDC's Education section of the website is accessible to people who use "accessible" software 70% of educational materials are available in HTML and/or Word formats on the HDC's website.	**Targets achieved** 85% of educational materials are available in HTML and/or Word formats on the HDC's website.
Material on the HDC's Education section of the website is available in plain English 15% of educational materials are available in "Plain English" format by 30 June 2012.	**Targets achieved** 15% of educational materials on the education section of the website are available in "Plain English" as at 30 June 2012.
Output 2 – Provide informative reports on the work of the Commissioner to key provider groups.	
DHBs find complaints trend reports useful for improving services 1. Six-monthly HDC complaint trend reports are sent to all DHBs. 2. 95% of DHBs responding to the reports rate them as useful for improving the safety and quality of their services.	**Targets achieved** DHB Reports for July to December 2011 were sent to 20 DHBs on 2 April. For this report, 100% of DHBs responded and rated them useful or very useful for improving their services.
Output 3 – Develop educational initiatives specifically for disability groups.	
Encourage the implementation of the Health Passport nationally in all DHBs – Health Passports assists health professionals' understanding of patient needs, and improves care experience of consumers Liaise with and assist 3 District Health Boards to implement the Health Passport. All consumers and professionals who use the passport will have access to complete an evaluation. 1. 80% of the "professional" respondents report that the passport assisted their understanding of patient needs. 2. 80% of the "consumer" respondents report that the passport assisted them in having a better overall care experience.	**Target achieved** A total of four DHB's have agreed to implement the Health Passport: Northland, Whanganui, South Canterbury and Auckland. Small response to survey but 100% of consumers who answered the relevant questions reported that the Health Passport assisted them in having a better overall care experience. A survey of 49 people with disabilities yielded responses from 5 people whose providers had read their Health Passport, 80% of whom reported that it had helped their healthcare worker to understand their needs.

Performance and measures	Achievement
Organise annual National Disability Conference – National Disability Conference programme meets participants' expectations All conference participants will be invited to complete an evaluation and 80% of the respondents report that the information received during the conference met their expectations and providers.	**Target achieved** The 2nd National Disability Conference was held on 11 June 2012 in Auckland. 86% of the respondents who completed an evaluation form reported that the information received at the conference "mostly met," "met" or "exceeded" their expectations.
Output 4 – Provide effective, informative seminars and educational presentations and training programmes on the work of HDC on the Act and Code.	
Educational presentations meet requesters' expectations 1. Provide 25 educational presentations by 30 June 2012. 2. 96% of people who requested the presentations report that the presentation met their expectations.	**Targets achieved** 53 educational presentations were made – this represents 212% of the annual estimated volume. 48 of 53 educational presentations have received feedback. 100% (48 of 48) of the requestors who provided feedback reported that the presentation met or exceeded their expectations.
Intensive training programmes meet participants' expectations 1. Provide two intensive provider education programmes by 30 June 2012. 2. 90% of participants report that they are satisfied with the content and delivery of the programme.	**Targets achieved** Three intensive provider education programmes were provided. 97% (66 of 68) participants reported that they were satisfied with the content and delivery of the programmes.
Output 5 – Develop initiatives to improve the quality of the disability workforce.	
Encourage use of Work Safe Card by disability service provides across the country for employing support workers – Work Safe Card assists disability service providers in ascertaining suitability of the support workers for working with disabled people Preliminary consultation work with disabled consumers and disability service providers will be undertaken to develop a new initiative entitled "Work Safe Card." This initiative is designed to issue people working with, or wanting to work with, disabled people with a Work Safe Card if they meet a certain safety and suitability criteria (e.g., no previous criminal record or no prior employment history of serious misconduct, etc).	**Target achieved** Preliminary consultation work with consumers with disabilities has been completed. One further phase of assessment will be undertaken before deciding whether or not to progress this initiative.
Output 6 – Provide high quality submissions addressing matters that affect the rights of health and disability services consumers.	
Recipient agencies are satisfied with the quality of HDC's submissions 1. A survey of people receiving submissions from HDC will be undertaken. 2. 95% of respondents rate that they are satisfied with the quality of HDC's submissions.	**Targets achieved** 17 submissions were made. Feedback forms were received in relation to eight of 17 submissions. 100% (8 of 8) respondents rated that they were satisfied with the quality of HDC's submissions.

7.0

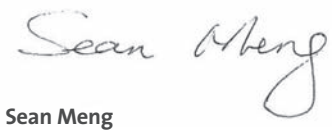
Statement of Responsibility

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

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

In the Health and Disability Commissioner's opinion, these financial statements and statement of service performance fairly reflect the financial position and operation of the Health and Disability Commissioner for the year ended 30 June 2012.

Anthony Hill
Health and Disability Commissioner



Sean Meng
Corporate Services Manager

31 October 2012

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Audit Report

Independent auditor's report

To the readers of Health and Disability Commissioner's financial statements and statement of service performance for the year ended 30 June 2012

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

We have audited:

- the financial statements of the Health and Disability Commissioner on pages 44 to 68, which comprise the statement of financial position as at 30 June 2012, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and notes to the financial statements that include accounting policies and other explanatory information
- the statement of service performance of the Health and Disability Commissioner on pages 36 to 40.

Opinion

In our opinion:

- the financial statements of the Health and Disability Commissioner on pages 44 to 68:
  - comply with generally accepted accounting practice in New Zealand
  - fairly reflect the Health and Disability Commissioner's:
    - financial position as at 30 June 2012
    - financial performance and cash flows for the year ended on that date.
- the statement of service performance of the Health and Disability Commissioner on pages 36 to 40:
  - complies with generally accepted accounting practice in New Zealand
  - fairly reflects, for each class of outputs for the year ended 30 June 2012, the Health and Disability Commissioner's:
    - service performance compared with the forecasts in the statement of forecast service performance for the financial year
    - actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2012. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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.

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

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied
- the reasonableness of the significant accounting estimates and judgements made by the Health and Disability Commissioner
- the adequacy of all disclosures in the financial statements and statement of service performance
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Health and Disability Commissioner

The Health and Disability Commissioner is responsible for preparing financial statements and a statement of service performance that:

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

The Health and Disability Commissioner is also responsible for such internal control as is determined necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

The Health and Disability Commissioner's responsibilities arise from the Crown Entities Act 2004 and section 15 of the Public Audit Act 2001.

Responsibilities of the Auditor

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

Independence

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

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

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

9.0

Financial statements

STATEMENT OF COMPREHENSIVE INCOME for the year ended 30 June 2012

	Note	Actual 2012 $	Budget 2012 $	Actual 2011 $
Income				
Revenue from Crown	2	9,464,000	9,170,000	9,170,000
Interest income		95,659	60,000	100,408
Other income	3	85,187	90,000	85,782
Total income		9,644,846	9,320,000	9,356,190
Expenditure				
Personnel costs	4	4,221,004	4,277,119	3,865,631
Depreciation and amortisation expense	9, 10	168,581	251,941	222,989
Advocacy services		3,569,986	3,595,998	3,540,198
Other expenses	5	1,807,911	1,908,622	1,605,517
Total expenditure		9,767,482	10,033,680	9,234,335
Net deficit for the year		(122,636)	(713,680)	121,855
Total comprehensive income for the year		(122,636)	(713,680)	121,855

The accompanying notes form part of these financial statements

STATEMENT OF FINANCIAL POSITION as at 30 June 2012

	Note	Actual 2012 $	Budget 2012 $	Actual 2011 $
Assets				
Current assets				
Cash and cash equivalents	6	1,636,227	645,966	1,656,353
Debtors and other receivables	7	39,764	26,000	262,632
Prepayments		350,881	54,000	53,639
Inventories	8	24,294	30,000	20,034
Total current assets		2,051,166	755,966	1,992,658
Non-current assets				
Property, plant and equipment	9	74,192	404,383	189,868
Intangible assets	10	28,770	39,442	66,683
Total non-current assets		102,962	443,825	256,551
Total assets		2,154,128	1,199,791	2,249,209
Liabilities				
Current liabilities				
Creditors and other payables	11	518,094	408,000	448,938
Employee entitlements	12	145,667	148,000	150,055
Total current liabilities		663,761	556,000	598,993
Non current liabilities				
Lease incentive	13	148,854	0	186,067
Total non current liabilities		148,854	0	186,067
Total liabilities		812,615	556,000	785,060
Net assets		1,341,513	643,791	1,464,149
Equity				
General funds	14	1,341,513	643,791	1,464,149
Total equity		1,341,513	643,791	1,464,149

The accompanying notes form part of these financial statements

STATEMENT OF CHANGES IN EQUITY for the year ended 30 June 2012

	Actual	Budget	Actual
	2012	2012	2011
	$	$	$
Balance at 1 July	1,464,149	1,357,471	1,342,294
Amounts recognised directly in equity:			
Total comprehensive income	(122,636)	(713,680)	121,855
Total net recognised revenues and expenses	1,341,513	643,791	1,464,149
Balance at 30 June	1,341,513	643,791	1,464,149

The accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS for the year ended 30 June 2012

	Note	Actual 2012 $	Budget 2012 $	Actual 2011 $
Cash flow from operating activities				
Current assets				
Receipts from Crown revenue		9,464,000	9,170,000	9,170,000
Interest received		99,482	60,000	102,328
Receipts from other revenue		238,449	90,000	68,458
Payments to suppliers		(5,553,652)	(5,480,000)	(5,123,540)
Payments to employees		(4,225,392)	(4,277,119)	(3,859,599)
Goods and services tax (net)		24,196	0	1,304
Net cash from operating activities	15	47,083	(437,119)	358,951
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		0	0	1,631
Purchase of property, plant and equipment		(33,377)	(200,000)	(31,256)
Purchase of intangible assets		(33,832)	(170,000)	(60,207)
Net cash from investing activities		(67,209)	(370,000)	(89,832)
Net increase (decrease) in cash and cash equivalents		(20,126)	(807,119)	(269,119)
Cash and cash equivalents at beginning of year		1,656,353	1,453,085	1,387,234
Cash and cash equivalents at end of year		1,636,227	645,966	1,656,353

The accompanying notes form part of these financial statements

NOTES TO THE FINANCIAL STATEMENTS

for the year ended 30 June 2012

1. Statement of accounting policies for the year ended 30 June 2012

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 2012, and were approved by the Commissioner on 31 October 2012.

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.

Changes in accounting policies

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

HDC has adopted the following revisions to the accounting standards during the financial year, which have had only a presentational or disclosure effect:

Amendments to NZ IAS 1 Presentation of Financial Statements. The amendments introduce a requirement to present, either in the statement of changes in equity or the notes, for each component of equity, an analysis of other comprehensive income by item. The HDC has no other comprehensive income.

FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments). The purpose of the new standard and amendments is to harmonise Australian and New Zealand accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The main effect of the amendments on the HDC is that certain information about property valuations is no longer required to be disclosed.

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

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following three main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, HDC is classified as a "Category C" reporting entity, and it will be required to apply corresponding Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the HDC expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the HDC is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Significant accounting policies

Revenue

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

Revenue from the Crown

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

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

Interest

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

Sale of publications

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

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

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

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

Property, plant and equipment

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

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

Additions

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

Disability Commissioner and the cost of the item can be measured reliably.

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

Disposals

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

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%)

Furniture and fittings
5 years (20%)

Office equipment
5 years (20%)

Motor vehicles
5 years (20%)

Computer hardware
4 years (25%)

Communication equipment
4 years (25%)

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

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

Intangible assets

Software acquisition and development

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

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

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

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is 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%

Capitalisation threshold

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

Impairment of non-financial assets

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

Value in use is the 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. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Creditors and other payables

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of creditors and other payables approximates their 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 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 Disability 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 2012:

Lease classification

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

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

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

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

2. Revenue from the 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 (2011 nil).

3. Other income

	Actual 2012 $	Actual 2011 $
Sale of publications	85,187	85,782
Total other revenue	85,187	85,782

4. Personnel costs

	Actual 2012 $	Actual 2011 $
Salaries and wages	4,198,687	3,822,086
Employer contributions to defined contribution plans	26,705	37,513
Increase/(decrease) in employee entitlements (note 12)	(4,388)	6,032
Total personnel costs	4,221,004	3,865,631

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

5. Other expenses

	Actual 2012 $	Actual 2011 $
Fees to auditor:		
Audit fees for financial statement audit	34,320	33,520
Staff travel and accommodation	129,429	108,295
Operating lease expense	382,074	525,634
Advertising	30,385	39,072
Consultancy	328,235	241,048
Inventories consumed	94,821	72,812
Net loss on property, plant and equipment	52,217	1,025
Other	756,430	584,111
Total other expenses	1,807,911	1,605,517

6. Cash and cash equivalents

	Actual 2012 $	Actual 2011 $
Cash on hand and at bank	636,227	26,353
Cash equivalents – term deposits	1,000,000	1,630,000
Total cash and cash equivalents	1,636,227	1,656,353

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 3.8% (2011: 3.9%).

7. Debtors and other receivables

	Actual 2012 $	Actual 2011 $
Trade receivables	35,330	254,375
Other receivables	4,434	8,257
Less provision for impairment	0	0
Total debtors and other receivables	39,764	262,632

The carrying value of receivables approximates their fair value.

The ageing profile of receivables at year end is detailed below. All receivables greater than 30 days in age are considered to be past due. As at June 2012 and 2011, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2012 $	2011 $
Not past due	18,710	253,059
Past due 1–30 days	5,501	7,762
Past due 31–60 days	2,830	794
Past due 61–90 days	3,856	1,017
Past due > 91 days	5,699	0
Total	36,596	262,632

8. Inventories

	Actual 2012 $	Actual 2011 $
Publications held for sale	24,294	20,034
Inventories	24,294	20,034

The carrying amount of inventories held for distribution that are measured at current replacement costs as at 30 June 2012 amounted to $24,294 (2011: $20,034).

9. Property, plant and equipment

Movements for each class of property, plant and equipment as at 30 June 2012 are as follows:

Cost	Comp hardware	Comms equip	Furn and fittings	Leasehold improvements	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 2011	840,625	28,410	204,499	675,711	40,889	192,482	1,982,616
Additions during year	7,972	0	4,478	17,140	0	2,588	32,178
Expensed during year	(96,758)	(1,687)	(14,252)	(1,705)	0	(21,884)	(136,286)
Balance at 30 June 2012	751,839	26,723	194,725	691,146	40,889	173,186	1,878,508
Accumulated depreciation							
Balance at 1 July 2011	714,759	27,145	193,474	665,272	17,719	174,380	1,792,749
Charge for year	72,139	316	3,371	6,551	8,178	6,281	96,836
Disposals	0	0	0	0	0	(5,795)	(5,795)
Depn recovered	(63,072)	(738)	(7,271)	(688)	0	(7,705)	(79,474)
Balance at 30 June 2012	723,826	26,723	189,574	671,135	25,897	167,161	1,804,316
Net book value 30 June 2012	28,013	0	5,151	20,011	14,992	6,024	74,192

Cost	Comp hardware	Comms equip	Furn and fittings	Leasehold improvements	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 2010	830,338	26,723	199,918	672,057	40,889	185,615	1,955,540
Additions during year	13,218	1,687	4,581	3,654	0	8,116	31,256
Disposals during year	(2,931)	0	0	0	0	(1,249)	(4,180)
Balance at 30 June 2011	840,625	28,410	204,499	675,711	40,889	192,482	1,982,616
Accumulated depreciation							
Balance at 1 July 2010	618,128	26,723	189,214	654,514	9,541	165,679	1,663,799
Charge for year	96,906	422	4,260	10,758	8,178	9,950	130,474
Disposals	(275)	0	0	0	0	(1,249)	(1,524)
Balance at 30 June 2011	714,759	27,145	193,474	665,272	17,719	174,380	1,792,749
Net book value 30 June 2011	125,866	1,265	11,025	10,439	23,170	18,103	189,868

In the year ended 30 June 2012, HDC decided to increase its capitalisation threshold to $1,000 from $200 in order to be consistent with other government entities. As a result, all pre-purchased assets with cost lower than $1,000 are written off in the 2011/12 Financial Year, totalling $51,000.

10. Intangible assets

Movements in intangibles as at 30 June 2012 are as follows:

	Actual 2012 $	Actual 2011 $
Computer software		
Balance at 1 July	1,038,656	978,449
Additions during the year	35,138	60,207
Disposals during the year	(14,363)	0
Balance at 30 June	1,059,431	1,038,656
Accumulated amortisation		
Balance at 1 July	971,973	879,458
Charge for the year	71,744	92,515
Disposals	0	0
Depn recovered	(13,056)	0
Balance at 30 June	1,030,661	971,973
Net book value at 30 June	28,770	66,683

All intangibles are 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 2012 $	Actual 2011 $
Creditors	239,353	165,680
Income in advance	0	5,258
Accrued expenses	41,040	68,802
Provisions	117,769	0
Lease incentive	37,213	37,213
Other payables	82,719	171,985
Total creditors and other payables	518,094	448,938

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.

HDC approved a detailed and formal office space allocation review, which was commenced in June 2012, including as a consequence of additional staff required to carry out mental health and addiction functions. The review and any associated payments are expected to be completed by March 2013. The provision represents the estimated cost for the reallocation of office space and potential associated costs.

12. Employee entitlements

	Actual 2012 $	Actual 2011 $
Current employee entitlements are represented by:		
Annual leave	144,473	148,315
Retirement and long service leave	1,194	1,740
Total current portion	145,667	150,055
Total employee entitlements	145,667	150,055

13. Non current liability

	Actual 2012 $	Actual 2011 $
Lease incentive liability	148,854	186,067
Total non current liability at 30 June	148,854	186,067

Lease incentive relating to Auckland office at Level 10, 45 Queen Street for period 1 July 2012 to 9 June 2017.

14. Equity

	Actual 2012 $	Actual 2011 $
General funds		
Balance at 1 July	1,464,149	1,342,294
Total comprehensive income for the year	(122,636)	121,855
Total equity at 30 June	1,341,513	1,464,149

15. Reconciliation of net deficit to net cash from operating activities

	Actual 2012 $	Actual 2011 $
Total comprehensive income	(122,636)	121,855
Add/(less) non-cash items:		
Depreciation and amortisation expense	168,581	222,989
Total non-cash items	45,945	344,844
Add/(less) items classified as investing or financing activities		
Impairment of property, plant and equipment	52,217	1,024
Total items classified as investing or financing activities	52,217	1,024
Add/(less) movements in working capital items		
Debtors and other receivables	(140,158)	(10,946)
Inventories	(4,260)	8,138
Creditors and other payables	97,727	9,859
Employee entitlements	(4,388)	6,032
Net movements in working capital items	(51,080)	13,083
Net cash from operating activities	47,083	358,951

16. Commitments and operating leases

Advocacy Service contracts

The maximum commitment for the 12 months from 1 July 2012 is $3,595,998 (2011: $3,539,998).

Operating leases as lessee

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

	Actual 2012 $	Actual 2011 $
Not later than one year	365,628	389,659
Later than one year and not later than five years	1,091,432	1,272,363
Later than five years	0	223,280
Total non-cancellable operating leases	1,457,060	1,885,302

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 office lease has been renewed with a new lease expiry date in June 2017 and the Wellington lease expires in April 2015.

17. Contingencies

Contingent liabilities

As at 30 June 2012 there were no contingent liabilities (2011 $Nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2011 $Nil).

18. Related party transactions and key management personnel

Related party transactions

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

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

The Health and Disability Commissioner has been provided with funding from the Crown of deemed $9.170m plus an additional $294k one-off funding (2011 $9.170m) for specific purposes as set out in its founding legislation and the scope of the relevant government appropriations.

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

The Health and Disability Commissioner also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown.

Purchases from these government-related entities for the year ended 30 June 2012 totalled $0.1m (2011 $0.1 m). These purchases included the purchase of electricity from Meridian, air travel from Air New Zealand, and postal services from New Zealand Post.

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 2012 $	Actual 2011 $
Salaries and other short-term employee benefits	1,094,740	899,313
Post-employment benefits	33,942	33,247
Other long-term benefits	0	0
Termination benefits	0	0
Total key management personnel compensation	1,128,682	932,560

Key management personnel include the seven Executive Leadership Team members.

19. Employee remuneration

Total remuneration paid or payable

	Actual 2012	Actual 2011
110,000–119,999	0	1
120,000–129,999	1	1
150,000–159,999	2	1
170,000–179,999	1	0
180,000–189,999	1	1
260,000–269,999	0	1
270,000–279,999	1	0
Total employees	6	5

During the year ended 30 June 2012, no employees received compensation and other benefits in relation to cessation (2011: $nil).

19a. Commissioner's total remuneration

In accordance with the disclosure requirements of section 152(1)(a) of the Crown Entities Act 2004, the total remuneration includes all benefits paid during the period 1 July 2011 to 30 June 2012.

	Actual 2012	Actual 2011
Commissioner	**$277,915**	**$264,193**

The current Commissioner took office on 19 July 2010

20. Significant events after the balance date

On 28 July 2011, the Cabinet decided to disestablish the Mental Health Commission and transfer its functions to the Health and Disability Commissioner. This transfer will take effect from 1st July 2012.

There were no other significant events after the balance date.

21. Categories of financial assets and liabilities

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

	Actual 2012 $	Actual 2011 $
Loans and receivables:		
Cash and cash equivalents	1,636,227	1,656,353
Debtors and other receivables	36,596	262,632
Total loans and receivables	1,672,823	1,918,985
Financial liabilities measured at amortised cost:		
Creditors and other payables	518,094	448,938
Total financial liabilities measured at amortised cost	518,094	448,938

22. Financial instrument risks

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

Market risk

Fair value interest rate risk

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

The average interest rate on the Health and Disability Commissioner's term deposits is 3.8% (2011: 3.9%).

Cash flow interest rate risk

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

Credit risk

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

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

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

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

Liquidity risk

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

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

Sensitivity analysis

As at 30 June 2012, if the deposit rate had been 50 basis points higher or lower, with all other variables held constant, the surplus/deficit for the year would have been $5,000 (2011: $8,150) higher/lower.

This movement is attributable to increased or decreased interest expense on the cash deposits.

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

	Less than 6 months	Between 6 months and 1 year	Between 1 and 5 years
	$	$	$
2012			
Creditors & other payables – carrying amount (note 11)	518,094	0	0
Creditors & other payables – contracted cashflows (note 11)	518,094	0	0
2011			
Creditors & other payables – carrying amount (note 11)	448,938	0	0
Creditors & other payables – contracted cashflows	448,938	0	0

23. Capital management

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

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

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

24. Explanation of significant variances

Statement of comprehensive income

The HDC consumed 2.5% fewer costs than budgeted. $253,000 was saved on budget. This saving was spread over a number of areas including staff (one fewer senior management position for most of the year), depreciation (due to less capital expenditure) and operating costs (including lower systems consultancy and lower external legal advice).

Statement of financial position

The lower than budgeted deficit per the Statement of Comprehensive Income gives the HDC a better cash position. This is also attributed to $294,000 one-off extra funding provided to support the integration of the Mental Health Commission.

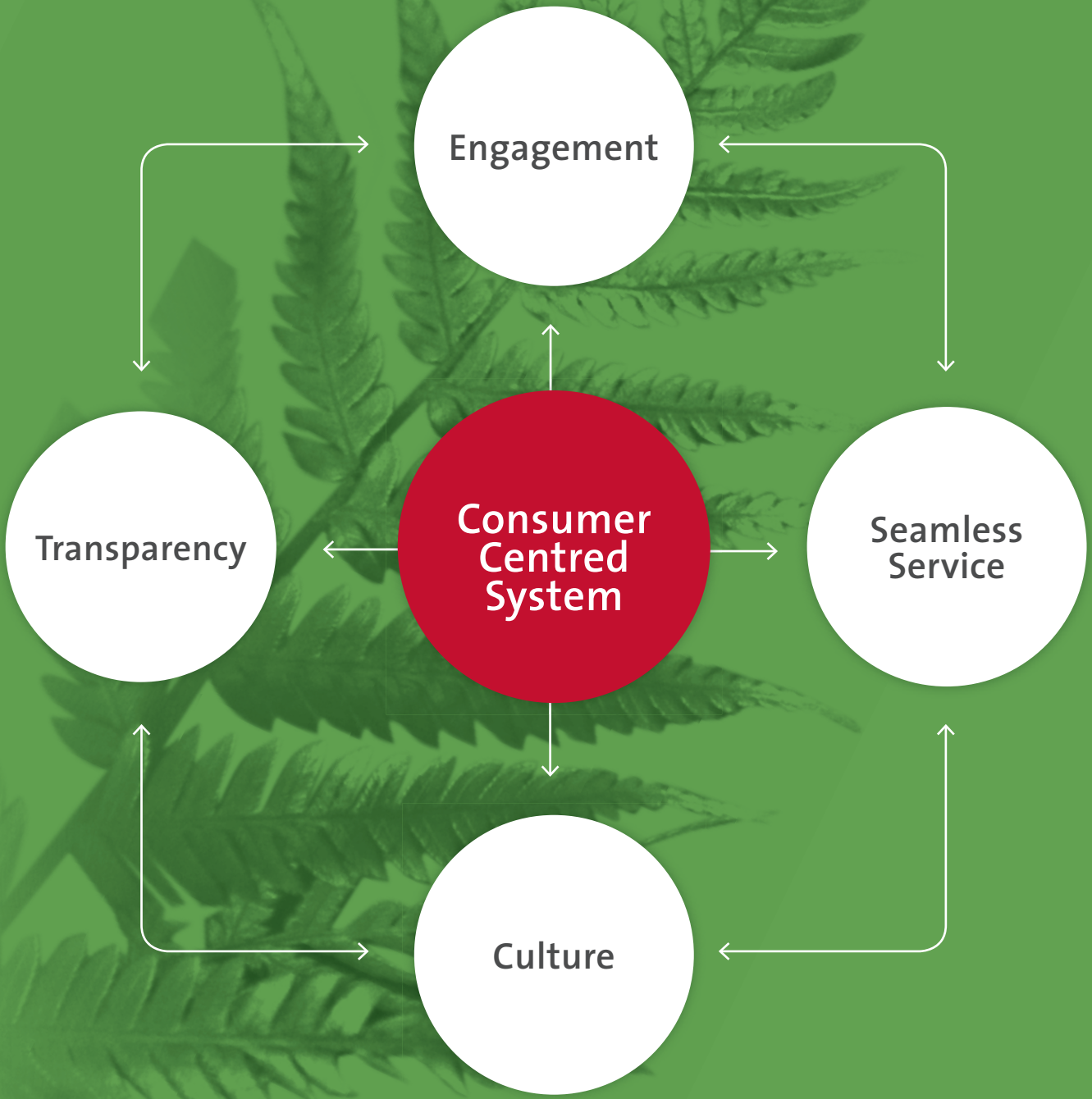
Prepayments include $295,000 GST exclusive relating to the Advocacy Service Contract, which is scheduled on the 1st of each month. As 1 July 2012 falls on a weekend, the payment was made before 30 June 2012.

Statement of changes in equity

As a direct consequence of the lower deficit, The HDC's reserves are higher than budget.

Statement of cash flows

The lower deficit translated directly to "cash from operating activities" being $45,000 in surplus vs. a $439,000 budgeted deficit. In addition, "cash from investing activities" was lower than budgeted with fewer assets purchased than budgeted.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