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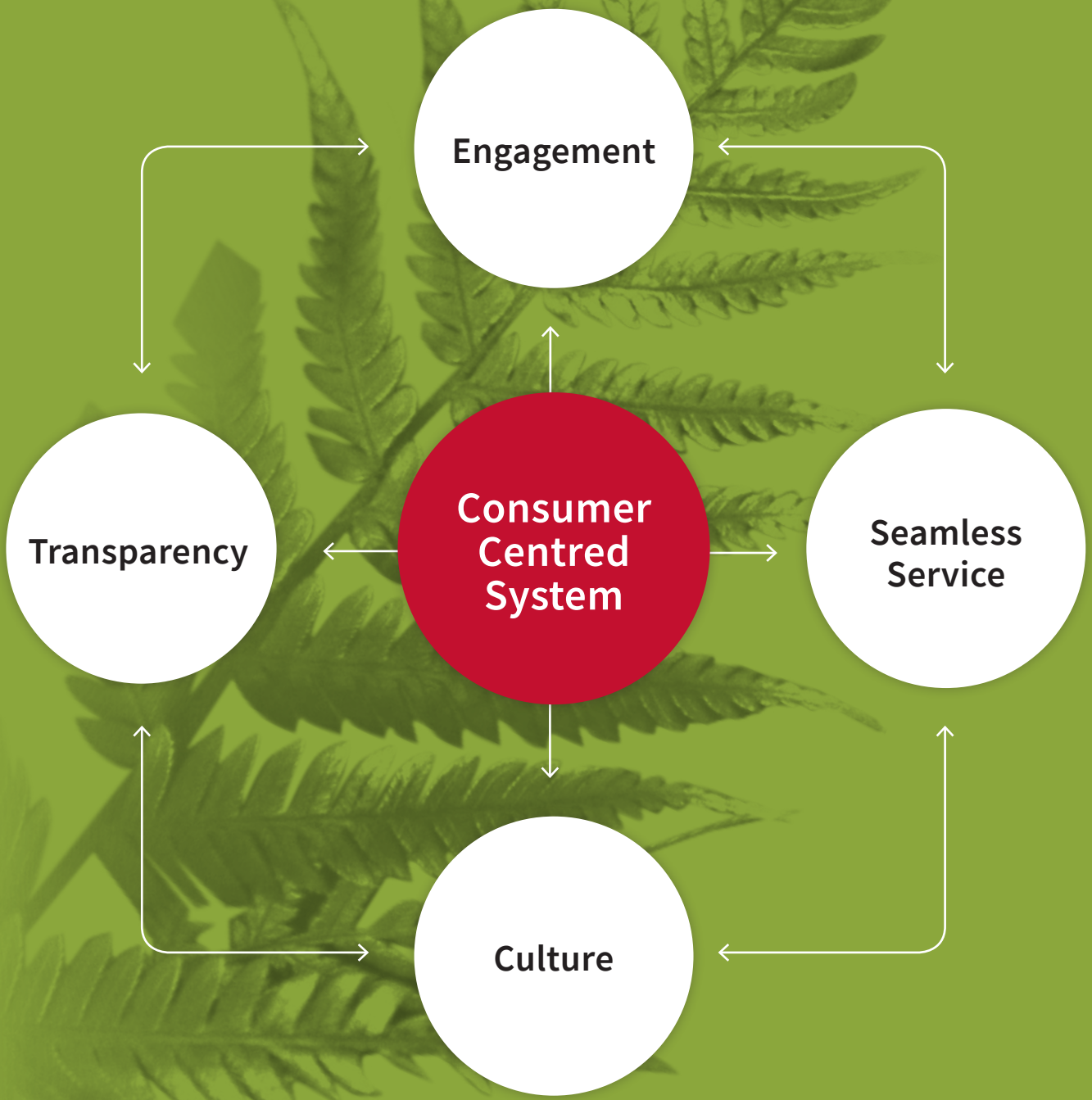
HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

ANNUAL REPORT
FOR THE YEAR ENDED
30 JUNE 2018


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

26 October 2018

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 2018.

Yours faithfully

Anthony Hill
Health and Disability Commissioner

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Commissioner's Foreword

Anthony Hill

Health and Disability Commissioner

I am pleased to report on another successful year for HDC.

HDC plays an essential role in the work of the New Zealand health and disability sectors as the independent watchdog for the promotion and protection of consumers' rights.

HDC remains committed to our vision of consumers at the centre of services. It is essential that systems and the people who work within them focus on the consumer — the person whose story it is and whose life is impacted. Providers must ensure that the consumer is adequately informed, and that the services provided meet the person's needs in a timely way, and are connected so that all services wrap around the person seamlessly and deliver appropriate care.

This year HDC has again seen significant growth in complaints received. The 2,498 complaints received in 2017/18 are a 13% increase on 2016/17 — a year that also featured growth of 13%. While absorbing this new level of activity, HDC closed 2,315 complaints — 8% ahead of plan and 15% more than last year. We demonstrated significant achievement in all output classes, and continue to make recommendations for improvement on hundreds of complaints. This was achieved with a break-even budget. Nonetheless, and despite this high performance, ongoing significant growth is having an effect, and is reflected in a higher number of open files at year end than in previous years.

As in every year, key themes in 2017/18 demonstrate the need for constant vigilance if health and disability service providers are to consistently and reliably achieve the standard of delivery required by the Code of Health and Disability Services Consumers' Rights (the Code). I comment on two of these below: increasing demand requiring effective prioritisation, and informed consent.

> HDC remains committed to our vision of consumers at the centre of services. It is essential that systems and the people who work within them focus on the consumer.

Increasing demand and the need for effective prioritisation

The development and introduction of new technology, therapies, and treatment can place pressure on the system by changing the treatment pathway for consumers, thus creating a need for an increased number of appointments, follow-up, or treatment by other services. Other factors, such as an aging population, can also result in an increased number of consumers seeking particular types of services. Provider accountability is not removed by the existence of systemic pressures. The Ministry of Health has a role in this area, but it is important that providers also assess, plan, adapt, and respond effectively to the foreseeable effects that new technologies and changing demographics will have on systems and demand. Additionally, in the context of resource constraint, appropriate prioritisation schemes become vital to managing risk.

This year I found two district health boards (DHBs) in breach of the Code for inadequate waiting-list management and the lack of an appropriate prioritisation system. One of these cases involved a young man with a family history of glaucoma, who experienced a six-month delay in receiving a follow-up appointment at a DHB ophthalmology service. By the time the man was seen again, he had suffered vision loss in his right eye. The service lacked capacity, in that the clinic did not have enough appointments for the number of patients clinicians needed to see, and the DHB did not have a prioritisation system in place that focused on patients' clinical need. The case is an important reminder that at all times, and particularly when a system is under pressure, patient prioritisation must be a key focus so that the patients with the highest clinical priority are seen first.

This case also illustrated themes often seen in matters that cross my desk — the importance of effective relationships between clinicians and management, and issues that arise when a culture of tolerance emerges, where the sub-optimal becomes normal. In this case, clinical staff had attempted to communicate to management their concerns about the clinical risk caused by the lack of capacity, but there was a lack of recognition of, and response to, this risk. Additionally, to some degree a culture of tolerance had developed — delays had become the norm. It is crucial that leadership is integrated — accountability lies across clinical and executive management. These are issues of central importance for all providers, and can have severe consequences for consumers if not recognised and acted on.

At their most basic level, these cases also serve to highlight the vision that underpins the work of HDC: the consumer at the centre of services. Since the inception of the Code, we have seen significant improvement in culture and practice when it comes to putting consumers at the centre of their care and obtaining informed consent. However, it is important that the health and disability sectors remain vigilant in ensuring that consumers' rights are upheld.

Informed consent

Informed consent lies at the heart of the Code. It is a theme that continues to present in complaints to HDC.

A man underwent anterior cervical discectomy and fusion surgery after sustaining a neck injury. The man said he was told that bone shavings would be taken from his hip and put between the vertebrae in his neck. However, donated material from a deceased person (allograft material) was used during the surgery without the man's knowledge or consent. At the time, the process at the DHB was such that it was not necessary to obtain consent for the use of donated material if the use of that material carried no risk. I considered that the fact that donated material was intended to be used, and that other options were available, was information that a reasonable consumer in those circumstances would expect to receive. As a result, I found that the DHB, the orthopaedic surgeon, and the consenting surgeon had each breached the Code for their respective failures to ensure that the man received sufficient information about the planned procedure in order to be able to provide informed consent. The DHB agreed to amend its informed consent policy to require explicit consent for the use of allograft material, and to review the "Agreement to Treatment" form with a view to including a prompt for consent to the use of human products in all procedures where human products are used.

Further details about these cases and the recommendations I made can be found later in the report.

Mental health and addiction

In February 2018, the Mental Health Commissioner published HDC's first monitoring and advocacy report addressing the state of mental health and addiction services in New Zealand. The report was timely, being released during a period in which there has been considerable discussion about mental health and addiction services in this country, and shortly after the government's announcement that it would establish an inquiry into these services.

The monitoring and advocacy framework for the report was developed in consultation with consumers, family and whānau, providers, and other sector representatives, and analysed HDC complaints data, consumer, whānau and sector feedback, and service performance information. A key finding of the report was that although growing numbers of New Zealanders are accessing mental health and addiction services, these services are under pressure and many needs are left unmet. The report noted that progress is being made, but identified a number of areas of concern. These included a lack of early intervention options, coordination challenges within and between services, poorer physical health outcomes for people with serious mental health and addiction issues, and disparity in mental health and well-being outcomes for Māori, Pacific peoples, young people, and people in prison. In addition to the need for action to relieve pressure on existing mental health services, the report highlighted the need for a broader range of health interventions that are available earlier and are better connected to community and social services in order to address these concerns.

The primary recommendation of the report was a call for a new action plan for mental health and addiction, and emphasis was placed on the importance of strong collaborative leadership in driving change. The report formed the basis of the Mental Health Commissioner's submission to the Government Inquiry into Mental Health and Addiction. HDC looks forward to the outcome of that Inquiry.

Conclusion

The 2017/18 year has been a productive and successful year for HDC.

I am extremely grateful to HDC's talented and dedicated staff, who have been committed to delivering high quality decisions, in higher volumes than ever before, while handling significant growth. Their commitment is demonstrated by the results in this report.

I also acknowledge the work of the Advocacy Service, which provides invaluable support to the consumers they assist, while continuing to achieve high rates of satisfaction amongst both consumers and providers.

Finally, I acknowledge that it takes courage to make a complaint. I extend my gratitude to consumers for raising their concerns with HDC and providing opportunities for learning, growth, and improvement in the sector. While the health and disability sector in New Zealand continues to provide excellent services overall, there remain improvements that can be made. HDC remains committed to promoting its vision of a consumer-centred system, and its purpose of promoting and protecting consumer rights.

1.0 The Year in Review

In 2017/18 HDC

RECEIVED
2,498
COMPLAINTS

INCREASED
13%
ABOVE PREVIOUS YEAR

CLOSED
2,315
COMPLAINTS

79%
WITHIN 6 MONTHS

15%
ABOVE PREVIOUS YEAR

HDC had another successful year in 2017/18, demonstrating considerable achievement in all output classes while dealing with further significant growth in complaint volumes.

HDC received 2,498 complaints. There has been a 13% increase in complaints received per year over the last two years. This is over double the average increase of 6% for the three years that preceded 2016/17. HDC also supported consumers by responding to 4,466 enquiries.

In 2017/18, HDC closed 2,315 complaints. This represents a 15% increase on the number closed in 2016/17, and is a record number for any financial year to date. The number of complaints closed within six months was 1,837 (79%). This is 7% higher than the number closed within that timeframe in 2016/17 (1,713).

One hundred and two investigations were completed (an increase of 28% on 2016/17). Of those investigations, 70 resulted in findings that one or more providers had breached the Code, with 11 providers referred to the Director of Proceedings for the purpose of considering whether proceedings should be taken against those providers.

As a consequence of actions taken on complaints, wide-reaching recommendations were made across the sector for real and lasting improvements to health and disability services and systems. In 2017/18, there was compliance with 98.9% of recommendations that were due.

The Nationwide Health and Disability Advocacy Service (the Advocacy Service) closed 2,825 complaints and responded to 11,000 public enquiries. Eighty-four percent of complaints received by the Advocacy Service were closed within three months and 99% were closed within six months. Since 2007, the Director of Advocacy at HDC has contracted with the National Advocacy Trust to provide advocacy services. This highly successful arrangement has been extended for another five-year term.

HDC continued to work with DHBs, providing detailed six-monthly reports on the numbers and types of complaints received in relation to DHB services, and also published an annual report of complaints about DHB services. DHBs continue to rate these reports as useful for improving the safety and quality of services.

In 2017/18, the Mental Health Commissioner published HDC's first monitoring and advocacy report in relation to mental health and addiction services in New Zealand. The report brings transparency and accountability to the performance of services, and included eight service improvement recommendations to the Minister of Health. The Mental Health Commissioner's monitoring activity in 2017/18 included nearly 100 stakeholder meetings, 6 consumer and whānau focus groups, and analysis of 23 key performance indicators by age, service type, and ethnicity. The Mental Health Commissioner also met with panel members of the Government Inquiry into Mental Health and Addiction and provided a written submission.

The Mental Health Commissioner continued to make recommendations for change to providers of mental health services through decisions on complaints about those services. Providers were fully compliant with all of the recommendations due in respect of mental health and addiction services in 2017/18.

HDC continued to deliver presentations to various provider and consumer groups. Topics included consumer rights and provider responsibilities under the Code, HDC's role, and the common issues that appear in complaints. HDC also delivered four complaints management workshops to group providers in 2017/18 with the aim of increasing provider capability to resolve complaints. Feedback on these presentations and workshops continues to be very positive. In addition, the Advocacy Service provided almost 1,500 education sessions to consumers and providers in their local communities, with a focus on the Code and managing complaints.

HDC's biennial conference was held in November 2017. The conference focused on consent, culture, and the consumer experience. Over 120 delegates attended the conference from across the health and disability sectors, and responses from the attendees were very positive.

The Deputy Commissioner, Disability supports people with a disability to receive information about the Code and the work of HDC. During 2017/18, an "easy-read" booklet was produced to explain what happens when HDC investigates a complaint. Information about the Advocacy Service was also translated into "easy-read" language. Both resources are available on HDC's website in an accessible format.

HDC has continued to work closely with key stakeholders in a range of areas. HDC works in collaboration with many other organisations in the disability and the mental health and addiction settings. HDC also made a range of recommendations to the health and disability sectors as a result of complaints received, and from issues identified in the complaints data collected by HDC.

HDC is reviewing whether changes are needed to the current rules regarding health and disability research involving adult consumers who are unable to give informed consent to their participation in the research. At present, the effect of Right 7(4) of the Code is that a consumer who cannot give informed consent can be enrolled in a research project only if the research is in the consumer's "best interests". It has been argued that the effect of Right 7(4) may be to prevent some potentially valuable ethical research from proceeding. People who are unable to give informed consent are vulnerable to exploitation, yet they or others with their impairing condition may be disadvantaged if they are excluded from involvement in research.

As part of the review, HDC undertook a public consultation, and received 157 written submissions. A summary of the submissions, together with the individual submissions, is available on HDC's website. Currently HDC is drafting a report that will set out the conclusions the Commissioner has reached regarding this complex and contentious issue, and his recommendations for next steps. The report will be published in 2018/19.

HDC continues to be managed with prudent financial controls, ensuring that costs are maintained within approved budgets, with a focus on financial sustainability. HDC continuously seeks further operational efficiencies, and has implemented a number of efficiency and process improvement initiatives whilst dealing with an increasing volume of complaints.

> In 2017/18, HDC closed 2,315 complaints. This represents a 15% increase on the number closed in 2016/17, and is a record number for any financial year to date.

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 Health and Disability Commissioner Act 1994 (the Act) to promote and protect the rights of consumers of health and disability services.

As part of its overriding purpose, HDC resolves complaints and holds providers to account, ensuring that practices are improved at an individual and system-wide level. The Health and Disability Commissioner is independent of providers, consumers, and of government policy, allowing HDC to be an effective watchdog for the promotion and protection of consumers' rights.

Informed consent sat at the heart of the cervical cancer inquiry, and is the cornerstone of the Code. Over the decades, culture and practice in the sector have improved around informed consent, but it continues to appear as an issue in complaints received by HDC. This demonstrates the ongoing importance of HDC's role in promoting a consumer-centred system that respects and upholds the rights of health and disability services consumers.

The Code

The Code applies to all health and disability service providers.

The 10 rights under the Code are described in Figure 1. Code rights can be upheld via the complaints process, and by proceedings taken by the Director of Proceedings before the Human Rights Review Tribunal and the Health Practitioners Disciplinary Tribunal. The Human Rights Review Tribunal may declare that conduct breached the Code and grant various remedies, including damages.

Our values

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

HDC is:

- Fair
- Responsive
- Professional
- Empathetic

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

HDC's key functions

1. **Complaints resolution:**
   Complaints resolution remains the central function for HDC, and provides the platform for achieving HDC's strategic objectives. HDC has a number of options for resolving complaints, focusing on a fair and early resolution.

2. **Advocacy:**
   HDC's Director of Advocacy contracts with the National Advocacy Trust to provide an independent Advocacy Service. The Advocacy Service plays a crucial role in supporting consumers to resolve those complaints that are suitable for resolution between the parties, and offers community-based education and training about the Code, to consumers and providers.

3. **Proceedings:**
   The Director of Proceedings, appointed under the Act, exercises independent statutory functions. The Commissioner may refer a provider found in breach of the Code to the Director of Proceedings, who will consider whether proceedings should be taken.

4. **Monitoring and advocacy:**
   HDC has a statutory role to monitor and advocate for improvements to mental health and addiction services. This role is delegated to the Mental Health Commissioner.

5. **Education:**
   HDC delivers a variety of education and training initiatives aimed at improving providers' knowledge of their responsibilities, and consumers' knowledge of their rights.

6. **Disability:**
   The Deputy Commissioner, Disability has a particular focus on promoting awareness of, respect for, and observance of, the rights of disability services consumers.

HDC's 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 who use health and disability services. This includes addressing the concerns of whānau and appropriately investigating alleged breaches of consumers' rights. HDC received funding of $12,870,000 from this appropriation in the year ended 30 June 2018 to fund six output classes as set out in the Statement of Performance. Despite the increase in demand for HDC's services, and HDC's record output for complaints resolution, a small surplus was still delivered. This was due to ongoing financial controls and an attitude of continuously looking to achieve more with our resources.

HDC's Executive Leadership

Anthony Hill
Health and Disability Commissioner

Kevin Allan
Mental Health Commissioner & Deputy Commissioner

Meenal Duggal
Deputy Commissioner, Complaints Resolution

Rose Wall
Deputy Commissioner, Disability

Jessica Mills
Director of Advocacy
(Reports to the Deputy Commissioner, Disability)

Kerrin Eckersley
Director of Proceedings

Jane King
Associate Commissioner, Legal

Dr Cordelia Thomas
Associate Commissioner

Mark Treleaven
Associate Commissioner, Investigations

Jason Zhang
Corporate Services Manager

3.0 Delivering HDC's Strategy

HDC's strategic intent

HDC's vision is that consumers are 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. Four strategic objectives support this overriding strategic intent.

HDC aims to:

1. Protect the rights of health and disability services consumers under the Act and the Code.
2. Support quality improvement within the health and disability sectors.
3. Hold providers to account appropriately.
4. Promote, through education and publicity, respect for and observance of the rights of health and disability services consumers.

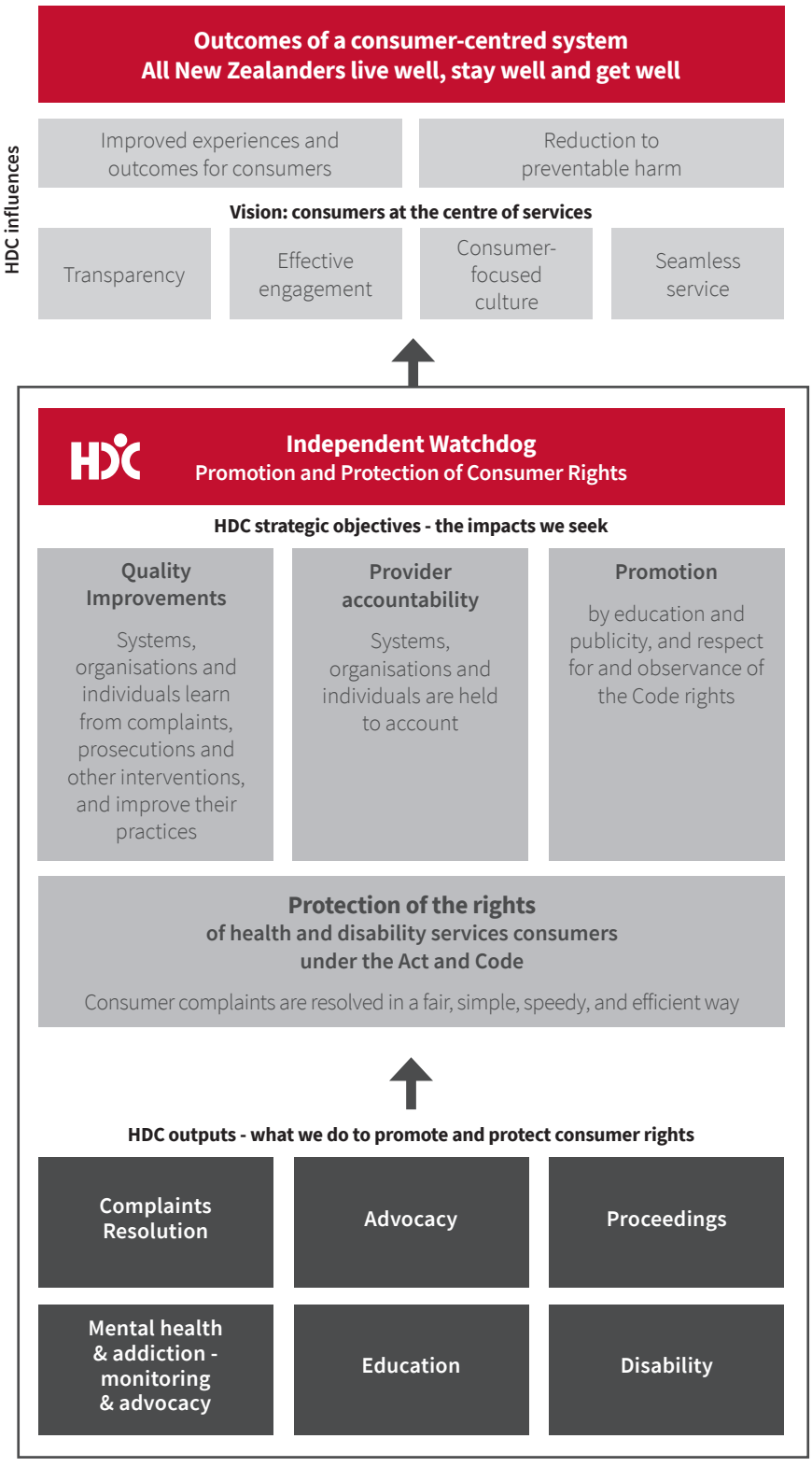
In line with HDC's Statement of Performance Expectations 2017–2018, HDC's strategic priorities for the 2017/18 year were to:

- Resolve complaints in a fair, timely, and effective way while dealing with the constantly increasing volume and complexity of complaints.
- Work with DHBs, health providers, and disability services providers to improve their complaints processes so that complaints are resolved at the lowest possible appropriate level.
- Monitor mental health and addiction services and advocate improvements to those services.
- Continue to work closely with the Health Quality & Safety Commission (HQSC) and other key stakeholders to effect recommended changes from complaint learnings.
- Operate a financially sustainable organisation with an appropriate resource level to manage volume and complexity.
- Strive for continuous improvement in the way HDC operates.

HDC's 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



The difference we make

Through complaints resolution, quality improvement, and provider accountability, HDC contributes to the minimisation of 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 and reduces preventable harm.

Alignment with New Zealand Health Strategy

HDC's strategic objectives and activities align with, and contribute to, the New Zealand Health Strategy for the health and disability system.

HDC's strategic objectives

HDC's strategic objectives 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, and quality improvement through the recommendations and educational 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. 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 consumer-centred services.

By learning, addressing unacceptable behaviour, and avoiding repetition of errors, the system improves experiences and outcomes for consumers and reduces preventable harm.

Progress towards strategic objectives

The measurement framework set out in Table 1 below is included in HDC's 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 HDC's performance in relation to complaints resolution is particularly important. We want to make sure HDC's complaints resolution and advocacy processes are responsive to consumers and effective at achieving satisfactory resolution.	In 2017/18, HDC responded to 4,466 enquiries where consumers were assisted to better understand their rights and encouraged to resolve concerns directly with providers. HDC closed 2,315 complaints in 2017/18. 102 investigations were completed, of which 70 resulted in breach decisions. 461 complaints were referred to the provider to resolve directly, and 301 were referred to the Advocacy Service to support the complainant to resolve the complaint. The Advocacy Service responded to 11,001 enquiries and closed 2,825 complaints. The Advocacy Service visited 79% (529 out of 667) of all certified aged care facilities and 78% (744 out of 949) of the certified residential care services catering to disabled people. These visits provide 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 HDC's impact in this area are:	
	• Timeliness of the process.	HDC closed 64% of complaints received within 3 months, 79% within 6 months, and 93% within 12 months. The Advocacy Service closed 84% of complaints received within 3 months, 99% within 6 months, and 100% within 9 months.
	• Participants' experience of the advocacy process.	90% of consumers and 87% of providers who responded to satisfaction surveys were satisfied or very satisfied with the Advocacy Service's complaints management process.

Table 1 continued: HDC's strategic objectives and performance

Strategic objectives	How we measure performance	Performance commentary
Quality improvement	HDC's 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.	Between 1 July 2017 and 30 June 2018, compliance with quality improvement recommendations[1] on 264 complaints was due to be reported to HDC by 207 providers. Recommendations in relation to 261 of those complaints (98.9%) were complied with, and recommendations in relation to 2 were partially complied with.
	We monitor compliance with HDC's recommendations to understand the extent to which they have led to positive change. This enables us to understand the extent to which our recommendations have been adopted into practice.	There was only one provider who did not comply with HDC's recommendations. This provider was referred to the provider's regulatory authority. HDC will continue to monitor and follow up the providers to whom recommendations are made to ensure their compliance.
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:	HDC completed 102 investigations. 70 resulted in breach decisions and 11 providers from 9 complaints were referred to the Director of Proceedings.
	• Professional misconduct was found in disciplinary proceedings taken.	• Professional misconduct was found in 100% (3 of 3) of Health Practitioners Disciplinary Tribunal proceedings.
	• A breach of the Code was found in Human Rights Review Tribunal proceedings.	• A breach of the Code was found in 100% (1 of 1) of Human Rights Review Tribunal proceedings.
	• An award was made when damages were sought.	• Resolution by negotiated agreement was achieved in 100% (1 of 1) of proceedings.

We monitor compliance with HDC's recommendations to understand the extent to which they have led to positive change.

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

Table 1 continued: HDC's strategic objectives and performance

Strategic objectives	How we measure performance	Performance commentary
Promotion, by education and publicity, and respect for and observance of the Code rights	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.	• HDC delivered 33 education sessions in 2017/18. These sessions included presentations to DHBs, disability service providers, professional colleges, aged care providers, and other professional bodies. 100% of respondents reported that they were satisfied or very satisfied with each session.
	• Provision of, and satisfaction with, education sessions provided by the Advocacy Service.	• The Advocacy Service provided 1,499 education sessions to consumer and provider groups to promote understanding of rights and responsibilities under the Code and what actions can be taken to resolve complaints. 87% of respondents were satisfied with the Advocacy Service education session they attended.
	• Provision of, and satisfaction with, consumer seminars held by HDC.	• HDC facilitated eight regional consumer seminars in 2017/18, with an average respondent satisfaction of 95%.

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

The Advocacy Service provided 1,499 education sessions to consumer and provider groups to promote understanding of rights and responsibilities under the Code and what actions can be taken to resolve complaints.

4.0 Performance on Key Functions

HDC key functions 2017/18

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

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

HDC seeks to resolve each complaint in a fair and timely manner and has a number of complaints resolution options available to achieve this.

4.1 Complaints resolution

The complaints resolution process is a crucial aspect of HDC's role in promoting and protecting the rights of consumers. HDC seeks to resolve each complaint in a fair and timely manner and has a number of complaints resolution options available to achieve this.

This section provides an analysis of the complaints resolution function in the 2017/18 year, reporting on key trends, discussing the options available to HDC to resolve complaints, and providing a number of case studies to illustrate how those options work in practice.

Further growth in complaints

In the 2017/18 year, HDC received a total of 2,498 new complaints. This represents an increase of 13% on the complaints received in 2016/17. HDC continued to demonstrate its capacity for responding to growth in complaint numbers in 2017/18. A total of 2,315 complaints were closed in 2017/18. This was an increase of 15% on the number of complaints closed in the previous year, and is the highest number of complaints ever closed by HDC in a single year. Although HDC resolved more complaints than in the preceding year, the growth in complaints is having an effect, and is reflected in a higher number of open files at year end than in previous years.

Figure 3: Complaints received and closed from 1 July 2013 to 30 June 2018

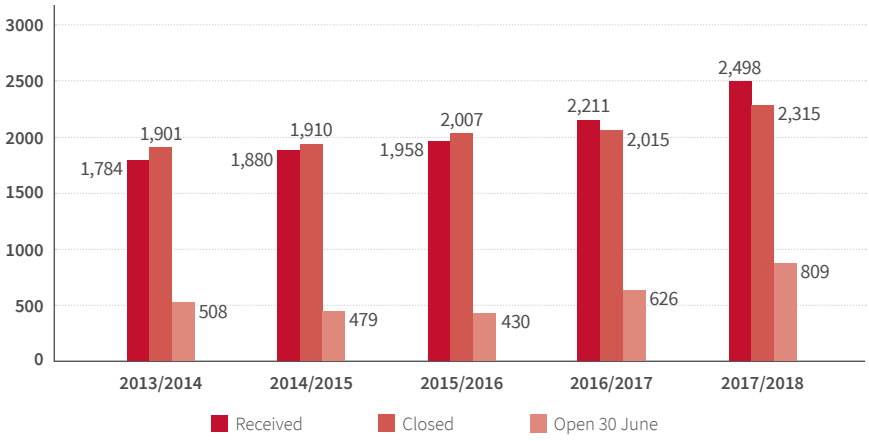


Figure 4: Complaints received — commonly complained about primary issues in 2017/18[2]

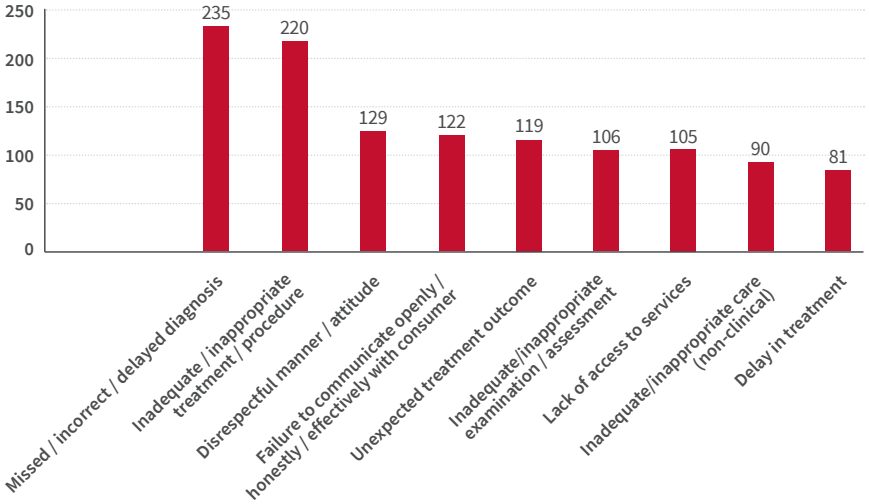


Figure 5: Complaints received — commonly complained about **individual** providers in 2017/18[3]

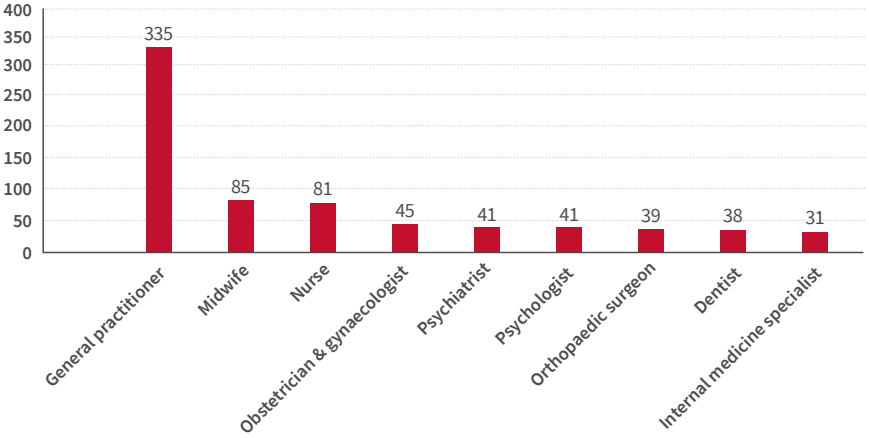
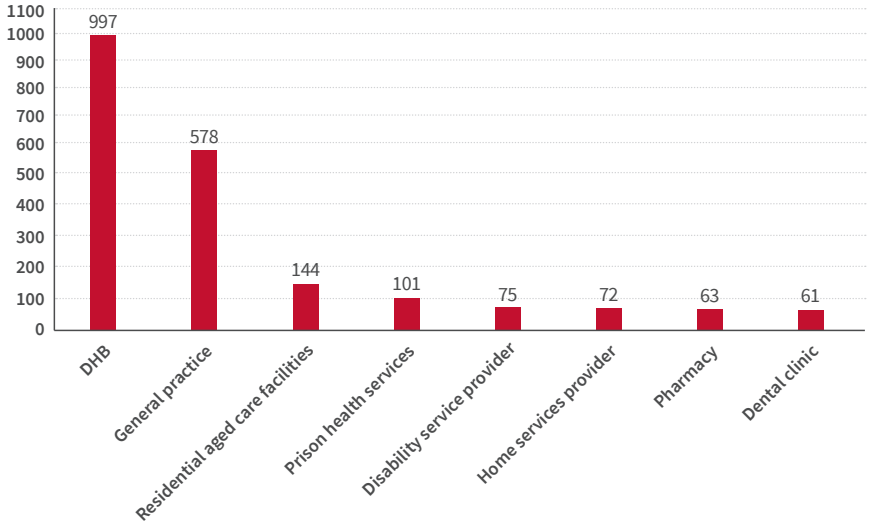


Figure 6: Complaints received — commonly complained about **group** providers in 2017/18[4]



[2] Data is provisional as of date of extraction (6 July 2018).

[3] 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 total number of individual providers complained about in 2017/18 will not equal the total number of complaints received in 2017/18. Data is provisional as of date of extraction (6 July 2018).

[4] 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 total number of group providers complained about in 2017/18 will not equal the total number of complaints received in 2017/18. Data is provisional as of date of extraction (6 July 2018).

Issues complained about

The issues complained about in 2017/18 were consistent with the trends seen in previous years. Figure 4 provides an overview of the common primary issues (the issue of most importance to the complainant) in complaints received. The two most common primary issues raised were those related to a missed/incorrect/delayed diagnosis or inadequate/inappropriate treatment.

Complaints received by HDC can raise a number of issues. When all issues raised in complaints in 2017/18 are considered (not just primary issues), the most common complaint issue categories were:

- Care/treatment (64%)
- Communication (50%)
- Access/prioritisation (16%)
- Consent/information (15%)

These categories are similar to what has been seen in previous years. Complaints regarding access/prioritisation issues increased for some service areas in 2017/18, including mental health and disability services. Communication is a common issue in complaints to HDC, featuring in around 50% of all complaints received each year. This indicates that although consumers may be complaining about a care/treatment issue, often they also feel that the manner of communication with them in the context of that care/treatment issue was inappropriate.

Providers

HDC receives complaints about both individual and group providers. It is not uncommon for a number of providers to be named in a complaint. Common individual and group providers complained about in 2017/18 are detailed in Figures 5 and 6. As has been seen in previous years, general practitioners (GPs) were the most common type of individual provider complained about in 2017/18, and DHBs were the most common type of group provider complained about. This is consistent with the fact that GPs and DHBs provide the majority of health care in New Zealand.

The complaints resolution process

Complaints received by HDC are carefully assessed and resolved in the most appropriate manner, taking into account the issues raised and the evidence available. The preliminary assessment process can involve a number of steps to assist in determining the most appropriate way to resolve a complaint. This process can include obtaining further information from the complainant, seeking a response from the provider concerned, and obtaining expert advice.

When the preliminary assessment has been completed, there are a number of options available to the Commissioner. These options include referral to the Advocacy Service or to the provider for direct resolution between the parties. HDC requires the Advocacy Service and providers to report back to HDC on the outcome of referrals made to them, ensuring that the consumers' concerns have been addressed appropriately. The Commissioner can also refer complaints to other agencies, or commence an investigation to determine whether providers have breached the Code.

Complaints may also be resolved pursuant to section 38(1) of the Act, which gives the Commissioner a broad discretion to take no action or no further action on a complaint. The decision to take no action or no further action on a complaint can be made for a range of reasons. For example, the Commissioner may be satisfied that the provider has taken appropriate steps to address the issues raised by the complaint or, in cases involving clinical issues, expert advice may have indicated that the clinical care provided was appropriate. In other cases, it may be that the issues raised cannot be resolved (for example, due to evidential issues). Decisions made pursuant to section 38(1) of the Act often contain educational comments or recommendations to effect positive change to systems and procedures. If appropriate, HDC may ask that a written apology be provided to the consumer, or encourage the parties to meet.

The outcomes of complaints resolved by HDC in 2017/18 are displayed in Table 2.

Table 2: How complaints were resolved by HDC in 2017/18[5]

Outcome	Number of complaints
Investigation	**102**
Breach finding	70
No breach finding with recommendations or educational comment	25
Referred to registration authority	2
No breach finding	5
Other resolution following assessment	**2,045**
No further action with recommendations or educational comment	398
Referred to registration authority	83
Referred to other agency	65
Referred to provider to resolve	461
Referred to Advocacy Service	301
No further action	648
Withdrawn	89
Outside jurisdiction	**168**
Total	**2,315**

[5] 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 (6 July 2018).

CASE STUDIES

Section 38 (1) with recommendations or educational comment

CASE STUDY ONE

A mother complained to HDC about an incident in which a glove filled with hot water was used to warm her baby's skin before a blood test. As a result, the baby received a large blistering burn. During the preliminary assessment of this complaint, HDC sought an explanation from the group provider for which the clinician involved worked.

The provider informed HDC that the method is commonly practised by phlebotomists in New Zealand. However, an internal review by the provider found that the individual clinician had not followed standard operating procedure. In particular, the phlebotomist should have asked the mother to test the temperature of the glove before placing it on the baby's skin.

In a provisional decision, the Deputy Commissioner recommended that the provider make all staff aware of the incident so that the importance of following the correct procedure would be understood. In response to this, the provider advised that it had decided to discontinue the practice because it could not guarantee that it was safe for infants. HDC then recommended that the provider also share the incident as an anonymised case study in a national quality forum so that other providers would be aware of the issue and could take steps to avoid similar incidents. The provider confirmed compliance with this recommendation.

CASE STUDY TWO

A consumer suffering from insomnia was prescribed zopiclone to help her sleep. She was given repeat prescriptions for the drug by several different GPs at the same medical practice over a period of two years. She became concerned about the lack of information provided to her about the risks of dependency from long-term use. Subsequently, she made a complaint to HDC.

After receiving the complaint, HDC obtained a response from the provider in question, and sought advice from an expert. The expert advised that although the treatment had been appropriate, the pattern of prescription was not consistent with best practice for treating insomnia. After receiving the expert's advice, the provider told HDC that it had undertaken an audit of all patients on sleeping medication, and held a clinical peer review meeting to discuss the particular case.

HDC considered that the case provided a valuable learning opportunity for the clinicians involved. In the interests of promoting consumer-centred care, the Deputy Commissioner recommended that the provider report back to HDC on the results of the audit, and detail the steps it had taken to improve the process for reviewing long-term medication use to ensure that consumers understand the risks of treatment. In response to these recommendations, the provider told HDC that it had implemented an alert system for repeat prescriptions, with one doctor allocated to each patient, and it follows a policy of documenting that a consumer has understood the risks of treatment.

CASE STUDY THREE

A consumer had a blood test for suspected muscular dystrophy. Although there is no treatment to stop or reverse muscular dystrophy, the consumer was awaiting a definitive diagnosis before making appropriate changes to his lifestyle. However, he did not receive the blood test results for more than a year. In making a complaint, the consumer's wife wanted to ensure that other consumers would not experience similar delays and uncertainty.

HDC obtained a response from the provider. The provider acknowledged that the delay, while partly related to the actions of an overseas provider, was not acceptable. The provider also agreed that communication with the consumer about the issue could have been better, and set out a number of system changes to its service to prevent such a situation happening again.

Having considered this response, the Deputy Commissioner recommended that the provider undertake an audit to ensure that the changes proposed by the service to avoid long delays in receiving test results were having the desired effect. The outcome of the audit demonstrated that systems changes had substantially reduced the turnaround time for external test results (and other referrals).

Referral for resolution between the parties — provider or advocacy referral

Sometimes complaints may be suitable for resolution between the parties. Under section 34(1)(d) of the Act, HDC may decide to refer a complaint to the provider for resolution. This allows complaints to be resolved at a local level in a timely and efficient manner. A provider referral may be appropriate 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.

HDC may also refer a complaint to the Advocacy Service under section 37 of the Act. This is an additional way for complaints to be resolved directly between the consumer and provider, and having the support of an advocate can be empowering for consumers. In light of continued high rates of consumer satisfaction with the advocacy process and the high resolution rate, in 2017/18 HDC continued to focus on identifying complaints that would be best resolved in this way. A total of 301 complaints were referred to the Advocacy Service in the past year. This represented 13% of all complaints closed by HDC during the year. Further information about the Advocacy Service is included later in this report.

CASE STUDIES

REFERRAL TO PROVIDER

A consumer presented to her family planning clinic with pelvic pain and menstruation difficulties. She underwent a physical examination, including diagnostic tests, and was referred for an ultrasound. Subsequently, the consumer received a text notifying her that the ultrasound was "normal". However, several days later she received a letter from the clinic via her GP advising that the ultrasound indicated that she had pelvic inflammatory disease.

The consumer then raised the matter with HDC. Given that the consumer had an ongoing relationship with the provider, HDC decided to formally refer the complaint directly to the provider for resolution. As a result, the consumer and provider met to discuss the consumer's concerns. The provider clarified that the letter omitted critical information that would have reassured the consumer. The provider apologised for having let down the consumer. The meeting identified how the provider could improve its communication with consumers in the future. At the conclusion of the meeting, the consumer considered that her concerns had been addressed adequately, and the parties agreed on a care plan going forward.

REFERRAL TO ADVOCACY SERVICE

A woman complained that an ambulance service did not provide appropriate support to her elderly mother after a significant fall at home. Initially the ambulance service had advised that an ambulance would be dispatched, but subsequently a nurse called back, asked a series of questions to rule out a medical emergency, and then advised that an ambulance would not be dispatched. The complainant was concerned at the poor communication.

HDC sought a response, and the provider acknowledged that there had been a failure in communication, with the key issue being that the initial call-handler had read from a script that contained ambiguous information. Both the provider and complainant indicated that they were willing to participate in further constructive dialogue to address the complaint. To facilitate this, HDC formally referred the matter to the Advocacy Service.

As a result of the Advocacy process, the provider made changes to the script read by call-handlers to ensure that consumers are fully informed about the options available to them, before any decisions are made about their care. The report from the advocate also noted that the consumer and complainant felt that their involvement in the process provided a meaningful resolution for them.

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 another agency such as the Office of the Ombudsman or the Office of the Privacy Commissioner.

Recommendations made to providers

In 2017/18, HDC made recommendations and/or educational comment on a total of 493 complaints, and providers complied with 98.8% of the quality improvement recommendations due in 2017/18. The purpose of these recommendations is to improve health and disability services and ensure that appropriate learnings are taken from complaints. Recommendations can include clinical audits, changes to policies or processes, education and training, and providing evidence to HDC of changes made by the provider following a complaint, and the effectiveness of those changes. HDC actively monitors and analyses compliance with these recommendations after the closure of a complaint, and has dedicated roles to undertake this work. Providers who do not comply are followed up regularly, and, where applicable, HDC may refer them to a regulatory authority or a funder for further action. Some examples of recommendations that HDC has made on complaints closed under section 38(1) of the Act are outlined on the following page.

CASE STUDIES

REFERRAL TO THE OFFICE OF THE PRIVACY COMMISSIONER

A consumer raised concerns about the conduct of a nurse during a hospital admission. Initially the matter was dealt with by the nurse's employer, without HDC involvement. However, subsequently the consumer was contacted by the hospital to advise that the nurse in question had accessed the consumer's patient records without permission or any legitimate reason to do so. The consumer brought this to the attention of the relevant regulatory authority. In turn, the authority notified HDC of the complaint.

After considering the matter, HDC consulted with the Office of the Privacy Commissioner. Because the complaint related to a purported interference with privacy, HDC decided to formally refer the matter to the Privacy Commissioner under section 36 of the Act. Furthermore, the regulatory authority was asked to review the professional conduct and fitness of the nurse involved.

In 2017/18, HDC made recommendations and/or educational comment on a total of 493 complaints, and providers complied with 98.8% of the quality improvement recommendations due in 2017/18.

1. A consumer complained that it was difficult to end her privately funded fertility treatment part-way through a cycle. In particular, the consumer described that she had felt unheard when she tried to raise her concerns with the service, and that the treatment continued without a formal meeting with her primary doctor to address her concerns. In the circumstances, HDC considered that a face-to-face meeting with the primary doctor and a support person would have been the most appropriate way to address the matter, in order to facilitate fulsome discussion of the woman's concerns and treatment options. HDC made a number of recommendations to the service as part of a decision under section 38(1) of the Act. In particular, HDC asked the provider to carry out a review of its informed consent processes, provide staff with additional training on consent and complaints, and present an anonymised case note to make other similar providers aware of the issue. The consumer reported that she was pleased with the final decision and, in particular, the recommendations. At a later date, she also gave feedback on the anonymised case note arranged by the provider. The case note, with input from the consumer, became the foundation for the provider's review of its informed consent policies.

2. A daughter complained about the care her terminally ill father received at an aged-care facility. In particular, the complainant was concerned about the quality of falls risk management at the facility, and poor communication from staff following a series of incidents, including for example a broken window. HDC obtained expert advice from a registered nurse. The expert advised that although the care was of an appropriate standard, there were a number of areas where the provider could improve its processes for managing falls risk. The Deputy Commissioner recommended that the provider ensure that all resident care plans include specific interventions to mitigate risk relevant to that resident in the context of their residential environment. It was further recommended that all maintenance issues that impact directly on resident safety, such as lighting, plumbing, and broken furniture, be recorded in clinical notes and incident records. In meeting these recommendations, the provider introduced a new electronic resident management system. The provider then undertook an audit to monitor compliance with HDC's recommendations. In response to the complaint, the aged-care facility also provided staff with additional training on the topic of effective communication with family members of residents who are receiving palliative care.

3. An elderly man underwent a surgical procedure to treat pancreatic cancer at a public hospital. He appeared to be recovering well and was moved from an intensive care unit (ICU) to a general ward. However, the consumer's condition suddenly deteriorated, and he passed away. Upon receiving a complaint from the man's family, HDC obtained both nursing and surgical advice from two experts. Both experts advised that the care the man had received in surgery and ICU had been appropriate. However, the experts did identify areas for improvement in the DHB's early warning score (EWS) policy. Accordingly, the Commissioner recommended that the DHB review its EWS policy to clarify the escalation process, and conduct an audit, over a one-month period, on the timeliness of the identification of patient deterioration and the frequency of senior medical reviews. The audit demonstrated that improvements had been made.

Investigations

As noted above, one of the options open to the Commissioner upon receiving a complaint is to conduct an investigation. Investigations may lead to an opinion that the consumer's rights have been breached. This year, 102 investigations were completed, and it was found in 70 of those investigations that the consumer's rights had been breached. In a small number of cases, a breach finding may also be referred to the Director of Proceedings to decide whether any further legal action should be taken. As a result of the breach decisions this year, 11 providers from 9 complaints were referred to the Director of Proceedings.

CASE STUDIES

Informed consent for the use of human products (16HDC00877)

An orthopaedic surgeon recommended that a man who had sustained a neck injury undergo an anterior cervical discectomy and fusion surgery. The surgeon did not recall the discussion, but said it was likely that he discussed using an allograft (donated material) rather than harvesting an iliac (hip) graft from the man, as using an allograft is his standard practice.

The man was seen by an orthopaedic medical officer for a pre-admission appointment. The man recalls being told that bone shavings would be taken from his hip and put between the vertebrae in his neck. The orthopaedic medical officer did not recall what he told the man, but said that he would have explained the operation in general terms but not the type of bone graft.

The orthopaedic surgeon saw the man again a few months later. The man said that he was told that the damaged bone between his vertebrae would be repacked with bone from his hip, and that his hip would be quite painful after the operation.

On the day of surgery, another orthopaedic surgeon saw the man to obtain informed consent. This surgeon did not remember the conversation, but said that he consented the man for the procedure stated in the clinical records. The consenting surgeon said that there was no documented preoperative plan to use an allograft, and he was not aware that this was the first orthopaedic surgeon's usual practice.

The man said that following the operation he asked the consenting surgeon three times why his hip was not sore and the consenting surgeon "talked around the subject".

In the orthopaedic outpatient clinic a few months later, the man said he asked the same questions about his hip bone, and the orthopaedic surgeon told him that bone from a deceased person had been put in his neck. The surgeon did not record that the man had any concerns about the informed consent process.

The Commissioner considered that as the responsible consultant, the orthopaedic surgeon had overall responsibility for ensuring that the man was provided with sufficient information about the proposed treatment. The Commissioner found that by failing to do so, the orthopaedic surgeon had breached Right 6(1) of the Code.

Further, the orthopaedic surgeon failed to make it clear to the orthopaedic medical officer and the consenting surgeon that an allograft was planned. Consequently, the clinicians who saw the man were unable to provide him with the necessary information. The Commissioner considered that it was the orthopaedic surgeon's responsibility to ensure co-operation among providers to ensure quality and continuity of services, and that by failing to do so, the orthopaedic surgeon breached Right 4(5) of the Code.

As the orthopaedic surgeon did not record his intention to use an allograft, the information he gave to the man, or the conversations that took place about the man's concerns regarding the informed consent process, the Commissioner also found that the orthopaedic surgeon failed to comply with professional and legal standards and breached Right 4(2) of the Code.

The Commissioner considered the fact that donated material was intended to be used, and that there were other options available, was information that a reasonable consumer in the man's circumstances would expect to receive and would need to make an informed choice and give informed consent. The Commissioner considered that it was the consenting surgeon's responsibility to ascertain the planned procedure, so he would be in a position to inform the man. Accordingly, the Commissioner considered that the consenting surgeon breached Right 6(1) and Right 7(1) of the Code.

The Commissioner was also critical that the culture at the DHB at the time was that it was not necessary to obtain consent for the use of donated material if the use of that material carried no risk. The Commissioner stated that providing services with reasonable care means operating a system that ensures that patients do not receive services unless they have been fully informed and have given consent. He found that the DHB breached Right 6(1)(b) of the Code by failing to provide the man with information that a reasonable consumer would expect to receive.

The Commissioner recommended that the orthopaedic surgeon attend training courses on record-keeping and communication. It was also recommended that the DHB report to HDC on the steps being taken to ensure full compliance with the use of surgical checklists in the orthopaedic service and that all the providers apologise to the man.

The DHB agreed to amend its informed consent policy to require explicit consent for the use of allograft material, and to review the "Agreement to Treatment" form with a view to including a prompt for consent to the use of human products in all procedures where human products are used and a space for the surgeon to counter-sign the consent stating that the patient has been informed appropriately if consent has been taken by another clinician.

Provision of information and care during stillbirth (15HDC00550)

A woman became pregnant with her third child and intended to have a home birth. The woman engaged a self-employed community-based registered midwife as her Lead Maternity Carer (LMC).

At approximately 6.30am, at 22 weeks' gestation, the woman contacted her LMC reporting vaginal bleeding and contraction-type pains. The woman and the LMC met at a hospital at 8am. The LMC assessed the woman and was unable to detect a fetal heartbeat. The LMC scheduled the woman for an ultrasound scan to "determine fetal viability". The ultrasound scan appointment was booked for 2.30pm.

The LMC documented in her retrospective notes that she informed the woman that "the current need was to finish the assessments then discuss with a doctor the options of 'wait and see' or referral to the gynaecology ward at a different hospital once she had her ultrasound scan". Prior to her attendance at hospital, the LMC attempted to telephone the on-call obstetrician but dialled the incorrect number. She did not attempt to make any further contact with an obstetrician. The LMC told HDC that she was under the impression that the woman needed to have her ultrasound scan prior to consultation with an obstetrician. The woman said that the LMC made no mention of needing to talk to, or consult with, any other medical professional, or of transferring to any other department.

Following the ultrasound scan at 2.30pm, intrauterine death was confirmed, and the LMC drove the woman and her husband home. At 3.05pm, the LMC left them at their home and documented that the woman was "[h]ome having increasing pains", and that they would "call [her] if needed". The LMC provided the woman with information leaflets relating to both miscarriages and stillbirths, but did not review the material with the woman.

The woman told HDC that her labour continued like a normal labour, and she delivered what she believed to be the placenta. She asked her husband to ask the LMC to return. The LMC returned at 4.15pm.

The woman's husband stated that he told the LMC when she arrived that the tissue delivered was in the basin. The LMC stated that she has no recollection of being told this, and she believed that a piece of placenta she located on the bathroom floor was the only tissue that had been delivered.

The LMC drove home to phone for collegial advice. She was concerned that the piece of placenta had been delivered without the fetus and that the labour had ceased temporarily.

The LMC returned at approximately 5.50pm and offered to take the woman and her husband to hospital. Prior to leaving, the woman asked the LMC whether they should take the placenta. The LMC collected the container in which she had placed the piece of placenta she had found earlier. She showed it to the woman, but the woman told her that this was not it. The LMC then went to where the mother said it had been placed and "found the baby and most of the placenta complete in its sac".

By not providing the woman with adequate information about her stillbirth, and not advising her of the recommendations in the Guidelines for Consultation with Obstetric and Related Medical Services 2012 (the Referral Guidelines), which state that in the circumstances of an intrauterine death the LMC must recommend to the woman that a consultation with a specialist is warranted, the LMC failed to provide essential information that a reasonable consumer in the circumstances would expect to receive, and breached Right 6(1) of the Code. The LMC also breached Right 7(1) of the Code because the woman was not therefore in a position to make informed choices about her care.

The Commissioner was critical that the LMC did not consult with an obstetrician when she was outside her scope of knowledge and experience in relation to stillbirths, and that the LMC failed to identify the need to request emergency services for the woman when she believed that a piece of the placenta had been delivered prior to the fetus. Accordingly, the LMC failed to provide services to the woman with reasonable care and skill and breached Right 4(1) of the Code.

By failing to record accurate and timely written progress notes, and by failing to document evidence of all decisions made and the midwifery care offered and provided, the LMC did not meet professional standards and breached Right 4(2) of the Code.

The Commissioner referred the LMC to the Director of Proceedings for the purpose of deciding whether proceedings should be taken, and recommended that the LMC apologise to the woman, arrange training on record-keeping, and provide HDC with confirmation of her attendance at the appropriate workshops, should she return to midwifery practice. The Commissioner also recommended that should the LMC return to midwifery practice, the Midwifery Council of New Zealand conduct a review of the LMC's competence.

CASE STUDIES

Delay in follow-up ophthalmology review (16HDC01010)

A young man with a family history of glaucoma presented to an ophthalmology service (the service) at a DHB, having been referred urgently by a community optometrist. He was prescribed eye drops and had a follow-up review the following week. Two months later, at a further scheduled appointment at the service, the man was diagnosed with ocular hypertension. The consultant ophthalmologist requested that the man be reviewed again in six months' time. That follow-up appointment was delayed for six months, despite the man telephoning the service and correspondence being sent by his general practitioner. By the time he was seen again, the man had suffered vision loss in his right eye and required an urgent referral for management and surgery.

The Commissioner noted a combination of factors — as detailed in an external review of the service commissioned by the DHB — that over the last 10 years have driven a rapidly increasing demand for ophthalmology services in New Zealand, including outpatient clinic time. A key factor has been the introduction of very effective new therapies and treatment, which have resulted in consumers needing to see specialists for regular ongoing follow-up and/or treatment, fuelling increased demand for ophthalmology services. The Commissioner commented that he considers the Ministry of Health to have a role, with DHBs, in recognising the effect of the introduction of such new technologies and associated pressures on the system, and planning accordingly.

The Commissioner stated that provider accountability is not removed by the existence of such systemic pressures, and that a key improvement that all DHBs and the Ministry must make, now and in the future, is to assess, plan, adapt, and respond effectively to the foreseeable effects that new technologies will have on systems and demand.

At the time of the man's care, the service lacked capacity, in that the clinics did not have enough appointments for the number of patients clinicians had to see. The Commissioner was critical of the DHB's failure to arrange a timely follow-up appointment because it did not have a prioritisation system that focused on patients' clinical needs, and instead relied on administration staff, who lacked training and clear guidance to prioritise appropriately. Despite concerns being raised with the DHB, it did not recognise the clinical risk created by the lack of capacity at the service, and did not take action to rectify the situation after an earlier serious event review in relation to a similar matter had raised associated concerns. In addition, there were missed opportunities for the DHB to rectify the delay in the follow-up appointment. It was found that the DHB did not provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

The Commissioner recommended that the DHB provide HDC with a detailed update report on the steps taken to carry out both the external reviewers' recommendations and those arising out of the DHB's own reviews, including specific reference to:

- An independent evaluation of the systems in place to identify and prioritise overdue ophthalmology patients.
- A quantitative and qualitative audit of the management of ophthalmology service referrals and follow-ups.
- The proactive steps taken to build departmental capacity, responsiveness, and adaptability.
- Routine telephone access to clinical staff so that staff can speak to an appropriately trained person to respond to clinical concerns.
- How the DHB's ophthalmology backlog programme project is tracking, and the progress towards zero patients waiting beyond clinically appropriate timeframes.

The Commissioner recommended that the Ministry establish systems to identify worthwhile major new healthcare technologies in the future so that adequate planning and funding responses can occur in a timely way. The Ministry is to report to HDC on this within six months, with an update on the progress towards addressing the other national improvement recommendations made by the external review.

The Commissioner referred the DHB to the Director of Proceedings for the purpose of deciding whether proceedings should be taken.

Wound care treatment failures at aged-care facility (15HDC01232)

A hospital-level resident at an aged-care facility developed pressure areas on her heels and sacrum. Over the following months, the wounds were assessed regularly and their condition described on wound-care plans by various aged-care facility staff. The sacral wound descriptions were sometimes contradictory in respect of how well the wound was healing.

A registered nurse, who was both the clinical manager and nurse manager, attempted to contact the regional wound care specialist at

the DHB for advice on managing the pressure areas. However, there were different versions of events regarding the number of attempts made, and the wound was not physically reviewed by the specialist.

The woman was reviewed regularly at the aged-care facility by GPs from a local medical centre, but the sacral wound was not reviewed physically by a GP until some time later. It was then noted to be at risk of infection, and antibiotics were prescribed. The woman died a week later.

The Deputy Commissioner considered that the aged-care facility had the ultimate responsibility to ensure that the woman received care of an appropriate standard. It was found that the descriptions of the woman's sacral wound in the wound-care plans, made by various staff, were inaccurate and inconsistent over a period of approximately three months. The aged-care facility's wound-care policy and form contributed to the inaccurate and inconsistent descriptions by staff because it did not guide staff on how to assess wounds objectively. Further, the aged-care facility's staff did not provide the GPs with full and accurate information to enable them to make sound, accurate decisions about whether to review the wounds physically. Overall, the Deputy Commissioner considered that the aged-care facility did not provide services to the woman with reasonable care and skill and breached Right 4(1) of the Code. Adverse comment was also made about the management of the aged-care facility and the communication with the woman's family.

The Deputy Commissioner considered that, as the individual responsible for the clinical oversight of other staff and for ensuring effective nursing care, the clinical and nurse manager should have done more to advocate for the woman and ensure that she received appropriate wound care. In particular, it was considered that a formal referral and a visit from the regional wound-care specialist much earlier would have been beneficial, and that the clinical and nurse manager should have ensured that the woman's condition was communicated accurately to the woman's GP and that the wounds were assessed by the GP. As a result of these failings, the clinical and nurse manager did not provide care to the woman with appropriate care and skill and breached Right 4(1) of the Code.

Having regard to the information available to the GPs at the time of the reviews, no criticism was made about the care they provided.

The Deputy Commissioner recommended that the aged-care facility arrange training for its staff on wound care, effective communication with family members, clinical documentation skills, and effective communication with GPs and other clinical personnel. It was also recommended that the aged-care facility and the DHB work together to agree on a standard process for requesting advice from the specialist wound-care team. The Deputy Commissioner recommended that apologies be provided to the woman's family.

Failure to manage a thyroid mass (17HDC00237)

A woman attended a GP because she was concerned about a mass in her neck. The GP arranged for blood tests to be carried out and asked a second GP to make a referral for an ultrasound scan once the results of the blood test were known. The second GP received the blood test results but did not make the referral at that time.

The woman saw the second GP six months later for a routine appointment. The second GP examined the mass but did not record this action or her findings.

One month after the appointment, the second GP sent a referral for an ultrasound scan. The referral was prioritised as routine based on the information in the referral.

The woman saw the second GP again on two further occasions in relation to other matters. The second GP did not examine the mass on the woman's neck or review its management, despite it having increased in size at the latter of these two occasions.

The woman then had the ultrasound scan, which identified a suspicious lesion. The woman attended an appointment with the second GP and a biopsy was arranged. The biopsy result showed an inoperable anaplastic carcinoma of the thyroid.

The Deputy Commissioner was critical that the second GP failed to refer the woman for an ultrasound scan when she was instructed to do so, failed to convey appropriate urgency when she did make the referral, and failed to track the progress of the referral and to review the management of the mass. As a result, the Deputy Commissioner considered that the second GP failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

The medical centre was found to be vicariously liable for the actions of the second GP.

The Deputy Commissioner recommended that the second GP undertake training in the management of thyroid masses, and provide a written apology to the woman's family.

Recommendations made to providers following investigations in 2017/18

1. An 83-year-old man presented to an emergency department with a history of severe end-stage chronic obstructive pulmonary disease with pulmonary hypertension, and later died in hospital following his admission. Staff inappropriately utilised oxygen delivery systems, and the nursing staff did not inform the medical team when the man's observations indicated the need for a medical review. The Commissioner recommended that the DHB consider whether a guideline on prescribing sedation for patients being treated with non-invasive ventilation would improve safety, and review the nurse-to-patient ratio in the respiratory ward and the availability of monitoring equipment and facilities. A number of recommendations were also made in relation to training and induction, including that the DHB review the details of the training provided to nursing staff regarding the management of non-invasive ventilation and patients at risk of hypercapnic respiratory failure; that further education be provided to clinical staff on the importance of accurate and detailed documentation; and that information be included in training and induction material that the asking of questions and reporting of concerns is expected and accepted from all members of the multidisciplinary team.

2. A disability residential service provider breached the Code when it failed to update a resident's Risk Management Plan (RMP), and failed to identify risks sufficiently and put in place prevention strategies. The provider also placed the man with another resident who exhibited inappropriate behaviour towards him, and moved him to an unfamiliar residence following another resident's violent behaviour. The Deputy Commissioner recommended that the provider commission an independent review of the effectiveness of changes made to the service in light of the Deputy Commissioner's report, the personal RMPs for each client to ensure that each has been reviewed and updated appropriately, and the ongoing training needs of support workers including in the area of first aid.

3. In a case where two midwives failed to appreciate signs indicative of a potentially growth-restricted baby, the Commissioner recommended that the midwifery service that employed the midwives develop policies regarding measurement of fundal height during pregnancy.

4. A case involving care provided to a woman who experienced delay in being transferred to the appropriate hospital, as had been directed by her GP owing to her clinical condition, led to recommendations being made to an ambulance service. The Commissioner recommended that the ambulance service confirm the implementation of its formal destination policies for serious conditions and, once finalised, conduct a review of the compliance with these policies and train staff on them.

5. Three DHBs were involved in evaluating a woman's suitability for a kidney transplant, and her daughter's suitability as a living donor. The Commissioner found that the woman's continuity of care was compromised because there were several points in the evaluation process where delays occurred because of errors, agreed processes not being followed, resource allocation issues, and lack of clarity regarding roles. The Commissioner made a number of recommendations, including that the three DHBs collaborate in reviewing their system for sharing information, and develop an agreed policy around renal transplants. The Commissioner also recommended that the DHB with overall responsibility update HDC on the changes put in place regarding the development of an IT platform and service improvements made and, with the assistance of the other DHBs, establish clear guidelines for the evaluation of living donors, review its staffing ratios for renal transplant coordinators, and provide a written apology to the woman's family. The Commissioner recommended that the second DHB establish a system for providing clear and specific instructions about what is necessary for recipient evaluation in circumstances that deviate from the norm, including where certain evaluations may not be required.

6. In a case where a man presented to an emergency department with a sudden onset of left-sided weakness and twitching and a week-long history of dizziness upon standing, there was a delay in a neurology review being undertaken. Use of the incorrect referral process contributed to the delay. Junior staff also did not inform the relevant consultant of the man's ongoing symptoms in the days following. The Commissioner recommended that the DHB conduct an audit of neurology referrals within the last three months to ensure that the correct process has been followed, and provide an update on the implementation of its "TransforMED" project. This project aims to ensure that time is set aside for subspecialists who participate in General Medicine to undertake a ward round daily on inpatients on their designated ward. The Commissioner also recommended that the DHB use the case as an anonymised case study for education on the importance of team communication.

7. In a case where a man was dispensed medication by a pharmacist at twice the dose that had been prescribed, the Deputy Commissioner recommended that the pharmacist review and familiarise himself with the pharmacy's standard operating procedures (SOPs) and arrange for training and an assessment through the New Zealand College of Pharmacists regarding the processing of prescriptions and accurate dispensing and checking processes. It was also recommended that the pharmacy conduct a review of its dispensary processes, in particular the arrangement of medications on dispensary shelves, to consider whether improvements could be made in labelling and placement to reduce errors in dispensing. Putting in place processes to ensure that new staff receive training on SOPs and other relevant matters was also recommended.

8. A 70-year-old man who experienced severe back pain following exercise in the morning presented to the emergency department of a public hospital. Initially the man had presented to an emergency medical centre and was transferred to hospital by a GP. The GP noted a possible thoracic aneurysm. This information was passed on to the emergency medicine consultant. After observations were taken and X-rays revealed normal appearances the man was discharged. The diagnosis on the discharge documentation was of musculoskeletal back pain. Before leaving the hospital, the man collapsed. Attempts to resuscitate him were unsuccessful. The Commissioner found that the emergency medicine consultant failed to carry out appropriate investigations to exclude a diagnosis of aortic dissection. It was recommended that the DHB provide training to emergency department medical staff about aortic dissections, and that the emergency medicine consultant apologise to the man's family for his breach of the Code.

4.2 Advocacy

The Nationwide Health and Disability Advocacy Service was formally established in 1996 as a free and independent service for consumers of health and disability services. Since 2007, the Director of Advocacy[6] at HDC has contracted with the National Advocacy Trust (a charitable trust) to provide and operate the Advocacy Service. In June 2018, this highly successful arrangement was extended for a further five-year term.

In 2017/18, approximately 36 advocates around the country, supported by three administrative staff and four regional managers, operated out of community-based offices from Kaitaia to Invercargill. The Advocacy Service responded to 11,000 enquiries; guided and supported consumers to process over 2,800 complaints; provided nearly 1,500 education sessions promoting the Code to consumers and providers; and networked extensively in their local communities, with a special focus on the hard-to-reach and the most vulnerable consumers.

Advocates

Advocates work within the jurisdiction set out in the Act, promoting the rights set out in the Code and supporting consumers in expressing and resolving concerns directly with service providers.

Through their professional development, which includes working towards the Advocacy Service's NZQA approved qualification, advocates acquire a thorough knowledge and understanding of the HDC Act and the Code, along with other relevant legislation and standards. Advocates also have a comprehensive understanding of the health and disability sector, and develop substantial knowledge about their local community. Advocates develop professional and respectful working relationships with providers and consumers of all backgrounds, and apply defined complaint resolution processes to achieve positive outcomes for consumers.

The Advocacy Service complaints resolution process

Complaints resolution is a key output in the achievement of HDC's strategic objectives, with HDC focusing on fair, effective, and timely resolution. The Advocacy Service is critical in ensuring success in that space by facilitating early resolution by agreement between the parties. Nearly 90% of the complaints managed by the Advocacy Service are considered by the consumer to be resolved or are withdrawn, and the majority of complaints are closed within three months.

Consumers are always at the centre of the Advocacy Service's complaints resolution process, with advocates guiding and supporting complainants to clarify their concerns and the outcomes they are seeking. This clarity enables the provider to write or speak effectively and directly to the complainant. Facilitating a process where both parties hear each other's stories is an essential precondition for resolution between the parties.

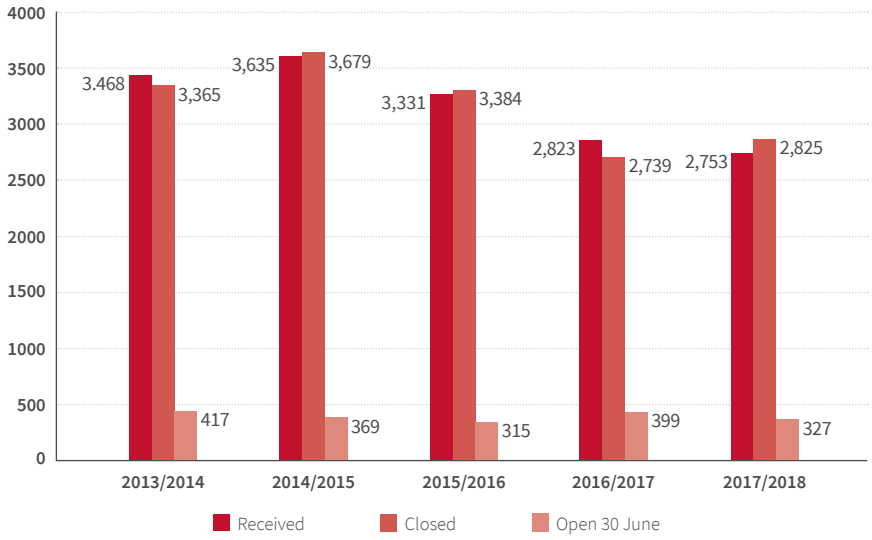
Often the advocacy process supports consumers and providers in rebuilding relationships. This is of particular importance when the consumer and provider will be having an on-going relationship. In some instances, just having the opportunity to talk through the events and to draft a complaint letter with an advocate enables a consumer to achieve a degree of personal reconciliation, and subsequently the consumer may withdraw his or her complaint.

As complaints to the Advocacy Service are resolved between the parties, it is important that providers are also fully involved and supportive of the process.[7] The high resolution rate achieved by the Advocacy Service 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.

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

[7] 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.

Figure 7: Complaints received and closed by the Advocacy Service from 1 July 2013 to 30 June 2018



Eighty-four percent of complaints made to the Advocacy Service were closed within three months, 99% within six months, and 100% within nine months.

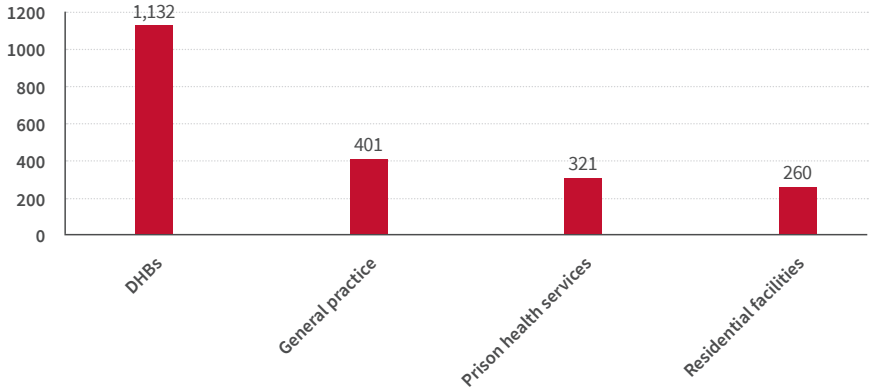
This year, the Advocacy Service received 2,753 new complaints and assisted consumers to close 2,825 complaints. Eighty-four percent of complaints made to the Advocacy Service were closed within three months, 99% within six months, and 100% within nine months. Nine percent of complaints were resolved following a resolution meeting between the consumer and the provider with an advocate's support.

In 2017/18, 88% of all complaints received by the Advocacy Service related to healthcare services, while 12% of complaints related to disability services.

Ten percent of all complaints to the Advocacy Service related to mental health services. The most common types of providers complained about in 2017/18 were DHB services (41%), general practice (15%), prison health services (12%), and residential care facilities (9%).

This is similar to the group providers complained about in complaints to HDC. However, the Advocacy Service received a higher proportion of complaints regarding prison health services than HDC.

Figure 8: Service providers commonly complained about to the Advocacy Service in 2017/18



Residential disability facility

A consumer said that she did not like a new support worker's style of communication with her, which she found abrupt, loud, and accusatory. The consumer said that she would like an advocate to support her at a meeting with the House Manager, so that she could raise her concerns. Following the meeting, the House Manager reported back that the support worker was now aware that the style of communication she had been using was not appropriate. The consumer said that she felt she had been heard and was happy to move on.

District Health Board

With the support of an advocate, a consumer raised her concerns about poor nursing care, a lack of effective communication, and a delay in receiving pain medication from DHB staff. The DHB apologised and advised that the nursing staff involved in the consumer's care would be monitored to determine whether they required further training, and that the DHB had revised its postoperative pain relief procedure. Following receipt of the DHB's response, the consumer wrote to the advocate, "I am in tears actually because I finally feel like I have been listened to."

General practice

A consumer went to her GP to have minor surgery to remove a basal cell cancer from her forehead. On the day of the procedure, the GP advised the consumer that the procedure would be carried out by a medical student because the student had better eyesight, and it would cost less. The consumer told her advocate that she was unhappy that she had not been informed prior to her appointment that the procedure would be done by a student. She felt that the GP had not listened to her concerns, had not offered any other options, and had pressured her into allowing the procedure to be done by the student.

A meeting was arranged, and the GP apologised and agreed that his response to the consumer's concerns on the day had not been appropriate. The GP practice decided to develop written information and a form for consent, the draft of which would be sent to the consumer for her input. The consumer was happy with the outcome, and said that she would not have been comfortable meeting with the GP if the advocate had not supported her.

Drug and alcohol residential service

A consumer approached an advocate during a scheduled visit to his residential service. The consumer was concerned about poor communication from staff about his request to transfer to another house where he could live with his son. An advocate supported the consumer at a meeting to discuss his concerns, and a transfer was then arranged. The consumer was pleased that he had approached the advocate, and was happy with the timely and effective response to his concerns.

Prison health services

The consumer was a prisoner with severe tooth pain. During a dental examination there was an incident between the consumer and a staff member, and treatment was halted. The consumer was advised by the hospital dental service that if he wanted to continue with his dental treatment he needed to apologise and provide reassurance that he would not be aggressive during treatment. The consumer refused, as he felt that he had been agitated only because of the pain he was experiencing. As his teeth remained untreated, he pulled them out himself, which created significant issues. The consumer felt that nobody was taking his concerns seriously, and that he was not being listened to.

An advocate assisted the consumer to write a complaint letter to the provider explaining the consumer's version of events. However, the consumer remained adamant that he did not want to undergo an X-ray or provide reassurances about his behaviour, and the provider declined to offer treatment. The consumer said that if the complaint was not resolved he would take the matter to court, and would go on a hunger strike. After further discussion with the advocate about achieving resolution, the consumer eventually agreed to have an X-ray and give reassurances about his behaviour, and further treatment was agreed.

The consumer advised that he was satisfied with the outcome of his complaint, and sent the following letter at the end of the advocacy process:

"I just wanted to say … thank you very much for your support, professionalism and passion on my behalf regarding my medical and dental issues. Since having a sit down with [the prison health services manager] she has done her best I believe to see that the issues come to a close … Your support gave me an avenue that gave me the confidence that I had someone with me."

Reaching consumers and promoting the Code

Advocates are grounded in their local communities and focused on contacting hard-to-reach consumers and those who are the most vulnerable. Advocates work to ensure that they are accessible and familiar and have community knowledge by networking with consumers and providers; by providing face-to-face education sessions; by distributing promotional leaflets and posters; and by responding promptly to telephone and email enquiries.

REACHING CONSUMERS AND PROMOTING THE CODE THROUGH NETWORKING

A key part of an advocate's role is promoting the Code and consumer rights. Advocates network within their local communities to establish a profile and to make contact with a wide range of consumers. Networking includes visiting residential facilities and day-care centres, and contacting those consumers who are least able to self-advocate and whose welfare may be most at risk. Networking also assists advocates to understand 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 over 2,200 networks. These included consumer or consumer-focused groups, public interest and community groups, and provider groups.

RESPONDING TO TELEPHONE AND EMAIL ENQUIRIES

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

During the 2017/18 year, staff responded to 18,603 calls, and managed 11,000 public enquiries. Ninety-eight percent of those enquiries were responded to and closed within two days. Enquiries covered a broad range of topics, as shown in Figure 9. The most common subject of enquiries concerned the role of advocates and information about how to make a complaint.

Figure 9: Subject of enquiries to the Advocacy Service

WEBSITE AND PROMOTIONAL MATERIALS

The Advocacy Service section of the HDC website — www.advocacy.org.nz — has been updated and improved substantially to facilitate contacting an advocate and to provide clear information about the Advocacy Service. This year the Advocacy Service also revised its logo and moved to a simple black-and-white presentation of advocacy information. All advocacy promotional information has been created in the new format, and the Advocacy Service has developed new promotional items with advocacy contact details, which are distributed to consumers.

PROMOTING THE CODE THROUGH EDUCATION SESSIONS

Advocates provide face-to-face education sessions to groups of consumers about their rights under the Code, and to groups of providers about their responsibilities and effective complaints management. These sessions are a great opportunity to discuss the Code within the context of the specific circumstances of the attendees, and also for advocates to explain successful complaints management processes and the advocate's role.

In the 2017/18 year, advocates presented a total of 1,499 face-to-face education sessions to a range of consumers and providers. While the majority of the sessions related to information on the Code, the Advocacy Service, HDC, and complaints resolution processes, advocates also provided sessions on topics such as self-advocacy, effective communication, open disclosure, health passports, effective informed consent, and the "Tell Someone" programme.[8]

Education sessions are very well received, with 87% of consumers and providers who attended an education session and responded to a satisfaction survey reporting that they were satisfied or very satisfied with the session.

[8] A programme based around scenarios shown on a DVD to demonstrate ways consumers can speak up. The actors are consumers who have a learning impairment and live in a residential home.

REACHING CONSUMERS IN RESIDENTIAL FACILITIES

Visits to residential facilities enable 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. Visits may include a meeting with either consumers or providers and/or an education session. Of the 1,921 total visits to certified and non-certified residential services, 638 included an education session. During the year, the Advocacy Service received 1,367 enquiries from consumers and providers in residential facilities, and 260 complaints about residential services.

Advocates visited 529 certified residential aged-care facilities nationwide, visiting 289 of those facilities at least twice. Seven hundred and forty-four certified residential services catering to disabled people had at least one visit from an advocate, and 149 had at least two visits.

CASE STUDIES

RESIDENTIAL DISABILITY FACILITY VISIT

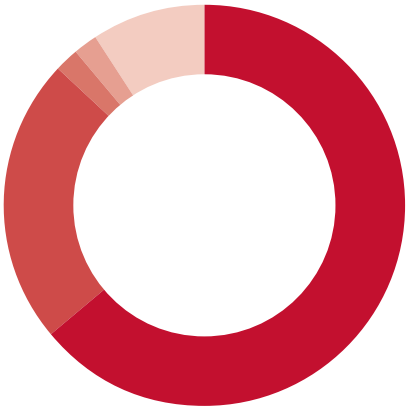
During a visit to a residential disability facility, one of the residents disclosed that she was unhappy at the home. She said that there had been arguments and some physical altercations with flatmates who had been there for some time and were significantly older than her. She felt that staff had taken the side of others, which made her feel isolated, and as a result she wanted to move. An advocate assisted the resident to raise her concerns. Following a meeting with the consumer, her father, and the advocate, the manager facilitated a visit to another home in a nearby suburb. It was agreed that the consumer and the residents of the new home would get to know each other before the consumer made a decision about moving. The consumer thanked the advocate and said that she felt excited about the possibility of a fresh start with new flatmates and staff members.

Complaint classification and demographics

Consistent with previous years, the majority of complaints received by the Advocacy Service concerned consumers aged between 41–60 years (38%), followed by those aged between 26–40 years (30%), and those aged between 61–90 years (24%). Around 57% of complainants identified as female and 43% as male.

Of the total complaints received, 64% of complainants identified as New Zealand European, 23% identified as New Zealand Māori, 2% identified as people from the Pacific, and 2% identified as Indian.

Figure 10: Ethnicity of complainants to the Advocacy Service



- New Zealand European (64%)
- New Zealand Māori (23%)
- Pacific (2%)
- Indian (2%)
- Other / Unknown (9%)

Figure 11: Gender of complainants to the Advocacy Service

- Female (57%)
- Male (43%)
- Other / Unknown (0.4%)

Satisfaction with the Advocacy Service

Complainants who resolve their disputes through the Advocacy Service process are generally very satisfied because they have been given the opportunity to be heard and to participate directly in working out their own resolution. Usually providers are also satisfied with the Advocacy Service process, in particular with the advocate's role in assisting the complainant to clarify the important issues and set out what resolution might look like. Often providers welcome the opportunity to explain their actions fully and, if appropriate, to apologise directly to the consumer and inform the consumer of the difference his or her complaint has made.

Consumers and providers who have worked with an advocate through the complaints resolution process, and have provided an email address, are asked to comment on their level of satisfaction with the service through an online survey. Thirty-three percent of those consumers who do not have access to the online survey are sent paper surveys. In 2017/18, 90% of consumers and 87% of providers who responded to satisfaction surveys said that they were satisfied or very satisfied with their contact with the Advocacy Service.

The following feedback was received from consumers:

- Exceptional service & support. I also had contact with another advocate and the response was similarly positive and exceeded all expectations.
- A very distressing problem for me, being ridiculed and ignored, was completely turned around by the advocate who put me on the right path to having my concerns addressed. I was at a low point & she turned me around by her continual encouragement to lead me to a satisfying conclusion. Thank you so much.
- Prompt and direct, clarified and summarised the agreement and changes to be made to avoid similar cases. She's very good and professional in her handling of my complaints.
- I would like to say a lot of people would just mark all 5s to make the person look good which isn't helpful to anyone, but the advocate deserves all 5s, he always contacted me when he said he would, he listened to me and made me feel heard and was easy to understand when it came down to the options available. Well done.

The following feedback was received from providers:

- Excellent service — timely response, good communicator and negotiator. Professional in manner/body language, is present with what is occurring. Understanding of staff/ residents, respectful to client and staff. Outcomes are win/win for client & staff.
- The advocate is a pleasure to work with. She is the consummate professional who is considered in her approach.
- We as the provider invited the advocate in as we were unable to resolve issues with this client. There was a positive outcome.

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.

> A consumer wrote to an advocate, *"I am in tears actually because I finally feel like I have been listened to."*

> Often providers welcome the opportunity to explain their actions fully and, if appropriate, to apologise directly to the consumer and inform the consumer of the difference his or her complaint has made.

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 an HRRT proceeding that was resolved by negotiated agreement, including a consent order for a declaration of a breach of the Code by the Tribunal.

In addition, the Director of Proceedings was successful in defending a practitioner's appeal to the High Court against a finding of professional misconduct made in the HPDT.[9] In the same hearing, the Director was successful in having the order for suppression of the practitioner's name overturned. The subsequent High Court decision is of particular note for its confirmation of the correct test to be met before a finding of "professional misconduct" can be made under the Health Practitioners Competence Assurance Act 2003.

Referral statistics

The Director of Proceedings had 28 referrals in progress during 2017/18, including 11 referrals received in the course of the year. Around 60% of the referrals in progress are referrals involving issues of practitioner competency. Table 3 identifies the 2017/18 referrals by provider type.

Table 3: Referrals received in the 2017/18 year by provider type

Provider	No. of referrals received in 2017/18
General practitioner	1
Midwife	1
Healthcare assistant	1
DHB	3
Residential aged-care facility	1
Nurse	1
Audiologist	1
Ambulance service	1
Rural hospital	1
Total	**11**

> 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.

[9] Johns v Director of Proceedings [2017] NZHC 2843 (20 November 2017)

Gynaecologist held accountable for breach of duty to obtain informed consent prior to treatment

The Director filed a charge against a consultant gynaecologist and obstetrician in the Health Practitioners Disciplinary Tribunal ("the Tribunal") concerning his decision to insert a Mirena (an intra-uterine contraceptive device (IUD)) into his patient when she had expressly declined that intervention and he did not have her informed consent to do so.

In 2015 the woman consulted her GP regarding post-coital bleeding. The woman was referred to the gynaecologist. At a consultation in March 2015, a diagnostic hysteroscopy, dilatation and curettage, an endometrial biopsy and insertion of a Mirena were recommended. The woman gave evidence that she told the gynaecologist that she had had an IUD previously and, while she had not had any problems with it, she did not want another one. A consent form for surgery was subsequently signed, which included "…+ Mirena insertion". However, on the day of surgery (May 2015), the woman deleted from the consent form reference to the Mirena. The gynaecologist acknowledged that the woman informed him that day that she did not want the Mirena, even when he advised her that what was then proposed would not assist with her diagnosed menorrhagia (heavy menstrual bleeding) and iron deficiency. The woman's elective surgery proceeded without incident.

At the woman's postoperative follow-up in July 2015, the gynaecologist erroneously told the woman that he had fitted her with a Mirena. After the woman expressed concern that this would have been contrary to her instructions, the gynaecologist checked his notes and recalled that the woman had changed her mind on the day. The woman disputed this and said that she had never wanted a Mirena. Other future options for management of the woman's menorrhagia were then discussed, and the woman said that she would return to consult the gynaecologist if she elected to pursue treatment.

The woman ultimately elected to proceed with a Novasure endometrial ablation, and this was arranged by email between the woman and the gynaecologist's surgery. No face-to-face consultations were had from July 2015 to the date of the woman's surgery (December 2015).

The woman signed the consent form for the endometrial ablation, on the day of her surgery. No consent was provided for insertion of a Mirena. When the gynaecologist came to perform the ablation he experienced difficulty and abandoned the procedure. He considered that "the only remaining valid option other than waking [the woman] up and doing nothing was to insert a Mirena". The gynaecologist said that before inserting the Mirena he "stated loudly in theater that although [the woman] might not like the idea of a Mirena it is the only valid option now to treat her bleeding and I will go and explain to her in the recovery room that this will be a temporary measure until we explore further options".

The gynaecologist inserted the Mirena. When the woman was advised that a Mirena had been inserted, she was angry and distressed. Consent was given for the removal of the Mirena, and the gynaecologist did so accordingly.

In his clinical notes, the gynaecologist acknowledged that he had not obtained the woman's consent for the Mirena insertion, and that he knew that she had declined that option previously. He later reiterated this in a letter to the woman's subsequent gynaecologist.

The charge before the Tribunal included two particulars. The first alleged that the gynaecologist inserted the Mirena without the woman's informed consent. The first particular was admitted to by the gynaecologist, and he accepted that this amounted to professional misconduct. The Tribunal had no hesitation in finding the first particular of the charge established as misconduct, being negligence and conduct that had brought discredit to the profession. The second particular alleged that the gynaecologist had inserted the Mirena contrary to what he knew, or ought to have known, of the woman's wish not to have a Mirena inserted. The gynaecologist defended the second particular.

The Tribunal found the second particular established, and specifically found that the gynaecologist knew of the woman's wish not to have a Mirena inserted. The Tribunal concluded that there was no confusion or opportunity for confusion about what the woman wanted on the day of surgery. The Tribunal found that the conduct established in the second particular amounted to malpractice and negligence, and had brought discredit to the profession.

In concluding that the gynaecologist's conduct warranted disciplinary sanction, the Tribunal confirmed that all patients are entitled to give informed consent, to have proper information on which to base this, and to decline to give consent. The Tribunal found the evidence to be clear that the gynaecologist knew that the woman did not want to have the Mirena, but that he had proceeded with the insertion of it under a patronising and paternalistic belief that that may be in her best interests.

The Tribunal regarded this case as a significant breach of standards. The Tribunal indicated that a message needed to be sent to the gynaecologist and the wider profession that the conduct to which the charge referred was serious and reflected outdated perceptions. The Tribunal concluded that a short period of suspension (three months)[10] was inevitable and was the only way for the gynaecologist to understand the gravity of what had occurred and his attitudes. The Tribunal also placed conditions on the gynaecologist's practice, including three months of supervision. The Tribunal censured the gynaecologist and ordered him to pay a fine of $2,500.

DECISION

The decision has not yet been published on the HPDT website.

Residential aged-care facility held accountable for failing to provide services with reasonable care and skill

The Director filed proceedings by consent against a residential aged-care facility, in the Human Rights Review Tribunal (the Tribunal), regarding its care of a younger resident (the aggrieved person) who developed an infected sacral pressure ulcer while she was a resident of the aged-care facility.

At the time of events, the aged-care facility was providing health and disability services to the aggrieved person while she was a private hospital-level resident. The aggrieved person was a younger resident who suffered from debilitating progressive multiple sclerosis and was largely bed bound. She also suffered from several co-morbidities, including diabetes. Sadly, the aggrieved person died from septic shock due to necrotising fasciitis caused by the infected sacral pressure ulcer that had developed while she was a resident. Over a period of a fortnight, several nurses had recorded the increasing deterioration of both the sacral wound and the aggrieved person's general condition. However, despite the wound appearing infected and not improving, no action was taken to change the wound care plan, refer the aggrieved person to a wound care specialist nurse, or to refer the woman for reassessment by her GP. Further, on several occasions an additional dose of "as required" zopiclone (a sleeping tablet) was administered to the aggrieved person after 3am, causing her day-time sleepiness and associated reduced appetite and nutrition.

According to expert nursing advice, there were recurring failures by several registered nurses who cared for the aggrieved person (both individually and as a team) in the face of several significant clinical presentations and several opportunities for further reassessment. The failures involved core nursing competencies and reflected a lack of insight into the recognition and management of significant presentations. The aged-care facility accepted that it had a responsibility to operate the aged-care facility and hospital in a manner that provided its residents with services of an appropriate standard, and accepted that it had ultimate responsibility for the failures in providing the expected standard of care required by a younger resident with chronic medical conditions and complex co-morbidities. The aged-care facility acknowledged that it had a responsibility to ensure that all nursing staff were adequately familiar with its policies and procedures and complied with them. The aged-care facility also acknowledged that the inaction and failure of multiple staff to adhere to policies and procedures pointed towards an environment that did not sufficiently support and assist staff to do what was required of them.

The aged-care facility accepted that its actions amounted to a breach of the Code, and the matter proceeded before the Tribunal by way of an agreed summary of facts. The Tribunal was satisfied that the aged-care facility had failed to provide services to the aggrieved person with reasonable care and skill, and issued a declaration that the aged-care facility had breached Right 4(1) of the Code.

DECISION

This decision can be found at: http://www.nzlii.org/nz/cases/NZHRRT/2017/55.html

[10] The gynaecologist has appealed the three-month suspension ordered by the Tribunal.

4.4 Monitoring and advocacy — mental health and addiction services

There has been a significant focus on mental health and addiction services in 2017/18.

- The Mental Health Commissioner released HDC's first monitoring and advocacy report in relation to mental health and addiction services in New Zealand. The report brings transparency and accountability to the performance of services, and makes recommendations for improvement.
- The Government established an inquiry into mental health and addiction to identify unmet needs and develop recommendations for a better mental health and addiction system for Aotearoa New Zealand. Supporting this work through information provision and submissions has been a priority for HDC.
- Mental health and addiction services continue to be a prominent service type in complaints to HDC, making up around 20% of complaints about DHBs and 10% of all complaints to HDC. In addition, 10% of all complaints to the Advocacy Service also related to mental health services.

Public reporting on the state of New Zealand's mental health and addiction services

The Mental Health Commissioner is responsible for HDC's statutory function to monitor mental health and addiction services and to advocate for improvements to those services. In February 2018, the Mental Health Commissioner published a report on the state of services, and made recommendations for improvements. The report introduced a more structured and public-facing approach to this statutory function.

REPORT DEVELOPMENT

The Mental Health Commissioner and his team engaged with consumers, family and whānau, and mental health and addiction sector representatives over 18 months to develop a monitoring and advocacy framework to:

- Support regular, evidence-based, public reporting on the state of services.
- Bring greater transparency and accountability to the performance and quality improvement of services.
- Provide trend data and a platform to make and follow up on recommendations for service improvement.

The framework was influenced by HQSC's New Zealand Triple Aim framework for quality improvement and quality indicators (which cover safety, patient experience, effectiveness, equity, access/timeliness, and efficiency). These quality indicators were referenced to develop six consumer and family and whānau-focused monitoring questions:

1. Can I get help for my needs?
2. Am I helped to be well?
3. Am I a partner in my care?
4. Am I safe in services?
5. Do services work well together for me?
6. Do services work well for everyone?

The Mental Health Commissioner released HDC's first monitoring and advocacy report in relation to mental health and addiction services in New Zealand. The report brings transparency and accountability to the performance of services, and makes recommendations for improvement.

A primary recommendation was a call to *"broaden the focus of service delivery from mental illness and addiction to mental well-being and recovery".*

Figure 12:

Mental Health And Addiction Services Monitoring and Advocacy Framework

HDC Complaints	Consumer and whānau feedback	Sector engagement	System and service performance information

System overview

The big picture: Population needs, services and funding landscape, workforce, leadership and strategy

Services: Are we meeting the needs of consumers?

Assessed by answering:

Can I get help for my needs?

Am I helped to be well?

Am I a partner in my care?

Am I safe in services?

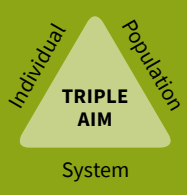
Do services work well together for me?

Do services work well for everyone?

Areas for improvement

Identifying successes and challenges, recommend system improvements

HEALTH QUALITY MEASURES – Safety – Patient experience – Effectiveness – Equity – Timeliness/Access – Efficiency



The report also has a particular focus on service performance in relation to Māori; Pacific peoples; infants, children and adolescents; and people in prison, due to poorer outcomes experienced by those population groups.

EVIDENCE UNDERPINNING THE REPORT

The report's six monitoring questions are answered by drawing on four sources of information:

1. HDC's complaints data
2. Service performance information
3. Consumer and whānau feedback
4. Insights gained from HDC's sector engagement

Monitoring activity in 2017/18 included attending 98 national mental health and addiction service network and key stakeholder meetings; facilitating a stakeholder workshop and six consumer and family focus group sessions; analysing information from consumers and family and whānau collected through HDC's Mārama Real Time Feedback survey tool (used in 18 of 20 DHBs and 7 NGOs as at 30 June 2018, and capturing nearly 16,000 voices since first piloted in 2014); analysing 2016/17 complaint trends about mental health and addiction services; and analysis of other service performance information.

Additionally, quantitative performance measures were selected to provide baseline performance data and trend information over time in relation to the six monitoring questions. A literature review, supported by sector engagement and information from the Ministry of Health, was also undertaken to provide an overview of the mental health and addiction system. The system overview covers population needs; services and funding landscape; workforce; and leadership and strategy.

KEY FINDINGS AND RECOMMENDATIONS

The Mental Health Commissioner found that while growing numbers of New Zealanders are accessing health services for mental health and addiction, these services are under pressure and many needs are left unmet. There are many signs of progress, including innovative service models, indicators that people improve in services, and quality improvement programmes that are starting to address areas of concern. Further, 80% of respondents to HDC's Mārama Real Time Feedback survey reported that they would recommend their service to friends or family if they needed similar care or treatment (as at 30 June 2017). However, areas the Mental Health Commissioner is concerned about include:

- A lack of early intervention options
- Low commitment by services to shared planning with consumers and their family and whānau
- Coordination challenges within and between services
- High use of compulsory treatment, especially for Māori
- Stagnation in reducing use of seclusion
- Poorer physical health outcomes for people with serious mental health and/or addiction issues
- Disparity in outcomes for Māori and other population groups

More of the same interventions will not deliver the well-being and recovery-oriented system that is required. A broader range of health interventions is needed, to be available earlier, and be better connected to other community and social supports — the health sector is only one part of an effective system response. At the same time, action is required to relieve pressure on existing mental health and addiction services.

Making change happen has been a challenge for the mental health and addiction sector — there is a loss of traction, and complex leadership structures that fail to drive change. This is evidenced by the expiry of the overarching 2012–17 government plan for service development of mental health and addiction services, Rising to the Challenge. With 100 actions, and a lack of relative priorities, clear accountabilities, an implementation plan, and clear milestones or measures of success, it has been difficult to measure progress at the completion of the plan. The suicide prevention strategy has also lapsed, despite extensive public consultation to replace it.

The Mental Health Commissioner made eight recommendations to the Minister of Health to support service improvement. The primary recommendation calls for a new action plan for mental health and addiction to:

- Broaden the focus of service delivery from mental illness and addiction to mental well-being and recovery
- Increase access to health and other support services
- Improve the quality of mental health and addiction services
- Ensure that we have timely information about changing levels of need, current services and support, and evidence about best practice
- Implement a workforce strategy that enables the sector to deliver better, more accessible services
- Achieve the required changes through collaborative leadership, supported by robust structures and accountabilities to ensure successful, transparent results

Another recommendation was to invite the Inquiry to consider:

- an action plan, in collaboration with Māori experts and leaders, and other sector leaders and providers, to reduce the exceptionally high rate of Compulsory Treatment Orders for Māori;
- a specific reduction target in the Government's suicide prevention plan;
- a goal of zero tolerance of suicides in services, with support for providers to work together to develop a consistent approach in achieving it;
- regular assessment of prevalence, help-seeking behaviour, and access to mental health and addiction services across the whole population, to identify and respond to changing needs; and
- a requirement on DHB-funded providers to undertake comparable, representative sampling of consumer experience of mental health and addiction services, and to report annually, from 2019, on that

information and actions taken to improve services as a result of the information.

The Mental Health Commissioner also recommended that the Ministry of Health be directed to:

- progress work on changes required to the Mental Health (Compulsory Assessment and Treatment) Act 1992 to ensure that it aligns with current expectations about human rights, supported decision-making and best practice in the provision of therapeutic health services, and with the United Nations Convention and the Code of Health and Disability Services Consumers' Rights so that this can be progressed quickly in any regulatory review following the Government Inquiry into Mental Health and Addiction; and
- record and, by 2019, report on prescriptions in mental health inpatient units.

Progress against these recommendations will be reported on in the Mental Health Commissioner's 2019 monitoring and advocacy report.

Government Inquiry into Mental Health and Addiction

In January 2018, the Minister of Health established the Government Inquiry into Mental Health and Addiction, appointing eight panel members and providing a budget of $6.5 million. This significant Inquiry is tasked with identifying unmet needs and developing recommendations for a better mental health and addiction system for Aotearoa New Zealand. It is due to report by the end of November 2018.

In 2017/18, the Mental Health Commissioner responded to an initial request for information, met with the Inquiry panel and secretariat members, and prepared a submission to the Inquiry. In his submission, the Mental Health Commissioner reinforced the findings and recommendations in his monitoring and advocacy report and focussed on leadership and oversight of the mental health and addiction sector. He outlined:

- A need for collaborative leadership to align the sector to shared goals, plans, practices and culture, and to implement change, and some measures to achieve this.
- The need for a statutory requirement, similar to that for disability, for an all-of-government mental health strategy to improve the mental well-being of New Zealanders, including through primary, community, and secondary health services.
- HDC's support for the establishment of a new Mental Health Commission to provide strong, independent monitoring of, and advocacy for, a mental health strategy. The new Commission should be seen as an important component of sector leadership and accountability, but not the only component. It should have a broad mental well-being and recovery focus, clear functions, independence, and adequate powers and resources.

The Mental Health Commissioner will provide independent advice to Government following the release of the Inquiry's findings and recommendations.

The Mental Health Commissioner's submission and public report are published on HDC's website.

Resolving complaints about mental health and addiction services

As part of monitoring mental health and addiction services and advocating for their improvement, the Mental Health Commissioner has responsibility for making decisions in relation to complaints to HDC about mental health and addiction services. This enables the insights about consumer experience and sector performance gained from complaints to be integrated with information gained through the monitoring function, including sector engagement and Mārama Real Time Feedback. It also enables the Mental Health Commissioner to make recommendations for service improvement in relation to individual complaints. Each complaint provides a valuable opportunity to identify key learnings and promote best practice within the sector.

COMPLAINTS RECEIVED

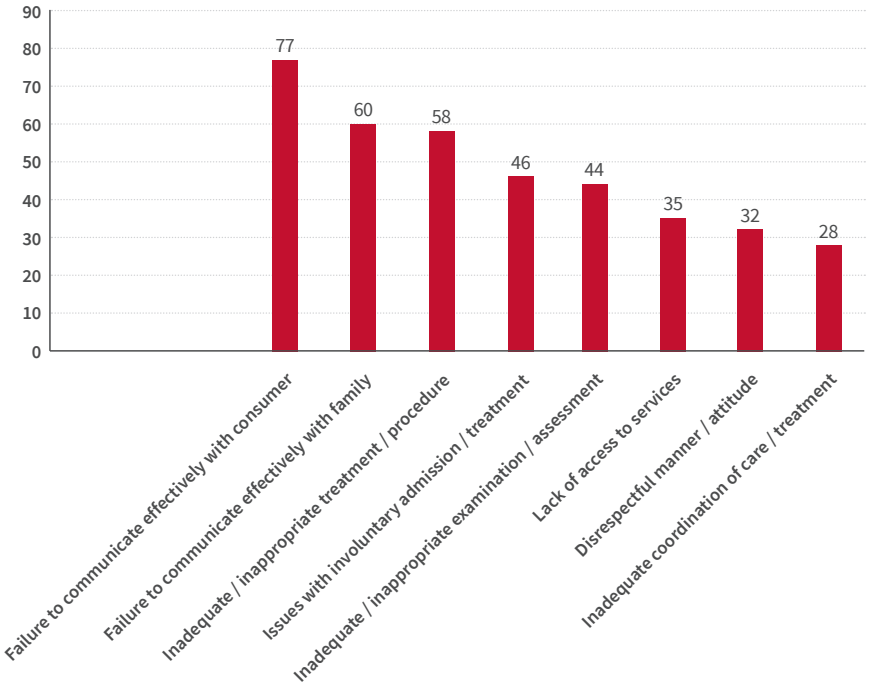
In 2017/18, HDC received 261 complaints about mental health and addiction services. This is an increase of 6% on complaints received about these services in 2016/17, and a 23% increase on 2015/16. This increase is in line with the overall increase in complaints to HDC, with complaints about mental health and addiction services continuing to make up around 10% of all complaints to HDC and 20% of complaints about DHBs.

When all issues complained about in relation to mental health services are considered, the most commonly complained about categories in 2017/18 were:

- Communication (57%)
- Care/treatment (55%)
- Consent/information (24%)
- Access/prioritisation (18%)
- Professional conduct (16%)
- Facility issues (15%)

These categories are similar to what was seen in 2016/17. Complaints about access/prioritisation issues have increased slightly from 15% of mental health complaints in 2016/17 to 18% in 2017/18, and consent/information issues have decreased from 32% in 2016/17 to 24% in 2017/18. The most common issues complained about within these categories are set out in Figure 13 below.

Figure 13: Mental health and addiction services complaints received — commonly complained about issues in 2017/18 [11]



Recommendations for service improvement

In 2017/18, providers were fully compliant with all of the 21 quality improvement recommendations due in respect of mental health and addiction services.

Recommendations were centred on updating policies or procedures, undertaking compliance audits, and additional training or professional development. In a number of cases, HDC also recommended that the provider formally apologise to the consumer or the consumer's family. In one example, the Mental Health Commissioner investigated the care a DHB provided to a consumer with borderline personality disorder. The Mental Health Commissioner was critical of the DHB for not developing an appropriate care management plan for the consumer, and not providing the consumer with an opportunity for psychiatric review or therapy in the community. Following the investigation, the Mental Health Commissioner recommended that the DHB provide evidence that it had implemented a range of changes. These included the development of a work programme to improve the management of borderline personality disorder, with an emphasis on improved access to psychological therapies, and reducing seclusion. These recommendations were met, and the DHB is now working with HQSC to ensure that further progress is made.

Another example concerns care provided by a community mental health team. The consumer suffered from a complex and chronic mental disorder. While receiving treatment under a Community Treatment Order, the consumer's regular medication was substituted with an alternative prescription. The consumer was concerned that he had been prescribed the incorrect medication and believed that this may have caused him to become ill. Following a thorough assessment of the complaint, during which HDC sought a response from the provider concerned and obtained expert advice from a consultant psychiatrist, the Mental Health Commissioner determined that the consumer should have been informed of the decision to alter the medication prior to the consumer collecting the prescription. Accordingly, the Mental Health Commissioner recommended that the provider use the complaint as a learning opportunity to ensure that all clinicians are aware of the requirement that any changes to a consumer's medications are discussed directly and agreed with that person. Subsequently, the provider amended its medication policy to reflect this recommendation, and provided staff with additional training in respect of communication.

[11] 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. Data is provisional as of date of extraction (6 July 2018).

Issues with the management and treatment of co-existing problems, most often co-existing mental health and addiction issues, and the treatment of personality disorders, are common issues identified in complaints about mental health and addiction services. Inadequate risk assessment and involvement of consumers and family in crisis care planning are also common themes identified in the assessment of complaints.

These issues are illustrated in the following case, where the Mental Health Commissioner found a DHB in breach of the Code for failings in the care provided to a man with complex mental health issues.

Care of man with complex mental health issues (15HDC01279)

A man who had a history of mental health and alcohol dependence issues was admitted to a public hospital following an episode of self-harm. He was diagnosed with adjustment disorder, alcohol dependence, and likely antisocial personality disorder, and treated as an outpatient. He was prescribed quetiapine to help with sleep, and was seen by the Mental Health and Addiction Service Crisis Team (the Crisis Team) several times before being referred to the Alcohol and Other Drug Service (AOD). Following this, he was seen by his key worker a number of times and a personal crisis plan was drafted.

Over the course of the next two months, the man made several calls to the Crisis Team number threatening self-harm and expressing suicidal thoughts. He had two voluntary stays in the Acute Psychiatric Unit, and visits from his key worker in an outpatient setting. During his second admission, a friend visited him and offered to be a support person. The man's crisis plan was not updated during these admissions. During this two-month period, the man also sent several inappropriate texts to his key worker. The key worker discussed the messages with the psychiatrist, who suggested that a formal complaint be made to the police and to her manager. She said that she was not told to complete an incident form.

A Complex Case Conference was held to discuss the man's care, and the key worker then drafted a management plan. The case management plan included a plan that if the man made any threats of self-harm, his appointment would be cancelled immediately, the police would be contacted, and he would be discharged from the AOD. The case management plan was discussed with the man and his support person.

The man later sent the key worker a text message stating that he wanted to die. When the key worker called him, the man reported a number of stressors and stated that he did not want to live, although he denied any specific suicidal plans owing to fear of the police being called. The key worker stated that during the call the man requested discharge from AOD. Later that day, the key worker visited the man and recorded that he had ongoing suicidal ideation, was using an intoxicating substance, appeared depressed, and was expressing thoughts of hopelessness. She also recorded that the man expressed no interest in addressing his issues regarding alcohol and substance misuse, and no intention of attending appointments with her. She informed him that he would be discharged from AOD owing to his unwillingness to engage in the treatment being offered.

The key worker discussed the man's case with a psychiatrist, who agreed that the man should be discharged from AOD. The key worker presented the man's case at a multidisciplinary team meeting, at which the psychiatrist was present. The man was discharged from AOD. The risk assessment recorded that the man was at chronic risk of suicide, and noted the current factors that placed him at high risk to himself, including limited social support.

Some weeks later, the man was found dead at his home.

The Mental Health Commissioner acknowledged that the man's needs were complex and that he required support from both mental health and addiction services, and that police support and intervention was at times required. However, the Mental Health Commissioner was concerned that towards the end of the man's care, emphasis appears to have been placed on dictating his behaviour, and that support and guidance for staff were lacking. The Mental Health Commissioner considered that a more compassionate and consumer-focused approach could reasonably have been taken.

The Mental Health Commissioner found that the DHB failed to provide the man with services with reasonable care and skill, in breach of Right 4(1)of the Code, by failing to maintain an accurate and updated crisis plan, including failing to involve the man and his support people adequately; developing and implementing an inappropriate case management plan; and discharging the man from the AOD without greater consideration of other ways to foster engagement, given his ongoing risk, expressed suicidal ideation, and substance abuse.

The Mental Health Commissioner also made adverse comments about the DHB for not effectively assimilating the man's care into a dual diagnosis understanding; for its lack of psychiatric input; and for its lack of an apparent strengths-based approach. Criticisms were also made in relation to the lack

CASE STUDIES

of DHB policies in place to assist the key worker in the performance of her role, and of AOD policies that were deficient in the guidance they provided in relation to psychiatric involvement.

The Mental Health Commissioner was also critical of a number of individual providers involved in the consumer's care in regard to reviews of the consumer's risk and documentation issues.

The Mental Health Commissioner made a number of service improvement recommendations to the DHB, including that it assess its mental health and addiction services with reference to strengths-based practice to identify service improvements, including consideration of consumer and family/whānau engagement in care planning; implement professional supervision for clinical staff working in this area; review policies and procedures in relation to boundary setting, professional supervision, incident reporting, discharge from the service, client engagement, and changing case workers; and review the orientation of new staff to ensure that they are provided with training and appropriate supervision in relation to the revised policies.

It was also recommended that the DHB report back on these recommendations, as well as the findings and actions taken as a result of the DHB's independent review of the assessment, care, and treatment of clients with dual diagnosis, and the DHB's progress in implementing new terms of reference for Complex Case Conferences that set out, amongst other things, lines of responsibility for decision-making.

Every complaint is an opportunity for learning.

4.5 Education

Every complaint is an opportunity for learning. While those opportunities are important to the providers who are the subject of such complaints, sharing those learnings and insights among other providers is an important aspect of HDC's work. Therefore, HDC undertakes a number of educational activities to ensure that the learnings are shared amongst the sector in order to support improvements in safety and quality.

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

HDC conducted 33 education sessions in 2017/18. The aim of these sessions is to provide consumers and providers with a clear understanding of consumer rights and provider responsibilities under the Code. These sessions also help to ensure that lessons from complaints are disseminated, by reporting on the common issues that appear in complaints, and reporting on the recommendations made by HDC to improve quality of care. In 2017/18, these education sessions included presentations to professional colleges, universities, DHBs, primary care organisations, prison health services, and residential aged-care providers. Feedback from these sessions was positive, with 100% of respondents who provided feedback reporting that they were very satisfied or extremely satisfied with the session provided.

Additionally, in November 2017 HDC held its biennial conference in Wellington. Over 120 delegates attended the conference from across the health and disability sectors. The conference focused on consent, culture, and the consumer experience, and included a high-calibre range of presentations from both external speakers and HDC staff. Topics presented included themes from HDC's cases regarding the importance of workplace culture and leadership, seamless service, and informed consent; consumer experience and the importance of designing services with consumers; current issues in mental health and addiction services in New Zealand; health service design for the disabled consumer; the Advocacy Service

and resolving complaints between the parties; insights and learnings from HDC's in-house expert advisors; clinical negligence and the threshold for professional discipline; learnings from HDC's analysis of complaints data; and maintaining a sense of purpose and being self-aware in the practice of medicine. The conference received a very positive response from attendees.

In support of HDC's strategic priority to work with providers to improve their complaints management processes, in 2017/18 HDC provided four complaints management workshops to two DHBs, a private hospital, and a primary health organisation. The workshops are designed to equip front-line staff with the confidence and capability to resolve and learn from complaints. The majority of attendees reported being satisfied or very satisfied with the workshops.

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 2017/18, HDC provided formal written responses to 76 enquiries.

Promoting learning through complaint trend reports

Much can be learned from the trends and patterns that emerge from the analysis of complaints data, and HDC is committed to reporting these trends back to the sector in a way that supports quality improvement. The primary way in which HDC does this is through the publication of complaint trend reports.

HDC continues to provide DHBs with six-monthly complaint trend reports. The reports detail the issues and services complained about for all DHBs nationally and for each individual DHB, allowing DHBs to identify aspects of their care commonly at issue in complaints to HDC. Because the reports are produced regularly, they allow DHBs to compare data about their individual DHB to all DHBs nationally and to themselves over time. In order to support HDC's strategic priority to work with providers to improve complaints processes, the reports also detail trends in relation to complaints about DHB complaints management processes. DHBs continue to rate the reports as useful for improving services.

HDC also regularly produces reports on areas of research interest to HDC. In 2017/18, HDC undertook an analysis into complaints where it was found that a medication error had occurred. The aim of the analysis was to shed light on patterns regarding contributing factors that lead to medication error. A report detailing the analysis, as well as recommendations designed to assist providers in addressing the factors that lead to medication errors, will be published in 2018/19.

Submissions

HDC made 32 submissions in 2017/18. HDC's aim in making these submissions is to advise 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 or disability services, or both.

In 2017/18, submissions included comments on policies, procedures, codes of conduct or ethics, guidelines, and practice standards to Labtests, the Ministry of Health, the Pharmacy Council of New Zealand, the University of Auckland, the Medical Council of New Zealand, the Dental Council of New Zealand, the Medical Radiation Technologists Board, the Advisory Committee on Assisted Reproductive Technology, and the Royal New Zealand College of General Practitioners.

4.6 Disability

Supporting disabled consumers

HDC has the responsibility to promote and protect the rights of all health and disability services consumers, including the more vulnerable groups within our society. As part of the overriding purpose, the Deputy Commissioner, Disability is responsible for HDC's work in relation to both the New Zealand Disability Strategy and the United Nations Convention on the Rights of Persons with Disabilities.

An important advance in the disability sector in the past year has been the development of a new disability support system, through a co-design process led by the Ministry of Health. The system will be based on the Enabling Good Lives (EGL) vision and principles. The idea of EGL is that disabled people and their families and whānau have more choice and control over their lives and the support they receive. This proposed model of care aligns with HDC's vision of consumers being at the centre of health and disability services — a vision that is promoted through the various activities of the Deputy Commissioner, Disability.

A key focus of the Deputy Commissioner, Disability is on increasing the awareness of disabled consumers of their rights as set out in the Code, and ensuring that HDC is accessible and responsive to all consumers, including those who are less able to speak up for themselves and who are more susceptible to abuse and neglect. The Deputy Commissioner, Disability promotes the Code and the work of HDC through meeting and providing education sessions to people who have a disability. In 2017/18, this included the Deputy Commissioner, Disability attending both the opening and closing ceremonies of the Special Olympics 2017 National Summer Games in Wellington in late November 2017. The National Summer Games are New Zealand's largest sports event for people with intellectual disabilities, and provided an invaluable opportunity for the Deputy Commissioner, Disability and advocates from the Advocacy Service to engage with the 3,000 athletes, coaches, and members of the management teams who attended the Games from across the country, and talk to them about their rights and what they can do if they have concerns about the health and disability services they receive.

Over the past 12 months, the Deputy Commissioner, Disability has also continued to build on the work that was started in 2016/2017. This included a particular focus on delivering seminars to young adult disabled students attending tertiary institutes in Christchurch and Auckland. A seminar was also delivered to students attending a school for the Deaf in Christchurch. Advocates from the Advocacy Service also regularly deliver education sessions and meet with disabled people and their whānau. In the past year, advocates visited 744 certified residential disability homes across the country. These visits allow disabled people and their families/

whānau to learn more about the support that advocates can offer to disabled consumers who are receiving health and disability services.

In addition to the Deputy Commissioner, Disability's particular focus on awareness building and empowering disabled people through direct education sessions, she also develops complementary resources. In the past 12 months, two new "easy-read" resources were completed. The first publication is a booklet explaining the process involved when HDC investigates a complaint. The second provides information about the Advocacy Service. Both resources are in an accessible format and can be accessed on HDC's website.

Other activities of note undertaken in 2017/18 include the completion of the first stage of content redesign of HDC's Health Passport. The review process of the Health Passport, funded by the Ministry of Health and undertaken in collaboration with Capital and Coast DHB, provides a basis for a possible development and implementation of an electronic version of the Health Passport in the future.

Complaints received about disability services

The Deputy Commissioner, Disability recognises the importance of continuing to strengthen the safeguards in place for disability services consumers, and promoting service and quality improvement. To that end, data from complaints relating to disability services is regularly reviewed to identify common issues and areas of concern, and information is shared with other agencies. Opportunities are also taken to increase the general public's awareness of consumer experiences, and bring about system improvement where this is warranted.

In 2017/18, HDC received 111 complaints about disability services. This number is a very small increase on the 107 complaints received in the 2016/17 year.

The most common primary issues complained about for complaints received about disability services in 2017/18 were:

- A lack of access to services (15%)
- Inadequate/inappropriate non-clinical care (11%)
- Failure to communicate effectively with the consumer (10%)
- Inadequate/inappropriate disability-related support provided (10%)
- Inadequate/inappropriate coordination of care/treatment (7%)

These issues are broadly consistent with what was seen in the previous year, although complaints primarily regarding a lack of access to services have increased from 8% in 2016/17 to 15% in 2017/18.

Complaints received about residential aged-care facilities

HDC is mindful of the particular vulnerabilities of some consumers who are receiving residential aged-care services, and we therefore pay close attention to the information received in complaints about those services. In 2017/18, HDC received 137 complaints about residential aged-care facilities — an increase on the 123 complaints received about these facilities in 2016/17. The increase is in line with the overall increase in complaints to HDC, with residential aged-care facilities consistently making up around 5% of all complaints to HDC. An analysis of the issues identified by HDC on the assessment of complaints about residential aged-care facilities found that the most common issues were:

- Recognition/management of deteriorating conditions
- Inadequate falls management, in particular inadequate post-fall assessments
- Inadequate wound care management
- Delay/failure to escalate care when clinically indicated
- Issues related to provision of end-of-life care
- Inadequate supervision of staff/ inadequate staff training
- Care plans not completed/ implemented
- Poor communication between facility staff and between facility staff and GPs
- Inadequate documentation

The complaints HDC received about residential aged-care and dementia-care services highlight the complex nature of the support that is required to maintain the safety and well-being of consumers who reside in such units, and ensure that their rights are complied with consistently. The following investigation completed by HDC in 2017/18 illustrates the importance of residents having the right to exercise self-determination, and the risks to, and consequences for, consumers when their legal status and competency is not verified correctly. It is important for service providers to be aware of the legal framework for providing such services, to respect and promote the autonomy of consumers, and to support consumers to make decisions for themselves.

In the past 12 months, two new "easy-read" resources were completed. The first publication is a booklet explaining the process involved when HDC investigates a complaint. The second provides information about the Advocacy Service.

Use of canvas belt without consent, and failure to ascertain competency (16HDC00720)

A 65-year-old man who had suffered a stroke was admitted to hospital. After a period of rehabilitation he was assessed as requiring hospital-level care, including assistance with all daily living activities, and a specialised wheelchair to mobilise.

The man was transferred to his preferred residential aged-care facility. He had executed an enduring power of attorney (EPOA) for property that appointed his daughter as his attorney, and an EPOA for personal care and welfare that appointed his sister as his attorney. Despite the man being competent and neither EPOA having been activated, the aged-care facility consulted his daughter about his personal care and welfare.

On admission to the aged-care facility, the specialised wheelchair was not available, but staff instigated the use of a recliner chair in its place. The aged-care facility's GP signed the "physical restraint/enabler form", as did the man's sister, who wrote on the form that she agreed to the use of "the chair". The man was secured in the chair with a hand-tied canvas belt, but there is no reference to the restraint/enabler consent form in the man's notes, or any evidence that he was consulted about having the canvas belt tied around him.

Subsequently, the man was found on the floor beside the chair on two occasions. He told staff that he had slipped out of the chair and that the footrest kept sliding down. The incidents of the man slipping out of the chair were noted in incident forms, but no proactive actions were taken to identify and prevent the causes that contributed to him slipping.

The Deputy Commissioner found that by failing to verify the man's legal status and competency, the residential aged-care facility failed to provide services to him with reasonable care and skill and, accordingly, breached Right 4(1) of the Code. The Deputy Commissioner stated that the assumption made about the man's competency showed a lack of respect for the man, and little awareness of the psychological impact that the loss of autonomy can have on vulnerable residents.

The Deputy Commissioner considered that the aged-care facility's processes regarding restraint were unsatisfactory, and that the use of the canvas belt was not in accord with the New Zealand standards or the rest home's own policy. Accordingly, she found that the aged-care facility had breached Right 4(1) of the Code.

The man's sister's consent to the use of the chair on behalf of him was not legally valid and, although he may have impliedly agreed to use a recliner chair initially, there is no evidence that he consented to the use of the canvas belt. It was found that by using the canvas belt without the man's consent, the aged-care facility breached Right 7(1).

It was recommended that the aged-care facility provide staff with further education and training on several topics, including informed consent, EPOAs, and restraint. The aged-care facility was asked to apologise to the man, and to audit all current residents' records to ensure that informed consent had been obtained appropriately.

5.0 Organisational Health and Capacity

Leadership

In 2017/18, 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.

> HDC is committed to being a good employer, promoting and maintaining equal employment opportunities.

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 2018, HDC had 88 staff members (76 full-time equivalents), as follows:

- 84% females and 16% males; and
- 61 full-time and 27 part-time positions.

HDC employs staff with disabilities. These staff members provide valuable insight into the challenges faced by people in our communities who live with disabilities. Staff who disclose their disabilities are given support by HDC to ensure that their needs are met. Some support options provided include sign language interpreters and special equipment.

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. When vacancies are advertised throughout the office, 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 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 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 occupational development 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 position accountability and market movement, and is based on EEO principles. HDC recognises staff achievements 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 does not tolerate any forms of harassment or 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 and organised the corresponding training for 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, influenza vaccination, sit/stand desks, and a wellness programme.

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; monitors 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 organisation. In 2017/18, HDC refreshed its website to improve accessibility and navigation. In addition, HDC has continued to make a series of improvements to its main database and telephone systems. These initiatives will help to enhance capability and efficiency, as well as to maintain associated costs at an economic level.

PHYSICAL ASSETS AND STRUCTURES

HDC manages its assets cost-effectively. In 2017/18, HDC redesigned parts of the Auckland office to further enhance capacity. The mailroom in the Auckland office was restructured to improve systems and make it more user-friendly. Our assets are maintained and cared for to ensure that they provide an appropriate useful life.

HDC provides a structured training programme to support staff as they develop and progress in their roles.

6.0 Statement of Performance

6.1 Output Class 1: Complaints resolution

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 1: Complaints resolution	Actual 2018 $	Budget 2018 $	Actual 2017 $
Revenue	7,000,562	6,805,000	6,404,647
Expenditure	6,985,858	6,805,000	6,464,354
Net surplus/(deficit)	**14,704**	**—**	**(59,707)**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 1.1 — COMPLAINTS MANAGEMENT		
		Targets achieved
Efficiently and appropriately resolve complaints *(which contributes to achievement of Strategic Objectives 1 and 3, see Section 3).*		2,498 complaints were received during the year. This represents a 13% increase on the previous year's volume (2017: 2,211).
Assume 2,150 complaints will be received.	Close an estimated 2,150 complaints. This includes an estimated 100 investigations.	2,315 complaints were closed during the year (8% above the SPE closure target, a year on year increase of 15%), which includes closing 102 investigations (2017: 2,015 total complaints closed including 80 investigations).
		Targets substantially achieved[12]
	Manage complaints so that:	Total open files at year end were 809 (2017: 626). Age of open complaints at 30 June 2018:
	• No more than 17% of open complaints are 6–12 months old.	• 6–12 months old, 133 out of 809 — 16.4% (2017: 19%)
	• No more than 15% of open complaints are 12–24 months old.	• 12–24 months old, 117 out of 809 — 14.5% (2017: 11%)
	• No more than 1% of open complaints are over 24 months old.	• Over 24 months old, 21 out of 809 — 2.6% (2017: 4%)

[12] HDC met the timeliness targets for open complaints that were 6–12 months old and 12–24 months old, and improved the result for open complaints over 24 months old, while absorbing 13% growth in complaint volumes received.

6.1 Output Class 1: Complaints resolution — continued

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 1.2 — QUALITY IMPROVEMENT		
		Targets achieved
Use HDC complaints management processes to facilitate quality improvement *(which contributes to achievement of Strategic Objective 2)*	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.	Between 1 July 2017 and 30 June 2018, compliance with quality improvement recommendations on 264 complaints were due to be reported to HDC by 207 providers. Recommendations in relation to 261 of those complaints (98.9%) were fully complied with, and recommendations in relation to two were partially complied with.
	Providers make quality improvements as a result of HDC recommendations and/or educational comments.	There was only one provider who did not comply with HDC's recommendations. This provider was referred to the appropriate regulatory authority. HDC will continue to monitor and follow up the providers who received HDC's recommendations to ensure their compliance.
	• HDC audit a sample of providers to verify their compliance with HDC quality improvement recommendations: 97% compliance.	• 98.9% compliance (2017: 99.6%)

6.2 Output Class 2: Advocacy

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 2: Advocacy	Actual 2018 $	Budget 2018 $	Actual 2017 $
Revenue	4,046,272	4,061,000	4,058,654
Expenditure	4,037,773	4,061,000	4,096,490
Net surplus/(deficit)	**8,499**	**—**	**(37,836)**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 2.1 — COMPLAINTS MANAGEMENT		
Efficiently and appropriately resolve complaints *(which contributes to achievement of Strategic Objective 1).*		**Targets achieved** 2,753 new complaints were received by the Advocacy Service in the year ended 30 June 2018 (2017: 2,823).
Assume 2,800 to 3,300 complaints will be received.	Close an estimated 2,800 to 3,300 complaints.	For the year ended 30 June 2018, 2,825 complaints were closed (2017: 2,739).
	Manage complaints so that: • 85% are closed within 3 months • 95% are closed within 6 months • 100% are closed within 9 months	**Targets substantially achieved** Complaints were managed so that: • 84% were closed within 3 months (2017: 82%) • 99% were closed within 6 months (2017: 98%) • 100% were closed within 9 months (2017: 100%)
Consumers and providers are satisfied with Advocacy's complaints management processes *(which contributes to achievement of Strategic Objective 1).*	Undertake a yearly consumer satisfaction survey with 80% of respondents satisfied with Advocacy's complaints management processes. Undertake a yearly provider satisfaction survey with 80% of respondents satisfied with Advocacy's complaints management processes.	**Targets achieved** 90% of consumers and 87% of providers who responded to satisfaction surveys were satisfied or very satisfied with the Advocacy Service's complaints management process (2017: 88% of consumers and 86% of providers).

6.2 Output Class 2: Advocacy — continued

Output and Assumptions	Performance Measures and Targets	Actual Performance
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 *(which contributes to achievement of Strategic Objective 4).*	Advocates visit 75%[13] of certified aged-care facilities at least once with multiple visits to facilities as required.	**Targets achieved** **Certified aged-care facilities** For the year ended 30 June 2018, 529 out of 667 (79.3%) certified residential aged-care facilities received at least one visit from an advocate (2017: 100%, 660 visits). 289 certified aged-care facilities received two or more visits (2017: 412 facilities received two or more visits).
	Advocates visit 75% of certified residential disability services at least once with multiple visits to facilities as required.	**Certified residential disability services** For the year ended 30 June 2018, 744 out of 949 (78.4%) certified residential disability services received at least one visit from an advocate (2017: 100%, 930 visits). 149 certified residential disability services received two or more visits (2017: 577 services received two or more visits).
OUTPUT 2.3 — EDUCATION AND TRAINING		
Promote awareness of, respect for, and observance of, the rights of consumers and how they may be enforced *(which contributes to achievement of Strategic Objective 4).*	Advocates provide 1,600 education sessions.	**Target substantially achieved** A total of 1,499 education sessions were provided (2017: 1,635). There was a lower than anticipated demand for education sessions in the 2017/18 year. Education sessions are demand driven and may result from complaints management processes or networking by advocates.
	Consumers and providers are satisfied with the education sessions: • Seek evaluations on sessions with 80% of respondents satisfied.	**Target achieved** 87% of consumers and providers who responded to a survey were satisfied with the Advocacy Service education session they attended (2017: 87% of consumers and providers).

[13] Acting on a recommendation in a recent review of the Advocacy Service, a more prioritised approach is being adopted for residential home visits and networking. The 20% reduction in fixed visits will allow time for more focused networking to other venues where contact can be made with groups of vulnerable consumers and/or their whānau.

6.3 Output Class 3: Proceedings

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 3: Proceedings	Actual 2018 $	Budget 2018 $	Actual 2017 $
Revenue	508,529	654,000	552,187
Expenditure	507,461	654,000	557,334
Net surplus/(deficit)	**1,068**	**—**	**(5,147)**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 3.1 — PROCEEDINGS		
Professional misconduct is found in disciplinary proceedings *(which contributes to achievement of Strategic Objective 3).*	Professional misconduct is found in 75% of disciplinary proceedings.	**Target achieved** For the year ended 30 June 2018, professional misconduct was found in 100% (3 of 3) of HPDT proceedings (2017: 100%, 3 of 3 proceedings).
Breach of the Code is found in Human Rights Review Tribunal (HRRT) proceedings *(which contributes to achievement of Strategic Objective 3).*	A breach of the Code is found in 75% of HRRT proceedings.	**Target achieved** For the year ended 30 June 2018, a breach of the Code was found in 100% (1 of 1) of HRRT proceedings (2017: 100%, 3 of 3 proceedings).
An award is made where damages are sought *(which contributes to achievement of Strategic Objective 3).*	An award of damages is made in 75% of cases where damages are sought.	**Target achieved** Resolution by negotiated agreement was achieved in 100% (1 of 1) of proceedings (2017: 100%, 2 of 2 proceedings).
Where a restorative approach is adopted, agreement is reached between the relevant parties *(which contributes to achievement of Strategic Objective 3).*	An agreed outcome is reached in 75% of cases in which a restorative approach is adopted.	**Not measurable** For the year ended 30 June 2018, no restorative approach was adopted in a case (2017: 100%, 2 of 2).

6.4 Output Class 4: Education

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 4: Education	Actual 2018 $	Budget 2018 $	Actual 2017 $
Revenue	438,941	440,000	372,735
Expenditure	438,019	440,000	376,210
Net surplus/(deficit)	**922**	**—**	**(3,475)**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.1 — INFORMATION AND EDUCATION FOR PROVIDERS		
Monitor DHB complaints and provide complaint information to DHBs *(which contributes to achievement of Strategic Objectives 2 and 4).*		**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% (17/17) of the DHBs who responded to an annual feedback form rated the complaint trend reports as useful for improving services (2017: 100%, 20 of 20).
Assist DHBs to improve their complaints systems *(which contributes to achievement of Strategic Objectives 2 and 4).*		**Targets achieved**
	Provide two complaints resolution workshops for DHBs.	Two complaints resolution workshops for DHBs were held.
	Seek evaluations on the workshops, with 80% of respondents satisfied with the session.	97% of respondents reported that they were satisfied or very satisfied with each session respectively (2017: 100% and 93%).
Assist non-DHB group providers to improve their complaints systems *(which contributes to achievement of Strategic Objectives 2 and 4).*		**Targets achieved**
	Provide two complaints resolution workshops for non-DHB group providers.	For the year ended 30 June 2018, two complaints resolution workshops for non-DHB group providers were held (2017: three).
	Seek evaluations on workshops, with 80% of respondents satisfied with the session.	100% of respondents reported that they were satisfied with each session (2017: 100%).

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.1 — INFORMATION AND EDUCATION FOR PROVIDERS — continued		
Promote awareness of, respect for, and observance of, the rights of consumers and how they may be enforced *(which contributes to achievement of Strategic Objective 4).*	Provide 30 educational presentations. Consumers and health and disability service providers are satisfied with the educational presentations.	**Targets achieved** For the year ended 30 June 2018, 33 educational presentations were made (2017: 36).
	Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	For the year ended 30 June 2018, 100% of respondents who provided feedback (28 of 28) reported that they were satisfied with the presentations (2017: 97%, 33 of 34).
	Make public statements and publish reports in relation to matters affecting the rights of consumers: • Produce and publish on the HDC website key Commissioner decision reports and related articles. Report on total number.	**Target achieved** For the year ended 30 June 2018, 76 decisions in relation to matters affecting the rights of consumers were published at www.hdc.org.nz (2017: 55).
OUTPUT 4.2 — OTHER EDUCATION		
HDC engages in sector education through making submissions on relevant policies, standards, professional codes, and legislation *(which contributes to achievement of Strategic Objective 4).*	HDC makes at least 10 submissions.	**Target achieved** For the year ended 30 June 2018, 32 submissions were made (2017: 13).
HDC responds formally to queries from consumers, providers and other agencies about the Act, the Code and consumer rights under the Code *(which contributes to achievement of Strategic Objective 4).*	At least 40 formal responses to enquiries provided.	**Target achieved** For the year ended 30 June 2018, 76 formal responses to enquiries were provided (2017: 44).

6.5 Output Class 5: Disability

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 5: Disability	Actual 2018 $	Budget 2018 $	Actual 2017 $
Revenue	588,388	592,000	501,081
Expenditure	587,152	592,000	505,752
Net surplus/(deficit)	**1,236**	**—**	**(4,671)**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 5.1 — DISABILITY EDUCATION		
Promote awareness of, respect for, and observance of, the rights of disability services consumers *(which contributes to achievement of Strategic Objective 4).*	Publish on the HDC website (and make accessible to people who use "accessible software") educational resources for disability services consumers and disability services. At least two new educational resources will be available in plain English. Facilitate four regional consumer seminars. Consumers are satisfied with the seminars: • Seek evaluations on seminars with 80% of respondents satisfied.	**Targets achieved** For the year ended 30 June 2018, an easy-read translation of HDC's investigation process brochure was completed. Contents from HDC's website about the Nationwide Advocacy Service were translated into easy read. Both resources are targeted at disabled consumers. For the year ended 30 June 2018, a total of eight regional consumer seminars were facilitated.

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 5.1 — DISABILITY EDUCATION — continued		
		Consumer seminars were held with: • Disabled people working at Skillwise, Christchurch (90% satisfaction) • Disabled students at Van Asch School for the Deaf (86% satisfaction) • Disabled students studying toward the certificate in Skills for Living for Supported Learners at Unitec in Auckland — Seminar 1 (91% satisfaction) • Disabled students studying toward the certificate in Skills for Living for Supported Learners at Unitec in Auckland — Seminar 2 (93% satisfaction) • Disabled students undertaking the Certificate in Skills for Living for Supported Learners at Ara Polytechnic, Christchurch (100% satisfaction) The Deputy Commissioner presented to the Ministry of Health's Consumer Consortium in April 2018. Feedback from respondents for content, relevance, delivery, and length was recorded as 74/75 or 99% (neutral or agree or strongly agree). Seminars were delivered at both the opening and closing ceremonies of the Special Olympics 2017 National Summer Games in Wellington in late 2017. Evaluations for the two HDC presentations were reported as "Extremely Satisfied".

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

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 6: Monitoring and Advocacy	Actual 2018 $	Budget 2018 $	Actual 2017 $
Revenue	618,375	643,000	505,058
Expenditure	617,076	643,000	509,767
Net surplus/(deficit)	**1,299**	**—**	**(4,709)**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 6.1 — MONITORING AND ADVOCACY		
Monitoring		
		Targets achieved
Monitor mental health and addiction services to identify potential improvements to services *(which contributes to achievement of Strategic Objective 2).*	Monitor and analyse issues and trends identified by HDC complaints and the Advocacy Service.	In 2017/18, HDC prepared an analysis of 2016/17 complaint trends about mental health and addiction services.
	Maintain engagement with key sector stakeholders and monitor sector performance information to keep informed about service issues and trends.	In 2017/18, HDC attended 98 sector and stakeholder meetings and three mental health and addiction conferences, undertook two site visits, and held one stakeholder workshop and six focus group sessions.
	Provide briefings to the Minister as required.	In 2017/18, the Mental Health Commissioner provided two briefings to the Minister in relation to mental health and addiction services.

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 6.1 — MONITORING AND ADVOCACY — continued		
Advocacy		
		Targets achieved
Advocate for improvements to mental health and addiction services *(which contributes to achievement of Strategic Objective 2).*	Make recommendations and educational comments to providers (and other organisations or individuals) when resolving complaints, to improve the quality of mental health and addiction services and complaints resolution processes.	HDC monitors providers' compliance with recommendations throughout the follow-up process by seeking evidence of the changes made. There were 21 quality improvement recommendations due in 2017/18.
	Monitor compliance with the implementation of recommendations: • 97% compliance.	For the year ended 30 June 2018, providers were: • Fully compliant with 100% of recommendations due this financial year.
	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.	In 2017/18, HDC published *New Zealand's Mental Health Services — The Monitoring and Advocacy Report of the Mental Health Commissioner*, presented to a total of 16 stakeholder groups, and appeared at the Health Select Committee on "a petition" calling for an inquiry into mental health services.

7.0 Financial Statements

Statement of comprehensive revenue and expense

FOR THE YEAR ENDED 30 JUNE 2018

	Notes	Actual 2018 $	Budget 2018 $	Actual 2017 $
Revenue				
Funding from the Crown		12,870,000	12,870,000	12,070,000
Other revenue	2	331,067	325,000	324,362
Total revenue		**13,201,067**	**13,195,000**	**12,394,362**
Expenditure				
Personnel costs	3	7,154,685	6,958,000	6,422,265
Depreciation and amortisation expense	8, 9	124,774	116,000	183,293
Advocacy services		3,487,781	3,590,000	3,535,281
Other expenses	4	2,406,099	2,531,000	2,369,068
Total expenditure		**13,173,339**	**13,195,000**	**12,509,907**
Surplus/(deficit)		**27,728**	**—**	**(115,545)**
Total comprehensive revenue and expense		**27,728**	**—**	**(115,545)**

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 2018

	Notes	Actual 2018 $	Budget 2018 $	Actual 2017 $
ASSETS				
Current assets				
Cash and cash equivalents	5	1,750,732	1,726,000	1,733,831
Receivables	6	24,173	55,000	96,320
Prepayments		97,003	80,000	84,473
Inventories	7	24,094	15,000	19,514
Total current assets		**1,896,002**	**1,876,000**	**1,934,138**
Non-current assets				
Property, plant and equipment	8	111,632	239,000	137,378
Intangible assets	9	165,282	81,000	111,206
Total non-current assets		**276,914**	**320,000**	**248,584**
Total assets		**2,172,916**	**2,196,000**	**2,182,722**
LIABILITIES				
Current liabilities				
Payables	10	391,503	548,000	457,459
Employee entitlements	11	408,292	350,000	361,090
Total current liabilities		**799,795**	**898,000**	**818,549**
Non-current liabilities				
Payables	10	42,371	21,000	61,151
Total non-current liabilities		**42,371**	**21,000**	**61,151**
Total liabilities		**842,166**	**919,000**	**879,700**
Net assets		**1,330,750**	**1,277,000**	**1,303,022**
EQUITY				
Contributed capital	13	788,000	788,000	788,000
Accumulated surplus/(deficit)	13	542,750	489,000	515,022
Total equity		**1,330,750**	**1,277,000**	**1,303,022**

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 2018

	Notes	Actual 2018 $	Budget 2018 $	Actual 2017 $
Balance at 1 July		1,303,022	1,277,000	1,418,567
Total comprehensive revenue and expense for the year		**27,728**	**—**	**(115,545)**
Balance at 30 June	**13**	**1,330,750**	**1,277,000**	**1,303,022**

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 2018

	Notes	Actual 2018 $	Budget 2018 $	Actual 2017 $
Cash flows from operating activities				
Receipts from the Crown		12,870,000	12,870,000	12,070,000
Interest received		55,254	60,000	54,928
Receipts from other revenue		110,843	70,000	83,478
Payments to suppliers		(5,787,907)	(5,933,000)	(5,778,931)
Payments to employees		(7,107,483)	(6,958,000)	(6,403,372)
GST (net)		29,298	—	(630)
Net cash from operating activities		**170,005**	**109,000**	**25,473**
Cash flows from investing activities				
Purchase of property, plant and equipment		(85,004)	(63,000)	(53,055)
Purchase of intangible assets		(68,100)	(59,000)	(97,450)
Net cash from investing activities		**(153,104)**	**(122,000)**	**(150,505)**
Cash flows from financing activities				
Receipts from capital contribution		—	—	—
Net cash from investing activities		**—**	**—**	**—**
Net increase/(decrease) in cash and cash equivalents		**16,901**	**(13,000)**	**(125,032)**
Cash and cash equivalents at beginning of the year		**1,733,831**	**1,739,000**	**1,858,863**
Cash and cash equivalents at end of the year	**5**	**1,750,732**	**1,726,000**	**1,733,831**

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 2018, and were approved by the Commissioner on 26 October 2018.

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 criterion 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 SERVICES 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 and amortisation are 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.

EXCHANGE REVENUE

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 2018 $	Actual 2017 $
Sale of publications	69,677	72,381
Interest revenue	56,218	54,133
Advocacy Trust contribution to IT costs	145,245	188,948
Sundry revenue	59,927	8,900
Total other revenue	**331,067**	**324,362**

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 2018 $	Actual 2017 $
Salaries and wages	6,902,628	6,225,655
Defined contribution plan employer contributions	204,855	177,717
Increase/(decrease) in employee entitlements	47,202	18,893
Total personnel costs	**7,154,685**	**6,422,265**

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

Employee Remuneration

	Actual 2018 $	Actual 2017 $
Total remuneration paid or payable:		
100,000–109,999	1	1
110,000–119,999	3	5
120,000–129,999	2	—
130,000–139,999	1	1
140,000–149,999	1	1
160,000–169,999	1	—
170,000–179,999	1	1
230,000–239,999	1	3
240,000–249,999	2	—
370,000–379,999	1	1
Total employees	**14**	**13**

During the year ended 30 June 2018, two employees received compensation and other benefits in relation to cessation totalling $6,231 (2017: $34,709).

Commissioner's total remuneration

In accordance with the disclosure requirements of sections 152(1)(a) of the Crown Entities Act 2004, the total remuneration including all benefits paid to the Commissioner during the period 1 July 2017 to 30 June 2018 is $377,807 (2017: $370,230).

4 Other expenses

Other Expenses

	Actual 2018 $	Actual 2017 $
Advertising	21,974	21,800
Audit fees	45,340	44,268
Clinical and legal advice	607,281	510,223
Communications & IT	571,197	542,489
Inventories consumed	47,051	54,216
Net loss on property, plant and equipment	—	647
Operating lease expense	466,121	421,448
Policy and operational consultancy	174,873	268,548
Staff travel and accommodation	180,439	152,377
Other expenses	291,823	353,052
Total other expenses	**2,406,099**	**2,369,068**

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 2018 $	Actual 2017 $
Not later than one year	427,859	487,516
Later than one year and not later than five years	1,003,318	1,143,545
Later than five years	—	240,183
Total non-cancellable operating leases	**1,431,177**	**1,871,244**

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

A significant portion of the total non-cancellable operating lease expense relates to the lease of these two offices and office equipment (2017: two office 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 2018 $	Actual 2017 $
Cash on hand and at bank	750,732	733,831
Term deposits with maturities less than 3 months	1,000,000	1,000,000
Total cash and cash equivalents	**1,750,732**	**1,733,831**

As at 30 June 2018, the Health and Disability Commissioner holds no unspent grant funding received that is subject to restrictions (2017: 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 2018 (2017: nil).

	Actual 2018 $	Actual 2017 $
Trade receivables	16,145	16,166
Other receivables	8,028	80,154
Total receivables	**24,173**	**96,320**
Total receivables comprises:		
Receivables from the sale of goods and services (exchange transactions)	24,173	23,230
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 2018 $	Actual 2017 $
Commercial inventories		
Publications held for sale	24,094	19,514
Total inventories	**24,094**	**19,514**

There was no write-down for inventories in 2018 (2017: nil). There were net write-down reversals of $310 (2017: $17,128). No inventories are pledged as security for liabilities (2017: 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 & fittings $	Leasehold improve-ment $	Motor vehicles $	Office equip $	Total $
Cost or valuation							
Balance at 1 July 2016	444,375	2,673	144,323	656,393	40,889	62,669	1,351,322
Balance at 30 June 2017	466,443	3,650	161,145	656,393	40,889	60,129	1,388,649
Additions	70,646	3,495	8,824	—	—	2,039	85,004
Disposals	—	—	(870)	—	—	(648)	(1,518)
Balance at 30 June 2018	**537,089**	**7,145**	**169,099**	**656,393**	**40,889**	**61,520**	**1,472,135**
Accumulated depreciation and impairment losses							
Balance at 1 July 2016	255,481	1,769	140,498	631,883	40,889	53,537	1,124,057
Balance at 30 June 2017	343,280	2,692	158,699	650,264	40,889	55,447	1,251,271
Depreciation expense	100,107	1,844	2,890	2,299	—	3,610	110,750
Disposals	—	—	(870)	—	—	(648)	(1,518)
Balance at 30 June 2018	**443,387**	**4,536**	**160,719**	**652,563**	**40,889**	**58,409**	**1,360,503**
Carrying amounts							
At 1 July 2016	**188,894**	**904**	**3,825**	**24,510**	**—**	**9,132**	**227,265**
At 30 June 2017 / 1 July 2017	**123,163**	**958**	**2,446**	**6,129**	**—**	**4,682**	**137,378**
At 30 June 2018	**93,702**	**2,609**	**8,380**	**3,830**	**—**	**3,111**	**111,632**

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 nil (2017: $647).

There are no capital commitments at balance date (2017: 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:

Acquired computer software
3 years 33%

Developed computer software
3 years 33%

Movements for each class of intangible asset are as follows:

	Acquired software $	Internally generated software $	Total $
Cost			
Balance at 1 July 2016	535,197	248,516	783,713
Balance at 30 June 2017/1 July 2017	632,647	248,516	881,163
Additions	68,100	—	68,100
Balance at 30 June 2018	**700,747**	**248,516**	**949,263**
Accumulated amortisation and impairment losses			
Balance at 1 July 2016	512,205	217,452	729,657
Balance at 30 June 2017/1 July 2017	521,441	248,516	769,957
Amortisation expense	14,024	—	14,024
Disposals	—	—	—
Balance at 30 June 2018	**535,465**	**248,516**	**783,981**
Carrying amounts			
At 1 July 2016	**22,992**	**31,064**	**54,056**
At 30 June 2017/1 July 2017	**111,206**	**—**	**111,206**
At 30 June 2018	**165,282**	**—**	**165,282**

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 (2017: nil).

10 Payables

Accounting policy

Short-term payables are recorded at their face value.

Breakdown of payables and deferred revenue

	Actual 2018 $	Actual 2017 $
Payables under exchange transactions		
Creditors	139,751	248,659
Accrued expenses	59,010	56,184
Lease incentive	17,514	20,970
Total payables under exchange transactions	216,275	325,813
Payable under non-exchange transactions		
Taxes payable (GST, PAYE and rates)	175,228	131,646
Total payables under non-exchange transactions	175,228	131,646
Total current payables	**391,503**	**457,459**
Lease incentives	42,371	61,151
Total non-current payables	42,371	61,151
Total payables	**433,874**	**518,610**

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 2018 $	Actual 2017 $
Current portion		
Annual leave	408,292	361,090
Total employee entitlements	**408,292**	**361,090**

12 Contingencies

Contingent liabilities

As at 30 June 2018 there were no contingent liabilities (2017: nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2017: 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.

Breakdown of equity and further information

	Actual 2018 $	Actual 2017 $
Contributed capital		
Balance at 1 July	788,000	788,000
Capital contribution	—	—
Balance at 1 July	**788,000**	**788,000**
Accumulated surplus/(deficit)		
Balance at 1 July	515,022	630,567
Surplus/(deficit) for the year	27,728	(115,545)
Balance at 30 June	**542,750**	**515,022**
Total equity	**1,330,750**	**1,303,022**

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 2018 $	Actual 2017 $
Leadership Team		
Remuneration	1,973,597	1,766,797
Full-time equivalent members	8.95	8.31
Total key management personnel remuneration	**1,973,597**	**1,766,797**
Total full-time equivalent personnel	**8.95**	**8.31**

15 Financial instruments

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

	Actual 2018 $	Actual 2017 $
Loans and receivables		
Cash and cash equivalents	750,732	733,831
Receivables	24,173	96,320
Investments — term deposits	1,000,000	1,000,000
Total loans and receivables	**1,774,905**	**1,830,151**
Financial liabilities measured at amortised cost		
Payables (excluding income in advance, lease incentive, taxes payable and grants received subject to conditions)	198,761	304,842
Total financial liabilities measured at amortised cost	**198,761**	**304,842**

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

TOTAL EXPENDITURE

Personnel costs were higher than budget, mainly due to more staff being hired in response to the increased volume of complaints received.

Service contract costs were lower than budget, mainly arising from a cost management strategy. Other expenses were lower than budget, as a result of prudent financial management and the benefit of unbudgeted court cost recoveries.

Overall, HDC managed its total expenditure closely in line with the budget.

Statement of financial position

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

Statement of equity

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

Statement of cash flows

The higher net cash movement was mainly a result of the unbudgeted court cost recovery received.

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 2018.

Anthony Hill
Health and Disability Commissioner

Jason Zhang
Corporate Services Manager

26 October 2018

9.0 Audit Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Health and Disability Commissioner's financial statements and performance information for the year ended 30 June 2018

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 62 to 80, that comprise the statement of financial position as at 30 June 2018, 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 50 to 60.

In our opinion:

- the financial statements of the Health and Disability Commissioner on pages 62 to 80:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; 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 Standards Reduced Disclosure Regime; and
- the performance information on pages 50 to 60:
    - presents fairly, in all material respects, the Health and Disability Commissioner's performance for the year ended 30 June 2018, 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;
- what has been achieved with the appropriation; and
- the actual expenses incurred compared with the appropriated or forecast expenses; and

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 26 October 2018. 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 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 HDC 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 for assessing the 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 its 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 48 and 81, 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.

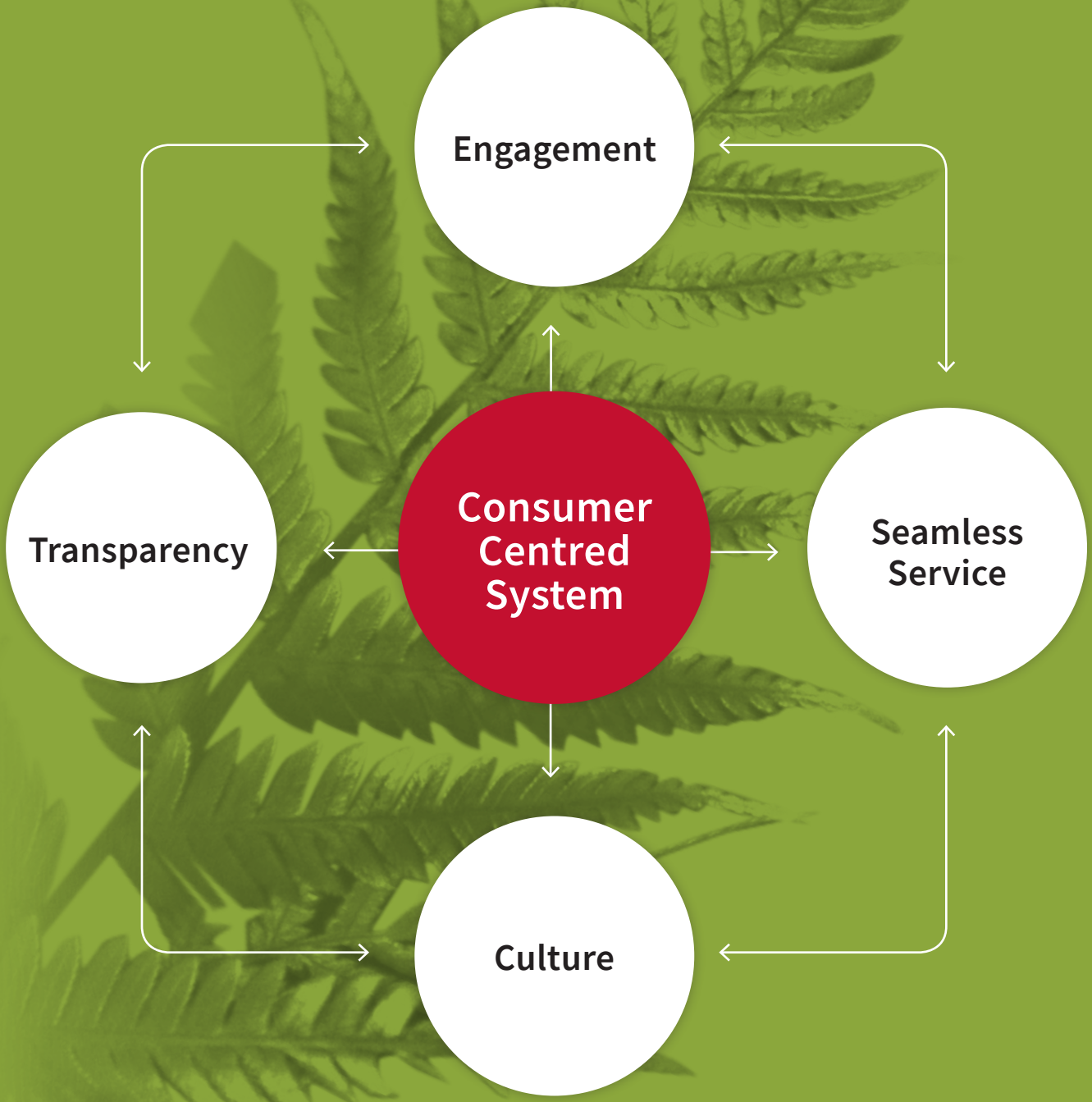
In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge 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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