HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

E.17

Learning from complaints

Annual Report for the year ended 30 June 2007

CONTENTS

1 Commissioner's Report
3 Complaints Resolution
11 Report of the Deputy Commissioner, Education & Corporate Services
17 Legal Services
19 Report of the Director of Advocacy
23 Report of the Director of Proceedings
27 Financial Statements
27 Financial Commentary
28 Expenditure by Output
29 Statement of Responsibility
30 Audit New Zealand Report
32 Statement of Financial Performance
33 Statement of Financial Position
34 Statement of Movements in Equity
35 Statement of Cash Flow
36 Statement of Accounting Policies
38 Notes to the Financial Statements
43 Statement of Service Performance
43 Output Class 1: Service Delivery
43 — Output 1: Complaints Resolution
44 — Output 2: Education and Promotion
45 — Output 3: Policy Advice
46 — Output 4: Advocacy
46 — Output 5: Proceedings

Presented to the House of Representatives Pursuant
to Section 198(1) of the Crown Entities Act 2004

21 September 2007

The Minister of Health
Parliament Buildings
WELLINGTON

Minister

In accordance with the requirements of section 198(1) of the Crown Entities Act 2004, I enclose the Annual Report of the Health and Disability Commissioner for the year ended 30 June 2007.

Yours faithfully

Ron Paterson
Health and Disability Commissioner

PO Box 1791, Auckland, Level 10, Tower Centre, 45 Queen Street, Auckland, New Zealand
Ph/TTY: 09 373 1060 Fax: 09 373 1061, Toll Free Ph: 0800 11 22 33, www.hdc.org.nz

Vision

Champions of consumers' rights.

Wawata

Kai kōkiri i nga tika kai hokohoko.

Mission

Resolution, protection, and learning.

Whainga

Whakataunga, whakamaru me te akoranga.

COMMISSIONER'S REPORT

Key features of 2006/07 were:

- A dramatic increase in the volume of complaints
- 98% compliance with HDC recommendations
- Advocates visited 98% of rest homes
- 100% success rate in Proceedings
- Greater openness in the health sector
- A much higher media profile for HDC's work

Ron Paterson
Commissioner

Introduction

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 are a public watchdog — we seek to 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 2006/07.

Complaint Outcomes

The volume of complaints received by HDC increased by 20%, 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 fewer cases (89 in total) leading to a formal investigation. In cases where we made specific recommendations of changes in a provider's practice, we followed up and achieved 98% 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. For the first time, there is a single national contract for the Advocacy Service. Increased funding saw five more advocates on the ground (36 in total around the country).

At the other end of the complaints spectrum, in 19 cases (36% of investigations with a breach finding) a provider was referred to the Director of Proceedings to consider further proceedings, because of major shortcomings in care or unethical practice. In 2006/07 the Director achieved a remarkable 100% success rate in disciplinary hearings.

Improving Quality of Care

In the words of Atul Gawande, "Though we traditionally associate significant improvements in healthcare with the big break-throughs in science — such as transplant surgery and gene therapies — much the biggest gains are likely to come from the *close attention to the detail of failure*." Two major HDC cases in 2007 spotlighted areas for improvement.

In case 05HDC17139, 82-year-old Mervyn McAlpine, a diabetic patient, died in hospital in August 2004 after a medication mix-up. Three unpaginated and unidentified pages relating to another patient's medication were affixed in error to Mr McAlpine's one-page referral after it was faxed by his GP to the hospital. The case has given impetus to the need to develop a national policy for medication reconciliation as a key plank in improving medication safety.

In case 05HDC11908, 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: individual staff and the hospital system failing to respond to signs of a deteriorating patient; a lack of compassion for the dying patient; and a lack of candour with his family (and the Coroner) after his death. The case was a wake-up call to district health boards as a result of two novel features: Capital & Coast DHB was referred to the Director of Proceedings (leading to a confidential settlement); and all DHBs were required to report to HDC on their own systems for keeping patients safe.

These and other HDC cases (accessible on our website, www.hdc.org.nz) were widely reported in the media and discussed in the health and disability sectors. From 1 November 2006 HDC adopted a practice of naming public hospitals and district health boards found in breach of the Code (in reports that identify systemic concerns). This was a conscious decision to promote greater transparency and accountability in the publicly funded health system. It is heartening to see providers recognising the benefits for everyone of open disclosure when things go wrong — a move that HDC has promoted by surveying all DHBs and providing guidelines on open disclosure.

There continue to be significant challenges in co-ordinating efforts in New Zealand to reduce the burden of unintended harm to patients, but there are some hopeful signs. Two encouraging developments are the recent announcement of a major medication safety initiative, and the appointment of a Quality Improvement Committee (QIC) to lead safety and quality efforts nationally. Director of Advocacy Judi Strid is a member of QIC, providing a key link with HDC.

Educational Initiatives

This year again saw a broad array of educational initiatives undertaken by HDC staff and advocates. As part of our commitment to improving the quality of care, we launched a booklet entitled *The Art of Great Care* (at a conference on "Putting Patients First", jointly organised by the University of Auckland and HDC) in which 14 patients tell their stories of receiving great care. We developed a new DVD, *Making it Easy to Do the Right Thing*, for use by disability service providers. We organised a highly successful medico-legal seminar in Wellington, attracting 200 practitioners.

Six seminars in Whangarei, Auckland, Wellington and Blenheim with targeted groups of consumers focused on putting the Code of Rights into practice, and provided valuable feedback on what consumers need and how HDC can advocate for their concerns. Under the leadership of Deputy Commissioner Tania Thomas, HDC is undertaking a range of disability initiatives and promoting the rights of disabled consumers. As part of an outreach to vulnerable consumers, advocates visited 98% of all rest homes in New Zealand.

Reaching the wider community and educating the public about their rights remains a challenge. 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. A town hall meeting with the community on the Chatham Islands prompted lively debate.

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. Our widely circulated quarterly e-bulletin, *HDC Pānui*, provides regular updates on our work. 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. A marae teaching session with rural hospital medical officers in the Hokianga was a personal highlight in 2006/07. I met with all DHB chairs and CEOs; visited Northland, Auckland, Bay of Plenty, Tairawhiti, Whanganui, Hutt Valley, Capital & Coast, and Otago District Health Boards; presented at national meetings of medical specialists and mental health providers; at international conferences of medical regulators (in Wellington) and Australasian Complaint Commissioners (in Melbourne); and (with Dr Marie Bismark) to the Health Council of Canada (in Fredericton, New Brunswick) on New Zealand's "no fault" compensation and complaints handling systems.

Acknowledgements

As I complete my second term as Commissioner, I wish to record what a privilege it has been to lead HDC and to serve the public of New Zealand in this role since 2000. 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 important work.

COMPLAINTS RESOLUTION

A huge influx of new complaints — 1,289 — gave us the biggest tally in five years. This meant an exceptionally busy, and challenging, year for Complaints Resolution staff. Nonetheless, it was very successful. Some of the cases we resolved had far-reaching implications for health and disability services. For the first time, we have formally monitored compliance with all HDC recommendations. We achieved a high rate of compliance (98%), with many examples of quality and safety improvements resulting from complaints to HDC.

Rae Lamb
Deputy Commissioner,
Complaints Resolution

Complaints

There were 1,273 complaints closed during the year, using the full range of resolution options available to the Commissioner under the HDC Act 1994. Each one was carefully considered and, where necessary, additional information obtained, including independent expert clinical advice. The focus was on resolving matters at the most appropriate level, in a fair and timely way.

The types of provider most commonly complained about were:

Individual Provider		Group Provider	
General Practitioner	28%	Public hospital	60%
Physician	7%	Rest home	9%
Midwife	7%	Medical centre	4%
Dentist	7%	Prison service	3%
Nurse	6%	Pharmacy	3%

Complaints were addressed in the following ways:

Outside Jurisdiction

Every complaint is initially assessed to determine whether it falls within the Commissioner's jurisdiction. Last year 154 complaints were closed because they were outside jurisdiction, for example, they related to access to services or to funding issues. Wherever possible, those people were given contact details for alternative sources of assistance.

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

	2006/07	2005/06	2004/05
Open at year start	279	313	347
New during year	1,289	1,076	1,124
Closed during year	1,273	1,110	1,158
Open at year end	**295**	**279**	**313**

Advocacy

One hundred and forty-nine complaints to HDC were closed after referral to the Nationwide Health and Disability Advocacy Service. In 63 cases, the Commissioner made a formal referral requiring a report back from the advocate. In 86 cases, the consumer was given information about the advocacy service and contact details, and encouraged to address his or her complaint in this way. Copies of the information were also sent to the advocacy service.

Complaints where communication is a key issue, where there are ongoing relationships to maintain, where consumers need immediate help, or where organising a face-to-face meeting seems sensible are particularly suitable for referral to advocacy.

FORMAL ADVOCACY REFERRAL — HOSPITAL NURSING

Two women complained about how the nurses treated their late mother prior to her death, when she was very ill in a public hospital. They felt that the nurses were uncaring and bullying. They had complained to the DHB but were unhappy with the response.

The Commissioner formally referred the matter to advocacy so that an advocate could help them to resolve the matter directly with the DHB.

The advocate reported back that a meeting had been held between the women and the DHB, and agreement reached about follow-up action. The women were particularly pleased that the DHB had agreed to compile an information booklet for families wishing to stay with someone in palliative care, and outlining the available services and support. (Case 06HDC14242)

INFORMAL ADVOCACY REFERRAL — RESIDENTIAL HOME NURSING

A man, Mr E, complained about an unnamed nurse at a residential home for disabled residents. He felt that the nurse was rude to ask about his weight loss and had invaded his personal space by telling him to take his pills and not allowing him first to butter his toast.

After complaints resolution staff telephoned the man to discuss his complaint, the Commissioner asked the advocacy service to contact Mr E and help him with his concerns. Both the advocacy service and Mr E were written to, and the HDC file was closed. (Case 07HDC03829)

Section 38(1)

Section 38(1) of the Act gives the Commissioner the discretion not to investigate, and to take no further action on a complaint if, having regard to the circumstances, he believes it is unnecessary or inappropriate. This option is frequently used to promote learning from complaints where matters do not meet the threshold for a formal investigation, or where an appropriate outcome can be achieved without investigation, in a more flexible and timely way.

It is also used to close complaints when the Commissioner decides that no further action is required because there is no apparent breach of the Code of Health and Disability Services Consumers' Rights (the Code). Occasionally complaints are closed because so much time has elapsed since the events occurred that it is not really possible to address the complaint.

Six hundred and seventeen complaints were closed under section 38, taking, on average, 10 weeks to close. In most cases, a lot of work was done on the complainant's behalf as information was gathered and assessed. Where appropriate, the information was reviewed by a clinical expert. As a result, many providers were sent "education letters" highlighting concerns raised by the complaint and aspects of care needing review. They were frequently asked to apologise; and in about 10% of these cases, other follow-up action was requested, for example, reporting back on changes that had been recommended or that were underway.

SECTION 38 CLOSURE — REST HOME CARE

Mrs A complained that a rest home had taken almost six months to respond to her repeated concerns about a growth on her husband's ear. When he was finally referred to a specialist, the growth was found to be cancerous, and the ear had to be removed. Mrs A felt that the rest home had not taken her seriously.

The Commissioner sought a response and the medical records. When the rest home supplied only the records and no response, he wrote again seeking answers to specific concerns raised in the complaint. He said that the initial response was inadequate. The rest home replied in more detail, outlining its investigation into the matter. It accepted that doctors' visits were poorly co-ordinated, the system was fragmented, and there had been a two-month delay in first documenting Mrs A's concerns. It outlined a plan of action to address these deficiencies, and provided apologies from both the rest home and one of the doctors involved.

The Commissioner's clinical advisor, a general practitioner, reviewed the response and the notes. He confirmed shortcomings in the clinical care, documentation, and systems, which had been identified by the rest home investigation and were being addressed.

The Commissioner requested an update, within two months, on the remedial action to be taken, and he referred the matter to the District Health Board and the Ministry of Health. He recommended that the Ministry undertake a special audit of the rest home. The complaint was then closed because no further action was considered necessary. Mrs A was happy with the way her complaint was handled. The Commissioner subsequently met with the CEO of the company that owned the rest home, to discuss quality of care issues, and visited the rest home. (Case 07HDC05818)

SECTION 38 CLOSURE — DISABILITY SUPPORT SERVICES

Miss C complained about the way in which an agency providing disability support services had withdrawn services from three elderly relatives. The family had addressed its concerns directly with the agency and were unhappy with the response.

The Commissioner asked the agency to explain how and why the services were withdrawn, and the process followed in dealing with the family's complaints.

After assessing the response, the Commissioner decided that the matter had not been handled appropriately. He wrote to the agency highlighting the unsatisfactory aspects of the response to the family's complaint (such as the tone). He reminded the agency of its responsibility to facilitate the "fair, simple, speedy, and efficient" resolution of complaints in accordance with Right 10, and that "mutual respect is a basic tenet" of the Code.

The Commissioner requested that a letter of apology be sent to the family. Copies of the complaint and the Commissioner's letter were sent to the Ministry of Health's Disability Services Directorate. The complaint was then closed under section 38. (Case 07HDC02979)

Referrals to Other Agencies

The Commissioner can refer complaints to other agencies such as the Medical Council of New Zealand, or statutory officers such as the Privacy Commissioner. He most often uses this power to refer matters raising competence or professional conduct issues, for review by the registration boards. In 2006/07, 126 complaints were closed after being referred to other agencies.

Investigations

An investigation determines whether or not there has been a breach of the Code. It is a formal, legal process, which can take 12 months or, in a very few cases, longer. As explained above, not all potential breaches are investigated because often appropriate outcomes can be achieved using the other options under the Act.

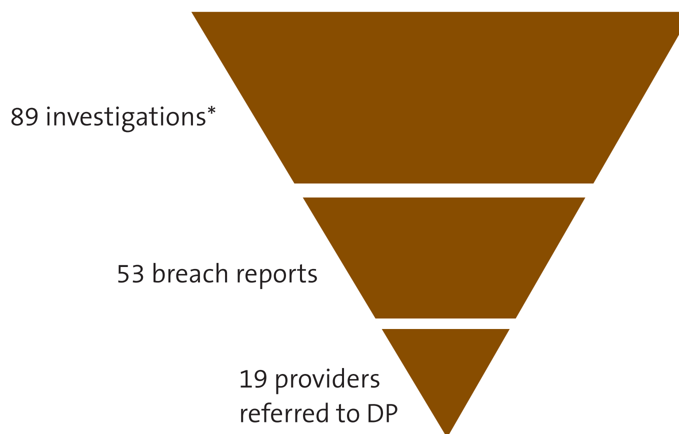
Complaints that are formally investigated involve potentially major breaches of the Code, for example, allegations of sexual impropriety and other behaviour involving serious breaches of ethical and professional boundaries, and significant lapses in standards of care that resulted in death or severe disability. 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.

Eighty-nine investigations were concluded last year, with 60% of these (53) finding breaches of the Code. The number of investigations has been dropping in recent years, but the high proportion of breach findings shows that this option is increasingly reserved for the most serious matters. Additionally, more than one in three breach findings (36%) last year resulted in providers being referred to the Director of Proceedings for disciplinary action to be considered.

During an investigation, the Commissioner may decide to take alternative action. An investigation may be discontinued because, for example, it becomes clear that the issues have been identified and the concerns appropriately addressed, or because expert clinical advice indicates that the care was, in fact, reasonable. Last year, 23 investigations were discontinued; eight were closed when the providers were referred to their registration boards; and three were resolved after referral to mediation. Two investigations found no breaches at all.

Just over half (54%) of the investigations were finished within a year, and all but three were closed within two years. The complexity of the issues, and the need to seek outside expert clinical advice and to be fair to all parties, may delay the process. We are committed to reducing investigation times, with the aim of concluding most within a year.

Figure 1: **Outcome of investigations 2006/07**



*this includes 25 discontinued or "no breach" findings; 8 closed after providers referred to registration boards; 3 resolved by mediation.

Referrals to Providers

HDC frequently receives complaints that have not been drawn to the attention of the provider. This may be for good reasons, such as a breakdown in the relationship. However, in some cases it is obvious that the matter could be sorted out between the parties because the provider can respond directly to questions and take appropriate action. Many District Health Boards have well-established complaints processes. Last year, 18 complaints were resolved after HDC referred them to providers. The providers were required to report back on how they resolved the complaint; and the consumers were offered advocacy support during the process.

SECTION 34 REFERRAL TO PROVIDER — DIABETES CLINIC AND DISABLED CONSUMERS

A District Health Board is changing its booking confirmation system for patients, following HDC's referral of a complaint.

Mr D complained that the DHB's diabetes clinic did not acknowledge that brain injury and hearing impaired patients might not be able to telephone to confirm appointments. This was a problem for him, and he asked that fax and email options be provided on the appointment form.

HDC referred this complaint to the DHB, which reported back that fax numbers had been added to correspondence for bookings at the diabetes clinic, and an email address was being set up for patients to use. These changes were also being applied to booking and scheduling for other hospital services.

The DHB said that the complaint allowed it to address a shortfall, and the changes would benefit other people experiencing difficulties using telephones to communicate with the public hospital services.

(Case 07HDC04333)

MEDIATION — SLEEP STUDY

Mrs B complained about a seven-month delay her late husband experienced when he was referred to a sleep study, and a further 10-month delay before the results were reported. Mr B had multiple, serious health problems, and the sleep study results arrived after he had died from a heart attack. The results showed that Mr B had also had severe obstructive sleep apnoea. There was no cover letter explaining the results or providing follow-up information.

Mrs B wanted assurance that improvements had been made to prevent other patients from experiencing similar delays. She also wanted to know whether a more timely referral, and better reporting procedures, would have meant earlier medical intervention, and made a difference. In response, the providers acknowledged that there had been delays, and that there had been deficiencies in Mr B's care, and they apologised for the distress this had caused.

With Mrs B's agreement, the Commissioner referred the matter to mediation. This was thought to be a good way of addressing Mrs B's questions and the changes she sought.

As part of the settlement, the providers agreed to advise Mrs B and the Commissioner on changes to their processes. As a result, several changes were made to the way patients were referred; new diagnostic equipment was purchased and staff training provided; and sleep study results were actively followed up and sent to patients with a management plan or closure letter. The process for managing patients with sleep disorders was actively monitored.

The Commissioner carefully reviewed the changes made and confirmed that he was satisfied with these measures, as was Mrs B. (Case 06HDC01682)

Mediation

As mentioned previously, three investigations were resolved after being referred to mediation last year. A further 11 complaints were successfully mediated.

This is an option HDC would like to use more frequently. It is free to the parties, and provides an impartial forum where concerns can be explored, and agreement reached about what needs to happen. The meetings are run by independent, trained mediators. Experience suggests that this is an effective way of resolving difficult and complex matters. The challenge is in getting the parties to agree to it.

A mediation seminar held in May 2006 has been followed by work exploring the potential for "patient safety statements" arising from mediations. Training opportunities for mediators and complaints resolution staff are planned for early in the 07/08 year.

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, 109 complaints were closed in this way.

Table 2: **Complaints closed**

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

1 "No apparent breach of the Code" is no longer logged as OJ; it is now logged as s 38.
2 Includes formal (63) and informal referrals (86) — see text.
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.
5 See text. Also now includes "no apparent breach" (see fn 1).

Recommendations

All recommendations are followed up by a Complaints Liaison Co-ordinator. These include recommendations from complaints not formally investigated. Updates are required until it is clear that the recommendations have been met. We also seek reports from the registration boards on the outcome of referrals.

One hundred and twenty-seven complaint files resulted in recommendations last year. Systems and documentation reviews, changes in practice, and specific initiatives to address identified failings were among the range of recommendations. In some cases more than one recommendation was made. An apology was commonly requested.

Recommendations most commonly refer to the following issues:

1. Need to review or change policies, procedures, systems or practice
2. Training and supervision of staff
3. Communication
4. Standard of documentation
5. Informed consent.

MAKING A DIFFERENCE — RECOMMENDATION OUTCOMES

The international pharmaceutical company Roche Products Ltd is looking at the feasibility of changing the labelling of Recorman pre-filled syringes, after an investigation highlighted packaging concerns.

This medication is available in two strengths, and there is similar labelling on the boxes. This similarity was not seen as a major factor in the dispensing error that led to the pharmacy and the pharmacist being found in breach of the Code. However, the Commissioner wrote to the company, drawing attention to the matter and recommending a review of the labelling.

As a result, Roche's New Zealand representatives contacted their office in Switzerland. A process to investigate the feasibility of amending the product labelling has begun, and the company has undertaken to advise the Commissioner of any changes. (Case 05HDC03953)

Hepatitis patients on interferon (drug) therapy at a large district health board are now being given more information about the risk of suicidal ideation, and patients are being more closely monitored. Those who have been using illicit drugs may also face random testing for substance abuse.

This follows an investigation by the Commissioner into the care provided to a man who died from a drug overdose soon after his participation in the interferon programme was stopped because he had resumed using illicit drugs.

The investigation was discontinued because, after reviewing the evidence, the Commissioner took the view that generally adequate information and care had been provided. However, he asked the providers to respond to specific concerns and suggestions from the family about how the service could be improved.

In response, the providers made several changes to the management of hepatitis patients on interferon therapy. Information about the risk of suicidal ideation was added to material about potential side effects given to, and discussed with, patients; the pharmaceutical company was asked to add this information to its DVD about the drug; screening for substance abuse during interferon therapy is under consideration; and random testing for those suspected of relapsing during treatment has been introduced. Additionally, follow-up appointment times have been extended to allow for more comprehensive mood assessment, and changes have been made to ensure more systematic use of measures to better assess and monitor the mental state of patients. (Case 05HDC15778)

Dying patients and their families at a large public hospital have access to better written information about what to expect, following a complaint from one family.

The family complained that while the care of their late father was adequate, they expected a higher standard of care, and the advice and support given to the family was substantially inadequate.

After reviewing the information and seeking expert clinical advice, the Commissioner closed the complaint under section 38 of the Act on the basis that reasonable care and support had been provided. However, he asked the District Health Board to follow up on improvements promised in response to the complaint.

The DHB apologised to the family and introduced a number of changes. They have begun phasing in a pathway to guide medical and nursing staff caring for dying patients. An easily understood, plain language pamphlet has been developed for patients and their families, providing information on aspects of the dying process, what may be involved, and how issues like pain are managed. Families are encouraged to share concerns with doctors or nursing staff as issues arise. Other consumer information and staff training initiatives are ongoing, and will be reported to the Commissioner. (Case 06HDC01884)

A rest home has completely changed its medication administration system following a complaint that an elderly woman was given another resident's medication in error and spent two nights in hospital.

The rest home apologised immediately and took steps to prevent a repeat of the error. However, the complainant asked the Commissioner to supervise the changes and to ensure a similar mistake did not happen to someone else.

The Commissioner wrote to the rest home highlighting concerns identified by the complaint and asking for a report on steps taken to ensure the safe administration of medications, details of training that had taken place, and the timetable for a regular review of policies and procedures. The letter was copied to a Ministry of Health/District Health Board regional working group dealing with complaints about residential care services.

In response, the rest home provided evidence that it has implemented in-service training for staff in relation to managing difficult behavior; it has made written material about its policy and procedures more accessible to staff, with regular reviews scheduled; a new medication chart has been introduced, which includes the resident's photo and a description of the prescribed drugs, their side effects and use; the new registered nurse has undertaken medication training; and further training for all staff has been organised with a local pharmacy. The medication administration competency of staff is being tested, and the results recorded and monitored. (Case 06HDC06070)

Recommendations from 97 files were due by 30 June. In 95 cases, providers have complied, and most recommendations are fully completed. Two individual providers, involved in two separate complaints, have not complied. One is a doctor who was investigated and had breached the Code. She has not responded to recommendations that she review her practice and apologise, and she has been referred to the Medical Council. The other is a pharmacist asked to change the Standard Operating Procedure (SOP) after a dispensing error. The Commissioner is not satisfied that the changes are sufficient and has referred the pharmacist to the Pharmacy Council.

Enquiries

A greater than expected number of enquiries (7,444) were recorded last year, but caution is needed in interpreting these figures as some of the increase is thought to reflect the introduction of a new telephone system, and differences in the way calls are logged.

Most enquiries are made by telephone. Calls logged as "enquiries" range from requests for speakers or information about providers' obligations or consumers' rights under the Code, through to requests about how to make a complaint. Ninety-six percent of enquiries were closed on the day they were received. Eighty-seven percent of written enquiries were responded to within a month.

Ngā mihi mahana ki a koutou katoa.
Warm greetings to you all.

The Deputy Health and Disability Commissioner's team has the following responsibilities: *Education*, including HDC's educational and promotional activities; *Corporate Services*, including the management of finance, information systems, and human resources; and leading HDC's work for *disability services consumers* and *Māori*, and in the areas of *allied health* and *prison health*.

Tania Thomas
Deputy Commissioner,
Education & Corporate Services

Education

Consumer Seminars

Six consumer seminars were held during the year. Each seminar focused on specific consumers: youth consumers, older persons, intellectual impairment services consumers, Māori health and disability services consumers, Pacific Islands consumers, and mental health services consumers.

Consumers who attended the seminars voiced the following needs:

- to feel safe and supported to make a complaint or to raise a query
- to be treated fairly and with respect
- to be involved in their own care and the services they receive
- to be communicated with clearly and in a timely manner
- to have information explained so that it can be understood
- to have easy access to an advocate
- to be safe
- to use promotional materials and resources that are better aimed at specific audiences
- a faster response to home modification services
- more accurate, responsive and timely needs assessment services
- personal and home care services that are reliable and caring
- more sign language interpreters
- to have their cultural values and beliefs respected
- for providers to see past the labels consumers are saddled with
- to put the patient first
- to reduce the number of people involved in obtaining a service
- for providers to be more flexible and creative in the design and delivery of services so that they truly meet the needs of the consumer rather than using "one size fits all" programmes
- better quality and increased options for respite care.

The challenge for HDC is to find ways to respond and act on the myriad of ideas and issues raised in the consumer seminars, so that consumers have confidence not only that they have been heard, but that their feedback will in some way be acted upon.

Consumer Advisory Group

The membership and terms of reference of the Consumer Advisory Group has been reviewed. The group's size will be increased by having three distinct segments within the advisory group: Māori, health and disability. There is a need for more in-depth knowledge and experience as well as a wider perspective from consumers in these three areas. A Māori perspective is now provided by the Iwi Advisory Group within the Consumer Advisory Group. Recruitment of consumer advisors to the broader health and disability advisory groups within the Consumer Advisory Group began in June 2007.

New Resource for Providers

A new educational resource — a DVD *Making it Easy to Do the Right Thing* — has been developed by HDC in association with the Diversityworks group to help providers increase their responsiveness to people with impairments, and to understand the issues they need to consider when working with disabled service users.

The package offers tools and strategies for implementing inclusive, respectful and non-discriminatory practice, helping to ensure that the provider's service supports and protects the rights of disabled people as set out in the Code. It is designed for use in group interactive learning situations (such as provider professional development), as well as individual study. The DVD is also providing a useful resource in provider training settings.

Provider Education

In collaboration with HealthCare Providers New Zealand, HDC has developed training programmes aimed at the specific needs of nurse managers, registered nurses and caregivers working in residential care facilities nationwide for delivery by trained advocates at regional locations. To date, more than 300 providers have attended these sessions.

The three-tier educational programme developed in 2006 to support nurses working for the Department of Corrections, and successfully introduced at Waikeria Prison, was extended to staff at Tongariro–Rangipo Prison; similar positive feedback was received about the way the sessions addressed the challenges of implementing rights-based practice in the context of a prison health service.

Education sessions have also been conducted with student providers — both undergraduate and postgraduate (the latter mostly in the area of quality and risk management), and with a variety of other health services providers, in seminars and conferences.

Provider education this year has included a focus on the value of complaints as a quality improvement tool; over all presentations, 98% of evaluations have recorded an increased appreciation amongst individual providers of the usefulness of complaints as a means of improving the quality and safety of health care.

In order to assist providers to identify opportunities for quality and safety improvements in their systems and practices, HDC has developed an initiative to share information throughout the sector about the numbers and types of complaints received. Data is disseminated on a six-monthly basis advising the statistics over all DHBs nationally, as well as the statistics for each individual DHB. Based on feedback received, data now also includes case summaries and lessons from complaints. It is anticipated that, over time, this data will provide information about trends in complaints, highlight areas of potential risk for DHBs, promote shared learning, and facilitate improvements in quality of services. Follow-up surveys reported that 100% of DHBs found the information useful, both for staff education and for systems management.

Similar information has been provided to the Medical, Pharmacy and Midwifery Councils.

Competence in Rights-based Practice

The HDC Act and Code are commonly included in competence frameworks for registered health providers as part of the legal requirement those providers must comply with. However, compliance with the Code can differ in some respects from compliance with other legislative requirements, which require knowledge, skills, and technical expertise. Implementation of rights-based practice involves a consumer-centred approach, reflected in a provider's attitudes and behaviours.

Discussions have been held with the Medical Council, Dental Council, and Pharmacy Council regarding the way competence in rights-based practice might be recognised as an independent

competence standard. The Osteopathic Council identifies communication (including informed consent, Rights 5 and 7) as a core competency in its Competency Framework; a major initiative this year was the development, delivery and evaluation of a tailored educational programme, focused on these rights, designed to meet osteopaths' core competency obligations under the Health Practitioners Competence Assurance Act. More than 200 osteopaths participated; 94% of respondents reported increased understanding of rights-based practice.

Promotion

Promotional activities have centred on the revision of our pamphlets, and have resulted in a new generic information pamphlet being published. Our website has been tested for accessibility for disabled people and, as a result, we are making improvements to the site. We have developed a set of web accessibility best practice guidelines and have begun to upload recent documentation on the web to HTML format to increase accessibility. Best practice guidelines have been drafted to improve accessibility of the information we provide. We currently provide information in 18 languages, in easy-read versions, and in DVDs with text subtitles; access to large print is also available.

Disability

Social Services Select Committee Inquiry

HDC made a major submission to the Social Services Select Committee Inquiry into the quality of care and services provision for disabled people. Through our consultation with consumers of disability services we felt it was important to pass on their concerns to the Inquiry along with our own.

Despite the Code, consumers are vulnerable when receiving health and disability services. The power imbalance between consumers and providers was emphasised in our submission. The point was made that it is hard for consumers to make a complaint, and it can take a long time to muster the courage to put forward a complaint. Some people need a support person to assist them to make a complaint. One consumer said that "it can feel like 'David confronting Goliath'".

Consumers need to feel safe when making a complaint. Some may be reluctant to make a complaint because they fear retribution from providers. This can be especially problematic where there are few providers available for a particular service, or the consumer is receiving ongoing care from the provider he or she wishes to complain about. Once a complaint is made, it needs to be resolved in a manner that ensures the existing relationships are preserved.

New Zealand Disability Strategy

We have completed the following:

- An accessibility audit of our two offices by the Barrier Free NZ Trust, and a plan to follow up the audit recommendations.
- Draft best practice guidelines for providers to improve their awareness of what is required to ensure that their premises are accessible.
- A contract services database of people with impairments to ensure that all HDC briefs or services are circulated more widely.
- A policy for offering work experience placements to university students with an impairment.
- A draft brief for a project exploring the issues faced by people with impairments using health services.
- An updated directory of disability service organisations and contact people to assist Complaints Assessment staff in the management of enquiries and complaints.

- A resource booklet entitled "Disability Issues" for all staff. The purpose of this resource is to give HDC staff guidelines on the use of language associated with disability, and when interacting with disabled people.
- New Zealand Sign Language classes are offered to staff.
- Use of alternative remedies to achieve compliance with the Code by disability service providers and health care providers who deliver services to people with impairments, for example, spot visits from advocates to residential facilities, staff satisfaction survey results to be reported to the Commissioner, mandatory Code training.
- A survey of 281 residential disability services providers to identify best practices in working in partnership with consumers.

Corporate Services

Finance

Much of the work in financial management this year has focused on compliance with Crown Entities legislative requirements, preparing for the transition to the New Zealand International Financial Reporting Standards (NZIFRS), and working to implement the CFISnet (Crown Financial Information System) requirements from Treasury.

Information Systems

Work to improve our computing environment has been slow but steady as we have developed and tested a custom-made option for three new case management databases within HDC and advocacy. The new databases will lead to better reporting and management of complaints, enquiries, proceedings and advocacy activities. Our information systems and technology environment is complex, with two regional offices for the Health and Disability Commissioner's staff and 25 separate offices for remotely based advocates. The expansion in the advocacy service saw us implementing a number of unique set-ups to support the technical requirements.

Human Resources

The Health and Disability Commissioner's office strongly supports the principle of being a "Good Employer". Valuing employees means looking after their health and well-being and ensuring they are able to perform at optimal levels. We want the people who work for us to be motivated, creative at finding solutions and improvements, able to work well on their own and in a team, and responsive to the diverse population we serve. We are a member of the Equal Employment Opportunities Trust and aim to treat all employees properly and fairly.

In the early part of 2007 we completed a Workforce Profile to assist in identifying, prioritising and addressing equity issues. Two issues emerged from the profile: lack of Māori recruits in the area of complaints resolution, and employees with a disability under-represented in management and senior positions within our organisation. These two issues have led to a revision of our "recruitment", "working from home" and "staff development" policies. The Workforce Profile will be undertaken again in the beginning of 2008 and will be overseen by a joint management and staff group.

We have concentrated on several elements in our "Good Employer" action plan:

Leadership, Accountability and Culture

- A two-day staff learning and development session was held focusing on our values, vision and plans for the year ahead.
- An action plan for introducing the State Services Code of Conduct was developed.
- An Iwi Advisory Group was established to advise on culturally appropriate employer practices.
- Te Reo Māori language classes were made available to all employees throughout the year.

- Employee activities were organised over two separate weeks (Matariki – Māori New Year and Māori Language Week) to increase Māori cultural awareness.

Recruitment, Selection and Induction

- An email alert system has been installed and will be used to alert a much wider network of the public to staffing vacancies within HDC.
- The induction process within HDC was reviewed via a survey. Based on the feedback, changes will be made in the latter part of 2007, including an intranet system to make inductions more thorough, timely and customised to meet individual needs.

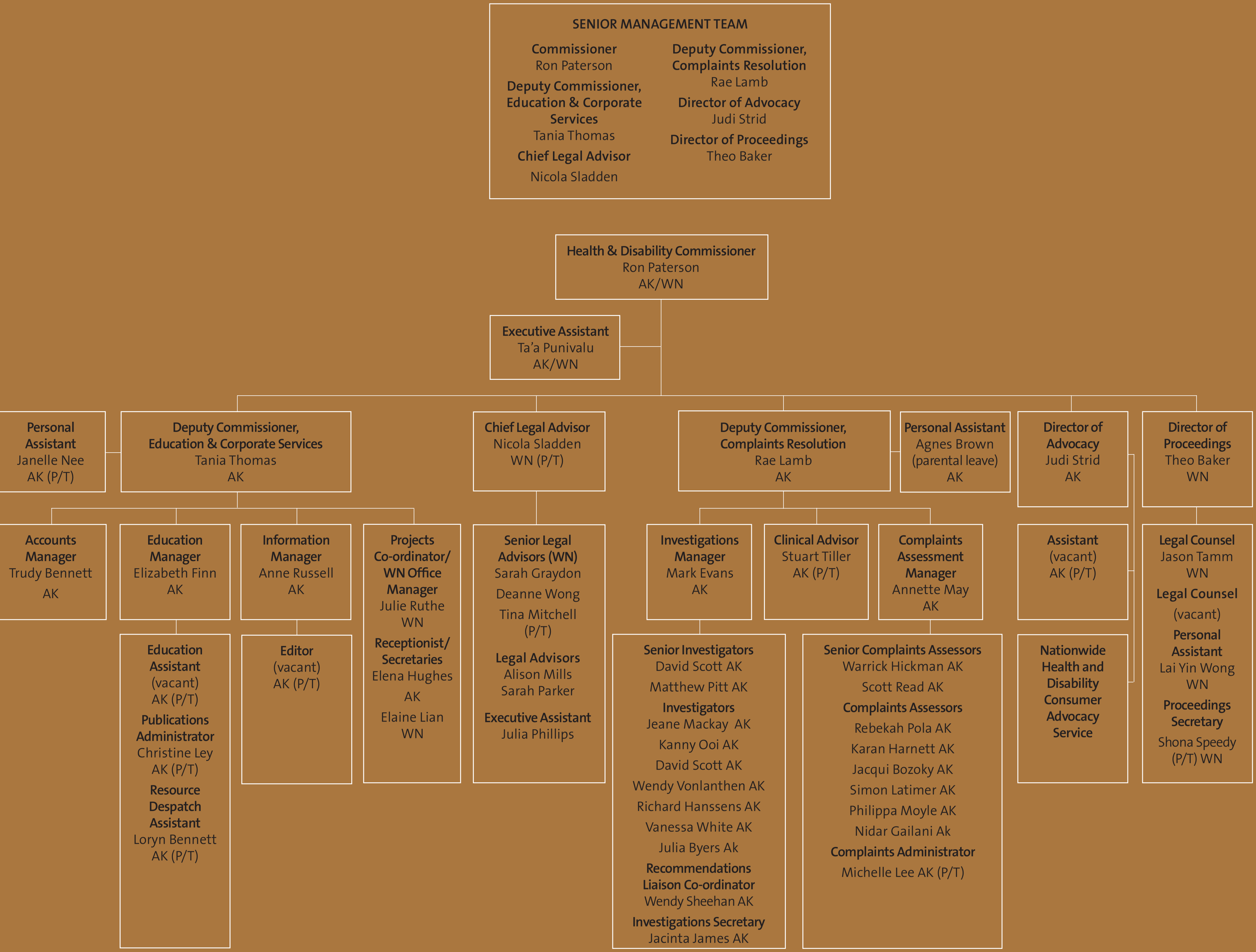
Flexibility and Work Design

- Flexi-time arrangements are in place with work start and finish times ranging between 6.30am and 7.30pm during the week.
- Employees returning from parental leave are able to work on a part-time basis prior to coming back to work full time.
- The option of working from home part time or on an as-needed basis is available to many staff.

Safe and Healthy Environment

- Staff who have identified themselves as having a disability can access telephone relay services; New Zealand Sign Language interpreters and/or stenographers; career coaching; and opportunities to attend relevant conferences and network meetings.
- An employee assistance programme continues to operate for all staff, and includes a confidential support/counselling service.
- Free training from the Red Cross is provided for all staff who wish to gain a First Aid certificate.
- Ergonomic work station assessments are provided on request to staff and within two months of their start date with HDC.
- Free flu inoculations are available to all staff.
- Anti-bacterial solutions are available in the washrooms and in the kitchens.
- Fresh fruit is available to staff as a healthy snack alternative.
- A stop smoking programme is available to staff who wish to give up smoking.

ORGANISATION CHART as at 30 JUNE 2007



LEGAL SERVICES

2006/07 was another productive year for Legal Services. Highlights were organising a very successful medico-legal seminar, providing guidance to DHBs on open disclosure policies, and producing 51 policy submissions.

Nicola Sladden
Chief Legal Advisor

Medico-Legal Seminar

The legal team organised a very successful one-day medico-legal seminar in Wellington on 28 March 2007. The seminar was very well attended by almost 200 medico-legal practitioners, representatives from the Ministry, ACC, the registration authorities, the DHBs, and key consumer groups.

The seminar attracted a very high calibre of external speakers, including Otago University Professor Peter Skegg, Auckland University Associate-Professor Joanna Manning, and Buddle Findlay Partner Jonathan Coates. HDC was also very well represented with a discussion about medico-legal secrecy, an update on HRRT cases, an interactive session on resolving a complaint, and an update on three recent HDC cases.

The feedback from the conference was very positive, with one attendee summing it up nicely:

> "Ron is obviously still leading a strong, dynamic team of passionate people."

Guidance on Open Disclosure Policies

HDC wrote to the 21 DHBs highlighting the importance of open disclosure and asking each DHB to advise whether it has a current open disclosure policy and whether any assistance was required. As a result, HDC developed guidelines on open disclosure policies and provided these to the DHBs. The DHBs were reminded of their responsibility to ensure that open disclosure is applied in practice, in particular, that staff need to be aware of the policy, and adequately trained and supported in its implementation.

Legal Advice

Legal staff provide advice to the Commissioner and staff on a range of legal and policy issues and assist in identifying and managing organisational risks. The team also responds to enquiries from stakeholders and the public. These include enquiries about patients' rights during industrial action, the relationship of the Code to the non-therapeutic use of human tissue, advance directives and "not for resuscitation" orders.

The legal team continues its involvement in complaints resolution work, providing advice, and liaising with consumers, providers, expert advisors, and external organisations. The team assumed responsibility for managing a number of complex complaint files and investigations, including the Commissioner's inquiry in relation to Wanganui Hospital.

From time to time, complainants or providers may contact HDC with concerns about the Commissioner's decision on a complaint. Such concerns may be about the accuracy, outcome or fairness of the decision. The legal team considers such requests, obtains further information, and advises the Commissioner on what action is appropriate — for example, whether the file should be reopened, or whether aspects of the decision or HDC's process need to be explained to the person who has raised the concern. The closed-file review policy was reviewed and updated during the year to clarify the process for reviewing the Commissioner's preliminary assessment decisions. It remains relatively rare for files to be reopened.

Policy Advice and Presentations

A total of 51 submissions on legislative and policy proposals were drafted; educational materials were reviewed; and many conference papers were prepared and presentations delivered. During the year, HDC made an important submission to the Social Services Select Committee inquiry into disability services and presented papers on the New Zealand complaints resolution/ regulatory system and recent medico-legal developments at the 16th World Congress on Medical Law in Toulouse. Key submissions and papers are posted on the HDC website.

HDC/Coroners Interface

The legal team was actively involved in the development of the new Coroners Act, which took full effect on 1 July this year, as well as the Coroners bench book. The team is also reviewing the protocol between Coroners and HDC.

The Act has significant implications for HDC because of the overlap between HDC investigations and coronial inquests in cases involving the death of a consumer while receiving health or disability services. It is important that the activities of coroners and HDC are co-ordinated to avoid duplication of process, resulting in wasted resources, lengthy delays and unnecessary stress on providers and families.

Medical Law in New Zealand

The legal team was pleased to contribute research assistance to an important new medico-legal text, Skegg & Paterson, *Medical Law in New Zealand* (2006).

The authors of *Medical Law in New Zealand* — (from left) Professor Warren Brookbanks; Associate Professor Joanna Manning; Professors John Dawson and Nicola Peart; co-editors Ron Paterson and Professor Peter Skegg — with Minister of Health Pete Hodgson at the launch in Dunedin in February 2007.

REPORT OF THE DIRECTOR OF ADVOCACY

The Nationwide Health and Disability Advocacy Service is available to any person in New Zealand who has a concern or wants to make a complaint about a health or disability service, or who requires information about health and disability services consumers' rights. Advocates are independent of HDC as well as providers and act 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, by free fax, or by email. The service they provide is free and confidential.

Judi Strid
Director of Advocacy

Introduction

The past 12 months has been a time of both considerable upheaval and positive change for the Nationwide Advocacy Service. A tendering process with a preference for national proposals followed two years of discussions about a move from separate contracts with different organisations to a national service, to achieve greater consistency and a stronger focus on quality. The issuing of a national contract by the Director of Advocacy for core health and disability advocacy services resulted in a legal challenge, in the form of a judicial review, from an organisation whose tender was unsuccessful. The Director's decision was upheld by the High Court and is now being appealed.

The Director now contracts with a new National Advocacy Trust to provide a core national health and disability advocacy service on her behalf. The Director is still able to contract for specialist advocacy services from other organisations. This year there have been four specialist advocacy projects for rural Māori communities, Deaf communities, and residents of an inpatient forensic unit.

The shift to a new national service and structure followed an in-depth review of the service. Implementing the review recommendations has resulted in changes that will continue to improve the quality of the advocacy service and provide better support for advocates, many of whom work in isolation within communities all over the country. The challenge of providing sufficient advocates to be readily available to consumers nationwide is being addressed through the allocation of additional funding to increase advocate numbers.

SORTING OUT A MEDICAL RECORD

A consumer was stunned to discover during a hospital admission for a minor procedure that her medical record referred to a mental health diagnosis that had been disputed many years ago.

The consumer believed the information to be incorrect and that it should not be on the file. She contacted the local advocate, who suggested that the concerns be taken in the first instance to the privacy officer at the District Health Board. The consumer did this but was very unhappy with the response and sought assistance from the advocate. The advocate agreed to support the consumer at a meeting with the DHB's Chief Medical Officer to discuss either removing the information or placing a statement from the consumer on the file.

The consumer was very pleased to be told at the meeting that the DHB had had the file independently reviewed and agreed that the old diagnosis was inaccurate. The hospital agreed to start a new file, with the consumer's statement and the review letter to be placed on the old file to deal with the historical issues. The consumer was delighted with this result, and also appreciative of the doctor on the ward who had first drawn the consumer's attention to the old information on file.

The "Hikoi Team" responsible for the successful Māori Specialist Advocacy project on the East Coast.

Over the past year, the service had a total of 44 personnel working out of 25 offices around the country; 36 (28.5 full-time equivalents) were advocates and eight provided management and administration services. Advocates responded to 8,388 enquiries, and assisted consumers with 4,078 complaints, of which 88% were either fully or partially resolved. In addition, they took part in 2,575 networking contacts and carried out 1,665 education sessions. These statistics are likely to under-represent the performance and workload of advocates owing to difficulties with the case management system and retrieval of the data. A new system is currently being introduced to address these problems.

As part of the expansion of the advocacy service, with five extra advocates on the ground, advocates visited 98% of all the country's rest homes to assist and be available to residents as well as provide education sessions and information for staff. This initiative was so successful in making it easy for vulnerable consumers to access an advocate and providing practical information for staff that it is to be extended to include disability homes and facilities.

As well as being responsive to requests for information and education sessions on consumer rights, and assisting consumers to resolve complaints at an early stage, the proactive work of advocates has been strengthened. Advocates actively promote complaints as opportunities for learning and

---

YOUNG PERSON NEEDING INFORMATION

A 14-year-old high school student, boarding away from home, was diagnosed with a condition that she was told required urgent surgery. She contacted the local advocate about the lack of information about her condition and when the surgery was to take place.

Following discussion with the advocate the consumer wrote to the surgeon outlining her concerns, including not fully understanding the condition or its seriousness. She received a response from the surgeon but unfortunately it did not provide the information she needed or answer her questions.

After further discussion with the advocate the consumer decided to complain to the hospital, enclosing copies of the letter to the surgeon and the surgeon's reply.

The next day the manager of the service contacted the student and arranged for the surgery to be performed by another surgical team straight away.

Following the successful surgery and her recovery, the consumer visited the advocate to say that the support and options provided by the advocate had helped her to decide on actions she felt comfortable with, and that they had ended with a great result.

---

improving service quality. They also promote the importance of consumer-centred care and use stories that consumers have provided to highlight services and practices that work well for them.

A new resolution agreement form has been introduced to ensure there is a shared understanding of what has been agreed to when there are actions to be carried out beyond the resolution meeting. The advocate assists the consumer by following up on any outstanding undertakings. Only six of the 89 agreements required a follow-up by the advocate. This reflects the goodwill and commitment shown by providers to resolve complaints.

Advocacy manager Lewis Ratapu speaking with Hikoi participants at the Ruaihana Marae in Te Teko.

A CONSUMER'S OWN STORY

For four years I had been on dialysis. I got there because I have arteriosclerosis (blocking of the arteries by plaque). The first, dramatic, intimations I had the disease was when I sustained a heart attack 16 years ago. Blocked arteries do not, of course, unblock — indeed they get worse and there came a time when the arteries to my kidneys got bunged up, stopping the blood flow, thus rendering my kidneys ineffective. Hence dialysis.

All had been going well for those four years. Apart from the tie of having to go to the hospital three afternoons a week I was doing well for a 74-year-old. My particular pleasure was to walk for an hour by the sea every day — weather permitting.

Then, without warning or explanation, things changed. My dialysis requires the insertion of a needle into the arm to allow the blood to flow through the machine. I had been on a gauge 14 needle but it was changed to a narrower gauge 15. This meant that the four hours I was accustomed to being hooked up was not long enough to effect a good dialysis. I found myself puffing and getting sore legs when I was walking. I could have opted to be on the machine longer — but four hours is quite long enough!

As well, I needed extra iron from time to time and this was done once a fortnight, intravenously, while I was dialysing. No problem. Then the consultant physician ordered this practice to be stopped (long-term effect, I was later informed. Long term? When I was 74?).

My efforts through the hospital management to get my former, perfectly satisfactory treatment regime reinstated were unsuccessful. In desperation I sought the help of my local health and disability advocate. I am glad to say that her efforts were successful and my former treatment was resumed. I am now feeling much better. And enjoying those seaside walks once more!

ASSISTING A DISABLED CONSUMER TO MAKE HIS OWN DECISIONS AND ACHIEVE INDEPENDENCE

A young man with cerebral palsy and a significant disability requiring 24-hour care sought the assistance of an advocate to deal with concerns about the care provided by family carers and their attitude towards him.

The advocate met with the consumer several times to explore ideas of how he might go about raising his concerns with his family. These included arranging a meeting with the family. This was a difficult situation for him as he wanted to leave the family home and live independently. He felt his family were very over-protective.

During visits to discuss how his concerns could be resolved, the advocate coached him on his rights and how he could exercise them. The advocate reiterated her support of him in discussing how he might resolve the situation, and encouraged him to identify and utilise other support people and agencies. This included his Case Support Worker, who provided daily support and arranged counselling to help him with his plans and self-confidence.

Eventually he felt able to meet with his family and others involved with his care to discuss his issues and concerns. The advocate attended the meeting to support him. He was successfully able to articulate his concerns and aspirations and consequently left the family home to live independently.

Although the advocate has continued to provide support and information on issues that arise for him with new caregivers and provider organisations, his increased confidence and ability to self-advocate and exercise his rights is very noticeable.

SORTING OUT A CONSUMER-CENTRED MENTAL HEALTH PLAN

Family members contacted an advocate about a consumer receiving voluntary psychiatric inpatient care. The consumer was concerned about medication changes and the hospital's insistence that a guardian be available when he went on leave. Following a discussion with the consumer of his rights and the options to resolve his concerns, a meeting was arranged with the psychiatrist, consumer, and family members, with advocacy support.

The consumer and his family were pleased with the meeting outcome. They received answers to their questions, and the medication changes were explained, along with the different treatment options available. The consumer's leave was also addressed and a plan put in place to transition him to a supported living situation in the community that he and his family are happy with.

QUALITY OF REST HOME CARE

A woman complained about the rest home care provided to her 89-year-old mother, which had led to her admission to hospital in a poor state. The complainant had a number of concerns relating to the standard of care, including the dehydrated state her mother was in, the failure of staff to identify her high temperature, and their difficulty locating a thermometer and not knowing how to read it when one was finally found. The woman was also unhappy about the reluctance of the staff to call an ambulance, necessitating her to drive her mother to hospital in her own car at 10.30pm.

The manager and two staff members attended the resolution meeting to hear the concerns of the resident's family. The rest home apologised to the family for what had happened, and the manager agreed to up-skill staff in the areas where shortcomings had been identified. The advocate also provided rest home staff with a presentation on the Code of Rights.

REPORT OF THE DIRECTOR OF PROCEEDINGS

It has been another steady year for the Proceedings Team, with the same number of referrals from the Commissioner as the previous year and a very similar number of substantive hearings. The high rate of successful proceedings has been a notable feature of the year.

Theo Baker
Director of Proceedings

Statistics

As Table 1 shows, action was not taken in relation to almost one-third of the 19 referrals received. Reasons for taking no further action may include concerns about the quality of the evidence, availability of witnesses, the delay since events, reluctance on the part of the consumer to pursue the complaint, or settlement of a matter between the parties. The 100% success rate of the 10 disciplinary hearings (Table 2) includes six cases where the practitioner admitted the charge.

The defence was successful in one appeal arising from a case heard by the Medical Practitioners Disciplinary Tribunal. The outcome of a further appeal involving the only remaining charge laid by the Director of Proceedings under a former registration act is awaited. All disciplinary charges are now heard by the Health Practitioners Disciplinary Tribunal under the Health Practitioners Competence Assurance Act 2003, and appeal is to the High Court.

In addition to the one hearing before the Human Rights Review Tribunal (HRRT), claims in respect of three providers settled (for example, see Isaac Case Note), and a decision arising from a hearing in the previous financial year was received (see Peters Case Note).

Table 1: **Action taken in respect of referrals to Director of Proceedings in 2006/07**

Provider	No further action	Decision in process	Hearing pending	Hearing taken place	Total
Caregiver			1		1
Counsellor	1				1
Dentist	1				1
DHB		1			1
Medical practitioner					
General practitioner			1		1
Gynaecologist		2			2
Urologist			1		1
Midwife			1		1
Natural therapist	1		2		3
Nurse	3		1		4
Pharmacist			1		1
Pharmacy technician			1		1
Psychologist				1	1
Total	**6**	**3**	**9**	**1**	**19**

Table 2: **Outcome of hearings in 2006/07**

Provider	Successful	Unsuccessful	Outcome Pending	Total
Discipline				
Substantive hearings				
Nurse	2			2
Psychologist	1			1
Medical practitioner				
General practitioner	4			4
General surgeon	2			2
Urologist	1			1
Appeals				
Dentist	1			1
Medical practitioner				
Gynaecologist		1		1
Psychiatrist	2			2
HRRT				
Substantive hearings				
Caregiver*			1	1
Total	**13**	**1**	**1**	**15**

*The HRRT delivered its decision in relation to this matter on 14 August 2007 and issued a declaration that the defendant had breached Rights 4(1), 4(2) and 4(5) of the Code.

Tribunal Survey

Of the six surveys sent to chairpersons and executive officers of the Human Rights Review Tribunal and the Health Practitioners Disciplinary Tribunal, three were returned. Feedback was largely very favourable, with expectations being fully met or exceeded in 13 out of 16 categories, and expectations mostly met, fully met or exceeded in 100% of the answers.

PROFESSIONAL AND ETHICAL BOUNDARIES IN COUNSELLING RELATIONSHIP

On 14 June 2007 by consent the Human Rights Review Tribunal made orders declaring that Ms Isaac, a school counsellor, had breached Right 2 of the Code (by engaging in a sexual relationship with a former client), and ordering her to pay compensatory damages of $25,000 and exemplary damages of $10,000. This is the highest quantum of damages awarded by the Tribunal to date in a claim brought by the Director of Proceedings.

From March 2000 to May 2001 Ms Isaac had provided counselling to a 14-year-old pupil, Miss B. During this time Miss B's issues with self-harming, drug use and violence towards others resulted in a referral to a local mental health service. She was admitted to hospital for acute alcohol intoxication in April and self-harm in May 2001. As a result of her disclosure of sexual abuse, an independent ACC-approved sexual abuse counsellor was appointed for Miss B and it was agreed that Ms Isaac would act as a support person for her, rather than a counsellor. Ms Isaac and Miss B continued to have frequent contact.

On 2 August 2001 Miss B was admitted to Tauranga Hospital following a drug overdose in relation to which she wrote a suicide note to Ms Isaac, referring to her as "Aunty Janette". As a result, the mental health service wrote a formal letter of complaint to Ms Isaac in which it raised concerns arising from boundary issues between Ms Isaac and Miss B and resulting harm to Miss B.

In November 2001 Ms Isaac and Miss B kissed and from then on there was regular intimate physical contact between them. They first had sexual intercourse in June 2002. Miss B was 16. Miss B moved towns temporarily and because she missed Ms Isaac greatly was drinking every day to help her deal with this. In August 2002 Miss B moved back and the pair continued a sexual relationship.

In October 2002 Miss B became very upset when she was told that Ms Isaac's flatmate was actually her partner of 16 years. On the understanding that this relationship had ended, Miss B continued her sexual relationship with Ms Isaac. In late November 2002 Miss B discovered that Ms Isaac was still having a great deal of contact with her partner, and the Police became involved on two occasions when altercations occurred. On the second occasion Miss B was arrested and the Crisis Team was involved. The next day Miss B took an overdose of aspirin, antidepressants and anti-nausea pills, but she vomited before they had any effect. The relationship ceased soon after this.

As a result of this relationship, Miss B became isolated from her friends and family, and did not attend any further counselling, and so a number of issues that pre-date the relationship as well as the ongoing effects of the relationship remained unresolved.

SEXUAL RELATIONSHIP BETWEEN COUNSELLOR AND CLIENT

In March and May 2006 the Human Rights Review Tribunal heard evidence and submissions in relation to a claim brought by the Director of Proceedings on behalf Ms A. In a decision dated 25 September 2006, the Tribunal made a declaration that Mr Peters, a counsellor, had breached Miss A's rights under the Code of Health and Disability Services Consumers' Rights as a result of a sexual relationship he had formed with her in 2001. Mr Peters' evidence was that he had commenced counselling Miss A after the sexual relationship had ended. For reasons detailed in the decision, the Tribunal preferred Miss A's evidence.

In February 2001 Ms A, a survivor of sexual abuse and rape, was dealing with subsequent issues of self-mutilation, eating disorders, a dissociative disorder, over-exercising and ignoring pain thresholds, and obsessive compulsive disorders. At this time she was self-mutilating at least every other day, sometimes two to three times a day. She was losing weight and over-exercising. She was depressed and somewhat suicidal.

At the college Ms A attended, Mr Peters' counselling and hypnotherapy services were available to students at a subsidised rate for three sessions, and Ms A had three appointments with him at the college. She then attended an appointment at his rooms and told him that she was developing feelings for him. He told her that he could not have a relationship with her because he was her counsellor, but they agreed to meet at a centre where Mr Peters would be working and, a few days after that, they began a sexual relationship. Mr Peters continued to counsel Miss A at his rooms on a number of occasions, following which they would have sexual intercourse.

In May 2001 Miss A was feeling depressed and engaged in some fairly severe self-mutilation. Mr Peters saw her wounds and persuaded her to go to hospital to have them attended to.

The sexual relationship ended in July 2001 when Mr Peters cancelled a date with Miss A because he wanted to spend time with his girlfriend. Miss A then cancelled her next counselling appointment and so the therapeutic relationship ended at this time.

The Tribunal found that there was a breach of Right 2 of the Code in that Mr Peters failed to provide health services that were free from sexual exploitation; a breach of Right 4(2) of the Code in that from March 2001 and during the course of the relationship that followed, Mr Peters failed to provide services that complied with professional, ethical and other relevant standards; and a breach of Right 4(4) by failing to provide services that minimised the potential for harm to Miss A's life.

Mr Peters was ordered to pay Miss A $15,000 compensatory damages and $8,000 exemplary damages.

A copy of the decision can be found at www.nzlii.org/nz/cases/NZHRRT.

Financial Commentary

Funding
HDC is funded from Vote Health. Funding increased from $7,214,222 to $7,554,000 (excluding GST) for this year. A funding increase of $776,620 has been approved for the year ended 30 June 2008.

Investments
HDC invests surplus funds in term deposits lodged with creditworthy institutions. Deposits have a range of maturity dates to maximise interest income while maintaining cash flow. Interest income for the year was $197,915 and investments totalled $1,624,000 at 30 June 2007.

Publications
HDC produces a range of educational materials for use by the public and health and disability service providers. Members of the public receive these items free while providers are charged a modest amount to recover costs. Revenue from this source in 2006/07 was $79,115 offset by production costs.

Operating Surplus
In 2006/07 HDC budgeted for a deficit of $258,042 and had an actual deficit of $94,747.

Expenditure by Type
Expenditure is summarised by significant categories below. Service contracts, staff costs and occupancy costs (collectively 78.4% of total expenditure in 2006/07) largely represent committed expenditure. Much of the remaining 21.6% (or $1.71 million) is discretionary.

	06/07		05/06	
	$000	%	$000	%
Service contracts	2,597	32.8	2,125	28.8
Audit fees	19	0.2	12	0.1
Staff costs	3,194	40.3	3,327	45.1
Travel & accommodation	190	2.4	195	2.6
Depreciation & amortisation	278	3.5	181	2.5
Occupancy	420	5.3	420	5.7
Communications	636	8.0	551	7.5
Operating costs	592	7.5	569	7.7
Total	**7,926**	**100.0**	**7,380**	**100.0**

Figures are GST exclusive.

The Office has only one output class, broken down into five interrelated sub-outputs as summarised below.

Figure 1: **Expenditure by output 2006/2007 ($000s)**

- Complaints Resolution $3,170 (40%)
- Advocacy $2,894 (36%)
- Proceedings $784 (10%)
- Policy $462 (6%)
- Education $616 (8%)

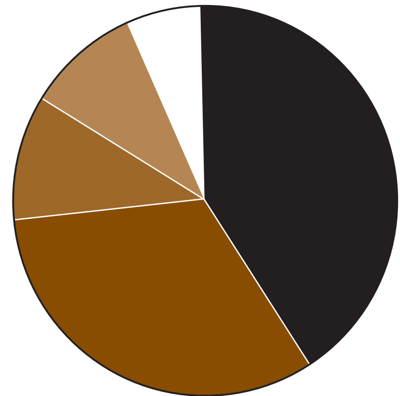
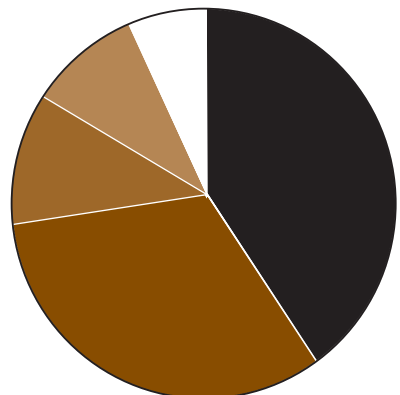


Figure 2: **Expenditure by output 2005/2006 ($000s)**

- Complaints Resolution $3,038 (41%)
- Advocacy $2,431 (33%)
- Proceedings $745 (10%)
- Policy $528 (7%)
- Education $638 (9%)



Expenditure on Complaints Resolution was $3.170 million ($3.038 million in 05/06). Spending on Advocacy was $2.894 million ($2.431 million in 05/06). Outputs consumed very similar resources year on year. The Office continued to look for efficiencies in all areas.

2007/2008

For the coming year the Office has budgeted for a deficit of $174,334.

In terms of the Crown Entities Act 2004:

1. We accept responsibility for the preparation of these financial statements and the judgements used therein, and

2. We have been responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting, and

3. We are of the opinion that these financial statements fairly reflect the financial position and operations of the Office of the Health and Disability Commissioner for the year ended 30 June 2007.

Ron Paterson
Commissioner

Tania Thomas
Deputy Commissioner,
Education & Corporate Services

21 September 2007

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

AUDIT REPORT

TO THE READERS OF THE HEALTH AND DISABILITY COMMISSIONER'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2007

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 2007.

Unqualified Opinion

In our opinion:

- The financial statements of the Health and Disability Commissioner on pages 32 to 42:
  - — comply with generally accepted accounting practice in New Zealand; and
  - — fairly reflect:
    - the Health and Disability Commissioner's financial position as at 30 June 2007; 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 43 to 46:
  - — 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 21 September 2007, 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 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 the 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 or 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 financial statements and a 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 2007 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 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 2007 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 21 September 2007 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 2007

Actual 2005/2006		Note	Actual 2006/2007	Budget 2006/2007
	Revenue			
$7,214,222	Operating Grant Received		$7,554,000	$7,554,000
$195,744	Interest Received		$197,915	$122,000
$72,329	Publications Revenue		$79,114	$70,000
$7,482,295	**Total Operating Revenue**		**$7,831,029**	**$7,746,000**
	Less Expenses			
$2,124,645	Advocacy Service Contracts		$2,596,735	$2,603,900
	Audit Fees			
$12,000	Financial statement audit		$12,600	$12,000
	NZIFRS transition		$6,000	–
$3,327,046	Staff Costs		$3,194,579	$3,407,204
$195,254	Travel & Accommodation		$190,029	$206,900
$181,381	Depreciation & Amortisation	**3, 4**	$277,762	$214,967
$419,748	Occupancy		$419,749	$452,109
$551,546	Communications		$636,739	$570,415
$568,675	Operating Costs		$591,583	$536,547
$7,380,295	**Total Operating Expenses**		**$7,925,776**	**$8,004,042**
$102,000	**Net Surplus/(Deficit)**		**($94,747)**	**($258,042)**

The accompanying accounting policies and notes form an integral part of these financial statements.

STATEMENT OF FINANCIAL POSITION as at 30 June 2007

Actual 2005/2006		Note	Actual 2006/2007	Budget 2006/2007
	Crown Equity			
$977,523	Accumulated Funds	1	$882,776	$677,565
$788,000	Capital Contributed		$788,000	$788,000
$1,765,523	**Total Crown Equity**		**$1,670,776**	**$1,465,565**
	Represented by Current Assets			
$19,913	Bank Account		$60,868	$8,969
$2,070,000	Call Deposits		$1,624,000	$1,450,000
$19,249	Prepayments		$34,591	$4,000
$14,665	Inventory		$21,718	$17,000
$39,127	Sundry Debtors		$38,230	$51,000
$2,162,954	**Total Current Assets**		**$1,779,407**	**$1,530,969**
	Non Current Assets			
$361,837	Fixed Assets	3a	$311,171	$242,196
$131,409	Intangibles	3b	$146,903	$122,000
$493,246	**Total Non Current Assets**		**$458,074**	**$364,196**
$2,656,200	**Total Assets**		**$2,237,481**	**$1,895,165**
	Current Liabilities			
$21,000	GST Payable		$45,987	$52,000
$869,677	Sundry Creditors	2	$520,718	$377,600
$890,677	**Total Liabilities**		**$566,705**	**$429,600**
$1,765,523	**Net Assets**		**$1,670,776**	**$1,465,565**

Ron Paterson
Commissioner

Tania Thomas
Deputy Commissioner,
Education and Corporate Services

21 September 2007

The accompanying accounting policies and notes form an integral part of these financial statements.

STATEMENT OF MOVEMENTS IN EQUITY for the year ended 30 June 2007

Actual 2005/2006		Actual 2006/2007	Budget 2006/2007
$1,663,523	Opening Equity at 1 July	$1,765,523	$1,723,607
$102,000	Plus Net Surplus/(Deficit) (Total Net Recognised Revenues and Expenses)	($94,747)	($258,042)
$1,765,523	**Closing Equity at 30 June**	**1,670,776**	**$1,465,565**

The accompanying accounting policies and notes form an integral part of these financial statements.

Actual 2005/2006		Note	Actual 2006/2007	Budget 2006/2007
	Cash Flow from Operating Activities			
	Cash was provided from:			
$7,214,222	Operating Grant		$7,554,000	$7,554,000
$196,025	Interest on Short-term Deposits		$201,971	$122,000
$123,100	Revenue		$76,306	$70,000
$7,533,347			$7,832,277	$7,746,000
	Cash was applied to:			
($6,863,938)	Payments to Suppliers and Employees		($7,994,731)	($7,788,080)
$669,409	**Net Cash Flow from Operating Activities**	**4**	**($162,454)**	**($42,080)**
	Cash Flow from Investing Activities			
	Cash was provided from:			
$1,246	Sale of Fixed Assets		$39	$0
	Cash was applied to:			
($134,790)	Purchase of Intangible Assets		($119,195)	($200,000)
($170,831)	Purchase of Fixed Assets		($123,435)	($60,000)
($304,375)	**Net Cash Flow from Investing Activities**		**($242,591)**	**($260,000)**
$365,034	**Net Increase/(Decrease) in Cash**		**($405,045)**	**($302,080)**
$1,724,879	Cash Brought Forward		$2,089,913	$1,761,049
$2,089,913	**Closing Cash Carried Forward**		**$1,684,868**	**$1,458,969**
	Cash Balances in the Statement of Financial Position			
$19,913	Bank Account		$60,868	$8,969
$2,070,000	Call Deposits		$1,624,000	$1,450,000
$2,089,913			**$1,684,868**	**$1,458,969**

The accompanying accounting policies and notes form an integral part of these financial statements.

Statement of Compliance

The Health and Disability Commissioner is a Crown Entity established under the Health and Disability Commissioner Act 1994. The role of the Commissioner is to promote and protect the rights of health consumers and disability services consumers.

These financial statements have been prepared in accordance with the Crown Entities Act 2004 and comply with Generally Accepted Accounting Practice in New Zealand ("NZ GAAP").

Measurement Base

The financial statements have been prepared on a historical cost basis.

Accounting policies are selected and applied in a manner that ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

Particular Accounting Policies

The following particular accounting policies, which materially affect the measurement of financial performance and financial position, have been applied:

Budget Figures

The budget figures are those approved by the Health and Disability Commissioner at the beginning of the financial year.

The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Health and Disability Commissioner for the preparation of the financial statements.

Recognition of Revenue and Expenditure

The Commissioner derives revenue through the provision of outputs to the Crown, interest on short-term deposits, and the sale of educational publications. Revenue is recognised when earned.

Property, Plant & Equipment

Property, plant & equipment are stated at their historical cost less accumulated depreciation.

Realised gains and losses arising from disposal of property, plant and equipment are recognised in the Statement of Financial Performance in the period in which the transaction occurs.

Depreciation

Depreciation is charged on a straight-line basis, so as to write off the net cost of each asset over its expected useful life to its estimated residual value.

Leasehold improvements are depreciated over the period of the lease or estimated useful life, whichever is shorter, using the straight line method.

The following estimated useful lives are used in the calculation of Depreciation

Furniture & Fittings	5 years	Office Equipment	5 years
Communications Equipment	4 years	Motor Vehicles	5 years
Computer Hardware	4 years		

Goods and Services Tax

All items in the financial statements are exclusive of GST, with the exception of accounts receivable and accounts payable, which are stated with GST included.

Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Sundry Debtors

Sundry debtors are stated at their estimated net realisable value after providing for doubtful and uncollectable debts.

Inventory
Inventory is valued at the lower of cost and net realisable value. Inventory is the brochures and publications HDC distributes to the public or sells to health service providers.

Operating Leases
Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as an expense on a straight-line basis over the lease term, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset are consumed.

Intangibles
Intangible assets comprise software applications that have a finite useful life and are recorded at cost less accumulated amortisation and impairment. These are amortised on a straight-line basis over their useful lives as follows:

Computer software	2 years

Employee Entitlements
Annual/special leave is recognised on an actual entitlement basis at current rates of pay.

Financial Instruments
The Commission is party to financial instruments as part of its normal operations. All financial instruments are recognised in the Statement of Financial Position and all revenues and expenses in relation to financial instruments are recognised in the Statement of Financial Performance.

Taxation
The Health and Disability Commissioner is exempt from income tax pursuant to the Second Schedule of the Health and Disability Commissioner Act 1994.

Cost Allocation
The Health and Disability Commissioner has derived the net cost of service for each significant activity of HDC using the cost allocation system outlined below.

Cost allocation policy
Direct costs are charged to significant activities. Indirect costs are charged to significant activities based on cost drivers and related activity/usage information.

Criteria for direct and indirect costs
"Direct costs" are those costs directly attributable to a significant activity.

"Indirect costs" are those costs that cannot be identified in an economically feasible manner with a specific significant activity.

Cost drivers for allocation of indirect costs
The cost of internal services not directly charged to activities is allocated as overheads using staff numbers as the appropriate cost driver.

Statement of Changes in Accounting Policies

Intangible Assets

Computer software: Computer software is classified as part of property, plant and equipment under NZ GAAP. The net book value of computer software is reclassified as an intangible asset as part of the transition to NZ IFRS.

Actual 2005/2006	Note		Actual 2006/2007
	1	**Accumulated Funds**	
$875,523		Opening Balance	$977,523
$102,000		Net Surplus (Deficit)	($94,747)
$977,523		**Closing Balance**	**$882,776**
	2	**Sundry Creditors**	
$516,253		Trade Creditors and Accruals	$297,244
$68,056		PAYE	$77,855
$285,368		Annual Leave	$145,619
$869,677			**$520,718**

3 Property, Plant & Equipment as at 30 June 2007

Cost	Computer hardware	Comms equipment	Furniture & fittings	Leasehold improvements	Motor vehicles	Office equipment	Total
Balance at 1 July	$631,273	$26,723	$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	$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

3a Property, Plant & Equipment as at 30 June 2006

Cost	Computer hardware	Comms equipment	Furniture & fittings	Leasehold improvements	Motor vehicles	Office equipment	Total
Balance at 1 July	$609,699	$26,723	$205,583	$506,585	$42,280	$148,192	$1,539,062
Additions during year	$24,310	$0	$6,137	$99,951	$0	$41,315	$171,713
Disposals during year	($2,736)	$0	$75	$0	$0	($26,700)	($29,361)
Balance at 30 June	$631,273	$26,723	$211,795	$606,536	$42,280	$162,807	$1,681,414
Accumulated Depreciation							
Balance at 1 July	$488,421	$26,723	$179,504	$317,169	$42,280	$122,845	$1,176,942
Charge for year	$68,132	$0	$10,142	$74,705	$0	$17,771	$170,750
Disposals	($220)	$0	$25	($341)	$0	($27,579)	($28,115)
Balance at 30 June	$556,333	$26,723	$189,671	$391,533	$42,280	$113,037	$1,319,577
Net book value 30 June 2007	$74,940	$0	$22,124	$215,003	$0	$49,770	$361,837

3b Intangible assets

Computer software	Actual 2006/2007	Actual 2005/2006
Balance at 1 July	$521,147	$386,357
Additions during the year	$119,195	$134,790
Disposals during the year	$0	$0
Balance at 30 June	$640,342	$521,147
Accumulated Amortisation		
Balance at 1 July	$389,738	$379,007
Charge for the year	$103,701	$10,731
Disposals	$0	$0
Balance at 30 June	$493,439	$389,738
Net book value at 30 June	$146,903	$131,409

2005/2006	Note			Actual 2006/2007
	4	**Reconciliation of financial position**		
$102,000		Net Surplus (Deficit)		($94,747)
		Add Non-cash items:		
$181,381		Depreciation & Amortisation		$277,763
		Movements in Working Capital Items		
$372,680		Increase/(Decrease) in Sundry Creditors	($349,310)	
($38,634)		Increase/(Decrease) in GST Payable	$24,987	
$3,125		(Increase)/Decrease in Inventory	($7,053)	
$50,771		(Increase)/Decrease in Sundry Debtors	($2,808)	
($2,194)		(Increase)/Decrease in Prepayments	($15,342)	
$280		(Increase)/Decrease in Interest Receivable	$4,056	
$386,028				($345,470)
$669,409		**Net Cash Flow from Operating Activities**		**($162,454)**

5 Commitments

(a) Advocacy Service contracts:

The maximum commitment for the 12 months from 1 July 2007 is $3,073,900.

(b) Premises Leases including leasehold improvements:

Auckland $290,856 per annum until May 2011
Wellington $88,000 per annum until April 2009

Actual 2005/2006			Actual 2006/2007
	6	(c) Classification of Commitments	
$2,981,345		Less than one year	$3,455,995
$353,324		One to two years	$357,445
$66,589		Two to five years	$557,474
$0		Over five years	$0
$3,401,258			**$4,370,914**

7 Contingent Liabilities

There are ongoing legal proceedings relating to a procurement issue. No demands for compensation or damages have been made and the Health and Disability Commissioner holds indemnity insurance.

8 Financial Instruments

As the Health and Disability Commissioner is subject to the Public Finance Act, all bank accounts and investments are required to be held with banking institutions authorised by the Minister of Finance.

The Health and Disability Commissioner has no currency risk as all financial instruments are in NZ dollars.

Credit Risk

Financial instruments that potentially subject the Health and Disability Commissioner to credit risk principally consist of bank balances with Westpac Trust and sundry debtors.

Maximum exposures to credit risk at balance date are:

Actual 2005/2006		Actual 2006/2007
$2,089,913	Bank balances	$1,684,868
$39,127	Sundry Debtors	$38,230
$14,665	Inventory	$21,718
$19,249	Prepayment	$34,591
$2,162,954		**$1,779,407**

The Health and Disability Commissioner does not require any collateral or security to support financial instruments with financial institutions that the Commissioner deals with as these entities have high credit ratings. For its other financial instruments, the Commissioner does not have significant concentrations of credit risk.

Fair Value

The fair value of the financial instruments is equivalent to the carrying amount disclosed in the Statement of Financial Position.

Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument will fluctuate owing to changes in market interest rates. The average interest rate on the Health and Disability Commissioner's investments is 8.0% (2006: 7.2%).

9 Related Party

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

During the year the Health and Disability Commissioner received $7,554,000 (2006: $7,214,222) (excluding GST) in operating grants from the Crown. There was no funding owing from the Crown at year end.

There were no other related party transactions.

10 Employee Remuneration

Total remuneration and benefits	Number of employees	
	2005/2006	2006/2007
$100–110,000	1	1
$110–120,000	1	1
$120–130,000	1	1
$130–140,000	0	2
$140–150,000	1	0
$210–220,000	1	0
$220–230,000	0	1

Note

The Commissioner's remuneration and allowances are determined by the Remuneration Authority in accordance with the Remuneration Authority Act 1977. The Commissioner's remuneration and benefits are in the $220,000 to $230,000 band.

11 Severance/Redundancy Payments

As part of an organisational review of the Commissioner, one redundancy payment was made in the year 1 July 2006 to 30 June 2007 totalling $12,500.

12 Indemnity Insurance

The Commissioner's insurance policy covers public liability of $21 million. Public liability includes cover for all amounts that the Commissioner becomes legally liable to pay as a direct compensation resulting from personal injury or damage to property, caused by an occurrence in connection with the organisation's operation. This also covers:

- General & Product Liability
- Association Liability
- Statutory & Employers Liability
- Landlord & Tenant Liability
- Plant & Machinery & Contents Liability
- Employee Travel Liability

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
	Deliverables/Quantity		
1.	Estimated 5,000 enquiries responded to in 2006/07.	30 June 2007	**Target achieved. 7,444 enquiries responded to (149%).**
2.	90% of enquiries closed on day received.	30 June 2007	**Target achieved (96%).**
3.	80% of enquiries requiring written responses closed within one month of receipt.	30 June 2007	**Target achieved. 87% of written responses closed within one month of receipt.**
4.	Estimated 1,100 new complaints received in 2006/07.	30 June 2007	**Target achieved. 1,289 new complaints received (117%).**
5.	Estimated 1,140 complaints closed in 2006/07.	30 June 2007	**Target achieved. 1,273 complaints closed (112%).**
6.	90% of all complaints closed within 12 months of receipt.	30 June 2007	**Target achieved. 1,221 of 1,273 closed (96%).**
7.	100% of all complaints closed within 2 years of receipt.	30 June 2007	**Target partly achieved. 99% of all complaints closed within 2 years of receipt. Three investigations took longer than usual because of their complexity.**
8.	50% of all investigations finalised within 12 months of receipt.	30 June 2007	**Target achieved. 54% of investigations finalised within 12 months of receipt.**
	Quality		
1.	100% compliance by providers with recommendations from the Commissioner for service improvements.	30 June 2007	**Target partially achieved (98%). Only 2 providers failed to comply with the Commissioner's recommendations; both have been referred to their professional bodies for follow-up action.**

Output 2: Education and Promotion

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	On-line satisfaction survey of website users accessing educational information and resources confirms 80% of website users find resources easy to access and helpful.	30 June 2007	**Target not achieved. The website on-line satisfaction survey has been monitored since 1 July 2006. Information about the articles and surveys placed on the HDC website was circulated to consumer groups and promoted in the December issue of *Pānui* (newsletter). By 31 January 2007 there were only four responses. The website was tested to ensure that links were intact and that all responses were being received. 100% of responses (4) indicate that the articles are easy to access and helpful. Work is being done to increase the disappointing survey response rate.**
2.	80% of consumers surveyed following HDC presentations, education or training sessions rate an improvement in their knowledge about the Code.	30 June 2007	**Target achieved. 100% of participants providing verbal evaluations indicated that their knowledge had increased. 80% of participants who provided written feedback recorded an increase in their knowledge.**
3.	6 regional consumer seminars to be held.	1 October–30 November 2006	**Target achieved. 6 regional consumer seminars held but not by due date.**
4.	80% of consumer seminar participants reported that the seminars were useful.	1 October–30 November 2006	**Target achieved but not by due date. On average 93% of participants found seminars useful.**
5.	Deliver 3 new customised educational programmes to group providers in prison health and residential care.	31 March 2007	**Target achieved. 3 customised education programmes developed and a total of 16 sessions delivered. Group providers were Tongariro–Rangipo Prison, Healthcare Providers New Zealand, and General Practices.**
6.	80% of provider respondents surveyed who participated in customised educational programmes reported an improvement in their awareness of their Code responsibilities and in the use of complaints as a quality improvement tool.	30 June 2007	**Target partly achieved. Providers reported an average of 67% improvement in awareness of Code responsibilities and 98% improvement in awareness of complaints as a means of improving quality and safety of health care.**

Output 2: Education and Promotion (continued)

	Performance Measure	Target Date	Actual
7.	Provide trend information to District Health Boards (DHBs) and professional bodies twice yearly.	31 August 2006 and 31 January 2007	Target achieved. Trend information was provided twice yearly to 21 DHBs.
8.	Six-monthly postal survey of DHBs reports 80% of respondents find trend information useful and outline how they used the information.	30 June 2007	Target achieved. 100% of DHBs reported trend information was useful.
9.	Develop, present and evaluate a training programme focused on rights-based practice as a core competency and meet with two registration authorities to obtain agreement of the inclusion of rights-based practice as a core competency for maintaining registration of providers by 30 June 2007 and have one registration authority agree to include rights-based practice as a core competency for maintaining registration of providers.	1 registration authority met with by 31 August 2006	Target achieved. Two registration authorities met with by 20 December 2006 — the Osteopathic Council and the Dental Council.
		2 registration authorities met with by 20 December 2006	Target achieved. A practice training programme (for osteopaths) focusing on rights-based practice as a core competency was developed, presented and evaluated.
		Agreement reached with 1 registration authority by 30 June 2007	Annual target achieved. Medical Council agreed to include collaborative rights-based practice as a core comptency.

Output 3: Policy Advice

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Estimated 32 submissions will be made in 2006/07.	30 June 2007	Target achieved. 51 requests for submissions responded to (159%).
	Quality		
1.	100% response rate to survey from people receiving our submissions and policy advice stating that they are satisfied with the quality and relevance of our work.	30 June 2007	Target partially achieved. 62% response rate to survey and 100% of those who responded rated that they were satisfied with the quality and relevance of our work.

Output 4: Advocacy

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Enquiries managed: 7,640.	30 June 2007	Target achieved. 8,388 (110%).
2.	Complaints managed and closed: 4,680.	30 June 2007	Target partially achieved. 7,573 managed (162%) and 4,078 closed (87%).
3.	Education sessions: 1,445.	30 June 2007	Target achieved. 1,665 (115%).
4.	Networking contacts: 1,545	30 June 2007	Target achieved. 2,575 (167%).
5.	75% of complaints resolved or partly resolved with advocacy.	30 June 2007	Targets achieved. On average, 88% of complaints resolved or partially resolved.
6.	80% of a random sample of consumers satisfied with advocacy services.	30 June 2007	80% of consumers satisfied with advocacy services.
7.	80% of a random sample of providers satisfied with the advocacy process and the professionalism of advocates.	30 June 2007	An average of 76% of providers satisfied with advocacy process and professionalism of advocates.
8.	80% of consumers and providers participating in presentations and educational sessions report satisfaction with quality of content and delivery.	30 June 2007	Target achieved (90%).
9.	Independent audit of advocacy services shows 95% compliance with contracted outputs.	30 June 2007	Target achieved.

Output 5: Proceedings

	Performance Measure	Target Date	Actual
	Quality		
1.	Tribunals are satisfied that 80% of proceedings are high quality.	30 June 2007	Target achieved (92%).
2.	100% of consumers, providers or counsel for the provider offered the opportunity to provide feedback on proceedings process.	30 June 2007	Target achieved (100%).

Health & Disability Commissioner

PO Box 1791
Auckland

Telephone: (09) 373 1060
Fax: (09) 373 1061

www.hdc.org.nz