



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Office of the Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Statement of Intent

2007/08

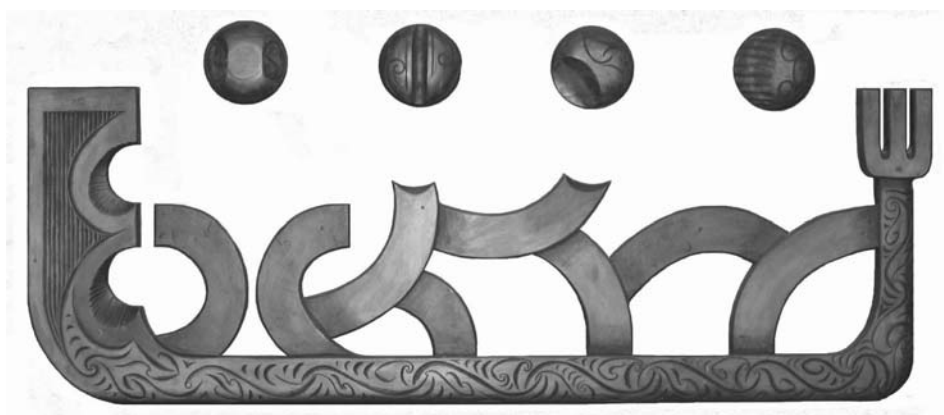


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E ngā mata-a-waka o te motu, tēnā koutou katoa

All groups throughout the land, greetings to you all.

Foreword

The 2007/08 Statement of Intent for the Office of the Health and Disability Commissioner (HDC) is year two of our Strategic Plan 2006–2010. This Statement of Intent describes what the Health and Disability Commissioner’s office is aiming to achieve. It outlines our roles and responsibilities as required by statute. It also describes the context within which we work, what we plan to do to achieve our vision, the challenges we are likely to face, the risks we need to manage and how we intend to measure the progress we have made. We also outline the capability needed within our organisation to achieve our goals. The fundamental principles and beliefs that underpin our intent, our behaviour and our way of working are fairness, care, compassion, responsiveness and quality.

HDC aims to be an organisation that:

- speaks up for the rights of health and disability services consumers throughout New Zealand
- champions safety and quality in all health and disability services
- is seen as a highly credible and relevant organisation by consumers, providers and key agencies
- attracts and retains the best people and provides them with the best possible work environment through being a “Good Employer”
- has strong and independent Advocacy and Proceedings functions
- is respected internationally for its expertise and knowledge.

In the 2007/08 year HDC will focus on the following areas:

- raising the profile of HDC and aligning our educational activities to our leadership role in safety and quality improvement by working more strategically with key stakeholders
- ensuring we have the internal capability and infrastructure needed to achieve our strategic goals
- improving the timeliness of all complaint processes, including complaints to providers, advocates and HDC, without compromising outcomes seeking to improve the accessibility of the Commissioner’s services and processes to long-term consumers of disability services, Māori, Pacific and other ethnic communities.

HDC's 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: 31 May 2007

PART ONE

1.0 Introduction

The preparation of the Health and Disability Commissioner's Statement of Intent (SOI) is a statutory requirement. It clarifies for the Minister of Health the activities being purchased on behalf of New Zealanders. It provides information to the public and parliament about the Health and Disability Commissioner's intentions, now and in the future, on how the role, functions and services provided by the Commissioner will be prioritised and delivered. The Statement of Intent consists of two parts.

Part One outlines who we are as an organisation, our key functions, the environment within which we work, the long-term outcomes we are working to achieve, and the steps we are taking to meet these outcomes. Part Two provides the annual component of the Statement of Intent, which includes financial and non-financial measures and standards by which the Health and Disability Commissioner's office (HDC) will be assessed in the coming year. There have been no key changes from the previous year.

2.0 Background

The background outlines the main characteristics of the environment we operate in, including specific aspects of legislation. It describes our key relationships, why they are key and how we propose to maintain them. This section also provides information about any operating and capability risks that might affect our financial situation and/or the services we deliver and how we plan to manage them.

2.1 The Act

The Act is a key element in the emerging environment of consumer-centred and consumer-accountable health and disability services, and has become the primary vehicle for dealing with complaints about any health or disability service provider in New Zealand. The Health and Disability Commissioner is an independent Crown entity and the Commissioner is generally independent of government policy.

The Health and Disability Commissioner Act was enacted in October 1994. The Act created the office of the Commissioner — with the role of promoting and protecting the rights of health and disability services consumers, and facilitating the fair, simple, speedy, and efficient resolution of complaints — together with a national network of independent advocates, under the Director of Advocacy, and an independent prosecutor, the Director of Proceedings.

The Code of Health and Disability Services Consumers' Rights (the Code) was made by regulations in 1996, and applies to all providers of health or disability services. The Code sets out 10 rights, including the right to be treated with respect, to be free from discrimination or exploitation, to dignity and independence, to services of an appropriate standard, to give informed consent, and to complain.

In September 2004, amendments to the Act came into effect giving HDC new options to "facilitate the fair, simple, speedy and efficient resolution" of complaints about the quality of health care and disability services. The new powers enhance the Commissioner's power to deal with complaints appropriately, help reduce duplication of process, and enable early resolution.

The Health and Disability Commissioner Act 1994 requires that the Commissioner review the Act at least every five years (subsection 18(1)), and the Code at least every three years

(subsection 21(1)). This section was not amended after the 2004 Review of the Act and Code. The Code will be reviewed with the Act in the 2008/09 year.

The Code gives rights to all consumers, and places obligations on people and organisations providing services. It covers a wide range of providers (whether 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

The Commissioner's jurisdiction is restricted to the quality of care; it does not cover issues of funding or entitlement to service.

2.2 Overview of the Commissioner's Office

2.2.1 Complaints Resolution Team

The Health and Disability Commissioner's office is made up of several functions: complaints resolution, education, advocacy and proceedings. The Commissioner has a team of complaints assessors who also manage enquiries into the office. He also has a team of complaints investigators, one of whom is a liaison investigator who follows up on all the recommendations for improvements made by the Commissioner to health and disability services providers.

2.2.2 Legal Advisors

The Commissioner and his complaints resolution team (assessors and investigators) are supported by a team of legal advisors who provide legal advice on a range of issues including advice from the Commissioner's office on policy and legislative matters that may impact on consumers of health and disability services.

2.2.3 Promotion and Education

Promotion of the services offered by the Health and Disability Commissioner is generally through our advertising material, the media, radio and television interviews, our web site, journal articles, newsletters, our reports and opinions and the many presentations at seminars and conferences and to provider and consumer organisations.

The Commissioner's office has a fairly limited ability to deliver a wide range of educational or training initiatives. The largest educational resource is via the community-based advocates. HDC tends to limit its educational initiatives to large group providers who have trainers on their staff, and to professional bodies and consumer-based organisations, rather than the general public. The educational resources developed revolve around helping providers to make sense of HDC opinions and recommendations and encouraging as many provider organisations as possible to implement changes in response to HDC recommendations. Thus education is pitched at a national rather than a community level.

HDC held several consumer seminars in 2005 and 2006. One issue raised was how difficult it is for consumers to make a complaint, and the length of time it can take to gather the courage to put forward a complaint. Those who find it particularly difficult require a support person to assist them to make a complaint. Some participants stated that consumers can feel like "David confronting Goliath", ie, their complaint disappears into a complaint machine, run by paid staff in an organisation with a life of its own — while the consumers are left to get on with their own lives as best they can. This feedback has assisted HDC in developing a national educational resource for large group providers who have complex complaints

management systems, to assist with management of their complaints processes and the implications for health professionals.

Sitting alongside the functions of the Commissioner are two independent Directors, the Director of Advocacy and the Director of Proceedings.

2.2.4 Director of Advocacy

The nationwide health and disability advocacy service is available free to any person in New Zealand who has a concern or complaint about a health or disability service. Advocates are on the side of the consumer, and the service operates independently of the Commissioner, practitioners/providers, government agencies and organisations that fund services.

Independent health and disability advocates are located all over New Zealand. Their role is to inform consumers about their rights when using health and disability services, and to assist consumers who have concerns and want to make a complaint. They also offer education and training about consumer rights and provider duties to providers of health and disability services.

Advocacy is a very successful way of resolving complaints, and is usually achieved more quickly than with other options.

A health and disability advocate belonging to the Nationwide Advocacy Service will listen to a consumer's concerns and explain the options available to try to resolve a complaint, and will support and assist the consumer in any actions he or she chooses to take. The service is free, confidential, and independent of service providers such as hospitals, organisations that fund services, government agencies, and the Health and Disability Commissioner. Although covered by the same legislation as the Health and Disability Commissioner, the advocacy service reports to an independent Director of Advocacy, Judi Strid.

Advocates are based in 28 offices, stretching from Kaitaia to Invercargill, with five in the South Island. All advocates can be contacted through a local telephone number or a free-phone 0800 number. Email and a free fax number are also available so that deaf consumers can make contact.

In areas where there is no advocacy office, particular effort is made to link with local networks to maintain a profile and to ensure that consumers are able to contact an advocate and receive assistance when they need it. Regular visits are also made to these areas by the closest advocate, to network with the local community and provide education sessions.

Participants of the consumer seminars run by the Commissioner were concerned that, despite the Code, consumers are vulnerable when receiving health or disability services, and the Commissioner therefore needs to be supportive of them. The power imbalance between consumers and health and disability service providers was emphasised, and it was expressed that consumers need to be supported to respond appropriately at the outset when faced with discriminatory or disrespectful behaviour from providers. In particular it was expressed that complaints about abuse in residential homes need to be taken seriously.

It is partly through this type of feedback that the advocacy rest home visiting initiative was established. This is where advocates across the country proactively visit rest homes in their area rather than waiting for a complaint to be made. It means that rest home residents can make their concerns known as part of a group rather than being singled out, and the rest home staff are more likely to view the advocates as a support for service quality

improvement. This is a long-term educational initiative for both group providers and communities of consumers receiving rest home care.

2.2.5 Director of Proceedings

The Director of Proceedings, Theo Baker, is an independent statutory officer appointed under the Act. Upon receiving a referral from the Commissioner, the Director (who is a lawyer) must decide whether or not to institute proceedings against the provider. Although the Director may provide representation or assistance to complainants in any forum (eg, a court, tribunal, or inquiry), the primary focus is on disciplinary proceedings and proceedings before the Human Rights Review Tribunal.

From 18 September 2004 the Health Practitioners Disciplinary Tribunal became the main body before which charges against a registered health practitioner could be laid. A definition of “registered health professional” is contained in Schedule Four of the Health Practitioners Competence Assurance Act 2003. It includes medical practitioners, nurses, midwives, dentists, chiropractors and pharmacists.

Where the health care provider is not a registered health practitioner, the Director considers filing proceedings before the Human Rights Review Tribunal. Non-registered health practitioners include providers such as counsellors, massage therapists and acupuncturists. Action before the Human Rights Review Tribunal may also be taken against bodies such as rest homes and District Health Boards or even against a registered health professional (whether or not disciplinary proceedings are also brought). Unlike the Disciplinary Tribunal, the Human Rights Review Tribunal has the power to order the provider to pay compensation to the aggrieved person. However, because of the limitations imposed by ACC legislation, compensatory damages are available only in limited circumstances.

Where the Commissioner has found a breach of the Code, but does not refer the matter to the Director of Proceedings, or where the Director of Proceedings decides not to institute proceedings before the Human Rights Review Tribunal, an aggrieved person may personally bring such proceedings.

The Proceedings Team is based in the Wellington Office. The Director is assisted by two other lawyers and two assistants. In order to maintain the efficient delivery of services, some cases are briefed to external counsel.

2.3 Complaints Resolution

2.3.1 Making a Complaint

Anyone can make a complaint, orally or in writing. This includes not only consumers, but also their families and other support people, and other third parties such as concerned staff members in a provider organisation.

2.3.2 Types of Complaint

Most complaints to our Office involve communications, regardless of the clinical or other issues. Concerns may relate to the manner or attitude of the person providing the health or disability service — how something was said or the lack of information provided. Communication may be the only issue, but more often it is part of multiple issues in relation to the care provided.

Other issues concern diagnosis and treatment and, in the case of rest homes, ongoing care. When reviewing a complaint, we look at what was reasonable in the circumstances at the time, given the information available to the provider. In determining whether the clinical

care met the standards set by the profession, we use expert advisors — independent advisors who are working in the same specialty, in a similar setting (eg, provincial or rural, District Health Board or private hospital). Advice is sought on whether the care departed from standards and, if so, the degree of departure.

2.3.3 *A Commissioner's Initiative*

The Commissioner does not have to wait until a complaint is received before he can take action. The Health and Disability Commissioner Act enables the Commissioner to undertake investigations on his own initiative. This allows the Commissioner to fulfil his role of “consumer watchdog” and to ensure public safety.

A Commissioner's initiative inquiry may be launched where a number of complaints have been received about the same provider (eg, a rest home) or where serious public concerns have been raised about the safety of services (as occurred in relation to Canterbury Health in 1997, Gisborne Hospital in 2000, Tauranga Hospitals in 2004, and the inquiry into the tubal ligations at Whanganui Hospital in 2007 — still in process).

2.3.4 *Enquiries and Complaints*

HDC receives some 5,000 enquiries and 1,100 complaints a year. We manage to address 89% of complaints without investigation. The main reason for the small number of investigations is that the purpose of the Act is to promote and protect the rights of health and disability service consumers and, to that end, to facilitate the *fair, simple, speedy and efficient resolution* of complaints relating to infringements of those rights. The focus of this Office is therefore on *local-level or direct resolution* of complaints, so that complaints can be resolved in a fair and speedy manner.

2.3.5 *Investigation*

Investigation is the most drawn-out form of complaint resolution, and is not necessarily consistent with the fair, simple, speedy and efficient resolution of complaints in all cases. Nor is it the most appropriate method where there is an ongoing relationship between the parties. It is often more likely that disability services consumers and consumers with chronic illnesses will require an ongoing relationship with providers. This can be a factor to consider when evaluating the most appropriate way to resolve a complaint, and whether an investigation is appropriate. Furthermore, the length of time it takes for an investigation should be noted — up to six to nine months for a simple investigation, while a complex investigation can take 18 months.

Investigation is therefore reserved for only a small proportion of the most serious complaints. Often it will not be necessary, for example if the consumer is happy with the provider's response. Also, it is not possible in cases that are outside this Office's jurisdiction. In such cases the Commissioner will always give constructive advice and/or recommendations of other authorities that may be more suited to help.

2.3.6 *Other Options for Complaints Resolution*

Most complaints are dealt with using other options such as “education letters”, advocacy and mediation. This is generally more appropriate in terms of trying to sort things out fairly and quickly for all concerned. Often there are relationships to be maintained — ongoing doctor–patient dealings for example. Also, it is common to see complaints where parties may be at cross purposes. They may have completely different ideas about what occurred, and simply meeting to discuss the issue can resolve a complaint.

2.3.7 Advocacy

Advocates receive around 8,600 enquiries and manage about 4,600 complaints a year in addition to the enquiries and complaints received by HDC. On average, 88% of complaints managed by advocates are resolved or partially resolved with advocacy.

The Commissioner is a strong advocate for the expansion of the Advocacy Service, and has been successful in gaining increased funding from Government to increase the number of advocates working in the community.

2.4 The Health and Disability Commissioner

Ron Paterson LLB (Hons), BCL Oxon, was appointed Health and Disability Commissioner for a five-year term in March 2000, and his term was renewed for a further three years from March 2005. He has law degrees from Auckland and Oxford Universities, and was a visiting law professor at the Universities of Ottawa and British Columbia in the mid-1980s, before returning to the University of Auckland as senior lecturer in health care law (1986-99).

Ron has worked in mental health, public health, and consumer protection policy roles at the Ministry of Health, including as Deputy Director-General, Safety & Regulation. He has taught and researched in the United States, as Fulbright Visiting Professor of Biomedical Ethics at Case Western Reserve University (1993) and Harkness Fellow in Health Care Policy at Georgetown University (1998-99).

Ron played a key role in the final development of the Code of Rights in 1996. He has lectured and published on a wide range of topics in health law, ethics and policy, and gave evidence on “Safeguarding Patients” as an expert witness before the Shipman Inquiry in England (January 2004).

In 2005 Ron chaired two major Australian health reviews: the Review of the System of Assessment of Overseas-Trained Surgeons in Australia; and the Review of Governance Arrangements for Safety and Quality in Healthcare in Australia.

In 2006 Ron published the Health and Disability Commissioner Compendium of Case Notes. The Compendium is a selection of opinions of the Health and Disability Commissioner from 2000-2004, covering a range of services and illustrating the application of the Code of Health and Disability Services Consumers’ Rights in situations where consumers complain that their rights were infringed. It is intended to be used to educate consumers, providers and the public about the scope and meaning of the rights affirmed in the Code.

In 2006 Ron also co-edited the book *Medical Law in New Zealand*, a collaborative effort by five other academics from the Law Faculties of Auckland and Otago Universities. Its release coincided with the 10th anniversary of the Code of Health and Disability Services Consumers’ Rights.

2.5 The Organisational Structure

The Health and Disability Commissioner works out of two offices, in Auckland and Wellington. There are 14 staff in the Wellington office comprising the Proceedings Team, the Legal Team and two corporate support staff.

There are 36 staff in the Auckland office. The teams in the Auckland office are Complaints Resolution, the Education and the Corporate Services Teams, and the Director of Advocacy and her assistant.

The Commissioner has six direct reports:

Independent Directors

- Director of Advocacy — Judi Strid. The Director of Advocacy contracts a Nationwide Advocacy Service Organisation, which employ a total of 42 advocates and advocacy support staff
- Director of Proceedings — Theo Baker

Senior Managers

- Deputy Health and Disability Commissioner Complaints Resolution — Rae Lamb
- Deputy Health and Disability Commissioner Education and Corporate Services — Tania Thomas
- Chief Legal Advisor — Nicola Sladden
- Executive Assistant — Ta'a Punivalu

An Organisational Chart depicting the staffing positions within HDC can be found in *Appendix 1*.

3.0 The Environment

HDC is required to identify ways of responding to the various external and internal drivers that ultimately affect the way we do our work in order to best achieve the desired outcomes.

Key policy documents and legislation, including a range of national strategies as well as the Health and Disability Sector Standards and the Health Practitioners Competence Assurance Act, are increasingly being incorporated into the provision of services. This is helping to increase the focus on quality, inclusiveness and the need to engage with consumers and their communities. These policies and strategies influence the way in which HDC prioritises its work and how it develops its own strategies.

Complaints are an important way of improving the quality of services. They offer vital “red flags” exposing poor care, public safety issues and systems problems. Complaints highlight areas for improvement and lessons to be learned. They can also provide an antidote to internal complacency.

The Health and Disability Commissioner is a “public watchdog”, speaking up to protect patients and disability support services users. We take our public protective role seriously — increasingly the Commissioner has been using investigation reports on our website (www.hdc.org.nz) to highlight patient safety concerns — medication safety in hospitals (eg, the Palmerston North case, 03HDC14692); credentialling of independent practitioners with access agreements at DHB maternity facilities (04HDC04652); and emergency departments at Dunedin Hospital (04HDC12081) and Gisborne Hospital (04HDC04456).

3.1 External Drivers

The Government is an external driver in terms of its requirements for Crown Entities to be involved in whole-of-Government initiatives and relevant health and disability strategies for New Zealand.

There is increasing pressure, in New Zealand and globally, on health budgets. Health workforce shortages, and the need for improved training and funding of caregivers for disabled and elderly consumers, are likely to be cost drivers.

Consumers are increasingly aware of their rights, including the right to make a complaint, but there are varying levels of ability, confidence, knowledge and expectations amongst different ethnic and cultural groups in exercising their rights. There has been a move towards greater inclusiveness of diverse groups and their “cultures” within New Zealand society — for instance, youth culture, gay culture, Deaf culture, migrants’ culture, and older persons’ culture. There has been a significant increase in the number of Māori providers, and in the visibility of disabled people, older people and those with mental illness.

The attitude of providers to the complaints process is shifting, with many seeing it as a more positive process than expected. Workforce changes are occurring in some parts of the health sector, for instance in rural areas where it is difficult to recruit medical staff. There are also greater numbers of overseas-trained practitioners who are unfamiliar with New Zealand’s health system and its approach to consumer rights.

Electronic processes and records are being used to a greater extent by the health sector. Technological change also means that consumers expect a more immediate response from providers. This raises potential safety issues, for example with the use of on-line prescribing, clinical videoconferencing, and the long-distance provision of services in areas such as radiology.

These external drivers provide an opportunity for HDC to:

- advise and assist providers to fulfil their responsibilities under the Code of Health and Disability Services Consumers’ Rights despite the economic pressures they may face
- better target education about consumer rights and provider responsibilities to inform and educate a provider workforce with increasingly varying backgrounds
- provide a more customised approach to its educational and promotional activities to better serve the diversity of consumer need
- consider how the new electronic ways of offering services will impact on the way HDC carries out its work in complaints resolution.

3.2 Internal Drivers

We need to ensure that HDC (including the Nationwide Advocacy Service) is a workplace of choice, and that we recruit and retain high-performing staff to better resolve more complex and wide-ranging complaints, to ensure that the time taken to complete investigations is shortened without compromising quality, and to work across divisions using a team-based approach.

Our information systems (for example, information technology, document management and website) need to be well connected to all our functions, so there is greater continuity and ability to share information readily. This information is integral to our educational function as well as our internal continuous improvement function.

Our resources are limited, so we need to be a smart organisation and use them effectively.

Selecting and training for the range of competencies our staff need is a priority as we seek to lift our performance as an organisation. Significant progress has been made in achieving a quicker turnaround for dealing with the majority of complaints, but reducing the timeframe for investigations remains a challenge. We need to make it easier for staff to work across divisional boundaries.

These internal drivers provide an opportunity for HDC to:

- ensure that our systems are more effective in supporting staff to carry out their roles across our education, complaints resolution, financial and human resource management functions
- increase our productivity with better systems and processes.

3.3 Priorities

HDC's priorities revolve around ensuring that the public know about their rights and the service provided by HDC; that providers are aware of their responsibilities under the Act; and that HDC resolves complaints and uses the learning from complaints to gain improvements in the safety and quality of health and disability services. HDC wants to prevent avoidable harm to consumers and make sure that all health and disability services are delivered with care, competence and compassion. To do this we have the following priorities:

- raising the profile of HDC and aligning our educational activities to our leadership role in safety and quality improvement by working more strategically with key stakeholders
- ensuring we have the internal capability and infrastructure needed to achieve our strategic goals
- improving the timeliness of all complaint processes, including complaints to providers, advocates and HDC, without compromising outcomes
- seeking to improve the accessibility of the Commissioner's services and processes to long-term consumers of disability services, Māori, Pacific and other ethnic communities
- continuing to build the capacity of the Nationwide Advocacy Service through a staged expansion of the service nationally, which began in the 2006/2007 year.

3.4 Key Initiatives

The Commissioner's office has three key initiatives on which it continues to work in support of the Health and Disability Commissioner's priorities and objectives within the NZ Health Strategy:

- Implementing the New Zealand Disability Strategy
- Implementing Initiatives from the Commissioner's Iwi Advisory Group
- Implementing Pacific education initiatives

3.4.1 New Zealand Disability Strategy

The Health and Disability Commissioner's office has a New Zealand Disability Strategy Implementation Plan. Aside from the universal responsiveness to disability issues activities (activities that all Government agencies and Crown Entities are required to implement as a bare minimum), the Commissioner's office has six disability-focused work areas:

- Employment
- Access to information
- Participation of disabled Māori
- Participation of Pacific peoples
- Responsiveness to complaints resolution processes
- Consumer participation

Desired outcomes in the focused work areas:

- Increase in the number of disabled people working in the Health and Disability Commissioner's office to better reflect the population the office serves and increase the level of skill and knowledge of disability in the Commissioner's office, by 2009.
- Residential care providers in the disability sector, nationally, have policies and procedures in place that support their disabled clients when experiencing any fear associated with making a complaint, including support to access an independent advocate, by 2009.
- The Health and Disability Commissioner is well informed with accurate information about matters of concern pertaining to the safety and quality of disability services and mainstream disability services provided to Māori, by 2008.
- The Health and Disability Commissioner is well informed with accurate information about matters of concern pertaining to the safety and quality of disability services and mainstream disability services provided to Pacific peoples, by 2008.
- Disabled people using the Health and Disability Commissioner's services find our organisation and our staff aware and responsive to the different needs of disabled people, by 2008.
- The perspective of disabled people is respected and actively sought by health and disability services providers, by 2009.

HDC plans to do this by:

- implementing its revised recruitment and selection policy that addresses recruitment of disabled people
- analysing the survey results from a sample of residential care providers who were asked to provide copies of their complaints and appeals procedures, and preparing an action plan for addressing any shortfalls in provider procedures
- implementing and trialling a communication plan to use with one member of the Iwi Advisory Network
- establishing an Advisory Network of Pacific peoples who use disability services
- identifying alternative remedies and actions that can be used to achieve compliance with the Code by disability service providers and health care providers who deliver services to disabled people, to ensure changes in identified non-compliant practices and systems
- establishing a Disability Consumers Advisory Group to work alongside the Commissioner's existing Consumer Advisory Group.

3.4.2 Iwi Advisory Group

The Commissioner has recently formed agreements with Ngati Whatua, Tainui and Tuwharetoa. All three Iwi have appointed mandated representatives to advise and work with our office. Ngai Tahu executive has also appointed a representative to our Iwi Advisory Group. This group is being asked for advice around the following issues:

- increasing awareness amongst both Māori providers and consumers about the Code of Health and Disability Services Consumers' Rights
- identifying barriers and possible solutions to Māori health and disability services consumers using complaints processes
- identifying key concerns that Māori with impairments have about the health and disability services they use
- identifying improvements in making the Commissioner's services more accessible to Māori.

The group will meet three times a year and will expand to include Northern Iwi representatives by 2009.

3.4.5 Pacific Education Initiatives

The Health and Disability Commissioner's office is currently working on a two-year plan to increase the level of awareness amongst Pacific peoples and their communities about their rights under the Code of Health and Disability Services Consumers' Rights.

The key objectives of the plan are to:

- develop train-the-trainer packages to use with Pacific representatives in local communities
- increase the level of media advertising via Pacific radio and community organisations including schools
- develop partnerships with Public Health Organisations to improve the accessibility of Pacific peoples to information about complaints processes and the advocacy service.

3.5 Key Relationships

HDC is keen to work alongside several sets of stakeholders to achieve our shared goals. The key relationships we wish to maintain and develop are with:

- consumers — both consumer organisations and the broader community
- providers — both individual practitioners and group providers, including District Health Board Chairs and Chief Executives
- professional bodies and registration bodies
- professional colleges
- 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
- National Health Epidemiology and Quality Assurance Advisory Committee
- Quality and Improvement Committee (QIC)

It is important to invest in relationships with people from the organisations listed above, by working on joint initiatives, sharing ideas, knowledge, information and costs where possible, reducing duplication of effort, and increasing the ability to work co-operatively. These kinds of relationship can help make services more accessible and more in line with consumers' needs and expectations.

HDC will establish, maintain and develop contacts through regular update meetings, and will encourage and lead interagency initiatives where relevant to the needs of those who use our services. In some relationships, for example with the Dental Council and the Medical Council, we will initiate a Memorandum of Understanding outlining our respective roles and how we propose to work together to ensure mechanisms for stronger working relationships that will benefit the health and disability sector.

3.5.1 Stakeholder Buy-in

We want our stakeholders to understand and “buy into” our vision, to help make it a reality. Ideally HDC will develop champions to support and further our cause and widen our sphere of influence.

HDC plans to obtain a commitment from those we see as key stakeholders by:

- clearly articulating HDC’s vision and the benefits for all stakeholders
- cultivating participation early and often
- communicating in multiple forms on an ongoing basis
- gathering and reporting evidence that shows buy-in
- formalising agreements with stakeholders, where appropriate.

4.0 Our Vision and Mission

Our vision is “Champions of consumers’ rights”. It reflects the purpose 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 that New Zealand should lead the world in its promotion and protection of the rights of health and disability services consumers.

Our mission reflects our purpose as an organisation — *resolution* of complaints, *protection* of individuals and the public, and *learning* from complaints to improve all health and disability services.

It is our responsibility to “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) and *protection* (ensuring the safety and quality of all health and disability services).

5.0 Strategic Goals

The following goals provide HDC with a plan for the next 3–5 years. The goals focus on HDC fulfilling its obligations under the Act, whilst at the same time supporting the Government to achieve its outcomes for New Zealanders. HDC views complaints as a mechanism for improving the safety and quality of health and disability services, based on the learning that comes from identifying poor practice and systems failure and identifying solutions to improve poor practice and minimise or eliminate systems failure.

5.1 Goal One: To achieve sustainable improvements in safety and quality in the health and disability sectors.

HDC aims to contribute to the Ministry of Health outcomes of:

- 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 intends to:

- fulfil an important leadership role in ensuring that there are ongoing systemic improvements in safety and quality in the health and disability sectors
- provide a valuable source of learning for both providers and consumers from information obtained from the complaints process
- ensure that information is shared effectively across the sectors and results in positive change
- facilitate the sharing of information about best practice and effective ways to improve poor practice
- be alert to patterns of poor practice and intervene at an early stage
- showcase good decisions and processes to demonstrate positive outcomes that have been achieved
- follow up our decisions to ensure that sustainable change has occurred and report back to consumers
- work with both consumers and providers to make a real difference to the safety and quality of health care and disability services in New Zealand.

Outcome indicators:

- All District Health Boards will have open disclosure policies in place by 2010.
- DHB responses to complaints received by HDC are monitored to assess the extent to which open disclosure policies are being put into practice throughout 2007/08.
- Health and Disability Sector Standards will require open disclosure policies by 2010.
- The Health and Disability Commissioner will monitor and report compliance by providers who have been given recommendations for improving the safety and quality of their services throughout 2007/08.
- Recommendations made by the Health and Disability Commissioner from three major investigations will be implemented nationally each year.
- Five District Health Boards will state that they have found the trend information on number and types of complaint made to HDC about their service useful, and will describe how they have used the information to make safety and quality improvements to their service, by 30 June 2008.
- 10% of providers who have participated in HDC's complaints process during 2007/08 will outline the significant systems changes they have made to improve the safety and quality of health and disability services as result of the complaint.

5.2 Goal Two: To ensure that consumers are protected and are able to exercise their right to complain without fear or retribution.

HDC aims to contribute to the Ministry of Health's outcomes of:

- reduced inequalities — we achieve an improvement in the health status of those currently disadvantaged, particularly Māori, Pacific peoples and people with low social economic status.
- better participation and independence — the health and disability support sector contributes constructively to having a society that fully values the lives of people with disabilities.

HDC intends to:

- increase awareness among health and disability services consumers about their rights under the Code, and ensure that they are able to exercise their rights

- provide a strong Advocacy service to assist consumers to understand their rights and the responsibilities of providers, and to assist consumers to resolve their complaints, recognising that knowledge and the ability to speak up is variable
- promote the involvement of consumers as partners in every stage of their care
- encourage and support more active consumer participation in the design and delivery of health and disability services
- provide greater opportunities for consumers to participate in our decision-making process. We will involve consumers in our educational activities and in Advocacy to promote and protect consumer rights
- be an effective watchdog for consumers, by alerting relevant agencies to problems, reporting publicly on breaches of the Code, and “speaking up” for the rights of consumers
- recognise that there is an important place for accountability through disciplinary and Human Rights Review Tribunal proceedings
- ensure that appropriate cases are referred to the independent Director of Proceedings and that the Director is well supported and funded to bring proceedings.

Outcome indicators:

- Survey results in 2008/09 will confirm an increase in public awareness amongst consumers who have in the past had low levels of awareness of their rights under the Code of Health and Disability Services Consumer’s Rights, for example, manual workers, youths, people in lower socio-economic groups, and people of Māori or Asian ethnicity.
- A random survey of consumers in 2008/09 will provide baseline information about how satisfied they are that their view was heard by HDC staff in a fair and unbiased way.
- Use of Advocacy services will increase and more consumers will have access to specialist advocacy.
- The complaints processes used by District Health Boards will be reviewed during 2007/08 and a report on the level of compliance with best practice in complaints management and the Code of Rights will be made available by 30 June 2009.

5.3 Goal Three: To facilitate the resolution of complaints at every step.

HDC aims to contribute to the Ministry of Health outcomes of:

- 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 intends to:

- develop our skills in complaints resolution
- build on providers’ greater willingness to acknowledge shortcomings, apologise where appropriate, and to work swiftly to resolve the complaints we receive
- further develop the greater range of options for resolving complaints, particularly advocacy and mediation, to ensure that complaints are resolved in appropriate settings, using fair and timely processes

- ensure greater use of advocacy and mediation to resolve complaints
- build capacity in the Nationwide Advocacy Service and ensure there are more advocates on the ground, including specialist advocacy
- improve the timeliness of our complaints handling, with 90% completed within a year.

Outcome indicators:

- An increase in the number of complaints resolved with mediation from six in 2005/06 to ten in 2007/08.
- Monitoring and reporting of the number of complaints successfully resolved by providers when the complaint has been referred to the provider by HDC.
- Achievement of the Advocacy Services expansion plan (see *Appendix 2*) by 2010.
- Greater use of interviewing to collect information more efficiently by reducing the level of written correspondence by 30 June 2008.

5.4 Key Risks and Management Strategies

The key risks that could prevent HDC making effective progress towards our vision and goals are:

- an unexpectedly high volume of complaints and/or the need to undertake a major complex inquiry
- our complaints handling not meeting consistent quality standards and, as a result, receiving negative media attention
- not being flexible and innovative enough to adapt our processes to meet the needs of consumers whose welfare is most at risk because they are least able to advocate for themselves, and parts of the community losing faith in our ability to carry out our functions.

HDC's strategies for dealing with these key risks are to:

- continue staff training and review our processes to improve the quality of our work and increase our capacity to handle increased demand
- ensure that complaints are resolved at the appropriate level and that we are responsive to the users of our services and timely in dealing with complaints
- provide more opportunities for consumers to have more say about what is important to them and ensure that consumer perspectives are well understood by HDC
- continue to gradually increase the number of advocates providing advocacy services so that Advocacy Services can be more proactive and responsive to the full range of consumers' needs.

5.5 Organisational Capability

HDC aims to make a positive difference to the quality of health care and disability services. In order to achieve this we need to influence change, and the health and disability sectors need to have confidence in our work. Staff within HDC have to clearly understand HDC's direction, and our actions must be aligned with our values. Those values are fairness, care and compassion, responsiveness and quality.

HDC has strong governance policies and practices in place, and the buildings and office space we work from are modern and well equipped. The office equipment is well maintained

and in good working order. All work processes are clearly documented. HDC has good basic Human Resource policies and practices in place. Staff retention overall is good.

However, there are a number of areas in which HDC aims to improve its capability to assist us to deliver on our stated outcomes. Our people are essential to ensure we maintain excellence and a high level of performance and results. Over the next three years we will continue to implement our obligations to be a “good employer” and develop and implement equal employment opportunities for all. This will ensure that we position ourselves to employ the diversity of staff reflected in the population groups we are working with now and in the future. HDC would like more Māori, Pacific peoples and disabled people to use our services, as the current usage does not reflect the comparatively high usage of health and disability services by these same communities.

Developing excellent leadership is an area HDC continues to view as an important task. Skilled leadership is required to nurture a more creative and innovative staff who can continually work to improve our processes, especially where we are trying to reduce the amount of time it takes to complete investigations without compromising quality. Leadership in work–life balance initiatives is also required to help HDC better manage the stress associated with the work of complaints resolution.

HDC has greatly improved the quality and responsiveness of our information systems and technology. We are now moving to make our document management system more in–step with Archives New Zealand requirements and to make the system more user friendly and faster at responding to reporting requests. We continue to use our complaints resolution findings as tools for informing and learning, and we are implementing a wider range of information sharing mechanisms with better use of our website.

The success of these capability-building initiatives will be measured by a change in our profile to more closely reflect the wider community, an increase in staff morale, improved confidence and relationships in the organisation, as well as staff perception of fairness and equity.

5.5.1 Good employer

The Health and Disability Commissioner’s Office views itself as an Equal Employment Opportunities (EEO) employer. We work at reducing and eliminating barriers to ensure that all employees are considered for the employment of their choice, work to their strengths, and have the chance to perform to their maximum potential.

We have had a three-year relationship with Mainstream (a government-sponsored recruitment and vocational placement service for disabled people and Government/Crown Entity employers) and have recruited successfully through this programme. The Commissioner’s Office also works with Crossroads Clubhouse, a community organisation offering employment transition placements, and this relationship has also provided a successful employee placement.

We have sound human resource practices that assist us to recruit the very best people from the diverse population, making the most of their skills, creativity and energy. Initiatives that encourage work–life balance are an important part of EEO as they enable people to perform to their full potential while still accommodating their commitments outside of work.

HDC’s capability as an organisation relies heavily on its staff being fully engaged. We need to make sure that staff know their role in the organisation, and the importance of their job to HDC’s success. HDC needs to consistently celebrate the success of the organisation and the

contributions individual staff make to that success. Good communication across the organisation is important so that staff feel and know that they matter. Our culture needs to be accepting of difference, and we need to demonstrate honesty and integrity at all times.

HDC wishes to be a good employer because we want to:

- attract and retain quality people
- be innovative and highly productive
- meet the diverse needs of the people who use our service.

HDC will concentrate on the following to retain staff:

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

We appreciate the need to ensure that our staff are fully engaged and satisfied in their work and that they feel valued. It will be important for senior managers at HDC to ensure that the policies we are developing around “working from home”, health and wellness, and remuneration are implemented consistently and thoroughly.

HDC aims to provide a safe and healthy environment for its staff to work from, and this includes staff feeling culturally and emotionally safe.

PART TWO

6.0 Statement of Service Performance

The services provided under the Health and Disability Commissioner Act are advocacy, complaints resolution, education and promotion, proceedings and submissions, 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 five 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 2007/08</i> |
|---|-----------------------------|
| Output Class 1 — Safety and Quality Improvement in Health and Disability Services Provision | \$8,762,000 (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.
- 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 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.

6.1 Output 1 — Complaints Resolution

Value 2007/08 \$3,426,000

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.

Sustainable improvements in safety and quality in the health and disability service sectors.

| Output | Performance Measures and Standards |
|--|--|
| <p><i>Enquiries</i></p> <p>6.1.1 Appropriate information about the Code of Health and Disability Services Consumers' Rights and HDC's complaints processes is provided to the public.</p> | <p><i>Enquiries</i></p> <p>90% of enquiries answered on the day they are received throughout 2007/08 with quarterly updates provided on the percentage of enquiries answered on the day they were received.</p> |
| <p><i>Complaints</i></p> <p>6.1.3 Complaints are managed in compliance with options under the HDC Act 1994 and where providers have been found to have breached the Code of Health and Disability Services' Consumers Rights there are recommendations to address safety and quality issues.</p> | <p><i>Complaints</i></p> <ol style="list-style-type: none"> 1. 90% of all complaints closed within 12 months of receipt throughout 2007/08 with quarterly updates provided on the percentage of all complaints closed within 12 months of receipt. 2. DHB practice of open disclosure is surveyed in April 2008 and their responses to complaints about events since July 2007 are monitored for evidence of open disclosure and attempts to facilitate early resolution. 3. 10% of providers who have participated in HDC's complaints process during 2007/08 will outline the significant systems changes they have made to improve the safety and quality of health and disability services as result of the complaint. 4. All investigations are followed up to encourage 100% compliance with recommendations by providers. |

6.2 Output 2 — Education and Promotion

Value 2007/08 \$649,000

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. These presentations generally use findings from the Commissioner's complaints resolution function 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 and Promotion

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.

Reduced inequalities — we achieve an improvement in the health status of those currently disadvantaged, particularly Māori, Pacific peoples and people with low social economic status.

HDC outcomes that contribute to the MOH outcomes

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

Performance Measures and Standards

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| <p>6.2.1 Provide a range of accessible promotional, informational and educational materials for use by the public and providers via posters, brochures, media interviews, media releases, DVDs, journal articles, consumer seminars, conference presentations, trend reports and on-line information that assists in increasing awareness of the services offered by HDC and sharing of the learning from the work of HDC.</p> | <p>60% of informational and promotional information meets best practice standards for accessibility.</p> |
| <p>6.2.2 Provide six-monthly Commissioner complaints trend reports to DHBs in September 2007 and March 2008.</p> | <p>DHBs report that they find the trend reports useful and describe how they have used the trend information.</p> |
| <p>6.2.3 Produce on-line educational resources for use by the public by the end of the third quarter.</p> | <p>60% of users of on-line educational resources rate that they find them useful, through an on-line survey.</p> |
| <p>6.2.4 Facilitate consumer seminars, one per quarter, and report on findings by 30 June 2008.</p> | <p>Four consumer seminars are held and 80% of consumers responding to an evaluation survey rate the seminars as useful to very useful.</p> |

6.3 Output 3 — Submissions

Value 2007/08 \$498,000

The rights of health and disability services consumers are championed through ensuring relevant health and disability services standards, workforce development, proposed and existing legislation includes the perspective of health and disability services consumers. It is important to view consumers as partners in their own care and to address power imbalances in all practices, processes and systems affecting the rights of consumers. The findings from the Commissioner's opinions and complaints that have been resolved without investigation provide very good insight into issues experienced by health and disability services consumers.

The Chief Legal Advisor and her team have provided input into a wide range of submissions made by the Health and Disability Commissioner. In the latter part of 2006 submissions were made to the Medical Council of New Zealand, the Ministry of Justice, the Ministry of Social Development, the New Zealand Speech Association, the Ministry of Health, Housing New Zealand Corporation and the Human Rights Commission.

| Output 3 — Submissions | |
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| <p>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.</p> <p><i>HDC outcomes that contribute to the MOH outcomes</i> To achieve sustainable improvements in safety and quality in the health and disability sectors. To ensure that consumers are protected and are able to exercise their right to complain without fear or retribution.</p> | |
| Output | Performance Measures and Standards |
| <p><i>Submission</i> 6.3.1 Provide quality responses to relevant submission documents affecting the rights of health and disability services consumers.</p> | <p><i>Submission</i> Provide an annual report on the impact of policy advice given and submissions made by 30 June 2008 with quarterly updates on the percentage of satisfaction with the quality of our policy advice and submissions.</p> |

6.4 Output 4 — Advocacy Services
Value 2007/08 \$3,399,000

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 4 — 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 | Performance Measures and Standards |
| <i>Advocacy Agreement</i> 6.4.1 Administer Advocacy Services agreement. | <i>Advocacy Agreement</i> Compliance with Advocacy Services agreement monitored and results reported quarterly. |
| <i>Promotion and Education</i> 6.4.2 Promote, by education and publicity, advocacy services. | <i>Promotion and Education</i> Compliance with Advocacy Services education targets monitored and results reported quarterly. |
| <i>Training</i> 6.4.3 Oversee the training of advocates. | <i>Training</i> Review and report findings of training undertaken by advocates during 2007/08. |

6.5 Output 5 — Proceedings

Value 2007/08 \$790,000

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.

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| Output 5 — 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 | Performance Measures and Standards |
| <i>Proceedings</i> | <i>Proceedings</i> |
| 6.5.1 Pursuant to s 49 of the Act, decide, on referral from the Commissioner, whether to institute proceedings or take any other action. | The Director will provide an annual report to the Minister on decisions made under s 49 of the Act, by 30 June 2008. |
| <i>Proceedings</i> | <i>Proceedings</i> |
| 6.5.2 Deliver high quality and fair proceedings throughout the process. | Tribunals are satisfied that 80% of proceedings are high quality, by 30 June 2008. |

7.0 Objective — Ownership Performance

HDC will continue to build capability and robust systems that meet our needs, are easy to use, and will 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, for example, organisational planning, interagency networking and liaison, and Ministry of Health reporting. It also includes initiatives that impact on HDC as a whole, for example, HDC's Implementation Plan for the New Zealand Disability Strategy and the work it does in increasing internal capability to work alongside Māori.

| Corporate Services | |
|--|---|
| Activity | Performance Measures and Standards |
| <p>Finance Management</p> <p>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>Maintain or improve the grading in each area of Financial Service Performance Management in Audit New Zealand's 2006/07 Audit Report, by 30 June 2008.</p> |
| <p>Information Management</p> <p>7.2 Implement solutions to simplify HDC's IS operating environment, speed up access to stored data and manage IT more cheaply and effectively.</p> <p>7.3 Increase HDC's capacity to access and collate structured and unstructured information so that it can be shared more easily and quickly, internally and externally.</p> | <p>Provide an annual report on the solutions implemented by 30 June 2008 with quarterly updates.</p> |
| <p>Human Resource Management — Good Employer Plan <i>Leadership, accountability and culture</i></p> <p>7.4 Implement a diversity awareness programme for all staff.</p> | <p>Diversity awareness programme implemented by the end of the third quarter.</p> |

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| <p>7.5 Hold a mentoring and coaching training seminar for managers and seniors.</p> | <p>Mentoring and coaching seminar implemented by the end of the second quarter.</p> |
| <p><i>Remuneration, recognition and conditions</i></p> | |
| <p>7.6 Review rewards and recognition policy and implement approved changes.</p> | <p>Revised remuneration policy completed by the end of the first quarter.</p> |
| <p><i>Flexibility and work design</i></p> | |
| <p>7.7 Implement a staged return to work from parental leave policy and process.</p> | <p>Staged return to work from parental leave policy implemented by the end of the second quarter.</p> |
| <p>7.8 Implement a work from home policy.</p> | <p>Work from home policy implemented by the end of the first quarter.</p> |
| <p><i>Safe and healthy environment</i></p> | |
| <p>7.9 Hold a health and wellness week for staff with a range of activities aimed at improving knowledge and information around health and well-being.</p> | <p>Health and wellness week held by the end of the first quarter.</p> |
| <p>7.10 Information on healthy eating, healthy activity and work–life balance provided to staff.</p> | <p>Information provided on healthy eating and activity by the end of the first quarter.</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 2007 | 24 October 2007 |
| Quarter 2 | 1 October – 31 December 2007 | 31 January 2008 |
| Quarter 3 | 1 January – 31 March 2008 | 24 April 2008 |
| Quarter 4 | 1 April – 30 June 2008 | 31 July 2008 |
| Annual | 1 July 2006 – 30 June 2008 | 31 October 2008 |

9.0 Financial Performance 2007/08

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 is transitioning to a new set of accounting standards. This means that the financial statements at the end of the financial years 2007/08 and onwards will be prepared in accordance with the new NZIFRS.

The prospective statements for 2007/08 and onwards in this SOI comply with FRS-42.

9.1 Key Assumptions for Proposed Budget 2007/08

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 2007/8. The staged expansion will take place over the next three years (see Appendix 2). 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. This level of reserve is adequate to fund a major Inquiry should one be required, and it will also provide a safety net were HDC to suffer a major disaster with its Information Systems.

HDC has approximately 1,150 individual assets on the asset register with a total cost of \$2.2m. HDC has an accumulation of small assets, with only one asset exceeding \$150,000 this was the fit out of our Auckland office in 2002. Therefore no valuation of large assets has been undertaken.

9.2 Statement of Financial Performance 2007/08

HEALTH AND DISABILITY COMMISSIONER FINANCIAL PERFORMANCE FOR THE Budget YEAR ENDED 30 JUNE 2008

| | Forecast Projected Actual 2006-07 \$000's | Proposed Budget 2007-08 \$000's | Estimated Budget 2008-09 \$000's | Estimated Budget 2009-10 \$000's |
|--|---|--|---|---|
| Income | | | | |
| Operating Grant Received | 7,554 | 8,331 | 8,606 | 8,881 |
| Interest Received | 177 | 177 | 138 | 105 |
| Publications Revenue | 77 | 80 | 81 | 84 |
| TOTAL INCOME | 7,808 | 8,588 | 8,825 | 9,070 |
| Less Expenses | | | | |
| Service Contracts | 2,589 | 3,074 | 3,315 | 3,382 |
| Staff Costs | 3,347 | 3,554 | 3,630 | 3,702 |
| Occupancy | 434 | 437 | 446 | 455 |
| Travel & Accommodation | 216 | 194 | 198 | 202 |
| Communications | 150 | 141 | 143 | 146 |
| Computer Costs | 250 | 352 | 359 | 366 |
| Promotion & Education | 248 | 216 | 221 | 226 |
| Depreciation & Amortisation | 264 | 262 | 263 | 264 |
| Operating Costs | 499 | 513 | 524 | 536 |
| Audit | 12 | 19 | 19 | 20 |
| TOTAL EXPENSES | 8,009 | 8,762 | 9,118 | 9,299 |
| Net Operating Surplus/(Deficit) | (201) | (174) | (293) | (229) |

Note: These figures are GST exclusive

9.3 Statement of Financial Position

HEALTH AND DISABILITY COMMISSIONER FINANCIAL POSITION AS AT 30 JUNE 2008

| | Forecast Projected Actual 2006-07 \$000's | Proposed Budget 2007-08 \$000's | Estimated Budget 2008-09 \$000's | Estimated Budget 2009-10 \$000's |
|--------------------------------|--|--|---|---|
| Crown Equity | | | | |
| Accumulated Funds Op Bal | 978 | 776 | 602 | 309 |
| Add Net Profit/(Loss) for Year | (201) | (174) | (293) | (229) |
| Capital Contributed | 788 | 788 | 788 | 788 |
| TOTAL CROWN EQUITY | 1,565 | 1,390 | 1,097 | 868 |
| Represented by: | | | | |
| Current Assets | | | | |
| Bank Account | 6 | 80 | 276 | 838 |
| Petty Cash | 1 | 1 | 1 | 1 |
| Call Deposits | 1,600 | 1,350 | 874 | 228 |
| Prepayments | 16 | 16 | 16 | 16 |
| Inventory | 15 | 15 | 15 | 15 |
| Sundry Debtors | 32 | 31 | 31 | 31 |
| Total Current Assets | 1,670 | 1,493 | 1,213 | 1,129 |
| Non Current | | | | |
| Intangible Assets | 150 | 100 | 100 | 100 |
| Fixed Assets | 339 | 397 | 334 | 269 |
| Total Assets | 2,159 | 1,990 | 1,647 | 1,498 |
| Current Liabilities | | | | |
| GST Payable | 28 | 40 | 50 | 50 |
| Sundry Creditors | 566 | 560 | 500 | 580 |
| | 594 | 600 | 550 | 630 |
| NET ASSETS | 1,565 | 1,390 | 1,097 | 868 |

9.4 Statement of Cashflows

HEALTH AND DISABILITY COMMISSIONER STATEMENT OF CASHFLOWS FOR THE BUDGET YEAR ENDED 30 JUNE 2008

| | Forecast Projected Actual 2006-07 \$000's | Proposed Budget 2007-08 \$000's | Estimated Budget 2008-09 \$000's | Estimated Budget 2009-10 \$000's |
|--|---|--|---|---|
| Cashflows From Operating Activities | | | | |
| Cash was provided from: | | | | |
| Operating Grant | 7,554 | 8,331 | 8,606 | 8,881 |
| Interest on Short Term Deposits | 177 | 177 | 138 | 105 |
| Revenue | 77 | 80 | 81 | 84 |
| | 7,808 | 8,588 | 8,825 | 9,070 |
| Cash was applied to: | | | | |
| Payments to Employees | (3,345) | (3,554) | (3,630) | (3,702) |
| Payments to Suppliers | (4,055) | (4,940) | (5,275) | (5,252) |
| | (7,400) | (8,494) | (8,905) | (8,954) |
| Net Cashflow From Operating Activities | 408 | 94 | (80) | 116 |
| 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 Fixed Assets & Intangibles | (260) | (270) | (200) | (200) |
| Net Cashflow from Investing Activities | (260) | (270) | (200) | (200) |
| NET INCREASE/(DECREASE) IN CASH | | | | |
| | 148 | (176) | (280) | (84) |
| Cash brought Forward | 1,459 | 1,607 | 1,431 | 1,151 |
| Closing Cash carried forward | 1,607 | 1,431 | 1,151 | 1,067 |
| Cash Balances in the Statement of Financial Position: | | | | |
| Bank Account | 7 | 81 | 277 | 839 |
| Call Deposits | 1,600 | 1,350 | 874 | 228 |
| | 1,607 | 1,431 | 1,151 | 1,067 |

9.5 Statement of Movements in Equity

**HEALTH AND DISABILITY COMMISSIONER
STATEMENTS OF MOVEMENTS IN EQUITY
FOR THE BUDGET YEAR ENDED 30 JUNE 2008**

| | Forecast Projected Actual 2006-07 \$000's | Proposed Budget 2007-08 \$000's | Estimated Budget 2008-09 \$000's | Estimated Budget 2009-10 \$000's |
|--|--|--|---|---|
| Opening Equity 1 July | 1,765 | 1,564 | 1,390 | 1,097 |
| Plus Net Surplus (Loss) (Total Recognised Revenues and Expenses) | (201) | (174) | (293) | (229) |
| Closing Equity 30th June | <hr/> 1,564 <hr/> | <hr/> 1,390 <hr/> | <hr/> 1,097 <hr/> | <hr/> 868 <hr/> |

9.6 Preliminary 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 2008, the comparative information presented in these financial statements for the year ended 30 June 2007, 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. These are amortised on a straight line basis over their useful lives as follows:

- Computer software 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 to be made by the Commission 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 Commission 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 Health and Disability 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.

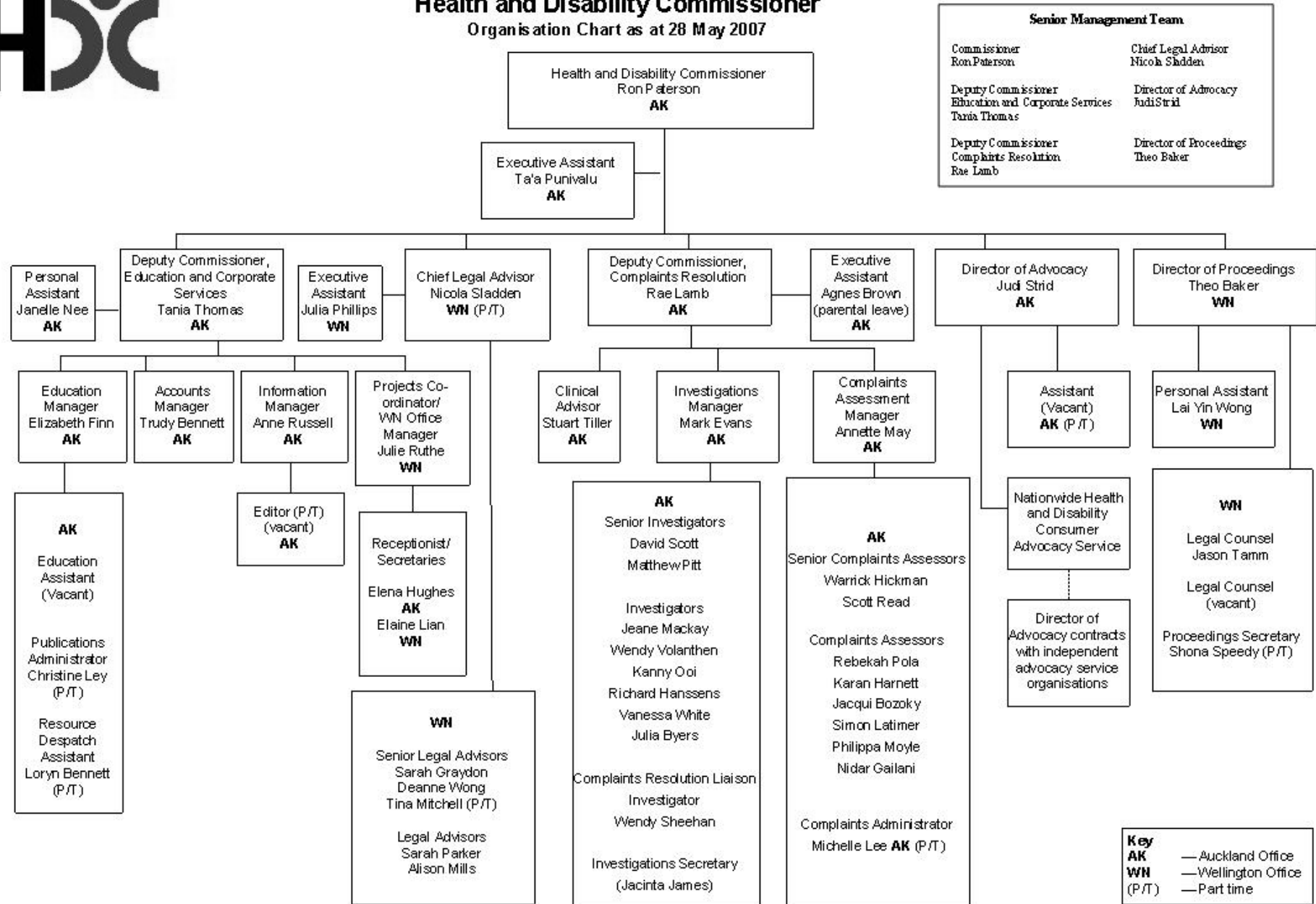
9.8 Statement of Changes in Accounting Policies

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 — Health and Disability Commissioner Organisational Chart



Health and Disability Commissioner Organisation Chart as at 28 May 2007



11.0 Appendix 2 — Proposal for Phase 2 of the Advocacy Expansion Project

A proposed implementation plan has been developed that reflects the priority areas signalled by the Ministry of Health. Some actions will overlap into several areas. The plan includes:

11.1 An increase in full time equivalent advocates from 28 to 41 FTE

Building the advocacy service capacity to the desired one advocate per 100,000 people will take time to achieve. A further increase in the number of advocates will take place in the 2007/08 year.

11.2 Address regional disparities in the distribution of the advocacy service

Priority will be given to increasing the advocacy presence and availability in areas with the greatest disparities and need. The increase in the number of advocate positions as well as improved support systems for them will enable regular advocate visits to towns within regions. A plan will be developed for regionally based advocates to have fixed times to visit towns where there is no dedicated advocacy office. A 12 month calendar of when advocates will be in certain areas will be provided on the website as well as to local organisations and networks.

11.3 Improvements in service quality and timeliness

11.3.1 Training for Managers

Advocacy managers will participate in training and professional development activities designed to focus on consistency and service standards, and to improve their skills in supporting advocates to provide a quality service. Peer support groups, supervision and mentoring arrangements will be strengthened to ensure a consistent approach is taken across the country.

11.3.2 National Call Centre Co-ordinator

The service has recently moved from three separate 0800 numbers to one national 0800 number. A National Call Centre Co-ordinator will be appointed to co-ordinate 0800 calls to the service. This will provide improved access for consumers with less reliance on answerphones. This position will ensure greater consistency and timeliness in the first line response to callers contacting the service, and will free up advocates across the country from having to be office-bound for calls.

11.3.2 National Education, Training and Resources Manager

An Education, Training and Resources Manager will be appointed to manage training and education initiatives at a national level to ensure a high standard is achieved both in relation to the education and training of the advocacy workforce, as well as the resources used to deliver quality education and training sessions.

11.3.3 Increased Access for Vulnerable Consumers

Increasing access to the advocacy service for vulnerable consumers who find it difficult to contact an advocate relies on two main approaches. These are increasing the presence and profile of advocates within their local communities and tailoring the way advocacy is provided to better meet the varying needs.

11.4 Deaf Advocacy Service

This service will be based in Wellington and cover the lower North Island region extending from New Plymouth across to Napier. This will make the independent advocacy service more accessible to the Deaf Community. Training for advocacy staff as well as providers to increase their knowledge and understanding of the Deaf Community will be part of this new service.

11.5 Providing advocacy services for residents of a forensic facility who have an intellectual disability

The current specialist advocacy pilot based at the Mason Clinic in Auckland will be extended to include consumers located within Regional Intellectual Disability Care Agencies (RIDCA), Regional Intellectual Disability Supported Accommodation Services (RIDSAS) and Regional Intellectual Disability Secure Services (RIDSS).

11.6 Extend rest home initiative to include all disability and mental health residential facilities

The rest home initiative will be extended to include **all** residential disability and mental health facilities. This means that each advocate will be provided with a list of all the licensed residential facilities in their region and will make at least one visit to each facility in each 12-month reporting period.

The success of this approach in rest homes has resulted in a number of positive outcomes including:

- increased access to independent advocates for residents and their representatives
- increased knowledge of the role of an advocate and how to contact one
- more positive attitudes towards complaints and better recognition of how these can contribute to quality improvement within rest homes
- improved relationships between rest home staff and advocates with significantly reduced resistance to advocates being contacted by residents or family members
- increased opportunities for education sessions for residents, their representatives and staff

11.7 A service that is more proactive

Improved contact with communities of vulnerable people, networking more effectively and identifying opportunities for working collaboratively with other organisations on areas of shared interest will be key features of a proactive national advocacy service. A number of ways to achieve this in addition to the residential facility initiative are currently being considered.

11.8 An increase in the number of education sessions

There will be an increase in the total number of education sessions. Priority will be given to specifically increasing sessions within residential facilities, RIDCA facilities as well as Māori, Pasifika, refugee and migrant communities.