HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

E.17

Learning from complaints

Annual Report
for the year ended 30 June 2008

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

HEALTH and DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

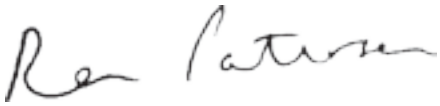
22 September 2008

The Minister of Health
Parliament Buildings
WELLINGTON

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 2008.

Yours faithfully



Ron Paterson
Health and Disability Commissioner

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Vision

Champions of consumers' rights.

Wawata

Kai kōkiri i nga tika kai hokohoko.

Mission

Resolution, protection, and learning.

Whainga

Whakataunga, whakamaru me te akoranga.

Cover photo — commemorating 20 years since the Cartwright Inquiry

The Spirit of Peace statue, situated in the grounds of the old National Women's Hospital, is the work of American sculptor Pierce Francis Connelly. The statue has become symbolic of the Cartwright Inquiry into events at National Women's Hospital.

(Photo by Rae Lamb)

COMMISSIONER'S REPORT

Ron Paterson
Commissioner

Introduction

Key features of 2007/08 were:

- Continued high volume of complaints
- 99% compliance with HDC recommendations
- Whanganui DHB inquiry
- Spotlight on safety in public and private hospitals
- 90% success rate in Proceedings
- Advocates visited 92% of disability homes and 96% of rest homes

HDC and the Code of Consumers' Rights had its genesis in the Report of the Cervical Cancer Inquiry in 1988, and its far-sighted recommendations to improve the recognition of patients' rights in New Zealand. Judge Silvia Cartwright's vision of putting patients first, with enforceable rights, independent patient advocates, effective complaint mechanisms, and the Commissioner as a "public watchdog", has largely been recognised over the past 20 years. But significant challenges remain for disabled consumers, rest home residents, and other vulnerable consumers.

HDC's statutory mandate is "to promote and protect" the rights of consumers and facilitate "the fair, simple, speedy, and efficient resolution of complaints". We champion the rights of health consumers and disability services consumers. Our work focuses on three areas: resolution of complaints; protection of the public; and learning from complaints. What follows are the highlights of our work in these areas in 2007/08.

Complaint Outcomes

The volume of complaints received by HDC remained high with 1,292 new complaints, but hard work kept the tally of open files under 300, with 88% of complaints resolved within six months. We maintained our focus on early resolution, with only 100 complaints leading to a formal investigation. In cases where we made specific recommendations of changes in a provider's practice, we followed up and achieved 99% compliance with HDC recommendations.

Advocacy continues to be a remarkably effective means of resolution, with 88% of complaints received by the Advocacy Service partly or fully resolved with advocacy support. Outreach activities by the advocates included visiting 92% of disability homes and facilities, and 96% of rest homes nationwide.

At the other end of the complaints spectrum, 22 providers were referred to the Director of Proceedings to consider further proceedings, because of major shortcomings in care or unethical practice. In 2007/08 the Director was successful in 10 of 11 proceedings.

Patient Safety in Public and Private Hospitals

As a follow-up to case 05HDC11908 (where HDC found serious failings in the care of a 50-year-old patient with a chest infection admitted to Wellington Hospital in September 2004, over the 40 hours prior to his death) all DHBs were required to report to HDC on their own systems for keeping patients safe. Analysis of the DHBs' responses led to our publication of a report by Dr Mary Seddon, "Safety of Patients in New Zealand Hospitals: A Progress Report" (October 2007), noting that a lot of excellent work was in progress, but that better coordination and less duplication of effort was needed.

In February 2008, we reported the findings of HDC's inquiry into Dr Roman Hasil and Whanganui District Health Board 2005–06. The inquiry, ably led by Chief Legal Advisor Nicola Sladden, examined why laparoscopic sterilisation surgery performed by Dr Hasil was unsuccessful for eight of 32 women. The report highlighted the major pressures on

provincial hospitals related to workforce and training, skill mix, and financial resources, and recommended greater regional and national service planning and collaboration across DHBs. The need to credential services and ensure regional support was also evident in an investigation of failed orthopaedic surgery at West Coast DHB (06HDC09552).

In May 2008 HDC reported on three cases involving patients who received poor postoperative care in private hospitals (06HDC17645, 06HDC13334, 06HDC09771). By releasing these reports together, we were able to spotlight the vulnerability of private hospital patients in the absence of effective back-up arrangements or an escalation of medical response to unresolved complications.

Within the public system, patients depend on efficient booking systems for outpatient appointments and access to specialist radiology procedures. Three cases from the south demonstrated the potential for things to go wrong. In case 06HDC15893, Southland DHB failed to properly manage its booking system for ophthalmology services. In two cases from Otago DHB (07HDC05942 and 07HDC11036), the harmful impact of strikes on patients was shown.

The risk of patients being lost within hospital systems, or between primary and secondary care, was sadly illustrated in case 07HDC08819 at Capital and Coast DHB. Overburdened radiology systems, inadequate handover, and a failure to report information to a patient or his GP, led to a significant, unexpected finding of carcinoma of the lung not being detected for three years, when it was too late. But the DHB's open disclosure to the family, thorough review, and wide-ranging improvements meant that sanction by HDC was not necessary.

This year there has been significant progress to improve the safety and quality of health services in New Zealand. The Ministerial Quality Improvement Committee (QIC) is leading several major safety and quality initiatives, which gained momentum after the release of the 21 DHBs' serious and sentinel event information in February 2008. It is very encouraging to see the moves to greater transparency and coordination throughout the sector.

Educational Initiatives

This year again saw a broad array of educational initiatives undertaken by HDC staff and advocates. Reaching the wider community remains a challenge, particularly Māori and Pacific peoples. A Health TV advertisement was trialled as a new way to reach these groups. Regular interviews on Radio New Zealand's "Nine-to-Noon" programme, and greater television, radio and print media coverage has led to increased enquiries to HDC from members of the public.

Our website continues to be frequently accessed by consumers, providers, and the media. Recent cases are usually reported by daily newspapers within 24 hours of posting on the website. A monthly "Health ethics, law and policy" column in *New Zealand Doctor* highlights recent cases to the general practice community.

HDC staff delivered numerous conference presentations and talks to health professionals (including a wide range of trainee providers) around the country. An evening workshop with Central Otago GPs, and a marae teaching session with rural hospital medical officers in the northern Hokianga were personal highlights in 2007/08. I presented at national meetings of general practice managers, palliative care workers, pain medicine specialists, intensive care specialists, emergency medicine providers, GPs and IPAs; met with the Australasian Health Complaint Commissioners (in Adelaide); led seminars for the Health Quality and Complaints Commission (in Brisbane) and the Australasian Commission on Safety and Quality of Health Care (in Sydney); and presented at the Commonwealth Fund's 2007 International Symposium on Health Care Policy (in Washington DC).

Acknowledgements

I thank all the staff at HDC, in particular Deputy Commissioners Tania Thomas and Rae Lamb, and everyone involved in the Nationwide Advocacy Service, for their dedication to our work in 2007/08.

COMPLAINTS RESOLUTION

Introduction

Complaint numbers remained high this year, with 1,292 new complaints received about health and disability services. Each complaint was carefully considered with the focus continuing to be on fairly and promptly resolving matters at the most appropriate level. This means not all potential breaches of the Code are formally investigated. An investigation is a formal, legal process that can take a long time, and our experience shows that good outcomes can often be achieved using the other options under the Act.

Complaints resolution staff also handled 5,658 enquiries about a range of matters, including consumers' rights and requests for information. Most (94%) were completed on the day they were received.

Rae Lamb
Deputy Commissioner,
Complaints Resolution

Complaints Closed

There were 1,295 complaints closed during the year, using the full range of resolution options available under the Act. Once again, 88% of complaints were resolved within six months. Ninety-six percent were completed within a year.

Complaints were addressed in the following ways:

Outside Jurisdiction

Complaints that do not relate to a health or disability service, or that raise funding or access issues, are outside the Commissioner's jurisdiction, and 113 were closed for this reason. Wherever possible, people were informed about alternative sources of assistance.

Advocacy

When communication is the main issue, where there are ongoing relationships to maintain, where consumers need immediate help, or where organising a face-to-face meeting seems sensible, using an advocate is often the best option.

The Commissioner referred 180 complaints to the Nationwide Health and Disability Advocacy Service. Of these, 63 were formal referrals requiring a report back from the advocate, and in 117 cases the consumer was given information and contact details for the service and encouraged to use it.

Table 1: **Number of open complaint files**

	2007/08	2006/07	2005/06
Open at year start	295	279	313
New during year	1,292	1,289	1,076
Closed during year	1,295	1,273	1,110
Open at year end	**292**	295	279

Table 2: **Complaints closed**

	2007/08	2006/07	2005/06	2004/05
Outside jurisdiction (OJ)	113[1]	154	213	302
Advocacy referrals[2]	180	149[2]	58	57
Referrals other agencies[3]	138	126	127	127
Formal investigation	100	89	116	172
Resolved by referral to providers	33	18	14	12
Resolved by mediation[4]	5	11	5	1
Section 38(1)	661	617[5]	467	364
Withdrawn/Resolved by parties or Commissioner	65	109	110	123
Total complaints closed	**1,295**	**1,273**	**1,110**	**1,158**

1 Since 06/07 "No apparent breach of the Code" has been recorded as a section 38 closure, rather than OJ.
2 Since 06/07, this has included formal and informal referrals.
3 Registration boards, agencies such as ACC and Ministry of Health, and officers such as District Inspectors, and the Privacy Commissioner.
4 Some investigations were also resolved through mediation.

ADVOCACY REFERRAL — EYE CARE

Mrs A complained about her optometrist's response when she broke her old glasses and needed reassessment, and a new pair. She outlined 15 months of delays, broken commitments, and difficulties trying to get the right frames and lenses. The relationship had ended.

The Commissioner referred this complaint to an advocate and a meeting between Mrs A and the optometrist was arranged. They agreed to a treatment plan, and that she would continue to see the optometrist. The relationship was repaired and Mrs A was happy with the outcome.

SECTION 38 CLOSURE — TWO SIGNIFICANT CASES

Key systems issues were highlighted and fixed as a result of two public hospital cases that closed without formal investigation during the year. One, 07HDC08819, led to improvements in radiology reporting and in the handover of clinical information at Wellington Hospital. The other, 07HDC05409, led to changes in the processes and checking procedures for administering medication in neonatal care at Palmerston North Hospital. Independent expert clinical advice was sought in both cases. Reports were published on the website and widely distributed to relevant agencies and all district health boards to draw attention to the issues.

SECTION 38 CLOSURE — AGED CARE IN A PUBLIC HOSPITAL

Mrs B's daughters had wide-ranging concerns about the care their late mother had received in a provincial hospital before she died. They had received conflicting advice about her prognosis, there was poor coordination and communication between the staff caring for their mother, and she had been left in distress and pain.

In highlighting their mother's experience, they wanted to contribute to positive change in the health system, particularly with regard to dignity, human rights, and the medical care of vulnerable elderly people.

When the Commissioner sent the complaint to the DHB, it responded very positively. The family's letter was widely circulated to staff who cared for Mrs B; there was a multidisciplinary review with clinicians discussing the matter thoroughly, and action was taken to correct the issues raised and areas identified for improvement. The family was invited to meet the General Manager.

The Commissioner decided to take no further action. He provided the complainants with advocacy details in case they wanted support in meeting the DHB. The family was happy with this and felt that their complaint had made a difference. (Case 07HDC19078)

Section 38(1)

Most of the complaints closed under this section of the Act are those where the Commissioner considers an educational approach is more appropriate than an investigation. This includes complaints where matters don't meet the threshold for a formal investigation, or where an appropriate outcome can be achieved without it, in a more flexible and timely way. Before any decision is made, considerable information is gathered and carefully assessed, and preliminary expert clinical advice is sought when needed. Before the complaint is closed, "education letters" are sent to providers, highlighting any issues and aspects of care needing review. An apology or other follow-up action is frequently requested.

Section 38 is also used to close complaints when no further action is required because there is no apparent breach of the Code of Health and Disability Services Consumers' Rights (the Code), or because matters are already being addressed through other appropriate processes or agencies. Occasionally complaints are closed because so much time has elapsed since the events occurred it is not really possible to address the complaint. There were 661 complaints closed under section 38.

Referrals to Other Agencies

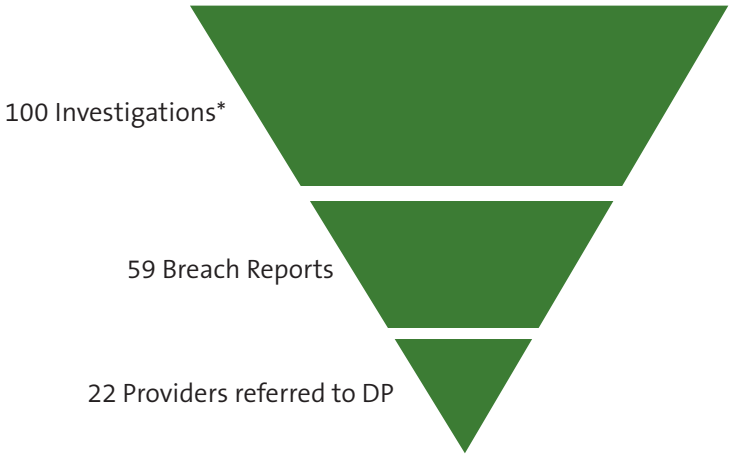
The Commissioner can refer complaints to other agencies, including registration boards, statutory officers, and the Ministry of Health. Most of last year's 138 referrals related to competence or professional conduct issues needing review by the boards (such as the Medical Council of New Zealand).

Investigations

One hundred complaints were formally investigated to determine whether there had been a major breach of the Code. In recent years, investigations have increasingly been used for only the most serious matters such as allegations of sexual impropriety and other behavior involving significant breaches of ethical and professional boundaries, and major lapses in standards of care.

Public safety concerns, the need for accountability, and the potential for the findings to lead to significant improvement in health and disability services, are other reasons for a formal investigation.

Figure 1: **Outcome of investigations 2007/08**



*31 discontinued, 5 "no breach" findings, 3 closed after referrals, 2 resolved by mediation.

Sixty percent of the investigations (59) found breaches of the Code, and 37% of breach findings resulted in 22 providers being referred to the Director of Proceedings for further proceedings to be considered. This confirms that while the number of investigations has dropped in recent years, this option is being used for the most serious matters.

An investigation may be discontinued if it becomes clear that the issues have been identified and the concerns addressed appropriately, or expert clinical advice indicates that the care was generally reasonable. Last year 31 investigations were discontinued; two were closed when the providers were referred to their registration boards; one was closed after being referred to the provider for follow-up action; and two were resolved by mediation. Five investigations found no breaches.

All investigations were concluded within two years, with just over half (53) completed in 12 months. Investigation reports ("final opinions") are published on the HDC website and sent to relevant agencies and organisations.

Referrals to Providers

Thirty-three complaints were referred to providers, who were required to report back on how they resolved the matter. Providers and consumers are advised that the Commissioner has the discretion to reassess the complaint if it is not appropriately addressed, and consumers are offered advocacy support during the process.

Mediation

Two investigations were resolved after being referred to mediation last year. A further five complaints were successfully mediated. Although this is an effective way of resolving difficult and complex matters, it continues to be a challenge to get the parties to agree to it.

Other Reasons for Closure

Some complaints are simply withdrawn, and others are closed because they have been resolved by the parties or as a result of some brief, informal, involvement by the Commissioner. Last year, 65 complaints were closed in this way.

RECOMMENDATIONS — MAKING A DIFFERENCE

Safer prescribing

A GP now carefully screens patients for any family history of pulmonary hypertension when considering medication such as phentermine, a weight loss drug. Medsafe and the NZ Pharmacovigilance Centre have also taken steps to remind prescribers of the contraindications to the use of phentermine. This followed a complaint that highlighted the potential risks of phentermine, and the need to carefully examine family medical history and consider contraindications when prescribing the drug.

(Case 07HDC09709)

Prison health services

A comprehensive orientation handbook is now available for health service providers in prisons. The handbook explains how internal systems work, and gives advice about prison facilities, equipment, and after-hours contacts. It is part of an induction pack developed by the Department of Corrections following a complaint about a woman prisoner who did not receive appropriate postnatal care. There was a communication breakdown between the prison and midwife.

(Case 06HDC10790)

Better communication with Pacific patients

A large DHB has run staff education sessions to boost understanding of Pacific culture, and improve communication with Pacific patients. A nurse is compiling resources to assist staff, and the DHB's Pacific Health team is also developing a site on the intranet so that other staff know what they do and how to contact them. This follows a complaint about a Pacific patient who was poorly communicated with, and not always adequately informed about his treatment.

(Case 06HDC18076)

Recommendations

Two hundred and twenty-two recommendations were made by the Commissioner following complaints closed during the year. Some complaints resulted in more than one recommendation. The recommendations included changes in individual and organisational practice, and specific initiatives to address identified failings. An apology was commonly requested. Compliance with recommendations is closely monitored. Ninety-nine percent of recommendations were complied with. The three providers who failed to act on the Commissioner's recommendations were referred to their registration boards.

ORGANISATION CHART as at 30 JUNE 2008

SENIOR MANAGEMENT TEAM

Commissioner
Ron Paterson

Deputy Commissioner, Education and Corporate Services
Tania Thomas

Chief Legal Advisor
Nicola Sladden

Deputy Commissioner, Complaints Resolution
Rae Lamb

Director of Advocacy
Judi Strid

Director of Proceedings
Theo Baker

Health and Disability Commissioner
Ron Paterson
AK/WN

Executive Assistant
Ta'a Punivalu
AK

Deputy Commissioner, Education and Corporate Services
Tania Thomas
AK

Personal Assistant
Mauryse Dix
AK (P/T)

Finance Manager
Trudy Bennett
AK

Executive Assistant
Julia Phillips
WN

Projects Co-ordinator/ Office Manager
Julie Ruthe
WN

Receptionist/ Secretary
Elaine Lian
WN

Elena Hughes
AK

Information Manager
Anne Russell
AK

Website Administrator
Helen Crompton
AK (P/T)

Education Manager
Elizabeth Finn
AK

Education Assistant
(vacant)
AK (P/T)

Publications Administrator
Christine Ley
AK (P/T)

Resource Despatch Assistant
Christine Skipper
AK (P/T)

Chief Legal Advisor
Nicola Sladden
WN (P/T)

Senior Legal Advisors
Deanne Wong WN
Tina Mitchell
WN (P/T)

Legal Advisors
(Vacant)
WN

Sarah Parker
WN

Elizabeth Browne
WN

Deputy Commissioner, Complaints Resolution
Rae Lamb
AK

Executive Assistant
Agnes Brown
AK

Investigations Manager
Mark Evans
AK

Clinical Advisor
Stuart Tiller
AK (P/T)

Complaints Assessment Manager
Warrick Hickman
AK

Senior Investigators
David Scott AK
Matthew Pitt AK

Investigators
Jeane Mackay AK
Wendy Vonlanthen AK
Kanny Ooi AK
Richard Hanssens AK
Vanessa White AK
Julia Byers AK

Recommendations Liaison Co-ordinator
Wendy Sheehan AK

Investigations Secretary
Jacinta James AK

Senior Complaints Assessors
Scott Read AK
Simon Latimer AK

Complaints Assessors
Jacqui Bozoky AK
Philippa Moyle AK
Nidar Gailani AK
Laura Vosloo AK
Stuart McLennan AK
Lyndon Stone AK
Rosemary Pohio AK

Complaints Administrator
Michelle Lee AK (P/T)

Director of Proceedings
Theo Baker
WN

Director of Advocacy
Judi Strid
AK

Personal Assistant
Sarah-Lee Ellis
AK (P/T)

Legal Counsel
Jason Tamm
WN

Alison Mills
WN

Executive Assistant
Karen Pyper
WN

Proceedings Secretary
Shona Speedy
WN (P/T)

Nationwide Health and Disability Consumer Advocacy Service

Consumer Seminars

Three consumer seminars were held during the year. Each seminar focussed on specific groups of consumers: intellectually impaired consumers, Pacific peoples and older persons.

Consumers who attended the seminars voiced the following needs:

- support people who are good communicators
- goals and lifestyle plans to suit the consumer, not staff preferences
- health professionals to talk directly to the consumer not the support person during consultations
- increased, readily available access to independent advocates
- better hospital discharge planning for older people leaving hospital
- best practice standards for after care following a stroke, in all hospitals
- more easy-to-read information and resources in all Pacific languages
- more health professionals and disability service workers who are better listeners and more respectful communicators
- faster response to referrals for home renovations and equipment to meet the needs of disabled people to ensure higher levels of dignity, independence and mobility
- increased reliability and quality of carers working with disabled people
- increased opportunities for socialising and outings and more recreational choices for disabled people in supported living and residential settings.

Tania Thomas
Deputy Commissioner,
Education and Corporate Services

Consumer Advisory Group

The Commissioner's Consumer Advisory group has been extended to include two more disability advisors, two more health advisors and four new Pacific advisors. The four iwi advisors are also part of the Consumer Advisory Group. The role of the extended advisory group is to provide insight, advice and input into improving HDC's education and promotion services and increasing HDC's responsiveness to consumers via its complaints resolution processes.

Provider Education

A variety of formats was used to deliver educational initiatives to providers, including:

- interactive case-based educational sessions with students in pharmacy, midwifery, chiropractic, osteopathy, medicine and nursing, and with postgraduate level providers in medicine and nursing. Feedback indicated that providers gained a greater understanding of how rights-based practice can be implemented, and increased appreciation of the usefulness of complaints in improving the quality and safety of health care;
- District Health Board (DHB) educational seminars;
- educational articles in professional publications for pharmacists, general practitioners and midwives.

A three-tier educational programme, developed to support nurses working for the Department of Corrections, was extended to staff at New Plymouth and Springhill Prisons. Feedback confirmed the value of the workshop in confronting the challenges nurses face in implementing rights-based practice in the prison environment.

A six-monthly report to DHBs, initiated in 2006 and intended to assist providers to identify opportunities for improvement in quality and safety, has been further developed in response to feedback to more clearly focus on the changes made to systems and practices as a result of complaints. Both statistical data regarding numbers and types of complaints, and case-based comment are included. Survey responses recorded that all DHBs found the report useful or very useful, and that information was widely disseminated to staff as a tool for reviewing processes and practices to see where improvements could be made.

Promotion

The Health and Disability Commissioner's stable of pamphlets, posters, cards and information handouts has been assessed against better practice print accessibility standards gathered from a range of sources nationally and internationally. These standards include accessibility to better meet the needs of people with partial sight, those who are blind, people who are Deaf, and people with other intellectual and/or learning impairments. For example, contrast, typeface, word spacing and alignment, language, font size, use of columns and navigational aids were among some of the standards HDC's promotional material was assessed against. The assessment revealed that 73% of HDC's promotional material meets better practice print accessibility standards.

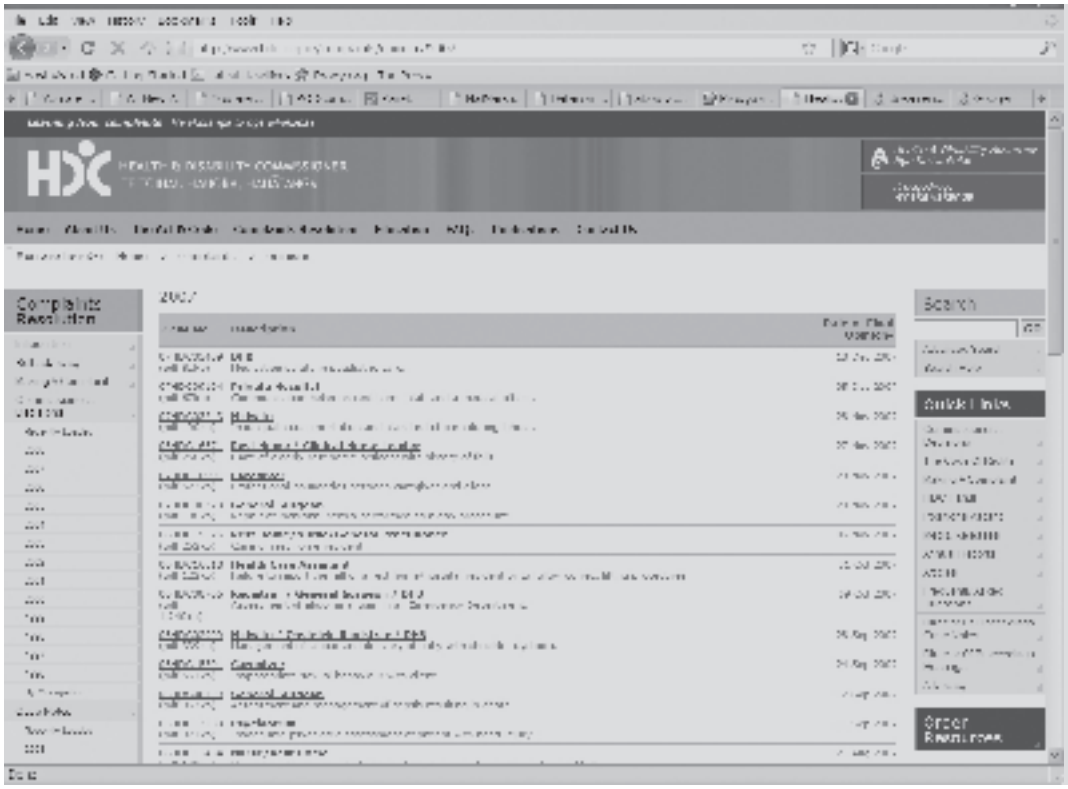
There is continuing demand for educational resources such as leaflets, videos, posters and pocket cards; compliance with audit requirements is raising awareness amongst providers of the need to provide information for consumers. More than 420,600 items were dispatched in the 07/08 year.

Disability

- The generic information leaflet "Learning from Complaints", which deals with the Code rights as well as the complaints process, has been produced in a Braille format. It is available through the Royal New Zealand Foundation of the Blind.
- We are in our second year of working with Crossroads Clubhouse implementing an employment transition programme for people who have been unemployed long term and have experience of living with a mental illness. To date we have had four people through the programme.
- Our Auckland reception area has been made more accessible to wheelchair users.
- Our first voice recognition computer access programme has been implemented.
- A disability provider and consumer contact database has been developed to increase the network of people we are able to contact.
- An agreement has been reached to jointly fund the production of a DVD resource for health professionals working with Deaf and hearing impaired people, in late 2008.
- A website accessibility review has been undertaken.
- A print accessibility review has been undertaken.

Pacific Peoples

In a new initiative, information about consumers' rights was presented to patients in medical centre waiting rooms using advertising on Health TV. As HDC research had identified low awareness of Code rights amongst consumers of Māori and Pacific Islands ethnicities, medical centres selected for the initiative were those where a high proportion of the residents were from those groups (as indicated by census data). The advertisement was run over two months in six practices and was estimated to have reached 60,000 viewers.



The Commissioner's reports are regularly posted on the HDC website. In 2007/08, total website hits averaged 87,902 per month.

The response of consumers to the advertising was obtained using follow-up interviews with a random group, and indicated that 69% of respondents thought the advertisement was relevant to them, 68% were interested in their rights, and that leaflets and an 0800 number were considered the best ways for consumers to obtain more information about their rights.

A plan drafted to act on ideas and suggestions from Pacific peoples consumer seminars includes:

- more regular use of Pacific radio stations and the Tagata Pasefika television programme
- more regular face-to-face meetings with Pacific leaders, church groups and health providers
- regular seminars for Pacific communities
- distribution of a bi-monthly email newsletter by HDC
- a Pacific-focused section of the HDC website linked to Pacific community group websites.

Māori

The Iwi Advisory group identified the need to increase awareness amongst Māori about the role of the Health and Disability Commissioner and their rights under the Code. Only a minority of Māori are enrolled with Māori-focussed primary health organisations. A Māori-specific mass media approach to educating Māori health consumers has been developed using regular editorials, interviews and case examples in Māori television, radio and Māori publications.

Human Resources

The Health and Disability Commissioner's Office is a member of the Equal Employment Opportunity Trust, and we have a "Good Employer" action plan. The key elements of the action

plan have focussed on ensuring a safe and healthy work environment, increasing flexibility and work design, and fostering a leadership culture within the organisation.

Safe and Healthy Work Environment

- An employee assistance programme continues to operate for all staff, and includes a confidential counselling service.
- Staff who wish to gain a First Aid Certificate from the Red Cross are funded to attend the training.
- We continue to provide ergonomic work station assessments for new staff and existing staff.
- Free flu inoculations are available to all staff.
- Fresh fruit is available to all staff as a healthy snack option.
- A stop smoking programme is available to all staff who wish to give up smoking.
- A week-long health and wellness week is held to raise awareness amongst staff about healthy eating, healthy activity, stress management and improving the quality of sleep.

Flexibility and Work Design

HDC continues to offer secondments across divisions, working from home options and flexible work start and finish times.

Leadership Culture

- We held a two-day learning and development conference covering topics such as organisational vision and values, disability perspectives, working with diversity, and the value of conciliation.
- Te reo Māori classes were made available to staff throughout the year, along with New Zealand Sign Language tuition.
- Employee activities were organised over three separate weeks (Matariki – Māori New Year and Māori Language Week to increase Māori cultural awareness, and Deaf Awareness Week to increase cultural awareness around deafness).
- We use New Zealand Sign Language interpreters for key training and development opportunities for staff who require it.
- Monthly "brown-bag" lunches are held in both offices, with interesting speakers from the health and disability and regulatory sectors.

REPORT OF THE DIRECTOR OF ADVOCACY

The Nationwide Health and Disability Advocacy Service is available to any person in NZ who has a concern or wants to make a complaint about a health or disability service, or who requires information about health and disability consumers' rights. Advocates are independent and on the side of the consumer. They use a uniquely Kiwi face-to-face approach to both promote the Code of Rights and work alongside consumers to help put things right. They can be easily contacted on an 0800 number as well as free fax and email. The service is free and confidential.

The past 12 months has seen the service working very well as a single national team. Significant improvements in consistency have been made, along with the sharing of expertise across the service and better support for advocates working in isolation. The Director organises an annual conference to bring all members of the service together to focus on the vision of strengthening the service for the benefit of consumers. The advocacy service also takes part in a combined conference each year with HDC staff to improve the linkages and understanding of the various divisions working under the HDC legislation.

Judi Strid
Director of Advocacy

Over the past year, 42 advocates (34.5 FTE) based in communities all over the country responded to 9,008 enquiries, and assisted consumers with 3,787 complaints of which 90% were either fully or partially resolved. Only 2.3% of the total complaints are formal referrals from the Commissioner. In addition, advocates took part in 5,734 networking contacts and carried out 1,716 education sessions.

The significant increase in networking reflects proactive initiatives to extend the profile of advocates and reach consumers who would generally find it difficult or impossible to contact an advocate themselves. They include consumers in residential facilities as well as those in rural and provincial locations. This feature of the expansion to the service has been possible because of the increase in the number of full-time advocates.

Over the past 12 months 96% of the 732 rest homes in the country had at least one advocacy contact, with a total of 1,438 advocacy contacts during the year.

The success of the previous year's rest home visiting was extended to include disability homes and facilities during 2007/08. During this time, 92% of the 963 disability homes and facilities received at least one advocacy contact, with 1,683 contacts in total. Advocates visit homes to assist and be available to residents as well as provide education sessions and information for them, their family members and staff. Health and disability advocates also work collaboratively alongside other advocacy services promoting service improvements, and offer an independent alternative for consumers.

One in seven complaints to the advocacy service related to residents of rest homes or other residential facilities.

Advocates continue to actively promote complaints as opportunities for learning and improving service quality as part of the Commissioner's increased focus on quality improvement. They also promote the importance of consumer-centred care and use great care stories that consumers have provided to highlight the services and practices they value. A number of consumers who made enquiries to the service said that just having someone listen and validate their concerns made them feel better and, as a result, they did not want to pursue a complaint.

The Nationwide Health and Disability Advocacy Service (including members of the National Advocacy Trust and Kaumātua Network) at the March 2008 Advocacy Conference in Wellington.

The largest age group of people who bring complaints are those between 41–60 years (33% of all complainants), the second largest is the 26–40 years age group (32%), and those between the ages of 61–99 years account for almost 18% of complaints.

Forty-three percent of people who complain to an advocate believe that they or the person they are representing did not receive care of an appropriate standard. The next two highest areas are the lack of effective communication (12.5%) and not being fully informed (12.1%).

Of those who disclose their ethnicity when they make a complaint, the vast majority are NZ Europeans/Pākehā who bring 53% of complaints, followed by NZ Māori at 10%. Two percent of complaints are brought by Pacific peoples; of these, almost 75% are from the Samoan community.

The resolution agreement form, which was developed to ensure that there is a shared understanding of agreed actions to be carried out beyond a resolution meeting, has now been printed in a generic form so that it can also be used by providers dealing with Right 10 complaints that are made directly to them.

The success of this approach continues to reflect the goodwill and commitment shown by providers to resolve complaints. In the small percentage of situations where an advocate needed to follow up the lack of action, this oversight was addressed straight away.

The role of a dedicated manager for education and training, along with the development of in-house trainers to build capacity within the service for ongoing quality training relevant to advocacy, has been a significant step towards improving the quality of training for advocates.

PROMOTING SPEAKING UP AND SELF-ADVOCACY

A consumer who attended an advocacy rights education hui on a marae made a complaint about charges made by the local pharmacy. He met with the pharmacist and together they reviewed the payments made and discussed which medications they related to. They agreed there had been a misunderstanding and the consumer was happy with the explanations provided. His relationship with the pharmacy has improved as a result of his actions. Attending the hui and knowing his rights gave him the confidence to deal with this issue himself.

GENERAL PRACTICE: THE RIGHT TO BE TREATED WITH DIGNITY AND TO BE LISTENED TO

A former POW complained that his GP would not listen to him and dismissed his requests for further referrals as suggested by specialists screening him for Veterans Affairs. It had taken him 60 years to speak up about his days as a POW and his GP made inappropriate remarks that the consumer felt belittled his past history. It was important to him that his severe chronic conditions were assessed and recognised as a result of his POW days so this information could be used for statistical and historical purposes. With the support of an advocate he was able to insist on further examinations which in turn recognised his conditions. He felt relief to be finally listened to and to obtain recognition after so long.

Advocates have already taken part in specific training to enhance their skills in communicating effectively with consumers with limited or no speech — a common feature of those living in residential facilities. This area of training is being further developed.

A number of new educational resources are being used to support a more professional and innovative approach for advocates delivering sessions in a range of settings and for a variety of audiences. The new specialist Deaf Advocacy service for the lower North Island offers a programme for providers to increase their understanding of Deaf culture and how to meet their Code obligations for Deaf consumers, as well as improving advocacy access for Deaf consumers.

There is a high level of satisfaction with the service, with consumers rating 85% and providers 81%. There is a 91% satisfaction level with the education sessions provided by advocates.

A highlight for the advocacy service was being able to actively support consumers attending the second Strengthening Consumer Voice National Summit in November 2007, which HDC co-hosted as part of our mission to champion consumer rights. An outcome of the Summit will be the establishment of a national consumer collaboration.

In conclusion, I would like to acknowledge the dedication and commitment of all those involved with the provision of the advocacy service, including the managers and support staff, and members of the National Advocacy Trust and the Kaumātua Network, and to thank them for their combined efforts in providing an excellent service for health and disability services consumers throughout the country.

Nationwide Health and Disability Advocacy Services display at the Deaf/Hearing Impaired Expo in Wellington in August 2007.

HOSPITAL: A REFERRAL TO ADVOCACY FROM THE COMMISSIONER

A terminal cancer patient was taken to hospital in the early hours of the morning as he was experiencing difficulty breathing, even with oxygen at home. Despite no improvement, family concerns about his well-being and a lack of mobility, the duty doctor discharged him home several hours later to a house with difficult access.

After a short time at home the District Nurse was called as he continued to experience difficulty breathing. She rang for an ambulance, but staff requested help from the fire service because of the difficult access at the home. This was humiliating for the consumer, who was admitted to hospital straight away and died two days later.

The advocate organised a meeting for the family to discuss their concerns with the Clinical Director and Area Manager. Family members wanted to know why he was sent home when he was clearly unwell and to discuss the humiliation and additional stress caused by the decision to discharge him.

The Clinical Director expressed his sincere condolences and apologised unreservedly for what happened. He said he felt that the discharge was a major error given the circumstances. A shortage of experienced staff at the time had contributed to the situation, so a staff meeting was organised to discuss the case and what needed to be done if they were faced with a similar situation.

Family members were offered counselling to assist with the grief process as well as issues arising from the complaint.

HOSPITAL CARE: REGAINING TRUST AND OBTAINING SERVICE IMPROVEMENTS

A woman contacted an advocate to discuss concerns relating to both the care her partner received during his terminal illness, and her own health care following a stillbirth that occurred whilst nursing her husband at the hospital. She had not sought medical help as she distrusted providers as a result of her experiences. The only person she felt comfortable with was a GP she had been a patient of previously who was not from the area she currently lived in. The advocate contacted the GP on her behalf and supported her at the consultation. After the GP had completed his examination he referred her for urgent surgery. When she felt fully recovered she went back to the advocate to get help to proceed with her complaint.

The woman wrote a letter to the provider outlining how distressing it was when upon arrival at the hospital her seriously ill partner was made to sit on a chair for an unacceptable length of time, and that she had to locate a bed where he could lie down. Staff were rude, abrupt and disrespectful, making disparaging remarks about the size of the wheelchair her husband needed and the condition of his legs. When she became ill during their wait, she was told she would need to get medication outside of the hospital. She later gave birth to a stillborn baby.

When her partner died, staff spoke rudely to the family and were overheard talking about sending him to the “chiller” and laughing. No one appeared concerned for her welfare and yet she had lost both a baby and a partner.

In her letter she said she wanted staff to receive training about caring for the dying and their families, as well as education on cultural and other needs of the individual. She also asked for an apology from those involved and steps to be taken to stop this happening to others. She was very happy with the response from the hospital.

Features

A striking feature of this financial year has been the large number of referrals of carers to the Director of Proceedings. The term "carer" or "caregiver" encompasses those unregistered individuals who provide health or disability services both in institutional settings such as rest homes, as well as in private residences, to the elderly and disabled. This year (seven complaints involving five individual carers) is in marked contrast to the one carer referred in each of the two previous years, with none referred prior to that. The increase perhaps reflects the significant impact these individuals can have on the safety and well-being of their clients, and the requirement for them to recognise and respect the rights of consumers under the Code.

Theo Baker
Director of Proceedings

Statistics

As Table 1 shows, action was not taken in relation to nine out of 22 referrals received, the consumer being unable or unwilling to give evidence in four matters where their evidence was pivotal to the success of the claim.

The prosecution was successful in six out of seven disciplinary cases, and four out of four Human Rights Review Tribunal claims, although damages were not awarded as claimed in one of those because of issues of causation. Three appeals against findings of professional misconduct were heard, and in the two High Court decisions received, the Tribunal's findings

Table 1: **Action taken in respect of referrals to Director of Proceedings as at 30 June 2008**

Provider	No further action	Decision in process	Hearing pending	Hearing taken place	Total
Carer	5[1]		2		7
Medical practitioner					
General practitioner	1		1	1	3
General surgeon		1			1
Midwife	1		1	1	3
Natural healer	1				1
Nurse	1	1	1		3
Physiotherapist			1[2]	1	2
Psychologist			1[3]		1
Rest home		1			1
Total	**9**	**3**	**7**	**3**	**22**

1 This included three complaints about one provider.
2 Hearing took place on 9 July 2008.
3 Hearing took place on 4 August 2008.

of professional misconduct were upheld, with the exception of one particular. There was some adjustment of penalty in two cases. The High Court upheld the Tribunal's decision to grant name suppression to a nurse and to decline name suppression to a general surgeon.

Tribunal Survey

With only two tribunals to be surveyed, and an understandable reluctance by chairs holding quasi-judicial roles to participate in the surveys, it is difficult to obtain any meaningful feedback by survey. We continue to keep open communication with the executive officers of the tribunals and consider the success rate of the proceedings team is evidence of a high standard of advocacy.

CAREGIVER IN BREACH OF ELDERLY RESIDENT'S RIGHTS

On 14 August 2007 the Human Rights Review Tribunal issued a decision in which it found that a caregiver, Ms Kaur, had breached an elderly rest home resident's rights under the Code. Ms Kaur was employed as a caregiver and was hoping to obtain registration as a nurse in New Zealand, having been a registered nurse in Punjab, India.

Mrs J was admitted to the rest home in September 2004. She was then aged 78. She had dementia and suffered from impaired memory and judgement, and by September 2005 she had only limited facial gestures and made noises, but nothing that could be described as speech. She needed assistance from two people to transfer her from a chair to her bed, and was almost completely immobile.

On 3 September 2005 at about 6pm Ms Kaur, without assistance, transferred Mrs J from a chair onto her bed. At about 9pm she completed an incident form in which she recorded that she had noticed a skin tear on Mrs J's arm at about 6.15pm and had dressed it. There was no description of how the injury had occurred.

Over the next day or so none of the caregivers or nurses noticed Mrs J's injuries until a caregiver on the morning of 5 September 2005 noticed a discolouration on the left-hand side of her face. On investigation the caregiver saw that Mrs J's shoulder was showing signs of bruising as well, and that the discolouration of bruising went over her shoulder and down beside her breast. She called a nurse, who immediately suspected a fracture, and an X-ray was arranged.

The rest home management interviewed all staff, and no one acknowledged having seen any incident that might have caused Mrs J's fracture and bruising. Age Concern was also involved in the investigation and, on 22 September 2005, two of its staff, the rest home manager, Ms Kaur and another staff member met to discuss rumours about who might have been responsible or had knowledge of how the injury occurred. During the discussion Ms Kaur asked if she could see the manager privately, and during the private conversation she admitted dropping Mrs J during a transfer on the evening of Saturday, 3 September 2005 when she (Ms Kaur) was transferring Mrs J to her bed. She then repeated her admission to the Age Concern staff and apologised. The manager suspended Ms Kaur on full pay, and asked her to report the next day to discuss matters further, but Ms Kaur did not come back to work.

When investigated by HDC, Ms Kaur denied that Mrs J had fallen during a transfer in her care and said that she had been induced by the manager to accept responsibility on a promise that she would keep her job. The Tribunal did not believe her because it was she who had suggested the meeting in private, she had alternatively said that she had voluntarily resigned and that she had been fired, and if the manager had guaranteed her job as claimed, it is surprising that she did not object if she was then fired.

The Tribunal found that:

(a) In failing to comply with the "two person lift" policy of the Home Ms Kaur failed to transfer Mrs J safely from her chair to her bed and therefore breached Right 4(1) of the Code by failing to provide services to Mrs J with reasonable care and skill;

(b) When Mrs J fell during the transfer from her chair to the bed, Ms Kaur failed to complete an adequate Incident Report in accordance with the policy and therefore breached Right 4(2) of the Code by failing to provide services that comply with legal, professional or other standards; and

(c) Ms Kaur breached Right 4(5) of the Code by failing to co-operate with other providers to ensure quality and continuity of services when on 3 September 2005 she did not notify the nurse on duty that Mrs J had fallen; and did not advise anyone until 22 September that Mrs J had fallen while in her care.

GP'S PROFESSIONAL MISCONDUCT IN TREATING DE FACTO PARTNER

On 11 June 2008 the High Court upheld a November 2007 finding of the Health Practitioners Disciplinary Tribunal that a general practitioner's care of his de facto partner amounted to professional misconduct. Dr E is a registered medical practitioner, practising as a general practitioner, on a part-time basis. Between December 2002 and May 2006 Dr E and Mrs A lived together in a de facto relationship. During that period Mrs A did not consult any other general practitioner.

The 2001 Medical Council of New Zealand "Statement of self care and family care" stated: "It is generally unwise for medical practitioners to care for themselves or family members in all but minor and emergency health matters. Self-care and family care is neither prudent nor practical because of the lack of objectivity and discontinuity of care. The Medical Council recognises that there are some situations where family treatment may be provided but maintains that this should occur only when overall management of patient care is being monitored by the family's practitioner." The Council further stated that all treatment should be documented in the patient's record.

The practitioner admitted that he had diagnosed his partner with depression, not kept any record of his care, and prescribed her with various medications. He did not accept that his conduct amounted to professional misconduct.

The agreed facts were that soon after Mrs A started living with Dr E, he diagnosed her with depression. Dr E explained that this was as a result of many factors, including her history, various conversations, and his observations of her mood fluctuations, her impulsive behaviour and alcohol consumption. Dr E prescribed Aropax (an antidepressant) for Mrs A. He made no record of his diagnosis or treatment. While at Dr E's request Mrs A had attended counselling between January and June 2002 for self-esteem and historical relationship issues, she had not previously been diagnosed with depression nor had Aropax prescribed for her.

On 24 April 2003 Mrs A had a prescription for 30 Aropax 20mg tablets filled. Over the next three years Mrs A presented a further 29 prescriptions for Aropax. They were all prescribed by Dr E, and were dispensed by one of three local pharmacies. On some occasions the prescription was for 30 tablets while on others it was for 60 tablets.

During the same period, Dr E prescribed a number of other medications for Mrs A. They included 13 prescriptions for Paradex (an analgesic), 9 prescriptions for Trisequens (hormone replacement) and 2 prescriptions for Losec (for gastric problems).

In early April 2006 Mrs A presented to the Emergency Mental Health Team, who noted that she appeared withdrawn and tearful with feelings of hopelessness and low energy and motivation. She was assessed for suicidal thinking with a background of low mood and relationship strain, as a result of which she was referred to Community Mental Health.

An assessment by a psychiatric registrar on 19 April 2006 did not reveal symptoms of Major Depressive Disorder. It was thought that Mrs A could be suffering from an Adjustment Disorder with depressed and anxious mood. A programme of reduction of Aropax from 40mg a day to 10mg was planned over the next two weeks, with a view to introducing a mood stabiliser.

On 8 May 2006 at a second Community Mental Health consultation with the psychiatric registrar, it was agreed that the Aropax would cease and Mrs A would try sodium valproate for her mood.

In late May 2006, following a heated dispute, Mrs A moved out of Dr E's house and the couple separated.

At a further Community Mental Health consultation in early June the psychiatric registrar increased Mrs A's mood stabiliser, and then at a consultation on 24 July 2006 it was reduced with a view to ceasing. Mrs A did not attend any further appointments with Community Mental Health and ceased taking the sodium valproate. The psychiatric registrar confirmed that at the time of this last assessment it was felt that Mrs A did not meet the criteria for mental disorder. The most appropriate treatment was thought to be individual psychotherapy for management of psychosocial stressors.

On appeal, the High Court judge observed that a diagnosis of depression is particularly sensitive in a family setting, and is not the same as noting that a family member has the flu. Documentation of the care of Dr E's partner was important where he was treating her with antidepressants for a serious illness. Records establish the justification for diagnosis and continuing treatment, not only of the depression but of other presentations.

The appellant was successful in having one aspect of the charge quashed. Because the Tribunal had not provided the practitioner with an opportunity to comment on its criticism that the prescribing of Aropax and Paradex together is contraindicated, that there were dependency risks of Paradex, and that mammography should be undertaken where Trisequens is prescribed over a three-year period, the prescribing of Paradex, Trisequens and Losec was not upheld as professional misconduct.

The penalty of censure and costs was upheld, with a fine reduced from $7,500 to $5,000. The Director of Proceedings consented to name suppression in order to protect the privacy of Mrs A.

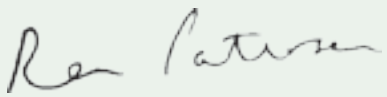
Statement of Responsibility for the year ended 30 June 2008

In terms of the Crown Entities Act 2004, the Health and Disability Commissioner is responsible for the preparation of the Health and Disability Commissioner's financial statements and statement of service performance, and for the judgements made in them.

The Health and Disability Commissioner has the responsibility for establishing, and has established, a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the Health and Disability Commissioner's opinion, these financial statements and statement of service performance fairly reflect the financial position and operation of the Health and Disability Commissioner for the year ended 30 June 2008.

Signed on behalf of the Health and Disability Commissioner.



Ron Paterson
Commissioner

Tania Thomas
Deputy Commissioner —
Education and Corporate Services

22 September 2008

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

AUDIT REPORT

TO THE READERS OF HEALTH AND DISABILITY COMMISSIONER'S FINANCIAL STATEMENTS AND STATEMENTOF SERVICE PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2008

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, John Scott, using the staff and resources of Audit New Zealand, to carry out the audit on his behalf. The audit covers the financial statements and statement of service performance included in the annual report of the Health and Disability Commissioner for the year ended 30 June 2008.

Unqualified Opinion

In our opinion:

- The financial statements of the Health and Disability Commissioner on pages 22 to 46:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health and Disability Commissioner's financial position as at 30 June 2008; and
    - the results of its operations and cash flows for the year ended on that date.
- The statement of service performance of the Health and Disability Commissioner on pages 47 to 50.
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards outlined in the statement of forecast service performance adopted at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses outlined in the statement of forecast service performance adopted at the start of the financial year.

The audit was completed on 22 September 2008, and is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Health and Disability Commissioner and the Auditor, and explain our independence.

Basis of Opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and statement of service performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Health and Disability Commissioner;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement and statement of service performance disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Health and Disability Commissioner and the Auditor

The Health and Disability Commissioner is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health and Disability Commissioner as at 30 June 2008 and the results of its operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health and Disability Commissioner's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses adopted at the start of the financial year. The Health and Disability Commissioner's responsibilities arise from the Crown Entities Act 2004 and the Health and Disability Commissioner Act 1994.

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

Other than the audit, we have no relationship with or interests in the Health and Disability Commissioner.

John Scott
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Matters relating to the electronic presentation of the audited financial statements

This audit report relates to the financial statements of the Health and Disability Commissioner for the year ended 30 June 2008 included on the Health and Disability Commissioner's web site. The Health and Disability Commissioner is responsible for the maintenance and integrity of the Health and Disability Commissioner's web site. We have not been engaged to report on the integrity of the Health and Disability Commissioner's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information, which may have been hyperlinked to/from these financial statements. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and related audit report dated 22 September 2008 to confirm the information included in the audited financial statements presented on this web site.

Legislation in New Zealand governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

STATEMENT OF FINANCIAL PERFORMANCE for the year ended 30 June 2008

	Note	Actual 2008 $	Budget 2008 $	Actual 2007 $
Income				
Revenue from Crown	2	8,331,000	8,330,620	7,554,000
Interest Income		211,587	177,000	197,915
Other revenue	3	84,435	80,000	79,114
Total income		8,627,022	8,587,620	7,831,029
Expenditure				
Personnel costs	4	3,653,072	3,553,677	3,328,751
Depreciation and amortisation expense	9, 10	312,195	262,000	277,763
Advocacy Services		3,085,750	3,073,900	2,596,734
Other expenses	5	1,823,227	1,872,378	1,856,701
Total expenditure		8,874,244	8,761,955	8,059,949
Net deficit for the year		**(247,222)**	**(174,335)**	**(228,920)**

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION as at 30 June 2008

	Note	Actual 2008 $	Budget 2008 $	Actual 2007 $
Assets				
Current Assets				
Cash and cash equivalents	6	1,479,900	1,430,466	1,684,868
Debtors and other receivables	7	29,471	30,000	38,230
Prepayments		62,971	16,000	34,591
Inventories	8	10,336	15,000	21,718
Total current assets		1,582,678	1,491,466	1,779,407
Non-current assets				
Property, plant and equipment	9	341,930	378,699	311,171
Intangible assets	10	127,983	119,151	146,903
Total non-current assets		469,913	497,850	458,074
Total assets		**2,052,591**	**1,989,316**	**2,237,481**
Liabilities				
Current Liabilities				
Creditors and other payables	11	469,636	319,600	421,086
Employee entitlements	12	159,401	280,000	145,619
Total current liabilities		629,037	599,600	566,705
Total liabilities		629,037	599,600	566,705
Net Assets		**1,423,554**	**1,389,716**	**1,670,776**
Equity				
General funds	13	1,423,554	1,389,716	1,670,776
Total Equity		**1,423,554**	**1,389,716**	**1,670,776**

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY for the year ended 30 June 2008

	Actual 2008	Budget 2008	Actual 2007
	$	$	$
Balance at 1 July	1,670,776	1,564,051	1,899,696
Amounts recognised directly in equity:			
Net deficit for the year	(247,222)	(174,335)	(228,920)
Total Net Recognised Revenues and Expenses	1,423,554	1,389,716	1,670,776
Balance at 30 June	**1,423,554**	**1,389,716**	**1,670,776**

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS for the year ended 30 June 2008

	Note	Actual 2008 $	Budget 2008 $	Actual 2007 $
Cash Flow from Operating Activities				
Receipts from Crown revenue		8,331,000	8,330,620	7,554,000
Interest received		223,032	177,000	201,971
Receipts from other revenue		82,047	80,000	76,306
Payments to suppliers		(4,878,462)	(4,941,280)	(4,670,204)
Payments to employees		(3,639,290)	(3,553,677)	(3,324,527)
Goods and services tax (net)		241	–	–
Net cash from operating activities	**14**	**118,568**	**92,663**	**(162,454)**
Cash Flows from Investing Activities				
Receipts from sale of property, plant and equipment		0	0	39
Purchase of property, plant and equipment		(202,256)	(240,000)	(123,435)
Purchase of intangible assets		(121,280)	(30,000)	(119,195)
Net Cash from Investing Activities		**(323,536)**	**(270,000)**	**(242,591)**
Net decrease in cash and cash equivalents		**(204,968)**	**(177,337)**	**(405,045)**
Cash and cash equivalents at beginning of year		1,684,868	1,607,803	2,089,913
Cash and cash equivalents at end of year	**6**	**1,479,900**	**1,430,466**	**1,684,868**

The accompanying notes form part of these financial statements.

1 Statement of accounting policies for the year ended 30 June 2008

Reporting Entity

The Health and Disability Commissioner is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. As such, the Health and Disability Commissioner's ultimate parent is the New Zealand Crown.

The Health and Disability Commissioner's primary objective is to provide public services to the New Zealand public, as opposed to making a financial return. The role of the Commissioner is to promote and protect the rights of health consumers and disability service consumers.

Accordingly, the Health and Disability Commissioner has designated itself as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

The financial statements for the Health and Disability Commissioner are for the year ended 30 June 2008, and were approved by the Commissioner on 22 September 2008.

Basis of Preparation

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 comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

First year of preparation under NZ IFRS

This is the first set of financial statements prepared using NZ IFRS, and comparisons for the year ended 30 June 2007 have been restated to NZ IFRS accordingly.

Reconciliations of equity and surplus/(deficit) for the year ended 30 June 2007 under NZ IFRS to the balances reported in the 30 June 2007 financial statements are detailed in note 24.

The accounting policies set out below have been applied consistently to all periods presented in these financial statements and in preparing an opening NZ IFRS statement of financial position as at 1 July 2006 for the purposes of the transition to NZ IFRS.

Measurement base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of certain items of property, plant and equipment, and the measurement of equity investments and derivative financial instruments at fair value.

Functional and presentation currency

The financial statements are presented in New Zealand dollars, and all values are rounded to the nearest dollar ($). The functional currency of the Health and Disability Commissioner is New Zealand dollars.

Significant Accounting Policies

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Revenue from the Crown

The Health and Disability Commissioner is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of the Health and Disability Commissioner meeting his objectives as specified in the statement of intent.

Revenue from the Crown is recognised as revenue when earned and is reported in the financial period to which it relates.

Interest

Interest income is recognised using the effective interest method. Interest income on an impaired financial asset is recognised using the original effective interest rate.

Sale of Publications

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

Leases

Operating Leases

Leases that do not transfer substantially all the risks and rewards incidental to ownership of an asset to the Health and Disability Commissioner are classified as operating leases. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the term of the lease in the statement of financial performance. Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.

Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at call with banks both domestic and international, other short-term, highly liquid investments, with original maturities of three months or less and bank overdrafts.

Debtors and other receivables

Debtors and other receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

Investments

At each balance sheet date the Health and Disability Commissioner assesses whether there is any objective evidence that an investment is impaired.

Bank Deposits

Investments in bank deposits are initially measured at fair value plus transaction costs.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method.

For bank deposits, impairment is established when there is objective evidence that the Health and Disability Commissioner will not be able to collect amounts due according to the original terms of the deposit. Significant financial difficulties of the bank, probability that the bank will enter into bankruptcy, and default in payments are considered indicators that the deposit is impaired.

Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at the lower of cost (calculated using the weighted average cost method) and current replacement cost. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

The replacement cost of the economic benefits or service potential of inventory held for distribution reflects any obsolescence or any other impairment.

The write-down from cost to current replacement cost or net realisable value is recognised in the statement of financial performance in the period when the write-down occurs.

Property, plant and equipment

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

Property plant and equipment are shown at cost or valuation, less any accumulated depreciation and impairment losses.

Additions

The cost of an item of property, plan 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 the Health and Disability Commissioner and the cost of the item can be measured reliably.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

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 statement of financial performance.

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 the Health and Disability Commissioner 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 statement of financial performance 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 (or valuation) 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 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.

Intangible Assets

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

Costs associated with the development and maintenance of the Health and Disability Commissioner'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 statement of financial performance.

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

Acquired computer software	2 years	50%

Impairment of non-financial assets

Property, plant and equipment and intangible assets that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the Health and Disability Commissioner would, if deprived of the asset, replace its remaining future economic benefits or service potential.

If an asset's carrying amount exceeds its recoverable amount the asset is impaired and the carrying amount is written down to the recoverable amount.

Creditors and other payables

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of creditors and other payables approximates their fair value.

Employee Entitlements

Short-term employee entitlements

Employee entitlements that the Health and Disability Commissioner expects to be settled within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned, but not yet taken at balance date, retiring and long-service leave entitlements expected to be settled within 12 months, and sick leave.

Superannuation Schemes

Defined contribution schemes

Obligations for contributions to Kiwisaver and the Government Superannuation Fund are accounted for as defined contribution superannuation scheme and are recognised as an expense in the statement of financial performance as incurred.

Goods and Service Tax (GST)

All 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 then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (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 an 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 charge for income tax has been provided for.

Budget Figures

The budget figures are derived from the statement of intent 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 IFRS, using accounting policies that are consistent with those adopted by the Health and Disabiity Commissioner for the preparation of the financial statements.

Cost Allocation

The Health and Disability Commissioner has determined the cost of outputs using the cost allocation system outlined below.

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

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Other direct 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 below:

Property, plant and equipment useful lives and residual value

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 statement of financial performance, and 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;
- asset replacement programmes.

The Health and Disability Commissioner has not made significant changes to past assumptions concerning useful lives and residual values. The carrying amounts of property, plant and equipment are disclosed in note 9.

Critical judgements in applying the Health and Disability Commissioner's accounting policies

Management has exercised the following critical judgements in applying the Health and Disability Commissioner's accounting policies for the period ended 30 June 2008:

Lease classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the Health and Disability Commissioner.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

The Health and Disability Commissioner has exercised its judgement on the appropriate classification of equipment leases, and has determined that no lease arrangements are finance leases.

2 Revenue from Crown

The Health and Disability Commissioner has been provided with funding from the Crown for the specific purposes of the Health and Disability Commissioner as set out in its founding legislation and the scope of the relevant government appropriations. Apart from these general restrictions there are no unfulfilled conditions or contingencies attached to government funding (2007 nil).

3 Other Revenue

	Actual 2008 $	Actual 2007 $
Sale of Publications	84,435	79,114
Total Other Revenue	**84,435**	**79,114**

4 Personnel Costs

	Actual 2008 $	Actual 2007 $
Salaries and wages	3,622,729	3,321,415
Employer contributions to defined contribution plans	16,562	12,912
Increase/(decrease) in employee entitlements (note 12)	13,781	(5,576)
Total Personnel Costs	**3,653,072**	**3,328,751**

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

5 Other Expenses

	Actual 2008 $	Actual 2007 $
Fees to auditor:		
Audit fees for financial statement audit	30,000	12,600
Audit fees for NZ IFRS transition	3,500	6,000
Staff travel and acommodation	123,534	190,029
Operating lease expense	379,990	339,398
Advertising	34,779	60,506
Consultancy	401,660	508,475
Inventories consumed	138,818	93,276
Net loss on sale of property, plant and equipment	498	39
Other	710,448	646,378
Total other expenses	**1,823,227**	**1,856,701**

6 Cash and cash equivalents

	Actual 2008 $	Actual 2007 $
Cash on hand and at bank	59,900	60,868
Cash equivalents — term deposits	1,420,000	1,624,000
Total cash and cash equivalents	**1,479,900**	**1,684,868**

The carrying value of short-term deposits with maturity dates of three months or less approximates their fair value.

The weighted average effective interest rate for term deposits is 8.8% (2007 8.0%).

7 Debtors and other receivables

	Actual 2008 $	Actual 2007 $
Debtors and other receivables	29,471	38,230
Less provision for impairment	0	0
Total debtors and other receivables	**29,471**	**38,230**

The carrying value of receivables approximates their fair value.

As at June 2008 and 2007, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2008 $	2007 $
Not past due	27,659	36,036
Past due 1–30 days	1,669	2,194
Past due 31–60 days	0	0
Past due 61–90 days	143	0
Past due > 91 days	0	0
Total	**29,471**	**38,230**

8 Inventories

	Actual 2008 $	Actual 2007 $
Publications held for sale	10,336	21,718
Total inventories	**10,336**	**21,719**

The carrying amount of inventories held for distribution that are measured at current replacement costs as at 30 June 2008 amounted to $10,336 (2007 $21,718).

9 Property, Plant and Equipment

Movements for each class of property, plant and equipment as at 30 June 2008 are as follows:

Cost	Comp Hardware	Comms equip	Furn and fittings	Leasehold improve-ments	Motor Vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 07	722,905	26,723	215,555	618,621	42,280	178,557	1,804,641
Additions during year	149,199	0	1,494	32,254	0	20,305	203,252
Disposals during year	(27,745)	0	(19,840)	0	0	(13,454)	(61,039)
Balance at 30 June 2008	844,359	26,723	197,209	650,875	42,280	185,408	1,946,854
Accumulated Depreciation							
Balance at 1 July 07	602,306	26,723	198,696	491,909	42,280	131,556	1,493,470
Charge for year	51,550	0	7,095	96,508	0	16,842	171,995
Disposals	(27,745)	0	(19,840)	0	0	(12,956)	(60,541)
Balance at 30 June 2008	626,111	26,723	185,951	588,417	42,280	135,442	1,604,924
Net book value 30 June 2008	**218,248**	**0**	**11,258**	**62,458**	**0**	**49,966**	**341,930**

Cost	Comp Hardware	Comms equip	Furn and fittings	Leasehold improve-ments	Motor Vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 06	631,273	26,763	211,795	606,536	42,280	162,807	1,681,414
Additions during year	91,840	0	3,760	12,085	0	15,750	123,435
Disposals during year	(208)	0	0	0	0	0	(208)
Balance at 30 June 2007	722,905	26,723	215,555	618,621	42,280	178,557	1,804,641
Accumulated Depreciation							
Balance at 1 July 06	556,333	26,723	189,671	391,533	42,280	113,037	1,319,577
Charge for year	46,142	0	9,025	100,376	0	18,519	174,062
Disposals	(169)	0	0	0	0	0	(169)
Balance at 30 June 2007	602,306	26,723	198,696	491,909	42,280	131,556	1,493,470
Net book value 30 June 2007	**120,599**	**0**	**16,859**	**126,712**	**0**	**47,001**	**311,171**

10 Intangible Assets

Movements for each class of property, plant and equipment as at 30 June 2008 are as follows:

	Actual 2008 $	Actual 2007 $
Computer Software		
Balance at 1 July	640,342	521,147
Additions during the year	121,280	119,195
Disposals during the year	0	0
Balance at 30 June	761,622	640,342
Accumulated Amortisation		
Balance at 1 July	493,439	389,738
Charge for the year	140,200	103,701
Disposals	0	0
Balance at 30 June	633,639	493,439
Net book value at 30 June	**127,983**	**146,903**

All software is acquired software.

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.

11 Creditors and other payables

	Actual 2008 $	Actual 2007 $
Creditors	320,984	279,941
Accrued expenses	19,751	17,301
Other payables	128,901	123,844
Total creditors and other payables	**469,636**	**421,086**

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms, therefore carrying value of creditors and other payables approximates their fair value.

12 Employee entitlements

	Actual 2008 $	Actual 2007 $
Current employee entitlements are represented by:		
Annual leave	158,363	143,196
Retirement and long service leave	1,038	2,423
Total current portion	159,401	145,619
Total employee entitlements	**159,401**	**145,619**

13 Equity

	Actual 2008 $	Actual 2007 $
General funds		
Balance at 1 July	1,670,776	1,899,696
Deficit for the year	(247,222)	(228,920)
Total equity at 30 June	**1,423,554**	**1,670,776**

14 Reconciliation of net deficit to net cash from operating activities

	Actual 2008 $	Actual 2007 $
Net deficit after tax	(247,222)	(228,920)
Add/(less) non-cash items:		
Depreciation and amortisation expense	312,195	277,763
Total non-cash items	312,195	277,763
Add/(less) items classified as investing or financing activities		
Loss on disposal of property, plant and equipment	(498)	0
Total items classified as investing or financing activities	(498)	0
Add/(less) movements in working capital items		
Debtors and other receivables	(19,323)	(14,094)
Inventories	11,382	(7,053)
Creditors and other payables	48,252	(118,574)
Employee entitlements	13,782	(5,576)
Net movements in working capital items	54,093	(211,297)
Net cash from operating activities	**118,568**	**(162,454)**

15 Commitments and operating leases

Advocacy Service contracts

The maximum commitment for the 12 months from 1 July 2008 is $3,320,998 (2007: $3,073,900).

Operating leases as lessee

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

	Actual 2008 $	Actual 2007 $
Not later than one year	363,367	382,095
Later than one year and not later than five years	561,287	914,919
Later than five years	0	0
Total non-cancellable operating leases	**924,654**	**1,297,014**

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

A portion of the total non-cancellable operating lease expense relates to the lease of these two offices. The Auckland lease expires in May 2011 and the Wellington lease expires in April 2009. The Wellington office is in the process of finding new premises.

16 Contingencies

Contingent liabilities

Legal proceedings relating to a procurement issue were concluded on 18 March 2008 and there are no current legal proceedings against the HDC. No compensation or damages were awarded against HDC, and no demands have been made. The HDC holds indemnity insurance.

Contingent assets

The Health and Disability Commissioner has no contingent assets (2007 $nil).

17 Related party transactions and key management personnel

Related party transactions

The Health and Disability Commissioner is a wholly owned entity of the Crown. The government significantly influences the role of the Health and Disability Commissioner in addition to being its major source of revenue.

The Health and Disability Commissioner enters into transactions with government departments, state-owned Commissioners and other Crown entities. Those transactions that occur within a normal supplier or client relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the Health and Disability Commissioner would have adopted if dealing with that entity at arm's length in the same circumstances have not been disclosed as related party transactions.

Key management personnel compensation

	Actual 2008 $	Actual 2007 $
Salaries and other short-term employee benefits	901,000	817,700
Post-employment benefits	13,560	12,912
Other long-term benefits	0	0
Termination benefits	0	0
Total key management personnel compensation	**914,560**	**830,612**

Key management personnel include the six Senior Management team members.

18 Employee remuneration

Total remuneration paid or payable

	Actual 2008 $	Actual 2007 $
100,000–109,999	0	1
110,000–119,999	1	1
120,000–129,999	1	1
130,000–139,999	1	2
150,000–159,999	2	0
220,000–229,999	0	1
230,000–239,999	1	0
Total employees	**6**	**6**

During the year ended 30 June 2008, no employees received compensation and other benefits in relation to cessation (2007: $12,500).

19 Events after the balance sheet date

There were no significant events after the balance sheet date.

20 Categories of financial assets and liabilities

The carrying amount of financial assets and liabilities in each of the NZ IAS 39 categories are as follows:

	Actual 2008 $	Actual 2007 $
Loans and receivables:		
Cash and cash equivalents	1,479,900	1,684,868
Debtors and other receivables	29,471	38,230
Total loans and receivables	**1,509,371**	**1,723,098**
Financial liabilities measured at amortised cost:		
Creditors and other payables	469,636	421,086
Total financial liabilities measured at amortised cost	**469,636**	**421,086**

21 Financial instrument risks

The Health and Disability Commissioner's activities expose it to a variety of financial instrument risks, including market risk, credit risk and liquidity risk. The Health and Disability Commissioner has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Market risk

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate owing to changes in market interest rates. The Health and Disability Commissioner's exposure to fair value interest rate risk is limited to its bank deposits which are held at fixed rates of interest.

The average interest rate on the Health and Disability Commissioner's term deposits is 8.8% (2007: 8.0%).

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Investments and borrowings issued at variable interest rates expose the Health and Disability Commissioner to cash flow interest rate risk.

Credit risk

Credit risk is the risk that a third party will default on its obligation to the Health and Disability Commissioner, causing the Health and Disability Commissioner to incur a loss.

Due to the timing of its cash inflows and outflows, the Health and Disability Commissioner invests surplus cash with registered banks. The Health and Disability Commissioner's Investment Policy limits the amount of credit exposure to any one institution.

The Health and Disability Commissioner's maximum credit exposure for each class of financial instrument is represented by the total carrying amount of cash and cash equivalents (note 6), net debtors (note 7). There is no collateral held as security against these financial instruments, including those instruments that are overdue or impaired.

The Health and Disability Commissioner has no significant concentrations of credit risk, as it has a small number of credit customers and only invests funds with registered banks with specified Standard and Poor's credit ratings.

Liquidity risk

Liquidity risk is the risk that the Health and Disability Commissioner will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities and the ability to close out market positions. The Health and Disability Commissioner aims to maintain flexibility in funding by keeping committed credit lines available.

In meeting its liquidity requirements, the Health and Disability Commissioner maintains a target level of investments that must mature within specified time frames.

Sensitivity analysis

As at 30 June 2008, if the deposit rate had been 50 basis points higher or lower, with all other variables held constant, the surplus/deficit for the year would have been $7,100 (2007: $8,100) higher/lower. This movement is attributable to increased or decreased interest expense on the cash deposits.

The table below analyses the Health and Disability Commissioner's financial liabilities into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date. Future interest payments on floating rate debt are based on the floating rate at the balance sheet date. The amounts disclosed are the contractual undiscounted cash flows.

	Less than 6 months	Between 6 months and 1 year	Between 1 and 5 years
	$	$	$
2007			
Creditors and other payables (note 11)	421,086	0	0
2008			
Creditors and other payables (note 11)	469,636	0	0

22 Capital Management

The Health and Disability Commissioner's capital is its equity, which comprises accumulated funds. Equity is represented by net assets.

The Health and Disability Commissioner is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

The Health and Disability Commissioner manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure the Health and Disability Commissioner effectively achieves its objectives and purpose, whilst remaining a going concern.

23 Explanation of significant variances against budget

There were no significant variations from the Health and Disability Commissioner's budgeted figures in the statement of intent.

24 Explanation of transition to NZ IFRS

Transition to NZ IFRS

As stated in note 1, these are the Health and Disability Commissioner's first financial statements to be prepared in accordance with NZ IFRS. The Health and Disability Commissioner's transition date is 1 July 2006 and the opening NZ IFRS balance sheet has been prepared as at that date. The Health and Disability Commissioner's NZ IFRS adoption date is 1 July 2007.

Exemptions from full retrospective application elected by the Health and Disability Commissioner

In preparing these financial statements in accordance with NZ IFRS 1, the Health and Disability Commissioner has not applied any optional exemptions to full retrospective application of NZ IFRS.

The only mandatory exemption from retrospective application that applies to the Health and Disability Commissioner is the requirement for estimates under NZ IFRS at 1 July 2006 and 30 June 2007 to be consistent with estimates made for the same date under previous NZ GAAP.

Reconciliation of equity

The following table shows the changes in equity, resulting from the transition from previous NZ GAAP to NZ IFRS as at 1 July 2006 and 30 June 2007.

Reconcilation of equity

	Note	Previous NZ GAAP $	1 July 06 Effect on Transition NZ IFRS $	NZ IFRS $	Previous NZ GAAP $	30 June Effect on Transition NZ IFRS $	NZ IFRS $
Assets							
Current assets							
Cash and cash equivalents		2,089,913	0	2,089,913	1,684,868	0	1,684,868
Debtors and other receivables		39,127	0	39,127	38,230	0	38,230
Prepayments		19,249	0	19,249	34,591	0	34,591
Inventories		14,665	0	14,665	21,719	0	21,718
Total current assets		2,162,954	0	2,162,954	1,779,407	0	1,799,408
Non-current assets							
Property, plant and equipment		361,837	0	361,837	311,171	0	311,171
Intangible assets		131,409	0	131,409	146,903	0	146,903
Total non-current assets		493,246	0	493,246	458,074	0	458,074
Total assets		**2,656,200**	**0**	**2,656,200**	**2,237,481**	**0**	**2,237,481**
Liabilities							
Current liabilities							
Creditors and other payables		605,309	0	305,309	421,086	0	421,086
Employee entitlements	a	285,368	(134,173)	756,504	566,705	0	566,705
Total current liabilities		890,677	(134,173)	756,504	566,705	0	566,705
Total liabilities		**890,677**	**(134,173)**	**756,504**	**566,705**	**0**	**566,705**
Net assets		**1,765,523**	**134,173**	**1,899,696**	**1,670,776**	**0**	**1,670,776**
Equity							
General funds	b	1,765,523	134,173	1,899,696	1,670,776	0	1,670,776
Total equity		**1,765,523**	**134,173**	**1,899,696**	**1,670,776**	**0**	**1,670,776**

Explanatory notes—Reconciliation of equity

Note a — Employee entitlements

Sick leave was provided for and "booked" under NZ GAAP. Under NZ IFRS, sick leave accrual has been reversed to equity.

Note b — Equity

Sick leave was provided for and "booked" under NZ GAAP. Under NZ IFRS, sick leave accrual has been reversed to equity.

Reconciliation of surplus for the year ended 30 June 2007

The following table shows the changes in the Health and Disability Commissioner surplus, resulting from the transition from previous NZ GAAP to NZ IFRS for the year ended 30 June 2007.

	Note	Previous NZ GAAP $	Effect on transition to NZ IFRS $	NZ IFRS $
Income				
Revenue from Crown		7,554,000	0	7,554,000
Interest		197,915	0	197,915
Other revenue		79,114	0	79,114
Total income		7,831,029	0	7,831,029
Expenses				
Personnel costs	a	3,194,578	134,173	3,328,751
Depreciation and amortisation expense		277,762	0	277,762
Advocacy Services		2,596,735	0	2,596,735
Other expenses		1,856,701	0	1,856,701
Total expenses		7,925,776	134,173	8,059,949
Deficit		**(94,747)**	**(134,173)**	**(228,920)**

Explanatory notes — Reconciliation of surplus

Note a — Personnel expenses

This represents a change in the accounting for sick leave provision, which was recognised differently under previous NZ GAAP.

Output Class 1: Service Delivery

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

- A nationwide, independent advocacy service promotes and educates consumers about their rights, and providers about their responsibilities, and assists consumers unhappy with health or disability services to resolve complaints about alleged breaches of the Code of Health and Disability Services Consumers' Rights, at the lowest appropriate level.
- The Commissioner responds to enquiries.
- The Commissioner assesses and resolves complaints.
- The independent Director of Proceedings initiates proceedings against providers.
- The Commissioner promotes and educates consumers, providers, professional bodies and funders about the provisions of the Code of Health and Disability Services Consumers' Rights.
- The Commissioner provides policy advice on matters related to the Code of Health and Disability Services Consumers' Rights and legislation that affects the rights of health and disability services consumers.

Output 1: Complaints Resolution

	Performance Measure	Target Date	Actual
	Enquiries		
1.	90% of enquiries answered on day received in 2007/08.	30 June 2008	**Target achieved. 5,288 enquiries responded to (93%).**
	Complaints		
2.	90% of all complaints closed within 12 months of receipt.	30 June 2008	**Target achieved. 1,240 of 1,295 closed (96%).**
3.	DHB practice of open disclosure (OD) surveyed.	30 April 2008	**Target achieved. 21 DHBs surveyed in April. 16 (75%) report practising OD most of the time and 5 (24%) report practising OD some of the time.**
4.	DHB responses to complaints about events since July 2007 are monitored for evidence of open disclosure and attempts to facilitate early resolution.	30 June 2008	**Target achieved. DHB responses to complaints about events between 1 July and 1 April were monitored. Results were inconclusive; monitoring will continue.**
5.	10% of providers who have participated in HDC's complaints process during 2007/08 outline the significant system changes made to improve the safety and quality of health and disability services as a result of the complaint.	30 June 2008	**Target achieved. 31% (62 of 202) of group providers subject to recommendations as a result of a complaint have made significant systems changes. 49% of group providers have made some systems changes.**
6.	All investigations are followed up to encourage 100% compliance with recommendations by providers.	30 June 2008	**Target partially achieved. 99% (219 out of 222) of recommendations complied with. The three providers who did not comply have been referred to their professional bodies for follow-up action.**

Output 2: Education and Promotion

	Performance Measure	Target Date	Actual
1.	60% of informational and promotional information meets best practice standards for accessibility.	30 June 2008	Target achieved. 73% (8 informational and promotional pamphlets out of 11) meet best practice accessibility standards.
2.	DHBs find trend reports useful and describe how they have used the trend information.	30 June 2008	Target achieved. DHBs reported that trend information was useful or very useful. DHBs reported that they used the information to teach staff, improve systems learning, and provide information for clinical boards and Complaints Review Committees.
3.	60% of users of on-line educational resources are surveyed and rate that they find the resources useful.	30 June 2008	Target not achieved. 100% (5) of those who responded to the survey rated the resources useful. The response rate was too low to make this a valid result.
4.	4 consumer seminars held and 80% of consumers responding to a survey rate the seminars as useful to very useful.	30 June 2008	Partially achieved. Three consumer seminars were held: one for Pacific peoples, one for people with an intellectual impairment, and one for older consumers. On average 96% of those who responded to the survey rated the seminar useful or very useful.

Output 3: Submissions

	Performance Measure	Target Date	Actual
	Submissions		
1.	Provide an annual report on the impact of advice given and submissions made, along with the percentage of satisfaction with the quality of our advice and submissions.	30 June 2008	Target achieved. 26 submissions made and recommendations from 7 adopted. 81% (21 out of 26) of people who received our submissions rated that they were satisfied with the quality and relevance of our submissions.

Output 4: Advocacy Services

	Performance Measure	Target Date	Actual
	Advocacy Agreement		
1.	Advocacy Services Agreements are monitored and reported on for compliance.	30 June 2008	Target achieved. Contractual requirements have been met. • 9,008 enquiries have been managed. • 7,584 complaints have been managed. • 3,339 of 3,806 (88%) individual complaints were closed. • On average 93% of closed complaints were partially or fully resolved.
	Promotion and Education		
2.	Compliance with Advocacy Services education targets is monitored and reported on.	30 June 2008	Target achieved. Compliance with education targets met: • 176 case studies completed showcasing quality consumer-centred care, implementation of the Code of Rights and the role of advocates in achieving early resolution. • 2,658 networking contacts were made.
	Training		
3.	Review and report on training undertaken by advocates during 2007/08.	30 June 2008	Target achieved. • Education, Training and Resources Manager appointed. • Advocates taught alternative engagement techniques to better communicate with consumers who are often difficult to reach. • Strengths-based casework training package developed. • Deaf awareness training undertaken by advocates. • Educational training resources for use with people with learning disabilities piloted. • Increased education resources developed for use in rest homes and disability care facilities. • Core strengths-based programme developed for in-house trainers.

Output 5: Proceedings

	Performance Measure	Target Date	Actual
1.	Provide an annual report on decisions made under s49 of the Act.	30 June 2008	Target achieved. 22 cases referred to the Director of Proceedings: • No action taken on 9. • 3 charges laid and were upheld. • 5 have hearings pending. • 5 are being reviewed.
2.	Tribunals are satisfied that 80% of proceedings are high quality.	30 June 2008	Target achieved. The two tribunals have preferred to provide direct feedback to the Director of Proceedings. The success rate of the proceedings team is evidence of high standard: • Total hearings 20. • Disciplinary charges upheld 6 out of 7. • Human Rights Review Tribunal claims upheld 3.5 out of 4. • Successful interlocutory hearings 2 out of 3. • Successful appeals 3 out of 4. • Other appeal — DP consented to order: 1. • Awaiting decision: 1.

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