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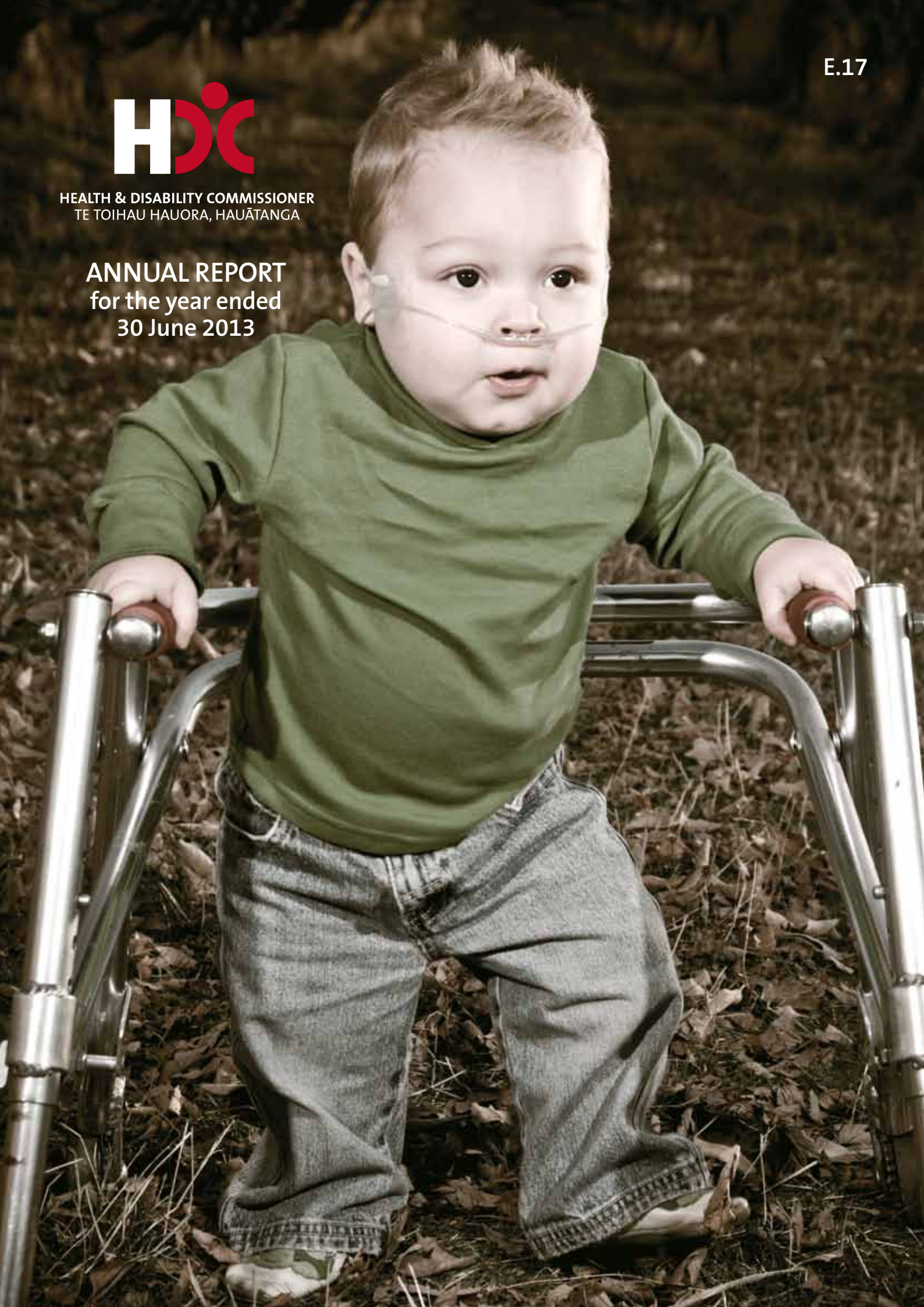
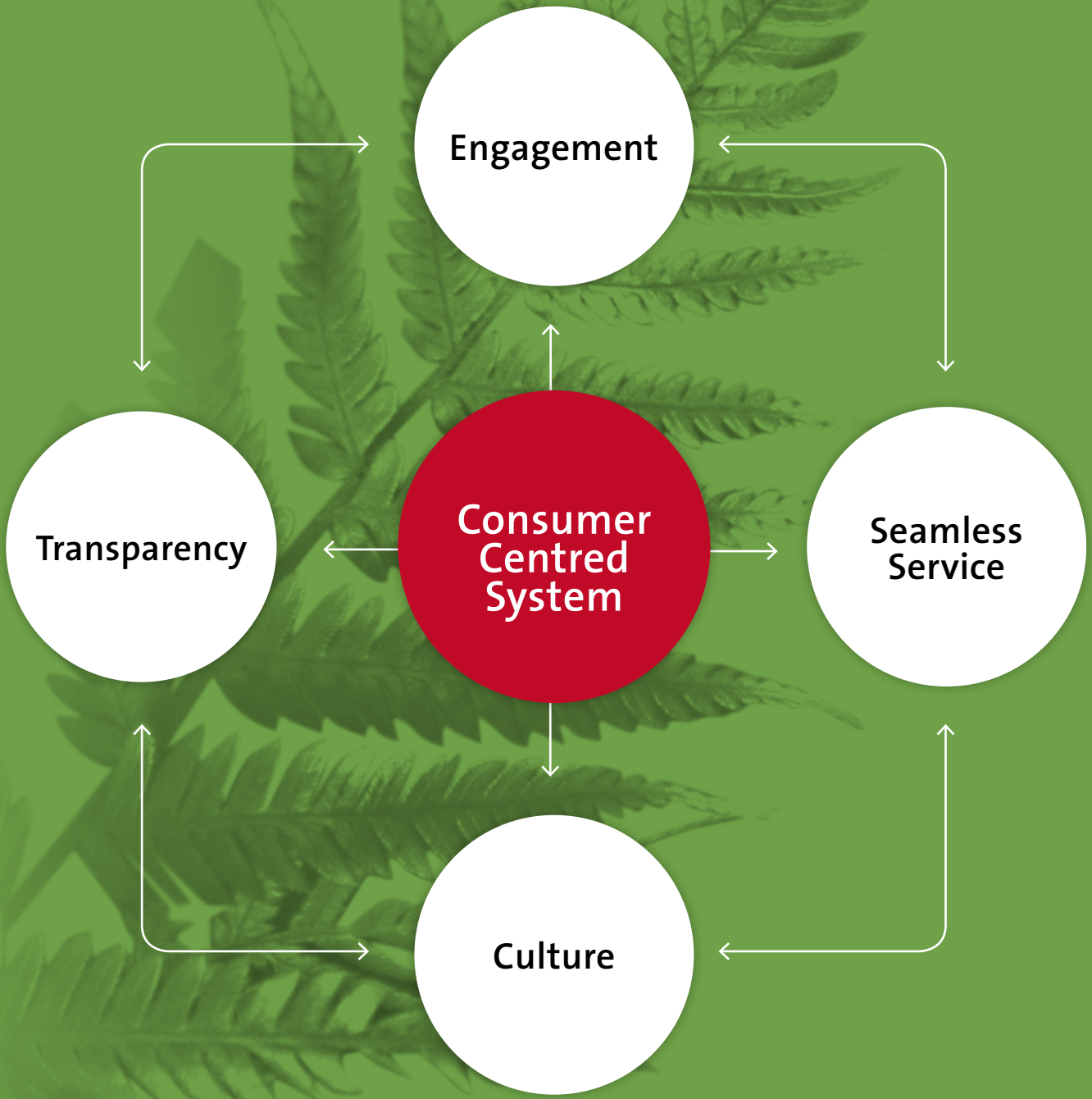
HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

ANNUAL REPORT
for the year ended
30 June 2013




Engagement
Transparency
Consumer Centred System
Seamless Service
Culture

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

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PO Box 1791, Auckland 1140

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

31 October 2013

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, 2013.

Yours faithfully

Anthony Hill
Health and Disability Commissioner

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1.0 Commissioner's foreword

Anthony Hill
Health and Disability Commissioner

Complaints matter. They are part of the conversation and reflect the experience consumers have with health and disability services. They reflect our humanity, and thus contain elements that speak of the joy, the pathos and sometimes the tragedy of life itself.

Complaints change things. They can reflect small steps, and big ideas. In the 2012/13 financial year the Health and Disability Commissioner received and closed more complaints than ever before in the history of the organisation. Those complaints traversed a wide range of issues from appointments delayed, to diagnoses delayed or missed, to poor communication, to the death of a loved one. It has been pleasing to see providers respond positively to complaints and make significant changes in response to them.

Complaints are an opportunity to learn. The journeys of many consumers with whom we have engaged this year have resulted in a myriad of changes and improvements in our system. Some of that change is reflected in this report. Through complaints, adverse events in a consumer's life can be given meaning and hope where a well held conversation offers explanation, provides an apology, accepts responsibility, and points to change which will avoid repetition. Many consumers care deeply that they have contributed to improvements in the system that may prevent harm to others. Appropriate accountability is also a part of that conversation. The consumer voice in bringing change is a powerful one.

Consumers at the centre of services

The HDC's vision is 'consumers at the centre of services.' We remain focussed on the dimensions of transparency, engagement, seamless service and a culture that supports the delivery of those dimensions.

Culture

As the third Health and Disability Commissioner, my priority is clear – it is to continue to move the culture of the health and disability sectors a few degrees closer to the true expression of consumers at the centre of services. There remain cases where harm occurs because someone was embarrassed to seek help, or afraid to speak up, or not listened to when they did. Teams must work effectively to deliver safe care in what can be a complex and pressured environment.

In a year when the Mid Staffordshire NHS Foundation Trust Public Inquiry report was issued in England to be followed by the Berwick report (A promise to learn – a commitment to Act, Improving the Safety of Patients in England), much thought continues to be given to culture and the way in which it is expressed in our institutions and systems. Culture has been the enduring theme in every significant international inquiry for the last quarter of a century including, in New Zealand, the Cartwright Inquiry itself. As was said (yet again) by Robert Francis QC in his report on Mid Staffordshire, culture trumps strategy:

"In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer... [system]... will depend far more on major cultural change than on a new regulatory regime."

Complaints and change

Complaints change things. A number of significant cases were investigated and reported on in the last year by this Office. A case involving a patient with Huntington's Disease reinforced the need for professional boundaries, effective family and patient engagement, and connections between services. The Commissioner Initiated Inquiry into the use of ketamine for patients suffering from treatment resistant depression recognised the need to ensure a safe, consistent, and appropriate approach to experimental treatment, including formalised guidance for off-label and innovative prescribing. It is important that innovation is able to flourish in the health and disability sectors. However, it is even more important that consumers are fully engaged in their treatment and fully informed as to their options and choices, and properly consent to their treatment course.

My resulting report on this investigation recommended all DHBs ensure they have in place appropriate policies on off-label prescribing, and protocols that set out what is required of staff members in relation to their clinical and research activities. The DHBs are taking a coordinated approach to meeting those recommendations, and our system will be stronger as a result.

Complaints draw attention to the need to do the basics well. A bowel cancer case reiterated the need for GPs to be alert to unresolved symptoms, repeat presentations, and adequate assessment and investigation of their patients. Complaints from the hospital sector have pointed to the need to ensure that new staff, be they experienced or in training, are effectively inducted, trained and supervised.

Complaints in the aged care sector reflect a need to ensure a caring culture and communicate effectively with consumers and their families/whānau. Recent decisions have highlighted the need for appropriate oversight and training of staff, appropriate policies and procedures, adequate and accurate documentation, and effective connections between providers.

Complaints and complaint systems

The HDC undertook work with the DHB sector with a view to improving and strengthening their internal complaints systems. The conversations with consumers matter, and an effective complaints system makes those conversations easier. Sector engagement has been positive, the resource HDC developed is being used, and complaints systems will be strengthened as a result. A key question for all organisations is what their Boards do know about complaint patterns in their institutions: trends, responses and learning. Leadership from the top is the most effective way to progress these matters. Providers of health and disability services, both as individuals and as organisations, are responsible for ensuring that the service they agree to deliver is actually delivered.

Disability Services

HDC has investigated several disturbing complaints from the disability sector over the past year, one of which resulted in a negotiated agreement that has significantly changed the life of the consumer for the better. The complaints are a sobering reminder for us all about the importance of listening to people, and being vigilant about the standard of care provided to a highly vulnerable population whose voices can sometimes be hard to hear. Encouraging people, including family members and support staff, to speak up and talk about issues that concern them has been, and will continue to be a particular priority for HDC. Providers need to actively facilitate a culture where this conversation is easy to have.

In keeping with this increased emphasis on speaking up, HDC held an extremely successful Disability sector conference in June this year on this very topic. The conference titled "Another Complaint, Another Improvement: Towards Better Disability Services" was aimed at encouraging both consumers and providers to view complaints as a tool for quality improvement.

Mental Health and Addictions

Cases arising in this area also reflected the need for good policies for informed consent, clarity of roles and responsibilities within and between services, listening to family/whānau, an integrated approach to service delivery and boundary issues.

The statutory changes bringing to the HDC the mental health addictions monitoring and advocacy functions have been successfully embedded in the organisation. The Mental Health Commissioner has successfully engaged with the sector and delivered on an impressive work plan. This area continues to flourish and deliver in partnership with stakeholders.

Advocacy Services

It is not possible to speak of HDC without reference to the work undertaken by the independent Advocacy Services. The Advocacy Service received over 11,000 enquiries and acted on more than 3,000 complaints, resolving 94% of these. Advocates assist with low level resolution by standing next to consumers as they resolve complaints with providers. They help people negotiate the system, and assist providers to deliver services more effectively by promoting complaints as opportunities for learning and quality improvement.

Culture – what's it like at your place?

In the course of this year we have spoken again to thousands of people in a variety of fora. We know what success looks like. There is an array of tools, systems, and styles of communicating that assist us to get it right. And mostly we do get it right. But in the margins where the HDC operates, basic errors are made all too frequently, and conversations that ought to have been held have not been. Part of HDC's role in promoting the learning from complaints is to invite organisations to answer the question "what's it like at your place?" and "what gives you confidence that the quality and behaviour that you expect today will in fact be delivered tomorrow?" As Mid Staffordshire again teaches us, the key to safety is eternal vigilance.

It has been a year of singular activity, and demand for HDC services continues to grow apace. I am extremely grateful to my passionate and loyal staff who have delivered an unprecedented amount of work to a very high standard. The complaint statistics shown reflect their commitment.

Complaints statistics at a glance

1.1 2012/2013 Priorities

In line with the HDC's vision and Statement of Intent for 2012–15, the key priorities for the HDC for the 2012/13 year were to:

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

1.2 Entity performance: Highlights

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

We have received and closed the highest ever number of complaints this year. This performance was delivered well within the HDC's available financial resources.

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

The HDC has received and resolved the following complaints;

- 1,619 complaints were received (4% increase from 2011-12 and 15% increase in the last two years)
- 1,551 complaints were closed (12% increase from 2011-12)
- 60 formal investigations were completed (36% increase from 2011-12)
- of the above investigations, 42 resulted in breach opinions
- 16 referrals to the Director of Proceedings (100% increase from 2011-12).

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.

The 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.

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 the HDC. Just in a small number of serious cases this may result in a prosecution being taken against a provider by the independent Director of Proceedings in the Health Practitioners Disciplinary Tribunal (HPDT)and/or the Human Rights Review Tribunal (HRRT).

Vision *Tā mātou matakite*

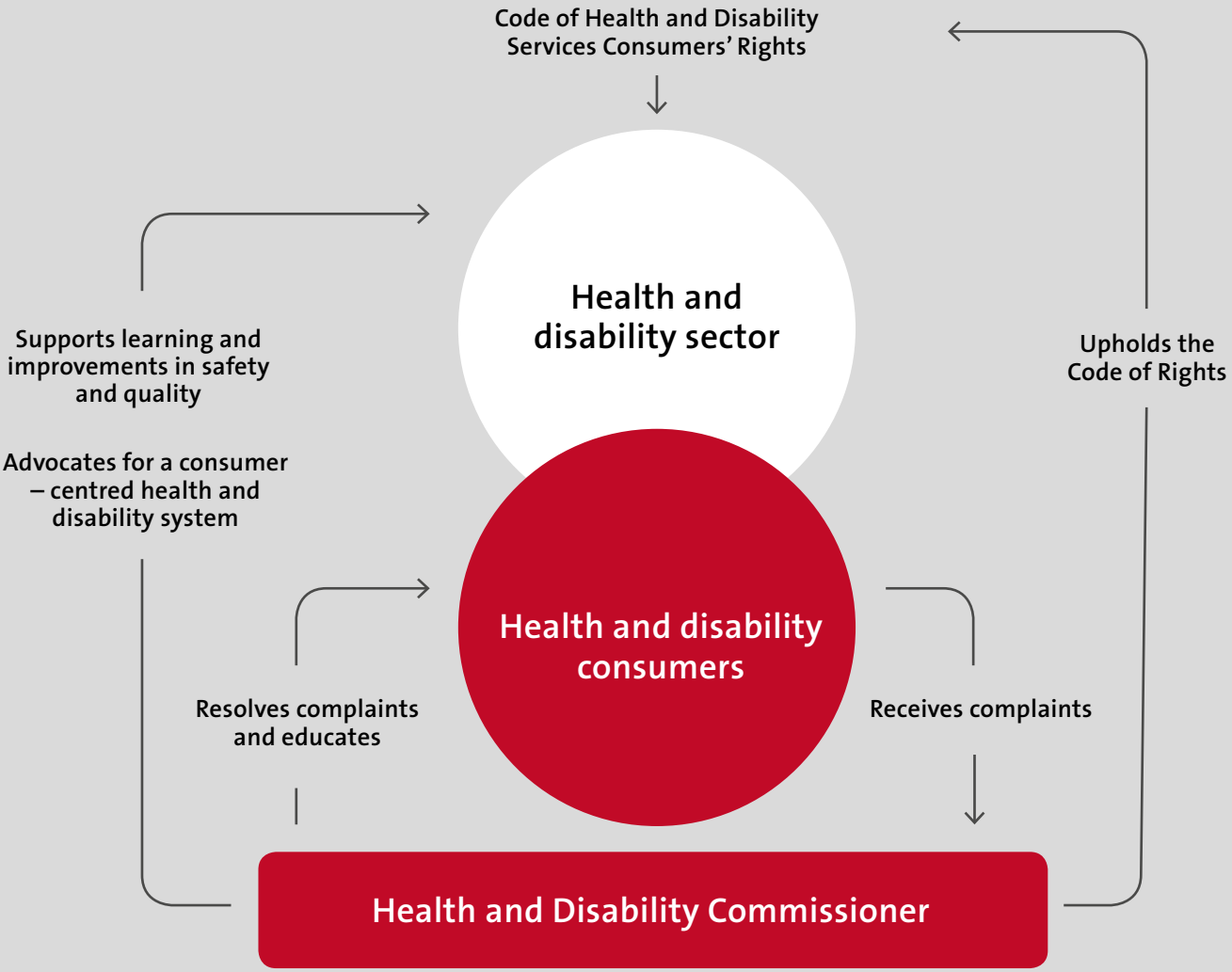
Consumers at the centre of services
Ko ngā kiritaki te mauri o ngā ratonga

Mission *Te Whāinga*

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

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

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 through advocacy, provides information and promotes consumers rights

Output 3: Proceedings: Proceedings are taken in serious cases to publicly redress breaches of the Code of Rights, professional 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 resolution

Output 5: Systemic monitoring and advocacy - mental health and addiction services: Monitoring the quality of mental health and addiction services and advocating for improvements

Figure 1: 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 five output classes of Complaints resolution, Advocacy, Proceedings, Education and Systemic monitoring and advocacy - mental health and addiction services.

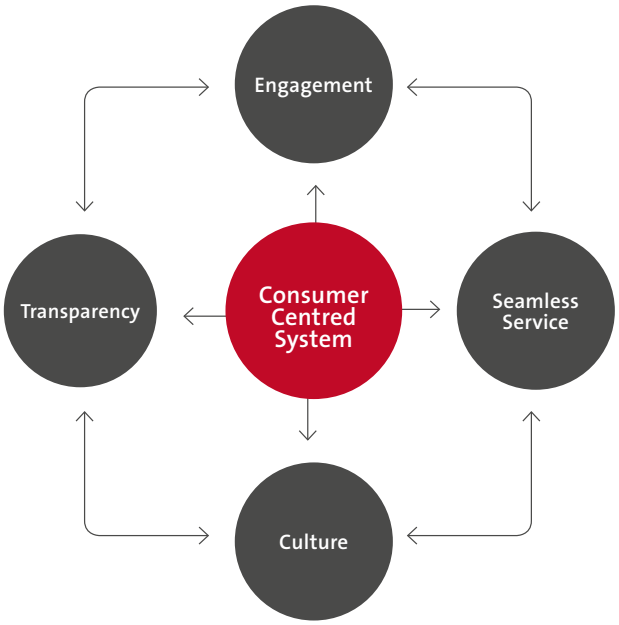
2.2 Impact and outcomes

The HDC and 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 (see Figure 2) is reflected in its outcomes framework (see Figure 3).

Figure 2: The consumer-centred system



The difference the HDC makes
From service provided to system outcomes

Output classes – the activities we undertake

Complaints resolution | Advocacy | Proceedings | Education | Systemic monitoring and advocacy - mental health and addiction services

Services outputs – the key outputs for our work in 2012/2013

Complaints addressed promptly and impartially | Sustainable improvements as a result of learning and change | Consumer-centred partnerships – consumers as partners in their own care

Impact – the difference we make for consumers

Less emotional and physical harm | Improved system performance | Improved communications and relationships between consumers and providers with an increase in consumer confidence

Outcomes – the change the HDC aims to contribute to New Zealanders

Health and disability services are safe, high quality and consumer-centred

Figure 3: The HDC outcomes framework

Changes made by providers as a result of complaints

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.

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

1. Following an investigation of a complaint about a lost test result, a hospital department identified a process error that has since been rectified. The booking and scheduling section also reviewed how information is currently distributed within and between internal and external services. They are also looking for an electronic solution to replace the current manual process so all patient test results are sent directly to their general practitioners.
2. When a spinal MRI ordered by an orthopaedic surgeon revealed a mass on a patient's kidney, no effort was made to alert the referring specialist to this unexpected and serious finding. As a result of the patient's complaint, an 'alerts folder' has been established for radiologists to lodge such matters. On a daily basis the folder is cleared, and a special email alert sent to the referring clinician.
3. As a result of a complaint concerning the use of restraint in aged care, a rest home has reviewed its restraint procedures, implementing monitoring of compliance with restraint standards, including training in de-escalation, and now ensures resident support plans contain individualised de-escalation strategies.
4. A consumer's complaint resulted in a number of changes at a public hospital for example, "stroke information pack" has been developed with a strong focus on information for Māori patients who have suffered from a stroke or transient ischemic attack. This includes information about local support services as well as where to locate relevant brochures and information for families on after care and management.
5. An audiologist who, over a period of 10 years and five consultations, failed to diagnose a boy's hearing loss was to found to have breached the Code of Rights. He and his employer, were referred to the Director of Proceedings.
6. The investigation of a complaint from the parents of a 15 year old boy with Down syndrome and autism led to a finding that the boy had been physically and verbally abused by the team leader of the home in which he resided. The DHB involved has subsequently strengthened its systems and processes in relation to investigating and reviewing allegations of abuse and related staff training.
7. Communication by text messages was a feature of several cases involving midwives. HDC emphasised that text messaging is appropriate for administrative matters such as appointments, but not for significant clinical advice unless the text message is followed up with personal contact to ensure the text message was received and understood.
8. Following an investigation into a complaint that a provider and NASC failed to take action when both were on notice that a vulnerable consumer was neglected the NASC reviewed and updated its policies and procedures and arranged training. The provider changed its employment procedures, and monitoring and review of the care provided.
9. Following an investigation related to the post-operative care of a young man following neurosurgery, a DHB reviewed post-operative monitoring, audited post-operative instructions and trained staff on their obligations should the instructions conflict. This case lead to sector debate about the rights of patients to be informed whether procedures are being conducted by trainees, and the make up of the surgical team.

2.3 The key differences to the health system

The HDC makes the following differences:

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

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

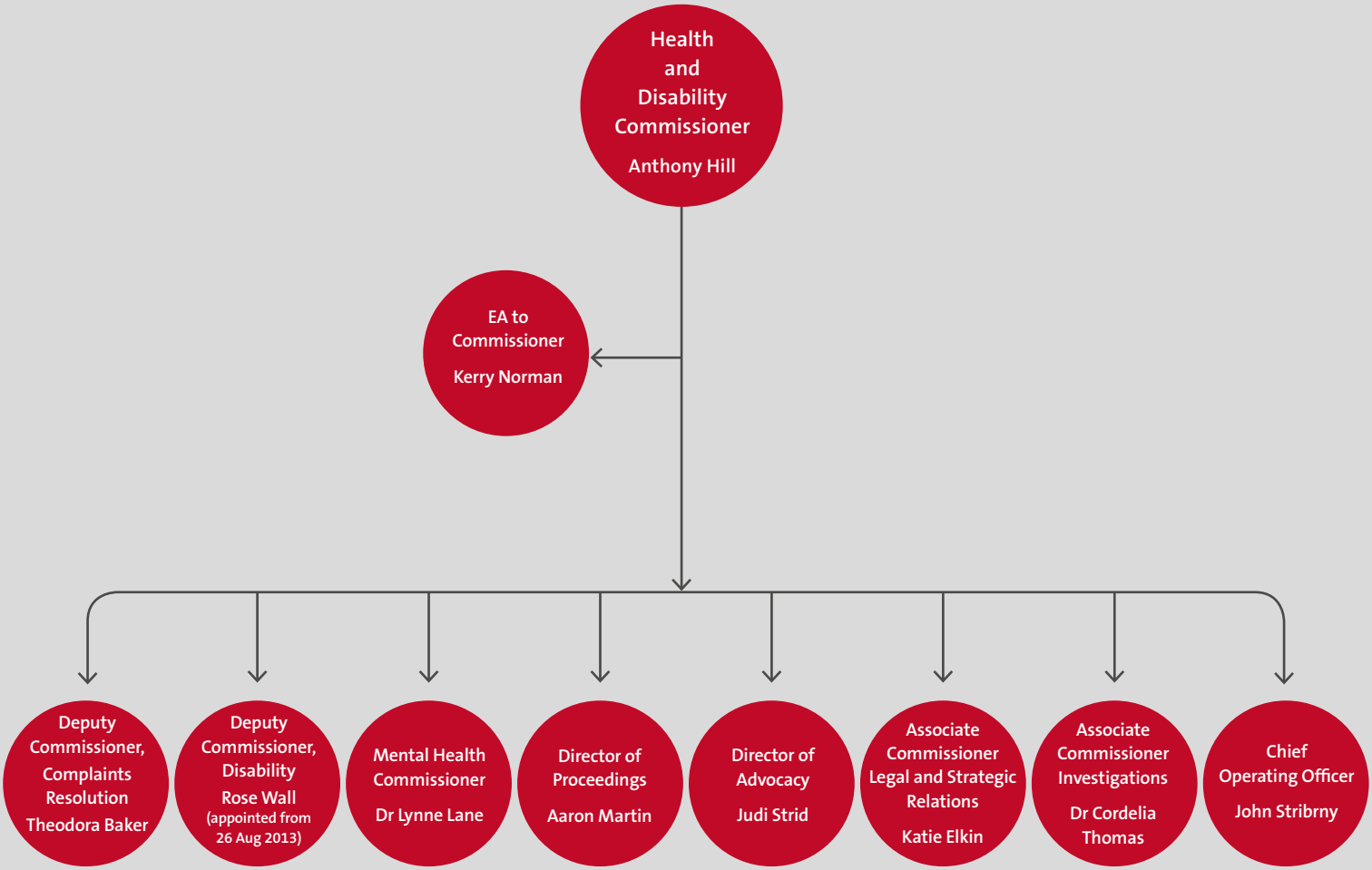
- New Zealanders live longer, healthier, more independent lives
- good health is protected and promoted
- people receive better health and disability services
- the health and disability systems are improved and unified
- health and disability systems and services can be trusted and used with confidence.

The key ways in which the HDC contributes to achieving 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 2013)



3.0 HDC key activities 2012/13

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

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

3.1 Complaints resolution

Anyone can complain to the HDC orally or in writing. When a complaint is made over the phone we always encourage the complainant to submit some sort of written complaint to ensure an accurate record of their concerns. We often direct a complainant to the Advocacy Service to assist with the compilation and expression of the complaint, or to help resolve it. The HDC has an online complaint form, which also helps the complainant identify the issues.

A complaint may be made by anyone: 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.

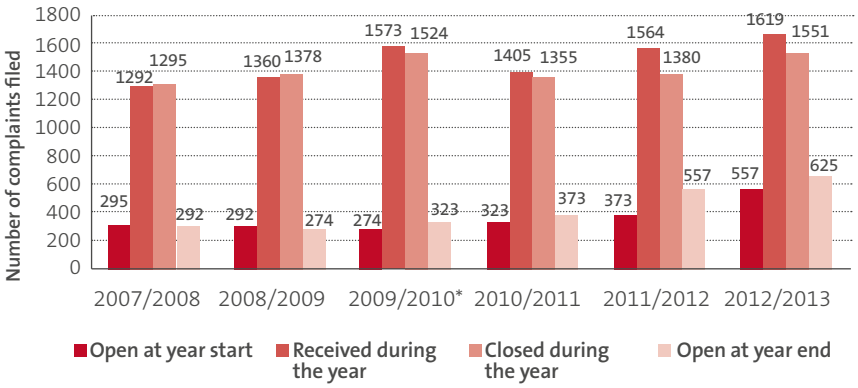
Third party complaints are usually by a family member. Where possible we confirm that the consumer or their legal representative supports the complaint and consents to the release of personal information to the complainant. Where this is not possible, we usually still make enquiries into the matter, in order to be satisfied that there are no serious issues that warrant further action, and release only limited information to the complainant.

Each complaint is considered carefully to decide the most appropriate means of resolution in accordance with the HDC's statutory mandate of "fair, simple, speedy, and efficient" resolution of complaints.

Complaints Received

The trend of increasing new complaints continues, with an unprecedented 1,619 received this year. This amounts to a 25% increase in five years, with a 15% increase in the last two years. The graph below shows that the incoming complaints have continued to grow, with a continual increase in numbers over a 15 month period from September 2011 to January 2013 before tapering off a little in the last few months of the financial year. This swell in complaints has challenged the organisation in the timeliness of complaints resolution, and this has been reflected in some of our results. However, with the allocation of more resources, the year ahead will see significant advances. Complaints closed also reached a record number of 1,551.

Figure 4: Number of open complaints filed



Why so many complaints?

Complaints range from significant events such as missed diagnosis, poor postoperative care and sexual misconduct, to seemingly less serious allegations such as a rude manner or poor communication. As is evident in Figure 5, the main issue complained about is treatment. The Code of Rights does not apportion weight to different rights. An inappropriate attitude may signify a potential breach of a right to respect, and it may also be an impediment to the consumer receiving appropriate treatment.

While most concerns cover recent events, about 10% of the 1,619 complaints received last year related to an episode of care or services that were completed over 12 months before the complaint was made to the HDC. There is no statutory period within which a matter must be raised with the HDC, and so each complaint is carefully considered to decide whether any action is appropriate. One of the grounds on which we may decide to take no action is the length of time since the event complained of, but it is also recognised that there are some circumstances in which the delay is understandable.

* The number of files received and closed during 2009/2010 were inflated by a large number of complaints arising from a change in the provision of Auckland Laboratory tests.

Providers complained about

Of the 1,619 complaints received last year, 1,063 individual providers were identified and 1,333 group providers. Figure 6 shows that, in line with previous years, public hospitals and DHBs make up for about half of all group providers identified in the complaints received. Figure 7 shows that about 30% of all individual providers complained about are general practitioners. A complaint may involve more than one provider.

Figure 5: Primary issue complained about (complaints received)

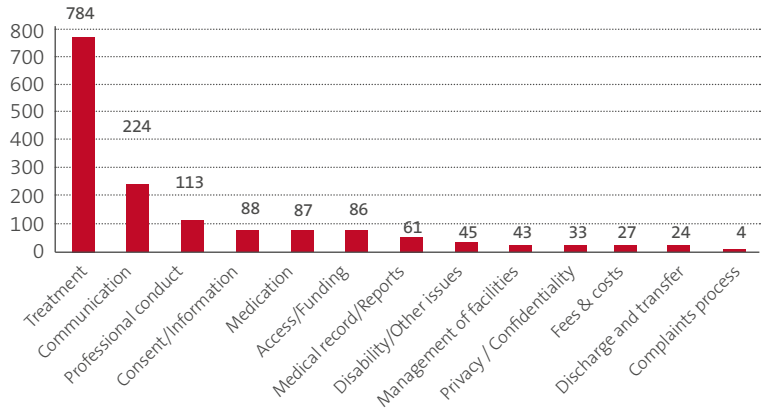
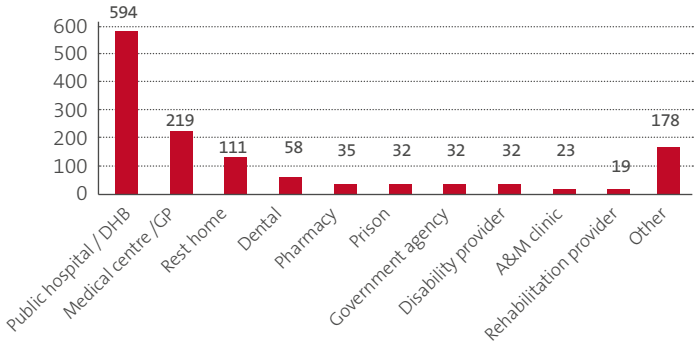


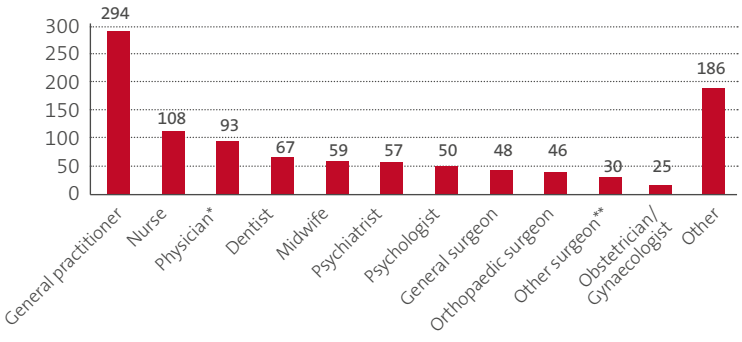
Figure 6: Complaints against groups of providers



Referrals to providers and to the Advocacy Service

Over 183 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 the Advocacy Service in order to enhance the communication between the parties, and empower the consumer to resolve their complaints without external intervention. The Commissioner referred 107 complaints to the Advocacy Service.

Figure 7: Complaints against individual providers



* includes haematologist, oncologist, geriatrician, paediatrician as well as general medicine physician

**includes urologist, ENT, paediatric, plastic, cardiothoracic, neurosurgeon

CASE STUDIES
A small selection

Referral to the Advocacy Service, follow-up upon discharge from Mental Health

A woman who had a history of bipolar and alcohol dependence was admitted to hospital as a result of her suicidal ideation. She felt she had been prematurely discharged without necessary psychological assistance, rehabilitation or reintegration plans to help her live safely in the community. A referral to the Advocacy Service led to a resolution meeting taking place with the staff at the DHB, who acknowledged and apologised for the poor communication and arranged for entry into a rehabilitation programme, followed by psychological and addictions therapy with the DHB. The woman was happy with this outcome.

Referral to the Director-General of Health, access to colonoscopy

Complaints in relation to access to colonoscopy services resulted in the Commissioner writing to the Director-General of Health seeking reassurance that effective systems and oversight was in place to ensure that access to colonoscopy services throughout the country was being monitored and implemented appropriately. The Director-General provided the assurance that there is a range of Ministry work that will improve the access and the quality of colonoscopy services in all DHBs. The National Endoscopy Quality Improvement Programme funded by the Ministry of Health is aimed at improving endoscopy services in New Zealand. It is currently being rolled out across the country. This is an area of on-going interest and we will continue to monitor this.

Section 38 - No follow-up action, communication prior to surgery

A woman was upset at the adverse outcome of her eye surgery. She experienced severe and prolonged swelling and pain. The doctor responded that while such risks were discussed, the degree and persistence of pain experienced by the woman would not have been raised, as in their experience this was rare and very unlikely. The doctor also conceded that, in retrospect, it seemed the woman had not fully understood the nature of one of the procedures that she had given consent for. While it was apparent from the clinical records that there had been reasonable efforts to inform her of the procedure and possible complications, the doctor recognised that their communication had not been effective, and apologised accordingly. The doctor is now more aware of ensuring that the patient has understood. The patient thanked the HDC, saying that she now understood everything and was happy with the outcome.

Section 38 - With follow-up, allergy alerts and General Practice

A man was prescribed a penicillin-based antibiotic to which he had a known allergy. This was noted in the medical warnings section of his notes, but it did not appear as an alert on the General Practitioner's (GP's) computer screen. It transpired the allergy had not been entered into his computer records. The man suffered an adverse reaction, which fortunately had only short-term effects. The doctor thought that the practice had followed their usual practice of asking about any allergies, but accepted that communication may have been poor. Both the doctor and the practice apologised for this, and the fact that staff had not introduced themselves.

The practice also undertook an audit of all patient files to ensure that allergies were noted on the Medtech computer system, as well as notifying community pharmacists to ensure their records were updated.

CASE STUDIES
A small selection

Section 38 - With follow-up, lithium toxicity

A woman complained about the management of her mother's lithium medication when her condition deteriorated in several ways, including impaired cognitive function, a heart attack and stroke. Her first two blood tests showed no lithium toxicity. A third one was ordered, but it is not clear why it did not eventuate. A month later, as she had become increasingly unwell, a further blood test did show some toxicity. The HDC in-house clinical advisor confirmed that the dose commencement and increments were within the manufacturer's advised doses and appropriate to the mother's clinical presentation. There were no symptoms to suggest lithium toxicity, but the failure to complete the third monitoring blood test was queried. It seemed that in hindsight, the mother's illness was due to a number of factors, of which lithium toxicity was one. It is likely that her other illnesses contributed to the unstable serum level, after initial tolerance. On being asked to report back to the HDC on the steps taken to ensure a blood test is not overlooked in future, the DHB provided a revised lithium policy which outlines recommended best practice across a range of settings. A shared lithium treatment plan specific to older adults, including clear monitoring responsibilities, was also developed and is to be used to facilitate discussion between teams and follow the patient through their journey.

A 'yellow envelope' project (where a yellow envelope carrying relevant patient information to accompany transferring patients) is also being rolled out by several DHBs to ensure continuity of care.

Section 38 - With follow-up, improvement in multi-disciplinary care and transition to adult services for young people with muscular dystrophy

A young man with muscular dystrophy and a history of aspiration pneumonia was admitted to hospital overnight, after choking on food. There were no signs of pneumonia, and he was discharged with antibiotics as a precautionary measure. He was re-admitted two days later with difficulty swallowing, coughing up secretions and a raised respiration rate. On diagnosis of aspiration pneumonia, intravenous antibiotics were commenced along with physiotherapy to facilitate clearing of his chest. While there was some improvement over the next few days, he deteriorated further overnight and was transferred to ICU. Chest X-rays showed the pneumonia had spread and while he was given periods of ventilator support, and secretions were aspirated, his oxygen saturation levels dropped to 40% and he deteriorated rapidly and sadly died. His family queried his care leading up to and including these two hospital admissions. After obtaining further comment from the hospital as well as the family, the HDC requested the independent advice of a respiratory physician who considered the patient was adequately assessed prior to discharge, but was mildly critical of the failure to involve the respiratory department during this admission and discharge planning, given that he was an outpatient of this service. It was considered that the care provided during the last admission was appropriate. The expert considered the outpatient services were largely satisfactory, but expressed concern about the failure to monitor the young man's cardiac function with echocardiography more frequently during the 12 months prior to these events.

The DHB provided a letter of apology to the family and undertook to engage better with patients' general practitioners to ensure continuity of care. The DHB identified other areas for improvement by ensuring overlap clinics where the adult specialist and the paediatrician are both present during the transitional period, and a core group of transition nurses would be appointed to cover this time, with the Respiratory Service being one of the first adult services to participate. A link to the Muscular Dystrophy Association was placed on the DHB website and staff resources page.

A new clinical workstation was also to be introduced to expedite the availability of a patient's history of contacts, so clinicians can more easily identify which patients are currently under outpatient care, and ensure the relevant services are informed in a timely manner.

Investigations

The Commissioner continues to conduct formal investigations into the more significant departures from a reasonable standard of care. This year 60 investigations were completed, and it was found in 42 cases that the consumer's rights had been breached. Of the breach decisions, 16 providers were referred to the Director of Proceedings for consideration of further tribunal proceedings. Figure 9 shows the manner in which complaints have been resolved in the past year.

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. An audit found 100% compliance of the recommendations audited.

Figure 8: Number and manner in which complaints have been resolved over 2011/12 and 2012/13

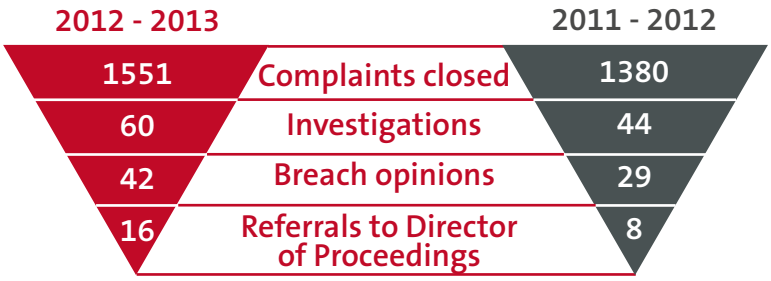
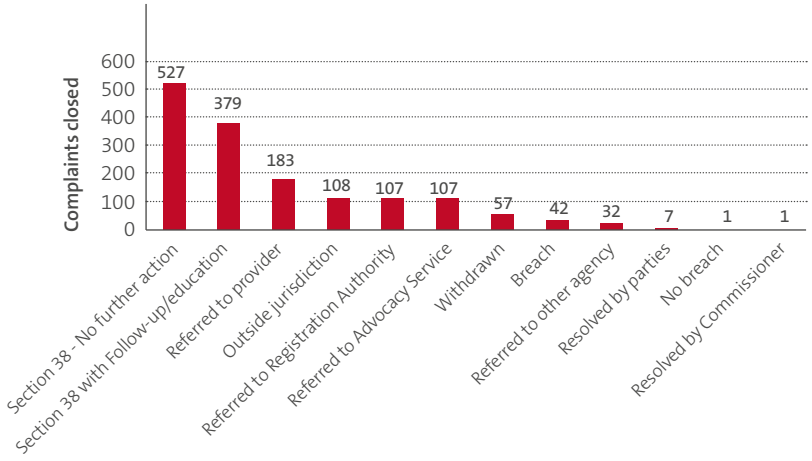


Figure 9: Complaints closed by category



Section 38

The Commissioner may assess a complaint and decide to "take no further action" under Section 38 of the "Act". A substantial amount of information is usually gathered before this decision is reached. The 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. Last year, in 379 cases where no further action was taken, there was still some follow up or education with 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, actions the provider has taken to ensure that the shortcomings are not repeated, or due to evidential difficulties.

CASE STUDY
Midwifery care and support for pregnancy

The Commissioner found a breach of the Code in a report about the care provided to a 24-year-old woman in the third trimester of her first pregnancy. At 38 weeks' gestation, the woman's Lead Maternity Carer handed over the woman's care to another midwife (the midwife).

A week before her due date, the woman sent the midwife a text message, indicating concerns about a lack of fetal movement and increased vaginal discharge with black spots. This was the woman's first contact with the midwife. The midwife replied to the woman by text message, advising her to drink ice-cold water and sit quietly on the couch to feel the baby move. Although the woman received the message, it confused her and she therefore did not follow the advice. The midwife did not follow up on the woman's concerns that day or ensure that she was reassured and/or had felt fetal movement.

A day or two later, the woman met the midwife and a student midwife for the first time at a clinic visit. The midwife and the student midwife assessed the woman. After a discussion about what fetal movement could be expected, the woman became unsure and decided she may have felt some small movements. The student midwife recorded that the movements were not as strong as they had been previously. The midwife and the student midwife had difficulty detecting the fetal heart rate (FHR), but the midwife said that she eventually heard it "in the background".

At 3.20 am the next day the woman began having contractions. At 2.20 pm the midwife and student midwife visited and assessed her at her home. She was in established labour. Again, the midwife and the student midwife had difficulty finding the FHR. The midwife and the student midwife left the woman, advising her to call them when she felt bowel pressure. At 7.35 pm, after being advised that the woman was feeling bowel pressure, the midwife and the student midwife returned to the woman's home and conducted a further assessment. The woman was driven to the hospital by her mother when she was close to delivery, while the midwife and the student midwife drove separately. The woman gave birth to her baby minutes after arriving at the delivery suite. Sadly, the baby was born with no heartbeat or respiratory effort, and resuscitation was unsuccessful.

The Commissioner found the midwife should not have responded to the woman's concerns via text message without also calling her to clarify and follow up her concerns. The midwife failed to respond appropriately to the history of reduced fetal movement by not checking the maternal pulse and not arranging a continuous fetal monitoring . She also did not remain with the woman to monitor the maternal and fetal well-being when the FHR was still difficult to find and the woman was in established labour. Furthermore, the midwife left the woman unsupported in travelling to the hospital when she was about to give birth. The midwife therefore did not provide services with reasonable care and skill and breached Right 4(1).

The midwife was referred to the Director of Proceedings. The Director decided to commence proceedings in the Human Rights Review Tribunal (HRRT).

(11HDC00596)

CASE STUDY
GP care for a woman with Huntington's disease

The Commissioner issued a report concerning the services provided to a woman with Huntington's disease by a general practitioner (GP) between 2002 and 2010.

In 2002, when the woman was becoming increasingly symptomatic, the GP talked to her about her future care. The woman was adamant she wished to remain living in her own home, and the GP promised to ensure she would be able to do so. It was agreed that the GP would visit the woman regularly. Once or twice a year, the GP discussed the woman's management with a psychiatrist. The psychiatrist had previously treated the woman, but she had declined further contact with him in 1999.

The woman became increasingly reclusive. She refused home help and other support. From 2005 she refused to allow the GP into her home and, thereafter, most of their documented contact was by telephone. The GP said there were also unrecorded face-to-face contacts on the balcony of the woman's flat. The woman was prescribed a nutritional supplement, and when she needed a repeat prescription or delivery she would telephone the GP or her practice.

The woman's daughter repeatedly expressed concerns to the GP about her mother's living conditions. The woman periodically refused to have contact with her daughter; at these times the daughter was dependent on the GP to ensure her mother was safe.

In 2006, the woman had an overnight admission to hospital. The GP advised the clinicians that support and care were in place for the woman and took her home. No competence assessment was undertaken.

During the four years that followed, the GP had limited face-to-face contact with the woman although on one occasion they had an hour-long conversation through a curtain, with the GP able to see only the woman's feet. The GP monitored the woman by visiting the flat to check for signs of life, such as whether the television was on, and whether there were flies or smells.

In 2008, the woman's landlord contacted the GP to say that there was a leak coming from the woman's bathroom into the garage below. The woman told the GP that she had fixed the toilet and no repairs were necessary. The woman had just turned off the water supply to the toilet so it was not able to be flushed, although she continued to use it.

From 2000 until 2010 the GP prescribed the nutritional supplement Ensure without taking adequate steps to assess the woman's weight or nutritional status.

In 2010, after it was discovered that the woman was living in conditions of extreme squalor, the GP certified that the woman was incompetent with regard to decisions about her personal care and welfare.

The Commissioner found the GP failed to assess the woman's competence early enough. In addition, the GP assumed responsibility for the woman but failed to ensure the provision of adequate care and support. Accordingly, the GP failed to provide services of reasonable care and skill, and breached Right 4(1) of the Code.

By prescribing for a patient she had not reviewed for an extended period, and forming a relationship that went well beyond the normal doctor - patient relationship which involved her acting as the gate-keeper for any contact by support services, the GP did not comply with professional standards and breached Right 4(2) of the Code.

By failing to keep adequate records, the GP also breached Right 4(2) of the Code. Adverse comment was made about the psychiatrist providing support for the GP's decisions when he had not seen the woman.

(11HDC00647)

3.2 Advocacy

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

Advocates are independent of the HDC and on the side of the consumer.

During the reporting year 27,587 people used the 0800 number to contact the Advocacy Service, with 96% being answered by a person.

There are 48 advocates (41 FTEs) located in 24 community-based offices around the country. This means that 86% of the total advocacy workforce of 57 people are frontline advocates. More than half the core advocates are Māori. Six advocates are specialist advocates working with the Deaf community (3) and refugee/migrant communities (3).

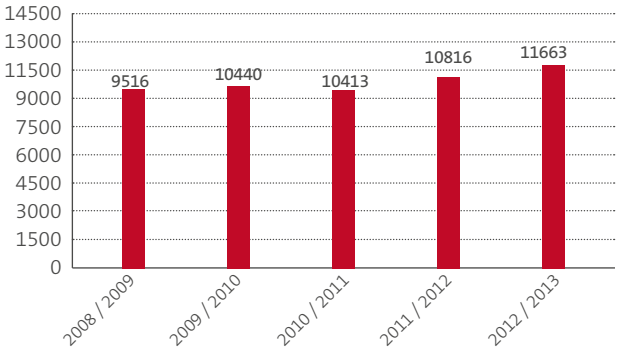
Enquiries

The Advocacy Service provides an effective clearing house function with 11,663 enquiries closed for the year. As the focus of advocacy is on timeliness it is pleasing that 98% of the enquiries were closed within two days and 99% within five days. The following table shows the increased number of enquiries. Advocates are encouraging confident callers to consider self-advocacy and are able to act as mentors if required.

Focus of enquiries

Of all enquiry calls made, 22.2% were from people wanting to know about advocacy and the role of an advocate, with 16.4% about how to make a complaint. Requests for education account for 10.7% of enquiries, followed by requests for information on mental health (5.3%). ACC and prison health enquiries remain constant at 5% and 2%, respectively. The remainder of enquiries relate to a variety of topics such as disability resources, access and funding, fees/treatment costs, privacy of information and rest home standards.

Figure 10: Enquiries closed by year



Complaints

This year there was an increase in new complaints from 3,025 to 3,194. Since 1 July 2010 the number of new complaints received by the Advocacy Service has risen by 13%. The total number of complaints managed during 2012/13 was 3,515.

This includes 321 open complaints carried forward from the previous year. In 2012-13 advocates closed 3,126 complaints.

Resolution rates have risen this year to 94%. These rates are a reflection of the strong consumer-centred process used by advocates. About 10% of consumers (319) chose to have a face-to-face advocacy-supported meeting with the provider. At 134 of these meetings the Ongoing Actions Resolution Agreement Form was used to record actions to be carried out after the meeting, with results showing all actions were completed within the agreed time frame.

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

CASE STUDIES

Restoring important mental health support

A woman rang the Advocacy Service desperate to receive help for her 19-year-old son who had a long history of mental illness and is receiving care from community mental health services. His mother became concerned when he stopped taking his medication and was becoming progressively unwell. In the past when he had stopped his medication he had become violent toward his parents. This resulted in police involvement and the consumer being put in a secure facility under the Mental Health Act for 10 days before being placed in a rest home for respite care. His family felt this was not the right place for him, even for a few days, so he was discharged home.

At her wits end and wanting to avoid this happening again the mother rang the Advocacy Service for help.

The advocate spoke with the son who said he was not receiving the care he needed. No follow-up visits or phone calls had been made and the isolation was affecting his wellbeing. Both he and his mother were desperately worried he would relapse if he didn't receive immediate help. They both wanted the community mental health team to keep appointments, establish dialogue with them, and have a key worker and a plan of action to help prevent any further acute admissions to hospital.

After considering the options, they asked the advocate to organise a face-to-face meeting with the mental health crisis team. This happened very quickly with the son being seen soon after by the team's doctor and his new key worker. The consumer received an apology for the breakdown in communication. Both mother and son believe the advocacy support and prompt actions of the advocate saved the consumer's life. He is finally getting the support he needs from the mental health team and is once again taking an interest in his own health issues and participating in a range of activities.

Assistance needed for reassurance of breast cancer fears

A consumer contacted the local advocate as she was very concerned about recent results she had received after a mammogram and breast biopsy. Although the specialist had told her there was nothing to worry about, he had used words she didn't understand. She was too embarrassed to ask any questions and was very worried as she could still feel a painful lump. Following the appointment, she discovered her grandmother had died of breast cancer so this increased her level of concern. She asked the advocate to support her at the next appointment so she could get the answers she needed.

At the appointment the specialist told the consumer that although a lump could be felt, the biopsy had revealed it was not cancerous. The consumer told the specialist about her family history and that she was still worried as the lump was painful. The specialist offered her an MRI scan to rule out any possibility of cancer and to put her at ease. She was pleased she got to ask the questions that she wanted and was very relieved to be having an MRI scan. The consumer told the advocate that she was very grateful for the support as she had felt very overwhelmed by the situation.

Source of complaints

Of those who complained, 54.2% made their initial contact via an advocacy office number and 26.1% used the 0800 number. Face-to-face contacts, including Skype, accounted for 10.3%, and the remaining 9.4% established contact with an advocate by email, letter, fax or via text messaging. Consumers were the source of information for the vast majority of complaints (69.9%) followed by family members and friends (27.3%). Formal HDC referrals accounted for 2.8%. The most common avenue of referral was through people who had used advocacy before.

Complaint comparisons

As with previous years, the vast majority of complaints brought to advocacy were about health services at 74% (2,307), with 14% (455) relating to disability services. Complaints about mental health services accounted for the remaining 12% (364). It is common for complaints to cover more than one particular right (from the rights described in the Code of Rights).

Figure 12 shows the number of complaints to advocacy by service provider category.

Figure 11: Complaint resolution rates by year

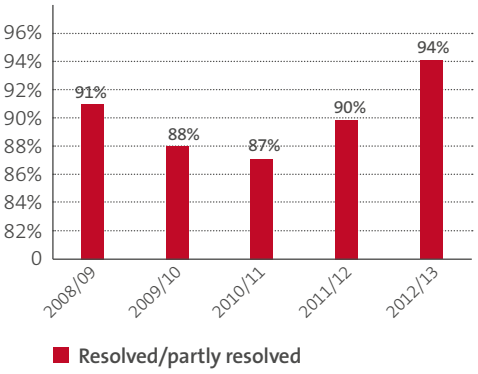
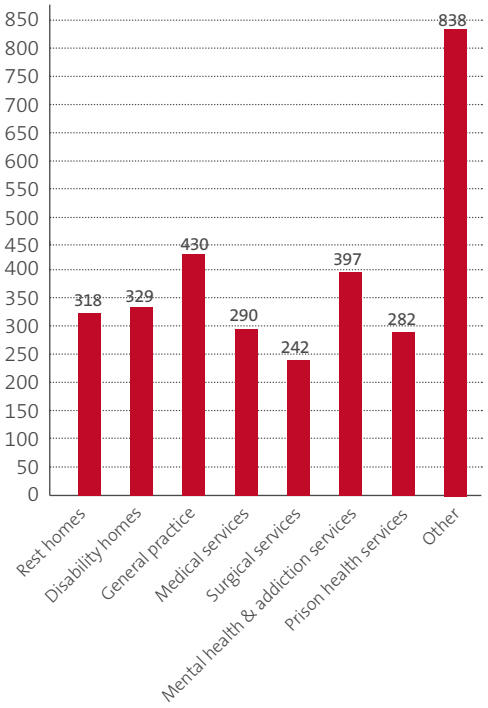


Figure 12: Number of complaints to advocacy, by service category



Demographics

The highest number of complaints (32.2%) came from people aged 41–60 years followed by those aged 61–90 years. People aged 26–40 years made 23.3% of complaints. Of those making complaints, 57% identified as female, 38% as male and 5% were people who describe their sex as other.

Of the total complaints closed, 64.9% were from people who identified as Pakeha, 14% from New Zealand Māori, 2.8% from people of the Pacific, 2.1% from people identifying as being English, 1.7% as Indian and 1.1% as Chinese.

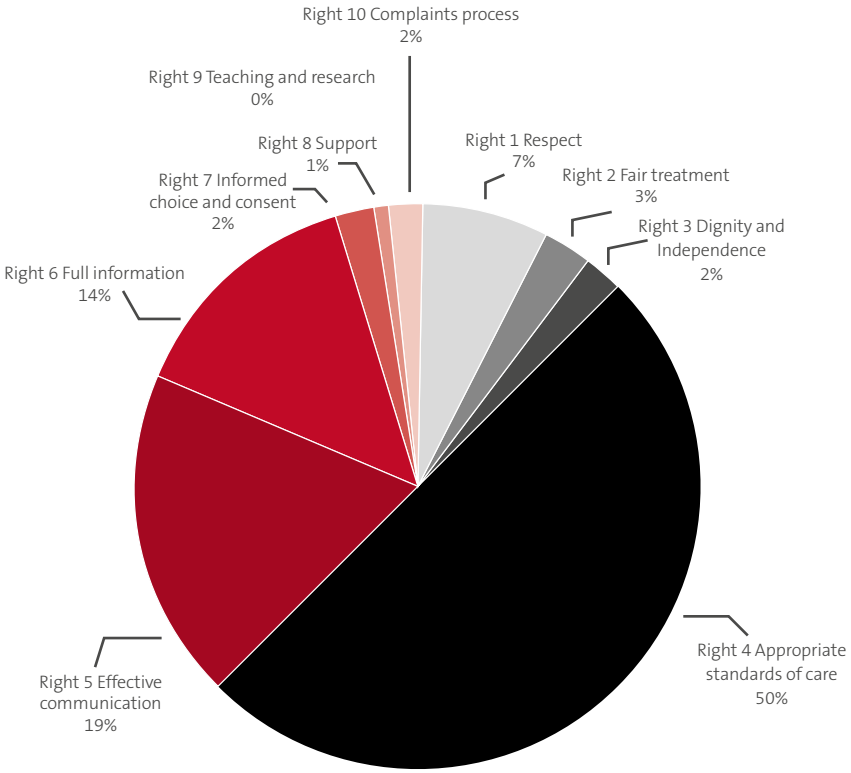
Residential visits

Advocates have been visiting rest homes for seven years and disability homes for six years. The purpose of these 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. Every residential home has been given a free copy of the "Tell Someone" DVD. This DVD was specially designed as an education tool for advocates to help people with a learning or intellectual disability to understand their rights.

We wanted to know whether distribution of the DVD had been effective. A survey of 233 residents at 113 different disability homes showed that 95% of them knew they had rights and 84% could identify some rights. It was reassuring to know that 54% feel confident to speak to staff if they are unhappy. Of these visits, 10% have been to assist residents and/or a third party acting on behalf of the resident to make a complaint.

In 2012-13 there have been a total of 3,096 rest home and 3,145 disability residential visits by advocates.

Figure 13: Advocacy complaints issues 2012/13



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. Over the past year advocates developed and maintained contact with 3,932 networks.

Networking and education are the key features of the role of the six specialist advocates. These advocates familiarise themselves with the different local issues across the country. They identify opportunities for letting these communities know about their rights, as well as raising their profile in Deaf, refugee and migrant communities.

Networking also helps advocates stay up-to-date so they know who to refer consumers to for ongoing support and matters outside HDC's jurisdiction.

One national issue identified by a Deaf advocate through networking is the lack of a standard approach when dealing with audiologists and the supply of hearing aids.

A highlight was the launch of a new refugee series of 15 brochures as well as a languages poster to reflect the translations on the website.

Satisfaction survey results

Being on the side of the consumer is about providing a consumer-centred approach. It is therefore very important that advocates do this well and set a great example to providers.

Each month 33% of consumers and providers who have worked with an advocate are asked to comment on their level of satisfaction with the service.

Survey results showed that 81% of surveyed consumers and providers were very satisfied with their dealings with the Advocacy Service.

The following are unsolicited comments from consumers about their advocate.

"...her dedication, knowledge and professionalism resulted in a victory... is a credit to your organisation and you are fortunate to have such an able person on your staff."

"I would just like to thank you so much for your support in getting something done about the care I received!"

"Just a note to say thank you so very much for all your kindness, compassion and advocacy. We appreciate all you have done to achieve a very successful result."

Education and training

Advocates presented a total of 2,225 education and training sessions to a range of consumers, providers and organisations. Including residential homes, 69% of education and training was provided to the disability sector.

Those responding to surveys gave high ratings to advocacy education and training. Of these, 89% of consumers and 90% of providers were very satisfied with the sessions.

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

Six advocates have completed the health and disability advocacy qualification and eight more are well on the way to completing it. This new national certificate is included in the NZQA framework and will form part of a career pathway for advocates.

Acknowledgements from the Director of Advocacy

The Director of the Advocacy 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.

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, as tribunal members or expert witnesses.

This has been another year in which meaningful outcomes were able to be achieved for consumers in proceedings taken. The case notes in this section of the report are two examples of successful prosecutions that highlighted important duties of providers. Where appropriate, attempts are made to reach agreement on facts and to negotiate settlements that can result in speedy and efficient resolution of cases. Two such negotiated agreements have been reached that will result in significant declarations of breach of the Code by the Human Rights Review Tribunal in the coming months. At year end the team was also preparing for four hearings that took place in August-September, two of these being week-long defended hearings.

The Director of Proceedings is grateful for the professionalism and dedication of his team and the expert advisors who assist him in this work.

Table 1: Action taken in respect of referrals to Director of Proceedings in 2012/13

Provider	No. of providers	No further action	DP decision in progress	Proceedings pending	Proceedings concluded	No. of consumers involved
Audiologist	1		1			1*
Caregiver	1		1			1*
Disability Services Provider	2		1	1		2*
District Health Board	2		2			2*
Medical Practitioner:						
- General practitioner	3		1	1	1	3
- Other	1			1		1
Midwife	2		1	1		2
Needs and Service Coordination (NASC)	1	1				1*
Nurse	2			1	1	2
Pharmacist	1			1		1*
Totals	**16**	**1**	**7**	**6**	**2**	**12**

***One consumer was the subject of a referral in relation to a pharmacist, NASC, and a disability services provider. Another consumer was the subject of a referral in relation to an audiologist and a DHB. A third consumer was the subject of a referral in relation to a caregiver and a DHB.**

CASE STUDY
Concerns about chaperoning marked by Tribunal sanction

In a case brought by the Director of Proceedings, a general practitioner pleaded guilty to a disciplinary charge of professional misconduct for undertaking an intimate examination of a patient without first offering a chaperone. The examination had involved the abdomen and breasts. The context of the charge is important. The doctor had undertaken the unchaperoned examination against the following background:

- Previous Medical Council requirements to use a chaperone.
- A previous voluntary undertaking to the Medical Council to use a chaperone.
- A Medical Council recommendation that the doctor use a chaperone.
- An obligation in the doctor's contract for services requiring him to comply with the practice's reasonable directions, policies, and instructions.
- The practice's chaperoning policy.

In April 2005, following a complaint regarding an unchaperoned breast examination that the doctor had performed on a young female patient, the Medical Council had imposed conditions on the doctor's practice, including that he not see any female patients without a third person being present. Another health practitioner was to be present during any intimate examinations of female patients. The requirement for the doctor to have a third person present whenever he saw female patients was removed at the doctor's request in August 2006.

In February 2007 the Medical Council was notified that the doctor's employment at a Medical Centre had been terminated following a complaint from a female patient on whom he had performed an unchaperoned breast examination. The Council subsequently placed conditions on his practice, including that he have a chaperone present when seeing female patients for any intimate examination.

In May 2008, on application by the doctor, the Medical Council removed all conditions from his practice. However, in doing so, the Council required the doctor to sign a voluntary undertaking to use a chaperone for every intimate examination on female patients. In May 2009 the doctor made an application for the voluntary undertaking to be removed, and this was accepted by the Council. However, in a letter to the doctor the Council strongly recommended that he continue to use a chaperone for any intimate examination on female patients.

The practice in which the doctor was by then working had a chaperoning policy and processes around it that included a chaperone being present for breast and abdominal examinations on females. On two occasions in 2009 the practice's clinical coordinator emphasised to the doctor the need to adhere to the practice's chaperoning policy.

The consultation that resulted in the charge being brought before the Tribunal occurred on 15 February 2011 when a female patient, aged 22, was seen by the doctor. She advised that her breasts were sore and aching, that she had stabbing pains where her ovaries were, had missed her period, and had been vomiting. She also informed the doctor that her "areola were larger than normal". The doctor conducted abdominal and breast examinations. He did so without offering his patient a chaperone. After leaving the consultation room the patient appeared upset, and after speaking with a nurse and with the clinical coordinator she made a written complaint to the practice.

The Tribunal was concerned that there might be a recurrence of the offending and by way of some further deterrence imposed a term of suspension on the doctor for a period of six months. The operation of the suspension was deferred for a period of one year. If any further complaint concerning an inappropriate intimate examination is received within the 12-month period, the term of suspension will automatically come into effect. The Tribunal imposed conditions on the doctor's practice, including that he have a female chaperone present when seeing female patients for any intimate examination, and display notices to this effect. The doctor was also censured, fined $1,000, and ordered to pay costs.

The Tribunal's decision is available at **http://www.hpdt.org.nz/portals/0/med12223ddecisionweb.pdf**

CASE STUDY
Practitioner disciplined for failing to raise alarm after medication error

The Director of Proceedings brought a disciplinary charge of professional misconduct against a registered nurse before the Health Practitioners Disciplinary Tribunal. The case concerned a nurse who mistakenly gave a patient medication that had been prescribed for another patient. The medication was contraindicated for the patient who received it and the patient died within hours of it being administered. The nurse discovered her error shortly after she had administered the incorrect medication, but failed to raise the alarm or take any action to come to her patient's aid by notifying a medical practitioner of the error.

Patient A was admitted to the high dependency unit of a cardiac ward. He was terminally ill and had been experiencing delirium, shortness of breath and a slow heartbeat. The nurse caring for Patient A went to obtain some sedation for him after he had been displaying difficult behaviours associated with his delirium. The nurse decided to administer Patient A his dinner time medications at the same time as the sedation and proceeded to withdraw the patient's charted medications from the medication dispensing system, the Pyxis.

Unfortunately, without the nurse's knowledge, the medication chart for another patient (Patient B) was pinned within the chart the nurse was using to withdraw Patient A's medication. The nurse withdrew Patient A's medications, flipped over the page of the chart and withdrew the medications prescribed for Patient B. The nurse did not check the patient name at the top of the chart, nor did the nurse heed the warning on the Pyxis that the medications had not been prescribed for Patient A. One of the medications had known negative effects on heart rate and was therefore contraindicated for Patient A. The nurse later accepted before the HPDT that her failure to check the medication and who it was prescribed for amounted to professional misconduct.

The nurse then administered the medication to Patient A, but did not record in the medical notes that she had administered to him the extra medications that were not prescribed for him. Shortly after administering the incorrect medicine to her patient, the nurse discovered her error. However, the nurse did not take any action to address the medication error or notify a medical practitioner of it. The nurse therefore failed to come to the aid of her patient. Patient A passed away two hours later. The nurse did not inform anyone of the error until two days later. The nurse accepted that her failure to report the medication error to a medical practitioner in a timely manner amounted to professional misconduct.

In a decision dated 30 April 2013 the Tribunal held that the case would ordinarily have warranted the imposition of a suspension of 12 months but this was not imposed in this instance because the nurse had not been practising since September 2010 (nearly two and a half years). Conditions were imposed on the nurse in the event that she returns to practice. These relate to training in pharmacology and professional ethics, supervision in the context of administration of medicines, and that she refrain from coordinator/leader roles. The Tribunal also censured the nurse and imposed an award of costs.

The Tribunal's decision is available at **http://www.hpdt.org.nz/portals/0/nur1227ddecision.web.pdf**

Statistics

The Director of Proceedings received 16 referrals during the year (in relation to 16 providers). Four disciplinary charges were heard by the HPDT. A decision was received in an HRRT case heard in the 2011/12 financial year. Also heard and decided in the 2012/13 year but not shown in Table 2 was an unsuccessful appeal (by the Director of Proceedings) and an unsuccessful cross-appeal by a general practitioner arising from a (partially) successful prosecution in the 2011/12 year *(Director of Proceedings v Vatsyayann* [2012] NZHC 2588*)*.

Table 2: Outcomes in 2012/13

Provider	Successful	Unsuccessful	Outcome pending	No. of providers	No. of consumers
HPDT					
Medical Practitioner:					
- General practitioner	1			1	1
- Other*	1			1	1
Midwife		1		1	1
Nurse	1			1	1
HRRT					
Massage practitioner	1			1	1†
Totals	**4**	**1**		**5**	**5**

***General scope of practice, working in a collegial relationship (cosmetic).**

3.4 Education

Through education, the HDC and Advocacy Service aim to improve consumers' and providers' understanding of consumer rights and provider responsibilities under the Code. Providers who understand what is required of them are better able to ensure they comply with their responsibilities, while consumers who understand their rights under the Code are better able to exercise those rights. The HDC and Advocacy Service deliver education and training for providers, professional bodies and consumer-based organisations.

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

The HDC and Advocacy Service have provided education sessions to staff in several general practices around the country in line with the requirements of the Cornerstone accreditation programme. Other education for providers has included presentations to regulatory authorities, to other professional bodies, to DHBs, and to disability service providers. 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, including Auckland, Otago, Victoria, and Massey Universities. HDC staff have also provided guest lectures to various professionals undertaking postgraduate courses, including medical practitioners, nurses, midwives, pharmacists, health services managers, and administrators. Conference presentations have included sessions at the Association of Salaried Medical Specialists Annual Conference, the Autism New Zealand 2012 Conference, the Day Surgery Conference, the New Zealand Dental Association Conference, New Zealand Home Help Association Conference, and the Royal Australasian College of Surgeons Scientific Conference.

Numerous presentations were also made to consumer groups including Care Association New Zealand, Grandparents Autism Network New Zealand, and the New Zealand Aged Care Association. Throughout the year, medico-legal sessions were also presented to a variety of audiences, including as part of a Health Law Intensive programme and at the annual Elder Law for the Health Sector Conference.

Promoting learning through DHB reports

Education is also about promoting learning from complaints. To this end, the HDC and Advocacy Service continue to provide six-monthly reports to DHBs covering the numbers and types of complaints and the outcomes of closed complaints. These reports provide a trend analysis to the DHBs on the key concerns and issues raised in the complaints for all DHBs nationally and for their individual DHB. These reports also include some case studies that illustrate significant lessons for all DHBs. In response to the request for feedback on the usefulness of complaints information for the period July to December 2012, all of the DHBs that responded indicated that they considered the reports useful for improving the safety and quality of DHB services.

During the year, the HDC also developed and sent to all DHBs a resource entitled "Complaints Management: How effective is your DHB's complaints management system?" The resource is designed to assist DHBs in evaluating their own complaints management system and the way in which they respond to actual complaints.

Submissions

Making policy submissions on matters concerning the rights of consumers under the Code is another way in which the HDC educates, and contributes to the education of, providers and consumers. In 2012/13, submissions by the HDC included comments on policies, procedures, codes of conduct, and guidelines to the Ministry of Justice, New Zealand Audiological Society Inc, Australian Medical Council, Dieticians Board, Pharmacy Council of New Zealand, Ministry of Health, Medical Council of New Zealand, Nursing Council of New Zealand, New Zealand Medical Association, and the Advisory Committee on Assisted Reproductive Technology.

The HDC also responds to enquiries from members of the public, providing general educational information about the rights of consumers and responsibilities of providers. This year, educational information was provided on a range of topics including advance directives, home support services, following up and managing test results, and HDC's jurisdiction and complaints resolution processes.

3.5 Systemic monitoring and advocacy – Mental Health and Addiction Services

The Mental Health Commission was disestablished in June 2012 and the primary statutory role to monitor and advocate for systemic improvements in mental health and addictions services was transferred to the Health and Disability Commissioner.

The Chair Commissioner of the former Mental Health Commission was appointed as the Mental Health Commissioner (MHC) within the Office of the Health and Disability Commissioner to deliver on this new responsibility. The MHC has established a team of 2.6 FTE to undertake this function.

Work plan to support implementation (2013–2016)

The MHC has developed a three-year work plan that identifies priority initiatives to support and evaluate implementation of Government priorities for service development in the sector (refer to Figure 14).

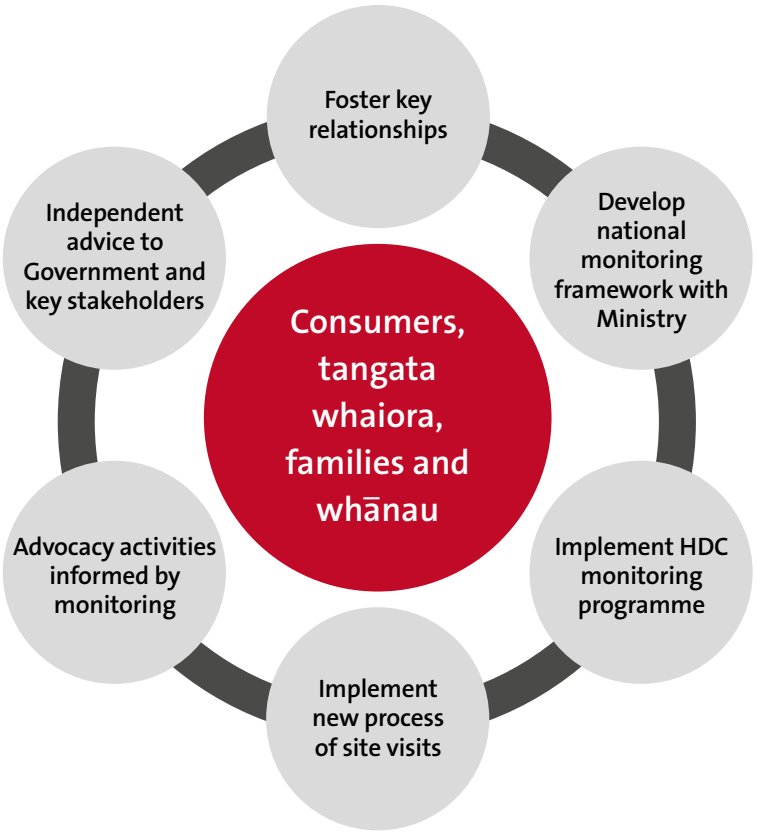
A new monitoring framework is being developed in consultation with sector stakeholders to reflect the current environment. The work plan also gives priority to collecting real time feedback of people's service experiences and using this information to inform change. The monitoring system will identify priority issues for systemic advocacy.

The following is a summary of the work plan for the MHC, and its rationale.

Mandate for change

Monitoring mental health and addiction services and advocating for systemic improvements is undertaken to support implementation of Government's priorities as set out in "Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012-17"[1] and informed by research and expert advice as set out in "Blueprint II"[2].

Figure 14: Mental Health Commissioner's Plan 2013–2016



1. Ministry of Health (December 2012) Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012-17.

2. Mental Health Commission (June 2012) Blueprint II: Improving mental health and well-being for all New Zealanders.

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

The mental health and addiction team's focus on advocating on behalf of consumers and their families/whānau aligns with the HDC's vision of consumers at the centre of services

Foster key relationships

The MHC is working through the existing sector networks at the national, regional and local levels for providers including clinical leaders and service managers, provider groups, and consumers and family/whānau groups. The MHC has also established working relationships with the Mental Health Commissioners in Australia and other countries to collaborate on agreed priorities for monitoring and supporting service improvement.

Develop national monitoring framework with the Ministry of Health

A new national mental health and addictions monitoring framework has been developed and agreed with the Ministry of Health (the Ministry) to monitor sector progress in implementing the Ministry response to Blueprint II "Rising to the Challenge."[1] Existing information and data sources will be used initially to determine if progress is being made against key goals.

Implement the HDC monitoring programme – Real Time Feedback

Real Time Feedback is an innovative way to capture service experiences at the point of contact and use the information to inform change and drive quality improvement. A tender process was conducted to contract for a system to be developed and piloted to collect electronic feedback on the experience of mental health and addictions service users and their family/whānau and provide real time reporting to providers. It is proposed that feedback on consumer experience will be submitted using cell phone, kiosks or tablets. Data would then be uploaded to a central database with design features for analysis and multi-layered reporting to providers and relevant agencies in real time.

Implement new process of site visits – DHB Balanced Scorecard

In recent years the MHC undertook sector visits to provide an independent view of services funded by DHBs. During this financial year the MHC undertook nine structured site visits. The overall findings indicated that DHBs were implementing Blueprint II concepts and consumers and family/whānau were positive about the resulting service improvements. All CEOs that provided feedback on the visits indicated the process had been valuable. The following DHBs were visited from August 2012 to June 2013: Wairarapa, Lakes, Bay of Plenty, Capital & Coast, Waikato, Auckland, Hawke's Bay, Nelson Marlborough and Northland.

The Balanced Scorecard project is now being used as an alternative approach to provide a consistent method for DHBs and the HDC to jointly monitor progress towards the achievement of service goals. Initial steps have been taken to develop and pilot this process with the National KPI Group.

Key findings from the visits undertaken this year have informed the systemic advocacy projects the MHC will give priority to in the following year. The advocacy activities informed by monitoring include:

Choice and medicines

A project was initiated to provide national access to information on medications for mental health conditions. It is estimated that only 50% of people prescribed mental health medications actually take their medications,[3] resulting in significant potentially avoidable illness and associated costs. This project will enable the sector to pilot access to an international database of consumer information on 200 medicines used in New Zealand to treat mental health and addiction. Consumers and their family/whānau will be able to source accurate and reliable information on key questions they have about the medicines they are prescribed, including why they need to take them, what side effects they may experience and the options and consequences if they don't. The MHC is advocating a joint project in association with PHARMAC, specialist mental health pharmacists, the DHB pharmacy manager, and consumer and family/whānau representatives.

3. Mackay, K., Taylor, M., Patel, M: Medication adherence and patient choice in mental health. British Journal of Hospital Medicine, January 2011, Vol 72, No 1.

Support consumer and family/whānau advisor networks

The participation of advisors in service development and provision that have "lived experience" as consumers and family/whānau is essential in ensuring recovery based services. The MHC actively supports leadership development in these roles through three national networks:

- NAMHSCA – National Association of Mental Health Consumer Advisors
- National Family/Whānau network
- NCAT – The National Council of Addiction Treatment.

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

The Mental Health Commissioner's work plan has been presented at multiple fora and feedback overall indicates key stakeholders are satisfied with the information and direction.

Table 3: Outcomes in 2012/13

Stakeholder Group	% Satisfaction	Comments
Consumers	100%	National Association of Mental Health Service Consumer Advisors (NAMHSCA).
Providers	88%	National Clinical Directors and General Managers.
Family/Whānau	100%	Northern Region Family/Whānau Supporters Meeting – 59% of attendees responded to a rating scale from 1 (dissatisfied) to 5 (satisfied) – scores for workshop content were between 4 and 5.

Improving mental health and wellbeing for Māori youth

Improving health outcomes for youth is a priority for the Government, and addressing the disparity in outcomes for Māori youth is a major challenge. There is a paucity of information on effective models of care for Māori youth to guide the development of services. A collaborative project has been initiated with Te Rau Matatini as part of a broader work programme to improve the responsiveness of services to Māori.

The purpose of the project is to support improved outcomes for rangatahi. It includes site visits to a range of recommended rangatahi mental health and addiction services to determine how these services are being provided, and the factors that are contributing to their success in building resilience and supporting recovery. During this year, seven site visits were completed. The project team has also been invited to present its findings at the fourth Transcultural Conference in Perth Australia.

Reducing seclusion of consumers within mental health inpatient units

The MHC and DHBs have agreed to collaborate on a project aimed at significantly reducing the use of seclusion and restraint. The MHC has contracted with Ko Awatea, the innovation centre at Counties Manukau DHB, to lead this project and to capitalise on the success of their national collaborative learning model. The project will investigate and report on the current state of seclusion reduction efforts across New Zealand including analysis of the available data, evidence of what works, examples of successful reduction in seclusion, and the resources available to do this. The project will provide recommendations for ways to accelerate these efforts.

Increasing productivity – releasing time to care

Health services around the world are struggling to keep pace with demand for their services because of health workforce shortages and changing population characteristics including ageing, increased multi-morbidity and complex presentations. The MHC is supporting the national DHB General Managers and Clinical Directors to undertake this project to identify the most effective initiatives that will increase access to appropriate mental health services and reduce waiting times. Recommendations on what works will be developed to maximise productivity improvement nationally.

Independent advice to Government and advocacy on emerging issues

A prime function of the MHC is to provide independent advice to Government and other key agencies as a result of the monitoring and advocacy activities. The MHC met on a regular basis with both the Minister and Associate Minister for Health. Examples of independent advice provided this year include:

- MEDSAFE, PHARMAC, HQSC – to investigate the risk of sudden death in people taking clozapine and other antipsychotics and to promote their safe use
- the New Zealand Drug Foundation Summit on reshaping New Zealand's drug policy.

4.0 Supporting disabled consumers

HDC investigated several disturbing complaints from the disability sector over the past year. The complaints are a sobering reminder for us all about the importance of listening to people, and being vigilant about the standard of care provided to a highly vulnerable population whose voices can sometimes be hard to hear. Encouraging people, including family members and support staff, to speak up and talk about issues that concern them has been, and will continue to be a particular priority for HDC. Providers need to actively facilitate a culture where this conversation is easy to have.

In keeping with this increased emphasis on speaking up, HDC held an extremely successful disability sector conference in June this year on this very topic. The conference titled "Another Complaint, Another Improvement: Towards Better Disability Services" was aimed at encouraging both consumers and providers to view complaints as a tool for quality improvement. The conference provided useful information to consumers on why it is important to speak up, and how to raise concerns including avenues of alternative dispute resolution. Providers heard about how they could make the complaint process accessible to disabled people and how to turn complaints into learning opportunities.

In 2012-13 the HDC's education programme included a consumer seminar that focused on people's rights as consumers of health and disability services and how the HDC can assist when things go wrong.

Our efforts at making the complaints process more accessible and acceptable are beginning to pay dividends. HDC received 186 disability related complaints in 2012-13. The nature of the complaints reported to HDC are consistent with previous years. The five most common issues complained about are standard of care, communication, management of facilities, professional conduct and access & funding. The complaints continue to highlight the importance of providers having:

- systems in place for ensuring their staff understand what they are expected to do and when; and
- adequate training in place to support the development of their workforce capability; and
- an appropriate and timely response to concerns that are brought to their attention.

Learning from complaints

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

- formally apologised for not meeting consumer service expectations
- taken corrective measures by developing or revising policies that guide service delivery
- implemented education and training for their staff to increase their capability and skill levels.
- made changes to systems and processes within their service administration and/or delivery.

CASE STUDY
Care of a boy with an intellectual disability

A 15-year-old boy with Down syndrome and autism with high support needs was accepted into the care of a community home operated by a disability support service of a DHB.

Within about three months of the boy moving into the home, concerns about the care he was receiving from the team leader were brought to the attention of the boy's parents by some of the carers in the house. Two carers met with staff at the DHB and raised concerns about the care the team leader was providing to the boy, in particular, concerns that she was physically and verbally abusing him. There was no evidence that the concerns about the team leader's behaviour were formally investigated, and the DHB did not inform the parents of the carers' complaints and actions taken in response.

The following year, one of the boy's carers informed the parents of two incidents where he witnessed the team leader physically and verbally abuse the boy. The parents complained to the Police and to the National Health Board. Following the complaint to the National Health Board, the DHB conducted an investigation. The investigation was paper-based. No staff were interviewed, and the parents were not involved in the investigation process. The review concluded that the complaints were not substantiated. A subsequent review conducted at a later date, which involved staff interviews, found that there was a high probability that the team leader had physically and verbally abused the boy.

It was held that it was more likely than not that the team leader behaved in a professionally and ethically inappropriate and inexcusable manner toward the boy. The team leader's behaviour towards the boy appears to have been intentional, direct, and repetitive. To act in that way was a serious departure from the expected standard of care and showed a flagrant disregard for the boy's rights.

The DHB's response to the concerns raised about the care provided to the boy fell well short of the expected standard, and its failures in that regard put the boy's safety at risk. The DHB failed to adequately respond to concerns about the boy's care, and failed to provide the boy's legal guardians with adequate information.

The team leader and the DHB were referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

This case study highlights the importance of having an organisational culture where staff are encouraged to and feel safe to speak up when they have concerns about the quality of care provided to their clients. This case also reminds providers to deal appropriately with the complaints they receive and fully investigate any complaints involving alleged abuse.

CASE STUDY
Home support for a man with severe physical impairments

A complaint was received about the standard of home support being provided to a man who had severe cerebral palsy and required assistance with all his personal cares. Concerns were raised that the man was being neglected and also unduly influenced by a woman who was known as the "agent" for the man's care.

The Needs Assessment and Service Coordination service (NASC) assessed the man as being eligible for 63 hours carer support per week. For a period of three years, a disability support provider employed various members of the agent's family to provide care to the man. Throughout this time, the agent made decisions about the man's care, asserting that she was the man's Enduring Power of Attorney, despite the man remaining competent.

The man was left unattended for extended periods, provided with inadequate meals, and neglected. The carers, aided by the agent, falsified their time sheets and the care claimed for was not provided.

The man's half-brother made a complaint to the NASC about the quality and quantity of the care being provided to the man. The disability service provider reviewed the care being provided but no changes were made.

Later, following further complaints from various parties, the disability service provider assumed direct responsibility for the staff working with the man. Another disability service provider subsequently took over the man's care.

The agent failed to provide disability services with reasonable care and skill, to ensure that the man had services provided in a manner consistent with his needs, and to provide services that minimised potential harm and optimised his quality of life. The agent also exploited the man.

The disability service provider, as the employer of the carers, failed to provide appropriate oversight of the care provided, or to provide services with reasonable care and skill.

The NASC failed to take adequate steps to respond to complaints that the man was not receiving the quantity or quality of services he needed. The NASC didn't monitor the actual delivery of the man's support plan. It did not ensure that its assessments were based on accurate information. The NASC also failed to cooperate with the disability service provider to ensure the quality of services provided to the man was appropriate, and its response to complaints was poorly managed.

The agent, the disability service provider and the NASC were referred to the Director of Proceedings. This case study highlights the importance of providers appropriate overseeing of the care received by their clients, particularly when an agent is involved in managing the care. This case also emphasises the significance of providers understanding the provisions under the Code for a consumer's right to make an informed choice and give informed consent.

National Disability Conference

The third National Disability Conference was held on 17 June 2013 in Wellington. The conference was aimed at encouraging both consumers and providers to view complaints as a tool for quality improvement. The conference provided useful information to consumers on why it is important to raise concerns, and how to raise concerns including avenues of alternative dispute resolution. Providers heard about how to make complaint processes accessible and how to go about turning complaints into learning opportunities. Nearly 250 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. Anthony Hill, Health and Disability Commissioner; Laurie Harkin, Disability Services Commissioner (Victoria, Australia); and Paul Gibson, Disability Rights Commissioner, Human Rights Commission were the keynote speakers at the conference.

Consumer seminars

Two consumer seminars were held in Auckland for people with high and/or complex care and support needs and their carers and family members who use any form of disability support services. The first seminar held in November 2012 covered topics such as people's rights as consumers of health and disability services and how the HDC can assist when things go wrong. The second seminar held in March 2013 provided information on community mediation and also included a panel discussion that gave the participants an opportunity to ask questions and/or raise service related issues with the representatives of the Ministry of Health, local needs assessment agency, and New Zealand Disability Support Network.

Health Passport

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. Over the 2012/13 year the HDC continued to work with a number of DHBs to assist with the implementation of the Health Passport in their hospitals. As at June 2013, the Health Passport was an established part of care delivery in seven DHBs and planning was underway to implement the Health Passport in six more DHBs.

Feedback received by the HDC from both consumers and providers has been strongly supportive of the health passport initiative. Some of the direct feedback received by the HDC includes comments such as:

"I think that the Health Passport is a good idea...its availability should be more widely known."

"It was brilliant!! I am sight impaired and did not have to keep telling everyone... Well done!"

"...this would be a wonderful way to communicate when they don't understand vision loss."

"...we used for two of our patients with good outcomes."

"...it was a truly brilliant idea. The HP would be very helpful for our young people."

From 1 July 2013, advocates from Advocacy Service began distributing the Health Passports to consumers in rest homes and disability residential homes across the country. It is an incremental process with the distribution likely to be completed by June 2014.

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 and addiction. One of the key discussions at the meeting in May 2013 was around a potential review of the Mental Health (Compulsory Assessment and Treatment) Act. This was in light of an Australian research paper that compared the strengths and weaknesses of various Mental Health Acts in the Australasia region in relation to the Convention on the Rights of Persons with Disabilities (CRPD).

Consumer Advisory Group (CAG)

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

Three meetings were held with the HDC's CAG during the year. CAG provided advice to the HDC on its new vision statement, the planning of the 3rd National Disability Conference, appointment of disability expert advisors for the HDC, planning of consumer seminars and the need for ongoing disability responsiveness training for disability service providers. CAG also brought a range of issues to the HDC's attention, which included:

- concerns around the potential for health providers using social media to discover information about their patients without the patient's consent
- the monitoring of appropriateness of care provided and the training of family members as caregivers in light of the recent Ministry decision on paying some family members as caregivers
- more support needed for some people with disabilities and their families to understand their rights, importance of speaking up and how to make complaints, in particular for new migrants with disabilities.

The HDC's CAG also continued to provide advice to the Medical Council of New Zealand (MCNZ) during the year on the matters relevant to their work. The MCNZ have been appreciative of the feedback received.

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, the HDC champions system-wide quality improvements and encourages working towards a health care system where providers and consumers are fully engaged as part of a consumer-centred culture.

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

5.2 Staff

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

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

The HDC is a member of the Equal Employment Opportunities 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 2013, the Health and Disability Commissioner has 61.57 Full Time Equivalents (FTE) staff, as follows:

- 80% females and 20% males
- 51 full-time positions and 10.57 FTE part-time positions.

The HDC currently employs five 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.

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

5.5 "Good employer" obligations

1. Leadership, accountability and culture

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

2. Recruitment, selection and induction

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

3. Employee development, promotion and exit

The 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. A number of staff work hours that enable them to study as well as gain valuable work experience.

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 fora.

6. Harassment and bullying prevention

The HDC has a "Non 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 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, use of VITAE which offers confidential counselling, provision of fruit in each office, and flexible hours.

5.6 Process 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. The HDC is exploring 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

6.1 Outcomes — the change HDC aims to achieve for New Zealanders

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

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

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

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

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

The HDC's contribution against these outcomes is measured through the output performance as reported within the statement of service performance.

6.2 The HDC key activities and service outputs

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.

The HDC carries out the above activities through five output classes: Complaints resolution; Advocacy; Proceedings; Education; and Systemic monitoring and advocacy – mental health and addiction services.

6.3 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 time frames Estimated 1,440 complaints received. Estimated Resolution Times: 1. 80% closed within 6 months (= 1,152 complaints). 2. 95% closed within 12 months (= 1,368 complaints). 3. 99% closed within 2 years (= 1,426 complaints).	**Targets achieved** 1,619 complaints were received. This represents 112% of the annual estimated volume. **Targets not achieved** 1. 74.7% (1,158/1,551) closed within 6 months. 2. 91.5% (1,419/1,551) closed within 12 months. 3. 97.4% (1,510/1,551) closed within 2 years. HDC received 12% more complaints than the previous year.
Providers make service improvements based on the HDC recommendations A random sample of providers who report that they have complied with the HDC recommendations between 1 July 2012 and 30 June 2013 will be audited to verify compliance. That 99% of the random sample will be found to have complied.	**Target achieved** 100% of the random sample was found to have complied with the HDC's recommendations.
Satisfaction Reports 80% of the respondents rate that they are "satisfied" or "highly satisfied" (on a 5-point scale) with the timeliness and fairness of the HDC complaints processes.	**Target not achieved** A total of 255 complainants and providers responded to the survey. 71% of respondents agreed and strongly agreed that overall the HDC complaint process was fair and 63% of the respondents agreed the process was timely.

	12/13 Target	12/13 Actual	Variance of Target
Files closed	1,440 files	1,551 files	111 files
Closed within 6 months	80% = 1,152 files	74.7% = 1,158 files	Extra 6 files
Closed within 12 months	95% = 1,368 files	91,5% = 1,419 files	Extra 51 files
Closed within 2 years	99% = 1,426 files	97.4% = 1,510 files	Extra 84 files

6.4 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 time frames An 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** 3,194 new complaints were received by advocates in this reporting year. This represented 84% of the estimated total complaints expected. Year to date, 3,126 of these complaints were closed. 1. 88% (2,739) were closed within 3 months. 2. 99% (3,111) were closed within 6 months. 3. 100% (3,126) were closed within 9 months.
Complaints managed reach resolution 90% of complaints managed by the Advocacy Service are partially or fully resolved. Resolution when the consumer is satisfied and happy to move on.	**Target achieved** 94% (2,950) of complaints managed by the Advocacy Service were partially or fully resolved.
Consumers and providers are satisfied with the service and the professionalism of the advocate Surveys of consumers and providers who have used/dealt with the Advocacy Service will report that 80% of the respondents are satisfied with the service and the professionalism of the advocate.	**Target achieved** 81% of consumers and providers who have dealt with the Advocacy Service said they were satisfied with the service and the professionalism of the advocate. A total of 486 surveys were received.
Output 2 – Advocacy will establish and maintain contact with consumers and providers within the community	
Vulnerable consumers (in rest homes and disability homes) have access to advocacy through regular contact 1. Advocates to have two contacts with 60% of rest homes by 30 June 2013. 2. Advocates to have two contacts with 60% of disability homes by 30 June 2013.	**Targets achieved** 100% (677 of 677) of rest homes have had one contact by an advocate and 71% (482 of 677) have had two contacts. The total number of rest home contacts for the year is 3,096. 100% (980 of 980) of disability homes have had one contact by an advocate and 66% (644 of 980) have had two contacts. The total number of disability homes visited for the year is 3,145. Contacts are counted based on visits to residential homes, whether or not residents are available at the time of visit. Statistics for these visits are provided by the Advocacy Service.
Consumer and provider networks have regular contacts from the advocates 3,500 network contacts with consumers and providers by June 2013.	**Target achieved** 3,932 network contacts with consumers and providers were made by the advocates over the reporting year. This represents 112% of the annual target.
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 2013. 2. 80% of the consumer respondents report satisfaction with the education session.	**Targets achieved** 2,225 education sessions have been provided which represents 111% of the annual target. 89% of consumers and 90% of providers who attended an advocacy education session said they were satisfied with the session. A total of 8,661 surveys were received. Definition of a session is when an advocate delivers a training or educational presentation at a venue.
Ongoing education is provided through Great Care Stories 180 case studies/stories of Great Care published by 30 June 2013.	**Target achieved** 180 case studies/stories of Great Care were collected and published. This represents 100% of the annual target.

6.5 Output Class 3: Proceedings

Performance and measures	Achievement
Output 1 – Proceedings are taken in appropriate cases	
Professional misconduct is found in disciplinary proceedings Professional misconduct is found in 75% of disciplinary proceedings.	**Target achieved** Decisions in four disciplinary proceedings were received. Professional misconduct was found in 75% (3 of 4) of proceedings.
Breach of the Code is found in Human Rights Review Tribunal (HRRT) proceedings A breach of the Code is found in 75% of HRRT proceedings.	**Targets not applicable** There were no breach of the Code proceedings during 2012-13. One HRRT proceeding has been set down for hearing in August 2013.
An award is made where damages sought An award of damages is made in 75% of cases where damages are sought.	**Targets not applicable** No awards were made.

6.6 Output Class 4: Education

Performance and measures	Achievement
Output 1 – Provide up-to date, accessible and informative educational materials for consumers and providers	
New informative resources for consumers and providers are added to the Education section of the HDC's website Development of two educational resources targeting vulnerable consumer groups and disability sector providers.	**Target achieved** Two educational resources were produced: "Getting the best out of your health passport" booklet and a fact sheet "Consent for consumers who are not competent"
Material on the HDC's education section of the website is accessible to people who use "accessible" software 75% of educational materials are available in HTML and/or Word formats on the HDC's website by June 2013.	**Target achieved** 78% 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 20% of educational materials published in the last 5 years are available in "Plain English" format by 30 June 2013.	**Target achieved** 34% of educational materials published in the last five years are available in "plain English" format.
Output 2 – Provide informative reports on the work of the Commissioner to keep provider groups	
DHBs find complaints trend reports useful for improving services 1. Six-monthly the 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** 97.5% (38/39). There are two six monthly reports issued each year per DHB. Of the 39 reports issued during 2012-13, 38 were rated by DHB's as being useful for improving the safety and quality of their services.
Output 3 – Disability education	
Output 3.1 – Encourage the implementation of the Health Passport nationally in all DHBs	
Health Passport assists health professionals' understanding of patient needs, and improves care experience of consumers Liaise with and assist three DHBs to implement the Health Passport. All consumers and professionals who use the passport will have access to 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.	**Targets not achieved** A total of six DHBs have agreed to implement the Health Passport: Counties Manukau, Southern, Whanganui, Northland, South Canterbury and Auckland. Completed evaluation forms were received from very few actual passport users. 60% (3 of 5) "professional" respondents reported that the passport assisted their understanding of patient needs. 66% (2 of 3) "consumer" respondents reported that the passport assisted them in having a better overall care experience. Other general feedback received via email was very supportive of the Passport and included comments such as: "brilliant idea", "great initiative".
Output 3.2 – Organise annual National Disability conference	
National Disability conference programme meets participants' expectations All conference participants will be invited to complete an evaluation. 80% of the respondents report that the information received during the conference met their expectations.	**Targets achieved** The third National Disability conference was held on 17 June 2013 in Wellington. 91% (88 of 97) respondents who completed an evaluation form reported that the information received at the conference met their expectations.

6.6 Output Class 4: Education - Continued

Performance and measures	Achievement
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 2013 and seek evaluations on those presentations. 2.96% of respondents are satisfied that presentations met their expectations.	**Targets achieved** 67 educational presentations were made – this represents 268% of the annual estimated volume. 100% (61 of 61) people who provided feedback reported that the presentation met or exceeded their expectations. Presentations is defined as a single event.
Intensive training programmes meet participants' expectations 1. Provide two intensive provider education programmes by 30 June 2013. 2. 90% of participants reporting that they are satisfied with the content and delivery of the programme.	**Targets achieved** Two intensive provider education programmes were provided. 97% of respondents reported that they were satisfied with the content and delivery of the programme. 51 people responded.
Consumer seminars meet participants' expectations 1.Provide two regional consumer seminars for people with high and complex needs and their families by June 2013. 2.80% of respondents report that they are satisfied that the seminar met their expectations.	**Targets not achieved** Two consumer seminars were conducted. 43 people attended the seminars and completed evaluation forms were received from 22 people. 73% (16 of 22) respondents were satisfied that the seminar met their expectations.

6.6 Output Class 4: Education - Continued

Performance and measures	Achievement
Output 5 – Provide high quality submissions addressing matters that affect the rights of the HDC consumers.	
Recipient agencies are satisfied with the quality of the HDC's submissions A survey of people receiving submissions from the HDC will be undertaken. 95% of respondents rate that they are satisfied with the quality of the HDC's submissions.	**Targets achieved** Year to date, 25 submissions were made. Feedback forms were received in relation to 12 of 25 submissions. 100% (12 of 12) of respondents rated that they were satisfied with the quality of the HDC's submissions.

6.7 Output Class 5: Systemic monitoring and advocacy – mental health and addiction services

Performance and measures	Achievement
Output 1 – Integration	
Full integration of the HDC's new functions in mental health and addictions is completed by 30 December 2012 Mental Health Commissioner is located in the HDC's Auckland office with appropriate operational/system supports and an interim work plan by 31 July 2012. Develop a plan for the delivery of monitoring and advocacy functions by 20 December 2012.	**Targets achieved** Three people have been appointed to permanent positions making up 2.6 FTEs and thereby establishing the team to support the Mental Health Commissioner's work plan 2013–2016. The work plan was finalised to include a set of objectives that is designed to add maximum value to the sector within available resources. The HDC Statement of Intent 2013–2016 reflects the objectives in the final plan.
Stakeholders are provided with information about the HDC's new functions in mental health and addictions A communications plan to inform key stakeholders of the HDC's new functions was implemented from 1 July 2012 until 20 December 2012. 80% of stakeholders attending mental health and addiction fora during 2012/2013 are satisfied that they are informed about the HDC's role in monitoring and provision of advocacy in mental health and addiction services.	**Targets achieved** The Mental Health Commissioner's work plan 2013–2016 was presented to key national mental health and addictions services fora and gained positive feedback. The fora included the National Association of Mental Health Service Consumers Advisors (NAMHSCA), DHB Clinical Directors and General Managers and the Addictions Leaders forum. Completed questionnaires at the various fora indicate 90% of stakeholders are satisfied that they are informed about the HDC's role in monitoring and provision of advocacy in mental health and addictions services. A total of 31 surveys were received from key stakeholders.

6.7 Output Class 5: Systemic monitoring and advocacy – mental health and addiction services - Continued

Performance and measures	Achievement
Output 2 – Systemic advocacy	
Stakeholders are satisfied with the expert advice provided by the HDC Independent advice from the HDC on the final draft of the Service Development Plan (SDP) and other policies on Mental Health and Addiction services is provided to the Ministry. Advice is provided within agreed time frames. Evaluation feedback from the Ministry indicates that they are satisfied with the quality of advice. Independent advice (initiated by the HDC or upon request) to the Minister and other stakeholders on mental health and addiction services. Evaluation feedback from sector presentation reflects overall satisfaction with advice provided.	**Targets achieved** Meetings have been held with multiple stakeholders during the year, including senior management teams from DHBs, NGOs, other Government entities, and the Ministry. Written feedback and evaluations were received indicating overall high level of satisfaction with the expert advice in support provided by the Mental Health Commissioner. Following the signing of the Memorandum of Understanding with the Ministry, formal feedback has been sought indicating satisfaction with the quality and timeliness of advice provided. The Commissioner funded National Committee for Addiction Treatment (NCAT) and Matua Raki to hold a National Meeting of Addiction Leaders hosted by Minister Dunne in Parliament to consider how to implement the Government's priorities for improving addiction services. The Mental Health Commissioner provided feedback during the review of the National Health and Disability Service Standards. The Mental Health Commissioner is currently redrafting publications and this work is still in progress and will be achieved in 2013-14. Some of the key stakeholders (eg. The Ministry) have written to the Mental Health Commissioner acknowledging their satisfaction with the information they were provided with.
Consumers and their family/whānau are satisfied that the information and advice provided by the HDC has supported their participation in mental health and addiction services Provide information and advice to consumers and their family/whānau to support their participation in mental health and addiction services. Evaluation feedback from consumers and family/whānau indicates satisfaction that the information and advice provided has supported their participation in mental health and addiction services.	**Targets achieved** Two key consumer and family/whānau resources developed by the former Mental Health Commission have been distributed to fill orders and are now out of stock. Due to ongoing demand, a review of both booklets was initiated in collaboration with the National Association of Mental Health Service Consumer Advisors (NAMHSCA) and the National DHB Family/Whānau Advisors Group. There is a high level of support throughout the sector to update these resources which have supported the participation of consumers and family/whānau in mental health and addiction services. The review and reprint will be completed in the 2013/14 financial year. Feedback from service users and family/whānau through the family networks indicated satisfaction with the information and advice provided in these resources. The feedback was gathered from NAMHSCA and the Northern Regional Network. The Mental Health Commissioner is currently redrafting publications and this work is still in progress and will be achieved in
Consumers, family and whānau are satisfied with the support they received from HDC for national fora Joint initiatives are undertaken with both the National Consumer and Family/whānau networks to strengthen their respective roles as active participants in mental health and addiction services. Evaluation feedback from consumers and their family/whānau reflects that they are satisfied with the support they received from the HDC for national fora.	**Targets achieved** The HDC jointly presented with the Co-Chair of the National DHB Family/Whānau Advisors' Group at the Code of Rights anniversary celebration in Auckland on 1 July 2013. The focus was on-going support for mental health and addictions services and consumers. Support was provided for the first northern regional network meeting of family whānau support networks. Feedback received showed the meeting was successful.

6.7 Output Class 5: Systemic monitoring and advocacy – mental health and addiction services - Continued

Performance and measures	Achievement
Output 3 – Monitoring	
Mental health and addiction services (MHA) are monitored for progress against the outcomes outlined by the Ministry's Service Development Plan (SDP) and the Mental Health Strategy, and reports are provided to the Ministry and MHA sector to support service improvement. Eight district sector visits completed by 30 June 2013. DHB CEOs and the Ministry rate the feedback from district sector visits was useful by 30 June 2013.	**Target achieved** Nine visits completed this financial year. Meetings with the Key Performance Indicator (KPI) Group were held to agree to jointly undertake the development of new tools to support a process of site visits, and is of value to DHBs. This process will build on the independent nature of the HDC, and maximises consumer and family/whānau input into service improvement. Feedback from the first six district sector visits this year has been unanimously positive, with CEOs reporting that the process and feedback have been useful. Feedback is still pending for the final three visits.

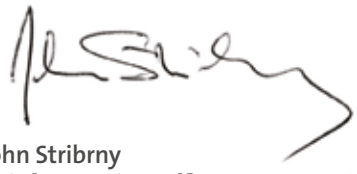
7.0 Statement of responsibility

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 2013.

Anthony Hill
Health and Disability Commissioner



John Stribrny
Chief Operating Officer

31 October 2013

8.0 Audit report

Independent Auditor's Report

To the readers of the Health and Disability Commissioner's financial statements and non-financial performance information for the year ended 30 June 2013

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

We have audited:

- the financial statements of Health and Disability Commissioner on pages 51 to 71, that comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and notes to the financial statements that include accounting policies and other explanatory information; and
- the non-financial performance information of Health and Disability Commissioner on pages 38 to 46 and page 50 that comprises the statement of service performance, and which includes outcomes.

Opinion

In our opinion:

- the financial statements of Health and Disability Commissioner on pages 51 to 71:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect Health and Disability Commissioner's:
    - financial position as at 30 June 2013; and
    - financial performance and cash flows for the year ended on that date.
- the non-financial performance information of Health and Disability Commissioner on pages 38 to 46 and page 50:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects Health and Disability Commissioner's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
    - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2013. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and non-financial performance information. The procedures selected depend on our judgement, including our

assessment of risks of material misstatement of the financial statements and non-financial performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of Health and Disability Commissioner's financial statements and non-financial performance information that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of Health and Disability Commissioner's internal control.

An audit also involves evaluating:

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

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

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

Responsibilities of the Health and Disability Commissioner

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

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

9.0 Financial statements

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE
for the year ended 30 June 2013

	Actual	Budget
	2013	2013
	$	$
OUTPUT 1 (Complaints Resolution):		
Resources employed		
Revenue	4,193,100	3,823,250
Expenditure	4,311,752	4,031,030
Net Surplus(Deficit)	**(118,652)**	**(207,780)**
OUTPUT 2 (Advocacy):		
Resources employed		
Revenue	4,300,552	4,289,500
Expenditure	4,512,681	4,598,840
Net Surplus(Deficit)	**(212,129)**	**(309,340)**
OUTPUT 3 (Proceedings):		
Resources employed		
Revenue	637,922	746,000
Expenditure	656,762	786,540
Net Surplus(Deficit)	**(18,840)**	**(40,540)**
OUTPUT 4 (Education):		
Resources employed		
Revenue	573,134	466,250
Expenditure	495,285	491,590
Net Surplus(Deficit)	**77,849**	**(25,340)**
OUTPUT 5 (Monitoring and Systemic Advocacy):		
Resources employed		
Revenue	1,000,000	1,000,000
Expenditure	987,213	1,000,000
Net Surplus(Deficit)	**12,787**	**0**
TOTALS:		
Resources employed		
Revenue	10,704,708	10,325,000
Expenditure	10,963,693	10,908,000
Net Surplus(Deficit)	**(258,985)**	**(583,000)**

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 30 June 2013

	Note	Actual 2013 $	Budget 2013 $	Actual 2012 $
Income				
Revenue from Crown	2	10,420,000	10,170,000	9,464,000
Interest income		71,454	80,000	95,659
Other income	3	213,254	75,000	85,187
Total income		**10,704,708**	**10,325,000**	**9,644,846**
Expenditure				
Personnel costs	4	5,104,013	4,757,000	4,221,004
Depreciation and amortisation expense	9, 10	69,250	225,000	168,581
Advocacy Services		3,546,580	3,600,000	3,569,986
Other expenses	5	2,243,850	2,326,000	1,807,911
Total expenditure		**10,963,693**	**10,908,000**	**9,767,482**
Net deficit for the year		(258,985)	(583,000)	(122,636)
Total comprehensive income for the year		**(258,985)**	**(583,000)**	**(122,636)**

The accompanying notes form part of these financial statements

The accompanying notes form part of these financial statements

STATEMENT OF FINANCIAL POSITION
as at 30 June 2013

	Note	Actual 2013 $	Budget 2013 $	Actual 2012 $
Assets				
Current assets				
Cash and cash equivalents	6	1,378,000	1,140,000	1,636,227
Debtors and other receivables	7	326,480	200,000	39,764
Prepayments		91,136	54,000	350,881
Inventories	8	53,502	30,000	24,294
Total current assets		**1,849,118**	**1,424,000**	**2,051,166**
Non-current assets				
Property, plant and equipment	9	81,921	284,000	74,192
Intangible assets	10	2,929	39,000	28,770
Total non-current assets		**84,850**	**323,000**	**102,962**
Total assets		**1,933,968**	**1,747,000**	**2,154,128**
Liabilities				
Current liabilities				
Creditors and other payables	11	511,302	446,000	518,094
Employee entitlements	12	228,497	150,000	145,667
Total current liabilities		**739,799**	**596,000**	**663,761**
Non-current liabilities				
Lease incentive	13	111,641	120,000	148,854
Total non-current liabilities		**111,641**	**120,000**	**148,854**
Total liabilities		**851,440**	**716,000**	**812,615**
Net assets		**1,082,528**	**1,031,000**	**1,341,513**
Equity				
General funds	14	1,082,528	1,031,000	1,341,513
Total equity		**1,082,528**	**1,031,000**	**1,341,513**

The accompanying notes form part of these financial statements

STATEMENT OF CHANGES IN EQUITY
for the year ended 30 June 2013

	Actual	Budget	Actual
	2013	2013	2012
	$	$	$
Balance at 1 July	1,341,513	1,314,000	1,464,149
Amounts recognised directly in equity:			
Capital contribution	0	300,000	0
Deficit for the Year	(258,985)	(583,000)	(122,636
Total net recognised revenues and expenses	**1,082,528**	**1,031,000**	**1,341,513**
Balance at 30 June	**1,082,528**	**1,031,000**	**1,341,513**

The accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS
for the year ended 30 June 2013

	Note	Actual 2013 $	Budget 2013 $	Actual 2012 $
Cash flow from operating activities				
Current assets				
Receipts from Crown revenue		10,170,000	10,170,000	9,464,000
Interest received		63,173	80,000	99,482
Receipts from other revenue		151,314	75,000	238,449
Payments to suppliers		(5,606,962)	(6,133,000)	(5,553,652)
Payments to employees		(5,021,183)	(4,757,000)	(4,225,392)
Goods and services tax (net)		36,492	0	24,196
Net cash from operating activities	**15**	**(207,166)**	**(565,000)**	**47,083**
Cash flows from financing activities				
Receipts from Capital Contribution		0	300,000	0
Net cash from financing activities		**0**	**300,000**	**0**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		78	0	0
Purchase of property, plant and equipment		(51,139)	(200,000)	(33,377)
Purchase of intangible assets		(0)	(50,000)	(33,832)
Net cash from investing activities		**(51,061)**	**(250,000)**	**(67,209)**
Net increase (decrease) in cash and cash equivalents		**(258,227)**	**(515,000)**	**(20,126)**
Cash and cash equivalents at beginning of year		1,636,227	1,655,000	1,656,353
Cash and cash equivalents at end of year	**6**	**1,378,000**	**1,140,000**	**1,636,227**

The accompanying notes form part of these financial statements

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 30 June 2013

1. Statement of accounting policies for the year ended 30 June 2013

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 2013, and were approved by the Commissioner on 31 October 2013.

Basis of Preparation

Statement of compliance

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

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

Measurement base

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

Functional and presentation currency

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

Changes in accounting policies

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

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which 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 3 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, Health and Disability Commissioner is classified as a "Tier 3" 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 Health and Disability Commissioner expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, Health and Disability Commissioner 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.

Sundry income
Sundry income is recognised when HDC's public-held conference is registered by the attendee.

Leases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subsequent costs

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

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

Depreciation

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

Leasehold improvements
3 years (33%)

Furniture and fittings
5 years (20%)

Office equipment
5 years (20%)

Motor vehicles
5 years (20%)

Computer hardware
4 years (25%)

Communication equipment
4 years (25%)

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

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

Intangible assets

Software acquisition and development

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

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

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

Amortisation

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

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

Acquired computer software
2 years 50%

Capitalisation threshold

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

Impairment of non-financial assets

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

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

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

Creditors and other payables

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

Employee entitlements

Short-term employee entitlements

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

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

Superannuation schemes

Defined contribution schemes

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

Goods and Service Tax (GST)

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Critical Accounting Estimates and Assumptions

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

Property, plant and equipment useful lives and residual value

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

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

- physical inspection of assets;
- asset replacement programmes.

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

Critical Judgements in Applying 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 2013:

Lease classification

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

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

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

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

2. Revenue from Crown

The Health and Disability Commissioner has been provided with funding from the Crown for the specific purposes of the Health and Disability Commissioner as set out in its founding legislation and the scope of the relevant government appropriations. Apart from these general restrictions there are no unfulfilled conditions or contingencies attached to government funding (2012 nil).

3. Other Income

	Actual 2013 $	Actual 2012 $
Sale of publications	107,570	85,187
Sundry Income	**105,684**	**0**
Total other revenue	**213,254**	**85,187**

4. Personnel costs

	Actual 2013 $	Actual 2012 $
Salaries and wages	4,918,540	4,198,687
Employer contributions to defined contribution plans	102,643	26,705
Increase/(decrease) in employee entitlements (note 12)	82,830	(4,388)
Total personnel costs	**5,104,013**	**4,221,004**

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

5. Other expenses

	Actual 2013 $	Actual 2012 $
Fees to auditor:		
Audit fees for financial statement audit	40,704	34,320
Staff travel and accommodation	220,794	129,429
Operating lease expense	430,027	382,074
Advertising	22,873	30,385
Consultancy	478,360	328,235
Inventories consumed	134,225	94,821
Net loss on property, plant and equipment	0	52,217
Other	916,867	756,430
Total other expenses	**2,243,850**	**1,807,911**

6. Cash and cash equivalents

	Actual 2013 $	Actual 2012 $
Cash on hand and at bank	378,000	636,227
Cash equivalents – term deposits	1,000,000	1,000,000
Total cash and cash equivalents	**1,378,000**	**1,636,227**

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 3.62% (2012 3.8%).

7. Debtors and other receivables

	Actual 2013 $	Actual 2012 $
Trade receivables	63,765	35,330
Other receivables	12,715	4,434
Less provision for impairment	0	0
Accrued Revenue	250,000	0
Total debtors and other receivables	**326,480**	**39,764**

Accrued Revenue includes a one-off funding amount of $250,000 exclusive GST as at 30/06/2013.

The carrying value of receivables approximates their face 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 2013 and 2012, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2013 $	2012 $
Not past due	307,691	18,710
Past due 1–30 days	4,747	5,501
Past due 31–60 days	412	2,830
Past due 61–90 days	811	3,856
Past due > 91 days	104	5,699
Total	**313,765**	**36,596**

8. Inventories

	Actual 2013 $	Actual 2012 $
Publications held for sale	53,502	24,294
Inventories	**53,502**	**24,294**

The carrying amount of inventories held for distribution that is measured at current replacement costs as at 30 June 2013 amounted to $53,502 (2012 $24,294).

9. Property, plant and equipment

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

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

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
Impairment 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)
Depreciation 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**	**6,025**	**74,192**

In the year ended 30 June 2013, Health and Disability Commissioner maintains its capitalisation threshold as $1,000. Health and Disability Commissioner has no restrictions or pledged security over the total of Health and Disability Commissioner's tangible assets nor any intangible assets pledged as security for liabilities.

10. Intangible assets

Movements in intangibles as at 30 June 2013 are as follows:

	Actual 2013 $	Actual 2012 $
Computer software		
Balance at 1 July	1,059,431	1,038,656
Additions during the year	0	35,138
Disposals during the year	0	(14,363)
Balance at 30 June	**1,059,431**	**1,059,431**
Accumulated amortisation		
Balance at 1 July	1,030,661	971,973
Charge for the year	25,841	71,744
Disposals	0	0
Depn recovered	0	(13,056)
Balance at 30 June	1,056,502	1,030,661
Net book value at 30 June	**2,929**	**28,770**

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 2013 $	Actual 2012 $
Creditors	294,521	239,353
Income in advance	0	0
Accrued expenses	49,600	41,040
Provisions	0	117,769
Lease incentive	37,213	37,213
Other payables	129,968	82,719
Total creditors and other payables	**511,302**	**518,094**

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

12. Employee entitlements

	Actual 2013 $	Actual 2012 $
Current employee entitlements are represented by:		
Annual leave	227,305	144,473
Retirement and long service leave	1,192	1,194
Total current portion	228,497	145,667
Total employee entitlements	**228,497**	**145,667**

13. Non-current liability

	Actual 2013 $	Actual 2012 $
Lease incentive liability	111,641	148,854
Total non-current liability at 30 June	**111,641**	**148,854**

Lease incentive relating to Auckland office at Level 10, 45 Queen Street for period 1 July 2013 to 9 June 2017.

14. Equity

	Actual 2013 $	Actual 2012 $
General funds		
Balance at 1 July	1,341,513	1,464,149
Total comprehensive income for the year	(258,985)	(122,636)
Total equity at 30 June	**1,082,528**	**1,341,513**

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

	Actual 2013 $	Actual 2012 $
Total comprehensive income	(258,984)	(122,636)
Add/(less) non-cash items:		
Depreciation and amortisation expense	69,250	168,581
Total non-cash items	**(189,734)**	**45,945**
Add/(less) items classified as investing or financing activities		
Disposal of property, plant and equipment	(78)	52,217
Total items classified as investing or financing activities	**(78)**	**52,217**
Add/(less) movements in working capital items		
Debtors and other receivables	(60,476)	(140,158)
Inventories	(29,208)	(4,260)
Creditors and other payables	(10,500)	97,727
Employee entitlements	82,830	(4,388)
Net movements in working capital items	(17,354)	(51,080)
Net cash from operating activities	**(207,166)**	**47,083**

16. Commitments and operating leases

Advocacy Service contracts

The maximum commitment for the 12 months from 1 July 2013 is $3,539,998 (2012: $3,595,998).

Operating leases as lessee

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

	Actual 2013 $	Actual 2012 $
Not later than one year	389,694	365,628
Later than one year and not later than five years	860,925	1,091,432
Later than five years	0	0
Total non-cancellable operating leases	**1,250,619**	**1,457,060**

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

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

17. Contingencies

Contingent liabilities

As at 30 June 2013 there were no contingent liabilities (2012 $Nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2012 $Nil).

18. Related party transactions and key management personnel

Related party transactions

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

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

The Health and Disability Commissioner has been provided with funding from the Crown of deemed $10,170m plus an additional $250k one-off funding (2012 $9.464m) 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 2013 totalled $0.1 million (2012 $0.1 million). These purchases included the purchase of electricity from Meridian, air travel from Air New Zealand, and postal services from New Zealand Post.

Key management personnel compensation

	Actual	Actual
	2012	2011
	$	$
Salaries and other short-term employee benefits	1,486,909	1,094,740
Post-employment benefits	37,949	33,942
Total key management personnel compensation	**1,524,858**	**1,128,682**

Key management personnel include the eight Executive Leadership Team members.

19. Employee remuneration

Total remuneration paid or payable

	Actual 2013	Actual 2012
100,000–109,999	1	0
110,000–119,999	2	0
120,000–129,999	0	1
130,000–139,999	1	0
150,000–159,999	1	2
160,000–169,999	1	0
170,000–179,999	0	1
180,000–189,999	0	1
190,000–199,999	1	0
250,000–259,999	1	0
270,000–279,999	1	1
Total employees	**9**	**6**

During the year ended 30 June 2013, no employees received compensation and other benefits in relation to cessation (2012: $nil).

19a. Commissioner's total remuneration

In accordance with the disclosure requirements of sections 152(1)(a) of the Crown Entities Act 2004, the total remuneration includes all benefits paid during the period 1 July 2012 to 30 June 2013.

	Actual 2013	Actual 2012
Commissioner	**$277,915**	**$277,915**

The current Commissioner took office on 19 July 2010.

20. Significant events after the balance date

There were no other significant events after the balance date.

21. Categories of financial assets and liabilities

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

	Actual 2013 $	Actual 2012 $
Loans and receivables:		
Cash and cash equivalents	1,378,000	1,636,227
Debtors and other receivables	326,480	39,764
Total loans and receivables	**1,704,480**	**1,675,991**
Financial liabilities measured at amortised cost:		
Creditors and other payables	511,302	518,094
Total financial liabilities measured at amortised cost	**511,302**	**518,094**

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 rate on the Health and Disability Commissioner's term deposit is 3.62% (2012:3.8%).

Cash flow interest rate risk

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

Credit risk

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

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

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

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

Liquidity risk

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

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

Sensitivity analysis

As at 30 June 2013, 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 (2012: $5,000) higher/lower. This movement is attributable to increased or decreased interest expense on the cash deposits.

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

	Less than 6 months	Between 6 months and 1 year	Between 1 and 5 years
	$	$	$
2013			
Creditors & other payables – carrying amount(note 11)	511,302	0	0
Creditors & other payables – contracted cashflows(note 11)	511,302	0	0
2012			
Creditors & other payables – carrying amount (note 11)	518,094	0	0
Creditors & other payables – contracted cashflows	518,094	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

This is the 1st financial year that Health and Disability Commissioner has integrated functions of previous Mental Health Commission. Therefore, Health and Disability Commissioner's operating expenditure and payroll is higher than the previous year. Nevertheless, Health and Disability Commissioner managed to keep its overall financial performance in line with its original budget for the financial year 2012/13.

Health and Disability Commissioner consumed fewer costs in a number of areas including depreciation (due to less capital expenditure) and operating costs (including lower consultancy and lower external legal advice) than budgeted.

Effectively, Health and Disability Commissioner earned $138,000 more other income mainly from its public-held conferences in addition to a one-off extra funding of $250,000 to hire more staff in order to manage continuously increasing complaints.

Statement of financial position

The lower than budgeted deficit per the Statement of Comprehensive Income gives Health and Disability Commissioner a better equity position than the budget. This is also attributed to $250,000 GST exclusive one-off extra funding provided to manage additional complaints. This amount is included in the Debtors and other receivables.

Health and Disability Commissioner has incurred few capital expenditures than budgeted as an IT infrastructure review was just completed. A procurement process is carried out after the balance date.

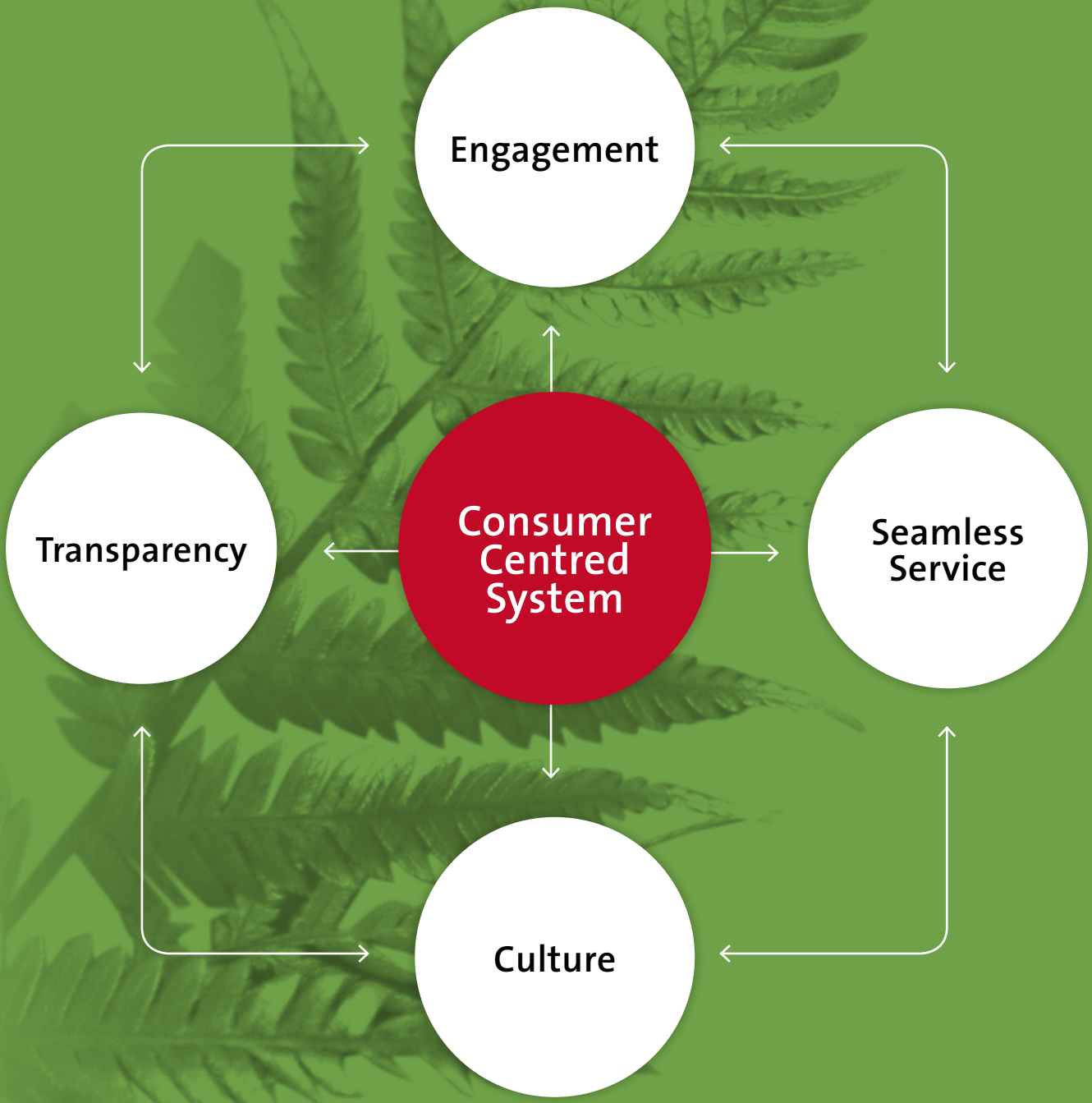
Health and Disability Commissioner hired more staff during last few months of the financial year to support increased business activities that directly resulted in a higher employee entitlement liability at the balance date.

Statement of changes in equity

As a direct consequence of the lower deficit, Health and Disability Commissioner's equity is higher than budget.

Statement of cash flows

The lower deficit translated directly to a lower "cash from operating activities" being $207,000 in deficit vs. a $565,000 budgeted deficit. In addition, "cash from investing activities" was $199,000 lower than budget with fewer assets purchased than budgeted because $300,000 expected capital contribution is not received during the 2012/13 financial year.


Engagement
Transparency
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Culture

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