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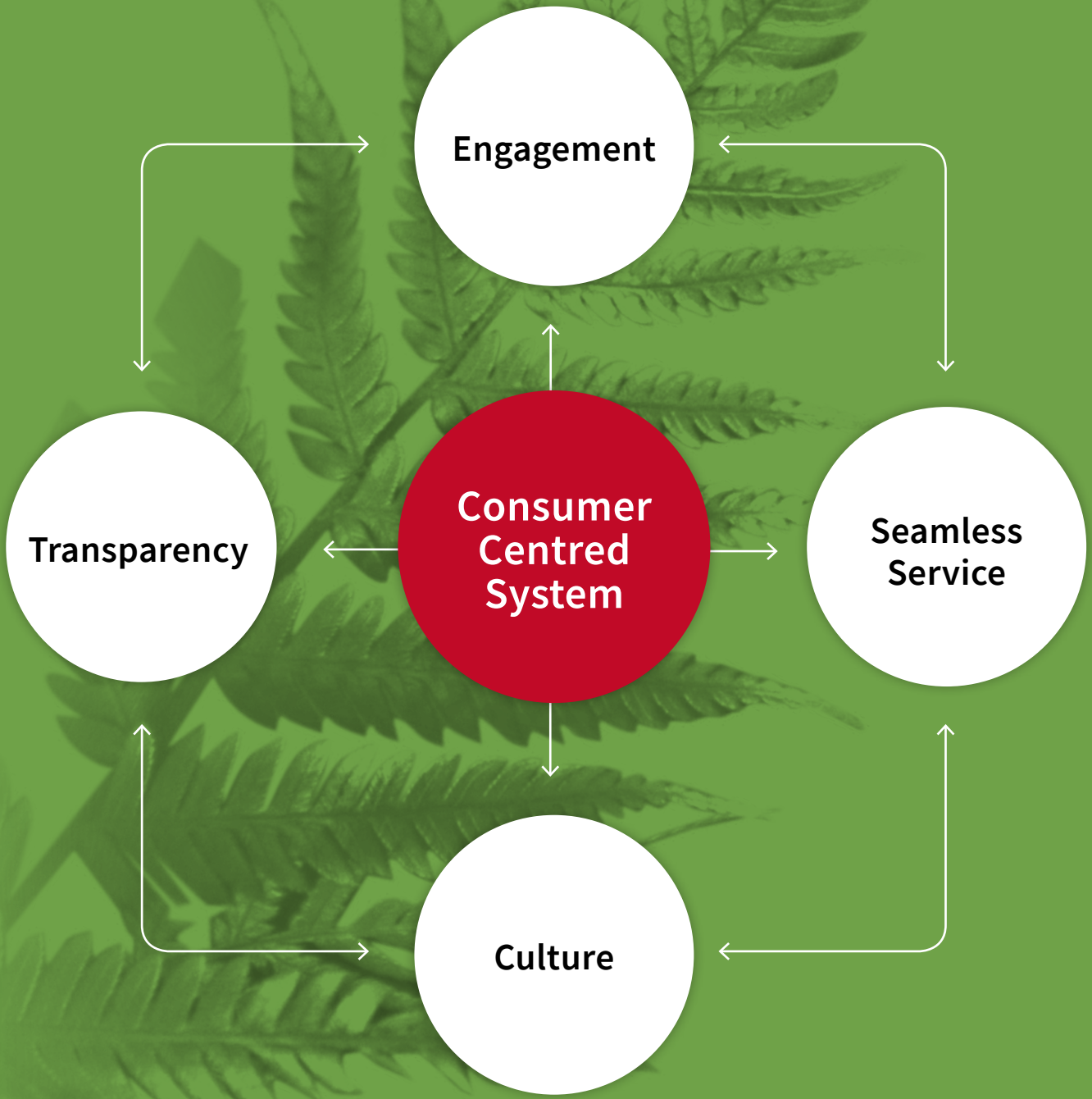
HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

ANNUAL REPORT FOR THE YEAR ENDED 30 JUNE 2017


Engagement
Transparency
Consumer Centred System
Seamless Service
Culture

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

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PO Box 1791, Auckland 1140

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

31 October 2017

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 2017.

Yours faithfully

Anthony Hill
Health and Disability Commissioner

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Commissioner's Foreword

Anthony Hill
Health and Disability Commissioner

I remain focused on cultures that embody transparency, engagement, and seamless service.

I have the privileged role of promoting and protecting the rights of health and disability services consumers. This year marked the 20-year anniversary of the Code of Health and Disability Services Consumers' Rights. HDC's journey began in 1988 with the Cartwright Inquiry, a commission of inquiry into an experiment on women with cervical cancer at New Zealand's National Women's Hospital. Dame Silvia Cartwright, who was at the time a judge of the District Court of New Zealand, advocated in her report on the inquiry for "a system which will encourage better communication between patient and doctor, allow for structured negotiation and mediation, and raise awareness of patients' medical, cultural and family needs. The focus of attention must shift from the doctor to the patient." She stated "health professionals need to listen to their patients, communicate with them, protect them, offer them the best healthcare within their resources, and bravely confront colleagues if standards slip". I continue to promote this today. The importance of informed consent and a consumer-centred culture continue to be major themes in the complaints I receive.

This year, HDC continued its work of engaging with the public and the health and disability services sector to consider the protection the Code offers in relation to informed consent. Under Right 7(4) of the Code, in some circumstances it is appropriate and lawful to provide health or disability services to a consumer without consent. An example is the provision of treatment to an unconscious patient. However, the inclusion of a person who cannot give consent in health and disability research is more complex. At present under Right 7(4), research involving a person who is unable to give consent can take place only if participation in the research is in that person's best interests. This year I released a consultation document on this issue. The consultation focused on two fundamental questions: are New Zealand's current laws regarding non-consensual research appropriate and, if not, how should they be amended? A report on this consultation will be released next year.

The principle of informed consent lies at the heart of the Code, and services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent. We have continued to hold a number of providers to account for their failure to obtain informed consent before providing services. This year I found a gynaecologist in breach of the Code for inserting an intrauterine device while a woman was under general anaesthetic, despite the fact that the woman had not provided informed consent for the procedure to be undertaken. When the woman awoke from the anaesthetic she was very distressed by what had happened, and the IUD was removed. The gynaecologist was referred to the Director of Proceedings. Another complaint closed this year concerned an orthopaedic surgeon who failed to inform a consumer that he may have operated on the wrong level of her spine, and that he intended to undertake further testing in order to clarify this. The woman was unable to make an informed choice, as the surgeon failed to disclose to her that this may have happened, and took action to assess the mistake without informing her.

In the margins where the health and disability sector does not do well, culture and leadership continue to play a part. Deficiencies in culture can be seen in an environment where junior staff do not feel able to ask questions and raise concerns with senior staff, or are not listened to when they do; it is seen when the system does not support staff to work together effectively, not allowing them to foster good working relationships and clear lines of communication; and it is seen in instances when a culture of tolerance emerges and the suboptimal becomes normal, when not following policies and procedures becomes everyday practice. That is why I remain focused on cultures that embody transparency, engagement, and seamless service as they put consumers at the centre of services.

The consumer's voice is a powerful one for bringing change, and continues to be the driving force behind much of my work. Consumers' primary motivation in making complaints is often to ensure that the events that happened to them do not happen to somebody else. Every complaint is an opportunity to learn, and preventative action is an important outcome of the complaints process. This year, my Office made recommendations for change and/or educational comments to providers on 445 complaints.

Through such preventative action, this Office embodies the spirit of Dame Cartwright's report by continuing to recommend systemic change as a result of complaints received. This year, I found a district health board's failure to have a clear, effective, and formalised system in place for the reporting and following up of

test results to be a breach of the Code. In this case, the lack of clarity between the roles of an emergency department and a general practitioner played a part in an unwell man falling through the cracks, and the diagnosis of his cancer being delayed. I recommended that the DHB review its ED policy to ensure that there is a clear process for the handover of care from ED to GPs, including follow-up of tests and X-rays ordered in ED. Looking to the wider picture, I also recommended that the National Chief Medical Officer Group work to put in place clear practice guidelines regarding the interface between EDs and GPs in relation to follow-up of test results, within all DHBs.

HDC advocates for improvement and responsive leadership in the health and disability sector. This year, Mental Health Commissioner Kevin Allan called for an action plan to set the direction for mental health and addiction services. The action plan would address access, the right mix of services, capacity, quality, and leadership.

Growth in complaints

The 2016/17 year has been one of significant growth for HDC. This year, 2,211 complaints were received, an increase of 13% on the previous year. HDC had a successful year while operating in an environment of ongoing increasing complaint volumes. At 30 June 2017, the growth in complaints received over the preceding five years was 41% (an average increase of 7.2% per annum).

Acknowledgements

I acknowledge the dedication demonstrated by HDC staff, and their contribution to the year's achievements. I also acknowledge the invaluable contribution of the experts who provide advice to HDC.

The Advocacy Service has a significant role in supporting consumers to resolve their concerns about health or disability services, and is an effective process for those complaints that are suitable for resolution between the parties. This year it closed 2,739 complaints and over 10,000 public enquiries. The Advocacy Service has excellent outcomes, both in its resolution rates and in consumer and provider satisfaction with the process.

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.

HDC advocates for improvement and responsive leadership in the health and disability sector.

1.0 The Year in Review

September 2016 marked the 20th anniversary of the Code of Health and Disability Services Consumers' Rights.

HDC had a successful year in 2016/17, while dealing with a significant increase in complaint volumes.

HDC received 2,211 complaints — an increase of 13% on the previous year. HDC also supported consumers in responding to a further 4,000 enquiries.

In 2016/17, 2,015 complaints were closed, 85% within six months.

Eighty formal investigations were completed — 61 resulted in breach opinions, and 11 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.

The Nationwide Health and Disability Advocacy Service (the Advocacy Service) closed 2,739 complaints and responded to over 10,000 public enquiries. Ninety-eight percent of complaints were closed within six months, and 91% of complaints were either resolved successfully between the parties or were withdrawn by the complainant.

September 2016 marked the 20th anniversary of the Code of Health and Disability Services Consumers' Rights (the Code), with the anniversary used to acknowledge and promote the significance of the Code.

HDC continued to work with district health boards (DHBs), providing detailed six-monthly reports on the numbers and types of complaints received in relation to DHB services. We also published our annual report of complaints about DHB services.

In 2016/17, HDC published two reports on areas of research interest to HDC. One report analysed the complaints received about residential aged care facilities, and the other report analysed complaints received about doctors. The reports were widely disseminated to the sector, ensuring that complaint trends were reported back to the sector in a way that supports quality improvement.

HDC continues to deliver relevant presentations to various provider and consumer groups. Topics include the Health and Disability Commissioner Act 1994 (the Act) and the Code, and HDC's role.

There is an ongoing focus on supporting providers to deal with complaints directly. Complaints management workshops are presented, and complaints management guides produced, to assist service providers to manage complaints. This year we focused on disability service providers, with new guides to help them to evaluate and improve their knowledge of their complaints management system, and assist them to respond to complaints appropriately.

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

HDC continues to be managed with prudent financial controls, ensuring that costs are maintained within approved budgets, with a focus on financial sustainability. We seek further efficiency continuously as we deal with the increasing demand for the delivery of services.

In February 2017, HDC commenced a public consultation with regard to the circumstances in which research can be conducted with participants who are unable to give informed consent. At present, Right 7(4) of the Code requires that the research be in the best interests of each participant. It has been argued that, given that the outcomes of research are speculative, the effect of Right 7(4) is to prevent some valuable and ethical research from proceeding. The public submissions have been analysed, and a report will be released next year.

2.0 Who We Are

Background

The landmark report from Dame Silvia Cartwright (then Judge Silvia Cartwright) on the cervical cancer inquiry changed the landscape of the consumer–provider relationship in New Zealand. As a result, HDC was established as an independent Crown entity by the Act.

New Zealand's no-fault accident compensation scheme takes away the right to sue a health provider for causing a treatment injury (except for exemplary damages in limited circumstances). In this legal environment, HDC provides the only practicable independent legislative means by which a consumer can request that the actions of a health provider be reviewed, and that the provider be held to account.

In addition to establishing HDC, the Act also creates two positions to act independently of the Commissioner:

- A Director of Proceedings, responsible for taking civil proceedings in the Human Rights Review Tribunal (HRRT) and disciplinary proceedings in the Health Practitioners Disciplinary Tribunal (HPDT)
- A Director of Advocacy, responsible for entering into and administering advocacy services agreements and monitoring the operation of advocacy services. The Act also provides for an advocacy service to operate independently of HDC and providers.

The HDC complaints resolution service was put in place in 1996. The Act was amended in 2003, giving the Commissioner a wider range of options for resolving complaints. On 1 July 2012, some of the functions of the former Mental Health Commission were transferred to HDC, and the Act was amended to give HDC responsibility for monitoring and systemic advocacy in relation to mental health and addiction services.

The Code

The Code applies to all health and disability service providers.

The ten rights under the Code are described in Figure 1. It was the first legislated code in the world giving consumers' rights the force of law. Code rights can be upheld via the complaints process, and by proceedings taken by the Director of Proceedings before the two Tribunals. The HRRT may declare that conduct breached the Code and grant various remedies, including damages.

Figure 1: The Code of Health and Disability Services Consumers' Rights.

Our purpose, role and functions

HDC's purpose is to promote and protect the rights of health and disability services consumers.

HDC plays an important role in New Zealand's health and disability system as an independent consumer watchdog, providing health and disability services consumers with a voice, resolving complaints, and holding providers to account for improving their practices at an individual and system-wide level. The Commissioner is independent of providers, of consumers, and of government policy, allowing him to be an effective watchdog in relation to consumers' rights.

To perform this role, we carry out six core functions:

1. **Complaints resolution**
   Complaints resolution remains the central function for HDC, and provides the platform for achieving our strategic objectives. HDC focuses on the fair and early resolution of complaints. Options for achieving resolution include referring the matter for advocacy support; referring the matter to the provider for resolution between the provider and consumer; referring to an appropriate regulatory body for further action; taking no action or no further action; making recommendations and educational comments; or formal investigation. The Commissioner can also undertake investigations on his own initiative, without the receipt of a complaint.

2. **Advocacy**
   Currently HDC's Director of Advocacy contracts with the National Advocacy Trust to provide an independent Advocacy Service. Advocacy is a highly successful mechanism for ensuring the fair, simple, speedy, and efficient resolution of complaints. The Advocacy Service plays a crucial role in managing complaints that are suitable for resolution between the parties, with advocates located in community-based offices assisting consumers to work with providers to achieve resolution. Advocates also offer community-based education and training about consumer rights and provider duties, to both consumers and providers of health and disability services.

3. **Proceedings**
   Sometimes there are cases in which formal proceedings against a provider are necessary to promote and protect consumer rights. The Director of Proceedings, appointed under the Act, exercises independent statutory functions. Where the Commissioner has found a breach of the Code, the Commissioner may refer the provider to the Director of Proceedings. The Director then makes an independent decision on whether to take proceedings.

4. **Monitoring and advocacy**
   We have a statutory role to monitor and advocate for improvements to mental health and addiction services. This role is delegated to the Mental Health Commissioner. Service monitoring is based on analysing themes and trends from HDC complaints, and assessing service performance information, and through sector engagement. Our advocacy work is informed by the results of that monitoring.

5. **Education**
   We deliver a variety of education and training initiatives aimed at improving providers' and professionals' knowledge of their responsibilities, and consumers' knowledge of their rights. Education initiatives are delivered to groups at national and community levels, and directly to consumers and providers (through response to individual enquiries). Promoting learning from complaint trends is also an important facet of our education function, and to this end we produce complaint trend reports in order to ensure that these learnings are reported back to the sector and to the general public in a way that supports quality improvement.

6. **Disability**
   The Deputy Health and Disability Commissioner, Disability, has a particular focus on promoting awareness, respect for, and observance of, the rights of disability services consumers. The role is also responsible for HDC's contribution toward the implementation of the New Zealand Disability Strategy 2016–2026 and the United Nations Convention on the Rights of Persons with Disabilities.

Our values

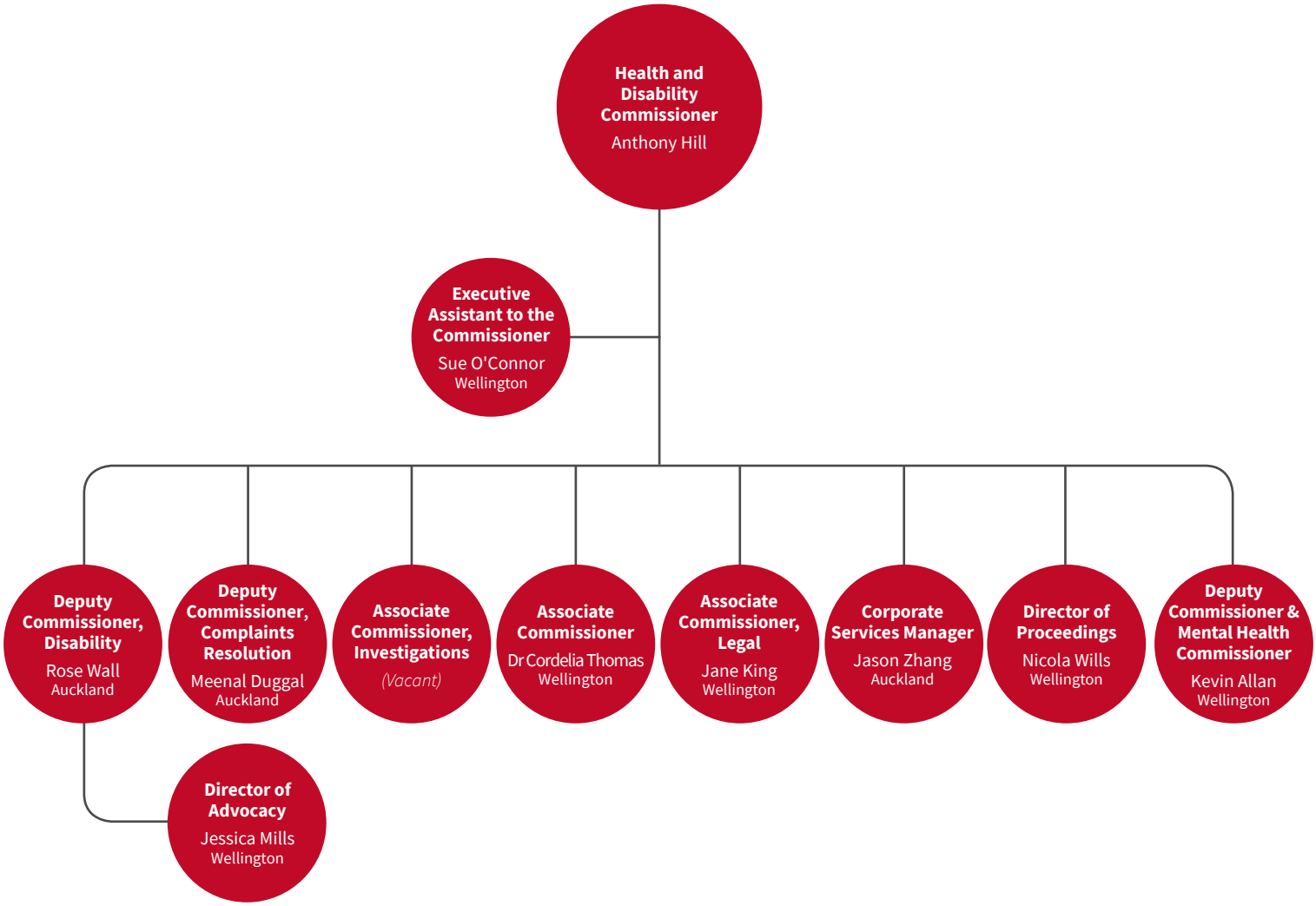
Our values guide our approach and the way we respond to all those with whom we interact, both internally and externally. We are:

- Fair
- Responsive
- Professional
- Empathetic

Our funding

HDC is funded under the Monitoring and Protecting Health and Disability Consumer Interests Appropriation in Vote Health. This appropriation is intended to protect the rights of consumers using health and disability services. This includes addressing the concerns of whānau and appropriately investigating alleged breaches of consumers' rights. HDC received funding of $12,070,000 from this appropriation in the year ended 30 June 2017. In addition, HDC earned other income of $324,362. This combined income was used to fund HDC's expenditure of $12,509,907.

HDC Organisation Structure



3.0 Delivering Our Strategy

Our strategic intent

HDC's vision is consumers at the centre of services. Consumer-centred services are characterised by transparency, engagement, seamless service, and a culture that supports the consumer-centred vision. The overriding strategic intent of HDC is to promote and protect the rights of consumers 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. There are three main strategic objectives that feed into this overriding strategic intent:

1. To protect the rights of health consumers and disability services consumers under the Act and the Code.[1]
2. To improve quality within the health and disability sectors.
3. To hold providers to account appropriately.

During the financial year, HDC reviewed the strategic framework. This resulted in the inclusion of a fourth strategic objective which will form part of our strategic framework in the future. This objective is to promote, by education and publicity, respect for and observance of the rights of health and disability services consumers, and reflects the significant activities in the area by HDC over the years.

In line with HDC's Statement of Performance Expectations 2016–2017, HDC's strategic priorities for the 2016/17 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 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.

Our strategy

The following diagram shows how our activities link to our strategic objectives and, ultimately, our vision for the sector.

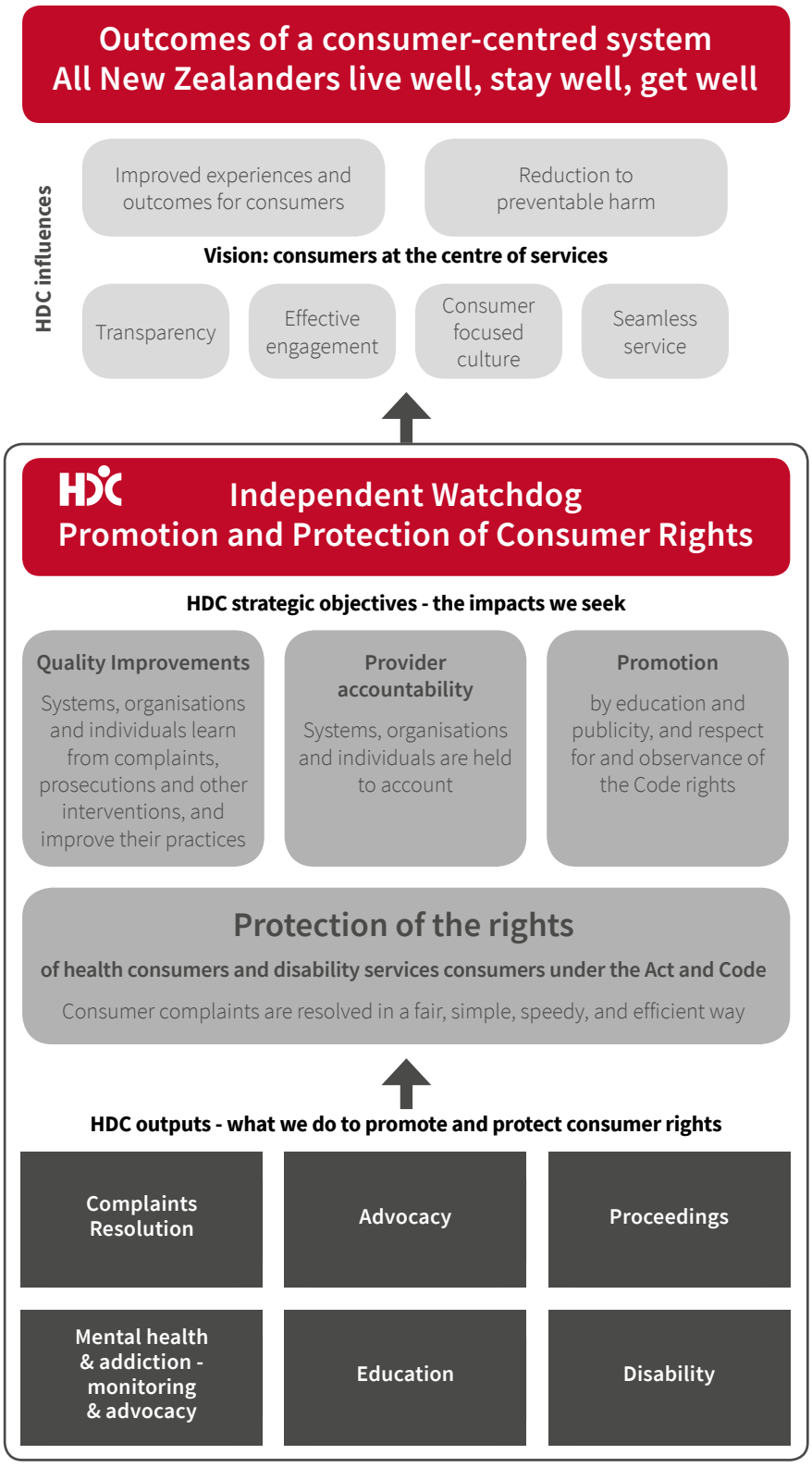


Figure 2: HDC's strategic objectives and vision.

[1] Within our 2014-18 Statement of Intent, this objective is referred to as "Resolution of Complaints". This was revised to the current statement during the financial year.

The difference we make

Through complaints resolution, 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 reduces system costs.

Alignment with Government objectives

HDC's strategic objectives and activities align with, and contribute to, the Government's goals for the health and disability system. The work of HDC contributes to the refreshed New Zealand Health Strategy 2016. HDC shares and supports the Government's vision for a better, more "fit for the future" system in New Zealand, in which all New Zealanders live well, stay well, and get well in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.

Our strategic objectives

HDC has four strategic objectives, which operate together to improve experiences and outcomes for consumers. These objectives work for individual consumers in response to a problem, and by improving the system so that it works more effectively the next time. The objectives are:

1. Protection of the rights of health service consumers and disability service consumers

The fair, effective, and timely resolution of complaints is an essential protection in a country where medico-legal litigation is largely unavailable to consumers. It is also a means of ensuring provider accountability through the Commissioner's findings of non-compliance, and quality improvement through the recommendations and educative comments that typically accompany such findings.

2. Quality improvement

Systems, organisations, and individuals learn from complaints, prosecutions and other interventions, and improve their practices. The objective of quality improvement has self-evident intrinsic value, but 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. Quality is improved by using the learning from complaints to promote best practice and consumer-centred care. Providers are also held to account for their own quality improvement through HDC's monitoring and analysis of providers' compliance with recommendations.

3. Provider accountability

Systems, organisations, and individuals are held to account. 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.

4. Promotion, by education and publicity, and respect for and observance of the Code rights

Consumers and providers understand their rights and responsibilities under the Code. For the system to operate in a consumer-centred way, the participants in that system — consumers and providers — need to understand what their rights and responsibilities are, particularly in relation to the Code. Awareness of rights enables consumers to advocate for themselves and seek support when they need it; awareness of responsibilities means that providers will be more proactive in designing and delivering a consumer-centred experience.

Quality is improved by using the learning from complaints to promote best practice and consumer-centred care.

Progress towards strategic objectives

The measurement framework set out in Table 1 below is included in our most recent Statement of Intent. Further details of HDC's performance against targets are set out in the Statement of Performance.

Table 1: HDC's strategic objectives and performance

Strategic objectives	How we measure performance	Performance commentary
Protection of the rights of health service consumers and disability service consumers	The fair, effective and timely resolution of complaints is critical to ensure protection of the rights of health and disability services consumers. Accordingly, measuring our performance in relation to complaints resolution is particularly important. We want to make sure our complaints resolution and advocacy processes are responsive to consumers and effective at achieving satisfactory resolution.	In 2016/17, HDC responded to over 4,000 enquiries where consumers were assisted to better understand their rights and encouraged to resolve concerns directly with providers. HDC closed 2,015 complaints in 2016/17. Eighty formal investigations were completed, of which 61 resulted in breach opinions. 457 complaints were referred to the provider to resolve directly and 239 were referred to the Advocacy Service to support the complainant to resolve the complaint. The Advocacy Service responded to 10,333 enquiries and closed 2,739 complaints. The Advocacy Service visited all 660 certified rest homes and all 930 certified residential care services catering to disabled people, at least once. These visits ensure contact with those residents who might otherwise find it impossible or extremely difficult to speak with and, if necessary, seek the assistance of, an advocate.
	The key measures we use to assess our impact in this area are: • Timeliness of the process.	HDC closed 71% of complaints received within 3 months, 85% within 6 months, and 92% within 9 months. The Advocacy Service closed 82% of complaints received within 3 months, 98% within 6 months, and 100% within 9 months.
	• Participants' experience of the advocacy process.	88% of consumers and 86% of providers who responded to satisfaction surveys were satisfied or very satisfied with the Advocacy Service's complaints management process.
Quality improvement	Our work aims to improve quality of services at a local and sector level. The primary means through which we influence this is by investigating complaints, understanding the causes, and making recommendations, which are disseminated through our reports and our educational initiatives. To understand the extent to which our recommendations have led to positive change, we monitor compliance with our recommendations. This enables us to understand the extent to which our recommendations have been adopted into practice.	Between 1 July 2016 and 30 June 2017, 228 complaints with quality improvement recommendations[2] were due by 164 providers, and 227 (99.6%) were complied with. There was only one provider who did not comply with HDC's recommendations. Referral to the provider's appropriate funder is being considered. HDC will continue to monitor and follow up the providers who received HDC's recommendations to ensure their compliance.

[2] Quality improvement recommendations exclude recommendations to provide an apology, and other accountability recommendations.

Strategic objectives	How we measure performance	Performance commentary
Holding providers to account	Holding providers to account is a lever for change and improvement. While the fact of taking action (e.g., through investigations and proceedings) holds providers to account by definition, we seek to ensure that we take proceedings in circumstances that are well judged, and that the processes we initiate lead to a result that holds providers to account in fact. We measure the extent to which: • Professional misconduct was found in disciplinary proceedings taken. • A breach of the Code was found in Human Rights Review Tribunal proceedings. • An award was made when damages were sought.	HDC completed 80 formal investigations. 61 resulted in breach opinions and 11 providers were referred to the Director of Proceedings. • Professional misconduct was found in 100% (3 of 3) of Health Practitioners Disciplinary Tribunal proceedings. • A breach of the Code was found in 100% (3 of 3) of Human Rights Review Tribunal proceedings. • Resolution by negotiated agreement was achieved in 100% (2 of 2) proceedings.
Promotion, by education and publicity, and respect for and observance of the Code rights[3]	Our educational initiatives and our interaction with consumers and providers (as part of monitoring, advocacy, and complaints handling) aim to build this awareness. The key measures include: • 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, consumer seminars held by HDC.	• HDC delivered 36 education sessions in 2016/17. These sessions included presentations to DHBs, disability service providers, professional colleges, aged care providers, and other professional bodies. 97% of respondents reported that they were satisfied or very satisfied with each session. • The Advocacy Service provided 1,635 education sessions to consumer and provider groups to ensure understanding of Code rights and responsibilities and complaint resolution actions that could be taken. 87% of consumers and providers (who responded to the survey) were satisfied with the Advocacy Service education session they attended. • HDC facilitated five regional consumer seminars in 2016/17, and 96% of the respondents reported that they were satisfied with the seminar.

Further details of performance against target are set out in the Statement of Performance, later in this report.

[3] This was not included within our 2014-18 Statement of Intent , however, it was added as a new strategic objective during the financial year.

4.0 Performance on Key Functions

HDC key activities 2016/17

As seen in Figure 2, HDC achieves its strategic objectives through six principal output classes (key activities). These are:

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

4.1 Complaints resolution

Resolving complaints remains at the heart of HDC's statutory role. HDC focuses on fair, effective and timely resolution of complaints.

This section sets out the key features of the 2016/17 year, analyses key trends, sets out the options available for complaints resolution, and provides case studies to illustrate how HDC utilises those options.

Increasing volume of complaints

Over the past five years, HDC has faced ongoing and accumulative increases in the number of complaints received (Figure 3). Since 2012/13, there has been a 37% increase in complaints received. The 2,211 complaints received in 2016/17 represent a 13% increase on the 1,958 complaints received in 2015/16. This increase in complaints is consistent with international trends, and is due to a number of factors, including the increasing public profile of HDC, increasing awareness among consumers of their rights, the accessibility of the complaints process, and the increasing health service activity. In 2016/17, HDC resolved 2,015 complaints. While HDC resolved more complaints in 2016/17 than in the preceding year, the steep increase in complaints has led to a larger volume of open complaints at the end of the year.

Issues complained about

The issues complained about in 2016/17 remained consistent with previous years (Figure 4). The majority of complaints were primarily about care/treatment issues, with missed/incorrect/delayed diagnosis and inadequate/inappropriate treatment being the most commonly complained about issues. Communication issues continue to feature prominently in complaints, with disrespectful manner/attitude featuring as the third most commonly complained about primary issue, and failure to communicate effectively with the consumer being the sixth most commonly complained about primary issue. Consumers continue to raise access issues in complaints, and this has moved from being the seventh most complained about primary issue in 2015/16 to the fifth in 2016/17.

Providers

Complaints can be about both individual providers and organisations (Figures 5 and 6). Often more than one provider is complained about within a single complaint. Where an individual provider is involved, general practitioners (GPs) continue to be the most commonly complained about providers. This may be due to the amount of patient contact with GPs, who undertake around 13 million consultations each year.

DHBs continue to be the most commonly complained about group providers, followed by medical centres and residential aged care facilities. This is consistent with previous years, and with the fact that DHBs and medical centres provide the majority of healthcare services in New Zealand.

Figure 3: Complaints received and closed from 1 July 2012 to 30 June 2017.

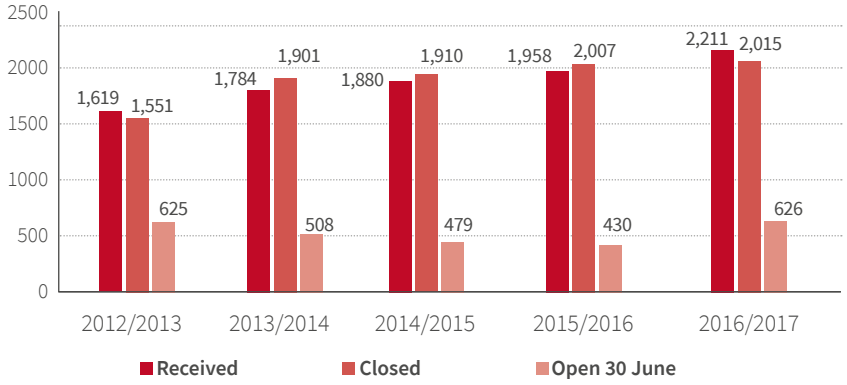


Figure 4: Complaints received – commonly complained about primary issues in 2016/17.[4]

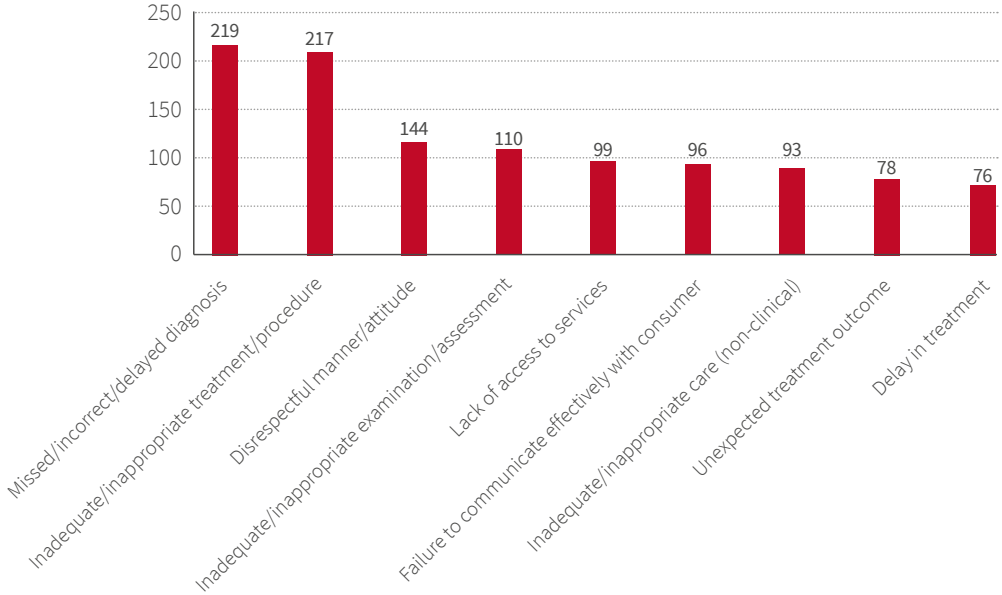
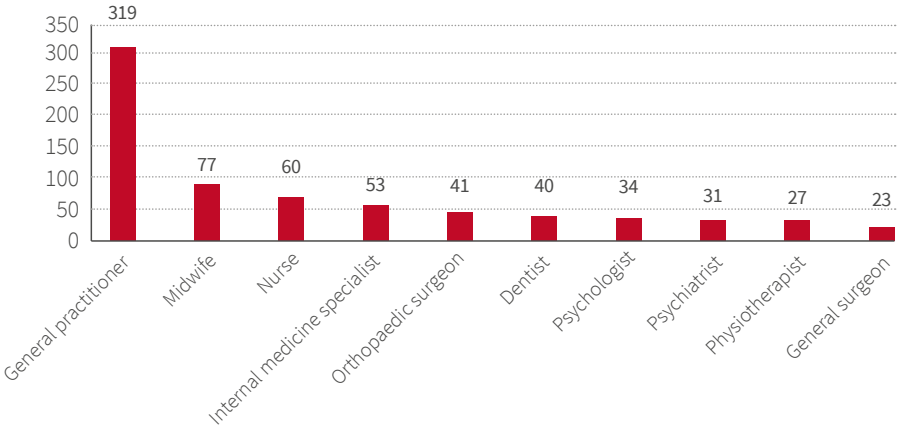


Figure 5: Complaints received – commonly complained about individual providers in 2016/17.[5]



[4] Data is provisional as of date of extraction (3 July 2017).

[5] 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 2016/17 will not equal the total number of complaints received in 2016/17. Data is provisional as of date of extraction (3 July 2017).

Figure 6: Complaints received — commonly complained about group providers in 2016/17.[6]

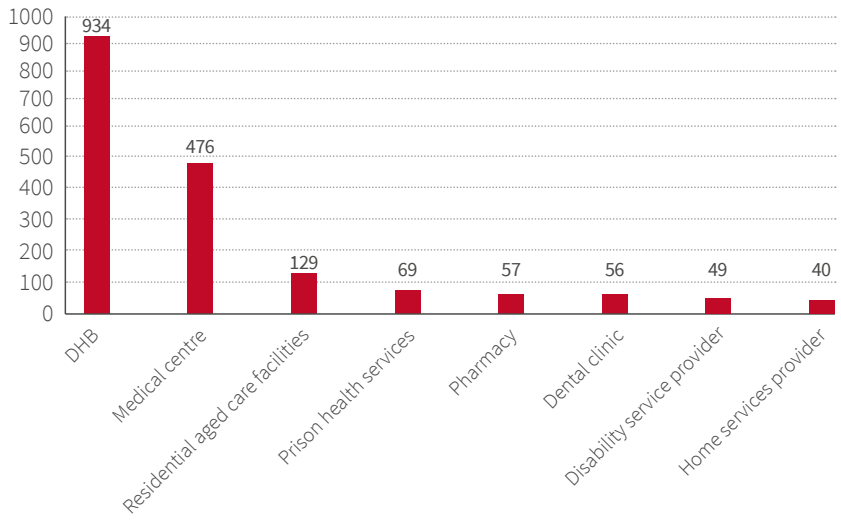


Table 2: How complaints were resolved by HDC in 2016/17.[7]

Outcome	Number of complaints
Investigation	**80**
Breach finding	61
No further action with follow-up or educational comment	10
Referred to registration authority	6
No breach finding	3
Other resolution following assessment	**1,801**
No further action with follow-up or educational comment	374
Referred to registration authority	79
Referred to other agency	49
Referred to provider to resolve	457
Referred to Advocacy	239
No further action	551
Withdrawn	52
Outside jurisdiction	**134**
TOTAL	**2,015**

The complaints resolution process

Each complaint is assessed carefully and resolved in the most appropriate manner, bearing in mind the issues raised and the evidence available. The preliminary assessment process is thorough and can involve a number of steps, including obtaining a response from the provider/s, and seeking expert advice and input/information from the consumer or other persons. Often the parties are provided with the opportunity to comment on a provisional preliminary assessment decision before it is finalised.

At the conclusion of a preliminary assessment, there are a number of options open to the Commissioner. These include: referral to the Advocacy Service or to providers for resolution between the parties; referral to other agencies, such as regulatory authorities; investigation by the Commissioner; or taking no further action in relation to the complaint. HDC requires the Advocacy Service and providers to report back to it on complaints that are referred to them for resolution, ensuring that consumers' concerns have been addressed adequately, and that any changes that the provider has agreed to make are carried out.

Where a complaint did not meet the threshold for formal investigation, the most common method of resolving the complaint was under s38(1) of the Act, with 45.9% of all complaints resolved pursuant to this provision in 2016/17. Referral to the provider for resolution was utilised in 22.7% of complaints, and referral to the Advocacy Service in 11.9% of complaints, illustrating HDC's strategic goal of resolving complaints at the lowest appropriate level.

Section 38(1) provides the Commissioner with a wide discretion to take no action or no further action on a complaint. While this is a decision to take no further formal action, decisions made under s38(1) can contain educational comments or recommendations to providers in relation to their practices and processes.

[6] 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 2016/17 will not equal the total number of complaints received in 2016/17. Data is provisional as of date of extraction (3 July 2017).

[7] 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. Data is provisional as of date of extraction (3 July 2017).

Where a decision is made to take no further action, this can be for a range of reasons. In complaints about clinical issues, this may be because expert advice has indicated the care to have been of an acceptable standard. In some complaints, the issues cannot be resolved (for example, when there are evidential issues that cannot be resolved). In other instances, the provider is able to supply information that addresses the concerns. It is also open to the Commissioner to take no action or no further action in relation to a complaint, because of the length of time since the events complained of occurred. The decision to take no further action on a complaint is often accompanied by recommendations for change, or educational comment to the providers involved. Recommendations for change and educational comments are discussed in more detail below.

Section 38(1) with recommendations and follow-up

Case study one

A woman with a family history of breast cancer had regular mammograms from a private radiology service provider. In the relevant year, the mammogram detected an asymmetrical non-specific density in one breast. This had not been present in the previous mammogram. The woman was referred for an ultrasound. The radiologist who carried out the ultrasound was reassured by the absence of lesions, and misinterpreted the area as normal tissue. Later, the patient was diagnosed with breast cancer. HDC sought a response from the provider, and expert advice from an independent radiologist.

The expert advisor noted that, given the difficulty of visualising the lesion on ultrasound, best practice would have been to recommend a biopsy. However, the advisor was of the view that although the diagnosis was missed, this was attributable to factors such as the relatively innocuous appearance of the area, which could lead even a careful and diligent radiologist into error.

A decision was made to close the file under section 38(1) of the Act. However, to address the concerns raised by this complaint, HDC recommended that the radiologist's reports from the previous six months be audited, and training on non-specific densities be provided to all radiology staff at the provider organisation. These actions were followed up to ensure compliance.

In addition, with the consumer's consent, HDC also asked the individual radiologist to publish an anonymised case report on the consumer's presentation. The report was published in an academic journal, ensuring that learnings from the complaint were shared widely within the profession. The recommendations were followed up and complied with fully by the providers involved.

Case study two

The consumer in this complaint had a diagnosis of prostate cancer that metastasised to his bones. The complainant, his daughter, complained about the care provided to him by a range of providers from the time of diagnosis to his death.

In particular, the complainant raised concerns about the care provided to her father at the rest home and hospital. Family members were concerned about pain management and communication between the family and the providers regarding both the man's condition and the need to transition to a different aged care facility.

As part of the preliminary assessment, HDC obtained responses from all providers involved, and sought expert advice from an aged care nurse.

A decision was made to close the file under section 38(1) of the Act. However, HDC recommended that the rest home develop an objective pain score tool to incorporate into its existing pain management processes, and report on the implementation of the plan. In relation to communication with the families/whānau of terminally ill patients, HDC was critical of the amount and quality of communication, and recommended that the DHB review its current practice with a view to increasing transparency and timeliness. The recommendations made were followed up by HDC, and careful analysis illustrated an appropriate review of communication, and the development of a pain tool.

Referral to provider

Sometimes complaints are best resolved between the consumer and the provider themselves. One of HDC's strategic priorities is to work with providers to improve their internal complaint processes. This allows complaints to be resolved at a local level in a timely and efficient manner. This is particularly the case when the complaint does not raise serious clinical or conduct issues, the health/safety of the public is not impacted, the provider has the necessary processes in place to respond to and address the consumer's concerns, and where there is an ongoing relationship between the consumer and the provider. In such cases, often HDC will refer complaints to providers to resolve, under section 34(1)(d) of the Act. HDC maintains oversight of these complaints as, under the Act, providers are required to report back to HDC on resolution of the complaint. The provider's report is reviewed and analysed by HDC to ensure that the issues raised in the complaint have been addressed appropriately by the provider.

Referral to provider

A woman complained about the follow-up care she was provided by a DHB after the death of her baby in utero. In particular, she had been advised that staff would discuss the post mortem results with her, but this did not happen in a timely manner. One of the key motivators for her complaint was her concern that other grieving parents not be put in the position of having to pursue information.

The Deputy Commissioner decided that this complaint was best addressed directly between the DHB and the consumer, as essentially the issue was about the timeliness of communication between the parties. Therefore, the decision was made to refer the complaint formally to the DHB, pursuant to section 34(1)(d) of the Act.

As a result of the referral, the DHB contacted the consumer by telephone to discuss the complaint and the DHB's proposed actions for improvement. The DHB then forwarded correspondence to the consumer, which included an apology. It explained that the post mortem results were not readily available to the maternity team at the hospital. It also advised that the DHB had created a new midwifery role to work with families/whānau who had experienced perinatal death. As required, the DHB reported back to HDC on the outcome of this.

Referral to Advocacy Service

A woman complained about the reduction of carer support days for her son, who has a disability. It was identified that, due to the ongoing relationship and the desirability of her involvement in the resolution process, a referral to advocacy would be the most appropriate way to resolve her complaint. Advocacy was also chosen as the most appropriate resolution mechanism because it would provide her with valuable support and empower her in the process of working through an issue that had a significant impact on her son and wider whānau/family.

HDC provided the woman with information about the Advocacy Service, and she agreed to the referral. The complaint was then formally referred to the Advocacy Service under section 37 of the Act.

As a consequence of the referral, a meeting was held between the woman, her advocate, and the needs assessment organisation. During the meeting, a plan of support for the consumer's ongoing needs was prepared. The plan included return of the carer support to the previous levels, no change to the Funded Family Care hours, respite care at the same or increased level, and a referral for the consumer to have further assessment. The provider put the plan into action and, as required, the Advocacy Service reported back to HDC on the process followed to resolve the complaint, and the outcomes achieved.

Referral to the Office of the Privacy Commissioner

A consumer complained to HDC that repeatedly her GP practice had mistaken her for another consumer with the same name. She was concerned that the other woman's information had been recorded in her clinical notes, and that she had been invoiced for the other woman's consultations. A preliminary assessment established that the issues related to information privacy. After consultation with the Office of the Privacy Commissioner, the complaint was referred.

Referral to regulatory authority

A complaint was received from an employing provider about one of its clinical staff. The complaint raised some concerning issues, including the employee's refusal to adhere to clinical protocols and standards, careless behaviour, and a failure to maintain an appropriate or adequate level of work performance. As the concerns related to the employee's fitness to practice and, moreover, did not concern a specific consumer or detailed information about specific instances where inappropriate care had been provided to consumers, HDC referred the complaint to the individual's regulatory authority, under section 34(1)(a) of the Act.

Referral to Advocacy Service

The Advocacy Service plays a critical role in the effective resolution of complaints. Feedback demonstrates the high degree of satisfaction experienced by consumers when working with skilled advocates, and the high resolution rate shows the success of the process for all parties. For this reason, over the 2016/17 year, HDC focused on identifying complaints that would be best resolved in this way. This resulted in a 149% increase in formal referrals to the Advocacy Service — from 96 to 239. This is a key strategy in ensuring the fair, simple, speedy, and efficient resolution of complaints, and for ensuring consumer and provider participation in the process. The advocacy process is empowering for consumers, and can be of particular value where there is an ongoing relationship between the parties, and where highly vulnerable consumers need support.

Other methods of resolution

HDC can also resolve complaints by utilising a number of other resolution methods such as referral to a regulatory authority or to another agency such as the Ombudsman or the Privacy Commissioner.

Recommendations made to providers

In 2016/17, HDC made recommendations or educational comments in relation to 445 complaints, and providers complied with 99.6% of the recommendations made.

Recommendations enable HDC to effect change in the sector and ensure that learnings are taken from complaints. Many complainants are motivated to complain to HDC because they want to see change occur, so that their experience with a health or disability service is not repeated. HDC works to improve service quality by using the learning from complaints to promote best practice and consumer-centred care. HDC monitors and analyses compliance with recommendations. HDC has dedicated roles for this work, reflecting the importance of the follow-up work undertaken after the closure of a complaint. Providers are also held to account for their own quality improvement through HDC's monitoring and analysis of the recommendations made. Follow-up actions are extensive and can include, for example, analysing the results of audits, reviewing changes made to policies/procedures, and ensuring that appropriate staff training has been undertaken. Some examples of the recommendations HDC has made on complaints closed under section 38(1) of the Act are detailed below.

HDC's assessment of a complaint regarding a consumer not being provided with a requested sign language interpreter identified concerns about the lack of clarity in the correct process to be followed when interpretation services were required. HDC recommended that the provider review its Interpreter Policy to accommodate the needs of Deaf and hearing impaired consumers. Subsequently, the provider developed a comprehensive Interpreter Policy for staff that outlined the process for identifying, organising, and providing interpreting services in accordance with the consumer's identified needs, thus addressing the identified gap in the service.

HDC's assessment of a complaint about the care delivered to a patient who was suffering from a leg pressure wound in a residential aged care facility identified concerns about a lack of wound assessment documentation. As a result of the complaint, the residential aged care facility created a new wound assessment form, to be completed by nurses. HDC recommended that the residential aged care facility undertake an audit of the efficacy of the new form, to ensure that its use was embedded into the daily practice of staff. The results of the audit found that nursing staff were completing the new wound assessment form as directed, ensuring that ongoing wound care and evaluations were completed.

Complaints are an opportunity for staff learning and development and, therefore, often HDC will recommend staff training in relation to the issues identified by a complaint. Frequently, HDC will recommend that an anonymised version of the complaint is used in such staff training to ensure that lessons are learnt from the consumer's experience. An example of this was a complaint HDC received regarding a delayed diagnosis by a public hospital, which identified issues around the follow-up of test results. HDC recommended that the public hospital share the learnings of the case at its shared team meeting, to highlight the importance of communicating test results, especially abnormal test results, with the registrar and other colleagues who are treating a patient. The public hospital confirmed to HDC that the case and its learnings had been shared at its team meeting, as well as with the senior medical officers and junior doctors.

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. Formal investigation may lead to an opinion that the consumer's rights have been breached. In a small proportion of cases, a breach finding may also be referred to the Director of Proceedings to decide whether any further legal action should be taken. 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, 11 providers were referred to the Director of Proceedings for consideration of whether to bring tribunal proceedings.

Insertion of intrauterine device without consent (15HDC01925)

A woman, aged 36 years at the time, privately consulted a gynaecologist for assessment and management of heavy menstrual bleeding and post-coital bleeding.

The woman signed a consent form for a hysteroscopy, dilatation and curettage, endometrial biopsy, and endometrial ablation, to take place under general anaesthetic. Prior to the commencement of surgery, a "Time Out" check took place in the theatre, which included reading out the procedure on the consent form.

The gynaecologist experienced technical difficulties with the endometrial ablation machine while attempting to perform the endometrial ablation, and therefore abandoned the procedure.

At this point, the gynaecologist considered several alternative procedures, and had devices for these alternatives brought into the operating theatre. The gynaecologist decided to insert an intrauterine device (IUD) into the woman's uterus, despite the woman having declined to have the IUD inserted on a previous occasion, and not having given consent to have the IUD inserted on this occasion. The gynaecologist said that he considered the IUD to be the safest and most easily reversible treatment option.

While in the recovery room, the woman discovered what had occurred, and was distressed that the IUD had been inserted without her consent. The gynaecologist apologised and removed the IUD.

The principle of informed consent is at the heart of the Code. Pursuant to Right 7(1) of the Code, services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent. It is the consumer's right to decide and, in the absence of an emergency or certain other legal requirements, clinical judgement regarding best interests does not apply. If the consumer will be under general anaesthetic, the Code provides an additional safeguard that consent must be in writing.

It was considered plainly unacceptable that the gynaecologist inserted the IUD without having first obtained the woman's consent. The woman was particularly vulnerable, as she was under a general anaesthetic. The right to decide was the woman's, and she was deprived of it. By inserting the IUD into the woman's uterus when she had not given informed consent, the gynaecologist breached Right 7(1) of the Code.

Adverse comment was made about a registered nurse, as she was aware of what was on the written consent form but, when the gynaecologist began considering alternative treatment options, she did not query with him the absence of written consent.

Adverse comment was made about the private hospital, as it was considered that this case illustrated a missed opportunity to advocate for the woman when she was under anaesthetic and vulnerable. Furthermore, the expectation set down by the private hospital in its informed consent policy, that "[n]o consent should be presumed", does not appear to have been adhered to.

The Commissioner referred the gynaecologist to the Director of Proceedings for the purpose of deciding whether proceedings should be taken, and recommended that the gynaecologist undertake further education and training on informed consent. The Director decided to issue proceedings, which are pending.

The Commissioner recommended that the private hospital:

a. Use an anonymised version of the case for the wider education of its staff and the surgeons who use its facilities, with particular emphasis on informed consent and advocacy for the consumer; and

b. Provide HDC with an update of the corrective actions taken since the incident, including copies of the updated consent form and informed consent policy.

The Commissioner recommended that the Medical Council of New Zealand consider undertaking a review of the gynaecologist's competence.

Patient admission to ED with signs of sepsis (15HDC01504)

After being unwell for four days, a man presented to the Emergency Department (ED) at 11.03am with an abnormal heart rate, temperature, and respiratory rate. Following his initial triage assessment, the man was monitored by a registered nurse, who recorded his blood pressure and oxygen saturation levels at 11.45am, 12.03pm, and 2.30pm. The registered nurse did not document the man's pulse, respiratory rate, or temperature over this time. The man's oxygen saturations were low enough to be indicative of significant hypoxia, but no actions were documented in response to the issue.

At approximately 11.30am, the man was reviewed by the senior doctor on duty in the ED. The doctor ordered a number of laboratory tests, the results of which included a lactate result consistent with cellular hypoxia. The doctor acknowledged the man's laboratory results electronically at 1.08pm. At 2.45pm, the doctor ordered the urgent administration of IV fluids. No observations were documented after that time.

The doctor diagnosed the man with bilateral basal pneumonia, and discharged him at 3.28pm. The doctor told HDC that the man's oxygen saturation levels and blood pressure were not brought to his attention, but said that he could not recall whether or not he was aware of the lactate level at the time he discharged the man.

The man was found dead in his bed the following day.

The Commissioner found that the registered nurse breached Right 4(1) of the Code by failing to: record the man's pulse, respiratory rate, and temperature during the period she was monitoring him in the ED; inform the doctor of the man's low oxygen saturations; administer oxygen to treat the man's hypoxia; and take vital sign recordings to assess the man's response to further IV fluids administered at 2.45pm.

The Commissioner also found that the doctor breached Right 4(1) of the Code by failing to review the man's observations before making decisions about his discharge.

It was held that the district health board was not vicariously liable for the registered nurse's and the doctor's breaches of the Code.

The Commissioner recommended that the registered nurse undergo peer review of her documentation, undertake further training on the monitoring of patients with abnormal observations, and provide a written apology to the man's family for her breach of the Code. It was also recommended that the Nursing Council of New Zealand consider undertaking a review of the registered nurse's competence.

The doctor provided a written apology to the family for his breach of the Code. It was recommended that he provide HDC with evidence of further training undertaken on monitoring and managing patients in the ED. The Medical Council of New Zealand resolved that the doctor would be required to undergo a performance assessment.

The Commissioner also recommended that the district health board undertake an early warning score audit to ensure appropriate use of the escalation protocol for all patients (or a sample of patients) who triggered an early warning score of 3 or more.

Misdiagnosis of fetal viability (15HDC01413)

A pregnant woman attended an appointment with a sonographer at a radiology clinic. This was the sonographer's second day working at the clinic. The sonographer performed a transabdominal scan and a colour Doppler scan. The sonographer was unable to detect a fetal heartbeat, and documented that there was no obvious fetal heartbeat, and that the colour Doppler scan had shown a flash of colour adjacent to the yolk sac. The sonographer did not offer the woman a transvaginal scan during this appointment.

After the woman left the department, a radiologist reported on the ultrasound scan from the sonographer's worksheet and images. This was the radiologist's first day undertaking clinical work at the clinic. The radiologist reviewed the images the sonographer had taken and the findings she had documented in her sonographer report, and recorded them in his radiology report. The radiologist documented that there was "no obvious fetal heartbeat seen" and "no evidence of viability".

The woman was informed of the results of the report and attended an appointment at a miscarriage clinic, where she was given misoprostol to assist with miscarriage. Later, the woman consulted with a general practitioner at a medical centre, with concerns that since her miscarriage she was yet to have a menstrual cycle. The general practitioner arranged for an urgent ultrasound.

The woman attended the radiology clinic for a transabdominal ultrasound scan. A radiologist documented that the woman had a viable pregnancy, and the gestation of the fetus was "approximately 17 weeks 3 days plus or minus 10 days".

It was held that the sonographer should have offered the woman a transvaginal scan at the time of her appointment.

With regard to the radiologist, it was held that by failing to obtain a second sonographer opinion, or recommend that a transvaginal scan should be performed, or recommend that the woman's β-hCG levels should be monitored, or organise a review scan in one week's time, and by reporting that there was no fetal viability, the radiologist did not provide services to the woman with reasonable care and skill and, therefore, breached Right 4(1) of the Code.

The radiology clinic had access to information regarding the radiologist's training, qualifications, work history, and references; however, it did not identify his inexperience in the area of obstetric ultrasound scans prior to allowing him to report on obstetric ultrasounds. In addition, the radiology clinic did not allow the sonographer sufficient time to familiarise herself with the department and protocols in place prior to giving her a full case load, and did not record which protocols were provided to her. Furthermore, the protocols in place at the radiology clinic were outdated, and did not provide adequate guidance for clinicians. Accordingly, the radiology clinic did not provide services to the woman with reasonable care and skill, and breached Right 4(1) of the Code.

The Commissioner recommended that the radiologist arrange for a clinical peer review of the standard of his radiology reporting on obstetric ultrasounds; undertake an audit of recent obstetric scans performed; and apologise to the woman. The Commissioner recommended that the radiology clinic audit its compliance with the changes made to its ultrasound protocols, including a requirement for transvaginal ultrasound scans to be performed when there is a question regarding fetal viability. The Commissioner also recommended that the radiology clinic use the case as an anonymised case study for staff education. Written apologies from the radiologist and the radiology clinic were forwarded to the woman.

Informed consent for acupuncture, and delayed recognition of pneumothorax symptoms (15HDC00947)

A woman had been seeing a physiotherapist for treatment for her scoliosis. At her third visit, the physiotherapist asked the woman whether she was "open to acupuncture". The woman said that she was.

The physiotherapist's documentation does not record whether adverse reactions were discussed prior to gaining the woman's consent to the treatment, or whether the increased risks the woman's scoliosis presented to the situation were discussed, and what safety-netting advice, if any, was provided to the woman for when she left the clinic.

Immediately after the appointment, the woman felt light-headed and began shaking. A few hours later she was in "extreme" pain on the left side of her chest. She called the clinic and reported right-sided ribcage pain with breathing, and pins and needles in her left arm, and also complained of being short of breath.

The physiotherapist rang back the woman shortly afterwards. The physiotherapist told HDC that the woman's symptoms were "not shortness of breath but pain on inhalation", and that the woman had complained of "pain in the chest, referred symptoms of 'pins and needles' in the left arm and an inability to take a deep breath". The physiotherapist told HDC that she specifically asked the woman whether she was experiencing shortness of breath or dyspnoea, and that the woman told her that her symptoms were "more, 'unable to take a deep breath'". The physiotherapist told the woman that her symptoms were "normal, as it was the muscles tightening back up". The woman was given a follow-up appointment for an assessment the following day.

After the telephone call, the physiotherapist carried out some research into acupuncture-induced pneumothorax (collapsed lung), and sent a text message advising the woman to go to the hospital if her symptoms worsened. The woman was already at the hospital when she received the text.

It was discovered that the woman had a pneumothorax at the site where the acupuncture needle had been placed. She had experienced a 30% collapse of the lung.

It was held that the physiotherapist failed to provide the woman with information that a reasonable consumer, in the woman's circumstances, would expect to receive. Accordingly, the physiotherapist was found to have breached Right 6(1) of the Code. Without this information, the woman was not in a position to make an informed choice and give her informed consent to having acupuncture. Accordingly, the physiotherapist was also found to have breached Right 7(1) of the Code.

Further, it was found that the woman's reported symptoms of being "unable to take a deep breath" should have raised concern that a pneumothorax might be present. By failing to turn her mind to this at the time of her initial telephone conversation with the woman, the physiotherapist failed to provide services in a manner that minimised the potential harm to the woman. Accordingly, it was found that the physiotherapist breached Right 4(4) of the Code.

In addition, adverse comment was made that it appeared that the physiotherapist did not consider the woman's scoliosis adequately prior to performing trigger point needling in this area. Criticism was also made that the physiotherapist did not complete an incident report form immediately on learning of the woman's adverse outcome. It was over a week before the incident was documented formally.

It was also found that there were learnings from the case for the clinic. It was recommended that the clinic review its current policies and procedures, in particular its policies relating to timeframes when there are reportable events.

It was recommended that the physiotherapist undertake further education and training on informed consent, review her practice, including her process for obtaining informed consent, and provide a written apology to the woman. The physiotherapist complied with all the recommendations, and provided a statement detailing what she had learnt from the complaint and the investigation process, and the changes she made to her practice as a result.

Failure to undertake red eye reflex screening (15HDC00661)

The Ministry of Health's Well Child/ Tamariki Ora (WCTO) Programme Practitioner Handbook states that red eye reflex screening (the accepted screening test for early detection of significant eye abnormalities) using an ophthalmoscope should be undertaken at birth or up to seven days of age, and definitely by the six-week assessment. The vision screening to be undertaken at the six-week Well Child assessment should also include red eye reflex screening.

A baby who was born at a public hospital did not receive a red eye reflex test during her time at the hospital. She was discharged when she was six days old, and her care was then provided by a registered midwife. There was no clear communication to the midwife that the red eye reflex screening had not been done in hospital.

It was not until the midwife's fourth postnatal visit with the baby and the baby's mother, when the baby was 33 days old, that the midwife realised that the baby's red eye reflex had not been tested. The midwife then undertook the screening. The midwife believed that she saw the red eye reflex, and documented accordingly.

A general practitioner saw the baby for her six-week check. When the GP performed the vision assessment he checked only the corneal reflexes,[8] and did not use an ophthalmoscope. The GP documented that the baby had passed her vision assessment.

The GP saw the baby for her three-month check, and checked the baby's corneal reflexes on this occasion. However, he did not check the red eye reflex.

The baby's mother took the baby to see the GP because of her concerns that the baby was not focusing on people's faces, and that her "wandering eye" had become worse. The GP noted that the baby had evidence of a squint. He checked the corneal reflexes on this occasion (not the red eye reflex), and did not use an ophthalmoscope.

The next day, the GP sent a referral to the district health board (DHB) ophthalmology department marked urgent, and noted: "3 month old baby with significant squint and concern about vision." The GP included notes from the consultation the previous day (including notes stating "light reflexes fine"). As the referral letter stated that the baby's light reflexes were normal, the referral was assigned priority B.

Subsequently, the baby was given an appointment with an ophthalmologist. The baby was diagnosed with a cataract, and underwent surgery the following day.

It was found that staff at the DHB failed to test the baby's red eye reflex while she was in the public hospital, and the DHB did not have adequate systems in place to communicate whether or not the testing had been carried out. The DHB did not provide services to the baby with reasonable care and skill, and breached Right 4(1) of the Code.

The midwife missed an opportunity to review the baby's documentation carefully and query whether the red eye reflex test had been done.

The GP failed to check the baby's red eye reflex at the six-week and three-month checks, failed to undertake a red eye reflex examination with an ophthalmoscope when it was clinically indicated, and, accordingly, wrote an inappropriate referral. In these circumstances, the GP did not provide services to the baby with reasonable care and skill, and breached Right 4(1) of the Code.

The Commissioner recommended that the DHB provide HDC with a copy of its updated policy regarding newborn care responsibility, and an update on compliance with internal documentation requirements.

The Commissioner also recommended that the GP undertake a review of current best practice with regard to red eye reflex assessments, and that the Medical Council of New Zealand consider the need for a review of the GP's competence.

The Commissioner noted that the Ministry of Health is undertaking policy work on the content and timing of the WCTO schedule, and that newborn vision screening (including the red eye reflex component) will be covered as part of this work. The Commissioner recommended that, as part of this work, the Ministry of Health consider working with stakeholders to achieve consensus on the timing and performance of red eye reflex testing, as well as the training and equipment requirements for red eye reflex testing.

[8] This can be used to assess eye symmetry.

Recommendations made to providers following investigations in 2016/17

1. Following an investigation about the care provided to a patient prior to and following surgery to remove an ovarian cyst, the Commissioner recommended that the Royal New Zealand College of Obstetricians and Gynaecologists (RANZCOG) consider whether the wording of a relevant consensus statement concerning advanced operative laparoscopy required revision. RANZCOG advised the Commissioner that currently the Endoscopic Surgery Advisory Committee (RANZCOG/AGES) is reviewing the Statement in its entirety, in particular in the context of the investigation. It is anticipated that a number of changes will be made to the guidelines. The revised statement will be submitted to the RANZCOG Women's Health Committee for consideration, prior to being reviewed by the RANZCOG Council and approved by the RANZCOG Board.

   In relation to the relevant DHB, the Commissioner recommended that the DHB survey new and existing employees in the relevant department regarding staff awareness of RANZCOG guidelines for performing laparoscopic procedures, and confirm that RMO (resident medical officer) and SMO (senior medical officer) orientation included such information. The Commissioner also recommended that the DHB review complex cases from the previous six months to confirm that SMOs regularly discuss complex cases at multidisciplinary meetings as part of expected practice. The relevant DHB circulated RANZCOG guidelines for performing laparoscopic procedures to all its SMOs, developed a policy for circulation and discussion on the issue of less commonly performed procedures, and advised HDC that all new staff and locums are provided with the RANZCOG guidelines as part of their orientation.

2. A delayed diagnosis of lung cancer led to recommendations that the DHB concerned review its ED policy to ensure that there is a clear process for the handover of care from ED to GPs, including follow-up of tests and X-rays ordered in ED. Noting that this was potentially a system-wide concern, the Commissioner recommended that the National CMO Group work to put in place clear practice guidelines regarding the interface between emergency departments and general practitioners in relation to follow-up of test results, within all DHBs.

3. Following an investigation into the discharge, triaging, and follow-up of test results of a patient in ED who subsequently died, the Commissioner made a number of recommendations, including that the DHB audit aspects of the effectiveness of its new triage process; develop a clear policy for responsibility for following up test results ordered by ED registered nurses; consider implementing a system that requires the laboratory to alert the patient's treating clinician urgently; review the ED's standard operating procedure; develop a care escalation plan for the general medicine team; review the role of on-call consultants to ensure that adequate supervision of junior doctors is occurring; and remind all staff working in the ED that the transfer, and the location to which the patient is transferred, must be clinically appropriate.

4. In a case in which a child received an incorrect medication dosage, the Commissioner made recommendations to a number of parties. The recommendations included amendments to the DHB recording of child weights, an audit of dispensing at the pharmacy involved, and consideration by the Pharmacy Council of a competency review of the individual pharmacist concerned. The DHB reported to the Commissioner that it has implemented Medchart ePrescribing in four wards, and it will seek funding to implement it throughout the DHB. The DHB also presented the case to the HQSC medication safety forum, and has formatted it for use in medical and nursing orientation and training. The pharmacy provided the results of two audits of dispensing it conducted. The Commissioner also recommended that the Ministry of Health actively continue to support the rollout of electronic prescribing across New Zealand's DHBs, in both inpatient and outpatient settings, and work with the sector to progress an integrated approach to medicines management.

5. In a case where a woman with mental health issues did not receive adequate coordination of her care by the DHB, the Mental Health Commissioner recommended that the DHB develop clear protocols for circumstances where key worker care may be shared in relation to a mental health care consumer, and include a clear method of documenting the care arrangement and the role of each key worker in the circumstances.

6. In a case where the assessment and management of an orthopaedic patient pre- and postoperatively did not meet accepted standards, the Commissioner noted that while individual clinicians need to be competent in their clinical management of patients, staff also need to be supported by systems that guide and facilitate good decision-making and promote a culture of safety. To address concerns in this matter, the Commissioner made a number of recommendations to the DHB and the orthopaedic surgeon involved. The recommendations included that the DHB clarify the roles and responsibilities of staff, and outline precisely when in the patient surgical pathway, and by whom, the patient's clinical history and records are reviewed and communicated. The Commissioner also recommended that the orthopaedic surgeon provide details to HDC on the steps taken to formalise handover of his surgical inpatients to orthopaedic colleagues in the event of taking leave, including a process of clear instructions for patient oversight. The orthopaedic surgeon reported that when taking leave he discusses all remaining inpatients with a consultant orthopaedic colleague, and documents the handover clearly in the clinical record.

7. In a case concerning the management of a man with psychosis withdrawing from his medication, the Mental Health Commissioner made a number of recommendations, including a review of the process for the development of recovery plans; a review of the processes and practices within the Psychosis Service for collaborative care planning with consumers and their families, and documentation of contacts; and an independent audit of the Psychosis Service documentation.

8. Following the failure of staff at a DHB to recognise the symptoms of diabetic ketoacidosis in a pregnant woman with poorly controlled Type 1 diabetes, the woman gave birth to a stillborn child. The Commissioner made a number of recommendations, including a review of patient information resources on diabetes management in pregnancy; the development of consistent glycaemic targets for pregnant women; and the development of protocols to ensure that when a patient under multidisciplinary care is admitted to hospital, all disciplines are informed and involved in the treatment decisions.

9. Following an investigation about the care provided to a man whereby an overdose of radiation treatment was administered, the Commissioner identified that the private radiation therapy centre did not have an appropriate policy for the pre-treatment check of beam parameters. The Commissioner made a number of recommendations to the centre, and also recommended that the Office of Radiation Safety share the anonymised details of the incident with the other radiation oncology departments in New Zealand, to ensure that they have adequate policies in place to prevent the incident occurring at another centre. The Office of Radiation Safety reported back to HDC that it would share the anonymised details of the incident with the other radiation oncology departments in New Zealand.

10. Following an investigation into the reasons why a doctor failed to follow up on a patient's test results, it was found that the DHB did not have in place an appropriate system to ensure that reports or results did not go unacknowledged by the DHB's clinicians. It was recommended that the DHB consider adding an electronic warning to its IT system to alert clinicians to the existence of unacknowledged results. Furthermore, it was recommended that an impartial IT expert with a medical background examine the DHB's electronic management system to determine whether user warnings and updates need to be built into the software, and training sessions provided.

11. Following an investigation about the GP care provided to an elderly patient who was diagnosed with chronic interstitial nephritis after being prescribed ibuprofen (a non-steroidal anti-inflammatory drug (NSAID)) for over 18 months without appropriate monitoring or consultation, the Commissioner recommended that the medical practice notify HDC of the date of its annual NSAID audit for 2017, and provide the results of the audit within three weeks of completion. The medical practice provided the results of its completed audit.

4.2 Advocacy

In 1996, the Nationwide Health and Disability Advocacy Service (the Advocacy Service) was formally established as a free and independent service for consumers of health and disability services. The Director of Advocacy[9] at HDC contracts with the National Advocacy Trust[10] to provide and operate the independent Advocacy Service. In 2016/17, approximately 40 advocates around the country operated out of 23 community-based offices from Kaitaia to Invercargill. The Advocacy Service is provided independently of health and disability service providers, the Ministry of Health, and HDC.

Figure 7: Complaints to the Advocacy Service by year.

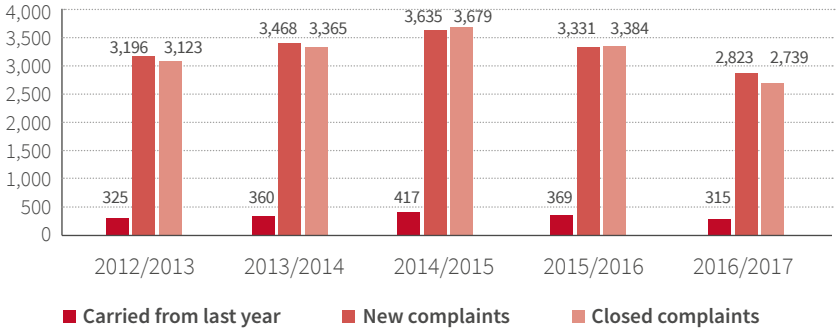
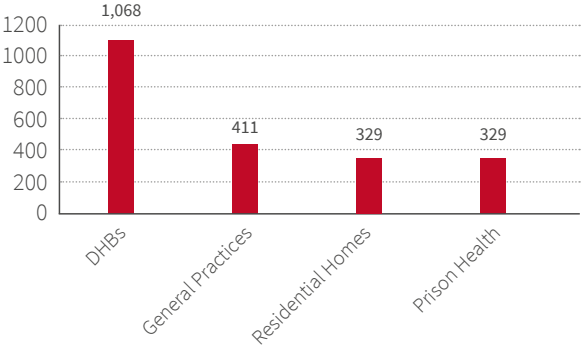


Figure 8: Types of service providers in complaints received by the Advocacy Service.



Advocates

Advocates apply defined complaint resolution processes and use interactive adult education skills when performing their role of supporting consumers to resolve complaints, and in promoting the rights set out in the Code. Advocates work towards an NZQA qualification as part of their ongoing professional development, and they demonstrate a thorough knowledge and understanding of the Code, including its application and impact, along with other relevant legislation and standards. In addition, advocates have substantial knowledge about their community, and a thorough understanding of the health and disability sector.

Complaints resolution

Complaints resolution is a key 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. The Advocacy Service is critical in ensuring success in that space, with advocates around the country supporting and guiding consumers to achieve prompt and successful resolution of their concerns through an alternative dispute resolution process that is flexible and time-effective. While advocates guide consumers to clarify the issues and the outcomes they are seeking, the consumer is at the centre of the process. The provider has the opportunity to respond to the consumer openly and directly, and often the process supports consumers and providers in rebuilding relationships. This is of particular importance where the consumer and provider will be having an on-going relationship. In some instances, just having the opportunity to talk through the events with an advocate enables a consumer to achieve personal resolution, and subsequently the consumer may decide not to proceed with the complaint.

The high rate of resolution achieved by the advocacy process reflects the strong consumer-centred approach of the Advocacy Service and a high level of provider goodwill and commitment to resolving complaints at an early stage.

This year, the Advocacy Service received 2,823 complaints and assisted consumers to close 2,739 complaints. Over the past two years, the Advocacy Service has been undergoing significant reviews to position it as an effective service for the future. While there has been a reduction in complaints to the Advocacy Service, the resolution, satisfaction, and timeliness rates remain high. In addition, complaints from some of the most vulnerable consumers, such as those in residential aged care facilities and residential disability facilities, remain stable, reflecting the strong advocacy presence in those areas this year.

Eighty-two percent of complaints made to the Advocacy Service were closed within three months, 98% within six months, and 100% of complaints were closed within nine months. Ninety-one percent of complaints were either resolved successfully between the parties or were withdrawn by the complainant.

[9] An employee of the Health and Disability Commissioner, but required to perform her role independently of the Commissioner.

[10] A charitable trust.

The Advocacy Service classifies complaints on the basis of the time spent managing a complaint, from opening to closing, and includes all the time spent on actions taken by the advocate during the course of the complaint. This year the number of complaints classified as simple (i.e., complaints that take up to two hours to manage) dropped by 13% to 21% of all complaints, while the number of standard complaints (those that require 2–8 hours) and complex complaints (8–15 hours) rose by 9% and 4% respectively. Ten percent of complaints were resolved following a meeting between the consumer and the provider with an advocate's support.

Eighty-five percent of all complaints received by the Advocacy Service in 2016/17 related to healthcare services, while 15% of all complaints received by advocates related to disability services. This year, 39% of all complaints involved DHB services; 15% related to services provided by GP practices; 12% related to prison health services; and 12% were about residential care facilities.

Reaching consumers

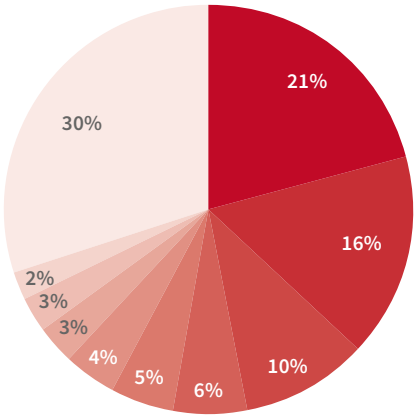
Advocates engage with consumers through online promotion and promotional leaflets and posters, by responding to telephone and email enquiries, through face-to-face education sessions, and by networking in their local communities, including making visits to residential facilities.

Telephone and email enquiries

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

During the 2016/17 year, the Advocacy Service received 10,333 enquiries. Ninety-seven percent of those enquiries were responded to and closed within two days. Enquiries covered a broad range of topics. In addition to requests for information on how to make a complaint, the role of advocates and HDC, and how to arrange an education session (approximately 47% of enquiries), advocates also received a substantial number of requests for information about mental health services (6% of enquiries), ACC (5%), access to services (3%), residential aged care and residential disability home standards (3%), and prison health services (2%). Other enquiries included enquiries related to the role of HDC, disability resources, funding and fees, and privacy concerns.

Figure 9: Subject of enquiries to the Advocacy Service.



Education sessions

A key part of an advocate's role is promoting the Code. Advocates network in their local communities to promote awareness of the Code, the Advocacy Service, and HDC, and provide face-to-face education sessions to groups of consumers about their rights under the Code, and to groups of providers about their responsibilities as providers of health and disability services.

In the 2016/17 year, advocates presented a total of 1,635 face-to-face education sessions to a range of consumers and providers. The majority of the sessions provided related to information on the Code, the Advocacy Service, and HDC. Advocates also provided sessions on topics such as self-advocacy, effective communication, open disclosure, health passports, effective complaints resolution processes, informed consent, and the "Tell Someone" programme.[11]

These sessions continue to be very well received. Eighty-seven percent of consumers and providers who attended an education session and responded to a satisfaction survey said that they were satisfied or very satisfied with the session.

[11] A programme based around scenarios on a DVD showing ways consumers can speak up. It is acted by consumers who have a learning disability and live in a residential home.

CASE STUDIES

Consumer education session

A consumer requested that the Advocacy Service provide education on the Code, focusing on Right 10 (the Right to Complain) and self-advocacy, to a lymphoedema support group, which was made up predominately of cancer survivors.

During the session some of the consumers advised that they were unhappy with the services being provided by the local DHB therapies department for lymphoedema, but they were concerned about speaking up.

The advocate talked the group through self-advocating and how to write their own complaint letters. Three of the consumers who attended the education session were able to communicate their issues to the provider as a result.

Provider education session

An advocate provided education, with particular emphasis on Right 10, to staff at a rural hospital. Following the session, the hospital's complaints manager advised that they had made significant changes to how the complaints process was managed. One of the most important changes was that the complaints manager was to be notified as soon as a complaint was received, so that the complaint could be entered onto a complaints register and into a resolution time frame. Managers then linked all their correspondence to that register, and the complaints manager monitored the responses to ensure that time frames were being met.

Networking

Advocates network within their local communities to establish a profile 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 1,714 networks. These included consumer or consumer-focused groups, public interest and community groups, and provider groups. Forty-three percent of network contacts involved older people, the Deaf community, and Māori and refugee/ migrant communities.

Visits to residential facilities

Visits to residential facilities ensure contact with those residents of aged care facilities and disability facilities 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 education sessions for residents, whānau/family members, and providers.

Advocates visited all of the 660 certified residential aged care facilities nationwide, and advocates visited 412 of those facilities at least twice. All 930 certified residential services catering to disabled people had at least one visit from an advocate, and 577 had at least two visits. In total, the Advocacy Service closed 1,374 enquiries and 338 complaints about residential services, and made 2,579 visits to residential services, which included providing 783 face-to-face education sessions at residential facilities.

Demographics

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

Complaint classification and demographics

Consistent with previous years, the majority of complaints received concerned consumers aged between 41–60 years (36%), followed by those aged between 26–40 years (29.5%), and those aged between 61–90 years (24.0%). Fifty-six percent of complainants identified as female, 42% as male, and the remaining 2% either declined to answer or described themselves as "other".

Of the total complaints received, 64% of complainants identified as New Zealand European, and 11% identified as New Zealand Māori.

Figure 10: Ethnicity of complainants to the Advocacy Service.

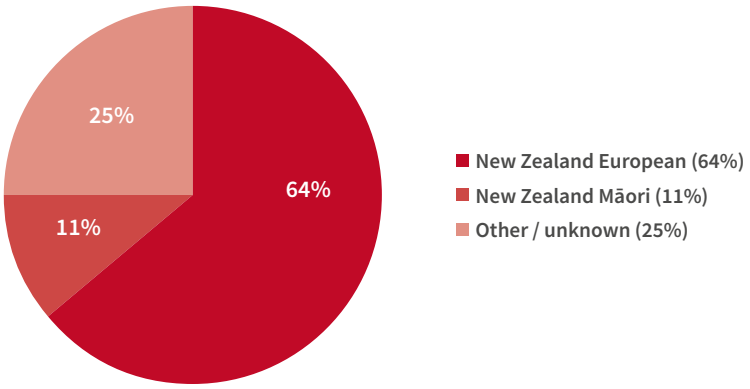
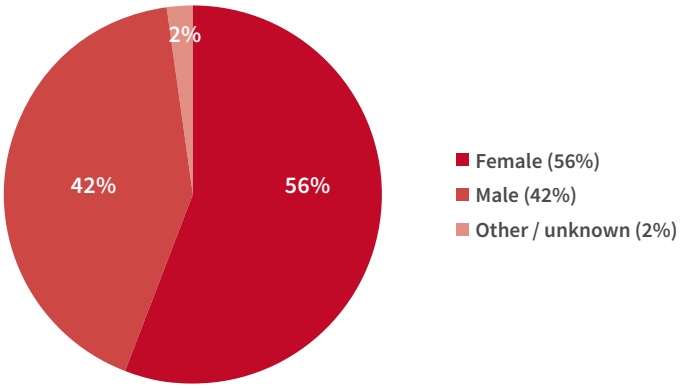


Figure 11: Gender of complainants to the Advocacy Service.



Linking with providers

As complaints to the Advocacy Service are resolved between the parties, it is important that providers are fully involved and supportive of the process.[12] The high resolution rate achieved by the Advocacy Service (this year, 91% of complaints to the service were either resolved or withdrawn) is a reflection of the belief and commitment of both consumers and providers that the advocacy process is effective and enables people to move forward.

Satisfaction with the Advocacy Service

Generally, people who resolve their disputes through the Advocacy Service process are very satisfied. Reasons for this include having been given the opportunity to participate directly in working out their own resolution. Often consumers want to ensure that what happened to them will not happen to someone else, and it is helpful for providers to hear this. Usually, providers are also satisfied with the Advocacy Service process, as the issues are clarified and they are given the opportunity to explain their actions fully and, if appropriate, to apologise directly to the consumer.

All consumers and providers who have worked with an advocate through the complaints resolution process are asked to comment on their level of satisfaction with the service through an online survey. Thirty-three percent of consumers who do not have access to the online survey are sent paper surveys. Survey results showed that 88% of consumers and 86% of providers who responded to satisfaction surveys were either satisfied or very satisfied with their contact with the Advocacy Service.

The following feedback was received from a consumer:

"I wanted to pass on my heartfelt appreciation for the support of your advocate in a recent complaint I took up with my health provider. [Your advocate] listened carefully from the start and made me feel understood. He empathised and provided me with concrete information about my rights and the process ahead. On the day we met the health provider, he was legendary! He was calm (which in turn helped calm me and I'm sure my health provider too) and only got involved diplomatically in measured ways when he needed to — which helped me feel empowered yet protected. I very much appreciate that these advocacy services exist in New Zealand."

The following feedback was received from a provider:

"Too often in life we only hear when people are unhappy. I thought I really must write and tell you how grateful I was for your most professional handling of the recent complaint we addressed together. I appreciated your input during our meeting, and was most grateful for your very prompt letter saying [the complainant] was willing to determine the matter settled; a great relief for me of course, and so much better to resolve it face to face than going further."

Acknowledgement from the Commissioner

The Commissioner acknowledges the skill and commitment of all those involved with providing a quality advocacy service to health and disability services consumers throughout the country.

[12] If providers are not supportive and proactive in working towards resolution, then usually the advocate will advise the consumer that the complaint should be forwarded to HDC for management.

Emergency department care of consumer who presented with respiratory distress

A consumer complained to HDC about the treatment she received in a public hospital's emergency department (ED) when she presented in respiratory distress. The consumer felt that staff did not respond to her in a timely way, did not take into account her own knowledge about her health condition, and did not give her adequate information about her immediate health problems and treatment. The Commissioner referred her complaint to the Advocacy Service for resolution between the parties.

An advocate supported the consumer at a resolution meeting. During the meeting, the consumer highlighted how frightening it is to be unable to breathe. The provider noted that ED staff followed internationally recognised protocols for dealing with consumers who present in respiratory distress, but that for consumers it could sometimes appear that staff were rigidly following protocol. The provider fully acknowledged the importance of staff collaborating with consumers, and the importance of consumers' insight into their own health.

Following the meeting, the consumer advised the provider staff and the advocate that her concerns had been addressed and resolved.

Mental health services

A mental health service consumer complained to the Advocacy Service that his request to have more input into his key support worker's report to the multidisciplinary team prior to his meeting with the team was ignored.

The key issues were identified as effective communication and full information. The consumer then wrote a letter with guidance from the advocate and requested an advocate-supported meeting to talk about his concerns with the key support worker and the Service Manager.

An outcome of the meeting was a suggestion from the Service Manager that the consumer should substantially contribute to the reports for the multidisciplinary team meetings. The Service Manager advised that as a result of the consumer's complaint he would be offering the same option to all other consumers receiving service from the organisation.

The consumer said that having advocate support had given him the confidence to speak up and work out a plan of action which actually "gave me back my power", and which led to improvement to the provider service.

Elderly/vulnerable consumer speaking up

An elderly consumer who was being discharged from respite care felt he would not be able to cope at home due to his failing health, limited vision and vulnerability. A social worker suggested he work with an advocate.

The advocate arranged a meeting in which the consumer told the provider of several concerning incidents that had occurred prior to his being admitted to hospital. The provider listened to those concerns and agreed it was not safe for him to return to his own home and he would be reassessed for permanent rest home care.

The consumer expressed his thanks to the advocate saying her presence had helped him to speak for himself about what he needed to feel safe.

4.3 Proceedings

The Director of Proceedings may commence proceedings against providers who have been referred to the Director by the Health and Disability Commissioner.

The Director of Proceedings is an employee of the Health and Disability Commissioner, but makes decisions whether to commence proceedings independently of the Commissioner.

Proceedings taken by the Director against health and disability services practitioners are in the Health Practitioners Disciplinary Tribunal (HPDT) and/or the Human Rights Review Tribunal (HRRT). The overall objective in taking proceedings is protection of the public interest through holding practitioners to account, determining and upholding appropriate standards for healthcare providers, and promoting 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 a breach of the Code, against both registered and unregistered providers. Remedies include formal declarations of a breach of the Code and, in limited 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.

During the course of the year there were three successful disciplinary hearings in the HPDT.

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. Two other matters were resolved without recourse to Tribunal proceedings.

In addition, the Director of Proceedings was successful in opposing a practitioner's application for leave to appeal in the Court of Appeal after professional misconduct was established on appeal at the High Court.

Referral statistics

The Director of Proceedings had 27 referrals in progress during 2016/17, including 11 referrals received in the course of the year. Around 75% of the referrals in progress are referrals involving issues of practitioner competency. Table 3 identifies 2016/17 referrals by provider type.

Table 3: Referrals received in the 2016/17 year by provider type.

Provider	No. of referrals in 2016/17
Gynaecologist	1
Oral & maxillofacial surgeon	1
Midwife	2
Mental health support worker	1
Nurse	2
Residential aged care facility	1
Podiatric surgeon	2
Physiotherapist	1
TOTAL	**11**

Anaesthetist held accountable for negligence

The Director filed a charge against an anaesthetist in the Health Practitioners Disciplinary Tribunal ("the Tribunal") for failing to ensure that adequate anaesthesia was provided to a woman during her Caesarean section ("C-section") and for failing to observe and communicate with the woman appropriately during her C-section to ascertain her level of discomfort and pain.

In February 2013, the woman attended hospital for delivery of her baby. Her labour did not progress and, subsequently, the decision was made to proceed to a C-section. The anaesthetist administered anaesthesia by way of a top-up to an epidural she had received for pain relief. Approximately two minutes into the surgery the woman complained of pain, and the surgeon stopped the surgery and brought this to the attention of the anaesthetist, but the anaesthetist reassured the surgeon that she could proceed with the surgery. The woman told the anaesthetist that it was hurting, and he assured her that she was not feeling pain, but that it was pressure. Multiple witnesses observed the woman moving her legs, including raising her knees and kicking the surgeon. Subsequently, the woman's legs were held down so that the baby could be delivered. The surgeon also gave evidence that the woman's abdominal muscles were unyielding and very tight. The woman's leg movement and tight muscles were both indicators that the anaesthesia was wearing off. Shortly thereafter, the woman's baby was delivered safely, and the surgeon commenced suturing the woman's incision. The woman continued to experience pain. Multiple witnesses asked the anaesthetist if the woman could have more pain relief, and described the anaesthetist's response as dismissive and disinterested in the woman's situation. The anaesthetist did not administer any further pain relief during the procedure.

The anaesthetist accepted that he was not able to recall the events in detail and relied in large part on what his usual practice was, and what he said he "would have" done in the circumstances outlined.

The Tribunal dismissed the charge, concluding that there was insufficient evidence that any of the other persons present during the surgery conveyed the woman's complaint of pain to the anaesthetist in a sufficiently compelling way for him to have considered conferring with the woman about pain relief. In addition, the Tribunal deferred to the anaesthetist's clinical "judgement call" about the management of the woman's pain, noting that such a judgement call (had it been made) would not have amounted to professional misconduct.

The Director appealed the decision of the Tribunal to the High Court. The High Court agreed with the Director that the Tribunal's focus on what others did to bring the woman's pain to the attention of the anaesthetist was misdirected. The Court agreed with the Director that the appropriate focus was, first, on the matters brought to the

anaesthetist's attention by the other people and the way in which the anaesthetist reacted to them and, secondly, whether the anaesthetist was at fault for being unaware of the signs of the woman's pain, regardless of whether someone else could or should have told him.

The High Court concluded that the anaesthetist displayed a lack of interest in or concern about his patient, and a seemingly blind insistence that she was not in pain. The High Court noted that the anaesthetist was particularly culpable, as he failed to explore with the woman exactly what she was feeling, and to react to concerns raised by professional colleagues. The High Court also noted that the anaesthetist's lack of attention was sustained through at least a 30-minute period.

The High Court expressed concerns regarding the level of deference shown in the Tribunal's decision to the idea of a clinical judgement call, and noted that the Tribunal's approach suggested that it viewed the fact that a decision was a clinical judgement call made it immune to review. The High Court commented that if that was what was meant, it was incorrect, and negated the very purpose of the ability to review and charge, and is the reason expert evidence is called. The High Court concluded that pain relief should have been given, that there were options for pain relief available, and that the anaesthetist was at fault in not providing that pain relief.

The High Court found the anaesthetist guilty of professional misconduct, and noted that he had fallen severely below the appropriate standard of care, and that the misconduct was within the higher boundaries for disciplinary sanction.

The High Court fined the anaesthetist $9,000 and, in light of the factual findings made by the Court, referred its decisions to the Medical Council for consideration of whether any action was required by way of conditions or monitoring.

The anaesthetist applied to the Court of Appeal for leave to appeal the High Court's decisions finding professional misconduct made out and imposing penalty. In denying the application, the Court of Appeal agreed with the High Court that the Tribunal had erred in asking itself the wrong question. The Court of Appeal noted that the proper question for the Tribunal was an objective question: whether the anaesthetist ought to have been aware of the woman's pain and discomfort during the operation (not whether or how much of the woman's pain was communicated to or understood by the anaesthetist). The Court of Appeal found that the proper question was open to only one answer once the evidence of the Director's witnesses was accepted: the anaesthetist ought to have been aware of the woman's pain.

Decisions

Tribunal: https://www.hpdt.org.nz/portals/0/760Med15323D.pdf

High Court: *Director of Proceedings v A* [2016] NZHC 229, [2017] NZHC 390.

Court of Appeal: http://www.nzlii.org/nz/cases/NZCA/2017/267.html

Disability support worker held accountable for failing to provide services with reasonable care and skill

The Director filed proceedings by consent against a support worker in the Human Rights Review Tribunal. The support worker accepted that his actions amounted to a breach of the Code, and the matter proceeded by way of an agreed summary of facts. The Tribunal was satisfied that the support worker failed to provide services to the aggrieved person with reasonable care and skill, and issued a declaration that he breached Right 4(1) of the Code.

The aggrieved person was a young adult male diagnosed with autism spectrum disorder, intellectual disability, attention deficit hyperactivity disorder, seizure activity, and global developmental delay. He was non-verbal, had complex needs and challenging behaviour, and required constant one-to-one care. He was a high flight risk and had a fascination with petrol and fire. The aggrieved person lived at home with his mother and received individualised funding for one-to-one respite care. His mother privately engaged a provider of home-based support services (the provider), to assist her. The support worker was contracted independently by the provider to provide disability support services to another high-needs client. In September 2012, the provider also engaged the support worker to provide support services to the aggrieved person while his usual support worker was away. The support worker provided these services in the aggrieved person's home. The support worker understood that he was allowed to care for only one client at a time. However, on more than one occasion he looked after his two high-needs clients at the same time, without the knowledge of the provider and his clients' families. On Friday 9 November 2012, the support worker again looked after both clients at the same time. The support worker deceived the provider into believing that he was looking after only his first client, while a replacement person approved by the mother was looking after the aggrieved person. In the evening, the support worker left both clients locked alone and unsupervised in his house while he left to collect food for them. While he was gone, a fire broke out at his home. Both clients were unable to get out of the locked house and, sadly, the aggrieved person died in the fire, and the other client suffered burns.

Expert advice was that the support worker was responsible for the care of very vulnerable clients, and unquestionably failed to provide adequate care to the aggrieved person. The support worker made some very poor decisions about risk, and knowingly went against the express directions of the provider when he knew that the aggrieved person required one-to-one care and constant supervision.

The Tribunal's full decision can be found at:

http://www.justice.govt.nz/assets/Documents/Decisions/2016-NZHRRT-34-Director-of-Proceedings-v-Taleni.pdf

4.4 Systemic monitoring and advocacy — mental health and addiction services

The Mental Health Commissioner assists the Health and Disability Commissioner to promote and protect the rights of people who use mental health and addiction services. This includes two areas of responsibility:

- To make decisions on complaints, including complaints about mental health and addiction services; and
- To monitor and advocate for improvements to mental health and addiction services.

Monitoring and advocacy through complaints

Our complaints resolution work enables HDC to identify individual and wider service and system issues that need to be addressed, and make recommendations to ensure that services improve as a result of what is learnt from the complaints we consider.

In 2016/17, HDC received 247 complaints in relation to mental health and addiction services. This is an increase on the 213 complaints received about mental health and addiction services in 2015/16. Commonly complained about issues in relation to mental health services in 2016/17 are set out below in Figure 12.

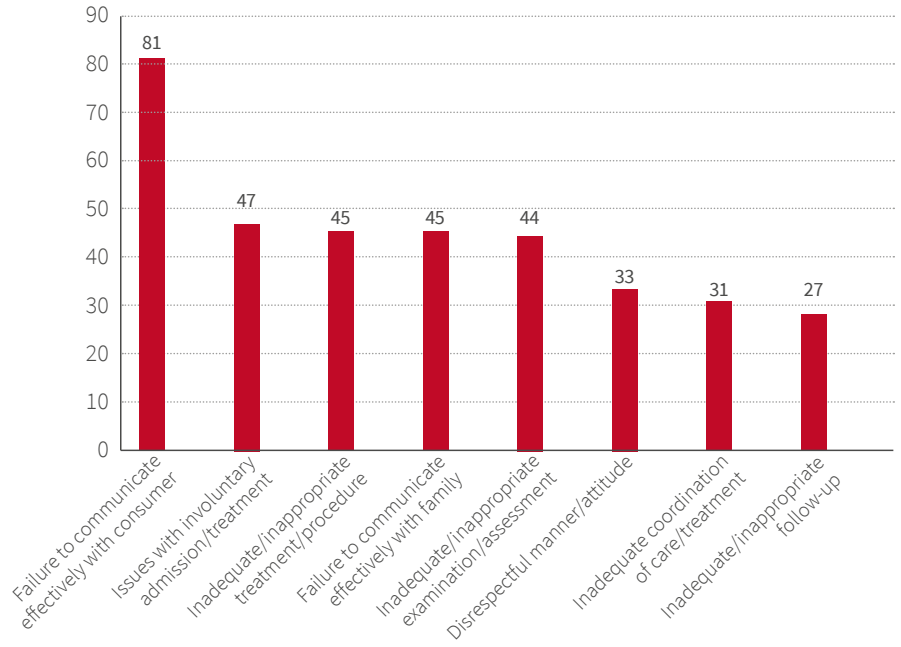
Communication issues featured prominently in complaints about mental health services in 2016/17, with "failure to communicate effectively with consumer", "failure to communicate effectively with family" or "disrespectful manner/attitude" being raised in up to 33% of complaints. "Issues with involuntary admission/treatment" were raised in 19% of complaints and related to issues about being placed under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Complaints about the adequacy or appropriateness of treatments/procedures, examinations/assessments or follow-up were also common, featuring in up to 18% of complaints.

HDC closed 231 complaints about mental health and addiction services in 2016/17. Service improvement recommendations were made in relation to 24 closed complaints, including seven cases where, following an investigation, it was found that a provider had breached the Code of Health and Disability Services Consumers' Rights.

The most common recommendations made to providers regarding mental health complaints in 2016/17 included apologies to the consumer and/or the consumer's family, audits of processes and policies, and additional staff training. One recommendation, made in relation to a complaint about excessive use of force during restraint, resulted in the inpatient unit improving access to sensory modulation tools for stress relief, including a massage chair, weighted blankets and weighted animals — an evidence-based approach to assist mental health consumers to moderate their responses when distressed and reduce the use of restraint. Another practical recommendation, arising from a complaint about inadequate provision of information to the consumer regarding prescribed medication, resulted in the provider producing information sheets about commonly used medications, for display in the patient and family areas of the service.

HDC monitors providers' compliance with recommendations by seeking evidence of changes made. In 2016/17, providers were fully compliant with the recommendations made to them by HDC in response to complaints about mental health services.

Figure 12: Mental health and addiction services complaints received — commonly complained about issues in 2016/17.[13]



[13] Note that this graph relates to all issues complained about in relation to mental health and addiction services, not just the primary issue complained about. Each complaint has been coded for up to seven issues, and therefore the number of complaints received in relation to each issue will not total the number of complaints received about mental health and addiction services.

Listening to consumers, whānau, and the wider sector

The Mental Health Commissioner regularly engages with key sector stakeholder groups, including consumer and family/whānau networks, providers, government agencies, and workforce organisations. HDC also collects the voices of consumers and their families through Mārama Real-time Feedback, our consumer engagement survey tool. This tablet-based survey is now used by 16 DHB providers, and 11 non-government organisations. By the end of 2016/17, approximately 12,800 consumer and family voices had been collected since the tool was first piloted in 2014. Over 80% of consumers surveyed would recommend the services they received to friends and family. The data gathered in the survey will contribute to the ongoing work of the Mental Health Commissioner to report publicly on the state of mental health and addiction services in New Zealand.

Feedback from providers using Mārama Real-time Feedback confirms that the data is useful in informing quality improvements. HDC is now investigating options to improve analysis of the data collected and provide additional support to organisations using the tool for service improvements.

Influencing the system

The Mental Health Commissioner also advocates for system improvements through submissions on major policy proposals, presentations to stakeholders and engagement with providers and others about services and improvements required, and following up on progress to improve services. Notable examples of this work in 2016/17 include:

- A call for an action plan to set the direction for mental health and addiction services in response to a pressing need to address significant growth in demand for services, and the subsequent pressure on consumers and providers — a collaborative approach was proposed to address demand, access, coordination, quality, and workforce issues;
- Submissions in relation to Ministry of Health consultations on the discussion documents "The Mental Health Act and Human Rights" and "A Strategy to Prevent Suicide in New Zealand: Draft for public consultation";
- Feedback on the revised Royal Australian and New Zealand College of Psychiatrists Code of Ethics; and
- Preparation and circulation of a report on stakeholder views to improve the safe use of the anti-psychotic medication clozapine.

Developing a public platform for system change

A major focus for HDC in 2016/17 has been to improve and promote public reporting on the state of mental health and addiction services in New Zealand. In particular, HDC is preparing the first of what will become an annual report on the state of mental health and addiction services in New Zealand. The purpose of the report is to bring transparency to the work of the Mental Health Commissioner, highlight challenges and successes for mental health and addiction services, and make recommendations for improving those services. The report, to be published in February 2018, will be underpinned by HDC's monitoring work — our complaints function, consumer and sector feedback, and analysis of sector performance information.

A major focus for HDC in 2016/17 has been to improve and promote public reporting on the state of mental health and addiction services in New Zealand.

Failure to undertake adequate risk assessment and involve family appropriately in care (14HDC01268)

A young man, accompanied by his parents, presented to an emergency department with a complaint of testicular pain. On assessment, no source for the testicular pain was found, and the impression was of "[a]nxiety and depressed mood — suicidal ideation". The man underwent an acute mental health review and an urgent psychiatric assessment for possible ward admission. The impression of the psychiatrist who completed the assessment was that of "[m]ajor [d]epression". His management plan was for the man to return home with his parents (who were present at the assessment), and to return for a further assessment the following morning.

At the following morning's assessment, which was also attended by the man's father, the psychiatrist concluded that the man was experiencing a major depressive disorder with no imminent risk of self-harm. The psychiatrist made the decision to discharge the man, with suggested follow-up with his GP for his testicular pain, and consideration of counselling in the community. The man returned home with his father. Subsequently, the man left the house and later was involved in an incident that resulted in injuries causing his death. The man's parents told HDC that the psychiatrist's assessment of their son was not discussed with them, their views were not sought, and they felt that they were given no choice but to have their son at home, despite their grave concerns about him.

The psychiatrist was found to have failed to provide services to the man with reasonable care and skill, in breach of Right 4(1) of the Code, by failing to:

- Ascertain adequately, and take into account, the man's parents' opinions on risk and their views on the proposed management plan at the initial assessment;
- Carry out an adequate risk assessment and formulate an adequate management plan for a man presenting with suicidal ideation;
- Admit the man, either voluntarily or compulsorily under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and, having decided not to admit the man, failing to offer him ongoing specialist follow-up, or to provide clear, specific guidelines to the man's GP; and
- Provide sufficient information to the man's father about his son's condition, and failing to discuss the proposed management plan adequately or provide clear information about that management plan during the second assessment.

In relation to this case, HDC's expert advisor stated: "[I]t would be widely clinically accepted that in the assessment of suicidal patients the views of the families/carers [should] be sought and documented."

In response to recommendations by the Mental Health Commissioner, the psychiatrist undertook further training on communication with patients and in relation to clinical assessment, and provided a letter of apology to the young man's family. Additionally, the Medical Council of New Zealand decided to undertake a review of the psychiatrist's performance, and the DHB agreed to undertake a review of all patients seen and discharged by mental health services during a one-month period, to look at short-term outcome and assess whether risk assessments had been assigned appropriately.

Coordination of care and failure to provide adequate pain relief (15HDC00563)

A man who was receiving long-term opioid substitution treatment from an addiction service presented to the emergency department at his local hospital after falling off a ladder. Following the presentation, the man was found to have multiple nodules on his lungs and a lesion on his liver. He was admitted into hospital for further investigation.

While in hospital, the man contacted an addiction clinician at the addictions service, to advise of his condition. The addiction clinician informed the manager at the addictions service. The minutes from the addictions service's weekly meeting noted that the man was being investigated for liver cancer and was requesting to have his methadone increased when discharged from hospital.

The hospital discharge summary referred to the man's "possible poor prognosis" and included a plan for outpatient follow-up and GP review of the man's abdominal pain and pain relief.

The man presented at the hospital again, reporting shortness of breath and abdominal pain. He was admitted to the medical ward and provided with morphine. The man's admission and pain were reported to the manager at the addictions service. The manager told the addiction clinician that she had spoken to an addiction specialist, and that they "should be looking at reducing [the man's] methadone not increasing it". However, the addiction specialist told HDC that he did not discuss the man with the manager at the addictions service at that time, and that the information was based on a previous discussion.

The man was discharged by a house officer, with a prescription for increased methadone intended for acute pain relief. The man was noted at the time to be in severe pain with a deteriorating clinical condition.

The man presented the house officer's prescription to a pharmacy. Because of the change in methadone dose, the pharmacy called the addictions service. The addiction specialist called the house officer to clarify the prescription, and was advised that the methadone was prescribed to help with abdominal pain. The addiction specialist told HDC that the house officer was unaware of the man's current prescription and the DHB policy on prescribing methadone for addiction services clients on discharge. The house officer then cancelled the prescription.

The addiction specialist did not follow up on the prescription when he returned to work the next day.

The man's wife told HDC that over this period the man was in pain, and his condition was deteriorating rapidly.

The man was discussed at the next addictions service meeting, at which time it was noted that the man was having an MRI that afternoon. The minutes note that the addiction clinician was "reluctant to increase [the man's] methadone, due to concern [that he was] drug-seeking".

The man underwent the MRI, but it could not be completed because he was unable to lie still owing to pain. This information was relayed by the addiction clinician to the addiction specialist. The addiction specialist told HDC that this was the first indication he had that the man could be requiring methadone for clinical reasons rather than addiction. Responsibility for the man's methadone prescribing was handed over to a palliative care specialist. The man was transferred to hospice care, and passed away shortly afterwards.

There were a number of missed opportunities for communication about the man's situation, his condition, and his pain relief requirements, as a result of service-based failures attributable to the DHB. The man did not receive the pain relief he should have been able to access. As a result, it was found that the DHB failed to provide services to the man with reasonable care and skill, and breached Right 4(1) of the Code.

The Mental Health Commissioner made a number of recommendations, including that the DHB develop a process for formal handover of addictions service clients when they move from outpatient to inpatient services and vice versa, conduct an audit to ensure that all interactions with clients are recorded in addictions service records and/or clinical records if relevant, and review and revise as necessary the position descriptions for addictions service staff to ensure clarity of role expectations, professional development and support. Refresher training for staff and an apology to the man's family were also recommended.

4.5 Education

HDC undertakes a number of educational activities in order to ensure that lessons from complaints are not lost, but are reported back to the sector in a way that supports systemic improvements in safety and quality.

HDC conducts a number of education sessions for both provider and consumer groups. The sessions are designed to equip providers and consumers with a better understanding of consumer rights and provider responsibilities under the Code, and of the common issues that appear in complaints.

Wherever possible, complaints are resolved at the lowest appropriate level to ensure early resolution. In many cases, early resolution is achieved by service providers resolving complaints themselves. As part of our focus on empowering providers to deal with complaints better themselves, HDC conducts complaints management workshops for DHBs and primary care providers.

HDC is working to ensure that analysis of our complaints data is undertaken and reported back to the sector and to the general public, allowing them to learn from the trends and patterns that emerge across complaints. HDC does this by publishing six-monthly reports on DHB complaints data, and a number of other reports on areas of research interest to HDC.

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

HDC conducted 36 education sessions in 2016/17. These sessions included presentations to professional colleges, universities, DHBs, private hospitals, and other provider groups. Presentations were also given at a number of conferences in 2016/17, including the Medical Law Conference, the Practice Managers and Administrators Association of New Zealand Conference, the 9th Annual Elder Law for the Health Sector Conference, and the General Practice Conference.

In line with HDC's strategic priority to assist providers to improve their complaints processes so that complaints are resolved at the lowest appropriate level, in 2016/17 HDC conducted two complaints management workshops for DHBs, and three such workshops for primary care providers. These interactive workshops are targeted at the front-line staff who deal with complaints as they happen. By conducting these workshops, HDC aims to increase the confidence of staff and their capability to resolve and learn from complaints. The vast majority of those who attended these workshops reported that they were satisfied or very satisfied with the session.

Education is also delivered directly to consumers and providers through responses to individual enquiries about the Act and Code and the work of HDC. In 2016/17, HDC provided formal written responses to 44 enquiries.

Promoting learning through complaints trend reports

One of the ways in which HDC promotes learning from complaints is through reporting on the learnings that come from the analysis of HDC complaints data.

HDC provides DHBs with six-monthly complaints trend reports, which detail the issues and service areas complained about in relation to individual DHBs and all DHBs nationally. The reports allow DHBs to identify aspects of care commonly at issue in complaints to HDC, and to ascertain how their complaint patterns compare both with themselves over time and nationally across all DHBs. In line with HDC's strategic priority to work with providers to improve complaints processes, the reports also include reference to any complaints about DHB complaints management processes. In 2016/17, all DHBs rated the reports as useful for improving services.

HDC also regularly produces reports on areas of research interest to HDC. In 2016/17, HDC produced two such reports. The first report was published in September 2016 and was entitled "Residential Aged Care: Complaints to the Health and Disability Commissioner 2010–2014". The report presented an analysis of the issues raised and the common care deficiencies identified. It also brought together the various learnings from the recommendations HDC had made in relation to the facilities complained about, with a view to improving quality of care.

The second report was published in December 2016 and was entitled "Complaints to the Health and Disability Commissioner involving Doctors". The report presented a descriptive analysis of the demographic characteristics of doctors complained about (such as gender, specialty, years in practice, etc) between 2009 and 2015, and of the issues commonly complained about in relation to doctors. The report is designed to encourage doctors to consider their service provision in relation to commonly complained about issues, and to contribute to the research literature on which providers may be at a greater risk of a complaint.

These reports on HDC's complaints data are widely disseminated to the sector, including to relevant providers, regulatory authorities, the Health Quality & Safety Commission, the Accident Compensation Corporation, the Ministry of Health, professional colleges, and consumer groups.

Submissions

Through making 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 consumers of health services or disability services, or both.

In 2016/17, submissions included comments on policies, procedures, codes of conduct, and guidelines to the University of Otago, the Ministry of Health, the Office for Disability Issues, the Dental Council of New Zealand, the Royal Australian and New Zealand College of Psychiatrists, the Nursing Council of New Zealand, Crown Law, and the Royal College of Pathologists of Australasia.

HDC undertakes a number of educational activities in order to ensure that lessons from complaints are not lost, but are reported back to the sector in a way that supports systemic improvements in safety and quality.

4.6 Disability

The New Zealand Disability Strategy was updated in November 2016. The Deputy Commissioner, Disability, is responsible for HDC's work on both the Strategy and the United Nations Convention on the Rights of Persons with Disabilities. The New Zealand Disability Strategy 2016–2026 contains specific outcomes that need to be achieved. Outcome Three focuses on "Health and Wellbeing". HDC's work as the independent consumer watchdog of health care and disability service providers links with the following elements of Outcome Three:

- Access to mainstream health services is barrier free and inclusive.
- Services that are specific to disabled people, including mental health and aged care services, are high quality, available, and accessible.
- All health and well-being professionals treat disabled people with dignity and respect.
- Decision-making on issues regarding the health and well-being of disabled people is informed by robust data and evidence.

With these areas of focus in mind, a review of the complaints received over the past year provides insight into the experiences of consumers and their family/whānau in relation to disability services, and the key issues of concern.

In 2016/17, HDC received 107 complaints relating to disability services. This represents a 10.3% increase on the 97 complaints HDC received in the preceding year.

The number of complaints may have increased since the previous year, but the primary issues most commonly complained about in 2016/17 are consistent with the issues reported in previous years. Complaints tended to focus upon care and treatment (27%), disability specific issues (24%), access and funding (18%), and communication (13%). The most common specific primary issues complained about in relation to disability services in 2016/17 were inadequate/inappropriate disability-related support provided (15%), lack of access to subsidies/funding (9%), lack of access to services (8%), inadequate/inappropriate non-clinical care (8%), inadequate coordination of care/treatment (7%), and failure to communicate effectively with a consumer (7%).

In 2016/17, the majority of complaints received about disability services came from either the consumer's family/whānau (47.7%) or consumers themselves (38.3%).

The Deputy Commissioner, Disability, has a particular focus on education within the disability sector, and is responsible for HDC's work on making complaints management processes more accessible to disabled consumers, and increasing their awareness of their rights under the Code, and what to do if they have concerns about a health or disability service. With this objective in mind, in the last year HDC produced a new Easy Read Code of Rights poster and an Easy Read booklet about HDC's complaints assessment process. Both resources can be downloaded from HDC's website.

HDC continues to value the opportunities it has to speak to disabled consumers about their rights and what to do if they have concerns. Over the past 12 months, we have concentrated on delivering seminars in the regions to young adult students who have a disability and are attending tertiary institutes. The seminars have allowed HDC to connect with young people who have a disability, and encourage them to complain if they are unhappy with a health or disability service they have received. In 2016/17, the Nationwide Health and Disability Advocacy Service also delivered education sessions and visited all of the 930 certified residential facilities across the country at least once, with over 577 certified residential facilities visited at least twice. The visits allow residents and their family/whānau to meet advocates and learn more about the support they can offer to people who receive health and disability services. This recognises the vulnerability of consumers in the disability sector, and the additional support they may require when making complaints.

An investigation closed by HDC in the past year (see the case study below) highlights the risks to disabled consumers if the health services received are not of an appropriate standard. Vulnerable consumers are often reliant on the support provided by health and disability service providers to maintain their immediate safety and well-being. This particular case is unique, but not isolated, and highlights the particular challenges when a younger consumer with severe disabilities is supported in an aged care facility.

HDC continues to value the opportunities it has to speak to disabled consumers about their rights and what to do if they have concerns.

Care of a person with disabilities in an aged care facility (15HDC00423)

A woman in her late forties was a resident in an aged care facility and required hospital-level care. The woman had multiple sclerosis (MS) and, as a result, was paraplegic and largely bed bound, was blind in her left eye, and required a long-term urinary catheter. She also suffered from diabetes and required insulin, had a cardiac pacemaker for complete heart block, and suffered from syndrome of inappropriate anti-diuretic hormone secretion (SIADH) and depression.

The woman was prescribed zopiclone for insomnia. Subsequently, following review, her general practitioner charted an additional dose of zopiclone, as required, at night. Often the second dose of zopiclone was administered at the woman's request between 2am and as late as 6.30am. This caused regular daytime sleepiness and associated reduced appetite and nutrition.

One of the woman's caregivers observed a pressure area on her sacrum. A wound care plan and an evaluation record were commenced and, over the next week, the wound area was re-dressed regularly.

The woman's general practitioner assessed the pressure wound as superficial. He expected it to respond well to good nursing care but, unfortunately, from that evening the wound began to deteriorate.

Over the next fortnight, nursing staff recorded the increasing deterioration in the wound, and in the woman's general condition. However, no action was taken to refer the woman to a wound care specialist nurse or to seek a reassessment by her general practitioner.

Nursing staff continued to record the woman's deteriorating general condition and diminished appetite, and a further deterioration in the sacral pressure wound was noted, but again no further medical advice was sought. On the same day that the further deterioration was noted, the woman was administered zopiclone at 2pm.

Two days later, staff found the woman to be unresponsive. By the time her vital signs were taken in the early afternoon, she was acutely unwell with a high fever, low blood pressure, diabetic ketoacidosis, and shock. The GP's practice was alerted by fax and telephone call, and two hours later recommended that the woman be sent to a secondary level hospital by ambulance.

The woman was transferred to a tertiary level hospital, and underwent urgent surgical debridement of the sacral pressure wound. Postoperatively, despite maximum inotropic support and ventilation, her condition became unsupportable. Sadly, she died from septic shock as a result of necrotising fasciitis associated with the sacral pressure wound.

The Deputy Commissioner, Disability found that staff at the rest home failed to assess, think critically, and act appropriately in response to the woman's deteriorating wound and general condition. In addition, staff repeatedly administered zopiclone at inappropriate times without reference to the prescriber to seek advice. Accordingly, it was found that the rest home failed to provide the woman with services with reasonable care and skill, in breach of Right 4(1) of the Code.

The clinical manager of the facility was also found in breach of Right 4(1), in relation to her management of the administration of zopiclone, and in her assessment of the woman's wound deterioration. The unit coordinator was found in breach of Right 4(1), as she failed to act appropriately in response to the deteriorating wound, and did not respond appropriately when the woman was found to be acutely unwell. The woman's allocated nurse also breached Right 4(1) in relation to wound management and the administration of zopiclone.

Adverse comment was made in respect of the oversight of the administration of "as required" zopiclone by the woman's general practitioner.

The Deputy Commissioner, Disability, recommended that the facility update HDC on the finalisation and implementation of the facility's Pressure Injury Prevention and Management policy and education pack, and its Short Term Care Plans policy; its implementation of the electronic medication management and electronic incident management systems; its Clinical Manager Framework and Orientation Programme; the position description for the clinical manager; and the implementation of the proposed new role of roving clinical manager.

It was also recommended that the clinical manager, the unit coordinator, and the woman's allocated nurse each provide a written apology to the woman's family.

The facility, the unit coordinator, and the woman's allocated nurse were referred to the Director of Proceedings.

5.0 Organisational Health and Capacity

Leadership

In 2016/17, the Commissioner led the organisation with the Executive Leadership Team of three Deputy Commissioners (one of whom is the Mental Health Commissioner), the Director of Proceedings, an Associate Commissioner Investigations, an Associate Commissioner Legal, a Corporate Services Manager, and an Associate Commissioner.

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, information technology, and financial management.

Equal employment opportunities

HDC is committed to being a good employer, promoting and maintaining equal employment opportunities. It has a "Good Employer and Equal Employment Opportunities Policy" that clearly outlines this commitment and the need to provide equal opportunities for employment, promotion, and training. The policy provides guidance to managers and staff, and ensures that these commitments are integrated throughout the business operation, including the recruitment process.

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.

Workplace profile

As at 30 June 2017, HDC had 67 full-time equivalent (FTE) employees, as follows:

- 78% females and 22% males; and
- 52 full-time and 30 part-time positions

HDC employs several people who have a range of impairments. These staff members provide valuable insight into the challenges faced by people in our communities who live with impairments. Staff who disclose their impairments are given support by HDC to ensure that their needs are met. Some support options include sign language interpreters, special equipment, and assistance to get to and from work.

HDC benefits from a diverse workforce from different ethnic backgrounds, including New Zealand European, Māori, Pacific, Asian, and other ethnicities, and aged between 20 to over 60 years.

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

Good employer obligations

Leadership, accountability, and culture

The Executive Leadership Team is dedicated to working collaboratively to achieve the organisation's strategic objectives. Managers are accountable for leading a performance culture that is supportive and equitable. Staff forums are held regularly in both the Auckland and Wellington offices to discuss and share 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.
We have a comprehensive induction programme and orientation plan for new staff. The induction programme is for all new staff members, and provides an introduction to the team; an oversight of the organisation's activities; information on policies, procedures and tools; and training as required. We also carry out a "Fresh Eyes" survey to obtain feedback from new staff members. The feedback received via these surveys supports continuous improvements to the organisation, to support staff and improve work practices.

Employee development, promotion, and exit

HDC's policies support professional development and promotion. Training and development needs and career development needs are formally identified as part of the performance appraisal process. Staff members jointly develop with their manager a performance management agreement tailored to their role, with clearly defined objectives and a supporting development plan.

HDC provides a structured training programme to support staff as they develop and progress in their roles. Professional development by employees is encouraged, and financial assistance and/or study leave may be granted by the Commissioner.

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.

HDC offers long service leave in addition to standard leave under the Holidays Act 2003, to acknowledge the commitment, dedication and valuable contribution of staff.

Harassment and bullying prevention

HDC has an "Anti-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 Executive Leadership Team meetings, and hazards are managed actively. During the year, HDC reviewed and updated its Health and Safety policy to ensure compliance with the Health and Safety at Work Act 2015, and organised training for all staff.

HDC has a number of initiatives in place to promote a healthy and safe working environment, including the use of VITAE (which offers confidential counselling services), provision of fruit in each office, and flexible working hours.

Process and technology

Sustainability

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

Technology

HDC continues to seek initiatives to bring positive changes to the business. In 2016/17, HDC upgraded its Advocacy Database System and improved its online database archiving system. These initiatives help to enhance capability and efficiency, as well as minimising associated costs. In addition, HDC is in the process of updating its website, and is making a series of improvements to its main database and telephone systems.

Physical assets and structures

HDC manages its assets cost-effectively. In 2016/17, HDC renewed its lease for its Auckland premises at a competitive rate in a challenging property market. HDC conducted a refit of the Auckland office to create a more open environment, which has enhanced capacity without requiring additional space. Our governance policies and practices are strong. Our assets are maintained and cared for to ensure that they provide an appropriate useful life.

6.0 Statement of Performance

6.1 Output Class 1: Complaints resolution

Financial Performance of Output Class

For the year ended 30 June

	Actual 2017 $	Budget 2017 $	Actual 2016 $
Revenue	6,404,647	6,172,000	5,869,704
Expenditure	6,464,354	6,246,000	5,776,764
Net surplus/(deficit)	**(59,707)**	**(74,000)**	**92,940**

Performance and measures	Achievement
Output 1.1 — Complaints management	
Efficiently and appropriately resolve complaints	**Targets achieved**
Receive an estimated 2,000 complaints.	2,211 complaints were received during the year. This represents a 12.9% increase on the last year's volume (2016: 1,958).
Close an estimated 2,000 complaints. Undertake an estimated 100 investigations.	2,015 complaints were closed during the year; this includes undertaking and closing 80 investigations (2016: 2,007).
	Targets partially achieved[14] Total open files at year end was 626 (2016: 430).
Manage complaints so that: • No more than 17% of open complaints are 6–12 months old. • No more than 15% of open complaints are 12–24 months old. • No more than 1% of open complaints are over 24 months old.	Age of open complaints at 30 June 2017: • 6–12 months old, 121 out of 626 — 19% (2016: 16.5%) • 12–24 months old, 70 out of 626 — 11% (2016: 16.3%) • Over 24 months old, 29 out of 626 — 4% (2016: 1.6%)
Output 1.2 — Quality improvement	
Use HDC complaints management processes to facilitate quality improvement	**Targets achieved**
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: 97% compliance.	Between 1 July 2016 and 30 June 2017, 228 complaints with quality improvement recommendations were due by 164 providers, and 227 (99.6%) were complied with. There was only one provider who did not comply with HDC's recommendations. Referral to the provider's appropriate funder is being considered. HDC will continue to monitor and follow up the providers who received HDC's recommendations to ensure their compliance. • 99.6% compliance (2016: 97%)

[14] This is a reflection of the 12.9% growth absorbed during 2016/17. HDC continues to focus on closing these older, and more complex files while managing a 28% increase in complaint receipts in the first quarter of 2017/18.

6.2 Output Class 2: Advocacy

Financial Performance of Output Class

For the year ended 30 June

	Actual 2017 $	Budget 2017 $	Actual 2016 $
Revenue	4,058,654	3,917,000	4,123,798
Expenditure	4,096,490	3,964,000	4,060,619
Net surplus/(deficit)	**(37,836)**	**(47,000)**	**63,179**

Performance and measures	Achievement
Output 2.1 — Complaints Management	
Efficiently and appropriately resolve complaints	**Target substantially achieved**
Receive an estimated 3,600 to 3,800 complaints.	2,823 new complaints were received by the Advocacy Service in the year ended 30 June 2017 (2016: 3,331).
Close an estimated 3,600 to 3,800 complaints.	During the year ended 30 June 2017, 2,739 complaints were closed (2016: 3,384).
Manage complaints so that: • 85% closed within 3 months • 95% closed within 6 months • 100% closed within 9 months	Complaints were managed so that: • 82% were closed within 3 months (2016: 88%) • 98% were closed within 6 months (2016: 99%) • 100% were closed within 9 months (2016: 100%)
Consumers and providers are satisfied with Advocacy's complaints management processes	**Target achieved**
Undertake a yearly consumer satisfaction survey with 80% of respondents satisfied with Advocacy's complaints management processes.	88% of consumers and 86% of providers who responded to satisfaction surveys were satisfied or very satisfied with the Advocacy Service's complaints management process (2016: 92% of consumers and 88% of providers[15]).

[15] Satisfaction surveys were reviewed in 2016 and new survey questions have been utilised from 1 July 2016.

6.2 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 95% of certified aged care facilities at least once with multiple visits to facilities as required.	***Certified aged care facilities*** Advocates visited 100% (660) of certified aged care facilities at least once in the year ended 30 June 2017 (2016: 100%, 617 visits). Advocates visited 62% (412) of aged care facilities more than once in the year ended 30 June 2017 (2016: 69%, 426 visits).
Advocates visit 95% of certified residential disability services at least once with multiple visits to facilities as required.	***Certified residential disability services*** Advocates visited 100% (930) of certified residential disability services at least once in the year ended 30 June 2017 (2016: 99.7%, 995 visits). Advocates visited 62% (577) of certified residential disability services more than once in the year ended 30 June 2017 (2016: 62%, 620 visits).
Output 2.3 — 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 1,635 education sessions were provided (2016: 2,005).
Consumers and providers are satisfied with the educational sessions: • Seek evaluations on sessions with 80% of respondents satisfied.	87% of consumers and providers who responded to a survey were satisfied with the Advocacy Service education session they attended (2016: 91% of consumers and 97% of providers).

6.3 Output Class 3: Proceedings

Financial Performance of Output Class

For the year ended 30 June

	Actual 2017 $	Budget 2017 $	Actual 2016 $
Revenue	552,187	627,000	582,551
Expenditure	557,334	634,000	573,367
Net surplus/(deficit)	**(5,147)**	**(7,000)**	**9,184**

Performance and measures	Achievement
Output 3.1 — Proceedings	
Professional misconduct is found in disciplinary proceedings Professional misconduct is found in 75% of disciplinary proceedings.	**Targets achieved** Professional misconduct was found in 100% (3 of 3) of HPDT proceedings during the year ended 30 June 2017 (2016: 86%, 6 of 7 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 2017 (2016: 100%, 3 of 3 proceedings).
An award is made where damages sought An award of damages is made in 75% of cases where damages are sought.	**Targets achieved** Resolution by negotiated agreement was achieved in 100% (2 of 2) proceedings (2016: 100%, 3 of 3 proceedings).
Where a restorative approach is adopted, agreement is reached between the relevant parties 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% (2 of 2) of cases where a restorative approach was adopted (2016: 100%, 1 of 1).

6.4 Output Class 4: Education[16]

Financial Performance of Output Class

For the year ended 30 June

	Actual 2017 $	Budget 2017 $	Actual 2016 $
Revenue	372,735	402,000	556,814
Expenditure	376,210	408,000	504,395
Net surplus/(deficit)	**(3,475)**	**(6,000)**	**52,419**

Performance and measures	Achievement
Output 4.1 — Information and Education for Providers	
Monitor DHB complaints and provide complaint information to DHBs	**Targets achieved**
Produce six-monthly DHB complaint trend reports and provide to all DHBs.	Two six-monthly DHB complaint trend reports for each DHB were produced and provided to all DHBs.
80% of DHBs who respond to an annual feedback form find complaint trend reports useful for improving services.	100% (20/20) of the DHBs who responded to an annual feedback form rated the complaint trend reports as useful for improving services (2016: 97%, 37 of 38).
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 93% of respondents reported that they were satisfied or very satisfied with each session respectively (2016: 100% and 97%).
Assist primary care providers to improve their complaints systems	**Targets achieved**
Provide two complaints resolution workshops for primary care providers.	Three complaints resolution workshops for primary care providers were held (2016: two).
Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	100% of respondents reported that they were satisfied with each session (2016: 100% and 96%).

[16] Education and Disability were shown as one combined output class prior to the 2016/17 year.

6.4 Output Class 4: Education — Continued

Performance and measures	Achievement
Output 4.1 — Information and Education for Providers	
Promote awareness of, respect for, and observance of, the rights of consumers and how they may be enforced	**Targets achieved**
Provide 30 educational presentations. Consumers and health and disability service providers are satisfied with the educational presentations.	36 educational presentations were made (2016: 49).
Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	97% of respondents who provided feedback (33 of 34) reported that they were satisfied with the presentations (2016: 98%, 45 of 46).
Make public statements and publish reports in relation to matters affecting the rights of consumers	**Target achieved**
Produce and publish on the HDC website key Commissioner decision reports and related articles. Report on total number.	55 decisions[17] were published at www.hdc.org.nz (2016: 59).
Output 4.2 — 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.	13 submissions were made (2016: 17).
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.	44 formal responses to enquiries were provided (2016: 51).

[17] Decisions published in 2016/17 were not all closed in 2016/17.

6.5 Output Class 5: Disability[18]

Financial Performance of Output Class

For the year ended 30 June

	Actual 2017 $	Budget 2017 $
Revenue	501,081	585,000
Expenditure	505,752	592,000
Net surplus/(deficit)	**(4,671)**	**(7,000)**

Performance and measures	Achievement
Output 5.1 — 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 2017, HDC produced two new educational resources: • An Easy Read Complaints Assessment process booklet targeting people with a learning disability. • An Easy Read Code of Rights poster. Both resources were published on HDC's website and are accessible to people using accessible software.
At least two new educational resources will be available in plain English.	Two new educational resources were made available in plain English in 2016/17: • An Easy Read Complaints Assessment process booklet. • An Easy Read Code of Rights poster. (2016: two resources were produced.)
Facilitate four regional consumer seminars. Consumers are satisfied with the seminars: • Seek evaluations on seminars with 80% of respondents satisfied.	In the year ended 30 June 2017, five regional consumer seminars were facilitated in Auckland (two seminars), Wellington, Tauranga and Napier. • 95.6% of the respondents reported that they were satisfied with the seminar (2016: four regional consumer seminars were facilitated with respondents' satisfaction reported at 100%).

[18] Education and Disability were shown as one combined output class prior to the 2016/17 year.

6.6 Output Class 6: Mental health and addiction services — Systemic monitoring and advocacy

Financial Performance of Output Class

For the year ended 30 June

	Actual 2017 $	Budget 2017 $	Actual 2016 $
Revenue	505,058	530,000	782,875
Expenditure	509,767	537,000	674,278
Net surplus/(deficit)	**(4,709)**	**(7,000)**	**108,597**

Performance and measures	Achievement
Output 6.1 — Systemic Monitoring and Advocacy	
Monitoring **Monitor mental health and addiction services to identify potential improvements to services**	**Targets achieved**
Monitor and analyse issues and trends identified by HDC complaints and the Advocacy Service.	HDC completed four quarterly analysis reports for Mental Health and Addiction complaints. These reports are used to inform HDC's advocacy role in relation to mental health and addiction services.
Maintain engagement with key sector stakeholders and monitor sector performance information to keep informed about service issues and trends.	HDC participated in 93 mental health and addiction sector stakeholder meetings in 2016/17, held three sector workshops to develop the monitoring and advocacy function, and sought feedback from stakeholders on a draft monitoring framework.
Determine HDC's future role in relation to the Real Time Feedback system (RTF).	HDC entered preliminary negotiations with a third party to undertake championing, management, and analysis of RTF data.
Provide briefings to the Minister as required.	The Mental Health Commissioner briefed the Minister of Health on findings of HDC's monitoring role, development of the role, and the introduction of a public report in early 2018.

6.6 Output Class 6: Mental health and addiction services — Systemic monitoring and advocacy — Continued

Performance and measures	Achievement
Output 6.1 — Systemic Monitoring and Advocacy	
Advocacy **Advocate for improvements to mental health and addictions services**	**Targets achieved**
Make recommendations and educational comments to providers (and other organisations or individuals) when resolving complaints to improve quality of mental health and addiction services and complaints resolution processes.	Service improvement recommendations were made in relation to 24 complaints relating to mental health and addiction services that were closed in 2016/17.
Monitor compliance with the implementation of recommendations: 97% compliance.	HDC monitors providers' compliance with recommendations by seeking evidence of changes made. In 2016/17, providers were fully compliant with 100% of recommendations made to them by HDC in response to complaints about mental health services.
Provide briefings or make recommendations or suggestions to any person or organisation in relation to issues or trends identified in HDC's monitoring of mental health and addiction services.	The Mental Health Commissioner briefed the Minister and the Director-General of Health regarding expectations for service development following the expiration of "Rising to the Challenge" and findings of the monitoring role to date. HDC also made submissions in relation to Ministry of Health consultations on the discussion document "The Mental Health Act and Human Rights" and "A Strategy to Prevent Suicide in New Zealand: Draft for public consultation" and provided feedback on the revised Royal Australian and New Zealand College of Psychiatrists Code of Ethics.

7.0 Financial Statements

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE
FOR THE YEAR ENDED 30 JUNE 2017

	Notes	Actual 2017 $	Budget 2017 $	Actual 2016 $
Revenue				
Funding from the Crown		12,070,000	12,070,000	11,670,000
Other revenue	2	324,362	163,000	245,742
Total revenue		12,394,362	12,233,000	11,915,742
Expenditure				
Personnel costs	3	6,422,265	6,484,000	5,845,081
Depreciation and amortisation expense	8, 9	183,293	215,000	279,188
Advocacy services		3,535,281	3,340,000	3,339,998
Other expenses	4	2,369,068	2,342,000	2,125,156
Total expenditure		12,509,907	12,381,000	11,589,423
Surplus/ (deficit)		**(115,545)**	**(148,000)**	**326,319**
Total comprehensive revenue and expense		**(115,545)**	**(148,000)**	**326,319**

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 2017

	Notes	Actual 2017 $	Budget 2017 $	Actual 2016 $
Assets				
Current assets				
Cash and cash equivalents	5	1,733,831	1,770,000	1,858,863
Receivables	6	96,320	42,000	30,181
Prepayments		84,473	90,000	92,661
Inventories	7	19,514	21,000	14,677
Total current assets		1,934,138	1,923,000	1,996,382
Non-current assets				
Property, plant and equipment	8	137,378	212,000	227,265
Intangible assets	9	111,206	85,000	54,056
Total non-current assets		248,584	297,000	281,321
Total assets		**2,182,722**	**2,220,000**	**2,277,703**
Liabilities				
Current liabilities				
Payables	10	457,459	653,000	496,181
Employee entitlements	11	361,090	320,000	342,197
Total current liabilities		818,549	973,000	838,378
Non-current liabilities				
Payables	10	61,151	-	20,758
Total non-current liabilities		61,151	-	20,758
Total liabilities		**879,700**	**973,000**	**859,136**
Net assets		**1,303,022**	**1,247,000**	**1,418,567**
Equity				
Contributed capital	13	788,000	788,000	788,000
Accumulated surplus/(deficit)	13	515,022	459,000	630,567
Total equity		**1,303,022**	**1,247,000**	**1,418,567**

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 2017

	Notes	Actual 2017 $	Budget 2017 $	Actual 2016 $
Balance at 1 July		1,418,567	1,395,000	1,092,248
Total comprehensive revenue and expense for the year		(115,545)	(148,000)	326,319
Balance at 30 June	**13**	**1,303,022**	**1,247,000**	**1,418,567**

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 2017

	Notes	Actual 2017 $	Budget 2017 $	Actual 2016 $
Cash flows from operating activities				
Receipts from the Crown		12,070,000	12,070,000	11,670,000
Interest received		54,928	68,000	72,469
Receipts from other revenue		83,478	95,000	200,892
Payments to suppliers		(5,778,931)	(5,622,000)	(5,553,067)
Payments to employees		(6,403,372)	(6,484,000)	(5,793,190)
GST (net)		(630)	-	(31,103)
Net cash from operating activities		25,473	127,000	566,001
Cash flows from investing activities				
Purchase of property, plant and equipment		(53,055)	(81,000)	(34,276)
Purchase of intangible assets		(97,450)	(120,000)	(16,850)
Net cash from investing activities		(150,505)	(201,000)	(51,126)
Cash flows from financing activities				
Receipts from capital contribution		-	-	-
Net cash from financing activities		-	-	-
Net increase/(decrease) in cash and cash equivalents		**(125,032)**	**(74,000)**	**514,875**
Cash and cash equivalents at beginning of the year		1,858,863	1,844,000	1,343,988
Cash and cash equivalents at end of the year	**5**	**1,733,831**	**1,770,000**	**1,858,863**

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

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 2017, and were approved by the Commissioner on 31 October 2017.

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.

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 2017 $	Actual 2016 $
Sale of publications	72,381	92,168
Interest revenue	54,133	67,524
Advocacy Trust contribution to IT costs	188,948	70,000
Sundry revenue	8,900	16,050
Total other revenue	**324,362**	**245,742**

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 2017 $	Actual 2016 $
Salaries and wages	6,225,655	5,623,054
Defined contribution plan employer contributions	177,717	170,136
Increase/(decrease) in employee entitlements	18,893	51,891
Total personnel costs	**6,422,265**	**5,845,081**

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

Employee Remuneration

	Actual 2017	Actual 2016
Total remuneration paid or payable:		
100,000 – 109,999	1	1
110,000 – 119,999	5	4
120,000 – 129,999	-	1
130,000 – 139,999	1	-
140,000 – 149,999	1	1
150,000 – 159,999	-	1
170,000 – 179,999	1	1
200,000 – 209,999	-	1
230,000 – 239,999	3	1
360,000 – 369,999	-	1
370,000 – 379,999	1	-
Total employees	**13**	**12**

During the year ended 30 June 2017, two employees received compensation and other benefits in relation to cessation totalling $34,709 (2016: 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 paid to the Commissioner, which includes all benefits paid to the Commissioner, during the period 1 July 2016 to 30 June 2017 is $370,230 (2016: $361,105).

4. Other expenses

Other expenses

	Actual 2017 $	Actual 2016 $
Audit fees	44,268	43,248
Staff travel and accommodation	152,377	144,279
Operating lease expense	421,448	412,092
Advertising	21,800	22,931
Clinical and legal advice	510,223	488,911
Policy and operational consultancy	268,548	146,358
Inventories consumed	54,216	54,762
Net loss on property, plant and equipment	647	1,734
Communications & IT	542,489	495,438
Other expenses	353,052	315,403
Total other expenses	**2,369,068**	**2,125,156**

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.

Operating leases as lessee

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

	Actual 2017 $	Actual 2016 $
Not later than one year	487,516	475,531
Later than one year and not later than five years	1,143,545	420,310
Later than five years	240,183	-
Total non-cancellable operating leases	**1,871,244**	**895,841**

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

The non-cancellable operating lease expense relates to the lease of these two offices and office equipment (2016: two offices leases and office equipment). The Auckland office lease expires in June 2023 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 2017 $	Actual 2016 $
Cash on hand and at bank	733,831	858,863
Term deposits with maturities less than 3 months	1,000,000	1,000,000
Total cash and cash equivalents	**1,733,831**	**1,858,863**

At 30 June 2017, the Health and Disability Commissioner holds no unspent grant funding received that is subject to restrictions (2016: 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. There was no receivable impairment in 2017 (2016: nil).

	Actual 2017 $	Actual 2016 $
Trade receivables	16,166	22,322
Other receivables	80,154	7,859
Total receivables	**96,320**	**30,181**
Total receivables comprises:		
Receivables from the sale of goods and services (exchange transactions)	23,230	30,181
Receivables from the lease incentive payment (exchange transactions)	73,090	-

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 2017 $	Actual 2016 $
Commercial inventories		
Publications held for sale	19,514	14,677
Total inventories	**19,514**	**14,677**

There was no write-down of inventories in 2017 (2016: $1,661). There were net write-down reversals of $17,128.

No inventories are pledged as security for liabilities (2016: 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 2015	460,813	1,980	155,099	647,199	40,889	58,391	1,364,371
Balance at 30 June 2016	444,375	2,673	144,323	656,393	40,889	62,669	1,351,322
Additions	28,138	977	23,834	-	-	804	53,753
Disposals	(6,070)	-	(7,012)	-	-	(3,344)	(16,426)
Balance at 30 June 2017	466,443	3,650	161,145	656,393	40,889	60,129	1,388,649
Accumulated depreciation and impairment losses							
Balance at 1 July 2015	194,175	1,191	149,736	610,339	40,889	51,921	1,048,251
Balance at 30 June 2016	255,481	1,769	140,498	631,883	40,889	53,537	1,124,057
Depreciation expense	93,787	923	25,213	18,381	-	4,689	142,993
Disposals	(5,988)	-	(7,012)	-	-	(2,779)	(15,779)
Balance at 30 June 2017	343,280	2,692	158,699	650,264	40,889	55,447	1,251,271
Carrying amounts							
At 1 July 2015	266,638	789	5,363	36,860	-	6,470	316,120
At 30 June 2016/1 July 2016	188,894	904	3,825	24,510	-	9,132	227,265
At 30 June 2017	123,163	958	2,446	6,129	-	4,682	137,378

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 $647 (2016: $1,735).

There are no capital commitments at balance date (2016: 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 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 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:

	2017		2016	
Acquired computer software	3 years	(33%)	2 years	(50%)
Developed computer software	3 years	(33%)	2 years	(50%)

Movements for each class of intangible asset are as follows:

	Acquired software	Internally generated software	Total
	$	$	$
Cost			
Balance at 1 July 2015	518,347	248,516	766,863
Balance at 30 June 2016/1 July 2016	535,197	248,516	783,713
Additions	97,450	-	97,450
Balance at 30 June 2017	632,647	248,516	881,163
Accumulated amortisation and impairment losses			
Balance at 1 July 2015	479,053	93,194	572,247
Balance at 30 June 2016/1 July 2016	512,205	217,452	729,657
Amortisation expense	9,236	31,064	40,300
Disposals	-	-	-
Balance at 30 June 2017	521,441	248,516	769,957
Carrying amounts			
At 1 July 2015	39,294	155,322	194,616
At 30 June 2016/1 July 2016	22,992	31,064	54,056
At 30 June 2017	111,206	-	111,206

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.

There are no capital commitments at balance date (2016: $12,350).

10. Payables

Accounting policy

Short-term payables are recorded at their face value.

Breakdown of payables and deferred revenue

	Actual 2017 $	Actual 2016 $
Payables under exchange transactions		
Creditors	248,659	241,884
Accrued expenses	56,184	75,829
Lease incentive	20,970	45,398
Total payables under exchange transactions	325,813	363,111
Payables under non-exchange transactions		
Taxes payable (GST, PAYE and rates)	131,646	133,070
Total payables under non-exchange transactions	131,646	133,070
Total current payables	**457,459**	**496,181**
Lease incentives	61,151	20,758
Total non-current payables	**61,151**	**20,758**
Total payables	**518,610**	**516,939**

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 to but not yet taken at balance date, and paid sick leave.

Employee entitlements

	Actual 2017 $	Actual 2016 $
Current portion		
Annual leave	361,090	342,197
Total employee entitlements	**361,090**	**342,197**

12. Contingencies

Contingent liabilities

As at 30 June 2017 there were no contingent liabilities (2016: nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2016: 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 2017 $	Actual 2016 $
Contributed capital		
Balance at 1 July	788,000	788,000
Capital contribution	-	-
Balance at 30 June	788,000	788,000
Accumulated surplus/(deficit)		
Balance at 1 July	630,567	304,248
Surplus/(deficit) for the year	(115,545)	326,319
Balance at 30 June	515,022	630,567
Total equity	**1,303,022**	**1,418,567**

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, Ministry of Inland Revenue, 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 2017 $	Actual 2016 $
Leadership Team		
Remuneration	1,766,797	1,547,248
Full-time equivalent members	8.31	6.80
Total key management personnel remuneration	**1,766,797**	**1,547,248**
Total full-time equivalent personnel	**8.31**	**6.80**

15. Financial instruments

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

	Actual 2017 $	Actual 2016 $
Loans and receivables		
Cash and cash equivalents	733,831	858,863
Receivables	96,320	30,181
Investments – term deposits	1,000,000	1,000,000
Total loans and receivables	1,830,151	1,889,044
Financial liabilities measured at amortised cost		
Payables (excluding income in advance, lease incentive, taxes payable and grants received subject to conditions)	304,842	317,713
Total financial liabilities measured at amortised cost	**304,842**	**317,713**

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
Advocacy services costs are higher than budgeted. The variance is a result of a change in funding arrangement with the National Advocacy Trust. The Trust was provided additional funding to enable it to pay for IT related costs. The majority of the Trust's IT support is provided by HDC. HDC recovered these costs from the Trust. This is reflected in the other revenue noted above.

Statement of financial position

Payables were lower than budgeted owing to fewer costs incurred towards the year end.

Prior to the year end, HDC renewed the lease of one of its premises. At the year end, an unbudgeted lease incentive was due to HDC. This had an impact of increasing receivables and non-current liabilities.

Statement of equity

The closing equity balance was higher than budgeted owing to a higher opening balance and the deficit for the year being lower than budgeted.

Statement of cash flows

The higher net cash outflow was mainly a result of payments related to the payable balance at the beginning of the year.

8.0 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 2017.

Anthony Hill

Health and Disability Commissioner

Jason Zhang

Corporate Services Manager

31 October 2017

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 2017

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, David Walker, 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 his behalf.

Opinion

We have audited:

- the financial statements of the Health and Disability Commissioner on pages 54 to 70, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of the Health and Disability Commissioner on pages 45 to 53.

In our opinion:

- the financial statements of the Health and Disability Commissioner on pages 54 to 70:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2017; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reduced Disclosure Regime Reporting Standards; and
- the performance information on pages 45 to 53:
    - presents fairly, in all material respects, the Health and Disability Commissioner's performance for the year ended 30 June 2017, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 31 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Commissioner and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

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

Responsibilities of the Commissioner for the financial statements and the performance information

The Commissioner is responsible on behalf of the Health and Disability Commissioner for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Commissioner is responsible for such internal control as he determines is necessary to enable the Health and Disability Commissioner to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Commissioner is responsible on behalf of the Health and Disability Commissioner for assessing the Health and Disability Commissioner's ability to continue as a going concern. The Commissioner is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the Health and Disability Commissioner, or there is no realistic alternative but to do so.

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

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health and Disability Commissioner's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit 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.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Commissioner.

- We evaluate the appropriateness of the reported performance information within the Health and Disability Commissioner's framework for reporting performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Commissioner and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Health and Disability Commissioner's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health and Disability Commissioner to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Commissioner regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Commissioner is responsible for the other information. The other information comprises the information included on pages 2 to 44 and 71, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

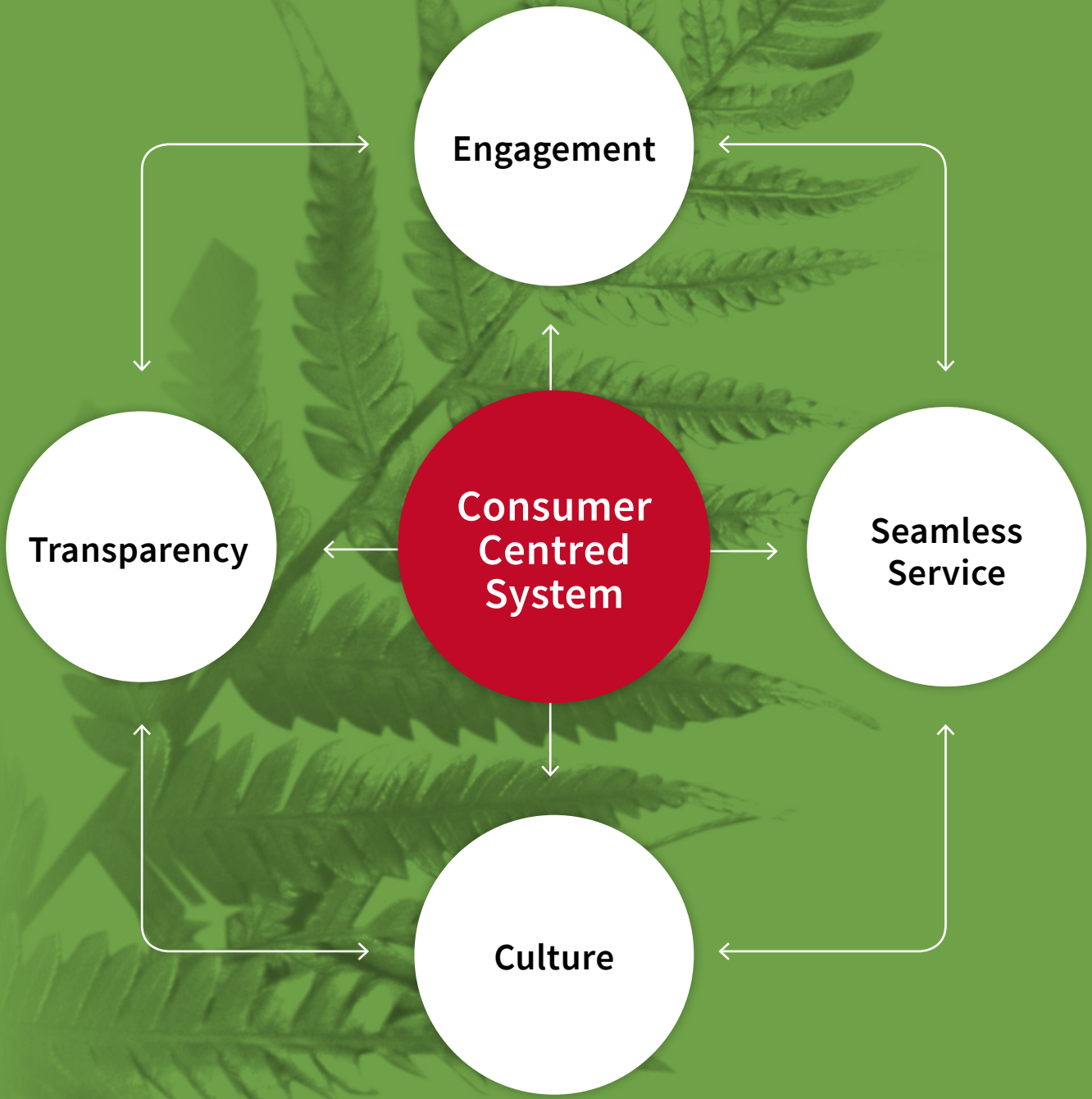
In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health and Disability Commissioner in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 (Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than in our capacity as auditor, we have no relationship with, or interests, in the Health and Disability Commissioner.

David Walker
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand


Engagement
Transparency
Consumer Centred System
Seamless Service
Culture

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