HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

ANNUAL REPORT
FOR THE YEAR ENDED
30 JUNE 2016

Cover photo: *An HDC staff member's young relative, who has had frequent interactions with health services.*

Contents

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

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PO Box 1791, Auckland 1140

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

31 October 2016

The Minister of Health

Parliament Buildings

WELLINGTON

Dear Minister

In accordance with the requirements of section 150 of the Crown Entities Act 2004, I enclose the Annual Report of the Health and Disability Commissioner for the year ended 30 June 2016.

Yours faithfully

Anthony Hill
Health and Disability Commissioner

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Commissioner's Foreword

Anthony Hill
Health and Disability Commissioner

New Zealand's health and disability sector is one that New Zealanders can have pride in. However, there are occasions where things do not go well, and it is in these margins that HDC stands, independently and impartially upholding the rights of consumers.

It is essential that when concerns are identified providers respond, reflect and react in ways that work, to address the concerns raised and to effect positive change.

To that end, HDC plays a unique role in ensuring that the stories we are told result in meaningful changes in the health and disability system.

Culture in consumer-centred care

HDC continues to recognise that one of the fundamental elements in the successful provision of health and disability services is a culture that is consumer centred in both theory and practice.

Culture matters. It goes to the very core of the quality of care provided. It is for this reason that throughout my time at HDC I have focused on cultures that empower consumers — cultures that embody transparency, engagement, and seamless services, by putting consumers at the centre of services. In the margins where things do not go well, culture often plays a role.

This is exemplified by a complaint closed this year. A two-year-old girl had a worsening cough and runny nose, fever, and an increased heart rate. She presented for a second time at the Emergency Department of a public hospital after she began making a wheezing noise when exhaling. A house officer assessed the child and discussed her presentation (increased temperature, heart rate and respiratory rate) with his supervising consultant, who did not assess the child personally. The house officer recorded an impression of a viral illness, and the child was discharged. The house officer did not document any discharge information provided to the child's parents, and did not request a follow-up telephone call.

The next morning, the child's temperature had increased significantly. The mother spoke with a registered nurse at a telehealth service. She told him the child's temperature, and that they had been to the Emergency Department twice in two days. The child's breathing was audible to the nurse throughout the call. The mother ended the call before the nurse had completed triage, saying that she was "going to go". The nurse did not call her back or contact the telehealth service's resource nurse for advice. Later that afternoon, the child stopped breathing. Her mother called an ambulance and the child was taken to the Emergency Department. Attempts to resuscitate her were unsuccessful and, sadly, she passed away.

HDC was critical of the standard of care provided by the DHB, by the consultant and house officer during the child's second presentation to the Emergency Department, and by the nurse at the telehealth service.

One of the key issues was culture at the DHB. Staff members felt unable to, or failed to, raise questions or concerns, despite remaining concerned about the child's condition. The DHB failed to encourage a culture where staff felt comfortable questioning or challenging decisions, and lacked a multidisciplinary approach to the child's care.

As in this case, culture is often seen in the failure to speak up, to ask questions, to make the connection, or to listen.

Culture matters. It goes to the very core of the quality of care provided.

A year of growth

The 2015/16 year has been one of growth for HDC.

I appreciate the hard work and dedication displayed by HDC staff, without which the year's achievements would not have been possible.

I also acknowledge the invaluable contribution of the experts who advise HDC during the decision-making process.

The Advocacy Service also plays an important role in empowering consumers to resolve their concerns about health or disability services.

As the number of complaints received by HDC grows, we remain committed to ensuring that each complaint receives the attention it deserves.

It takes courage to complain. I extend my gratitude to the consumers and their families who have shared their stories with us here at HDC. When things do not go well, the impact can be devastating and wide reaching. If we can learn from the complaints we receive, and make meaningful changes to the system, we can avoid these stories being repeated.

Resolving complaints

HDC again received and resolved a record number of complaints in the 2015/16 year.

Complaint trends in 2015/16 have remained consistent with previous years. The primary issues complained about are often in relation to care/treatment, with inadequate treatment and misdiagnosis the most common issues complained about. Complaints about communication also continue to feature. These trends continue to highlight the importance of getting the basics right — read the notes, ask the questions, talk with the consumer.

Effecting change

Each complaint received presents an opportunity to effect positive change. We remain mindful of the need to ensure that real and lasting improvements result from the recommendations HDC makes.

HDC is committed to using the learnings from complaints to improve the health and disability services provided to New Zealanders at the individual, local and sector levels. An example of recommendations made with a view to effecting sector-wide change can be found in a recent recommendation to the National District Health Board Chief Medical Officer Group. HDC recommended that the group take steps to ensure that all DHBs' policies/guidelines in relation to stroke thrombolysis were clear and consistent, following two cases involving that issue.

We have disseminated learnings to the sector in a number of ways — through published case notes and reports of investigations, direct communication to colleges and regulatory agencies, direct communication to providers, and a wide range of public speaking engagements.

HDC has continued to deliver presentations to both provider and consumer groups on topics including HDC's role, the Health and Disability Commissioner Act 1994, and the Code of Health and Disability Services Consumers' Rights. Of particular note are DHB complaint management workshops carried out in the 2015/16 year. These workshops are a unique opportunity for providers to evaluate and improve knowledge of their complaints management systems, and to become better equipped to respond to complaints.

HDC has also continued to harness complaint data to ensure that the sector learns from complaint trends and patterns. This includes publishing six-monthly reports to DHBs and working towards increased publications in the 2016/17 year, including an in-depth topical analysis of our complaint data about residential aged care facilities.

In disseminating learnings, one of the key questions we want providers to consider is, "Could this happen at my place?" and, if so, what changes can be made to prevent this.

Disability

Investigations completed by HDC in this area have shone a light on a number of key facets of the provision of high quality disability services, including the need for comprehensive care plans and risk management plans, appropriate staff training programmes, and appropriate and clearly articulated policies and procedures. HDC has produced complaints management resources to assist disability service providers to offer appropriate responses to complaints.

HDC has also observed increased support for disabled consumers, including through the piloting of "Enabling Good Lives", and the continued application of individualised funding has seen an increasing number of disabled consumers make decisions about the care they receive.

Mental health and addictions

This year saw the appointment of a new Mental Health Commissioner, Kevin Allan.

Themes of involving families and whānau in care conversations, and the importance of connections between services have recurred this year.

Conclusion

The 2015/16 year has again seen HDC close more complaints than ever before.

HDC has delivered on what it set out to achieve this year, and I look forward to building on these successes in the year ahead. While the health and disability sector continues to provide good services to New Zealanders overall, there continue to be occasions where things do not go so well.

The priority for HDC continues to be to protect and promote consumers' rights and effect change to ensure that providers put consumers at the centre of their services.

1.0 The Year in Review

1.1 HDC strategic intent

The purpose and overriding strategic intent of HDC is to promote and protect the rights of consumers as set out in the Code of Health and Disability Services Consumers' Rights (the Code). There are three main strategic objectives that feed into this overriding strategic intent.

- To resolve complaints.
- To improve quality within the health and disability sectors.
- To hold providers to account appropriately.

In line with HDC's vision and Statement of Intent for 2014 to 2018, HDC's strategic priorities for the 2015/16 year were to:

- Resolve complaints in a timely and effective way while dealing with increasing volume;
- Work with district health boards (DHBs), health providers, and disability service providers to improve their complaints processes so that complaints are resolved at the lowest possible appropriate level;
- Continue to work closely with the Health Quality and Safety Commission (HQSC) and other key stakeholders to effect change from complaint learnings;
- Operate a financially sustainable organisation resourced appropriately for business size and complexity; and
- Strive for continuous improvement in the way HDC operates.

1.2 2015/16 performance highlights

HDC had a very successful year in 2015/16, and met its strategic priorities in a number of ways.

The 2015/16 year saw HDC receive and close its highest ever number of complaints:

- 1,958 complaints were received.
- 2,007 complaints were resolved.
- 80 formal investigations were completed.
- 61 formal investigations resulted in breach opinions.
- 5 providers were referred to the Director of Proceedings.

As a result of these complaints, wide-reaching recommendations were made across the sector for real and lasting improvements to health and disability services and systems.

HDC has continued to provide detailed six-monthly reports to DHBs on the numbers and types of complaints received in relation to DHB services, and published the second annual report of complaints about DHB services.

As in previous years, HDC has continued to deliver presentations to various provider and consumer groups about relevant topics, including HDC's role, the Health and Disability Commissioner Act 1994 (the Act) and the Code.

HDC also continued its focus on empowering providers to deal with complaints better themselves, including by running complaints management workshops at DHBs, and by producing complaints management guides to assist disability service providers to evaluate and improve their knowledge of their complaints management system, and assist them to respond appropriately to complaints.

HDC has continued to work closely with key stakeholders in a range of areas. In particular, learnings from HDC complaints have been shared with HQSC, ACC, and the Ministry of Health through involvement in a regular information sharing forum. HDC has also worked in collaboration with many other organisations in the mental health and addictions, and disability settings.

Despite the increase in demand for HDC's services, and HDC's record output, a reasonable surplus was still delivered. This was due to ongoing tight financial controls and an attitude of continuously looking to achieve more with our resources. The surplus will help HDC to manage financial constraints in the coming years.

2.0 Role of the Health and Disability Commissioner

2.1 Purpose and role

HDC was established under the Act to promote and protect the rights of health and disability services consumers. The rights of consumers are set out in the Code.

The Code places corresponding obligations on all providers of health and disability services, including both registered and unregistered providers, in respect of those consumer rights.

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

1. Respect.
2. Fair treatment.
3. Dignity and independence.
4. Appropriate standard of care.
5. Effective communication.
6. Full information.
7. Informed choice and consent.
8. Support.
9. Teaching and research.
10. Right to complain.

Vision *Tā mātou matakite*

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

Mission *Te Whāinga*

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

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

HDC's Strategy

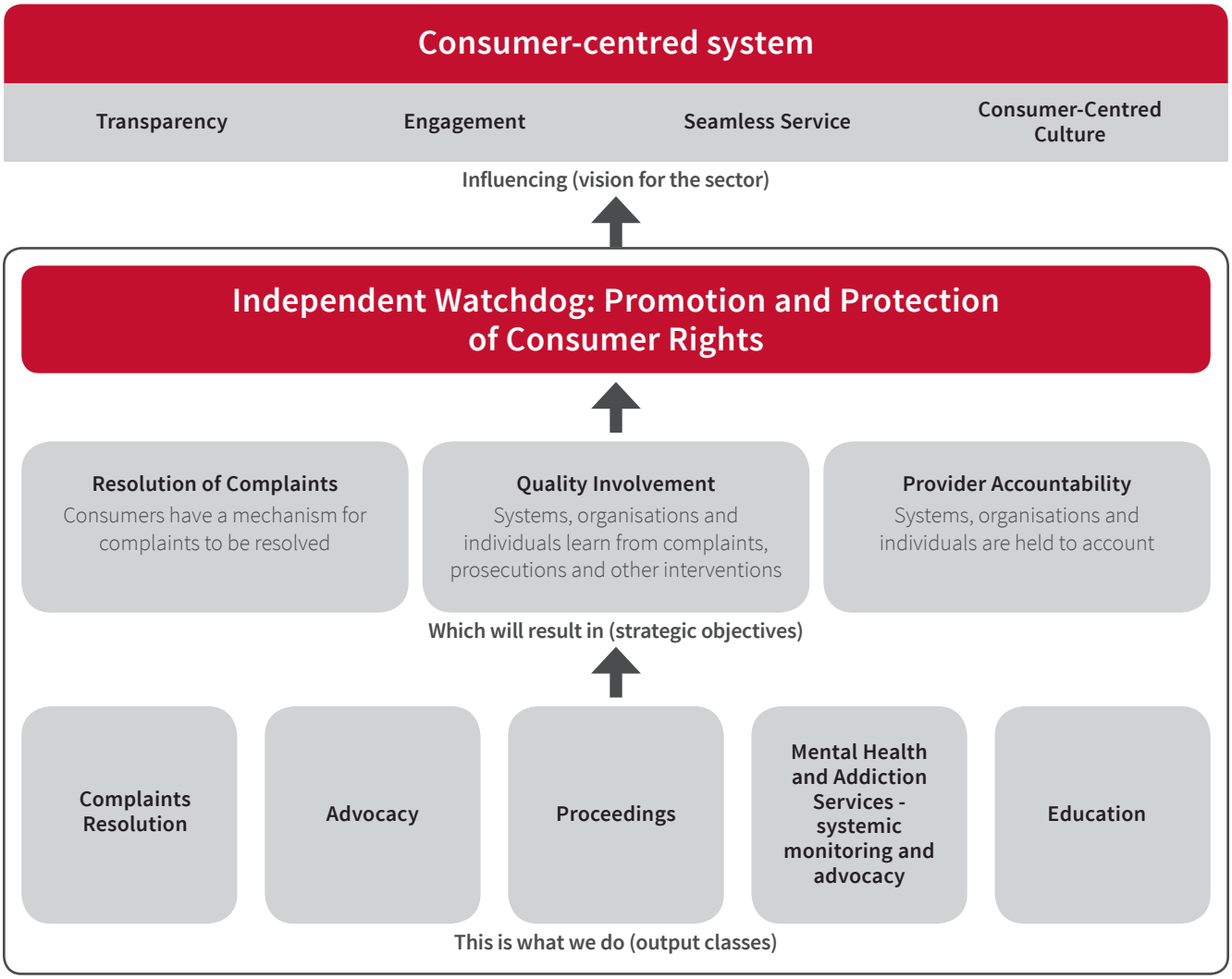


Figure 1: Overview of how HDC's output classes link to its strategic objectives in order to support the overriding strategic intention. The impact of HDC's outputs and objectives then flow through to HDC's consumer-centred vision for the sector.

2.2 HDC's strategic intent

As noted above, HDC's principal statutory mandate is to promote and protect consumers' rights as set out in the Code. The Commissioner is independent of providers, of consumers, and of government policy, allowing him to be an effective watchdog in relation to those rights.

The mere existence of accountability mechanisms is an important driver for change, and thus quality improvement, both at an individual and systemic level.

2.3 HDC's strategic objectives

HDC has three principal strategic objectives, which together promote and protect consumer rights more effectively than any one of them could do alone. These are:

- Resolution of complaints.
- Quality improvement.
- Provider accountability.

The effective resolution of complaints is a legitimate and valuable outcome in and of itself in a country where medico-legal litigation is largely unavailable to consumers. However, it is also the route to provider accountability through the Commissioner's findings of non-compliance, to quality improvement through the recommendations and educative comments that typically accompany such findings and, where appropriate, referral to the Director of Proceedings. Provider accountability is also important in the context of New Zealand's no fault treatment injury regime. The mere existence of accountability mechanisms is an important driver for change, and thus quality improvement, both at an individual and systemic level. In addition, in some cases, it is only through appropriate accountability that true resolution can occur.

The outcome of quality improvement has self-evident intrinsic value, but it also plays a part in effective complaints resolution, as the express motivation of many complainants is to see change occur so that what happened to them does not happen to others. Providers are also held to account for their own quality improvement through HDC's monitoring and audit of the recommendations made.

These strategic objectives are important for the difference they make to consumers, as well as the difference they make to the wider population.

HDC has identified specific strategic priorities for 2014 to 2018. These, and progress towards these, are described in section 1 of this report, and the deliverables are specifically measured as described in section 6.

2.4 The difference HDC makes

The difference HDC makes for consumers

Through resolution of complaints, quality improvement, and provider accountability, HDC minimises the harm and maximises the well-being that consumers experience in their dealings with, and use of, health and disability services. By learning, addressing unacceptable behaviour, and avoiding repetition of errors, the system improves experiences and outcomes for consumers, reduces preventable harm and, over time, reduces system costs.

The key difference HDC makes to consumers is to:

- resolve consumer complaints;
- increase the focus on consumers with increasing transparency, integration and engagement of consumers with the system;
- reduce the incidence of preventable physical injury and death through unsafe, poor quality systems and practices;
- increase consumer confidence in health and disability services, including provider complaint processes;
- increase the quality of communication and improve relationships between consumers and health and disability service providers; and
- promote awareness of, respect for, and observance of, the rights of consumers, with particular emphasis on the rights of vulnerable consumers.

The difference HDC makes for New Zealand

HDC's strategic objectives are consistent with the achievement of the Government's intermediate and long-term health and disability systems outcomes:

- New Zealanders live longer, healthier, more independent lives.
- The health system is cost effective and supports a productive economy.
- High-quality health and disability services are delivered in a timely and accessible manner.
- Future sustainability of the health and disability system is assured.

The key ways in which HDC contributes to the Government's outcomes are through our own strategic objectives of:

- resolving complaints about health and disability services (resolution of complaints);
- using the learning from complaints to improve the safety and quality of health and disability practices and systems, and to promote best practice and consumer-centred care to providers (quality improvement); and
- ensuring providers are held accountable for their actions (provider accountability).

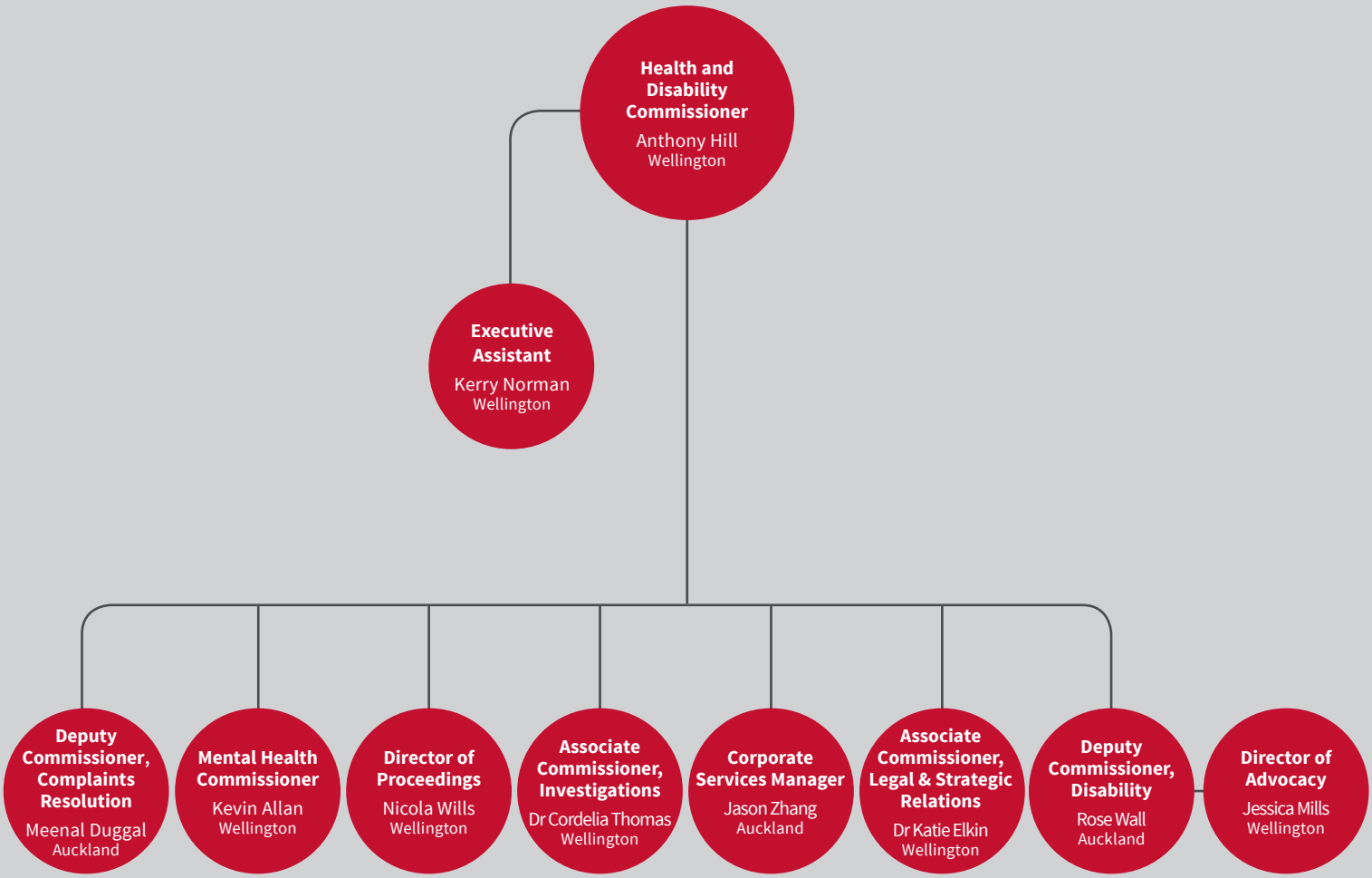
Figure 2: Available actions on assessment of a complaint

Recommendations made to providers as a result of complaints in 2015/16

During the year, HDC made recommendations or educational comments in relation to 464 complaints. In many cases more than one recommendation for improvement was made. Recommendations are complied with in the overwhelming majority of cases, and during the 2015/16 year a significant number of providers made changes to their systems, policies and procedures as a result of a consumer's complaint. Below is a small selection of recommendations and changes made both by providers and their wider regulatory systems:

1. Following two cases involving stroke thrombolysis the Commissioner recommended to the National DHB Chief Medical Officer (CMO) Group that it take steps to ensure that all DHBs' policies/guidelines in relation to stroke thrombolysis are clear and consistent, including in relation to the appropriate medication, dose and mode of administration, and the level of supervision required, and report back to HDC. As a result, the CMO group coordinated an approach to the National Stroke Network and, following that, the CMOs are taking a number of steps to further improve safety and quality of services provided to stroke patients and, in particular, aspects of care relating to stroke thrombolysis.
2. As a result of HDC's recommendations, a rest home developed a communication education programme for registered and enrolled nurses, who then taught this to the healthcare assistants. The same rest home also arranged education for its staff regarding medication management and indicators for deterioration.
3. Following a case where a man with cardiac issues died after being inappropriately discharged from an Intensive Care Unit without clinicians recognising the severity of damage to his heart (he had an abnormally high troponin T result), the Commissioner recommended that the DHB implement a system that requires the laboratory to alert the patient's treating clinician urgently (eg, by telephone) when troponin T results are abnormally high.
4. The Commissioner recommended that a Mental Health Admissions Unit, over the period of one month, audit the rate of cross-referencing information about overnight observations into the patient's clinical records (in cases where the patient had been subject to a formalised level of observations overnight).
5. The Commissioner recommended a review of Emergency Department policies regarding the management of at-risk patients, to ensure that there is clarity about the status of such patients, the extent of any powers to detain, and the basis for liaison with Police, and asked the DHB to provide evidence that staff had been trained on these matters.
6. The Commissioner recommended a review of the terms of reference and/or guidelines related to the extended capacity of the Liaison Psychiatry Service, and provide quarterly statistics to HDC regarding the use of the service in other settings (eg, on medical wards).
7. As a result of HDC's recommendations, a Chinese massage provider developed an information flyer to explain clearly what Chinese massage involves and how it differs from other types of massage.
8. Following a case where midwives did not follow the Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines), the Commissioner recommended that the Midwifery Council of New Zealand reinforce to all midwives the importance of consistently and appropriately applying the Referral Guidelines. The Council has subsequently published a reminder to all midwives.
9. A delay in a consumer's care occurred because the surgical booking form completed after the consumer's clinic appointment did not reach the surgical booker and, consequently, the consumer was not added to the surgical waitlist. To prevent this from occurring again, the DHB initiated a new report that shows all patients who have attended an outpatients appointment and have been referred for surgery, and any associated surgical waitlist entry. The report is issued weekly and monitored, allowing any patients who do not appear on the surgical waitlist to be tracked and corrective action taken.
10. In response to the corrective actions outlined in expert advice to the Commissioner, a rest home reported progress on care planning and communication. In addition, changes were made to its management of complex wound procedures, arrangements were made with a wound care specialist to provide ongoing training on wound management, a fast-track wound consultation referral process was introduced, a registered nurse is to be nominated as a wound management champion, and a multidisciplinary team was implemented.
11. In response to a complaint about inadequate discharge planning, a DHB implemented additional mechanisms to require sign-off of patient discharges so that incomplete summaries are followed by the appropriate service leader. The DHB reported that since this has been implemented the number of incomplete discharge summaries has reduced.
12. Following a case where a sonographer did not follow accepted professional practice and scan the lymph nodes adjacent to the thyroid gland, the Commissioner recommended that the Medical Radiation Technologists Board consider taking steps to ensure that all New Zealand sonographers adopt a consistent approach to ultrasound scanning of the thyroid, including the adjacent lymph nodes, and clear documentation thereof.

HDC Organisation Structure



3.0 HDC Key Activities 2015/16

As seen in Figure 1, HDC achieves its strategic objectives through five principal output classes (key activities). These are:

1. Complaints resolution.
2. Advocacy.
3. Proceedings.
4. Education.
5. Mental health and addictions — monitoring and systemic advocacy.

Complaints resolution is perhaps the most significant output in the achievement of HDC's strategic objectives. Complaints may be resolved in a number of ways but, consistent with legislative requirements, HDC's focus is on effective local and early resolution. HDC, through the Director of Advocacy, contracts with the National Advocacy Trust for the provision of advocacy services. This is critical in ensuring success in local and early resolution. At the other end of the spectrum, there are cases in which formal proceedings against a provider are necessary to promote and protect consumer rights.

Systemic advocacy is informed by the results of both service monitoring (which is undertaken in a variety of ways) and the insight HDC gathers from its complaints resolution service. The education output class is informed by the other output classes, which may identify the need for education on specific consumer rights, and is also an outcome of those output classes, particularly in relation to the specific providers engaged in those other processes.

The following sections report on each of HDC's five principal output classes, including a focus on disability, and also reflect how these outputs have effected change in the provision of services to health and disability service consumers. The following sections also reflect on the specific ways in which each output class has contributed to the delivery of HDC's strategic priorities for 2014 to 2018.

3.1 Complaints resolution

HDC achieves its statutory role of promoting and protecting the rights of consumers primarily by facilitating the "fair, simple, speedy and efficient resolution of complaints". As such, complaint resolution is a critical part of HDC's overall operation.

During the past year, HDC continued to operate in an environment of increasing complaints. A total of 1,958 complaints were received, representing a 4% increase on last year and a 25% increase in the four years since June 2012 (see Figure 3). Despite this continued increase in complaint numbers, HDC's ability to respond to complaints remained robust. A number of significant milestones were achieved in 2015/16 in terms of the speedy resolution of complaints, including:

- A record number of complaints were closed (2,007), representing an increase of 5% on the previous year's performance.
- 430 complaints remained open at the end of the year, representing a decrease of 10% on last year and a decrease of 23% from June 2012.
- 90% of complaints were closed within six months, compared with 77% last year.

In 2015/16 HDC closed a greater number of complaints than it received, and did so faster with fewer open files at the end of the year. Each of these achievements is significant, as they demonstrate that complaints are being resolved in a timely manner.

The Act allows anyone to make a complaint about health or disability services in New Zealand. Complaints are typically made by health or disability services consumers directly. Last year 63% of all complaints received were made by consumers. However, it is also common for complaints to be made by third parties, with 31% of complaints received being made by family or friends of the consumer. When a complaint is received from anyone other than the consumer, HDC speaks to the consumer (or the consumer's legal representative) to ascertain whether the consumer supports the complaint. However, even in the absence of such support, the Commissioner can review the care provided.

Complaint trends have remained consistent with previous years. The primary issue complained about was often in relation to care/treatment issues, with inadequate treatment and misdiagnosis being the most common issues complained about. Communication issues also continue to feature prominently, with the disrespectful manner/attitude of a provider being a common issue in complaints (see Figure 4). In terms of individual providers complained about, general practitioners were the most commonly complained about providers. This is a consistent trend internationally, and may be a result of the large number of interactions that GPs have with patients (see Figure 5). The most common group providers complained about were DHBs and medical centres (see Figure 6). This is consistent with previous years.

HDC closed a greater number of complaints than it received, and did so faster with fewer open files at the end of the year.

Figure 3: Complaints received and closed from 1 July 2011 to 30 June 2016

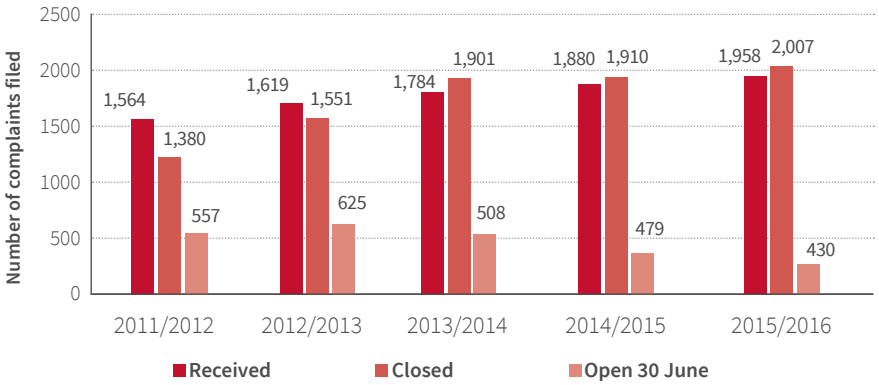


Figure 4: Complaints received – Commonly complained about primary issues in 2015/16

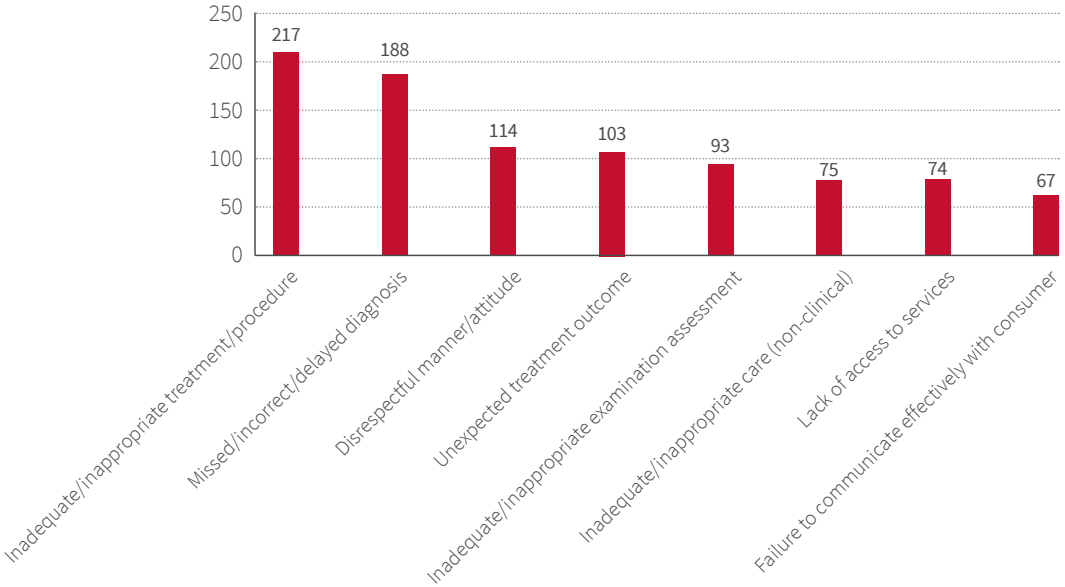
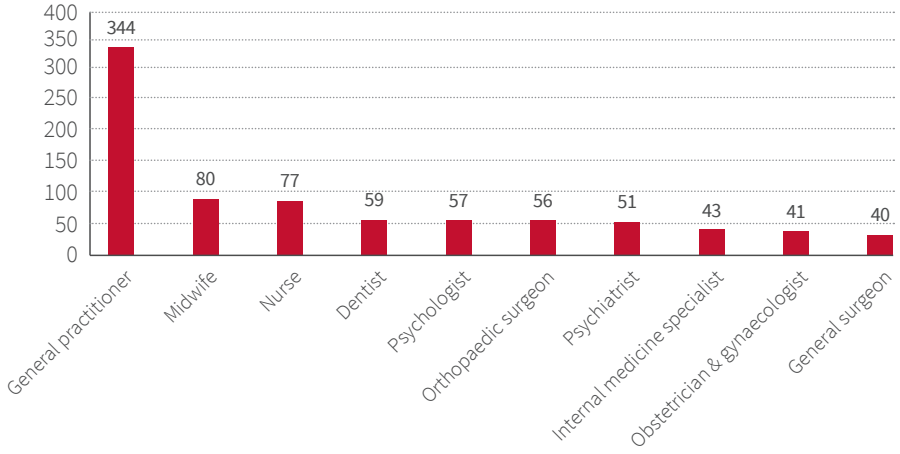


Figure 5: Complaints received – Commonly complained about individual providers in 2015/16*



*This graph relates to the number of individual providers complained about. Because some complaints will not have involved an individual provider, while others will have involved more than one individual provider, the number of individual providers complained about in 2015/16 will not equal the total number of complaints received in 2015/16.

Every complaint is assessed carefully, and expert advice is obtained when appropriate. The Act provides a range of options for resolving complaints. A wide range of resolution options were utilised to ensure that complaints were resolved in the most appropriate manner. Where a complaint did not meet the threshold for formal investigation, the most common means of resolving a matter was under s38(1) of the Act. Section 38(1) provides the Commissioner with a wide discretion to take no action or no further action. Each complaint represents an opportunity to make improvements to the sector, and often a decision to take no further action will be accompanied by an educational comment or recommendations to assist the provider in improving future services. Last year, 34% of decisions made under s38(1) contained follow-up actions or educational comments (see Table 1). Alternatively, the Commissioner may decide that further action is unnecessary or inappropriate. This may be due to a range of factors, including that independent expert advice finds the care to be of a reasonable standard, the matters at issue in the complaint have been addressed appropriately by other means, the provider has made the necessary changes to address the issues, the provider has been able to provide information that addresses the issues, it is recognised that evidential issues cannot be resolved by further assessment, or the length of time that has elapsed since the events complained of occurred.

Figure 6: Complaints received – Commonly complained about group providers in 2015/16*

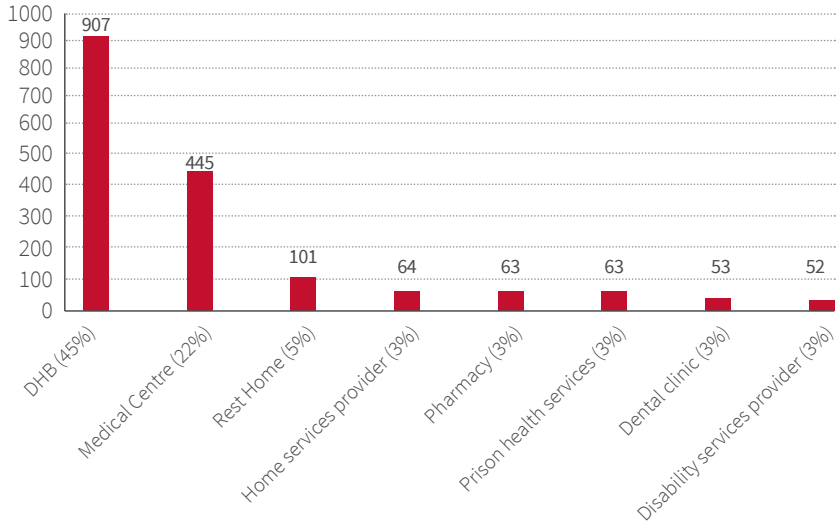


Table 1: Complaints closed — Outcomes**

Outcome	Number of complaints
Investigation	**80**
Breach finding	61
No further action with follow-up or educational comment	14
Referred to registration authority	2
No further action	2
No breach finding	1
Non-investigation	**1783**
No further action with follow-up or educational comment	389
Referred to registration authority	45
Referred to other agency	35
Referred to provider to resolve	418
Referred to Advocacy	96
No further action	756
Withdrawn	44
Outside jurisdiction	**144**
TOTAL	**2007**

*This graph relates to the number of group providers complained about. Because some complaints will not have involved a group provider, while others will have involved more than one group provider, the number of group providers complained about in 2015/16 will not equal the total number of complaints received in 2015/16.

**Outcomes are displayed in descending order. If there is more than one provider listed on a complaint and, therefore, more than one outcome upon resolution of a complaint, then only the outcome that is listed highest in the table is included.

Section 38(1) with recommendations and follow-up: Multidisciplinary teams in aged care

A woman complained about the care provided to her father at a residential aged care facility. The complaint raised concerns about the medical, nursing and carer support provided to the man. HDC sought advice from a general practitioner (GP) and a nurse. HDC's GP advisor acknowledged the complexity of the man's medical and mental health issues. The GP advisor noted that there was specialist involvement in the man's care, but that it was not clear from the notes whether the GP was kept fully informed about the development of the man's wounds. The nursing advisor identified several departures from the expected standard of care. In particular, the nursing advisor identified that while a care plan was put in place initially, it was not evaluated or updated, resulting in a lack of coordination and inconsistent care for a complex patient. In addition, the care plan did not address wound management adequately, and there was a lack of documentation given the seriousness of the man's wounds.

Overall, a picture emerged of the absence of a coordinated, consistently evaluated care plan that was supported by regular communication between the multidisciplinary team caring for the man. HDC recommended that the facility implement a multidisciplinary team approach. While such an approach is relatively new in aged care, it has the potential to address many of the deficits identified in the care provided to the man.

As a result, the facility carried out a number of corrective actions, including a weekly multidisciplinary meeting for complex patients, changes to its wound management procedures, training, and audit of care planning.

Section 38(1) with recommendations and follow-up: discharge from hospital

A man underwent a procedure at a hospital and was discharged during the weekend. One of his regular medications was replaced with an alternative medication. However, he was not told that this was a replacement or given any information about the replacement medication generally. He also required a new medication following the procedure, but a prescription for this was not provided.

The DHB accepted that the new medication should have been prescribed, and that insufficient information was provided about the replacement medication. The DHB identified that discharge over a weekend was a factor in both issues, as the doctor working over the weekend was not familiar with the man's medication. In addition, discharge over the weekend meant that the man was not reviewed by a specialist rehabilitation nurse.

HDC recommended an audit of discharges from the unit over 12 consecutive weekends to ascertain whether appropriate information and prescriptions had been provided, as well as training for staff based on the complaint.

Referral to provider

The Act allows for complaints to be resolved at the lowest appropriate level and, under s34(1)(d), complaints that do not raise questions about the health and safety of members of the public can be referred to the provider to address. This statutory option was well utilised, and can serve an important purpose where the issues raised in the complaint are about communication, the matter is capable of resolution with better information, or there is an ongoing relationship between the consumer and provider. Referral of complaints to providers allows parties to work together with the added protection of providers being required to report back to HDC regarding their consideration of the complaint and the outcome.

Referral to Advocacy Service

Another resolution option, under s37 of the Act, is formal referral to the Advocacy Service. Advocates support consumers in resolving their concerns. This year, referral to the Advocacy Service was utilised in 96 cases, and is considered to be of the greatest value where the consumer would benefit from support in resolving his or her concerns, or where there is an ongoing relationship with the provider.

Other methods of resolution

A number of other methods can also be utilised to resolve complaints, including referral to a registration authority or to another agency such as the Privacy Commissioner or the Director-General of Health where appropriate.

CASE STUDIES

Referral to provider: Communication in Primary Care

A pregnant woman complained about her GP. The woman had arranged an appointment with the GP as she was concerned about her unborn baby and wanted to hear the baby's heartbeat to be reassured. The GP referred the woman for a scan, even though one had been arranged previously, and asked the practice nurse to listen to the baby's heart with a Doppler monitor. However, after a period of waiting, it transpired that the practice did not have a Doppler monitor. The woman felt unheard during the appointment. The complaint was referred to the practice for resolution. The practice reviewed the care provided thoroughly and made a number of changes, including to the orientation of new doctors to ensure that they are aware of the practice's systems, resources and equipment, and provided training for all staff on addressing the emotional needs of patients as well as their presenting issue.

Referral to Advocacy Service: Communication

A woman complained about communication from a fertility services provider. She had received conflicting advice about the waiting time until she could receive services. Initially she complained to HDC, but subsequently indicated her willingness to use the Advocacy Service. Given this, the nature of the issues complained of, and the need for an ongoing relationship, a formal referral to advocacy was made by HDC under s37. A teleconference was held with the woman and the provider, during which the provider heard the consumer's concerns and agreed to a range of actions including provision of better information to consumers, reviewing ways of ensuring better information about waiting times, and appointing a key person for each consumer to deal with.

Referral to the Office of the Privacy Commissioner

A man sustained an injury while at work and visited his regular GP, who recommended time off work. The man's employer asked for a medical assessment from a different GP. The man attended and was assessed by the second GP. After the assessment, the man's employer entered the consultation room, and the GP engaged in conversation with the employer about the man's condition and the amount of time he would require off work. The complaint was assessed by HDC and, during this process, the second GP accepted that her actions were inappropriate, and apologised to the man. The practice also carried out a series of corrective actions, including implementing a policy on assessments for third parties, undertaking privacy training, and revising its information privacy policy. In addition to these actions, given that primarily the issues related to privacy, HDC referred the matter to the Office of the Privacy Commissioner.

Provision of health care to prison inmate (14HDC01769)

An older man who had been diagnosed with lymphoma was transferred from one prison to a second prison for short periods on two occasions in order to appear in Court. The man's hospital discharge summary and other healthcare information were provided to the health centre at the second prison. This included instructions to dress blisters on the man's toes daily and at other times as needed. At this time, the man was prescribed medications for pain relief. Some of the man's medications and his drug chart and signing sheets were left on the bus when he was transferred to the second prison. They were returned to the second prison several days later.

There is no record that the man's feet were checked or treated while he was at the second prison. The clinical record states that the man was to be seen in a nurse clinic to review the blisters on his feet, but there is no record that this occurred. A doctor saw the man and recorded in the notes that staff were to watch carefully for any signs of infection. However, there is no record that this occurred or that the man's feet were checked or treated after this appointment.

The man shared a cell with another prisoner, who said that he cleaned the man's toes with toilet paper every morning.

The medication administration signing sheets show that the man was not always administered paracetamol, OxyContin and OxyNorm in accordance with the prescriptions, and there is no documentation reporting the reason for non-administration.

When the man returned to the first prison, nursing staff recorded comments in the clinical record about his poor physical state, and noted that toilet paper was soaked off his toes with warm water.

The man returned to the second prison for a few days. The healthcare plan sent to the second prison required health staff to "check and dress feet daily to prevent further damage"; however, there is no record that this occurred.

On his return to the first prison, the man handed a bag of medications to an officer and said he had been given it when he left the second prison, without instructions on what to take or how often. The man was not an approved self-medication prisoner, and there is no record of this medication having been handed to him at the second prison.

The lack of treatment of the man's feet and the failures in relation to medication management cumulatively amount to a significant departure from accepted standards. There was a pattern of failures by multiple providers responsible for the man's care, and ultimately the operator of the second prison is responsible for those failures. The operator of the second prison failed to ensure that the man was provided services with reasonable care and skill, and breached Right 4(1).

Adverse comment was made about the failure of the operator of the first prison's systems to ensure that the man's documentation and medications arrived at the second prison.

The Deputy Commissioner recommended that the second prison provide evidence that its revised audit schedule has been implemented, and provide the results of the first audit; conduct an audit to assess compliance with professional standards regarding documentation; provide training to health service staff about respect and appropriate responses to prisoners' healthcare needs; and provide training on wound care management.

Investigations

As noted above, one of the options open to the Commissioner upon receiving a complaint is to conduct a formal investigation to establish whether a provider has breached the Code. This year, 80 formal investigations were completed, and it was found in 61 of those investigations that the consumer's rights under the Code had been breached. As a result of those breach decisions, five providers were referred to the Director of Proceedings for consideration of whether to bring tribunal proceedings.

Recommendations

Recommendations play a key role in HDC's complaint resolution process and many complainants indicate that their desired outcome is to ensure that quality and safety are improved. In many instances, providers themselves identify areas for improvement, and proactively make changes to their practice as a result of being subject to a complaint. HDC also makes recommendations for change in many cases, and then monitors the implementation of those recommendations. Between 1 July 2015 and 30 June 2016, HDC made recommendations or educational comments in relation to 464 complaints, including the 61 cases in which a breach of the Code was found. HDC recommendations are complied with in the overwhelming majority of cases.

Failure to provide adequate care and failure to recommend transfer of antenatal care to a specialist (15HDC00540)

A 27-year-old woman was pregnant with her first baby. She had an introductory consultation with a registered midwife who was the lead maternity carer (LMC). The woman's body mass index (BMI) was high at 44.6.

The Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (the Referral Guidelines) require that if the mother's BMI is above 40, the LMC must recommend to the woman that the responsibility for her care be transferred to a specialist, given that her pregnancy, labour, birth or the post-partum period is or may be affected by the condition. The LMC did not discuss this recommendation with the woman during her pregnancy, or refer her to the obstetric team for specialist review.

Six days after her due date, the woman began experiencing back pain and then regular contraction pains. She sent two text messages and had two telephone conversations with the LMC that afternoon about the pains, and one telephone conversation with the back-up midwife overnight, during which the woman was advised to stay at home.

The woman's membranes ruptured spontaneously at 7am the next day. She arrived at hospital at about 8am. The LMC began cardiotocograph (CTG) monitoring, which was non-reassuring. The LMC discontinued the CTG monitoring after 30 minutes so that the woman could go to the toilet, and did not recommence it.

The LMC next tried to listen to the fetal heart rate (FHR) after about 90 minutes. She could not hear a heartbeat, so she attached a fetal scalp clip. The tracing was abnormal. The LMC sought assistance from a hospital midwife, and then the obstetrics and gynaecology registrar. An ultrasound scan confirmed that there was no fetal heartbeat. The woman's care was taken over by the obstetrics team, and she delivered her stillborn baby.

The LMC failed to provide adequate care to the woman in a number of ways. The woman had clear risk factors, and the LMC should have recommended to the woman that the responsibility for her care be transferred to a specialist at an early stage of her pregnancy, as required by the Referral Guidelines. The LMC did not document telephone assessments on 11 April 2015, including whether or not the baby was active, and the advice given. The LMC also did not follow the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Intrapartum Fetal Surveillance Clinical Guideline and the DHB policy, which both recommend continuous FHR monitoring in labour when a woman has a high BMI. In addition, even if the LMC did not consider that a CTG was warranted, she failed to auscultate the FHR every 15 to 30 minutes, which the RANZCOG Guideline recommends as the minimum fetal assessment required for any woman at this stage of labour.

Overall, the LMC failed to provide services to the woman with reasonable care and skill, and, accordingly, breached Right 4(1) of the Code.

By not recommending to the woman that the responsibility for her care be transferred to a specialist, the LMC failed to provide the woman with essential information that a reasonable consumer in her circumstances would expect to receive. Accordingly, the LMC breached Right 6(1) of the Code.

The Commissioner referred the LMC to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken, and recommended that the LMC provide a written apology to the woman. The Commissioner noted that, should the LMC wish to return to midwifery practice, the Midwifery Council of New Zealand would decline to issue a practising certificate prior to undertaking a review of her competence. The Commissioner supported this approach.

The Commissioner recommended that the DHB provide an update to HDC on the implementation of the recommendations made in the root cause analysis that the DHB had undertaken.

3.2 Advocacy

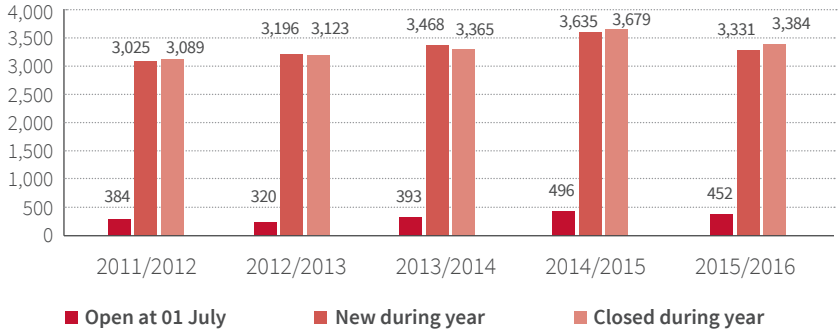
The Nationwide Health and Disability Advocacy Service (the Advocacy Service) is a free service, which operates independently of health and disability service providers. Advocates use a consumer-centred empowerment model to support consumers to resolve their concerns about health or disability services.

The Director of Advocacy is an employee of the Health and Disability Commissioner but performs her role independently of the Commissioner. HDC, through the Director of Advocacy, contracts with the National Advocacy Trust to provide the Advocacy Service. Forty-three advocates around the country operate out of 23 community-based offices from Kaitaia to Invercargill. The National Advocacy Trust Board provides governance and oversight of the Advocacy Service.

Supporting complaint resolution

The role of the advocate in complaint resolution is to assist consumers to identify what is needed to achieve resolution, and then to support them in their chosen actions. Advocacy is a very successful way to achieve early resolution, as it involves contact between the parties. Consumers usually want to ensure that what happened to them will not happen to someone else. It is helpful for providers to hear this directly from the consumer. Many providers comment on how thought-provoking it is to hear from the consumer, as they had not realised the impact of their actions or remarks. The high rate of resolution reflects the strong consumer-centred approach of the Advocacy Service and the significant provider commitment to the process.

Figure 7: Complaints to the Advocacy Service by year*

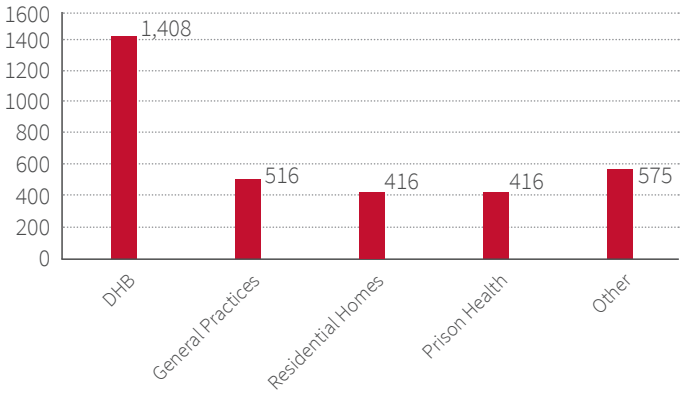


The Advocacy Service received over 3,300 complaints this year, and assisted consumers to close 3,384 complaints.

Eighty-eight percent of complaints were closed within three months, 99% within six months, and 99.97% of complaints were closed within nine months. This high rate of resolution reflects the strong consumer-centred process used by advocates, and the quality of the process, as well as a high level of provider goodwill and commitment to resolving complaints at an early stage.

The majority of complaints received by advocates relate to large service providers. This year, 1,408 complaints, or 42% of all complaints, involved DHB services, and 1,348 complaints, or 40% of all complaints, related to general practices, prison health services and residential care services combined.

Figure 8: Types of service providers in complaints received by the Advocacy Service



*Complaint reporting has been adjusted, resulting in minor changes to figures previously reported.

Education and training

Education is a key part of an advocate's role. Sessions are provided to consumers about their rights under the Code, and to providers about their responsibilities as providers of health and disability services. Advocates aim to promote understanding of the Code and to be influential in shifting the focus of health and disability services towards a more consumer-centred approach.

In the 2015/16 year, advocates presented a total of 2,005 education and training sessions to a range of consumers and providers. The majority of education sessions provided related to information on advocacy, the Code and HDC. Advocates also provided focus sessions on topics such as self-advocacy, effective communication, open disclosure, health passports, and effective complaints resolution processes.

It is important for advocates to reach the most vulnerable consumers and to establish, build and maintain positive working relationships with the providers/caregivers of those consumers whose welfare is most at risk — in particular, in circumstances such as residential care where consumers are required to use the ongoing services of the provider or caregiver. Education sessions are an important way of reaching the most vulnerable consumers and their caregivers and building those relationships, and 51% of all education sessions (1,024) were provided to consumers and providers living or working in residential homes.

Ninety percent of consumers and 97% of providers who attended education sessions and responded to a satisfaction survey expressed satisfaction with the sessions.

Reaching consumers

The Advocacy Service operates an 0800 national call centre and provides email and local office numbers in promotional material and on the HDC website.

Through telephone and email enquiries

During the 2015/16 year, the Advocacy Service received 10,787 enquiries. Ninety-eight percent of those enquiries were closed within two days. Enquiries covered a broad range of topics. In addition to requests for information about the role of advocates, information on how to make a complaint, and requests for education sessions, advocates received requests for disability resources, information on the role of HDC, mental health matters, funding, fees and treatment costs, information privacy, and rest home and residential disability home standards.

Through residential visits

Advocates visited all of the 617 certified rest homes nationwide, and 426 rest homes had at least two visits. Nine hundred and ninety-five of the 998 certified residential services catering to disabled people had at least one visit from an advocate, and 426 had at least two. In total, the Advocacy Service closed 1,437 enquiries and 452 complaints about residential services, and made 2,658 visits to residential services, in addition to providing education sessions at residential facilities.

These visits ensure contact with those residents of rest homes and residential disability services who might otherwise find it impossible or extremely difficult to speak with and, if necessary, seek the assistance of, an advocate. Advocates also utilise these visits to provide information and arrange free education sessions for residents, whānau/family members, and providers.

Through networking

Networking is an important way for advocates to establish a profile in their communities and to make contact with a wide range of consumers, including those consumers who are least able to self-advocate and whose welfare may be most at risk. Networking also assists advocates in understanding local issues, and enables them to keep up to date with local support services so that they are able to provide practical information when necessary.

Over the past year, advocates developed and maintained contact with 1,972 networks. Forty-five percent of the networking undertaken nationwide was with consumer or consumer-focused groups, and 47.4% of contacts included public interest groups and community groups, including those involving older people, the Deaf community, and Māori and refugee/migrant communities.

The high rate of resolution reflects the strong consumer-centred approach of the Advocacy Service and the significant provider commitment to the process.

Demographics

The following figures show some of the demographics of those who made complaints to the Advocacy Service this year.

Figure 9: Ethnicity of complainants to the Advocacy Service

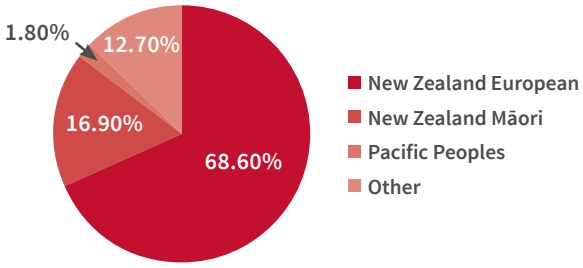
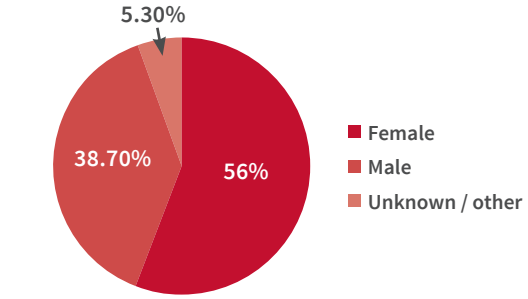


Figure 10: Gender of complainants to the Advocacy Service



"The service was very professional, I was kept well informed. Therefore I would recommend this service to all who need help and guidance..."

Satisfaction with the Advocacy Service

Each month, a minimum of 33% of consumers and providers who have worked with an advocate through the complaint resolution process are asked to comment on their level of satisfaction with the service. Survey results showed that 91.8% of consumers and 87.5% of providers were satisfied with their dealings with the Advocacy Service.

The following feedback comments are from consumers:

"The service was very professional, I was kept well informed. Therefore I would recommend this service to all who need help and guidance ..."

"I was totally satisfied with the role of the advocacy service and am glad I pursued the exercise because I learned from it."

"Listened to my concerns and followed up when she said she would, was also very polite and empathetic to my situation."

"Very approachable, only too willing to help and listen, highly recommend her and would go back to her."

The following feedback comments are from providers:

"Though the advocate did not say an awful lot in the meeting, I appreciated what she did say — which was objective and helpful. Lovely open body language and demeanour."

"Helped both parties to feel at ease. Directed the discussion to resolution."

Acknowledgement from the Commissioner

The Commissioner would like to acknowledge the dedication and commitment of all those involved with the provision of the Advocacy Service. The combined efforts of the advocates, managers and support staff, and members of the National Advocacy Trust Board have all contributed to the provision of an excellent service for health and disability services consumers throughout the country.

Response to complaint about Emergency Department services provided to consumer with a disability

A disabled consumer complained to the Advocacy Service that he had not been listened to and his requests regarding his treatment were ignored when he attended the Emergency Department at the local hospital. With the assistance of an advocate the consumer requested a meeting with the DHB.

The representative from the DHB listened to the consumer, and the consumer was given a Health Passport to take with him if he needed to go to the Emergency Department again, and he was referred to the Older Persons Rehabilitation Service for further assistance. The DHB also agreed to look at putting in place a management plan for future admissions, including completing a Disability Support Needs Alert document for inclusion on consumers' NHI files and referring the consumer to the Community Health Team to look at what could be done for him in his home environment.

Resolution meeting about actions of nurse on rehabilitation ward

A family member made a complaint to the management of a rehabilitation ward that a nurse had been terse and had not provided pain relief to her mother over two nights. The family also complained to the Advocacy Service. After considering the options, the family decided to request a resolution meeting with the ward management, the nurse, and an advocate.

At the meeting the nurse apologised, and it was agreed that she would meet with the manager on a monthly basis for one year to monitor her behaviour. Changes were also made to the rehabilitation ward as a result of the complaint, with a "Dignity for patients" programme being introduced and the management requesting that the Advocacy Service provide education on the Code to its ward staff.

3.3 Proceedings

The Director of Proceedings brings proceedings against providers on referral from the Health and Disability Commissioner.

The Director of Proceedings is an employee of the Health and Disability Commissioner but performs her role independently of the Commissioner.

The Director of Proceedings takes proceedings against health and disability services practitioners in either the Health Practitioners Disciplinary Tribunal (HPDT) and/or the Human Rights Review Tribunal (HRRT). Case outcomes provide accountability, determine and uphold appropriate standards for healthcare providers, and promote consumer confidence.

In cases of professional misconduct by a registered health practitioner, the HPDT has a range of penalties available including a fine, conditions on practice, and suspension or cancellation of the practitioner's registration as a health practitioner.

The HRRT considers allegations of breach of the Code against both registered and unregistered providers. Remedies include formal declarations of a breach of the Code, and in some circumstances compensation is available.

Significant outcomes this year have included a number of successful disciplinary proceedings in the HPDT, and declarations of breaches of the Code in the HRRT (as detailed in Table 2 and the case notes below).

Statistics

The Director of Proceedings had 25 referrals in progress during 2015/16, including five referrals received in the course of the year. Consistent with previous years, around half of the referrals in progress are referrals involving issues of practitioner competency. Table 1 identifies 2015/16 referrals by provider type. Table 2 sets out the status of all referrals in progress during the year.

During the course of the year there were seven successful disciplinary hearings in the HPDT.[1]

Three HRRT proceedings were resolved by negotiated agreement, including consent order declarations of a breach of the Code by the Tribunal. A significant number of settlements were obtained for consumers. Another matter was resolved without recourse to Tribunal proceedings.

Table 2: Referrals received in the 2015/16 year by provider type

Provider	No. of referrals in 2015/16
Caregiver	1
Psychologist	1
Midwife	2
General practitioner	1
TOTAL	**5**

Significant outcomes this year have included a number of successful disciplinary proceedings in the HPDT, and declarations of breaches of the Code in the HRRT.

[1] In one case professional misconduct was made out on appeal to the High Court following an unsuccessful hearing at HPDT.

Table 3: Status of referrals in progress during 2015/16

Provider	No. of referrals	DP decision in progress	No further action	Proceedings pending / Awaiting decision	Successful proceedings	Unsuccessful proceedings	Other resolution
Caregivers	1			1			
Disability services provider	2			1	1 (HRRT)		
Private medical hospital	1				1 (HRRT)		
Midwife	6	2		2	1 (HPDT)		1
Nurse	2		1	1			
Anaesthetist	1				1 (High Court)	1 (HPDT)	
General surgeon	1		1				
Counsellor	1				1 (HRRT)		
Pharmacist	1			1 (HPDT)			
Physiotherapist	1				1 (HPDT)		
General practitioner	2	1		1	1 (HPDT)		
Psychologist	1				1 (HPDT)		
Obstetrician	2			1	1 (HPDT)		
Dentist	1				1 (HPDT)		
Detention services healthcare provider	1			1			
Health care assistant	1		1				
TOTALS	**25**	**3**	**3**	**9**	**10**	**1**	**1**

Note: Some referrals appear in two columns, as sometimes there is more than one proceeding per referral.

Private hospital held accountable for poor care planning and risk assessment

The Director brought proceedings in the Human Rights Review Tribunal against an aged care facility provider regarding the services it provided to a 70-year-old man.

The man was admitted to respite care at an aged care facility for just over two weeks. The man had multiple co-morbidities, including type II diabetes. His left leg had been amputated below the knee, and his right foot had two chronic infective ulcerative wounds on his big toe and heel. These wounds had been managed in the community for two years. In addition to the two ulcerative wounds, the man had a skin tear on his right leg.

The man did not receive adequate care during his stay at the facility. Upon admission, staff did not complete adequate risk assessments (including falls risk and pressure sore risks) and care plans for the man's wounds. Basic observations were not carried out. No wound care plan was put in place on admission for the man's wounds on his right toe, left leg or left stump. Once identified, the wounds were not reviewed regularly. The man did not receive dressing changes for his wounds at the frequency required by the existing wound care plans.

During his time at the facility, the man's right foot wounds deteriorated, particularly his right big toe, which became necrotic. Nursing staff did not respond to the change in the man's toe wound adequately. The man's family and GP were not informed of his change in health status, and medical assistance was not sought.

Two days following his discharge from the facility, the man was admitted to a public hospital, presenting with gangrene of his right big toe. The man's right leg was amputated above the knee.

The proceedings were resolved by way of negotiated agreement involving a declaration by the Tribunal that the provider did not provide services to the man with reasonable care and skill with regard to the man's assessment on admission, his care planning and wound care, and a lack of adequate assessment and follow-up of his change in health status. The Tribunal found that the provider breached Right 4(1) of the Code.

The Tribunal's full decision can be found at:
http://www.nzlii.org/nz/cases/NZHRRT/2015/50.html

Obstetrician held accountable for negligence

The Director of Proceedings laid a charge against an obstetrician/gynaecologist in the Health Practitioners Disciplinary Tribunal concerning the care he provided to a high-risk pregnant woman and her unborn baby.

The charge related to a failure to respond appropriately to a cardiotocograph (CTG), which was abnormal then progressively pathological, indicating that severe fetal compromise was very likely. In particular, the obstetrician/gynaecologist failed to perform an emergency Caesarean section promptly; further delayed appropriate action by awaiting the arrival of his registrar before collecting a fetal blood sample (lactate); failed to respond to his registrar's concerns; and chose to perform a lactate when it was contraindicated.

The charge also concerned a failure to communicate adequately with the woman and her husband, specifically to discuss a management plan for the progress of her labour (including having the registrar perform a lactate), failure to discuss options including a Caesarean section, and failure to ascertain the woman's wishes. The matter proceeded by way of a defended hearing. The obstetrician/gynaecologist accepted that he failed to respond in a clinically appropriate manner to the unfolding emergency, and that he failed to communicate effectively with the woman and her husband. However, he argued that his clinical errors did not meet the threshold for a finding of professional misconduct.

The obstetrician/gynaecologist was both the consultant obstetrician on call and performing registrar duties on the day in question. The woman had been in hospital for two days when she was commenced on Syntocinon at 10.45am on the third day. The obstetrician/gynaecologist visited her at 2.15pm but did not see her again until the charge midwife called him at 9.12pm. The woman made little progress with labour during the day, and there had been some shows of blood. After 6.50pm some fetal heart rate (FHR) decelerations were noted. After 7.30pm there were frequent losses of contact in the CTG recording, and midwifery staff had difficulty assessing whether it was recording the fetal or maternal heart rate. At 8.12pm an epidural was administered. Over the next 28 minutes there were further losses of contact on the CTG, and FHR decelerations were recorded. Each time the staff midwife and the charge midwife moved the woman's position the FHR improved. Following the attachment of a fetal scalp electrode at 9.05pm, the FHR dropped significantly and did not recover, prompting the charge midwife to call the obstetrician/gynaecologist.

At 9.15pm the obstetrician/gynaecologist reviewed the CTG, which recorded the FHR as 60 beats per minute. He conducted a vaginal examination and noted the cervix as 3–4cm dilated with the fetal head at station +1, and decided to monitor the situation with the expectation that vaginal delivery was still possible. He did not discuss the FHR with the woman, or the implications of prolonged bradycardia (abnormally low heart rate). He did not discuss the delivery options available, their risks, his recommendation, or the woman's preferences, and he did not discuss his plan with the midwifery team. He waited for his registrar to come on shift at 9.30pm, by which time the bradycardia had persisted for some 20 minutes. The registrar told the obstetrician/gynaecologist that an urgent Caesarean section was needed. The obstetrician/gynaecologist declined to do one and asked for a lactate. When his registrar challenged his decision, he insisted on the lactate. The lactate confirmed severe acidosis of the baby's blood and, at 9.43pm, a code red Caesarean section was called. Sadly, the baby was delivered stillborn.

The Tribunal was satisfied that all particulars of the charge (separately and cumulatively) were established, both as serious negligence and bringing discredit to the medical profession. In considering whether the obstetrician/gynaecologist's conduct reached threshold, the Tribunal accepted the expert evidence that the obstetrician/gynaecologist should have been called by the charge midwife to assess the woman earlier that evening. However, the Tribunal also acknowledged that it will remain unresolved whether calling the obstetrician/gynaecologist earlier would have made any difference to his decision to await vaginal delivery.

The Tribunal also accepted the expert evidence that the obstetrician/gynaecologist should have paid more attention to the woman as a high-risk patient, at least from 2.15pm that day. Irrespective of these earlier deficiencies, the Tribunal was satisfied that the obstetrician/gynaecologist's errors were basic decision-making errors, and his continuing failures were serious acts of negligence. From 9.15pm the obstetrician/gynaecologist "had an unimpeded opportunity to make an obvious clinical decision". The misconduct "was so seriously negligent that, while not deliberate, it does unfortunately portray an indifference and abuse of the privileges that accompany registration as a medical practitioner". The Tribunal was satisfied that the external factors raised by the obstetrician/gynaecologist (late call to an urgent situation, tiredness, understaffing) were not out of the expected range experienced from time to time by consultants, and were not sufficient to avoid a finding of professional misconduct.

3.4 Education

HDC is committed to ongoing systemic improvements in safety and quality in the health and disability sector. HDC delivers education sessions to both providers and consumers in order to assist providers and consumers to have a clear understanding of consumer rights and provider responsibilities under the Code. Providers who understand their responsibilities are better able to comply with the requirements of the Code, and consumers who understand their rights are better able to exercise those rights.

Important learnings can be found from the analysis of complaint trend data, and it is important that these learnings are reported back to the sector and to the general public. To this end, HDC continues to report on complaint trends in a way that supports quality improvement.

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

HDC delivered 49 education sessions in 2015/16. The sessions included presentations to DHBs, disability service providers, professional colleges, aged care providers, and other professional bodies. HDC also provided education sessions to staff in general practices in line with the requirements of the Cornerstone Accreditation Programme. HDC continued to provide regular sessions on the Code for those studying to become health and disability service providers at universities and other training institutions, such as to those studying medicine, nursing, natural medicine and midwifery. Presentations were also given at a number of conferences in 2015/16, including the Medical Law Conference, the Osteopathic Council of New Zealand Conference, the New Zealand Emergency Departments Conference, the Engineering and Physical Sciences in Medicine Conference, and the Elder Law Conference.

HDC provided two half-day complaint management resolution workshops for DHBs in 2015/16. These interactive workshops aim to increase: the proportion of complaints effectively resolved by the DHB; complainant satisfaction with the DHB's response to complaints; and learning from complaints in order to improve service quality. In 2015/16 HDC also extended these complaint management resolution workshops to primary care providers, conducting two workshops for primary healthcare organisations. The vast majority of those who attended these workshops reported that they were satisfied or very satisfied with the session.

HDC also provided formal written responses to 51 enquiries from consumers, providers, and other agencies about the Act and Code and consumer rights under the Code.

Promoting learning through complaint trend reports

An important aspect of HDC's education function is promoting learning through the analysis of complaint trends. HDC continues to provide six-monthly reports to DHBs outlining complaint trends, both nationally and for individual DHBs. The purpose of these reports is to assist DHBs to identify areas of service and aspects of care that are most commonly at issue in complaints to HDC. When asked to rate the usefulness of these reports, 95% of those DHBs who responded reported that they found the reports useful for improving services. HDC continues to consult with DHBs about how these reports can be best developed to assist them to improve the quality and safety of their services.

In 2015/16 HDC also produced the second report detailing a national full-year analysis of complaints involving DHBs. This report outlined the type of complaints HDC received about services run by DHBs, how HDC resolved these complaints, and the positive changes that have been made to services as a result. Case studies were included to encourage readers to consider their own service provision and to ask, "Could that happen at my place?" and, if so, what changes can be made to prevent it. The report aimed to assist DHBs, and the individual providers who provide care within DHBs, to learn from complaints received about other DHBs, and to better understand how their complaint patterns compared nationally. The report also aimed to empower consumers to become stronger partners in their own healthcare. HDC intends to continue to produce these reports yearly, and to continue to analyse the data to the degree of specificity demonstrated in the report, as the additional time series analysis will be of significant use.

Following on from HDC's report "Delayed Diagnosis of Cancer in Primary Care: Complaints to the Health and Disability Commissioner: 2004–2013", in 2015/16 we carried out work analysing our complaint data in order to publish two reports in 2016/17. The first report presents an in-depth topical analysis of our complaint data about residential aged care facilities. As well as identifying key issues in complaints, this report brings together the recommendations made by HDC in this area, with a view to improving the quality of care. The second report will present an analysis of all doctors complained about between 2009 and 2015. This report will look at the demographic variables of doctors complained about (such as gender, specialty, years in practice, etc), as well as the common issues that are complained about in relation to doctors.

Submissions

HDC advises on the need for, or desirability of, legislative, administrative, or other action to give protection or better protection of the rights of health services consumers or disability services consumers or both, through making submissions.

In 2015/16, submissions included comments on policies, procedures, codes of conduct, and guidelines to the Dental Council of New Zealand, the Advisory Committee on Assisted Reproductive Technology, the New Zealand Nurses Organisation, the Medical Council, the University of Otago, the New Zealand Audiological Society, the Ministry of Health, and the Midwifery Council of New Zealand.

3.5 Systemic monitoring and advocacy – Mental Health and Addiction Services

HDC has a statutory role in monitoring and advocating for improvements to mental health and addiction services (MH&A Services). The Mental Health Commissioner (MHC) is responsible for the performance of those functions under delegation from the Commissioner.

Monitoring MH&A Services and advocating for systemic improvements is undertaken to support the implementation of the Government's priorities to achieve mental health and well-being for all, as set out in "Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2013–2017".

The foundation for HDC's monitoring role is the work undertaken in complaints resolution. That work enables HDC to identify wider system and service issues that need to be addressed to ensure that services improve as a result of what is learnt from the complaints we consider. Other important components of HDC's monitoring work are engagement with key sector stakeholder groups, including consumer and family/whānau networks, and monitoring and supporting the development of national performance information.

Major achievements for the year

Engagement

On behalf of HDC, the MHC engages extensively with the wider MH&A Services sector, including consumer and family/whānau representative forums. This is done through exchanging knowledge and facilitating national benchmarking, and by identifying and supporting key projects for collaborative learning. The collaborative approach provides HDC with the best expertise in the sector, and supports the development of sector capability and capacity to lead change.

Highlights from the 2015/16 year in this respect included attending and presenting at several national forums — for example, the National Association of Mental Health Services Consumer Advisors, and the National DHB Clinical Directors and General Managers Group — for the purpose of shared learning and identification of emerging issues to inform HDC's advocacy role. Feedback from the national forum chairs indicated that 100% were satisfied that the HDC input has been useful in supporting quality improvement.

Monitoring and analysis

Monitoring MH&A Services and analysing national data on mental health and well-being is a part of the MHC's functions. In 2015/16, substantial progress was made in the national roll-out of the real-time consumer feedback system (RTF), with 22 service providers, including 15 DHBs and 7 NGOs, adopting the system. Service providers have received over 7,700 surveys from consumers and family/whānau since RTF surveys commenced in 2015. Feedback from providers using RTF confirms that the data is useful in informing quality improvements. Information on RTF can be found at www.hdcrtf.co.nz.

In addition, HDC continued to contribute to the development of two important national performance reporting tools: the provider-led New Zealand Mental Health and Addictions KPI Programme, and the Ministry of Health-led National Mental Health and Wellbeing Outcomes Framework.

Systemic advocacy

HDC is in a unique position to report on consumer and family/whānau experiences of interaction with MH&A Services. As part of this role, and in collaboration with others, projects were completed as follows:

- The trial of the Choice and Medication website at Waitemata DHB. This website provides access to information on all medicines used in MH&A Services in New Zealand, across a range of literacy levels. A survey of users of the website indicates that the website is useful in empowering consumers and their family/whānau to be active participants in consumers' care.
- During the year, HDC provided support to the National DHB Consumers and Family/whānau forums to strengthen their roles in decision-making within their services. Feedback from these groups indicated satisfaction with HDC's contribution in these sector groups.
- Over a thousand copies of the HDC publications "Oranga Ngākau" and "When someone you care about has mental health or addiction issues" were distributed throughout national networks.

The foundation for HDC's monitoring role is the work undertaken in complaints resolution.

4.0 Supporting Disabled Consumers

Disability services are evolving, and over the past 12 months disabled consumers have been supported in a greater variety of ways. The piloting of "Enabling Good Lives" and the continued application of individualised funding has seen an increasing number of disabled consumers make decisions about the nature and type of support they are receiving.

HDC's analysis of the complaints received about disability service providers provides insight into consumers' experiences of the services provided, and is indicative of the issues that are most important to consumers and their family/whānau. This year HDC received 97 complaints about disability services, and closed 109 complaints. This included five investigations and, in three of those investigations, HDC found that the consumer's rights under the Code had been breached.

The most common issues complained about in relation to disability services in 2015/16 were inadequate coordination of care or treatment (14%), inadequate/inappropriate non-clinical care (11%), failure to communicate openly/honestly/effectively with consumers (11%), lack of access to services (9%), and inadequate or inappropriate disability related support provided (8%).

However, at a time where the total number of complaints received by HDC is increasing by approximately 5% per annum, the total number of disability related complaints has reduced by close to 14% from the 2014/15 year. The reasons for this decrease in complaint numbers are unclear. It may be that there are fewer concerns, or concerns are being raised with individual service providers and are being resolved appropriately. It is also possible that there are more events than there are complaints made. These events may be occurring where people are not aware of their rights, or if they encounter difficulties accessing the complaints process, or possibly if they do not have family/whānau or community support to advocate on their behalf. We know that the majority of disability related complaints referred to HDC come from either the consumer/consumer's representative (45% in 2015/16) and family (40% in 2015/16), with a minimal number from caregivers (1% in 2015/16) and providers (1% in 2015/16).

HDC continues to value opportunities to speak with disabled consumers about their rights and the challenges they face. In 2015/16 the Advocacy Service delivered education sessions and visited 995 certified residential homes across the country at least once, with 620 certified residential homes visited more than once. Their visits allow disabled consumers to meet advocates and learn more about the support advocates can offer to disabled consumers receiving health and disability services.

HDC recognises the importance of service providers having sound complaints management systems and processes, with the knowledge and resources to respond to complaints appropriately when brought to their attention. In the past year, HDC has produced complaints management guides to assist disability service providers to evaluate and improve their knowledge of their complaints management system, and assist them to respond appropriately to complaints. The two guides, which have been published on HDC's website, are designed first to act as a checklist for services providers to work through with staff to evaluate their complaints management systems, and, secondly, to help support staff to evaluate and improve their own knowledge of their organisation's complaints management system, and assist them to respond appropriately to complaints.

The five investigations closed in 2015/16 have again highlighted the key factors in the provision of high quality disability support to vulnerable disabled consumers. In the past 12 months these have included:

- Having comprehensive care plans and risk management plans in place for all individuals receiving support, including disabled consumers receiving respite care services.
- Ensuring information is sufficiently clear to be understood by all staff, including support staff.
- Having appropriate staff training programmes in place.
- Communicating appropriate standards of care to staff, including support staff working remotely or unsupervised within a service.
- Having appropriate and clearly articulated policies and procedures.

An important focus for HDC with the resolution of complaints and the closure of investigations is to ensure that opportunities to affect change and improve systems and processes are taken to reduce the likelihood of disabled consumers having similar experiences in the future. As such, in HDC's recommendations to service providers, a particular focus has been given to the support and training provided to support staff, the robustness of the organisation's policies and procedures, and the adequacy of care and support plans.

The Advocacy Service visits allow disabled consumers to meet advocates and learn more about the support advocates can offer to disabled consumers receiving health and disability services.

Care of a disabled person in a residential care home (14HDC00007)

A 20-year-old man lived three nights per week in a residential care home and required 24-hour care because of his acute obstructive sleep apnoea, cerebral palsy and epilepsy. He was unable to walk, and used a wheelchair. On the other four nights he lived at home with his parents.

One night, the man was cared for overnight at the residential care home by a sole caregiver, who was also supporting three other clients with complex needs. The caregiver on duty was to remain awake during the night, and complete client and household duties during the shift. The caregiver's shift started at 11pm. At approximately 11.10pm, the caregiver transferred the man from his chair to his bed.

The man's night-time care plan required that the caregiver attach the man's shoulder harness after transferring him into his wheelchair, and place a pillow under his head and shoulders after transferring him back to bed to perform personal cares. At approximately 3am, the man woke up. The caregiver left the man on his back in bed for 10–25 minutes before transferring him to his wheelchair, but did not attach the man's shoulder harness. At approximately 5am, the caregiver transferred the man from his wheelchair back to bed, with the bed raised at the head end, in order to perform his personal cares. The caregiver did not place a pillow under the man's head and shoulders. The caregiver went to the en suite bathroom to wet a flannel and, when he came back, the man had moved so that he was diagonal on the bed, and was struggling to breathe. The caregiver tried to move the man back into position (lying straight on the bed), but the man's breathing became more difficult, and he stopped breathing. The caregiver called 111 and performed CPR until two ambulances arrived. The man was taken to hospital, where, sadly, he died.

The caregiver breached Right 4(1) of the Code by failing to comply with the man's night-time care plan.

The residential care home failed to provide services to the man with reasonable care and skill, as its care planning for the man did not meet the accepted standard. Information and training was provided at house meetings, but the care home did not have an adequate system in place to verify whether the caregiver had accessed or received the information and training provided when he missed house meetings. For these reasons, the residential care home breached Right 4(1) of the Code. In addition, the residential care home breached Right 4(4) of the Code by failing to minimise the potential harm to the man, as the hours the caregiver was allowed to work put the clients he cared for at risk.

It was recommended that both the caregiver and the service provider apologise to the man's family. Several recommendations were made to the service provider, including a review of the effectiveness of changes it had implemented following this incident, and the new changes proposed. The service provider was also asked to conduct an internal audit of all client care plans to ensure that all key information had been transferred into each client's care plan. It was also to review the responsibilities of the "awake" night shift staff in each of the service provider's residential homes in light of the complexity of the clients being cared for, and to seek external expertise to review the adequacy of its staff training programme.

Respite care of a vulnerable young man with high needs (16HDC00085)

A 15-year-old man had cerebral palsy, epilepsy, profound intellectual disability, and spastic quadriplegia. He was fully dependent for all cares. A residential service provided respite care for the young man in a house where up to six young people at a time received respite care. One evening, two support workers were on an overnight shift together, caring for six high-needs clients.

The residential service had two bathrooms, each with a bath. There were instructions for bathing service users, which included, "Never leave the children unsupervised whilst they are in the bathroom area", "full supervision", and "always be present when a person is bathing". However, a practice had developed whereby support workers would leave children/young people alone in the bath for short periods of time. The young man's personal support information included statements that he must be "supervised at all times" and "cannot be left alone".

The first support worker assisted the young man into the bath in Bathroom A using the hoist. The first support worker then assisted with the other young people, including running a bath in Bathroom B for another child. The first support worker checked on the young man every few minutes. Once the second bath was run, the first support worker assisted the second support worker to bring the other child inside and help him into the bath. Both support workers then left the bathrooms to do other tasks. About half an hour later the second support worker checked on the young man and discovered that his head was submerged in the water and he was not breathing. The two support workers removed the young man from the bath. One of the support workers telephoned 111 and the other commenced CPR until an ambulance arrived and paramedics took over. The young man was taken to hospital, where, sadly, he later died.

The young man was vulnerable with high needs. He relied on the service provider to provide him with services of an appropriate standard. By failing to ensure that adequate policies and procedures were in place, and complied with, to support the young man effectively and prevent him being left unsupervised in the bath, the residential service breached Right 4(1) of the Code. There was a lack of clarity in the service's policies and procedures regarding bathing, and the first support worker did not receive adequate training in caring for the young man. Despite the lack of clarity in the service's policies and procedures, the Deputy Commissioner considered it evident that it was an unsafe practice to leave the young man unattended in the bath. The first support worker breached Right 4(1) of the Code by leaving the young man unattended. The second support worker on duty at the time was aware that the young man had been left unsupervised. Accordingly, it was found that by allowing the young man to remain unsupervised, the second support worker breached Right 4(1) of the Code.

Following this incident, it was recommended that the service provider commission an independent review of: the changes made since the event; the personal plans and risk management plans for each client at the residential home to ensure that they contain clear instructions specific to the person; and the manner in which important information is conveyed to staff to ensure that this accommodates the reading skills of staff.

It was also recommended that, with the assistance of an independent reviewer, the service provider develop a methodology for allocating staff levels commensurate with the needs of the consumers, and develop policies and provide training to ensure that community support workers are aware of their ability to access on-call staff at any time.

5.0 Organisational Performance, Development and Capability

5.1 Leadership

HDC continues to be a leader in the resolution of complaints about health and disability services, and in the medico-legal field. As the health and disability consumer watchdog, HDC encourages providers to alert it to issues as they arise, and supports providers to resolve complaints at the lowest possible level. The Advocacy Service strives to empower consumers to manage on-going relationships with their health or disability service providers, and supports consumers in complaint resolution.

In 2015/16 the Commissioner led the organisation with the Executive Leadership Team of three Deputy Commissioners (one of whom is the Mental Health Commissioner), two Associate Commissioners, the Director of Proceedings, and a Corporate Services Manager.

5.2 Staff

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

5.3 Equal employment opportunities

HDC is committed to being a good employer and promoting and maintaining equal employment opportunities. Its Human Resources policies recognise the need to provide equal opportunities for employment, promotion and training, both within the office and through its recruitment processes. Staff involved in recruitment follow the requirements of HDC's Equal Employment Opportunities (EEO) policy, which is part of new staff induction.

HDC's policies require all employees and other workers at HDC to take responsibility to ensure that the objectives in the New Zealand Disability Strategy are put into practice.

5.4 Workplace profile

As at 30 June 2016, HDC had 66 full-time equivalent (FTE) employees, as follows:

- 83% females and 17% males; and
- 52 full-time and 25 part-time positions

HDC employs several disabled people, covering a range of different impairments. These staff members provide a valuable contribution to the work of HDC, including insight into the challenges faced by those in our communities who live with impairments. They are supported by staff in the office.

The Office benefits from a diverse workforce, with a variety of ethnicities including Māori, Sāmoan, Asian, Brazilian, and English, and aged between 20 to over 60 years.

HDC organised programmes throughout the year to celebrate Māori Language Week, International Day of Persons with Disabilities, and Matariki.

5.5 Good employer obligations

Leadership, accountability and culture

The Executive Leadership Team is dedicated to working collaboratively to operate the whole organisation as one team. Managers are accountable for leading a performance culture that is supportive and equitable. Staff forums are held in both the Auckland and Wellington offices regularly to talk about the work and current issues across divisions, and to recognise staff and team successes.

Recruitment, selection and induction

HDC's recruitment policy and practices ensure the recruitment of the best qualified employees at all levels using the principles of EEO, while taking into account the career development of existing employees. Vacancies are advertised throughout the Office as well as externally, and employees are encouraged to apply for positions commensurate with their abilities. The induction for all new staff members provides an introduction to the team; an oversight of the organisation's activities; information on policies, procedures and tools; and training as required.

Employee development, promotion and exit

HDC policies support professional development and promotion. Training and development needs and career development needs are formally identified as part of the annual performance appraisal process. Staff members jointly develop with their manager a performance management agreement tailored to their role and development requirements.

Professional development by employees is encouraged, and financial assistance and/or study leave may be granted by the Commissioner. Several staff have been given the opportunity to cover vacant senior management roles and thereby further develop their management and leadership skills.

HDC has processes in place to ensure good practice in regards to staff exits and retirements.

Flexibility and work design

HDC continues to offer secondments across divisions, working from home options, and flexible work start and finish times. A number of staff work hours that enable them to study as well as gain valuable work experience.

Remuneration, recognition and conditions

HDC provides fair remuneration that is linked to employee performance and based on EEO principles. HDC recognises staff achievements in its internal newsletter "Highlights" and at staff forums.

Harassment and bullying prevention

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

Safe and healthy environment

HDC supports and encourages employee participation in health and safety through its Health and Safety Employee Participation System and its Health and Safety Committee, which meets regularly. Health and safety is a regular agenda item at staff forums, and hazards are actively managed in the office. During the year, HDC reviewed its Health and Safety policy to ensure compliance with the Health and Safety at Work Act 2015, and organised training for all staff.

Support is given to those staff with acknowledged impairments by way of sign language interpreters, special equipment, and assistance to get to and from work. In addition, HDC has a number of initiatives in place to promote a healthy and safe working environment, including sponsorship for health and wellness activities, use of VITAE (which offers confidential counselling services), provision of fruit in each office, and flexible hours.

5.6 Process and technology

Sustainability

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

Technology

HDC continues looking for initiatives to bring positive changes to the business. In the 2015/16 year, HDC improved its printing package solution, adopted an online payroll system, and introduced document processing software. These initiatives help enhance capability and efficiency as well as minimising non-value added steps and associated costs. In addition, HDC is exploring website and database enhancements. HDC continues to improve its information management systems to ensure compliance with the Public Records Act 2005 standards.

5.7 Physical assets and structures

HDC continues to manage its assets cost-effectively. Our governance policies and practices are strong. Our assets are maintained and cared for to ensure they provide an appropriate useful life.

Together, HDC's people bring to the organisation a wide range of skills in management, training, investigation, litigation, clinical practice, research and development, information technology, and financial management.

6.0 Statement of Performance

6.1 Strategic objectives (the change HDC aims to achieve for New Zealanders) and outputs (HDC's key activities)

HDC continues to act as an independent watchdog in line with its strategic intent to effectively promote and protect consumers' rights. To do this, HDC engages with health and disability services and other organisations in the health and disability sector, leading to ongoing improvements for both consumers and the wider New Zealand population. This assists all New Zealanders to live well, stay well and get well.

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

- New Zealanders live longer, healthier, more independent lives.
- The health system is cost effective and supports a productive economy.
- High-quality health and disability services are delivered in a timely and accessible manner.
- The future sustainability of the health system is assured.

HDC aims to resolve complaints at the lowest possible level. When a complaint is received, HDC has a range of resolution options available to it under the Act. These include referring the complaint back to the provider, to a professional body, to another agency or to the Advocacy Service. The Commissioner may also decide to take no further action on a complaint. Often a decision to take no further action will be accompanied by an educational comment designed to assist the provider to improve future services. Where appropriate, the Commissioner may formally investigate a complaint. One of the possible outcomes of a formal investigation is that the provider may be found to have breached the Code. Such findings, along with reasons, are usually set out in a formal report, which may be anonymised and published on the HDC website for educational purposes. Relevant regulatory authorities, other agencies, and the consumer/complainant are also advised of the breach finding, thus holding the provider to account for the failure. The Commissioner may also decide to refer the provider to the Director of Proceedings, who may elect to bring proceedings against the provider. Such proceedings provide an additional mechanism for holding a provider to account, either in a professional disciplinary context (where proceedings are brought in the Health Practitioners Disciplinary Tribunal) or in the Human Rights Review Tribunal (a forum in which damages may be awarded against the provider).

The key ways in which HDC contributes to the Government's outcomes, and the principal ways those contributions are measured (as reported in the statement of performance), include:

1. Resolving complaints about health and disability services. This is measured by the:
   - *number of complaints received and closed by HDC;*
   - *timeliness of complaints resolution by HDC;*
   - *number of complaints received and resolved by the Advocacy Service;*
   - *timeliness of complaints resolution by the Advocacy Service; and*
   - *level of stakeholder satisfaction with the Advocacy Service's complaints management processes.*
2. Using the learning from complaints to improve the safety and quality of health and disability services' practices and systems. This is measured by the:
   - *improvements made by providers based on HDC recommendations;*
   - *provision of, and satisfaction with, HDC complaint trend reports to District Health Boards;*
   - *provision of, and satisfaction with, HDC complaint resolution workshops; and*
   - *provision of, and satisfaction with, education sessions provided by HDC.*
3. Promoting best practice and consumer-centred care to providers. This is measured by the:
   - *provision of, and satisfaction with, education sessions provided by HDC;*
   - *provision of, and satisfaction with, education sessions provided by the Advocacy Service;*
   - *provision of, and satisfaction with, HDC complaint resolution workshops;*
   - *provision of up-to-date, accessible and informative educational material;*
   - *provision of high quality submissions addressing matters that affect the rights of consumers; and*
   - *provision of, and satisfaction with, consumer seminars held by HDC.*
4. Ensuring that providers and their employees are held accountable for their actions. This is measured by the:
   - *number of complaints received and closed by HDC;*
   - *proportion of disciplinary proceedings in which professional misconduct was found;*
   - *proportion of Human Rights Review Tribunal proceedings in which a breach of the Code was found; and*
   - *proportion of cases in which awards of damages were made.*
5. Supporting the mental health and addiction functions to strengthen advocacy, collaboration and communication. This is measured by:
   - *HDC's engagement with the sector for collaborative learning;*
   - *proportion of DHBs using Real-time Feedback to report consumer experience;*
   - *success in developing and implementing key projects in the mental health and addictions sector to support best practice, through advocacy and monitoring; and*
   - *provision of, and satisfaction with, reports on issues relating to mental health and addiction services.*

Monitoring and Protecting Health and Disability Consumer Interests Appropriation

HDC is funded under the Monitoring and Protecting Health and Disability Consumer Interests Appropriation. This appropriation is intended to achieve the following: the rights of people using health and disability services are protected. This includes addressing the concerns of whānau and appropriately investigating alleged breaches of patients' rights. HDC received funding of $11,670,000 from this appropriation in the year ended 30 June 2016. In addition, HDC earned other income of $245,742. This combined income was used to fund HDC's expenditure of $11,589,423.

6.2 Output Class 1: Complaints resolution

Financial Performance of Output Class

For the year ended 30 June

	Actual 2016	Budget 2016	Actual 2015
OUTPUT 1: Complaints resolution	**$**	**$**	**$**
Revenue	5,869,704	5,518,000	5,592,305
Expenditure	5,776,764	5,518,000	5,456,856
Net surplus/(deficit)	**92,940**	**–**	**135,449**

Performance and measures	Achievement
Output 1 — Complaints management	
Efficiently and appropriately resolve complaints	**Targets achieved**
Receive an estimated 1,900 complaints.	1,958 complaints were received during the year; this represents a 4.1% increase of the last year's volume (2015: 1,880).
Close an estimated 1,900 complaints. Undertake an estimated 100 investigations.	2,007 complaints were closed during the year; this represents 105.6% of the annual estimated volume. 80 investigations were undertaken and closed. (2015: 1,910)
	Targets partially achieved
	Total open files at year end was 430[2] (2015: 479).
Manage complaints so that:	Age of open complaints at 30 June 2016:
• No more than 17% of open complaints are 6–12 months old.	• 6–12 months old, 71 out of 430 — 16.5% (2015: 13.6%)
• No more than 15% of open complaints are 12–24 months old.	• 12–24 months old, 70 out of 430 — 16.3% (2015: 8.6%)
• No more than 1% of open complaints are over 24 months old.	• Over 24 months old, 7 out of 430 — 1.6% (2015: 1%)

[2] 430 complaints remained open at the end of the year, representing a decrease of 10% on last year. A smaller open file pool resulted in a higher percentage, in particular for files aged in the "12–24 months" and "over 24 months" categories.

6.2 Output Class 1: Complaints resolution - Continued

Performance and measures	Achievement
Output 2 — Quality improvement	
Use HDC complaints management processes to facilitate quality improvement Make recommendations and educational comments to providers to improve quality of services and monitor compliance with the implementation of recommendations and encourage better management of complaints by providers: • Providers make quality improvements as a result of HDC recommendations and/or educational comments. Audit a sample of providers to verify their compliance with HDC quality improvement recommendations: 100% compliance.	**Targets partially achieved** Between 1 July 2015 and 30 June 2016 HDC made recommendations or educational comments on 464 complaints, including 61 breach opinions (a breach opinion is where a provider has been found in breach of the Code following a formal investigation) (2015: 470 including 70 breach opinions). Of these, 282 led to HDC making quality improvement recommendations or educational comments. Quality improvement recommendations exclude recommendations to apologise and other accountability recommendations. During the year, 331 complaints with recommendations were due to be met by 253 providers and 322 (97%) were fully met. Seven were partially met, and HDC will continue to monitor and follow up these. Only two providers have not complied. One of these providers has retired and is unable to be contacted. HDC has advised the other provider's regulatory authority of the provider's refusal to comply. HDC monitors compliance on all files where we have made a recommendation by seeking evidence of the changes made. Where the level of compliance is not satisfactory, HDC does not record it as fully met. The target has been recognised as partially achieved because all but two providers have either fully or partially met the quality improvement recommendations (as per the details above). 97% compliance (2015: 99.4%)
Output 3 — Education	
Promote awareness amongst consumers and providers of the rights of consumers and how they may be enforced Make public statements and publish reports in relation to matters affecting the rights of consumers: • Produce and publish on the HDC website key Commissioner decision reports and related articles. Report on total number. • Release media statements in relation to key Commissioner decisions and other issues as appropriate. Report on total number.	**Targets achieved** 59 decisions[3] were published at www.hdc.org.nz for the year ended 30 June 2016 (2015: 73). 57 of these decisions were sent to national media by way of media alert (2015: 71).

[3] Decisions published in 2015/16 were not all closed in 2015/16.

6.3 Output Class 2: Advocacy

Financial Performance of Output Class

For the year ended 30 June

	Actual 2016	Budget 2016	Actual 2015
OUTPUT 2: Advocacy	**$**	**$**	**$**
Revenue	4,123,798	4,160,000	4,215,006
Expenditure	4,060,619	4,160,000	4,140,190
Net surplus/(deficit)	**63,179**	**–**	**74,816**

Performance and measures	Achievement
Output 2.1 — Complaints Management[4]	
Efficiently and appropriately resolve complaints	**Target achieved**
Receive an estimated 3,800 complaints.	3,331 new complaints were received by advocates in the year ended 30 June 2016 (2015: 3,635).
Close an estimated 3,800 complaints.	During the year ended 30 June 2016, 3,384 complaints were closed (102% of complaints received) (2015: 3,679).
Manage complaints so that: • 85% closed within 3 months • 95% closed within 6 months • 100% closed within 9 months	Complaints were managed so that: • 88% were closed within 3 months (2015: 87%) • 99% were closed within 6 months (2015: 99%) • 100% were closed within 9 months (2015: 100%)
Consumers and providers are satisfied with Advocacy's complaints management processes	**Target achieved**
Undertake a twice yearly consumer satisfaction survey with 80% of respondents satisfied with Advocacy's complaints management processes. Undertake a twice yearly provider satisfaction survey with 80% of respondents satisfied with Advocacy's complaints management processes.	Surveys[5] of consumers and providers who used/dealt with the Advocacy Service reported that 92% of consumers who responded and 88% of providers who responded were satisfied with the complaints management process (2015: 93.5% of consumers and 85.5% of providers).

[4] HDC, through the Director of Advocacy, reviews the Advocacy Service data collected by the National Advocacy Trust to scrutinise performance results. The Director of Advocacy commissioned an independent audit to test the accuracy and completeness of the National Advocacy Trust's complaints management performance results for the period from July 2015 to March 2016.

[5] Throughout the year 33% of consumers and providers who worked with an advocate through a complaint resolution process received posted satisfaction survey forms. The results of surveys are reported to HDC twice yearly. 33% of consumers and 41% of providers surveyed this way responded. In addition, a pilot Survey Monkey satisfaction survey process was commenced in May 2016. All consumers and providers who had an email address were offered the option of completing an online survey. 19% of consumers and 31% of providers who were sent the survey link responded.

6.3 Output Class 2: Advocacy - Continued

Performance and measures	Achievement
Output 2.2 — Access to Advocacy	
Vulnerable consumers (in aged care facilities and residential disability services) have access to advocacy and regular visits from advocates	**Targets achieved**
Advocates visit 75% of certified aged care facilities at least once with multiple visits to facilities as required.	***Certified aged care facilities*** Advocates visited 100% (617) of certified aged care facilities at least once in the year ended 30 June 2016 (2015: 100%). Advocates visited 69% (426) of aged care facilities more than once in the year ended 30 June 2016 (2015: 73%).
Advocates visit 75% of certified residential disability services at least once with multiple visits to facilities as required.	***Certified residential disability services*** Advocates visited 99.7% (995) of certified residential disability services at least once in the year ended 30 June 2016 (2015: 100%). Advocates visited 62% (620) of certified residential disability services more than once in the year ended 30 June 2016 (2015: 61%).
Output 3 — Education and Training	
Promote awareness, respect for and observance of the rights of consumers and how they may be enforced	**Targets achieved**
Advocates provide 1,600 education sessions.	A total of 2,005 education sessions have been provided. (2015: 2,252)
Consumers and providers are satisfied with the educational sessions: • Seek evaluations on sessions with 80% of respondents satisfied.	91% of consumers (who responded to the survey) and 97% of providers (who responded to the survey) were satisfied with the Advocacy Service education session they attended (2015: 91% of consumers and 96% of providers).

6.4 Output Class 3: Proceedings

Financial Performance of Output Class

For the year ended 30 June

	Actual 2016	Budget 2016	Actual 2015
OUTPUT 3: Proceedings	**$**	**$**	**$**
Revenue	582,551	572,000	579,406
Expenditure	573,367	572,000	575,714
Net surplus/(deficit)	**9,184**	**–**	**3,692**

Performance and measures	Achievement
Output 1 — Proceedings	
Professional misconduct is found in disciplinary proceedings Professional misconduct is found in 75% of disciplinary proceedings.	**Target achieved** Professional misconduct was found in 88% (6 of 7) of HPDT proceedings during the year ended 30 June 2016. (2015: 60%, 3 of 5 proceedings).
Breach of the Code is found in Human Rights Review Tribunal (HRRT) proceedings A breach of the Code is found in 75% of HRRT proceedings.	**Target achieved** A breach of the Code was found in 100% (3 of 3) of HRRT proceedings during the year ended 30 June 2016. (2015: 100%, 5 of 5 proceedings).
An award is made where damages sought An award of damages is made in 75% of cases where damages are sought.	**Target achieved** Resolution by negotiated agreement was achieved in 100% (3 of 3) of proceedings (2015: 80%, 4 of 5 proceedings).
Where a restorative approach is adopted, agreement is reached between the relevant parties (new measure) An agreed outcome is reached in 75% of cases in which a restorative approach is adopted.	**Target achieved** An agreed outcome was reached in 100% (1 of 1) of cases where a restorative approach was adopted. (This is an additional performance measure introduced for the year ended 30 June 2016.)

6.5 Output Class 4: Education

Financial Performance of Output Class

For the year ended 30 June

	Actual 2016	Budget 2016	Actual 2015
OUTPUT 4: Education	$	$	$
Revenue	556,814	666,000	777,622
Expenditure	504,395	666,000	672,410
Net surplus/(deficit)	**52,419**	**–**	**105,212**

Performance and measures	Achievement
Output 1 — Disability Education	
Promote awareness, respect for and observance of the rights of disability services consumers	**Targets achieved**
Publish educational resources for disability services consumers and disability services providers on the HDC website (and accessible to people who use "accessible software").	In the year ended 30 June 2016 HDC produced a set of complaints management guides for disability services. These guides have been published on HDC's website and are accessible and in plain English.
At least two new educational resources will be available in plain English.	The first guide is tailored to services management, with a second guide designed for disability services staff. HDC created the guides to help disability services providers evaluate their complaints management systems and identify areas warranting further attention. The guide for staff is intended to help individuals evaluate their knowledge and understand how they should respond to a complaint (2015: three resources were produced).
Facilitate four regional consumer seminars. Consumers are satisfied with the seminars: • Seek evaluations on seminars with 80% of respondents satisfied.	HDC facilitated four regional consumer seminars (Auckland, Hamilton, Christchurch and Dunedin) in the year ended 30 June 2016 with 100% of respondents satisfied with the seminars (2015: four regional consumer seminars were facilitated with respondents' satisfaction reported at 86–100%).
Output 2 — Information and Education for Providers	
DHBs find complaints trend reports useful for improving services	**Targets achieved**
Produce six-monthly DHB complaint trend reports and provide to all DHBs.	Produced two six-monthly DHB complaint trend reports for each DHB and provided these reports to all DHBs.
80% of DHBs who respond find complaint trend reports useful for improving services.	95% (18/19) of the DHBs who responded rated the first six-monthly report as useful for improving services. 100% (19/19) of the DHBs who responded rated the second six-monthly report as useful for improving services. (2015: 100%, 39 of 39.)

6.5 Output Class 4: Education - *Continued*

Performance and measures	Achievement
Assist DHBs to improve their complaints systems	**Targets achieved**
Provide two complaint resolution workshops for DHBs.	Two complaint resolution workshops for DHBs were held.
Seek evaluations on the workshops with 80% of respondents satisfied with the session.	100% and 97% of respondents reported that they were satisfied or very satisfied with each session. (2015: 95% and 97%).
Assist primary care providers to improve their complaints systems	**Targets achieved**
Provide two complaints resolution workshops for primary care providers.	Two complaint resolution workshops for primary care providers were held.
Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	100% and 96% of respondents reported that they were satisfied with each session.
Promote awareness, respect for and observance of the rights of consumers	**Targets achieved**
Provide 30 educational presentations. Consumers and health and disability service providers are satisfied with the educational presentations.	49 educational presentations were made — this represents 163% of the target (2015: 59).
Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	98% of respondents (45 of 46) who provided feedback reported that they were satisfied with the presentations (2015: 100%, 59 of 59).
Output 3 — Other Education	
HDC engages in sector education through making submissions on relevant policies, standards, professional codes, and legislation	**Target achieved**
HDC makes at least 10 submissions.	17 submissions were made during the year ended 30 June 2016 (2015: 11).
HDC responds formally to queries from consumers, providers and other agencies about the Act, the Code and consumer rights under the Code	**Target achieved**
At least 40 formal responses to enquiries provided.	51 formal responses to enquiries were provided during the year ended 30 June 2016 (2015: 60).

6.6 Output Class 5: Systemic monitoring and advocacy — Mental health and addiction services

Financial Performance of Output Class

For the year ended 30 June

	Actual 2016	Budget 2016	Actual 2015
OUTPUT 5: Monitoring and systemic advocacy	**$**	**$**	**$**
Revenue	782,875	900,000	1,019,531
Expenditure	674,278	900,000	983,409
Net surplus/(deficit)	**108,597[6]**	**–**	**36,122**

Performance and measures	Achievement
Output 1 — Systemic Monitoring and Advocacy	
Engagement	
Engage with national sector forums to identify and support key projects for collaborative learning	**Target achieved**
Attend at least three national forums.	During the year ended 30 June 2016, HDC attended and presented at seven meetings of three national forums. These were: • Four meetings of the National DHB Mental Health & Addiction Service Clinical Directors and General Managers Group • Two meetings of the National Committee on Addictions Treatment • One meeting of the National Regional Mental Health & Addictions Advisory Group Ngā Hau E Whā.
Feedback from the national forums chairs indicates at least 75% are satisfied that HDC input has been useful in supporting quality improvement.	Feedback from national chairs indicates that 100% are satisfied that HDC input has been useful in supporting quality improvement.
Monitoring and Analysis	
Report on consumer and family/whānau experience of interacting with mental health and addiction services	**Target partially achieved**
At least 80% of all DHBs use Real Time Feedback (RTF) to report consumer experience feedback to the MOH	The Real Time Feedback system collects information on consumer and family/whānau experience of mental health and addiction services. During the year ended 30 June 2016, the RTF system was rolled out to DHBs and Non Government Organisations (NGOs). The RTF system has been implemented into 22 NGO and DHB services. 16 DHBs (80%) had agreed to use RTF and 15 DHBs (75%) were using RTF to report consumer experience feedback to the MOH by 30 June 2016.

[6] The surplus is mainly due to position vacancies.

6.6 Output Class 5: Systemic monitoring and advocacy — Mental health and addiction services - *Continued*

Performance and measures	Achievement
Output 1 — Systemic Monitoring and Advocacy	
Monitoring and Analysis - *Continued*	
Feedback from providers indicates 80% are satisfied that the system supports service improvements	A survey of all providers using RTF was undertaken in June. Their feedback indicates that 80% are satisfied that the system supports service improvement.
Systemic Advocacy	
Use HDC complaints management processes to facilitate quality improvement The MHC will make recommendations and educational comments to providers when resolving complaints to improve quality of Mental Health and Addiction services and monitor compliance with the implementation of recommendations and encourage better management of complaints by providers. • Providers will make quality improvements as a result of HDC recommendations and/or educational comments. Audit a sample of providers to verify their compliance with HDC quality improvement recommendations: 100% compliance.	**Target achieved** Complaints about mental health and addiction services are being managed in accordance with HDC's statutory complaints resolution role. HDC monitors providers' compliance with recommendations throughout the follow-up process by seeking evidence of changes made. In the year ended 30 June 2016, providers were fully compliant with 100%[7] of recommendations.
Advocate for increased partnership with mental health and addiction consumers and their families/whānau HDC to contribute to two national forums for the DHB Consumers Advisors and Family/ Whānau Advisors to strengthen their roles. 80% satisfaction with HDC's contribution in these sector groups.	**Target achieved** HDC contributed to two national forums for the DHB consumers and family/whānau advisors during the year ended 30 June 2016. 100% of feedback received indicates satisfaction with HDC's contribution in these sector groups.
Advocate for improved outcomes for Māori and Pacific peoples Ensure HDC has current agreements in place to work collaboratively with Māori and Pacific workforce development agencies on priority areas to improve outcomes for their population groups. Feedback from these agencies indicates that satisfactory progress is being made.	**Target achieved** ***Improving Outcomes in Rangatahi and Pasifika Mental Health:*** Priority areas for collaboration in the context of the Memorandums of Understanding (MOUs) are identifying the barriers to access to services for Māori and Pacific people, and implementing strategies to ensure that services are culturally appropriate and meet their needs. The progress review of the two MOUs was undertaken in June with the workforce development agencies. Their feedback indicates that satisfactory progress is being made.

[7] HDC audited one provider sample out of 12 mental health complaints with quality improvement recommendations during the year. The provider was fully compliant with the quality improvement recommendation made by HDC.

6.6 Output Class 5: Systemic monitoring and advocacy — Mental health and addiction services - *Continued*

Performance and measures	Achievement
Output 1 — Systemic Monitoring and Advocacy	
Systemic Advocacy - *Continued*	
Reporting to Minister on progress in implementing "Rising to the Challenge" (ref: MoH 2012) Provide briefings to the Minister as requested.	**Target achieved** A face-to-face briefing with the Minister was held in June.

7.0 Statement of Responsibility

Statement of Responsibility

We are responsible for the preparation of the Health and Disability Commissioner's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Health and Disability Commissioner under section 19A of the Public Finance Act 1989.

We have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Health and Disability Commissioner for the year ended 30 June 2016.

Anthony Hill

Health and Disability Commissioner

Jason Zhang

Corporate Services Manager

31 October 2016

8.0 Audit Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the
Health and Disability Commissioner's financial statements and performance information
for the year ended 30 June 2016

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, Athol Graham, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health and Disability Commissioner on her behalf.

Opinion on the financial statements and the performance information

We have audited:

- the financial statements of the Health and Disability Commissioner on pages 48 to 64, that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health and Disability Commissioner on pages 34 to 44.

In our opinion:

- the financial statements of the Health and Disability Commissioner:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2016; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards Reduced Disclosure Regime.
- the performance information:
  - presents fairly, in all material respects, the Health and Disability Commissioner's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
      - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
      - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
  - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 31 October 2016. This is the date at which our opinion is expressed. The basis of our opinion is explained below. In addition, we outline the responsibilities of the Health and Disability Commissioner and our responsibilities, and explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and the performance information are free from material misstatement. Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and the performance information. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

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

An audit also involves evaluating:

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

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

We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Health and Disability Commissioner

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

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

The Health and Disability Commissioner's responsibilities arise from the Crown Entities Act 2004 and the Public Finance Act 1989.

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board. Other than the audit, we have no relationship with or interests in the Health and Disability Commissioner.

Athol Graham
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

9.0 Financial Statements

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE
FOR THE YEAR ENDED 30 JUNE 2016

	Notes	Actual 2016 $	Budget 2016 $	Actual 2015 $
Revenue				
Funding from the Crown		11,670,000	11,670,000	11,670,000
Other revenue		245,742	146,000	513,870
Total revenue	2	11,915,742	11,816,000	12,183,870
Expenditure				
Personnel costs	3	5,845,081	5,896,000	5,717,614
Depreciation and amortisation expense	8, 9	279,188	263,000	238,276
Advocacy services		3,339,998	3,340,000	3,546,298
Other expenses	4	2,125,156	2,317,000	2,326,391
Total expenditure		11,589,423	11,816,000	11,828,579
Surplus/ (deficit)		**326,319**	**0**	**355,291**
Total comprehensive revenue and expense		**326,319**	**0**	**355,291**

Explanations of major variances against budget are provided in Note 17.
The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2016

	Notes	Actual 2016 $	Budget 2016 $	Actual 2015 $
Assets				
Current assets				
Cash and cash equivalents	5	1,858,863	1,286,000	1,343,988
Receivables	6	30,181	85,000	37,327
Prepayments		92,661	80,000	92,897
Inventories	7	14,677	45,000	21,487
Total current assets		1,996,382	1,496,000	1,495,699
Non-current assets				
Property, plant and equipment	8	227,265	236,000	316,120
Intangible assets	9	54,056	42,000	194,616
Total non-current assets		281,321	278,000	510,736
Total assets		**2,277,703**	**1,774,000**	**2,006,435**
Liabilities				
Current liabilities				
Payables	10	496,181	450,000	586,667
Employee entitlements	11	342,197	250,000	290,306
Total current liabilities		838,378	700,000	876,973
Non-current liabilities				
Payables	10	20,758	0	37,214
Total non-current liabilities		20,758	0	37,214
Total liabilities		**859,136**	**700,000**	**914,187**
Net assets		1,418,567	1,074,000	1,092,248
Equity				
Contributed capital	13	788,000	788,000	788,000
Accumulated surplus/(deficit)	13	630,567	286,000	304,248
Total equity		**1,418,567**	**1,074,000**	**1,092,248**

Explanations of major variances against budget are provided in Note 17.
The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2016

	Notes	Actual 2016 $	Budget 2016 $	Actual 2015 $
Balance at 1 July		1,092,248	1,074,000	736,957
Total comprehensive revenue and expense for the year		326,319	0	355,291
Balance at 30 June	**13**	**1,418,567**	**1,074,000**	**1,092,248**

Explanations of major variances against budget are provided in Note 17.
The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2016

	Notes	Actual 2016 $	Budget 2016 $	Actual 2015 $
Cash flows from operating activities				
Receipts from the Crown		11,670,000	11,670,000	11,670,000
Interest received		72,469	40,000	51,900
Receipts from other revenue		200,892	106,000	475,191
Payments to suppliers		(5,553,067)	(5,839,000)	(5,933,461)
Payments to employees		(5,793,190)	(5,896,000)	(5,695,873)
GST (net)		(31,103)	0	34,534
Net cash from operating activities		566,001	81,000	602,291
Cash flows from investing activities				
Purchase of property, plant and equipment		(34,276)	(40,000)	(90,139)
Purchase of intangible assets		(16,850)	(10,000)	(172,945)
Net cash from investing activities		(51,126)	(50,000)	(263,084)
Cash flows from financing activities				
Receipts from capital contribution		0	0	0
Net cash from financing activities		0	0	0
Net increase/(decrease) in cash and cash equivalents		**514,875**	**31,000**	**339,207**
Cash and cash equivalents at beginning of the year		1,343,988	1,255,000	1,004,781
Cash and cash equivalents at end of the year	**5**	**1,858,863**	**1,286,000**	**1,343,988**

Explanations of major variances against budget are provided in Note 17.
The accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

Notes index

NOTES TO THE FINANCIAL STATEMENTS

1. Statement of accounting policies

REPORTING ENTITY

The Health and Disability Commissioner (HDC) has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for the Health and Disability Commissioner are for the year ended 30 June 2016, and were approved by the Commissioner on 31 October 2016.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the year.

Statement of compliance

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

The financial statements have been prepared in accordance with PBE Standards Reduced Disclosure Regime (RDR). The criteria under which HDC is eligible to report in accordance with PBE Standards RDR is that its total expenses are less than NZD30m.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest dollar ($).

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below.

Foreign currency transactions

Foreign currency transactions (including those subject to forward foreign exchange contracts) are translated into NZ$ (the functional currency) using the spot exchange rates at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Goods and service tax (GST)

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost allocation

HDC has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are costs directly attributed to an output. Indirect costs are costs that cannot be attributed to a specific output in an economically feasible manner.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

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

Critical accounting estimates and assumptions

In preparing these financial statements the Health and Disability Commissioner has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed in the relevant notes.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are:

- Useful lives and residual values of property, plant and equipment – refer to Note 8.
- Useful lives of software assets – refer to Note 9.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

- Leases classification – refer to Note 4.

2. Revenue

Accounting policy

The specific accounting policies for significant revenue items are explained below:

Funding from the Crown (Non-exchange revenue)
The Health and Disability Commissioner is primarily funded from the Crown. This funding is restricted in its use for the purpose of the Health and Disability Commissioner meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

The Health and Disability Commissioner considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

The fair value of revenue from the Crown has been determined to be equivalent to the amounts due in the funding arrangements.

Interest revenue
Interest revenue is recognised using the effective interest method.

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

Sundry revenue
Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date.

Breakdown of other revenue and further information

	Actual 2016 $	Actual 2015 $
Sale of publications	92,168	88,173
Interest revenue	67,524	56,881
Advocacy Trust contribution	70,000	250,000
Sundry revenue	16,050	118,816
Total other revenue	**245,742**	**513,870**

3. Personnel costs

Accounting policy

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

Breakdown of personnel costs and further information

	Actual 2016 $	Actual 2015 $
Salaries and wages	5,623,054	5,528,385
Defined contribution plan employer contributions	170,136	167,489
Increase/(decrease) in employee entitlements	51,891	21,740
Total personnel costs	**5,845,081**	**5,717,614**

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

Employee Remuneration

	Actual 2016	Actual 2015
Total remuneration paid or payable:		
100,000-109,999	1	2
110,000-119,999	4	2
120,000-129,999	1	1
130,000-139,999	0	1
140,000-149,999	1	1
150,000-159,999	1	0
170,000-179,999	1	0
180,000-189,999	0	1
200,000-209,999	1	0
210,000-219,999	0	2
230,000-239,999	1	0
240,000-249,999	0	1
340,000-349,999	0	1
360,000-369,999	1	0
Total employees	**12**	**12**

During the year ended 30 June 2016, no employee received compensation and other benefits in relation to cessation (2015: nil).

Commissioner's total remuneration

In accordance with the disclosure requirements of sections 152(1)(a) of the Crown Entities Act 2004, the total remuneration includes all benefits paid during the period 1 July 2015 to 30 June 2016.

	Actual 2016 $	Actual 2015 $
Commissioner	361,105	346,986
Total	**361,105**	**346,986**

4. Other expenses

Accounting policy

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

	Actual 2016 $	Actual 2015 $
Audit Fees	43,248	43,197
Staff travel and accommodation	144,279	167,718
Operating lease expense	412,092	393,475
Advertising	22,931	21,377
Consultancy	635,269	610,504
Inventories consumed	54,762	98,197
Net loss on property, plant and equipment	1,734	1,354
Communications & IT	495,438	640,865
Other expenses	315,403	349,704
Total other expenses	**2,125,156**	**2,326,391**

Operating leases as lessee

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

	Actual 2016 $	Actual 2015 $
Not later than one year	475,531	267,273
Later than one year and not later than five years	420,310	279,178
Total non-cancellable operating leases	**895,841**	**546,451**

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

A significant portion of the total non-cancellable operating lease expense relates to the lease of these two offices, a telephone system and a number of Canon MFDs (2015: two office leases and a telephone system). The Auckland office lease expires in June 2017 and the Wellington lease expires in March 2019.

5. Cash and cash equivalents

Accounting policy

Cash and cash equivalents includes cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

	Actual 2016 $	Actual 2015 $
Cash on hand and at bank	858,863	343,988
Term deposits with maturities less than 3 months	1,000,000	1,000,000
Total cash and cash equivalents	**1,858,863**	**1,343,988**

At 30 June 2016, the Health and Disability Commissioner holds no unspent grant funding received that is subject to restrictions (2015 $nil).

6. Receivables

Accounting policy

Short-term receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that the Health and Disability Commissioner will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

	Actual 2016 $	Actual 2015 $
Trade receivables	22,322	24,524
Other receivables	7,859	12,803
Total receivables	**30,181**	**37,327**
Total receivables comprises:		
Receivables from the sale of goods and services (exchange transactions)	**30,181**	**37,327**

There is no impairment provision at balance date (2015: nil).

7. Inventories

Accounting policy

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method) adjusted, when applicable, for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition. Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost (using the FIFO method) and net realisable value.

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

	Actual 2016 $	Actual 2015 $
Commercial inventories		
Publications held for sale	14,677	21,487
Total inventories	**14,677**	**21,487**

The write-down of inventories amounted to $1,661 (2015: $nil). There have been no reversals of write-down.

No inventories are pledged as security for liabilities (2015: $nil).

8. Property, plant and equipment

Accounting policy

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

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

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

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

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

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

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

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

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

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

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

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

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

- physical inspection of assets; and
- asset replacement programmes.

The Health and Disability Commissioner has not made significant changes to past assumptions concerning useful lives and residual values.

Movements for each class of property, plant and equipment are as follows:

	Computer hardware	Comms equip	Furniture and fittings	Leasehold improvements	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Cost or valuation							
Balance at 1 July 2014	1,018,203	2,223	188,358	648,518	40,889	146,527	2,044,718
Balance at 30 June 2015	460,813	1,980	155,099	647,199	40,889	58,391	1,364,371
Additions	18,525	693	0	9,194	0	6,825	35,237
Disposals	(34,963)	0	(10,776)	0	0	(2,547)	(48,286)
Balance at 30 June 2016	444,375	2,673	144,323	656,393	40,889	62,669	1,351,322
Accumulated depreciation and impairment losses							
Balance at 1 July 2014	746,092	1,337	181,562	588,268	40,889	141,583	1,699,731
Balance at 30 June 2015	194,175	1,191	149,736	610,339	40,889	51,921	1,048,251
Depreciation expense	93,955	578	1,538	21,544	0	4,163	121,778
Disposals	(32,649)	0	(10,776)	0	0	(2,547)	(45,972)
Balance at 30 June 2016	255,481	1,769	140,498	631,883	40,889	53,537	1,124,057
Carrying amounts							
At 1 July 2014	272,111	886	6,796	60,250	0	4,944	344,987
At 30 June 2015/1 July 2015	266,638	789	5,363	36,860	0	6,470	316,120
At 30 June 2016	188,894	904	3,825	24,510	0	9,132	227,265

There are no restrictions on the Health and Disability Commissioner's property, plant and equipment.

During the year, HDC disposed of some computer hardware that had reached the end of its useful life.

The net loss on all disposals was $1,735 (2015: $1,354).

There are no capital commitments at balance date (2015: nil).

9. Intangible assets

Accounting policy

Software acquisition and development

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

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development, employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

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

Costs associated with the maintenance of the HDC's website are recognised as an expense when incurred.

Amortisation

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

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

- Acquired computer software 2 years 50%
- Developed computer software 2 years 50%

Movements for each class of intangible asset are as follows:

	Acquired software	Internally generated software	Total
	$	$	$
Cost			
Balance at 1 July 2014	659,951	100,000	759,951
Balance at 30 June 2015/1 July 2015	518,347	248,516	766,863
Additions	16,850	0	16,850
Balance at 30 June 2016	535,197	248,516	783,713
Accumulated amortisation and impairment losses			
Balance at 1 July 2014	617,655	0	617,655
Balance at 30 June 2015/1 July 2015	479,053	93,194	572,247
Amortisation expense	33,152	124,258	157,410
Disposals	0	0	0
Balance at 30 June 2016	512,205	217,452	729,657
Carrying amounts			
At 1 July 2014	42,296	100,000	142,296
At 30 June 2015/1 July 2015	39,294	155,322	194,616
At 30 June 2016	22,992	31,064	54,056

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

HDC has one capital commitment of $12,350 related to the ECDS development as at 30 June 2016 (2015: nil).

10. Payables

Accounting policy

Short-term payables are recorded at their face value.

Breakdown of payables and deferred revenue

	Actual 2016 $	Actual 2015 $
Payables under exchange transactions		
Creditors	241,884	354,193
Accrued expenses	75,829	45,248
Lease incentive	45,398	37,213
Total payables under exchange transactions	363,111	436,654
Payables under non-exchange transactions		
Taxes payable (GST, PAYE and rates)	133,070	150,013
Total payables under non-exchange transactions	133,070	150,013
Total current payables	**496,181**	**586,667**
Lease Incentives	20,758	37,214
Total non-current payables	**20,758**	**37,214**
Total payables	**516,939**	**623,881**

11. Employee entitlements

Accounting policy

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date and sick leave.

Employee Entitlements

	Actual 2016 $	Actual 2015 $
Current portion		
Annual leave	342,197	290,306
Total employee entitlements	**342,197**	**290,306**

12. Contingencies

Contingent liabilities

As at 30 June 2016 there were no contingent liabilities (2015: nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2015: nil).

13. Equity

Accounting policy

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- contributed capital; and
- accumulated surplus or deficit.

	Actual 2016 $	Actual 2015 $
Contributed capital		
Balance at 1 July	788,000	788,000
Capital contribution	0	0
Balance at 30 June	788,000	788,000
Accumulated surplus/(deficit)		
Balance at 1 July	304,248	(51,043)
Surplus/(deficit) for the year	326,319	355,291
Balance at 30 June	630,567	304,248
Total equity	**1,418,567**	**1,092,248**

14. Related party transactions

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

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect HDC would have received in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Ministry of Health, Inland Revenue Department, ACC and New Zealand Post) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel compensation

	Actual 2016 $	Actual 2015 $
Leadership Team		
Remuneration	1,547,248	1,775,782
Full-time equivalent members	6.80	8.54
Total key management personnel compensation	**1,547,248**	**1,775,782**
Total full time equivalent personnel	**6.80**	**8.54**

15. Financial instruments

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

	Actual 2016 $	Actual 2015 $
Loans and receivables		
Cash and cash equivalents	858,863	343,988
Receivables	30,181	37,327
Investments – term deposits	1,000,000	1,000,000
Total loans and receivables	1,889,044	1,381,315
Financial liabilities measured at amortised cost		
Payables (excluding income in advance, lease incentive, taxes payable and grants received subject to conditions)	317,713	399,441
Total financial liabilities measured at amortised cost	317,713	399,441

16. Events after the balance date

There were no significant events after the balance date.

17. Explanation of major variances against budget

Explanations for major variances from HDC's budgeted figures in the statement of performance expectation are as follows:

Statement of comprehensive revenue and expense

Other revenue
More revenue was received than budgeted, mainly arising from a cost recovery contribution from the National Advocacy Trust.

Total expenditure
A favourable variance in personnel costs due to position vacancies, some of which were filled by hiring external temporary contractors.

A delay in leasing the additional office space in Wellington resulted in further savings.

Statement of financial position

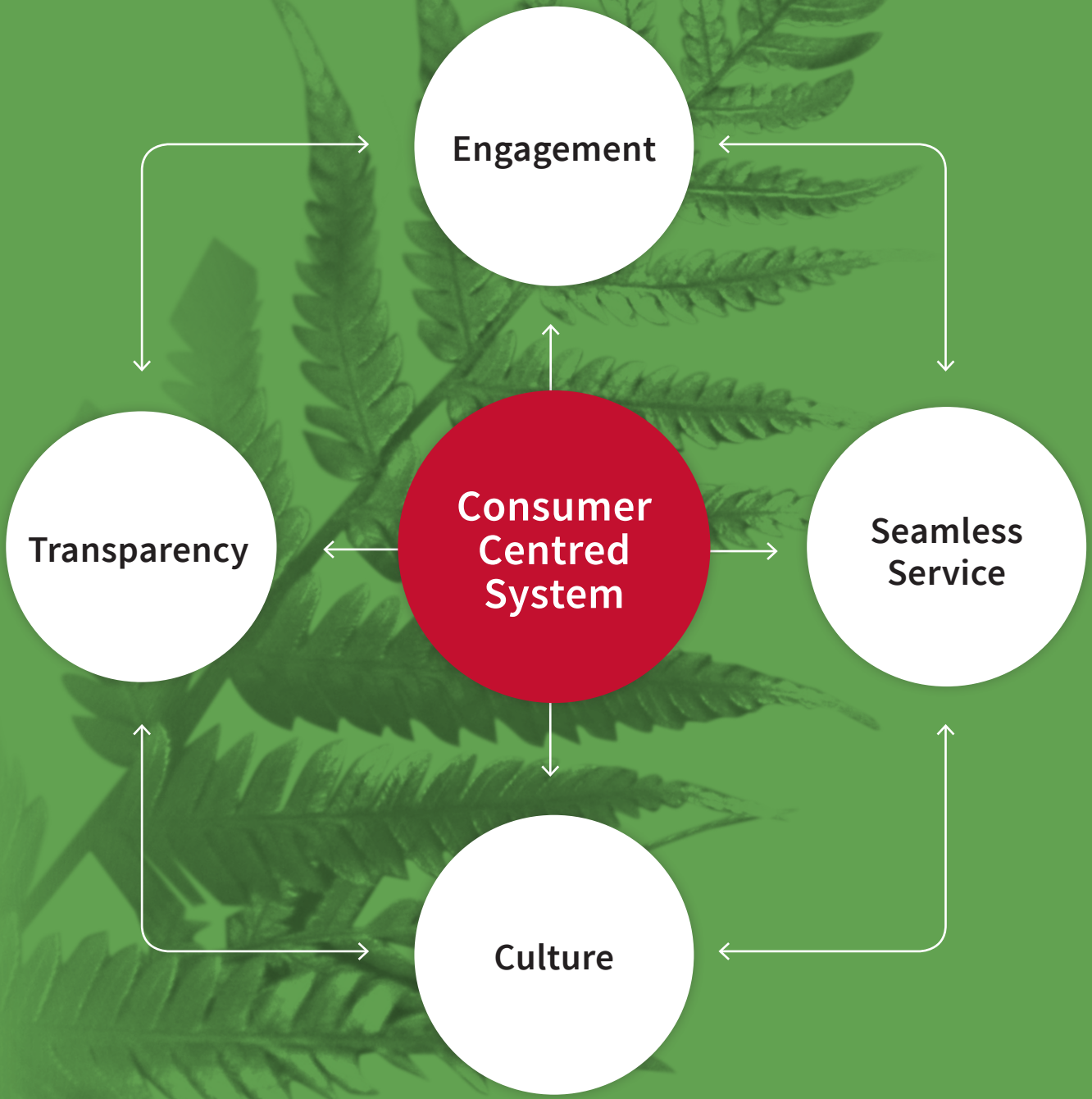
The closing cash balance was higher than budgeted largely due to the higher than budgeted surplus for the year, as detailed above.

Statement of equity

The closing equity balance was higher than budgeted because of the surplus for the year and a higher opening balance.

Statement of cash flows

The higher net cash movement was mainly attributed to the one-off cost recovery contribution from the National Advocacy Trust, favourable personnel cost variance and occupancy savings.


Engagement
Transparency
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Culture

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