



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Office of the Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Statement of Intent

2008/09

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E ngā mata-a-waka o te motu, tēnā koutou katoa
All groups throughout the land, greetings to you all.

This Statement of Intent explains the context we work in, how we intend achieving our vision, challenges we are likely to face, risks we must manage, and how we will measure our progress. It also describes the organisational assets we rely on to achieve our goals.

Our foundation principles are: fairness, care, compassion, responsiveness and quality. We aim to:

- speak up for the rights of all New Zealand health and disability service consumers
- champion the safety and quality of all such services
- be perceived by consumers, providers and key agencies as significant and credible
- be a good employer, attracting and retaining the best people and creating the best work environment
- maintain strong, independent Advocacy and Proceedings functions
- gain international respect for our expertise and knowledge.

During 2008/09, HDC will:

- maximize opportunities for less serious complaints to be resolved locally between complainants and providers
- maintain our high profile through education initiatives and media opportunities
- ensure we have the best people in the right jobs working to achieve our goals
- push to have information available to the public about the safety and quality of health and disability services in their communities
- improve the timeliness and accessibility of our complaint resolution processes.

My two Deputy Commissioners and I look forward to working with staff, advocates, consumers, providers, key agencies and the wider community to make this plan a reality.



Ron Paterson
Health and Disability Commissioner



Rae Lamb
Deputy Health and Disability Commissioner



Tania Thomas
Deputy Health and Disability Commissioner

Dated: 25 March 2008

PART ONE

1.0 About this report

We outline what the Minister of Health, on behalf of all New Zealanders, is purchasing from HDC. We inform the public and Parliament how HDC intends, now and in the future, to prioritise and carry out its functions and services.

Part 1 describes the organisation, our main work and working environment, what we hope to achieve in the long term, and how we will achieve it.

Part 2 contains the annual financial and non-financial measures and standards by which HDC will be assessed.

2.0 Our operating environment

2.1 Our legal environment

The Act

HDC is a Crown entity, its Commissioner independent of government policy. The office was created by the Health and Disability Commissioner Act 1994, which tasked it with promoting and protecting the rights of health and disability service consumers, and resolving complaints fairly, simply, speedily and efficiently.

The Act also created a Director of Advocacy, responsible for a national network of independent advocates, and a Director of Proceedings. Since 1994, HDC has taken a central role in dealing with complaints about New Zealand health and disability service providers.

The Commissioner's jurisdiction is confined to quality of care; it does not extend to funding issues or service entitlement. The Commissioner must review the Act at least every five years. The next review is scheduled for 2008/09.

The Code

The Code of Health and Disability Services Consumers' Rights (the Code) was established in 1996, and applies to all health and disability service providers. Its 10 rights include the right to be treated with respect and without discrimination or exploitation, to dignity and independence, to services of an appropriate standard, to give informed consent, and to complain.

Code rights extend to all consumers, and impose obligations on every person and organisation providing health or disability services, public or private including:

- hospitals
- doctors
- counsellors
- nurses
- optometrists
- rest homes
- home care providers
- homeopaths
- therapeutic masseurs
- midwives
- rehabilitation workers
- physiotherapists
- disability support service providers

2.2 Our organisational services

The Health and Disability Commissioner, Ron Paterson leads a team of 50 staff. Fourteen staff, comprising the Proceedings and Legal teams and two corporate support staff, work in our Wellington Office. The Auckland office houses 36 staff – the Complaints Resolution team, Education and Corporate Services teams, and the Director of Advocacy and her assistant.¹

Promotion and education

HDC promotes its services through advertising, via media, radio and television interviews, our website, journal articles, newsletters, reports and opinions, and in many seminar and conference presentations for provider and consumer organisations.

Community-based advocates are our most powerful educational resource. Apart from them, HDC itself delivers limited education and training initiatives. These are pitched at the national, rather than community, level and at large providers with staff trainers, and professional bodies and consumer-based organisations, rather than the public. Our resources are designed to help providers make sense of HDC opinions and recommendations, and encourage as many as possible to improve their services.

Director of Advocacy

The nationwide advocacy service is available free to anyone with a concern or complaint about a health or disability service. Although created by the HDC Act, the advocacy service reports to independent Director Judi Strid.

The service is confidential. Advocates take the side of the consumer, and the service operates independently of the Commissioner, practitioners/providers, government agencies and funding bodies.

Working out of offices from Kaitaia to Invercargill, advocates tell consumers about their health and disability service rights, and help those wanting to make a complaint. They also offer provider education and training on consumer rights and provider duties.

Director of Proceedings

Director of Proceedings Theo Baker, a lawyer, is an independent statutory officer appointed under the Act. She decides whether referrals from the Commissioner should progress to proceedings against the provider. The proceedings team is based in Wellington, and includes two other lawyers and two assistants. Sometimes, to maintain efficient service delivery, outside counsel are briefed.

Although the Director may represent or help complainants in any forum (court, tribunal or inquiry), she focuses on disciplinary proceedings and proceedings before the Human Rights Review Tribunal.

The main body for hearing charges against registered health practitioners is the Health Practitioners Disciplinary Tribunal.² If the provider is not a registered health practitioner,³ the Director may file proceedings with the Human Rights Review Tribunal. The tribunal

¹ An Organisational Chart depicting the staff positions within HDC is attached as Appendix 1.

² Schedule Four of the Health Practitioners Competence Assurance Act 2003 defines a registered health practitioner to include medical practitioners, nurses, midwives, dentists, chiropractors and pharmacists.

³ Non-registered practitioners include providers such as counsellors, massage therapists and acupuncturists.

may hear claims against bodies such as rest homes and district health boards, or against a registered health professional, regardless of whether disciplinary proceedings are also brought. Unlike the Health Practitioners Disciplinary Tribunal, the Human Rights Review Tribunal has the power to order the provider to pay compensation to a consumer. Compensatory damages are available only in limited circumstances, however, because of ACC legislation.

An aggrieved consumer may bring their own proceedings when the Commissioner has found a breach of the Code but does not refer the provider found in breach to the Director of Proceedings. Consumers may also bring their own proceedings before the Human Rights Review Tribunal when the Director of Proceedings decides not to do so.

2.3 How we resolve complaints

Who makes complaints?

Anyone can complain, orally or in writing – consumers, their families and support people, and third parties, such as concerned staff in a provider organisation.

The kind of complaints we get

Most complaints relate to communication, regardless of any clinical or other issues. They focus on the manner or attitude of whoever provided the service – that they gave too little information or gave it in an unacceptable way. Usually, communication is only one of many issues raised about the care the consumer received. Others concern diagnosis and treatment and, in the case of rest homes, ongoing care.

How HDC responds

We try to determine what the provider could reasonably have known at the time. We rely on expert independent advisors working in the same specialty in a similar setting (provincial or rural, district health board or private hospital) to decide whether clinical care met professional standards. We ask the expert advisors whether, and to what extent, care failed to meet these standards.

Taking the initiative

The Commissioner need not wait for a complaint before taking action. The Act allows him to investigate situations on his own initiative enabling him to be a “consumer watchdog”, protecting public safety.

He may launch a Commissioner’s initiative inquiry when HDC has had several complaints about the same provider (a rest home, for instance) or when there is public concern about safety.

This was the case with Canterbury Health in 1997, Gisborne Hospital in 2000, Tauranga Hospitals in 2004, and Wanganui Hospital in 2007.

Fielding enquiries, dealing with complaints

HDC receives around 5,000 enquiries and 1,100 complaints a year. We deal with 89% of complaints without formally investigating them. Because the Act aims to promote and protect the rights of health and disability service consumers, HDC focuses on local-level or direct resolution in order to address complaints quickly and fairly.

Investigation

Investigation is the most drawn-out way of resolving a complaint – a simple investigation can take six to nine months, a complex one, 18 months. Investigation, then, is not always consistent with fair, simple, speedy and efficient resolution. Nor is it most appropriate where parties have an ongoing relationship, which is often the case with disability service consumers and people who are chronically ill.

Investigation is usually unnecessary if the consumer is happy with a provider's response. Some cases fall outside our jurisdiction, in which case HDC refers the consumer to the appropriate agency.

Other ways of resolving complaints

Most complaints are dealt with through “education letters”, advocacy and mediation. These are more suitable to sorting things out fairly and quickly for all concerned. They also allow relationships (such as doctor-patient) to continue, and resolve complaints arising from parties being at cross purposes, with different ideas about what happened. A meeting can often resolve outstanding issues.

How advocacy works

Advocates get around 8,600 enquiries a year, and manage about 4,600, as well as dealing with enquiries and complaints received by HDC. On average 88% of complaints managed by advocates are wholly or partly resolved.

Advocacy is a very successful way to achieve early resolution as it involves face-to-face contact and is the consumer's process. The advocate assists the consumer to identify what is needed to resolve the complaint and supports them in their chosen actions. This can be a very effective process for teaching self-advocacy skills to consumers, so they feel more confident about handling any future difficulties, as well as providing direct feedback to providers.

Consumers are keen for an outcome of their complaint to be a reduction in the likelihood of a similar thing happening to someone else. It is helpful for providers to hear this face-to-face. Many comment on how profound this is to hear as they had not realised the impact of their actions.

In addition, Advocacy intervention helps build relationships, which may be important if the consumer and provider need to have ongoing contact.

3.0 What impacts on HDC work

3.1 External influences on our work

Government requires HDC, as a Crown entity, to participate in its wider initiatives as well as in relevant health and disability strategies.

HDC response: We make submissions to inform legislative changes that may affect health and disability services consumers. HDC works with other agencies to better contribute to government's wider initiatives.

Health budgets, here and overseas, are under increasing pressure. Health workforce shortages, and the need to better train and fund those caring for disabled and elderly consumers is likely to drive up costs.

HDC response: We take into account providers workforce and other resource constraints (especially in the public system in assessing whether a provider's actions complied with the Code).

Consumers are becoming more aware of their rights, including the right to complain. But ability to exercise these rights, along with confidence, knowledge and expectations, vary between ethnicities and cultures. Society has embraced more diverse groups – youth, gay, Deaf, migrants' and older people's "cultures". People with disabilities, older people and people with experience of mental illness are more visible than ever before. Numbers of Māori providers have risen significantly.

HDC response: We customise education and promotion to diverse consumer needs. HDC convenes consumer seminars to gain insight and input into the way we do our work. Our work plan includes initiatives developed by consumer advisors from vulnerable communities.

Providers are changing their attitudes to complaints, many seeing the process as more positive than they expected.

HDC response: Referrals to HDC from providers has increased and many providers are making good use of the opportunity to resolve complaints referred to them by HDC. We are working with registration authorities to develop competencies that are consistent with the Code.

Workforce changes are occurring in parts of the health sector, such as rural areas, where it is difficult to recruit staff. We have more overseas-trained practitioners unfamiliar with New Zealand's health system and its approach to consumer rights.

HDC response: We target education on consumer rights and provider responsibilities to the increasingly diverse workforce.

Technological change means the health sector relies more on electronic processes and records, leading consumers to expect a quicker response from providers. This raises potential safety issues in areas such as online prescribing, clinical video-conferencing, and long-distance service provision in areas such as radiology.

HDC's response: We consider the impact of health sector technology in assessing provider conduct on HDC's work and are pushing for greater transparency of health information, especially comparative quality data.

3.2 Internal influences on our work

Staffing is a key issue: potential staff must see HDC (including the Advocacy Service) as a desirable employer so we can recruit and retain high-performers capable of better resolving complex, wide-ranging complaints. Good staffing facilitates working across divisional boundaries, thus speeding up complaint turnaround times without compromising quality. We process most complaints faster than we used to, but still need to reduce time spent on investigations. Selecting staff and training them is a priority for lifting our overall performance.

HDC response: We continue to improve our systems and to enable staff do their jobs.

Information systems (information technology, document management and website) must link strongly to everything we do in order to maximise the quality of our data and our ability to share information.

HDC response: We continue to improve our information management systems.

3.3 What is most important to us

- ensuring public knowledge of consumer rights and the services we provide
- ensuring provider knowledge of responsibilities under the Act
- resolving complaints
- applying our findings to the improvement of health and disability services
- preventing avoidable harm to consumers by ensuring services are delivered with care, competence and compassion.

We address these priorities by:

- maintaining HDC's high profile
- aligning education initiatives to leadership in safety and quality improvement by working more strategically with key stakeholders
- ensuring we have the organisational ability to achieve our strategic goals
- speeding up our complaint processes without compromising quality
- making our services and processes more accessible to long-term disability service consumers, Māori, Pacific and other ethnic communities
- continuing the staged expansion of the Nationwide Advocacy Service, which began in 2006/2007.

3.4 Two key initiatives

The New Zealand Disability Strategy
The Commissioner's Consumer Advisory Group

The New Zealand Disability Strategy

HDC's strategy includes the response to disability issues required from all government agencies and Crown entities, plus six specific disability-focused work areas:

- **Employment**
Goal: greater working knowledge and expertise of disability sector issues and how they impact on HDC's ability to do its job.
To be achieved by: increasing the number of staff with disabilities and experience in working with disabled people in the complaints resolution function of HDC.
- **Access to information**
Goal: increase accessibility of health and disability services information and HDC information and educational materials to Deaf consumers.
To be achieved by: increasing the range of formats used to promote HDC information and by advocating for increased use of New Zealand Sign Language interpreters and captions within the health and disability sectors.
- **Participation of Māori with disabilities**
Goal: Strengthen the voice of disabled Māori, using disability support services.
To be achieved by: facilitating a Northern region hui for disabled Māori to develop an action plan to improve Māori participation in health and disability services planning and provision.

- Participation of Pacific peoples
Goal: HDC to have by 2008 accurate information on concerns about the safety and quality of disability and mainstream services for Pacific peoples.
To be achieved by: setting up an advisory network of Pacific peoples who use disability services.
- Responsiveness to complaints resolution
Goal: By 2008, HDC clients with disabilities find our organisation and staff aware of, and responsive to, their particular needs.
To be achieved by: identifying other ways of getting to disability service providers to comply with the Code, and ensuring non-compliant practices and systems change.
- Consumer participation
Goal: Health and disability service providers seek and understand the perspective of people with disabilities by 2009.
To be achieved by: setting up a Disability Consumer Advisory Group to work alongside HDC's existing Consumer Advisory Group.

Consumer Advisory Group

We are expanding our Consumer Advisory Group to develop strategies for making HDC's service more accessible and more responsive. An Iwi Advisory Group has been established and is tasked with assisting in the development of a Māori service within HDC. A Pacific Consumer Advisory Group and a Disability Consumer Advisory Group are planned.

3.5 Our most significant working relationships

HDC's most significant working relationships are with:

- consumers – their organisations plus the wider community
- providers – individual and group, including district health board chairs and chief executives
- professional colleges and registration bodies
- the media
- commissions and commissioners with overlapping and associated jurisdictions
- the Office of the Ombudsmen
- the Office of the Chief Coroner and coroners
- District Inspectors
- prison inspectors
- the Quality Improvement Committee.

Championing Consumer Rights

In 2007 HDC jointly organized the 'Putting Patients First' Conference with the University of Auckland's School of Population Health. There was a far bigger turnout than expected with strong interest from providers in improving the quality of their service and providing consumer-centred care as well as creating a safe forum for consumers and providers to share experiences and perspectives.

HDC also co-hosted the Strengthening Consumer Voice: 2nd national consumer summit with the NZ Guidelines Group. Representatives from almost 200 consumer groups from around the country attended the national summit to discuss how they could work

collaboratively together. 50 government agencies and non-governmental agencies agreed to join a partnering initiative in support of strengthening consumer voice.

HDC will continue to seek out opportunities to actively promote the strengthening of consumer voice using a ‘patients first and consumer-centred’ approach in the development, delivery and evaluation of health and disability services.

Joint interagency work

HDC actively works as part of a inter agency group with the Human Rights Commission, Mental Health Foundation, Office for Disability issues and the Mental Health Commission on a Multi Agency Plan. This is a collaborative action to benefit mental health services consumers to eliminate discrimination and promote social inclusion.

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

Leadership on quality

Quality Improvement Committee (QIC) links with HDC have been important in influencing the adoption of quality initiatives that have been demonstrated overseas to make a very real difference. HDC has worked alongside QIC in promoting system changes to improve the quality of services provided, for example, medicine safety, reporting of adverse and sentinel events.

HDC has worked on the review of the health and disability sector standards as required by legislation and facilitated by Standards NZ. The new sector standards currently before the Minister now include the New Zealand Disability Strategy, medicine reconciliation and open disclosure due to HDC’s input.

4.0 Our Vision and Mission

Our vision is “Champions of consumers’ rights”, reflecting the aim of the Health and Disability Commissioner legislation “to promote and protect the rights of consumers”.

HDC champions consumer–centered health and disability services for all New Zealand – services delivered with care, competence and compassion. We believe this country should lead the world in promoting and protecting the health and disability service consumers’ rights.

Our mission echoes our organisational goals: *resolution* of complaints; *protection* of individuals and the public; *learning* from complaints to improve all health and disability services.

We “speak up” in three key areas: *partnership* (making consumers true partners in their own care); *participation* (ensuring consumers are heard at every level of the health and disability systems); *protection* (ensuring the safety and quality of all health and disability services).

5.0 Our strategic goals

Three goals are the foundation for our next three to five years, fulfilling our obligations under the Act and contributing to Government’s overall goals.

5.1 Goal One: Achieving sustainable improvements in health and disability sector safety and quality

HDC will contribute to Ministry of Health goals by:

- enhancing New Zealanders' security and trust, allowing them to feel protected from the financial risks of ill health, and to trust in the health system's high performance standards, which answer their needs and invite community participation
- helping improve health and disability support services, so they are clinically sound, culturally competent, and well coordinated, and coupled with ongoing service quality improvement processes.

HDC will also:

- lead the field in ensuring ongoing, systemic improvements in health and disability sector safety and quality
- be a valuable resource for providers and consumers who can learn from information gathered during the complaints process
- ensure information is shared across sectors, and results in improvements
- facilitate information sharing on best practice and ways of improving poor practice
- showcase good processes and decisions to show what can be achieved
- follow up decisions to ensure permanent change has occurred, and report back to consumers
- work with consumers and providers to make a real difference to the safety and quality of New Zealand health care and disability services.

HDC's success will be measured by:

- HDC monitoring and reporting throughout 2008/09 on provider compliance with recommendations for improving safety and quality of services
- implementing nationally each year HDC recommendations arising from three major investigations.

5.2 Goal Two: Ensuring consumers are protected and can exercise their right to complain without fear or retribution

HDC will contribute to Ministry of Health goals by:

- reducing inequalities thus improving the health of those currently disadvantaged, particularly Māori, Pacific peoples and those with low socio-economic status
- encouraging better participation and independence so the health and disability support sector contributes to building a society that values the lives of those with disabilities.

HDC will also:

- build health and disability service consumers' awareness of their rights under the Code, and ensure they can exercise them
- provide a strong Advocacy service that helps consumers understand their rights and providers' responsibilities, and resolve complaints, while recognising that knowledge and ability to speak up varies widely
- encourage consumers to act as partners at every stage of their care

- offer greater opportunities for consumer participation in our decision-making, involving consumers in educational activities and advocacy to promote and protect their rights
- be an effective consumer watchdog by alerting appropriate agencies to problems, reporting publicly on breaches of the Code, and speaking up for the rights of consumers
- recognise the importance of accountability through Disciplinary and Human Rights Review Tribunal proceedings
- ensure appropriate cases are referred to the Director of Proceedings, and the Director is supported and funded to bring proceedings.

HDC's success will be measured by:

- 2008/09 survey results confirming greater awareness of their rights under the Code of consumers – on the part of manual workers, the young, lower socio-economic groups, and those of Māori or Asian ethnicity
- a random 2008/9 consumer survey yielding baseline information on satisfaction with HDC complaints handling
- more advocacy services used, and more consumers accessing specialist advocacy
- reviewing DHBs' 2008/9 complaints processes, and reporting by 30 June 2009 on best-practice compliance with complaints management and the Code.

5.3 Goal Three: Facilitate complaint resolution at every step

HDC will contribute to Ministry of Health goals by:

- enhancing New Zealanders' security and trust, allowing them to feel protected from the financial risks of ill health, and to trust in the health system's high performance standards, which answer their needs and invite community participation
- helping improve health and disability support services, so they are clinically sound, culturally competent, and well coordinated, and coupled with ongoing service quality improvement processes.

HDC will also:

- further develop skills in resolving complaints
- build on greater provider willingness to acknowledge shortcomings, apologise, and work swiftly to resolve complaints
- develop more options for resolving complaints, in particular, advocacy and mediation, to ensure this occurs in appropriate settings by way of fair, timely processes
- ensure greater use of advocacy and mediation to resolve complaints
- build the Nationwide Advocacy Service, ensuring more advocates, including specialists, on the ground
- speed up complaints handling, with 90% completed within a year.

HDC's success will be measured by:

- monitoring and reporting on successful resolution by providers after HDC has referred complaints back to them
- achieving the Advocacy services expansion plan by 2010.

5.4 The risks we face and how we will manage them

Significant risks to our vision and goals are:

- unexpectedly high numbers of complaints
- unavoidable delays in handling complaints
- insufficient capability in being flexible or innovative enough to adapt processes to the needs of consumers who are least able to speak for themselves and whose welfare is most at risk, so that parts of the community lose faith in our ability to do our job.

We will manage these risks by:

- continuing to train staff and review processes so the quality of our work improves and we can handle more of it
- ensuring complaints are resolved quickly and at an appropriate level
- offering consumers more opportunities to speak up about what matters to them
- gradually increasing advocate numbers so the service can be more proactive and responsive to the full range of consumer needs
- changes to the information provided on our website and the complaint form (in order to encourage consumers to consider advocacy and/or taking their complaints to providers in the first instance)
- internal process changes to increase the ability of complaints assessors to respond more quickly to complaints and enquiries, and make earlier decisions (one example is a new telephone system which means more of the team can be freed up for uninterrupted complaints file work)
- constant vigilance and file review
- setting and working towards internal, as well as external, timeliness targets, which are carefully monitored on a monthly basis.

5.5 Our organisational assets

To improve the quality of health and disability services, HDC needs the confidence of the sector. HDC staff must thoroughly understand our direction, and our actions must reflect our values: fairness, care and compassion, responsiveness and quality.

What we have

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. We document all processes. We have good human resource policies and practices, and good overall staff retention.

What we will develop

Staff: Our people are essential to ensuring excellent performance and results, so the next three years will see us continuing to implement actions required to maintain being a good employer.

We will employ staff whose diversity reflects the populations we serve, now and in the future.

We will implement a Code of Conduct within HDC to support a culture of high achievement, a strong culture of learning and a commitment to excellent service.

Leadership: HDC continues to see its skilled leadership as crucial in nurturing creative and innovative staff who continually work to improve processes. This is especially important in trying to reduce the time it takes to complete investigations without compromising quality. We are developing work–life balance initiatives to help staff better manage the stress arising from handling complaints.

Information and technology (IT): HDC has vastly improved the quality and responsiveness of our IT. We are developing a new document management system to meet Archives New Zealand and the Public Records Act requirements and to ensure a more user-friendly and faster system to respond to reporting requests. We continue to use complaints resolution findings as a resource for learning, and (via our website,) are implementing a wider range of information-sharing mechanisms.

HDC's success will be measured by surveying staff to:

- identify HDC's workforce profile to find out whether it reflects the communities it serves
- gauge the level of staff engagement within HDC
- gauge the level of staff commitment to public service
- identify the strength of internal working relationships
- identify staff perception of fairness and equity.

Much of this work with staff is new. HDC will be setting a baseline that will assist in finding out what staff perceptions are and how closely aligned these are with the aims HDC has for developing and supporting an organisational culture of high achievement, learning and commitment to excellent service.

HDC as a good employer

As a good employer we will continue to:

- attract and retain quality people
- be innovative and highly productive
- meet the diverse needs of those using our services.

We retain staff by focusing on:

- leadership, accountability and a healthy culture
- remuneration, recognition and working conditions
- flexibility and work design
- safe and healthy environment.

We have been associated for four years with Mainstream (a government-sponsored recruitment and vocational placement service for disabled people and Government/Crown Entity employers), and have successfully recruited through it. HDC also works with Crossroads Clubhouse, a community organisation offering employment transition for disabled people, which has also led to successful placements.

Sound human resource practices help us recruit the best people, and make the most of their skills, creativity and energy. Work-life balance initiatives allow staff to work to their potential while accommodating outside commitments.

PART TWO

6.0 Statement of Service Performance

The services provided under the Health and Disability Commissioner Act are advocacy, complaints resolution, education, promotion, and proceedings, all of which make up Output Class 1 — Safety and Quality Improvement in Health and Disability Services Provision, in Part Two of this Statement of Intent. HDC will deliver four outputs through this output class. A description of the output, the outcome we hope to achieve, what we will do to achieve our aim, how we will measure the success of our intervention, and the timeliness or standard we hope to achieve is described under each output.

The Health and Disability Commissioner has one Output Class:

<i>Output Class Name</i>	<i>Value 2008/09</i>
Output Class 1 — Safety and Quality Improvement in Health and Disability Services Provision	\$9,678,000 (GST exclusive)

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

- The Commissioner responds to enquiries, and assesses and resolves complaints.
- The Commissioner promotes the Code of Rights and educates consumers, providers, professional bodies and funders about the provisions of the Code of Health and Disability Services Consumers' Rights.
- A nationwide, independent advocacy service under the direction of the independent Director of Advocacy promotes and educates consumers about their rights and providers about their responsibilities. The advocacy service 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 a local level.
- The independent Director of Proceedings initiates proceedings against referred providers who have been found in breach of the Code.

Each output has been costed to include a percentage of HDC's overhead costs. In HDC's 2007/08 Statement of Intent there was an additional output named Submissions, a function of the Legal division within HDC, at a cost of \$498,000. This activity is now included in the Statement of Intent 2008/09 as part of Output 2 – Education. This year's costing in the Statement of Intent more accurately reflects the Legal function within HDC which is in the main an internal output with 85% of its effort being to assist with complaints resolution. The \$498,000 is now divided across the Education, Advocacy and Complaints Resolution outputs.

6.1 Output 1 — Complaints Resolution

Value 2008/09 \$3,844,438

The Commissioner has various options when a complaint is received to secure a fair, simple, speedy and efficient resolution. He may decide to take no action, for example, where the passage of time makes it impracticable to take any action, or where a complaint is made by someone other than the consumer and the consumer does not wish the matter to proceed.

The other options open to the Commissioner include:

- gathering additional information and sharing this with the parties concerned, which can often resolve the matter for the complainant
- writing an educational letter to the relevant party
- referring the complainant to the provider to work with the complainant to resolve the concerns raised, and asking both the provider and the complainant to report back on the outcome
- referring the complainant to advocacy for assistance in resolving his or her complaint
- referring the parties to formal mediation to resolve the complaint
- referring the complaint for investigation
- referring the complaint to an agency who is better placed to manage the complaint, for example, the Privacy Commissioner or the Human Rights Commission.

Where complaints are outside jurisdiction, the Commissioner's approach is always to assist the complainant or enquirer to identify the correct agency, as many callers find it difficult to discern the Commissioner's role from the name of the office, and often expect the office to be able to deal with any matters related to the broader health and disability sector issues.

HDC responds to enquiries from the public, health and disability service providers, and from a range of other associated bodies and organisations in the health and disability sectors. In responding to enquiries, HDC offers advice and information in order to assist consumers to better understand health and disability services and systems and to participate more fully in their care. The information and advice is provided both verbally and in writing. It can assist people to take their own action in managing concerns they have with a health or disability service provider. Sometimes it simply helps to clarify a matter and no further action on the part of the enquirer is needed.

When someone makes a complaint about a health or disability service, HDC looks for the lessons from the complaint and uses this to encourage improvements to the service in question. Complaints help consumers to have their needs and expectations known and understood. They assist in identifying poor practice and poor systems and allow remedial action to be taken. Complaints help to keep people safe by offering a learning

opportunity to all involved, especially the health or disability service provider. Complaints offer insight into the reasons for near misses, preventable injuries, emotional harm and preventable deaths.

Serious complaints that are upheld offer an opportunity not only for learning but also for accountability. An individual or organisation that has seriously breached the Code of Rights may be censured by the Commissioner and face disciplinary action. Very serious cases are referred to the Director of Proceedings for prosecution, and this may result in loss of the right to practise as a registered health professional. This protects the public from providers whose practice is significantly below the acceptable standard and at risk of causing harm.

Where the Commissioner makes recommendations for improvements to services or an individual provider's practice, he follows up to ensure that action has been taken. Information about the Commissioner's findings, recommendations, and resulting action, is widely circulated to professional bodies and relevant organisations in order to share the learning from this work.

Output 1 — Complaints Resolution

Outcome

Ministry of Health Outcomes

Trust and security — New Zealanders feel secure that they are protected by the system from substantial financial costs due to ill health, and trust it because it performs to high standards, reflects their needs and provides opportunities for community participation.

System outcomes/Quality — Health and disability support services are clinically sound, culturally competent and well co-ordinated, and ongoing service quality improvement processes are in place.

HDC outcomes that contribute to the MOH outcomes:

Consumers are protected and are able to exercise their right to complain without fear of retribution.

Complaints about health and disability services result in significant improvements in the safety and quality of services.

Output 1	Performance Measures and Standards
<p><i>Complaints</i></p> <p>6.1.1 Every complaint is addressed promptly and impartially, using the most appropriate option under the HDC Act 1994.</p>	<p><i>Complaints</i></p> <ol style="list-style-type: none"> 1. 80% of complaints are closed within six months, and 95% are closed in 12 months, with no files aged over 2 years. Quarterly updates on progress are provided. 2. Less than one percent of complaints files are reopened after a closed file review⁴ to determine the fairness and appropriateness of the original decision. Quarterly updates are provided. 3. A random sample of consumers and providers is surveyed and feedback is sought regarding the timeliness and fairness of HDC complaints' processes. Reported in the final quarter.
<p><i>Complaints</i></p> <p>6.1.2 Where quality and safety issues are identified, changes are recommended. Recommendations are followed up to ensure improvements have occurred.</p>	<p><i>Complaints</i></p> <ol style="list-style-type: none"> 4. Follow-up of recommendations confirms 100% compliance by providers. Progress is reported in the 3rd quarter. 5. 10% of group providers (organisations) subject to recommendations from HDC, report systems changes to improve the quality and safety of their service. Reported in the final quarter.
<p><i>Complaints Resolution Process</i></p> <p>6.1.3 Review the Health and Disability Commissioner Act and Code of Rights as required by the HDC Act 1994.</p>	<p><i>Complaints Resolution Process</i></p> <ol style="list-style-type: none"> 6. Review of Act and Code completed with findings and recommendations reported to the Minister of Health by 30 June 2009.

⁴ All requests for the Commissioner to reconsider his decision result in a closed file review.

6.2 Output 2 — Education

Value 2008/09 \$888,505

Through education HDC aims to have providers understand their responsibilities and comply willingly with the requirements of the Health and Disability Commissioner Act 1994, and have consumers know their rights under the Act and feel free from fear to exercise those rights. The Advocacy Service is the primary vehicle for promoting awareness of the Code of Rights to the public, both to consumers and providers of health and disability services. However, the Commissioner's Office also focuses on several types of promotional and educational initiatives:

- *Presentations* at conferences and seminars, both nationally and internationally, on specific areas of interest to provider and consumer audiences. Findings from the Commissioner's complaints resolution work are used to facilitate a deeper understanding of issues providers and consumers need to be cognisant of, along with suggestions for service improvement. Staff from the Commissioner's Office often work in a co-facilitation role with advocates and consumers to deliver educational sessions to special interest groups.
- *Customised training* working with consumers to help them build support networks in situations where they are likely to need ongoing help to work in partnership with a particular provider or a number of providers. Customised training is also developed and implemented with individual providers and group providers to address their specific needs in relation to better meeting their obligations under the Code, whether it is changes to their practice or their systems.
- *Opinions* given by the Commissioner provide information for the public and, in particular, professional bodies on issues for improvement in the delivery of health and disability services. The opinions outline areas for learning around professional accountability and systems failure. Case studies are also available. These can be found on the Commissioner's website, www.hdc.org.nz.
- *Publications* in a range of media are available from the Commissioner's Office and can be ordered on-line or by post or fax. These publications explain the role of the Health and Disability Commissioner, the processes used in carrying out the Commissioner's functions, and information about the services offered by the Commissioner's Office. Many of these publications are available in languages other than English and Māori. There are easy-read versions of the key publications. All information produced is free to the public.
- *Articles* written by the Commissioner and members of his senior management team are published regularly in a wide range of health and disability journals, magazines and newsletters.
- *Media interviews and releases* are given where there are opportunities for wider learning as a result of HDC findings or where there is a perceived public safety issue.
- *DVD movies* are provided for use as training and awareness-raising tools and for providing general information.

Output 2 — Education	
<p>Outcome <i>Ministry of Health Outcomes</i> <i>Trust and security</i> — New Zealanders feel secure that they are protected by the system from substantial financial costs due to ill health, and trust it because it performs to high standards, reflects their needs and provides opportunities for community participation.</p> <p><i>System outcomes/Quality</i> — Health and disability support services are clinically sound, culturally competent and well co-ordinated, and ongoing service quality improvement processes are in place.</p> <p><i>Reduced inequalities</i> — we achieve an improvement in the health status of those currently disadvantaged, particularly Māori, Pacific peoples and people with low social economic status.</p> <p><i>HDC outcomes that contribute to the MOH outcomes</i> Consumers are protected and are able to exercise their right to complain without fear of retribution. Sustainable improvements in safety and quality in the health and disability sectors are achieved through learning from complaints.</p>	
Output 2	Performance Measures and Standards
<p>6.2.1 Provide six-monthly Commissioner complaints trend reports to DHBs in September 2008 and March 2009.</p> <p>6.2.2 Develop two national educational initiatives aimed at strengthening consumer voice and increasing the use of consumer-centred approaches by providers, by 30 June 2009.</p> <p>6.2.3 Produce a DVD on the Code of Rights in New Zealand Sign Language by 30 June 2009.</p> <p>6.2.4 Produce and deliver 300,000 units of educational material by 30 June 2009.</p> <p>6.2.5 Facilitate two consumer seminars by 30 June 2009.</p> <p>6.2.6 Provide 20 education presentations to health and disability sector organizations by 30 June 2009.</p> <p>6.2.7 Provide two intensive provider training programmes for providers who may work in isolation or in settings where there is little or no input from consumers of the service.</p> <p>6.2.8 Provide quality responses to relevant submission documents affecting the rights of health and disability services consumers.</p>	<ol style="list-style-type: none"> 1. 80% of DHBs report that they find the trend reports useful and describe how they have used the trend information. 2. Educational initiatives implemented. 3. DVD produced. 4. Percentage of new orders rather than repeat orders for educational material increases from 3% to 5% a month. 5. 80% of participants who respond to the seminar evaluation rate that they were satisfied or very satisfied with the usefulness of the seminar. 6. 100% of requestors of education presentations rate that the presentations met their expectations. 7. 80% of participants who respond to an evaluation of the intensive training programme rate that they were satisfied or very satisfied with the content and delivery of the programme. 8. Provide an annual report on the impact of policy advice given and submissions made by 30 June 2009 with quarterly updates on the percentage of satisfaction with the quality of our policy advice and submissions.

6.3 Output 3 — Advocacy Services

Value 2008/09 \$4,201,299

A primary goal of advocates is to assist consumers to resolve complaints about the quality of a health or disability service directly with the service provider. Independent advocates assist consumers to ensure that their rights are respected. This service is free. Advocacy services operate independently of government agencies, the Commissioner, and providers and funders of health and disability services.

Advocates provide a consumer-centred service for consumers, and those making complaints on their behalf, by acting on the instructions of the consumer/complainant. To achieve this, advocates assist consumers to:

- clarify their issues and identify their desired outcome in relation to their complaint. Consumers will be provided with the information they need to take action on their complaints, or where to go and who can help if the matter is outside jurisdiction
- make a complaint
- meet with or communicate with the health or disability service provider
- assert their concerns
- increase their confidence in speaking up
- achieve direct resolution of their complaint at a local/low level
- resolve complaints effectively between the parties
- understand the various ways to make a complaint, including how to contact the Health and Disability Commissioner.

Advocates also:

- give information and provide education about rights to consumers and providers
- encourage providers to view complaints as opportunities for learning and improving the quality of their service
- network assertively within their local communities to maintain contact with vulnerable populations and keep abreast of local issues.

Output 3 — Advocacy	
<p>Outcome <i>Ministry of Health Outcomes</i> <i>Reduced inequalities</i> — we achieve an improvement in the health status of those currently disadvantaged, particularly Māori, Pacific peoples and people with low social economic status.</p> <p><i>Better participation and independence</i> — the health and disability support sector contributes constructively to having a society that fully values the lives of people with disabilities.</p> <p><i>HDC outcomes that contribute to the MOH outcomes</i> Sustainable improvements in safety and quality in the health and disability sectors is achieved. Consumers are aware of their rights under the Code. Consumers are protected and are able to exercise their right to complain without fear or retribution. Consumers have the assistance of an advocate to resolve their complaints.</p>	
Output 3	Performance Measures and Standards
<i>Advocacy Agreement</i> 6.3.1 Administer Advocacy Services agreement.	<i>Advocacy Agreement</i> Compliance with Advocacy Services agreement monitored and results reported quarterly.
<i>Promotion and Education</i> 6.3.2 Promote, by education and publicity, advocacy services.	<i>Promotion and Education</i> Compliance with Advocacy Services education targets monitored and results reported quarterly.

6.4 Output 4 — Proceedings

Value 2008/09 \$743,758

The Director of Proceedings is a lawyer appointed under the Health and Disability Commissioner Act. In certain circumstances where the Commissioner has found a breach of a consumer's rights, he may refer the provider to the Director of Proceedings. The Director of Proceedings reviews the Commissioner's file and makes an independent decision on whether or not to take any further action. The Director of Proceedings can lay a disciplinary charge before the Health Practitioners Disciplinary Tribunal, issue proceedings before the Human Rights Review Tribunal, or both. The Director of Proceedings can also issue proceedings or provide representation or assistance in any other form. A team of lawyers and assistants works with the Director of Proceedings, reviewing files and prosecuting cases.

The Commissioner's staff discuss any proposed referral with the consumer or person who made the complaint. When the Commissioner issues his final report, he will advise whether the matter has been referred. Because the Director of Proceedings and her team have had no involvement in the investigation, the file is reviewed. The Director considers all the information contained on the file, as well as all relevant law, and then decides whether or not to issue proceedings.

The purpose of laying a charge to the Health Practitioners Disciplinary Tribunal is to ensure that standards for the profession are maintained, that the individual practitioner is held accountable for his or her actions, and that the public is protected. Proceedings in the Human Rights Review Tribunal are used to obtain remedies for the complainant and to set standards for providers, particularly non-registered providers. Therefore the work of the Director of Proceedings is very important in helping to set precedents for professional standards for both registered and non-registered providers. When a case is successfully prosecuted the decision can often send a very clear and strong message to health and disability services providers. This opens up a further opportunity for providers to take heed of the decisions and to improve the level of safety and quality of health and disability services.

Output 4 — Proceedings	
Outcome <i>Ministry of Health Outcomes</i> <i>System outcomes/Quality</i> — Health and disability support services are clinically sound, culturally competent and well co-ordinated, and ongoing service quality improvement processes are in place. <i>HDC outcomes that contribute to the MOH outcomes</i> Consumers are protected and are able to exercise their right to complain without fear of retribution. Sustainable improvements in safety and quality in the health and disability sectors are achieved through learning from complaints.	
Output 4	Performance Measures and Standards
<i>Decision to Prosecute</i> 6.4.1 Decisions are made in a timely manner.	<i>Decision to prosecute</i> 1. 80% of decisions are made within 2 months of referral
<i>Compliance with Directions</i> 6.4.2 Ensure compliance with directions of Tribunals and Courts.	<i>Compliance with Directions</i> 2. 100% compliance with Tribunal/Court directions
<i>Successful Proceedings</i> 6.4.3 A high success rate is maintained in proceedings.	<i>Successful Proceedings</i> 3. A finding of professional misconduct is made in 75% of disciplinary proceedings. 3. A breach of the Code is found in 90% of HRRT proceedings. 4. An award of damages is made in 80% of cases where damages are sought.
<i>Cost Recovery</i> 6.4.4 Costs are awarded and recovered.	<i>Costs Recovery</i> 5. 75% of costs awarded are recovered.

7.0 Objective — Ownership Performance

HDC will continue to build capability and robust systems that meet our needs, are easy to use, and assist us to carry out our work in a thorough and consistent manner across the following areas:

- Financial planning, monitoring and management
- Information systems management
- Human resources management
- Corporate support.

Corporate Services	
Activity	Performance Measures and Standards
<p>Finance Management 7.1 The management of HDC’s finances will be consistent with relevant requirements under the State Sector Public Finance Act and applicable Crown Entity legislation to ensure sound management of public funding.</p>	<p>1. Maintain or improve the grading in each area of Financial Service Performance Management in Audit New Zealand’s 2007/08 Audit Report, by 30 June 2009.</p>
<p>Information Management 7.2 Implement a document management system that enables HDC to meet Public Record Act requirements and Archive New Zealand’s guidelines, by 2010.</p>	<p>2. Managers assess the speed of retrieval of key information, the range of information available and the accuracy of reports produced by HDC as having improved between 30 June 2008 and 30 June 2009.</p>
<p>Human Resource Management 7.3 Revise and implement the improved staff performance appraisal process and tools by 31 March 2009</p>	<p>3. 90% of staff rate high satisfaction with the revised performance appraisal process and tools by 30 June 2009.</p>

8.0 Reporting

HDC will provide quarterly reports to the Minister of Health that cover:

- progress on our operations, including commentary on any significant variations from objectives and measures in our Statement of Service Performance relevant to the quarter
- an update on key operations, identifying any emerging risks and how these are being managed, and providing a commentary on any significant variation from the objectives and measures in the Commissioner's Statement of Forecast Service Performance
- current financial reports in the same format as the agreed Forecast Financial Statements prepared on an accrual basis.

Reports will be provided to the Ministry by the following dates unless otherwise requested:

Report	Period covering	Due Date
Quarter 1	1 July – 30 September 2008	24 October 2008
Quarter 2	1 October – 31 December 2008	31 January 2009
Quarter 3	1 January – 31 March 2009	24 April 2009
Quarter 4	1 April – 30 June 2009	31 July 2009
Annual	1 July 2008 – 30 June 2009	31 October 2009

9.0 Financial Performance 2008/09

The financial reporting standard about preparing prospective financial statements (FRS-42) says that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The prospective (forecast) financial statements in this SOI have been prepared in accordance with New Zealand International Financial Reporting Standards (NZIFRS). From 1 July 2007 HDC transitioned to a new set of accounting standards. This means that the financial statements at the end of the financial years 2007/08 and onwards have been prepared in accordance with the new NZIFRS.

The prospective statements for 2008/09 and onwards in this SOI comply with FRS-42.

9.1 Key Assumptions for Proposed Budget 2008/09

HDC will continue to provide the same range of services as for the previous year and will continue to implement the expansion of its Advocacy Service during 2008/9. The staged advocacy expansion will be in its third year in 2008/09. The implementation plan for the nationwide expansion relies on HDC being able to successfully manage the use of its reserves and funding from the Ministry of Health to ensure a sustainable funding outcome is achieved by 2010 without compromising the quality of HDC's other complaints resolution functions. The planned increase in the number of adequately resourced full-time equivalent (FTE) advocates is to improve the access and availability of advocates nationally.

HDC has undertaken to use its reserves to support the expansion of the Advocacy Service and aims to have its reserves at \$500,000 by 2011. This level of reserve is adequate to fund a major Inquiry should one be required.

HDC has approximately 1,206 individual assets on the asset register with a total cost of \$2.2M.

9.2 Statement of Financial Performance

HEALTH AND DISABILITY COMMISSIONER FINANCIAL PERFORMANCE FOR THE Budget YEAR ENDED 30 JUNE 2009

	Forecast Projected Actual 2007-08 \$000's	Proposed Budget 2008-09 \$000's	Estimated Budget 2009-10 \$000's	Estimated Budget 2010-11 \$000's
Income				
Operating Grant Received	8,332	8,990	9,444	9,633
Interest Received	242	173	105	86
Publications Revenue	80	80	84	78
TOTAL INCOME	8,654	9,243	9,633	9,797
Less Expenses				
Service Contracts	3,074	3,321	3,596	3,596
Staff Costs	3,537	3,899	3,940	3,940
Occupancy	413	584	584	584
Travel & Accommodation	135	172	172	172
Communications	100	104	104	104
Computer Costs	368	449	449	449
Promotion & Education	236	281	281	281
Depreciation	318	284	284	258
Operating Costs	653	543	542	543
Audit	19	41	41	41
TOTAL EXPENSES	8,853	9,678	9,993	9,968
Net Operating Surplus/(Deficit)	(199)	(435)	(360)	(171)

9.3 Statement of Financial Position

HEALTH AND DISABILITY COMMISSIONER FINANCIAL POSITION

Budget year AS AT 30 JUNE 2009

	Forecast Projected Actual 2007-08 \$000's	Proposed Budget 2008-09 \$000's	Estimated Budget 2009-10 \$000's	Estimated Budget 2010-11 \$000's
Crown Equity				
Accumulated Funds Op Bal	883	684	249	(111)
Add Net Profit/(Loss) for Year	(199)	(435)	(360)	(171)
Capital Contributed	788	788	788	788
TOTAL CROWN EQUITY	1,472	1,037	677	506
Represented by:				
Current Assets				
Bank Account	93	9	10	47
Petty Cash	1	1	1	1
Call Deposits	1,500	1,100	806	736
Prepayments	38	34	34	34
Inventory	18	18	18	18
Sundry Debtors	32	30	30	30
Total Current Assets	1,682	1,192	899	866
Non Current				
Intangible Assets	97	84	84	164
Fixed Assets	299	362	244	106
Total Assets	2,078	1,638	1,227	1,136
Current Liabilities				
GST Payable	50	50	50	50
Sundry Creditors	556	551	500	580
	606	601	550	630
NET ASSETS	1,472	1,037	677	506

9.4 Statement of Cashflows

HEALTH AND DISABILITY COMMISSIONER STATEMENT OF CASHFLOWS FOR THE Budget YEAR ENDED 30 JUNE 2009

	Forecast Projected Actual 2007-08 \$000's	Proposed Budget 2008-09 \$000's	Estimated Budget 2009-10 \$000's	Estimated Budget 2010-11 \$000's
Cashflows From Operating Activities				
Cash was provided from:				
Operating Grant	8,332	8,990	9,444	9,633
Interest on Short Term Deposits	242	173	105	86
Revenue	80	80	84	78
	8,654	9,243	9,633	9,797
Cash was applied to:				
Payments to Employees	(3,536)	(3,899)	(3,940)	(3,940)
Payments to Suppliers	(4,959)	(5,495)	(5,720)	(5,720)
	(8,495)	(9,394)	(9,660)	(9,660)
Net Cashflow From Operating Activities	159	(151)	(27)	137
Cashflows From Financing Activities				
Cash was provided from:				
Capital Contribution	0	0	0	0
Net Cashflow from Financing Activities	0	0	0	0
Cashflows from Investing Activities				
Cash was provided from:				
Sale of Fixed Assets	0	0	0	0
Cash was applied to:				
Purchase of Intangible Assets	(90)	(110)	(100)	(50)
Purchase of Fixed Assets	(160)	(223)	(166)	(120)
Net Cashflow from Investing Activities	(250)	(333)	(266)	(170)

NET INCREASE/(DECREASE) IN CASH	(91)	(484)	(293)	(33)
Cash brought Forward	1,685	1,594	1,110	817
Closing Cash carried forward	1,594	1,110	817	784

**Cash Balances in the Statement of Financial
Position:**

Bank Account	94	10	11	48
Call Deposits	1,500	1,100	806	736
	1,594	1,110	817	784

9.5 Statement of Movements in Equity

HEALTH AND DISABILITY COMMISSIONER STATEMENTS OF MOVEMENTS IN EQUITY FOR THE Budget YEAR ENDED 30 JUNE 2009

	Forecast Projected Actual 2007-08 \$000's	Proposed Budget 2008-09 \$000's	Estimated Budget 2009-10 \$000's	Estimated Budget 2010-11 \$000's
Opening Equity 1 July	1,671	1,472	1,037	677
Plus Net Surplus(Loss) (Total Recognised Revenues and Expenses)	(199)	(435)	(360)	(171)
Closing Equity 30th June	<hr/> 1,472 <hr/>	<hr/> 1,037 <hr/>	<hr/> 677 <hr/>	<hr/> 506 <hr/>

9.6 NZ IFRS Accounting Policies

The Health and Disability Commissioner is a public benefit entity for financial reporting purposes.

These financial statements have been prepared in accordance with the Public Finance Act 1989 and section 152 of the Crown Entities Act 2004.

The financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand ('NZ GAAP'). They comply with the New Zealand Equivalents to International Financial Reporting Standards ('NZ IFRS').

9.6.1 Measurement Base

The financial statements have been prepared on an historical cost basis. Cost is based on the fair value of the consideration given in exchange for assets.

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

The Commissioner's office has changed its accounting policies to comply with NZ IFRS. The transition to NZ IFRS is accounted for in accordance with NZ IFRS-1: First-time Adoption of New Zealand Equivalents to International Financial Reporting Standards, with 1 July 2006 as the date of transition.

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2009, the comparative information presented in these financial statements for the year ended 30 June 2008, and in preparation of the opening NZ IFRS balance sheet at 1 July 2006, the Commissioner's office date of transition.

9.7 Particular Accounting Policies

The following particular accounting policies, which materially affect the measurement of financial performance and financial position, have been applied:

9.7.1 Budget Figures

The budget figures are those approved by the Health and Disability Commissioner at the beginning of the financial year.

The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Health and Disability Commissioner for the preparation of the financial statements.

9.7.2 Recognition of Revenue

The Commissioner derives revenue through the provision of outputs to the Crown, interest on short-term deposits, and the sale of educational publications. Revenue is recognised when earned.

Interest revenue is recognised on a time proportionate basis that takes into account the effective yield on the financial asset.

9.7.3 *Property, Plant and Equipment*

Property, plant and equipment are stated at cost less accumulated depreciation and impairment.

Realised gains and losses arising from disposal of property, plant and equipment are recognised in the Statement of Financial Performance in the period in which the transaction occurs.

The carrying amounts of property, plant and equipment are reviewed at least annually to determine if there is any indication of impairment. Where an asset's recoverable amount is less than its carrying amount, it will be reported at its recoverable amount and an impairment loss will be recognised. Losses resulting from impairment are reported in the Statement of Financial Performance.

9.7.4 *Depreciation*

Depreciation is charged on a straight-line basis, so as to write off the net cost of each asset over its expected useful life to its estimated residual value.

Leasehold improvements are depreciated over the period of the lease or estimated useful life, whichever is shorter, using the straight line method.

The following estimated useful lives are used in the calculation of depreciation:

- Furniture & Fittings 5 years
- Office Equipment 5 years
- Communications Equipment 4 years
- Motor Vehicles 5 years
- Computer Hardware 4 years

9.7.5 *Goods and Services Tax*

All items in the financial statements are exclusive of GST, with the exception of accounts receivable and accounts payable, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

9.7.6 *Debtors*

Debtors are stated at their estimated net realisable value after providing for doubtful and uncollectable debts.

9.7.7 *Inventory*

Inventory is valued at the lower of cost and net realisable value.

9.7.8 *Operating Leases*

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as an expense on a straight-line basis over the lease term, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset are consumed.

9.7.9 Intangibles

Intangible assets comprise software applications which have a finite useful life and are recorded at cost less accumulated amortisation and impairment. Computer software is amortised on a straight line basis over its useful life ie, 2 years.

9.7.10 Employee Entitlements

Provision is made in respect of the Commissioner's liability for annual leave, long service leave, retirement leave, and sick leave when it is probable that settlement will be required and they are capable of being measured reliably.

Provisions made in respect of employee benefits expected to be settled within 12 months, are measured at their nominal values using remuneration rates expected to apply at the time of settlement.

Provisions made in respect of employee benefits which are not expected to be settled within 12 months are measured as the present value of the estimated future cash outflows in respect of services provided by employees up to reporting date.

Long service and retirement leave have been calculated on an actuarial basis on the present value of expected future entitlements.

9.7.11 Financial Instruments

The Commissioner is party to financial instruments as part of its normal operations. All financial instruments are recognised in the Statement of Financial Position and all revenues and expenses in relation to financial instruments are recognised in the Statement of Financial Performance.

9.7.12 Financial Assets

Cash and Cash Equivalents

Cash and cash equivalents comprise cash on hand and demand deposits and other short-term highly liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of changes in value. Cash and cash equivalents (including short-term deposits) are stated at the lower of cost and net realisable value.

Trade Receivables

Trade receivables are recorded at amortised cost less impairment.

9.7.13 Financial Liabilities

Payables

Trade payables and other payables are recognized when the Commissioner becomes obliged to make future payments resulting from the purchase of goods and services.

9.7.14 Taxation

The Health and Disability Commissioner is exempt from income tax pursuant to the Second Schedule of the Health and Disability Commissioner Act 1994.

9.7.15 Cost Allocation

The Health and Disability Commissioner has derived the net cost of service for each significant activity of the Commissioner using the cost allocation system outlined below.

Cost allocation policy

Direct costs are charged to significant activities. Indirect costs are charged to significant activities based on cost drivers and related activity/usage information.

Criteria for direct and indirect costs

“Direct costs” are those costs directly attributable to a significant activity.

“Indirect costs” are those costs which cannot be identified in an economically feasible manner with a specific significant activity.

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to activities is allocated as overheads using staff numbers as the appropriate cost driver.

9.8 Statement of Changes in Accounting Policies

With the exception of changes in policies required as a result of the adoption of NZ IFRS there have been no changes in existing accounting policies.

10.0 Appendix 1 — HDC Organisational Chart



Health and Disability Commissioner
Organisation Chart as at 30 May 2008



