

# Briefing to the Incoming Minister



Health and Disability Commissioner  
*Te Toihau Hauora, Hauātanga*

**10 November 2020**

# The Code of Health and Disability Services Consumers' Rights

---

Ōu mōtika ina  
whakamahi  
koe i tētahi  
ratonga hauora,  
hauātanga rānei

- 1. Respect**  
Whakamana
- 2. Fair treatment**  
Manaakitanga
- 3. Dignity & independence**  
Tu rangatira motuhake
- 4. Appropriate standard of care**  
Tautikanga
- 5. Effective communication**  
Whakawhiwhitinga  
whakaaro
- 6. Full information**  
Whakamōhio
- 7. Informed choice & consent**  
Whakaritenga mou ake
- 8. Support**  
Tautoko
- 9. Teaching & research**  
Ako me te rangahau
- 10. Right to complain**  
Mana to amuamu



# Key points

## 1. What we do

- HDC is New Zealand's independent watchdog upholding the rights of people using health and disability services.
- We are an independent Crown entity, established by the Health and Disability Commissioner Act 1994.
- We protect and promote the rights of people as set out in the Code of Health and Disability Services Consumers' Rights (the Code), primarily through the resolution of complaints.
- HDC is a high-performing organisation – resolving between 2,200 and 2,400 complaints a year. 76% of complaints are resolved within six months, and 89% are resolved within a year.
- HDC also funds a national advocacy service to promote the Code and support people to resolve complaints directly with their providers. The service receives approximately 2,700 complaints a year and has a particular focus on more vulnerable consumers.

## 2. What we are seeing in the sector

- HDC has a unique lens on the system. The intelligence we gather is grounded in the consumer perspective and reflects the issues that consumers care most about and the realities of health and disability practice.
- The systemic issues HDC is currently focused on are:
  - Recovery from COVID-19
  - Equity
  - Workplace culture and leadership
  - A fragmented system that is under pressure
  - Informed consent
  - New Zealand's response to mental health and addiction
- HDC has a strong focus on services for vulnerable populations, including:
  - Disability
  - Aged care
  - Prison health services
  - Women's health

## 3. HDC's priorities

- Responding sustainably and equitably to growing demand and increasing complexity of complaints, including the impact of COVID-19 (between 2014/15 and 2019/20 there was a 27% increase in demand for HDC's services, with a 15% increase in funding).
- Strengthening our focus on equity and enhancing our contribution to an equitable health and disability system.
- Preparing to become the complaints agency/watchdog for assisted dying.
- Successfully transitioning our monitoring and advocacy function for mental health and addiction services to the new Mental Health and Wellbeing Commission.
- The appointment of a Deputy Commissioner to contribute to governance and decision-making capacity.

# 1. What we do

## New Zealand's independent watchdog for the rights of people using health and disability services

**The Health and Disability Commissioner (HDC) has the unique role of promoting and protecting consumer rights within the health and disability system. This critical function ensures consumers have a voice and preserves trust in the health and disability system. HDC uses its insights and powers to identify and leverage systemic change.**

HDC is an independent Crown entity, established by the Health and Disability Commissioner Act 1994. New Zealand's unique no-fault accident compensation scheme for treatment injury creates a medico-legal environment where HDC is the only practicable independent way for people to ask for a provider's actions to be reviewed, and for that provider to be held to account. HDC's independence – from consumers, providers and government policy – is critical to enable us to be an effective watchdog.

HDC upholds the rights of people as set out in the Code, primarily through the resolution of complaints about infringements of those rights. HDC focuses on fair and early resolution of complaints, and resolves around 2,300 complaints a year. 76% of these complaints are resolved within six months, and 89% are resolved within a year. Resolution can range from receiving an explanation and/or apology directly from the provider, to HDC formally investigating a person's care and finding a provider in breach of the Code.

To address the power imbalance between consumers and providers, and to support people to raise their concerns directly with a provider where appropriate, HDC also funds the independent Nationwide Health & Disability Advocacy Service (the Advocacy Service), which receives around 2,700 complaints a year. Promoting awareness of the rights of consumers is a central part of an advocate's role, with a focus on consumers who are least able to self-advocate and whose welfare may be most at risk.

Every complaint is an opportunity to learn. HDC's work improves the quality of services at both a local and a wider system level. Whether through individual complaints, a pattern of complaints, sector engagement, or public and ministerial reporting, HDC shines a light on areas for improvement, makes recommendations for change, and shares lessons from complaints. In this way, people and the systems in which they work are held to account — individuals learn, systems improve, preventative action is taken, and consumers' rights are protected.

HDC is funded under the Monitoring and Protecting Health and Disability Consumer Interests Appropriation in Vote Health. In the year ended 30 June 2020, HDC received \$12,870,000 from this appropriation and an additional \$500,000 from the Ministry of Health at the end of the financial year. Despite a higher demand for HDC's services and the impact of COVID-19, HDC maintained a high output for complaints resolution in 2019/20, closing a record number of investigations with a small financial deficit. As at 30 June 2020, HDC had 86 staff members (75 full-time equivalents).

## 2. What we are seeing

HDC sits in the margins where things do not go well and as such has a unique lens on the system. We monitor the trends that appear across complaints to target areas of concern within the sector. HDC ensures that these trends are reported back to the sector in a way that supports quality improvement. We regularly liaise with other agencies who have a responsibility for quality and safety, including the Health Quality and Safety Commission, in an effort to ensure that we all have a complete picture. We are committed to working with these other agencies to help ensure we are all using our powers and functions effectively to leverage change.

New Zealand has a high-functioning and well-regarded health and disability system, of which we can be justifiably proud. The system is, however, under pressure, fragmented and facing unprecedented levels of change.

### Systemic issues

The systemic issues HDC is currently focusing on are detailed below. We note that the review of the New Zealand Health and Disability Sector, Hauora Manaaki ki Aotearoa Whānui has identified many of the same issues, and provides a significant blueprint for change.

### Recovery from COVID-19

The impact of COVID-19, and the health and disability system's response to it, is ongoing and will be felt for some time. The system has displayed high levels of resilience and agility, and delivered flexibility and new ways of working together that will have ongoing benefits. However, the pandemic response has also highlighted vulnerabilities of a fragmented system that is under pressure.

Access to services was deferred for many people during the COVID-19 restrictions, as they stayed away from health services and non-urgent care was postponed. A number of complaints we have received about COVID-19 centre on reduced access to care and delayed treatment, including reduced access to primary, secondary and emergency health care. Reduced access to care raises clear equity issues. Clear, consistent and integrated whole-of-system solutions are needed as we respond to the ongoing pandemic and manage the resulting growth in pressure. Mechanisms must be in place to ensure that seamless coordination between providers enables maximum availability of, and access to, services.

A number of the complaints received by HDC regarding COVID-19 relate to the care provided by aged residential care (ARC) facilities during Alert Levels 3 and 4. These complaints highlight the risks in relation to inconsistency of practice across the sector, and the reduced visibility of services provided by ARC facilities. It is important that the update of the Health and Disability Standards (mandatory Standards that apply to hospitals, aged care facilities and some providers of residential disability care services) ensures that they are fit-for-purpose in a post-COVID world, and can provide a mechanism for ensuring that safe and high quality services are consistently delivered during a pandemic when visibility is reduced. These Standards need to take account of the acuity of the aged care population and the management of challenging behaviours in a restricted environment. It is clear that the current

infection control Standard was not far-reaching enough to respond to a pandemic situation. Review of this Standard should be undertaken as a matter of priority to safeguard this particularly vulnerable population group.

Consumers have reported that the COVID-19 pandemic emergency response also had a disproportionate impact on disabled people, many of whom were isolated from their support networks. The lack of respite or day services during this time placed a significant strain on other disability services and informal support networks, and created uncertainty and a sense of helplessness for many. This was particularly significant for those who rely on the support that they receive. Ensuring that the health and disability system can meet the needs of disability consumers and other vulnerable populations must be an essential consideration as New Zealand prepares for any future outbreaks or other emergencies.

### **Trends in complaints about COVID-19**

HDC has been closely monitoring the trends in complaints about COVID-19 related issues.

Between 3 February 2020 (when HDC received its first COVID-19 related complaint) and 30 September 2020, HDC had received 224 complaints about COVID-19 related issues. This equates to around 15% of all complaints received by HDC during that period.

Common issues complained about in relation to COVID-19 are:

- Lack of access to hospital care and/or deferred treatments/procedures
- Inadequate infection control policies or failure to follow such policies
- Visitor restrictions and policies around support people, including communication with family about their relative's condition when they were restricted from visiting
- Inadequate access to primary care
- The manner in which COVID-19 screening questions and infection control policies were communicated to consumers by providers
- Care standards during Level 4 and Level 3, particularly in respect of aged residential care facilities
- Inadequate access to testing for COVID-19 and/or delays in receiving test results

In April 2020 HDC raised equity and patient safety concerns with the Minister of Health regarding aspects of the COVID-19 response, including:

- Inconsistencies around the country in the ways DHBs applied the National Hospital Response Framework, including unwarranted inconsistencies in the degree to which services accepted GP referrals, variable service withdrawals, and inconsistent treatment of patients who had elective surgery cancellations; and
- Reduced health sector activity, levels of unmet need, and the importance of planning for demand – the consequences of which are particularly serious for those for whom early diagnosis and treatment is key to a successful outcome.

## Equity

People in New Zealand have differences in health that are not only avoidable but are unfair and unjust, with Māori experiencing the poorest outcomes. It is encouraging to see that building an equitable health and disability system is a priority for this government.

The complaints we receive highlight differential access to, and quality of care depending on where people live. A number of our complaints point to consumers' concerns about discriminatory attitudes and approaches, and failures by people and services to act in a culturally safe way. This aligns with what we have found in our mental health and addiction monitoring and advocacy work, where there is clear evidence of inequitable treatment for Māori consumers from primary right through to tertiary care, resulting in poorer outcomes overall and a lack of trust in the system. The same issues are also apparent in the disability sector, where despite higher levels of disability for Māori, significant inequalities exist regarding access to services and the quality of care received.

Greater Māori participation and leadership in the design and delivery of services is needed to improve outcomes and better reflect commitments under Te Tiriti o Waitangi. A commitment from leadership at all levels to culturally safe practice is essential.

People's complaints to us also highlight that the way our health system is organised does not work well for those with complex needs, including those with co-morbidities. Siloed services – particularly when they are under pressure – do not see themselves as responsible for addressing people's needs holistically. The system needs to be designed to meet the needs of consumers, rather than the needs of a system under pressure. It is unacceptable that those most in need face the greatest barriers to accessing appropriate care.

## A fragmented system

When we look across the complaints we receive, we see a health and disability system that is complex and fragmented – both locally and nationally. Leadership is not always integrated or collaborative. Access to care and the quality of care available to people differs depending on where they live. In his 2018 report, the Mental Health Commissioner noted the fragmentation and loss of traction in the mental health sector, caused in part by a lack of leadership and coordination. We note that Hauora Manaaki ki Aotearoa Whānui has made recommendations for significant structural change in an effort to address this fragmentation.

Transitions of care are particularly prone to error. Inadequate communication, coordination and integration are often seen at key transition points in a patient's journey. Critical information does not always reach the people it needs to because of failings in administrative processes and systems that do not talk to each other. This can result in people becoming 'lost in the system'. A national electronic patient record would be of significant value.

Common issues that we have seen recently regarding coordination of care include:

- Inadequate follow-up of test results and referral management
- Delays in ED – often exacerbated by patient flow issues and a lack of integration between the ED and rest of the hospital

- A lack of continuity of care for patients seeing multiple GPs
- Coordination of care between aged residential care facilities and primary care and/or hospital services
- Coordination of care for mental health consumers on discharge
- Lack of communication between secondary and tertiary hospitals
- Lead Maternity Carers not adhering to the guidelines for consultation with obstetric and related medical services

## **Workplace culture and leadership**

The impact of the hierarchal culture in medicine continues to be seen in the complaints we receive. Prominent themes in complaints about DHB care include a lack of consultant involvement, inadequate escalation of care and inadequate supervision of junior doctors. These issues can be exacerbated when staffing levels and skills do not match acuity of demand.

A lack of integrated leadership (poor relationships between clinicians and executive management) and a lack of proactive risk management are a feature of cases where a service is under pressure. This can lead to cultures of tolerance developing, where suboptimal practices become normalised. These cultures of tolerance are a common feature of complaints where systemic deficiencies are identified. Collaborative and mutually accountable relationships between clinicians and executive management have a central role to play in the effective delivery of services.

## **A system under pressure**

A quarter of complaints about DHB services involve issues of access or prioritisation. Inadequate prioritisation systems, where patients are not prioritised according to clinical risk, have been a common feature of investigations into treatment delays. Patient prioritisation must be a key focus to manage risk.

Inadequate planning for demand is also seen in these cases. It is important that the sector assesses, plans, adapts and responds effectively to the foreseeable impact that new technology and changing demographics will have on systems and demand.

A common theme that runs through our complaints data is the pressure the health and disability workforce is under – pressure which is growing alongside the complexity and acuity of the population they serve.

A system where pressure has become normalised encourages a culture in which the suboptimal is tolerated and the needs of the system are prioritised over the needs of the patient. These are significant issues as DHBs work to clear backlogs caused by COVID-19 restrictions.

## **Informed consent**

The principle of informed consent lies at the heart of the Code and is the foundation of all medical treatment. However, a lack of information provision and informed consent continues to be a feature of complaints – these issues are raised by complainants in around 15% of the complaints we receive.



When we look across complaints, there are inconsistencies in the practice of informed consent across the health and disability sectors.

Issues around informed consent point to a system that is not truly consumer-centred. In a consumer-centred system people are fully engaged in their own care and information is shared freely. In order to be truly consumer-centred, our health care system needs to be able to meet people wherever they are throughout their health care journey. Care needs to be culturally safe and safeguards must be strengthened for people who are unable to consent, including greater use of supported decision-making for people with impaired capacity.

In November 2019, HDC submitted a report to the Minister of Health recommending changes to the rules governing the circumstances when health and disability research can occur that involves adults who are unable to give informed consent. If introduced, these changes would, with robust safeguards in place, allow some useful research to occur that is currently not permitted.

Currently, health and disability research involving adults unable to consent must, among other things, be in that person's "best interests", as required by Right 7(4) of the Code. While this is an important safeguard for vulnerable people, there is a view that it creates barriers to potentially valuable low-risk research, meaning that some groups could be missing out on improvements and progress in health and disability services. HDC's recommendations to the Minister included that the current "best interests" test remain for treatment and services, but to introduce a new test, with additional safeguards, for research involving adult participants unable to provide informed consent. The test would be that such research could take place only if it posed "no more than minimal foreseeable risk and no more than minimal foreseeable burden" to participants. If introduced, these changes would, with robust safeguards in place, allow some useful research to occur that currently is not permitted.

## **New Zealand's response to mental health and addiction**

There has been significant progress since *He Ara Oranga* was released, particularly around the Ministry's capacity to lead change and the increase in early support available in primary care and investment in kaupapa Māori services. However, New Zealand still has a long way to go to truly transform its approach to mental health and addiction and its ability to meet the need that exists – particularly as we expect this need to increase with the impact of COVID-19. *He Ara Oranga* has set the direction, but much more needs to be done to get us there.

In June 2020, HDC made a number of recommendations to the previous Minister of Health, including the development, by the end of the year, of a clear plan of action to deliver on the approach set out in *He Ara Oranga*. A response to these recommendations, which will be published on our website, was requested by 30 November 2020.

Our report noted that while the shift in focus towards better support for people with mild/moderate needs is important, there is still a pressing need to improve services for people with complex and ongoing needs, including connections to wider social supports. This continues to be evident in the complaints we receive. As well as issues with overall sector capacity, common themes identified in complaints regarding mental health and addiction services include: inadequate risk assessments; inadequate discharge planning; poor communication with family; issues with management of co-

existing problems; treatment of personality disorders; delays in crisis care; and inadequate provision of emergency mental health care in Emergency Departments.

## Population groups

HDC has a focus on services for vulnerable populations, including:

### Disability

Commonly complained about issues regarding disability support services include: a lack of access to funding and services; individual support needs not being met; and inadequate training/skills of staff. These issues are indicative of the need for funding and flexibility in support services to reflect an expansion of choice and control of disabled people over their own lives.

Complaints about home and community support services are becoming more common, and generally relate to the availability of the service and its staff (e.g. communication issues with the call centre and staff not turning up at prescribed times). These issues are of particular concern for vulnerable consumers who rely on the care provided to them by support staff. We also have concerns about the ability of people to access timely needs assessment services to obtain the support they require.

### Aged care

Systemic issues of concern in this sector include:

**Appropriate standards of care and skills of staff:** Residents are entering residential aged care facilities with high levels of dependence and complex healthcare needs. The aged care workforce is under pressure, and the skills mix of staff within these facilities does not always reflect this complexity and acuity. It is important that the update of the Health and Disability Standards takes into account the needs of residents with higher levels of acuity. It may be that a separate set of Standards for dementia care is warranted. Additionally, inadequate provision of end-of-life care is a growing trend across aged care complaints. Residential aged care facilities are increasingly expected to provide end-of-life care services, and it is important that staff are appropriately trained in end-of-life care, and that they are supported to maintain close links with palliative care teams.

**Dementia care and management of challenging behaviours:** People with dementia are particularly vulnerable, and often lack the ability to self-advocate. Issues in complaints about their care highlight concerns around the informed consent processes for the use of restraint and medication management, including obtaining consent from the person's Enduring Power of Attorney (EPOA). Additionally, we have concerns about the responsiveness of the EPOA enactment process. This process can be very convoluted and can result in people with declining capacity being kept in inappropriate facilities for too long.

**Home care support services:** Complaints about home care services often reflect complainants' concerns about the skills and responsiveness of this workforce. While HDC is supportive of older people being helped to maintain their independence, the reduced visibility of services being provided by home care support staff can place consumers at greater risk.

## **Prison health services**

There has been a recent increase in the number of complaints received about prison health services. Prisoners are particularly vulnerable as they have little to no control over their own care, and tend to have high and complex health needs which can be exacerbated by incarceration.

Common themes identified in complaints about prison health services highlight some of the tensions between custodial priorities and the provision of best practice health care, and the artificial disconnect between the prison and community settings. They include: inadequate medication management processes; delays in prisoners receiving medical care; delay/failure to escalate care; lack of communication with secondary care/prisoner's community GP; and inadequate coordination of care during prison transfers.

HDC meets quarterly with the Department of Corrections to update them on themes arising from complaints. We are encouraged by their focus on improving health services for prisoners, and note the progress they have made toward providing appropriate treatment for people with mental health and/or addiction issues. However, we have significant concerns about the capacity of forensic mental health services, which has not kept up with the increasing need and number of people requiring forensic care.

## **Women's health**

HDC has received a number of complaints indicating pressure on women's health services across a number of DHBs. Additionally, the complaint profile for maternity is more serious than for other services, and common themes recur. We are currently drafting a report which will detail an analysis of our maternity complaints and associated recommendations to the sector.

The two most common recurring themes regarding maternity care are inadequate fetal heart rate monitoring and interpretation, and lack of adherence by LMC midwives to Ministry of Health guidelines (Referral Guidelines) for when a woman should be referred to a specialist. We have made a number of recommendations around the need for mandatory multi-disciplinary fetal surveillance training.

The Referral Guidelines are an essential safety net for women. These guidelines were due to be updated in 2017, and this has not occurred. HDC has discussed with the Ministry the need for this to occur as a matter of urgency. HDC has also discussed with the Ministry a need to make mandatory the provision of information to women about when a specialist referral is warranted, so that all women can make an informed choice about their care.

Other common themes in maternity care include informed consent and discussion of a woman's options during labour; assessment and management of fetal growth; coordination of care between LMCs and secondary care; monitoring of the baby's blood glucose levels postnatally, midwifery and obstetric staffing levels; and theatre availability for obstetrics.

We are pleased to see that improving maternal mental health is a priority. Mental distress during this period is common and can have significant impacts on the whole whānau, including the death of the mother and lifelong issues for the child. It is essential that this work develops solutions that work for Māori, includes a focus on addiction, and increases integration between maternal and infant services.

# 3. HDC's Priorities

Morag McDowell took office as the Health and Disability Commissioner on 7 September 2020. Her two immediate priorities on taking the office are strengthening HDC's equity approach and reducing delay in the complaint resolution process.

## **Responding sustainably to growing demand and increasing complexity of complaints**

There continues to be a steady rise in the number of complaints to HDC. Between 2014/15 and 2019/20 there was a 27% increase in demand, with a 15% increase in funding. Funding pressure in 2020/21 has been partially alleviated by a one-off funding of \$1 million from the Ministry of Health to address additional pressures created by the COVID-19 pandemic. HDC anticipates ongoing growth in both volume and complexity of complaints. Given our financial constraints, the impact of this, compounded by the continuing effects of COVID-19 and the future enactment of the End of Life Choice Act, will put significant pressure on the time it takes to assess, investigate, and resolve complaints.

HDC strives to ensure that all complaints are resolved in a fair, simple, speedy and efficient way. To achieve this, we work closely with the Ministry to ensure that we have the capacity to respond growing demand sustainably, and continue to be innovative and open to new ways of working in order to tackle complex matters and further increase efficiencies while maintaining quality and enhancing HDC's impact on the health and disability system.

Additionally, ensuring critical communications and analytical and policy capacity would enable HDC to proactively investigate, report, and influence decision-makers on areas of significant ongoing service and system-wide concern.

## **Strengthening our focus on Equity**

HDC was established to address the power imbalance that exists between consumers and providers by ensuring people have a say in their care and an impartial avenue for challenging the actions of those providing it. We provide an important platform for equity issues to be raised and addressed – both locally and system-wide.

Our ability to contribute to equity within the health and disability sector relies on us making sure that the way we operate is equitable. Strengthening our own approach and enhancing our contribution to an equitable health and disability system is HDC's current priority.

HDC affirms Te Tiriti o Waitangi and the importance of working with Māori, and working in ways which work for Māori, to achieve equity. While we want to make sure that we are accessible, acceptable and responsive to anyone who wants our help, we will continue to focus on ensuring that the way we do things works for those who are most at risk of poor treatment and outcomes, and those less able to advocate for themselves. Work currently under way or in development includes:

- Strengthening HDC's data collection, analysis, monitoring, and reporting of matters relating to equity

- Enhancing staff training to support cultural safety and responsiveness
- Working with more vulnerable consumers to understand how we can better promote and protect their rights
- Tailoring engagement and resolution to the needs of Māori and less advantaged consumers
- Developing accessible materials to support consumers of disability services to understand their rights and make complaints
- Focusing on systemic issues for vulnerable populations, including in relation to mental health and addiction, disability, aged care, and people in prisons.

### **Preparing to become the watchdog for assisted dying**

With the majority of the public voting to enact the End of Life Choice Act in the recent referendum, HDC's mandate will expand to cover assisted dying from November 2021. Complaints are likely to be sensitive and complex, focused on issues such as informed consent, coercion and capacity, and are potentially less likely to involve the consumer directly. Our initial decisions will set a precedent and provide direction for the sector, and are likely to be the subject of significant media and public interest. Playing our role effectively will have a significant impact on HDC's capacity, particularly if we need to target promotional activity to those most vulnerable, undertake a Commissioner's initiated inquiry and/or take proceedings.

### **Supporting the successful transition of our monitoring and advocacy function for mental health and addiction services to the new Mental Health and Wellbeing Commission**

The Mental Health and Wellbeing Commission Act 2020 will come into force by 9 February 2021, establishing a permanent standalone commission which will take on the Mental Health Commissioner's monitoring and advocacy function, within a broader wellbeing mandate. HDC will continue to consider and resolve complaints relating to mental health and addiction services, and to assess and respond to systemic issues arising from complaints.

The new Mental Health and Wellbeing Commission will play a critical role in holding government and other decision-makers to account for the mental health and wellbeing of people in New Zealand, and its successful establishment will be a key milestone for the implementation of *He Ara Oranga*. HDC is working closely with the initial Mental Health and Wellbeing Commission to support a successful transition, and meets regularly with them and their secretariat to share data, insights, networks and our experience developing a monitoring framework for the sector.

Following a recommendation in *He Ara Oranga*, HDC is currently working with tangata whaiora, whānau and providers to enhance understanding and observance of the Code in the mental health and addiction sector.

# 4. Key People



## **Health and Disability Commissioner**

Morag McDowell

Appointed: September 2020

Morag took up the Commissioner role after serving nearly 13 years as a Coroner. She was formally a Crown Prosecutor, Director of Proceedings at HDC and a Senior Legal Advisor at Crown Law. Morag is committed to promoting and protecting the rights of health and disability services consumers, and strongly values fair, timely, transparent and culturally appropriate processes, where people are engaged and given the opportunity to be heard.



## **Deputy Commissioner, Disability**

Rose Wall

Appointed: August 2013

Rose, who is a nurse by training, has been involved in the public health system for most of her career, and has worked in a number of different areas. This has given her a broad insight into service quality, government strategy, the regulatory environment, and how the health and disability system works. Her role at HDC fulfils her natural desire to help people, particularly the more vulnerable who are less able to speak for themselves.



## **Mental Health Commissioner/Deputy Commissioner**

Kevin Allan

Appointed: February 2016

Kevin is committed to helping ensuring that everyone has the opportunity to participate in the community and have access to high quality health, disability and social services. He came to HDC after three years as Deputy Chief Executive/Chief Operating Officer at the Crown Law Office, and prior to that held senior leadership roles in the health, disability and justice sectors. Kevin holds a Bachelor of Laws degree from the University of Canterbury.