HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

E.17

Learning from complaints

Annual Report
for the year ended 30 June 2010

CONTENTS

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

HEALTH and DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

1 November 2010

The Minister of Health
Parliament Buildings
WELLINGTON

Minister

In accordance with the requirements of section 150 of the Crown Entities Act 2004, I enclose the Annual Report of the Health and Disability Commissioner for the year ended 30 June 2010.

Yours faithfully

Anthony Hill
Health and Disability Commissioner

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Vision

Champions of consumers' rights.

Wawata

Kai kōkiri i nga tika kai hokohoko.

Mission

Resolution, protection, and learning.

Whainga

Whakataunga, whakamaru me te akoranga.

Cover photograph

Advocate Peta Paia'aua promoting Code of Rights Day (1 July) at Kenepuru Hospital, Porirua.

COMMISSIONER'S REPORT

Introduction

I took office as the third Health and Disability Commissioner on 19 July 2010. I join the organisation at an exciting time. The Office has a proud history of championing consumer rights and has been a strong voice and player in the evolution of the New Zealand health system. The health safety and quality environment is one that continues to develop. As I write, the legislation establishing the Health Quality and Safety Commission is before Parliament, representing a new step in New Zealand's commitment to the safety and quality journey. I look forward to working closely with the Commission in this new era.

Patient safety starts with doing the basics well — reliably, consistently. New Zealand has a health and disability system of which it can rightly be proud. There is also room to improve.

Anthony Hill
Commissioner

The recurring themes in the cases already before me tell me that while the system is strong, there is progress yet to be made in the journey towards a consumer-centred health and disability system.

I acknowledge Ron Paterson, who left office in March this year after 10 years in the role. His is a worthy legacy, and a significant contribution sustained over a decade of change in the New Zealand health sector. I also acknowledge Robyn Stent, who as the first Commissioner successfully drafted the Code of Health and Disability Services Consumers' Rights, which has endured for 15 years.

Special thanks are due to the Senior Leadership Team of the HDC, and in particular Deputy Commissioner Rae Lamb, who acted as Commissioner in the period between March and July and ensured that delivery was maintained throughout the transition.

The HDC continues to see a sustained rise in the number of complaints, and their complexity. Consequently the demands on the organisation continue to grow. I am extremely grateful for the calibre and commitment of my staff and the passion and wisdom they bring to dealing with these complex matters. It is a privilege to be involved in work such as this, where the daily experience of the office concerns personal moments in the lives of those we serve, and the system that serves us all.

Entity Performance

Key features of 2009/10 were:

- Responding to a continuing upward trend in the volume of complaints — an all-time high of 1,573 complaints
- 89% of complaints closed within six months
- 99% compliance with HDC recommendations
- 29,887 calls were made to the Nationwide Health and Disability Advocacy service
- 88% of complaints managed by advocates were partially or fully resolved
- 90% of consumers expressed satisfaction with the advocate who assisted them
- 100% success rate in tribunal outcomes this year
- Reduced budgeted deficit.

Advocacy Service

I wish also to acknowledge the Nationwide Health and Disability Advocacy Service. This service is contracted by the Health and Disability Commissioner and run by an independent trust. The service received nearly 30,000 calls in this reporting year, and dealt with over 3,800 complaints. The advocacy service plays a critical role in supporting health and disability services consumers.

Ron Paterson with Lesa Su'a-Larsen and Temu Su'a-Tuitausifusi, at the former Commissioner's farewell at Parliament. Guests included Hon Tony Ryall, the former Director General of Health, Stephen McKernan, and medical law expert Professor Peter Skegg. Lesa Su'a-Larsen and Temu Su'a-Tuitausifusi presented a gift on behalf of the family. Their father died after the early evidence of his lung cancer was not acted on by doctors. The family complained to HDC and were most appreciative of the way the Commissioner responded to their complaint.

Education

The focus on learning from complaints continued throughout the year.

Prisons

Following completion of the delivery of the HDC Workshop programme for prison nurses in June 2009, HDC has continued to be involved in working to promote the delivery of health care to prisoners in line with their rights under the Code. In September 2009, a submission was made to the Ombudsmen's own motion investigation into the provision, access and availability of health services for prisoners. The submission included comments based on complaints made to HDC about prison health services, and observations from the workshops delivered in 13 prisons since 2008. Information was also provided to the National Health Committee during their consultation for the Health in Justice report (released in July 2010).

Patients' Perspectives of Hospital Care Project

A major HDC initiative aimed at improving the care provided to hospital patients is being carried out in collaboration with staff at Waitakere Hospital in the Waitemata DHB. The project involves the collection of interview data from a random sample of Māori and non-Māori patients and their whānau/families to examine their experiences of care during a hospital admission. In addition, information about the experience of providing care to the patients has been gathered from health care practitioners. Gaps between patients' and practitioners' experiences about the delivery of hospital care can then be identified. This information will enable HDC to develop initiatives in education, training and support for health care services providers, and provide data that can be used to promote service improvements. The study was approved by the Northern Regional Ethics Committee.

DHB trend reports

HDC continues to provide six-monthly reports to District Health Boards (DHBs) covering the numbers and types of complaints, and the outcomes of closed complaints, making a total of

eight reports since January 2006. In addition to the regular and valuable feedback received in response to the reports, DHB complaints staff had an opportunity to discuss the reports with HDC staff at the Complaints Workshops held in Auckland, Wellington, Dunedin and Christchurch in March and April 2010. Discussion included topics such as potential limitations on the comparability of data, and the need for continuing anonymity of the DHBs regarding the number and types of complaints made about them to HDC. DHBs report that the information is used for educational purposes, including discussion at clinical governance and service quality meetings, and in consumer feedback meetings.

Cornerstone accreditation

In line with the requirements for general practices seeking accreditation, HDC provided Level One education sessions to practice staff (doctors, practice nurses and administration staff). Training sessions were held for staff from three PHOs (Auckland PHO, Partnership Health Canterbury PHO, and Marlborough PHO) representing over 460,000 consumers of health services.

HDC medico-legal conference

The legal team organised a very successful HDC medico-legal conference, A Decade of Change, in Wellington on 24 March 2010. The conference was well attended by about 210 medico-legal practitioners, and representatives from the Ministry, ACC, the registration authorities, the DHBs, and key consumer groups.

External speakers included Professor Peter Skegg, Associate-Professor Jo Manning, and Adam Ross, Chapman Tripp. There was also an "on the mat" interview with the former Commissioner, Ron Paterson, by Radio New Zealand journalist Karen Brown, and an engaging debate on "the public's right to know vs practitioner privacy". Professor Alan Merry and Dr Mary Seddon presented their perspective on legal barriers to health care quality improvement. Further information about the conference and some papers are available on the HDC website.

Consumer Advisory Group

Thanks also to the Consumer Advisory Group, who provided advice and constructive criticism when appropriate, aimed at assisting the Office to stay relevant and responsive to consumers. The Group has provided guidance on the majority of educational initiatives.

Cosmo, Martine Able's guide dog — a regular member of the CAG meetings.

ORGANISATION CHART as at 30 JUNE 2010

SENIOR MANAGEMENT TEAM

Health and Disability Commissioner
Anthony Hill

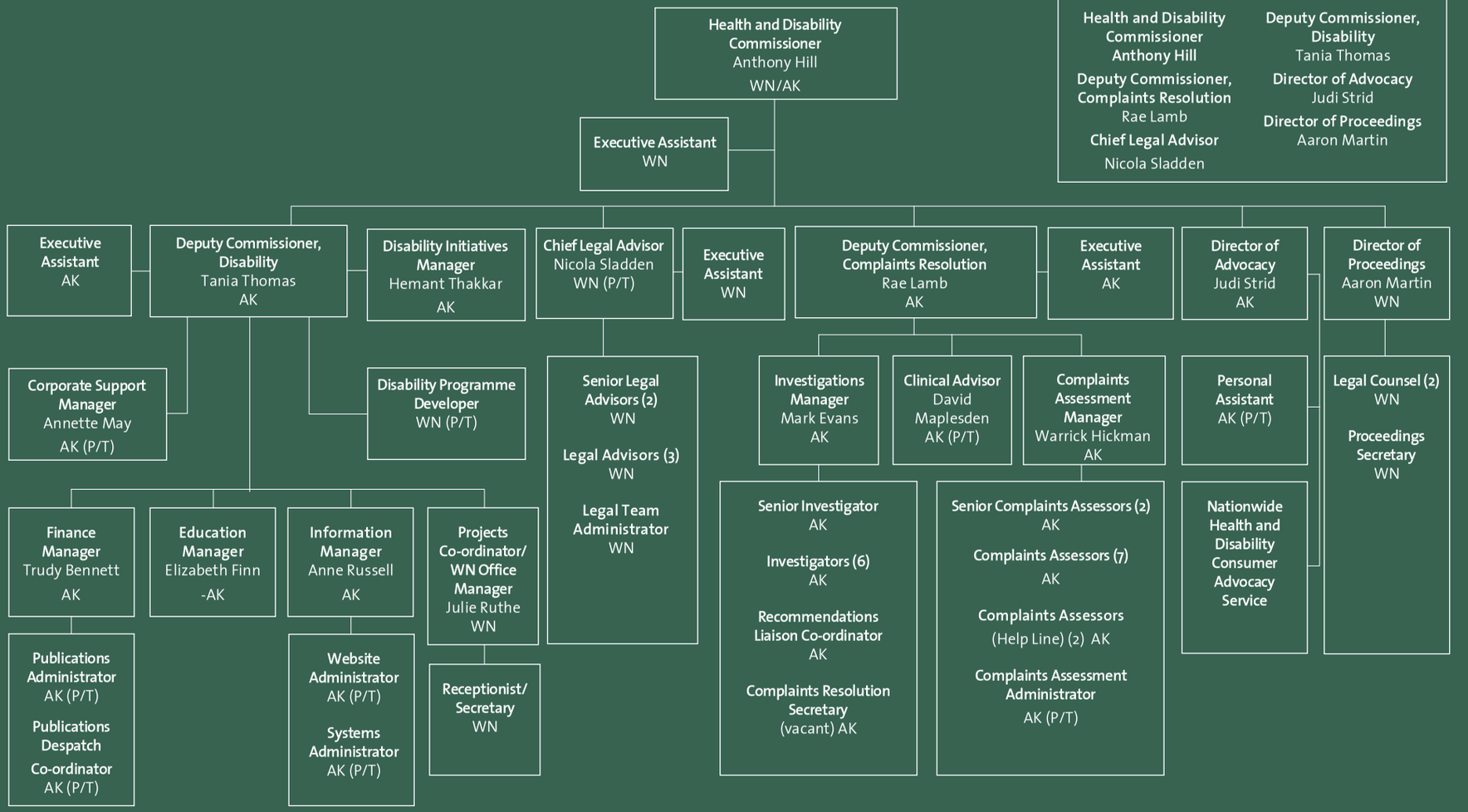
Deputy Commissioner, Disability
Tania Thomas

Deputy Commissioner, Complaints Resolution
Rae Lamb

Director of Advocacy
Judi Strid

Chief Legal Advisor
Nicola Sladden

Director of Proceedings
Aaron Martin



COMPLAINTS RESOLUTION

Complaints about health and disability services hit an all-time high of 1,573 this year — an average of 131 new complaints a month. Nonetheless, 89% were resolved within six months.

Some of the increase was undoubtedly due to public concern and news media coverage of the controversial change to a new laboratory service in Auckland. There were 161 complaints about this issue alone. A dramatic increase in complaints about disability services was another factor. Disability service providers were the third most commonly complained about group (after public hospitals and laboratories), with 120 complaints compared with 36 in 2008/09 and 18 in 2007/08.

The growth in complaint numbers also continues the trend of recent years, and this suggests much greater awareness of consumers' rights and HDC.

Rae Lamb
Deputy Commissioner,
Complaints Resolution

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

	2009/10	2008/09	2007/08
Open at year start	274	292	295
New during year	1,573	1,360	1,292
Closed during year	1,524	1,378	1,295
Open at year end	**323**	274	292

During the year, complaints resolution staff also handled 6,114 enquiries about a range of matters, including consumers' rights and requests for information. Most (5,720) were telephone enquiries.

Issues

Most complaints featured more than one issue. Treatment issues were the most common and included concerns about diagnosis, the adequacy and appropriateness of treatment, complications and unexpected outcomes, co-ordination of care, and referrals to other services.

Communication and consent and information issues also figured highly. These included concerns about the attitude and manner of the provider, communication with families, the adequacy and accuracy of information, informed consent, and the communication of test results.

Providers Complained About

Many complaints also involved more than one provider. There were 2,023 providers complained about in this period. Of these, 1,170 were group providers (organisations) while 853 were individuals. There was an average of two issues raised per provider.

Table 2: **Providers most commonly complained about**

Group providers			Individual providers		
Public hospital	42%	(491)	General practitioner	31%	(269)
Laboratory	14%	(163)	Physician	7%	(62)
Disability provider	10%	(120)	Nurse	7%	(58)
Rest home	10%	(112)	Dentist	7%	(57)
Medical centre	6%	(76)	Midwife	5%	(45)
			Psychiatrist	5%	(45)

Action Taken on Complaints

Each complaint was carefully assessed to determine the most appropriate way to fairly and promptly resolve it. Eighty-nine percent were closed in six months, 98% within a year.

Complaints were addressed in the following ways:

Referrals to other agencies

As seen in Table 3, there has been a marked increase in the number of complaints referred to other agencies. This recognises that when urgent action is required to address public safety or other urgent issues, the registration boards, funding contract holders, and agencies such as HealthCERT are often better placed to act more quickly than HDC. This was one reason why more than 95% of the complaints about the Auckland laboratory changes were referred to the District Health Board that held the funding contract. The DHB was required to report back

Table 3: **Complaints closed**

	2009/10	2008/09	2007/08
Outside jurisdiction (OJ)	131	132	113
Advocacy referrals	162	149	180
Formal investigation	51	109[1]	100
Referrals to other agencies[2]	359	184	138
Resolved by referral to providers	217	158	33
Resolved by mediation	5	4[3]	5
Section 38(1)	550	584	661
Withdrawn/Resolved by parties or Commissioner	49	58	65
Total complaints closed	**1,524**	**1,378**	**1,295**

1 Excludes investigations resolved by mediation.
2 Registration boards, agencies such as ACC and Ministry of Health, and officers such as District Inspectors and the Privacy Commissioner.
3 Includes investigations resolved by mediation.

to the Commissioner on action taken, and it provided regular updates. When these types of referrals are made, HDC uses its role as watchdog to independently monitor the response to the complaints, and follow up as necessary.

Where a complaint raises issues of competence or professional conduct, registered health practitioners are often referred directly to their registration boards, who have well established systems for addressing such concerns. The board is asked to report back on the outcome of the referral. Ninety practitioners were referred in this way.

Referrals to providers

In our experience, the earlier and more directly a complaint is dealt with, the greater the chance of successful resolution. This is why HDC has made greater use of the power to refer complaints back to the service provider for resolution. Often, complaints have not been made to the provider in the first instance. Even when this has happened, sometimes the Commissioner finds there is more that can be done to appropriately resolve the issues.

Providers are required to report back on how they resolved the matter, and the Commissioner has the discretion to reassess the complaint if it has not been appropriately addressed. Additionally, consumers are offered advocacy support during the process. As the case studies show, there have been some very good outcomes from these referrals.

REFERRAL TO PROVIDER — MAKING A DIFFERENCE TO NURSING CARE

The personal story of a woman who died from cancer is being used to improve the nursing care being provided to other patients in a small provincial hospital. This follows HDC's referral of her husband's complaint to the DHB.

The woman's husband complained about the standard of basic nursing care she received while she was in hospital. He first complained to the DHB but was unhappy with the response and came to HDC. He wanted to ensure that his wife's experience led to improvements in the care for other patients.

The Commissioner felt that more could be done by the DHB, and referred the complaint back to the DHB. As a result, DHB staff met with the husband. They subsequently worked with him to record a powerful DVD about the care his wife experienced, and the concerns. With his permission, a teaching package for nursing and clinical staff has been created including the DVD.

There has been positive feedback from staff who have used the package so far, and it will continue to be part of the ongoing education programme at the DHB.

REFERRAL TO PROVIDER — COMMUNICATION PROBLEM SOLVED

When a public hospital paediatrician apparently refused to see an infant following a private referral, the mother complained to HDC. She felt that her concerns about her daughter's health were not being taken seriously, that her daughter should have been accorded greater priority, and that the tone of the letter was condescending.

When the complaint was referred to the DHB it wrote to the woman with a full explanation of the process, the reasons for the way this referral had been handled, an apology for the distress caused, and an offer to discuss and organise alternative arrangements for the child to be seen.

The mother took up the offer and contacted the DHB. She subsequently reported that she was very happy with the outcome. She appreciated HDC's assistance.

Section 38(1)

Although there has been a big increase in complaints, there has been a drop in the proportion where the Commissioner ultimately decided to take no further action. Nonetheless, large numbers of complaints were still managed this way.

As has been stated in previous reports, most of these complaints are those where the Commissioner considers an educational approach is appropriate. This includes complaints where an appropriate outcome can be achieved without formal investigation, in a more flexible and timely way. Before any decision is made, considerable information is gathered

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SECTION 38 CLOSURE

Making sense of a misdiagnosis

A mother complained that a GP misdiagnosed her baby's condition. The doctor had diagnosed a simple rash, but subsequently the baby had to be hospitalised and was found to have the Herpes Simplex virus with ongoing serious implications for the baby's development. The mother was very angry with the doctor.

HDC sought a response to the complaint and a copy of the medical records. These were reviewed by the Commissioner's clinical advisor, who advised that despite the misdiagnosis, the care was in line with expected standards. The GP had been presented with an atypical presentation of an uncommon condition, and had acted appropriately given the information available at the time.

This advice was shared with the mother and followed up with a phone call to explain the advice and answer questions. The mother reported that this had helped her to make sense of what had occurred. No further action was taken.

Changing a dentist's practice

A woman complained that her dentist failed to correctly diagnose and treat ongoing tooth pain. No X-ray was done and she had repeated treatment. When she sought a second opinion, an infection was promptly diagnosed and effectively treated, although follow-up oral surgery was also needed. The woman wanted her dentist to be disciplined.

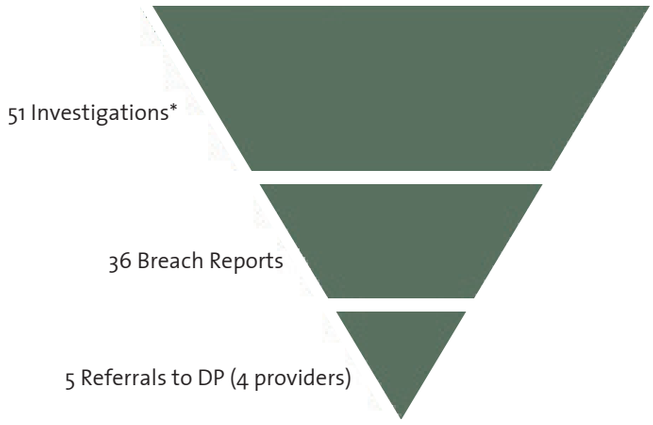
In response, the dentist provided a detailed account of the care. She conceded an X-ray would have been useful, and explained that apologies and some reimbursement had been given for aspects of the treatment that could have been better. She outlined some changes she had made as a result of these events.

HDC sought preliminary expert advice from an independent dentist, who advised that this was an evolving situation and, while the initial care was reasonable, further tests such as an X-ray should have been done when the symptoms continued. This advice was sent to the dentist, who agreed with the findings.

When the expert advice and the dentist's response were sent to the woman, she was happy for HDC to take an educational approach. Her concerns had been acknowledged and she wanted to make sure the dentist improved her practice.

The Commissioner wrote to the dentist pointing out that, as she had acknowledged, there were some genuine concerns about her treatment. She was asked to report back on further changes she was making to her practice. She reported that she was now taking X-rays and using other tests to investigate symptoms of pain, she had enrolled for an education course, and she had reimbursed the woman for her oral surgery. This was fed back to the complainant, who was happy with the outcome.

Figure 1: **Outcome of investigations 2009/10**



*10 discontinued, 10 found no breach, 1 resolved by mediation, 1 referred to registration board, 1 referred to provider to resolve.

and carefully assessed, and preliminary expert clinical advice is sought when needed. Before the complaint is closed, "education letters" are sent to providers, highlighting any issues and aspects of care needing review. An apology or other follow-up action is frequently requested.

In some cases, no further action is taken because, after careful assessment, there is no apparent breach of the Code, or because matters are already being addressed through other appropriate processes or agencies. Occasionally complaints are closed because so much time has elapsed since the events occurred it is not really possible to address the issues.

As the case studies show, good results can be achieved through an educational approach to complaints.

Investigations

HDC's focus on appropriate low-level resolution has again resulted in few formal investigations this year.

Investigations continue to be an important part of the Commissioner's role. They can result in providers being referred to the Director of Proceedings for consideration of disciplinary or other legal action. Providers found in breach of the Code of Health and Disability Services Consumers' Rights may also be publicly named.

Potentially significant breaches of ethical boundaries, major lapses in standards of care that have 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 all reasons why a complaint may be formally investigated.

In deciding whether to investigate, the Commissioner also considers the provider's response and action taken to address the concerns and fix any identified failings. These days it is common for there to have already been an investigation, sometimes involving independent external reviewers, and for remedial action to have been undertaken or planned.

In these cases, if the provider's investigation was a satisfactory one, HDC's focus will be on ensuring appropriate action has been taken rather than repeating the investigation. In some cases, other agencies such as Coroners are already involved and there is a need to avoid duplicate simultaneous inquiries. Sometimes it is simply the case that an appropriate outcome to the complaint can be achieved without an investigation.

INVESTIGATIONS

Financial exploitation of vulnerable consumer

A community health coordinator who accepted gifts and money worth about $55,000 from a mental health patient was referred to the Director of Proceedings following an investigation.

The investigation found that the coordinator had acted unethically and had inappropriately accepted the gifts and money. She had financially exploited and abused the trust of a vulnerable consumer and therefore breached Right 2 of the Code of Health and Disability Services Consumers' Rights (the Code). She was asked to pay back the money. Case 09HDC01375 (www.hdc.org.nz).

Anaesthesia during circumcision

A doctor and an unregistered overseas-trained colleague were investigated after a pre-school-aged boy had to be hospitalised following an unsuccessful attempt to circumcise him under local anaesthetic.

The investigation found that the decision to circumcise the boy without general anaesthetic was outside generally accepted practice and unreasonable given the circumstances in this case. The boy was not adequately anaesthetised and unreasonable force was used. The boy was not provided with services of an appropriate standard, his parents were not given sufficient information, and therefore informed consent was not obtained. The primary doctor and his practice were found to have breached the Code. The doctor was referred to the Director of Proceedings.

HDC also found that the unregistered overseas-trained doctor had provided a medical service by assisting the other doctor. He was referred to the Medical Council of New Zealand as he was seeking registration allowing him to practise here. Case 09HDC00810 (www.hdc.org.nz)

Robotic-assisted surgery

A surgeon's duty to inform a patient of his limited experience with robotic-assisted laparoscopic surgery and the risks involved with the procedure was the focus of an investigation.

This followed a complaint from a man whose surgery took almost twice as long as expected, following technical difficulties. The man developed a deep vein thrombosis (DVT) and had to have substantial further treatment. He suffered ongoing health problems.

The investigation found that the surgeon had failed to inform the patient about his limited experience with this technique, the length of time it had previously taken him to provide this treatment, that the risk of complications was increased if the treatment was prolonged, and what those risks were. He breached Rights 6(1) and (2) and failed to obtain informed consent (Right 7(1)).

Case 08HDC20258 (www.hdc.org.nz)

An investigation involves a formal legal process, which can be protracted owing to necessary procedural steps and, increasingly, legal challenge. It is not particularly consumer friendly. Investigations are also resource intensive and often appropriate learning and change, and resolution, can be achieved by other means. For these reasons the Commissioner's powers to investigate are used sparingly and where they can have greatest effect.

Recommendations

Another growing area of activity at HDC is following up complaints to ensure that appropriate improvements have been made to services and practices. This ensures that there is learning from the complaints that we see.

This year there were 347 recommendations covering changes to individual and organisational practice, and specific initiatives to address identified failings. An apology was commonly requested.

Once again, there has been a high level of compliance with the recommendations (99%), regardless of whether the follow-up action resulted from investigations recommendations or education letters.

RECOMMENDATIONS — MAKING A DIFFERENCE

Improving the care for acute surgery patients

A District Health Board has introduced a protocol for the management of acute surgery patients and is redesigning the pathway it follows. This results from a review recommended by HDC after an investigation into the case of a woman whose surgery for acute appendicitis was delayed for more than 48 hours.

The investigation highlighted issues around the process for determining clinical priority for competing acute surgery cases when there was only one operating theatre, as well as the need for better communication with patients about delays. The DHB was found to have breached the Code.

(Case 09HDC00836)

Better information about sedation during dental surgery

A dentist now suggests that patients have a support person with them during discussion about intravenous sedation, and the written consent form clearly indicates that "IV sedation is not a general anaesthetic". Patients are advised to raise their hand if they feel discomfort during the procedure, and all patients who have had IV sedation for oral surgery are telephoned the next day to check their well-being.

The dentist made these changes following an educational letter from HDC. The letter, which included preliminary expert advice, highlighted ways the dentist could have improved the care of a woman who understood she would be under general anaesthetic during a tooth extraction, and was distressed when she was not.

GP systems changes

Cultural awareness training for staff has been improved at a DHB after a complaint from a patient about a doctor from overseas.

The complaint raised issues about the return or disposal of tissue and/or substances following a miscarriage, as well as issues of sensitivity and respect. It revealed failings in the process for returning body products as well as inadequacies in the orientation and cultural training provided to the doctor. These were highlighted by HDC and acknowledged by the DHB.

As a result, the DHB introduced specific cultural training for women's health staff. The process for handling the return or disposal of body products was reviewed and the complainant was invited to comment on changes to the process.

DISABILITY

E ngā iwi, e ngā reo, e ngā karangatanga maha o
ngā hau e whā, tēnei te hihi atu ki a koutou katoa.

All people, all voices, all the alliances from the four winds, I greet you all.

Role of the Deputy Commissioner, Disability

"When people not used to speaking out are heard by people not used to listening then real change can be made." — John O'Brien, international commentator and author on person-centred approaches.

When I was appointed to the role of Deputy Commissioner Disability in March 2009, this quote set the scene for my approach to working with the disability sector. The aim is to have HDC recognised as an organisation that actively promotes "Best Practice" in the disability and health sectors, and be acknowledged as a resourceful agency that people can look up to for support and guidance on issues affecting disabled people.

Tania Thomas
Deputy Commissioner,
Disability

This dedicated role aims to support disabled people to retain control of their lives and the decisions that affect them, regardless of the services required. I have the delegated authority to manage all disability-related investigations and to focus on complaints resolution and education within the disability sector.

The Deputy Commissioner, Disability is also responsible for the Health and Disability Commissioner's work on:

1. The New Zealand Disability Strategy — work focused on includes:

- disability responsiveness training provided to HDC staff to increase disability sector knowledge and experience capability within HDC's staffing;
- improved accessibility features on HDC's website;
- circulating HDC vacancies through disability networks;
- using the Mainstream Programme;
- offering practicum and work experience placements for disabled tertiary students.

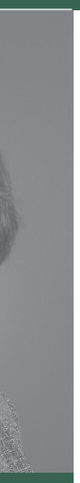
2. Recommendations from the Inquiry into the Quality and Care and Services Provision for People with Disabilities Report. The key work for HDC in response to the Inquiry Report has been to:

- make our complaints processes easier to understand and simpler to use;
- assist disabled people and their families to raise complaints without fear of retribution;
- raise issues from the report about quality of service provision with appropriate government authorities.

3. The United Nations Convention on the Rights of Persons with Disabilities.

The Convention's purpose is to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

HDC has taken proactive measures to promote the purpose of the Convention by creating two informative resources. Both the resources have gone through a process of consultation with Consumer Advisory Group members (advisors to the Commissioner) and other stakeholders in the disability sector. The resources were launched in March 2010:



- For disability service providers: "Are you committed to the Convention?" This resource provides useful tips for implementing the United Nations Convention at an organisational level for disability service providers. The resource also includes links to useful websites that could provide further information.
- For Government agencies: "Is your agency committed to the Convention?" This resource provides useful tips for implementing the United Nations Convention at an organisational level for government agencies. The resource also includes links to useful websites that could provide further information.

HDC takes into account the Convention when assessing disability complaints, and aligns our education for providers with the Convention.

Improving Accessibility and Responsiveness of HDC's Services to Disabled People

- HDC's role has been promoted in magazine advertisements, in newsletters that are widely read by people in the disability sector, on community notice boards, and in radio advertisements. A range of languages and accessible formats has been used where appropriate.
- HDC provides regular monthly updates to a wide database of consumers and providers in the disability sector.
- The Deputy Commissioner addressed a number of forums/training sessions organised by consumer groups and service providers in the disability sector, including: Healthcare of New Zealand, NZASID, Ngati Kapo, CCS Disability Action, IHC, Te Piringa, McIsaac Care Giving Agency, and the Muscular Dystrophy Association.
- The Disability Initiatives Manager attended a number of forums organised by consumer groups and service providers in the disability sector and presented at the Otago University Disability Symposium, to social work students at Unitech and Manukau Institute of Technology, and supervised a project for OT students at the Auckland University of Technology.
- One-on-one meetings have been held with senior managers and chief executives of a number of disability service provider organisations.
- Three consumer forums were held during the year in Dunedin — two with Mental Health and disability support service users and one with Deaf and hearing impaired consumers.
- Three meetings were held with HDC's Consumer Advisory Group.

Disability-related Complaints Received during 2009/10

A total of 198[1] disability-related complaints were received between 1 July 2009 and 30 June 2010. These include all complaints received from disabled consumers (receiving health or disability services) and all complaints involving a disability service provider. A statistical analysis of the complaints received appears on page 14. The top five categories are shown in each table.

Engagement within the Disability Sector

I have spent much of the first year in the role meeting with and listening to people from the disability sector. I have been struck by the sheer tenacity and resilience of consumers, their families, friends and carers. I have also been heartened by the passion and commitment of the many disability support providers I have spent time with.

1 The total figure includes 62 complaints received from people on a waiting list for hearing aids. All of these complaints were referred to the Ministry of Health to resolve directly with consumers through two key providers — Enable New Zealand and *access*able.

1. What people complained about

Table 1: **Primary issue**

Issue	No. of Complaints
Access and funding	74 (37%)
Management of facilities	25 (13%)
Treatment	21 (11%)
Communication	20 (10%)
Professional conduct	12 (6%)
Other	46 (23%)
Total	198

2. Who people complained about

Table 2: **Service category**

Service Category	No. of Complaints
Specialist equipment services	64 (32%)
Rest home care	26 (13%)
Residential care services	24 (12%)
Assessment services	20 (10%)
Home care	13 (7%)
Other services	51 (26%)
Total	198

3. What we did with the complaints

Table 3: **Complaint outcome (based on complaints closed during 2009/10)**

Outcome	No. of Complaints
Referred to Ministry of Health	63 (33%)
Educational letter/follow-up	62 (32%)
Referred to provider	32 (17%)
Referred to advocacy	19 (10%)
Outside jurisdiction	13 (7%)
Breach finding	2 (1%)
Total	191

4. People's major concerns

Table 4: **Top five complaint key words**

Complaint Key Word	No. of Complaints
Communication with family	22
Special needs not accommodated	22
Attitude/manner	20
Inadequate treatment	17
Access to subsidies/funding	13

(Since many complaints have multiple key words, the above table does not include a total column.)

Many thorny and complex issues have been raised with me — some longstanding, and none with an easy solution. Many of the issues raised were about access to services and funding of services — both areas of concern that are outside HDC's jurisdiction. HDC continues to refer these complaints to the relevant bodies to resolve. However, we have managed to achieve successful resolutions for disabled consumers even for issues outside HDC's jurisdiction by talking to the appropriate authorities.

Key Disability Initiatives

There was an increase of 20% in disability-related complaints received during the six-month period from July to December 2009 compared with the period 1 January to 30 June 2009. This has been attributed to the increased resource and focus that has been put into working within the disability sector to raise awareness of the work of HDC.

New Disability Programme Developer

Pam MacNeill started with HDC as our Disability Programme Developer in May 2010. Pam has extensive experience in the public sector and is well known in the disability community.

Disability section on the new HDC website
In addition to having improved accessibility features, the new HDC website has a separate disability section that provides useful information to disabled consumers, including news and event updates from the sector.

Health Passport
Often health professionals struggle to understand and meet the care needs of patients with disabilities. They may know how to treat the illness of a person, but some struggle when it comes to dealing with the person's impairment.

A Health Passport is a document that contains vital information about a person with a disability, to assist health professionals to understand the person's unique support needs. HDC is working in partnership (as a lead agency) with disability coordinators of various DHBs, consumer advisors, and a Ministry of Health representative to develop this document. Disabled patients face various physical, attitudinal, and service delivery barriers in accessing health care — this includes hospitals and medical centres.

Working in Partnership
This project is aimed at developing best practice guidelines on what it means to have person-centred and consumer-directed service where the consumer is an equal partner in decision-making about his or her care and services.

Educational Resources

Making it Easy to Get the Right Service
This is a DVD resource on the Code of Rights, for disabled consumers. This educational resource is another proactive measure of the Office to assist disabled consumers to understand their rights and to encourage them to exercise their rights when things go wrong. The DVD is directed by a deaf person, and a number of disabled consumers have acted in the DVD. The DVD has full accessibility features including subtitles and on-screen NZSL translation of the script.

Are You Committed to the Code
This is a print resource on the Code of Rights, for caregivers. This resource is designed to be a practical guide to the Code of Health and Disability Services Consumers' Rights for aged care and disability support workers. It gives 10 practical tips for each of the 10 rights in the Code. This resource, too, has gone through a process of consultation with Consumer Advisory Group members, as well as a few service providers. Based on the provider feedback, final changes are being made, and the resource will be launched later this year.

You have Rights — Easy Read Version of the Code of Rights
This resource is being updated to include information from the "Learning from Complaints" brochure, and to include more appropriate pictures/illustrations. HDC is working in partnership with People First to modify the resource.

Making it Easy to Understand Informed Consent and Supported Decision-Making
HDC is working in partnership with Auckland Disability Law to develop a print resource that explains the various provisions of the Protection of Personal and Property Rights Act (PPPR Act) and the concepts of Welfare Guardianship, Power of Attorney, etc in simple to understand (non-technical) language.

Multi Agency Group (MAG)

HDC belongs to MAG, which includes membership from mental health services consumers, the Mental Health Commission, the Mental Health Foundation, the Ministry of Health's Like Minds, Like Mine group, the Human Rights Commission, and the Office for Disability Issues.

MAG is working on a project called "Measuring Change in Discrimination and Social Inclusion", to measure changes in the extent of social inclusion and rates of discrimination against people with mental illness. Processes are being established to collect data to assist in addressing the discrimination associated with mental illness. The project follows up the report on measuring change produced for the Multi Agency Group (MAG) by Phoenix Research in June 2009. Much of the data collection will be from existing sources, but some of the key tasks will involve the group advocating for items to be added to the existing collection.

The primary outcome will be the production of a five-yearly report on discrimination experienced by mental health service users, which draws together all the relevant findings. The first of these reports will be published in July 2011.

QUALITY NEEDS ASSESSMENT

Mr A, a 61-year-old man with Parkinson's disease, received disability support services from the local District Health Board (DHB) under the Ministry of Health's "close in age and interest" policy. Mr A's neurologist recommended that a care package for "under 65" would be more appropriate for Mr A's overall quality of life. The request to reassess Mr A was declined by the local "under 65" Needs Assessment and Services Coordination (NASC) agency. According to Ms B, Mr A's partner and primary caregiver, if the neurologist's recommendations were accepted, they would be able to access a particular service provider who they believed could cater more appropriately for Mr A's specific care needs. Since ongoing correspondence with the DHB and the local NASC was unable to resolve matters, Ms B lodged a complaint with our office. She wanted Mr A to be reclassified for "under 65" services and to be able to access services from the service provider of their choice.

The broad issue of "access to a service" is outside our jurisdiction, and therefore we were unable to help Mr A access the "under 65" services. However, during the complaint assessment process we obtained a copy of a reassessment of Mr A's needs that was done by the DHB's NASC. Questions arose about the circumstances in which the reassessment took place, and the quality of the assessment itself. We raised our concerns with the DHB but were not satisfied with the response. We then sought expert advice on the quality of the reassessment.

The expert's report concluded that the assessment appeared to have been done in haste, without all appropriate people present, and contained insufficient information to inform service coordination of a plan that would reflect the holistic needs and outcomes of Mr A and his full-time carer and partner to enable a quality of life for both.

The expert's report was sent to the DHB for comment. In its response, the DHB acknowledged the shortcomings in the assessment document and accepted HDC's recommendation to provide further training to NASC staff. The DHB also agreed to provide Mr A with another reassessment with input from Ms B. Given the DHB's positive approach, further action was not necessary and we closed the file. An educational letter with a case study and recommendations to improve the quality of needs assessments and reporting was send to all NASC agencies throughout the country.

REPORT OF THE DIRECTOR OF ADVOCACY

The Nationwide Health and Disability Advocacy Service is a confidential service available, at no cost, to any person in New Zealand who wants to know about their rights when using a health or disability service. This includes how to make and resolve a complaint, as well as how to achieve improvements to the quality of services provided. Advocates are independent and on the side of the consumer. They can be easily contacted on an 0800 number as well as by free fax and email.

There are 48 advocates (41 FTEs) located in 25 community-based offices around the country. This means that 86% of the total advocacy workforce (56 people) are frontline advocates. Over half the core advocates are Māori, with three from Pasifika communities. Six advocates are specialist advocates working with the Deaf community (3) and refugee/migrant communities (3). Although they are based in Auckland, Wellington and Christchurch, the specialist advocates cover large geographical regions to improve access for consumers from these communities. Despite many people calling their local advocate directly, a total of 29,887 calls came to the 0800 number during the 2009/10 year.

Judi Strid
Director of Advocacy

Enquiries

The service provides a very effective clearing house with 10,440 enquiries managed for the year — an increase of 9% on the previous year. The highest percentage of enquiries was about the role of an advocate (18%), followed by how to make a complaint (17.5%), with the next highest being requests for education sessions (10%). The remainder related to a variety of subjects including mental health, queries regarding the role of the Commissioner's office, waiting lists, and rest home standards.

Advocates also receive a significant number of enquiries about matters that are outside the jurisdiction of the HDC legislation. These include access issues (6%) and ACC (5%). Although advocates are unable to assist consumers with resolving complaints about matters outside our jurisdiction, they can provide self-advocacy training to consumers so they can deal with these matters themselves. In these situations, advocates are able to act as mentors.

Sixty-eight percent of callers were provided with verbal and/or written information about advocacy and the Code, and 17% of callers were referred to other agencies such as the Privacy Commissioner, District Inspector, WINZ, ACC, Human Rights Commission, Police and Ombudsmen. Close to 6% of enquiries were escalated to complaints by consumers.

Complaints

The service received 3,408 new complaints, bringing forward 412 open complaints from the previous year. Of the total of 3,820 for the year ending 30 June 2010, 88% were fully or partially resolved. In 159 complaints where there was a resolution meeting, providers agreed to take post-meeting actions, which were recorded on the resolution agreement form. In all but 10 cases the provider completed the action within the agreed timeframe. The 10 who did not were very quick to follow up when the advocate contacted them to remind them of the agreement. Once again, this shows a high level of goodwill amongst providers, who are also keen to resolve complaints at an early stage. An increasing number of providers continue to use these agreement forms (available from advocates) for Right 10 complaints that go directly to them. The use of the agreement form removes the focus on minutes, which can trigger further dispute as well as the risk of a misunderstanding about what has been agreed to. The form also provides a prompt for an agreed date for reporting back to the consumer.

DENTAL COMPLAINT — SELF-ADVOCACY

A consumer complained about services provided by a dental surgeon. The consumer had paid for crowns, which had fallen off a number of times over a period of five months. When the consumer raised the issue with the dentist he was told that he would need to pay an additional fee.

The advocate explained the Code of Rights and how the advocate could support the consumer. The consumer advised that he had a good relationship with the dentist and felt able to manage the situation himself. He just wanted information about the options and the process.

The consumer said that he wanted to meet the dentist, so the advocate discussed how he might manage the meeting.

The consumer contacted the advocate following the meeting and advised that the parties had reached agreement. The treatment/repairs were to be carried out at no cost to the consumer. He was very happy with this outcome and thanked the advocate for the help she had given him to manage the process himself.

Timeliness is an important part of achieving a successful resolution, as the longer the matter goes on, the less likely there will be a successful outcome. During the 12-month period advocates closed 3,295 complaints, with 90% of those being closed within three months, and a total of 99% closed within six months. Complaints are classified according to the number of hours an advocate spends working with the consumer/complainant. During the past year, 41% were simple (up to 2 hours), 50% of complaints closed were classified as standard (2–8 hours), 7% were complex (8–15 hours), and 2% of complaints were classified as taking more than 15 hours.

Source of complaints

Fifty-eight percent of people who complained rang a local advocate directly; 22% used the 0800 number; 10% called in to the local advocacy office or discussed their complaint with the advocate during an education or networking session; and 10% contacted the advocate by letter, text, fax or email.

Complaints received directly from consumers accounted for 62% of all complaints, 35% were from complainants such as family members or friends, and 3% were formal referrals from the Health and Disability Commissioner.

At 81%, the vast majority of complaints relate to health service providers. The 19% relating to disability service providers is not reflective of consumers with impairments, as the statistics record the service used rather than the details about the consumer.

Recent changes to DHB complaint processes from a centralised system to each department dealing with its own complaints has created difficulties for consumers, particularly where more than one department is involved in a complaint. Advocates also report significant delays in getting responses to complaints where this approach is being used.

Complaint comparisons

It has been interesting to look once again at the similarities and differences between the nature of complaints about health services and disability services. Complaints about respect (Right 1) are the same at 6% each. Complaints about dignity and independence (Right 3) are very different, with 8.5% about disability providers and less than 1% about health services. Right 4 is clearly a major factor for both, with 38% of complaints about the standard of care in disability services, and 49% in health services. There has been an increase in complaints about disability services (5%) and a drop in complaints about health services (3%) in relation to the

right to be free from discrimination and exploitation (Right 2). The combined complaints about communication, information and consent (Rights 5, 6, and 7) give the same collective total of 33% each for both disability and health providers. The right to support (Right 8) features in just 3% of disability complaints (a significant drop from 10% last year) compared with 2% of health complaints. Four percent of complaints about a disability service related to the complaint process, compared with 3% about health service complaint processes.

Demographics

Most complaints come from female callers (58.6%); male consumers make up 41.2%; and people who describe their gender as "other" make up the remaining 0.2% of complainants.

Consumers under the age of 15 years account for 4% of complaints, although all bar two complaints were made by a parent or other family member. At 36%, the highest number of complaints were made by people in the 41–60 years age group, followed by 29% from the 26–40 years age group, with 23% being about consumers aged between 61–90 years.

New Zealand Pākehā continue to bring the largest number of complaints (70%) with New Zealand Māori making 13% of the complaints. The remainder of complaints are from a wide range of ethnic groups.

Service type category

Complaints relating to residential homes accounted for 26% of the complaints closed, with 453 (14%) of those being about rest homes, and 401 (12%) being about disability homes. Fourteen percent of complaints related to general practice, 13% to medical services, 10% to surgical services, and 10% were about mental health services. A total of 228 (9%) of the complaints were made by consumers in relation to prison health services. The remaining complaints are spread across a variety of service types such as home-based support, complementary medicine/therapy, accident and emergency, dental, outpatient clinics and alcohol and drug services.

Highlights

Highlights for the year have included the launch of two consumer resources — the *Tell Someone* DVD in Whakatane in October, as well as *The Art of Great Care* publication — giving weight to consumer stories to influence consumer-centred care. *The Art of Great Care* was launched at the national advocacy conference in March by former Commissioner

World premier launch of the *Tell Someone* DVD in Whakatane on 22 October 2009.

Code of Rights Day, Nelson Marlborough Hospital.

Ron Paterson. The conference was also an opportunity for the advocacy division to farewell the Commissioner.

The other highlight has been the national focus on celebrating the anniversary of the launch of the Code of Rights (1 July 1996). Code of Rights Day provides a very real opportunity to draw the attention of the public to the unique features of the Code, and how it can be used to improve the quality of services for consumers.

Advocates have been visiting rest homes for four years, and disability homes for three years, to provide free education sessions for residents as well as providers, and to make it easy for residents to speak with an advocate. The new DVD *Tell Someone* has been specially designed to help people with a learning or intellectual disability to understand their rights. Advocates use it in education sessions, as there are pauses to prompt discussion on what to do when you need to speak up and tell someone. There is an excellent section on the different types of abuse.

USING INTERPRETERS TO PROMOTE DIGNITY AND INDEPENDENCE

A Deaf consumer requested advocacy assistance to address his concerns about the loss of dignity and independence in the rest home where he lived. He asked the advocate to arrange a meeting with the manager, organise an interpreter, and support him at the meeting.

Using the interpreter, the consumer was able to communicate his concerns to the manager. These included the manager communicating with his family instead of him. The meeting proved useful in that it provided an opportunity for the consumer to raise his concerns and discuss other matters such as medication and activities. It also provided an insight for the manager into interpreters, how they work, how to make a booking, and how to access funding when an interpreter is required.

Following the resolution meeting the consumer told the advocate that he felt very empowered and said, “Just because I have a disability, it doesn’t mean I have something wrong with my brain.”

As a result of the meeting, the advocate identified that there was a need to have information available about interpreters in the area, how to book them, and information about funding. The advocate worked with local interpreters to develop a pamphlet which is currently being piloted.

VALUE OF FACE-TO-FACE MEETINGS

A consumer contacted her local advocate after a disappointing response to her complaint from a hospital. Despite receiving a 12-page response, the key points of her complaint were not addressed, and the letter contained conflicting information. After discussing the options, the consumer decided she wanted advocacy support to meet with the provider.

The advocate assisted the consumer to clarify the issues that had not been addressed in the provider's letter, as well as the additional issues arising from the response. The advocate then assisted her to write to the provider with an outline of the issues to be discussed at a meeting with the advocate to support her.

At the meeting the consumer was able to discuss her concerns. As the provider had been given information in advance of the issues to be discussed and what would resolve the matter, the provider was able to respond in a positive way. This included coming prepared with a written response, which the provider was able to discuss with the consumer and which she was able to take away at the end of the meeting. When the advocate and consumer debriefed following the meeting, the consumer said she was delighted with the result.

Over the past year, advocates have made 2,943 contacts with all of the 697 rest homes across the country. A total of 2,807 advocacy contacts have been made with all of the 884 disability homes.

Satisfaction Results

Ninety percent of consumers expressed satisfaction, making many positive comments about the advocate who assisted them. These included comments on the professionalism of the advocate, his or her knowledge and ability to communicate well, the courtesy and empathy shown, as well as helping the consumer to be clear about the issues and options for addressing them. Consumers were also pleased to have the advocate on their side.

Although advocates are on the side of consumers, it is important for providers to have confidence in the advocacy process. Eighty percent of providers who have had contact with the service and responded to the survey were satisfied with the professionalism of the advocate. A number commented on how well advocates facilitate communication between the parties, focusing on resolution rather than apportioning blame. Others commended the support given to the consumer by the advocate, and particularly how the advocate encouraged consumers to voice their concerns.

Networking

Over the past year, advocates developed and maintained contact with 4,363 networks. Forty-nine percent of the networks had a disability focus, and 51% a health focus. Of these, public interest groups made up 22% of the networks, and 20% were with people with an intellectual or learning impairment. Thirteen percent of networks were with older people's groups, 9% were with groups supporting people with a mental illness, and 6% were with groups supporting people with other disabilities. Māori and refugee/migrant networks were 3.4% each, with the remainder being spread across a variety of other groups.

Education

Advocates presented a total of 2,051 education and training sessions to a range of consumers, providers and organisations. The greatest number of requests for education were for

basic information on advocacy, the Code, and HDC. The next most popular topic was open disclosure, with advocates delivering 324 sessions on that topic alone over the past year. The demand for these sessions reflected the change to the health and disability sector standards that HDC was influential in achieving. Although open disclosure has always been an aspect of Right 6 (the right to be fully informed), open disclosure practices are now required as part of the certification process for DHBs and residential facilities.

The remainder of the sessions covered a variety of topics such as informed consent, self-advocacy, responding appropriately to Deaf consumers, and managing effective complaint processes.

Eighty-seven percent of consumers and 90% of providers who responded to the surveys were satisfied with the education sessions provided by advocates.

In-house advocacy trainers are trained to up-skill advocates in areas of strength-based practice and peer review, as well as Makaton and other communication aids to ensure they are confident in dealing with non-verbal consumers. Part of the role of the specialist advocates is to up-skill core advocates to build capacity within the service when working with the Deaf community as well as the many different refugee/migrant communities.

A dedicated qualification for health and disability advocates is in the final stages of being completed. This will form part of a career path framework for advocates.

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

AN ADVOCATE WRITES ABOUT A BREAKTHROUGH WHEN USING ALTERNATIVE FORMS OF COMMUNICATION WITH CONSUMERS WHO ARE NON-VERBAL

"I have been supporting a young consumer who has progressive multiple sclerosis and is non-verbal. He communicates by using a communication board with some pictures and phrases. His physical disability means he cannot always use his communication board, as when he is tired communication becomes much more difficult for him. I will usually arrange a visit in the morning, when he is less tired and better able to communicate.

I was delighted to be able to utilise my Makaton skills in working with this consumer, so I was able to support him to clarify his main issues and his desired outcome.

I assisted this young man to write a letter to his GP, requesting more information about his choices and stating some of the concerns he had regarding his diagnosis."

REPORT OF THE DIRECTOR OF PROCEEDINGS

Legal proceedings before the Health Practitioners Disciplinary Tribunal and the Human Rights Review Tribunal play a key role in vindicating the rights under the Code of Health and Disability Services Consumers' Rights, deterring future breaches of the Code, ensuring professional accountability, maintaining standards, and supporting access to justice for consumers.

In this my first full year in the role of Director of Proceedings it has been a privilege to have been able to work with so many people committed to improving outcomes for health and disability services consumers. Importantly, these people include the health professionals who provide the expert evidence that is so important in these cases, as well as the other witnesses — again, often health professionals — called upon to give evidence about difficult issues and traumatic events.

I must also acknowledge the dedication of my team in achieving an excellent success rate this year.

Aaron Martin
Director of Proceedings

Statistics

The Director of Proceedings team received five referrals during the year (in relation to four providers). There were seven substantive hearings, as compared to 12 in the previous year. However, those seven substantive hearings related to care provided to 11 consumers. In addition to these substantive hearings, two claims (each relating to the care received by two consumers) were dealt with "on the papers", without the need for a formal hearing. Two other cases were settled without the need for hearings, one of these outcomes being achieved through a restorative justice approach. In all, settlements were achieved for six consumers following decisions to take proceedings before the Human Rights Review Tribunal. There were also two appeal hearings in the High Court.

Table 1: **Action taken in respect of referrals to Director of Proceedings in 2009/10**

Provider	No. of providers	No further action	DP decision in progress	Proceedings pending	Proceedings concluded	Total No. of consumers involved (referrals)
Counsellor	1				1[1]	1
Medical practitioner						
General practitioner	1	1				1
Rest home	1		1	1		2
Massage practitioner	1				1	2
Nurse	1				1	2
Caregiver	1			1		1
Total	**6**	**1**	**1**	**2**	**3**	**9**

1 Resolved by way of a "restorative justice" approach, without a statement of claim being filed.

Note: Table 1 records the Director of Proceedings' actions on referrals in the 2009/2010 year, irrespective of whether the referral was received in that year or in the previous year. As reported under the heading "Statistics", the Director of Proceedings received five referrals in the 2009/2010 year (in relation to four providers).

Table 2: **Outcomes in 2009/10**

Provider	Successful	Unsuccessful	Outcome Pending	Total No of Providers	Total No of Consumers
Substantive hearings					
Medical practitioner					
Surgeon	1[1]			1	1
Psychiatric nurse	1			1	2
Psychologist	1			1	1
Nurse	3			3	5
Chiropractor	1			1	2
Appeals					
Medical practitioner					
General practitioner		1		1	1
Nurse	1[2]			1	1
HRRT					
Massage practitioner	2[3]			2	4
Counsellor	1[4]			1	1
Nurse	1[5]			1	1
Total	**12**	**1**	**0**	**13**	**19**

1 Penalty decision pending.
2 Appeal by practitioner against refusal to grant name suppression.
3 There was an interlocutory hearing in relation to one of these matters, with both of the substantive matters ultimately determined "on the papers".
4 Settled without the need for substantive hearing (restorative justice approach).
5 Settled without the need for substantive hearing.

Note: One HRRT proceeding was withdrawn before the first directions teleconference when a defendant who had not previously engaged with HDC provided a late response.

All of this year's substantive hearings resulted in successful outcomes, although a practitioner found guilty of professional misconduct in the 2008/09 year successfully appealed that finding to the High Court.

PSYCHIATRIC DISTRICT NURSE HELD ACCOUNTABLE FOR SERIOUS FAILURES OF CARE

In a decision dated 8 June 2010 the Health Practitioners Disciplinary Tribunal found Graeme Torrance, a registered psychiatric district nurse, guilty of professional misconduct in his care of two longstanding mental health service clients (Mr R and Ms N).

Following a reduction in Mr R's dose of anti-psychotic medication, Mr R's condition gradually deteriorated with him experiencing delusional thoughts and displaying disturbed behaviour. In response to the stress arising from Mr R's deterioration, Ms N's condition also deteriorated, this then being exacerbated by stress she experienced owing to impending eviction from their home at the end of 2007. In late December 2007 Mr Torrance went on leave and, when he returned, he found that his clients had been evicted from their home and that Ms N had gone missing. Sadly, she had taken her own life.

Following the decision to reduce Mr R's dose of antipsychotic medication, Mr Torrance failed to undertake adequate assessment of risk to his clients, and failed to adequately manage that risk in that he failed to arrange timely psychiatric reviews for his clients. He also failed to plan or conduct adequate follow-up care for them, and to adequately respond to concerns raised by his clients' families about their well-being. Further, he failed to engage the assistance of appropriate members of the broader DHB care team in managing those risks or to provide relevant information to appropriate members of the care team in a timely manner. His documentation of the care he provided to his clients was inadequate. When Mr Torrance went on leave in late December 2007 he failed to develop an adequate plan of care or undertake an adequate handover of care to other staff.

Mr Torrance admitted the charge against him, and the matter proceeded by way of an agreed summary of facts, although the scope of the case was such that even on this basis the hearing still occupied four days.

The Tribunal concluded that the standard of care Mr Torrance provided to Mr R and Ms N fell well below the standard expected of a registered nurse, and that given the extremely serious nature of the charges and the issue of public safety it had no option other than to cancel Mr Torrance's registration.

The Tribunal's decision can be found at: http://www.hpdt.org.nz/Default.aspx?tabid=254

CHIROPRACTOR SUSPENDED FOR UNETHICAL, CLINICALLY UNJUSTIFIED AND INAPPROPRIATE PRACTICE

On 15 June 2010 the Tribunal issued its first decision concerning a chiropractor, finding Dr Sean Parker guilty of professional misconduct in relation to the care and treatment he provided to two consumers. The two charges were heard together and both proceeded by way of an agreed summary, with the prosecution also calling expert evidence in each case.

Dr Parker promoted a "Deep Treatment programme" with an upfront fee of $3,700.00. The contract he offered clients was contrary to the NZ Chiropractic Board's Code of Ethics as it was not specific about the number of treatments per week, how the cost was calculated, the reasons for the treatment, the ability of a consumer to withdraw, or the clinical necessity of the treatment. In both cases the treatment he provided or recommended was clinically unjustified or inappropriate for the client's condition.

In one of the two cases, in addition to finding that the treatment provided to the consumer was not clinically appropriate and that the contract for the prepaid treatment was unethical, the Tribunal also expressed concern that the long-term treatment plan provided raised safety issues, and the longer it continued the greater the risk of Dr Parker exacerbating the consumer's condition and delaying the receipt of medical care. The Tribunal also expressed concern about the financial consequences of the programme on that consumer.

The Tribunal imposed a significant penalty on Dr Parker including:

- 18 months' suspension to be followed by 18 months' supervision, with regular reports to the Board, followed by a further 18 months of case load supervision;
- conditions including that prior to recommencing practice he undertake training and can demonstrate competency to the satisfaction of the Chiropractic Board with respect to various matters; and
- costs of $5,000 ($3,000 to the prosecution and $2,000 for the Tribunal).

The Tribunal's decision can be found at: http://www.hpdt.org.nz/Default.aspx?tabid=266

PSYCHOLOGIST STRUCK OFF FOR FAILING TO MAINTAIN PROFESSIONAL BOUNDARIES WITH CLIENT

On 12 January 2010 the Health Practitioners Disciplinary Tribunal found Ms Susan Jury, a psychologist, guilty of professional misconduct. Ms Jury did not attend the Tribunal's hearing.

Ms Jury faced a charge alleging that she failed to maintain appropriate professional boundaries with a client and provided misleading and inaccurate information about the relationship to her employer DHB, and to the Health and Disability Commissioner.

Mr W was referred to Ms Jury after a period of acute in-patient care following attempted suicide. He faced a number of stressors in his life, was diagnosed with bi-polar disorder, was depressed, at risk of suicide, had problems with anger, violence, and alcohol, and was experiencing relationship difficulties including with his wife, towards whom he had been violent.

Within months of her first consultation with Mr W, Ms Jury entered into an inappropriate relationship with him. The charge alleged a number of particulars including that she disclosed her own personal health concerns, went drinking with him at licensed premises, and permitted him to stay overnight or reside at her home. The charge also alleged that she allowed him to undertake work around her property and help her son to purchase a car, and allowed him to pay her to store personal items at her home.

The Tribunal considered that Ms Jury's actions had a significant impact on Mr W's care, put him and members of his family at risk, and represented a significant failure to comply with professional obligations owed to the proper authorities.

The prosecution allegation that Ms Jury had entered into a sexual relationship with Mr W was not upheld by the Tribunal as there was insufficient evidence. However, the Tribunal did find that she had entered into an inappropriate relationship and upheld all other particulars of the charge.

The Tribunal cancelled Ms Jury's registration, censured her, and ordered that in the event that she reapplies for registration she undertake training to the satisfaction of the Psychologist Board on appropriate professional boundaries, the dynamics of violent relationships, the Code of Ethics, the need for supervision, and candour in supervision. She was fined $5,000 and ordered to pay costs of $18,000.

The Tribunal's decision can be found at: http://www.hpdt.org.nz/Default.aspx?tabid=245.

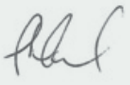
Statement of Responsibility for the year ended 30 June 2010

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

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

In the Health and Disability Commissioner's opinion, these financial statements and statement of service performance fairly reflect the financial position and operation of the Health and Disability Commissioner for the year ended 30 June 2010.

Signed on behalf of the Health and Disability Commissioner.



Anthony Hill
Health and Disability Commissioner

Tania Thomas
Deputy Health and Disability Commissioner, Disability

1 November 2010

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Audit Report

To the readers of the
Health and Disability Commissioner's
financial statements and statement of service performance
for the year ended 30 June 2010

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 her 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 2010.

Unqualified opinion

In our opinion:

- The financial statements of the Health and Disability Commissioner on pages 30 to 49:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health and Disability Commissioner's financial position as at 30 June 2010; 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 50 to 54:
  - 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 1 November 2010, and is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

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

Audit procedures generally include:

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

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

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

Responsibilities of the Health and Disability Commissioner and the Auditor

The Health and Disability Commissioner is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health and Disability Commissioner as at 30 June 2010 and the results of its operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health and Disability Commissioner's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses adopted at the start of the financial year. The Health and Disability Commissioner's responsibilities arise from the Crown Entities Act 2004 and the Health and Disability Commissioner Act 1994.

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

Independence

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

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 and statement of service performance

This audit report relates to the financial statements and statement of service performance of the Health and Disability Commissioner for the year ended 30 June 2010 included on the Commission's website. The Commission is responsible for the maintenance and integrity of the Commission's website. We have not been engaged to report on the integrity of the Commission's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements and statement of service performance. 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 statement of service performance as well as the related audit report dated 1 November 2010 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

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

STATEMENT OF COMPREHENSIVE INCOME for the year ended 30 June 2010

	Note	Actual 2010 $	Budget 2010 $	Actual 2009 $
Income				
Revenue from Crown	2	9,170,000	9,445,000	8,990,000
Interest income		82,588	50,000	152,438
Other revenue	3	89,704	90,000	85,637
Total income		9,342,292	9,585,000	9,228,075
Expenditure				
Personnel costs	4	3,761,113	4,059,832	3,788,066
Depreciation and amortisation expense	9, 10	241,142	288,992	296,670
Advocacy Services		3,523,585	3,595,998	3,229,230
Other expenses	5	1,855,564	2,052,248	1,956,257
Total expenditure		9,381,404	9,997,070	9,270,223
Net deficit for the year		**(39,112)**	**(412,070)**	**(42,148)**
Total comprehensive income for the year		**(39,112)**	**(412,070)**	**(42,148)**

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION as at 30 June 2010

	Note	Actual 2010 $	Budget 2010 $	Actual 2009 $
Assets				
Current Assets				
Cash and cash equivalents	6	1,387,234	1,064,922	1,296,657
Debtors and other receivables	7	35,738	30,000	87,900
Prepayments		58,097	34,000	85,329
Inventories	8	28,173	18,000	31,798
Total current assets		1,509,242	1,146,922	1,501,684
Non-current assets				
Property, plant and equipment	9	291,741	286,008	365,316
Intangible assets	10	98,990	107,000	98,971
Total non-current assets		390,731	393,008	464,287
Total assets		**1,899,973**	**1,539,930**	**1,965,971**
Liabilities				
Current Liabilities				
Creditors and other payables	11	413,656	453,000	436,448
Employee entitlements	12	144,023	148,000	148,117
Total current liabilities		557,679	601,000	584,565
Total liabilities		557,679	601,000	584,565
Net Assets		**1,342,294**	**938,930**	**1,381,406**
Equity				
General funds	13	1,342,294	938,930	1,381,406
Total Equity		**1,342,294**	**938,930**	**1,381,406**

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY for the year ended 30 June 2010

	Actual 2010	Budget 2010	Actual 2009
	$	$	$
Balance at 1 July	1,381,406	1,351,000	1,423,554
Amounts recognised directly in equity:			
Total comprehensive income	(39,112)	(412,070)	(42,148)
Total Net Recognised Revenues and Expenses	1,342,294	938,930	1,381,406
Balance at 30 June	**1,342,294**	**938,930**	**1,381,406**

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS for the year ended 30 June 2010

	Note	Actual 2010 $	Budget 2010 $	Actual 2009 $
Cash Flow from Operating Activities				
Receipts from Crown revenue		9,170,000	9,445,000	8,990,000
Interest received		84,826	50,000	156,910
Receipts from other revenue		134,081	90,000	29,725
Payments to suppliers		(5,379,445)	(5,648,246)	(5,280,248)
Payments to employees		(3,765,207)	(4,059,832)	(3,799,350)
Goods and services tax (net)		13,658	–	7,072
Net cash from operating activities	14	**257,913**	**(123,078)**	**104,109**
Cash Flows from Investing Activities				
Receipts from sale of property, plant and equipment		250	0	4,019
Purchase of property, plant and equipment		(66,427)	(166,000)	(175,703)
Purchase of intangible assets		(101,159)	(120,000)	(115,668)
Net Cash from Investing Activities		**(167,336)**	**(286,000)**	**(287,352)**
Net increase (decrease) in cash and cash equivalents		**(90,577)**	**(409,078)**	**(183,243)**
Cash and cash equivalents at beginning of year		1,296,657	1,474,000	1,479,900
Cash and cash equivalents at end of year	6	**1,387,234**	**1,064,922**	**1,296,657**

The accompanying notes form part of these financial statements.

1 Statement of accounting policies for the year ended 30 June 2010

Reporting Entity

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

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

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

The financial statements for the Health and Disability Commissioner are for the year ended 30 June 2010, and were approved by the Commissioner on 4 September 2010.

Basis of Preparation

Statement of compliance

The financial statements of the Health and Disability Commissioner have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirements to comply with New Zealand generally accepted accounting practice (NZ GAAP).

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

Measurement base

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

Functional and presentation currency

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

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

HDC has adopted the following revisions to the accounting standards during the financial year, which have had only a presentational or disclosure effect:

- NZ IAS 1 *Presentation of Financial Statements (Revised 2007)* replaces NZ IAS 1 *Presentation of Financial Statements (Issued 2004)*. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. HDC has decided to prepare a single statement of comprehensive income for the year ended 30 June 2010 under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated accordingly. Items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes in equity.
- Amendments to NZ IFRS 7 *Financial Instruments: Disclosures*. The amendments introduce a three-level fair value disclosure hierarchy that distinguishes fair value measurements by the

significance of valuation inputs used. A maturity analysis of financial assets is also required to be prepared if this information is necessary to enable users of the financial statements to evaluate the nature and extent of liquidity risk. The transitional provisions of the amendment do not require disclosure of comparative information in the first year of application. HDC has elected to disclose comparative information.

Significant Accounting Policies

Revenue

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

Revenue from the Crown

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

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

Interest

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

Sale of publications

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

Leases

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

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

Investments

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

Bank deposits

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

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

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

Inventories

Inventories (such as publications) held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at the lower of cost and net realisable value, adjusted when applicable, for any loss of service potential. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the statement of financial performance in the period of the write-down.

Property, plant and equipment

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

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

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the Health and Disability Commissioner and the cost of the item can be measured reliably.

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

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are included in the statement of comprehensive income.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the Health and Disability Commissioner and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the statement of financial performance as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Leasehold improvements	3 years	(33%)
Furniture and fittings	5 years	(20%)
Office equipment	5 years	(20%)
Motor vehicles	5 years	(20%)
Computer hardware	4 years	(25%)
Communication equipment	4 years	(25%)

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year end.

Intangible assets

Software acquisition and development

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

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

Costs associated with the development and maintenance of the Health and Disability Commissioner's website are recognised as an expense when incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each period is recognised in the statement of financial performance.

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

Acquired computer software	2 years	50%

Impairment of non-financial assets

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

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

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

Creditors and other payables

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

Employee entitlements

Short-term employee entitlements

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

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

Superannuation schemes

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

Goods and Service Tax (GST)

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

The Health and Disability Commissioner is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

Budget figures

The budget figures are derived from the statement of intent as approved by the Health and Disability Commissioner at the beginning of the financial year. The budget figures have been prepared in accordance with NZ IFRS, using accounting policies that are consistent with those adopted by the Health and Disabiity Commissioner for the preparation of the financial statements.

Cost allocation

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

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

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

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical Accounting Estimates and Assumptions

In preparing these financial statements the Health and Disability Commissioner has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Property, plant and equipment useful lives and residual value

At each balance date the Health and Disability Commissioner reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires the Health and Disability Commissioner to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by the Health and Disability Commissioner, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the statement of financial position. The Health and Disability Commissioner minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programmes.

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

Critical Judgements in Applying the Health and Disability Commissioner's Accounting Policies

Management has exercised the following critical judgements in applying the Health and Disability Commissioner's accounting policies for the period ended 30 June 2010:

Lease classification

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

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

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

2 Revenue from Crown

The Health and Disability Commissioner has been provided with funding from the Crown for the specific purposes of the Health and Disability Commissioner as set out in its founding legislation and the scope of the relevant government appropriations. Apart from these general restrictions there are no unfulfilled conditions or contingencies attached to government funding (2009 nil).

3 Other Revenue

	Actual 2010 $	Actual 2009 $
Sale of Publications	89,704	85,637
Total Other Revenue	**89,704**	**85,637**

4 Personnel Costs

	Actual 2010 $	Actual 2009 $
Salaries and wages	3,749,224	3,780,246
Employer contributions to defined contribution plans	15,983	19,104
Increase/(decrease) in employee entitlements (note 12)	(4,094)	(11,284)
Total Personnel Costs	**3,761,113**	**3,788,066**

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

5 Other Expenses

	Actual 2010 $	Actual 2009 $
Fees to auditor:		
Audit fees for financial statement audit	30,870	29,400
Staff travel and accommodation	92,298	124,858
Operating lease expense	506,677	486,974
Advertising	91,928	31,218
Consultancy	359,832	391,530
Inventories consumed	184,418	160,164
Net profit on sale of property, plant and equipment	(250)	(3,692)
Other	589,791	735,805
Total other expenses	**1,855,564**	**1,956,257**

6 Cash and cash equivalents

	Actual 2010 $	Actual 2009 $
Cash on hand and at bank	27,234	36,657
Cash equivalents — term deposits	1,360,000	1,260,000
Total cash and cash equivalents	**1,387,234**	**1,296,657**

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

The weighted average effective interest rate for term deposits is 3.9% (2009 4.2%).

7 Debtors and other receivables

	Actual 2010 $	Actual 2009 $
Trade receivables	25,561	75,485
Other receivables	10,177	12,415
Less provision for impairment	0	0
Total debtors and other receivables	**35,738**	**87,900**

The carrying value of receivables approximates their fair value.

As at June 2010 and 2009, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2010 $	2009 $
Not past due	30,593	87,374
Past due 1–30 days	4,461	526
Past due 31–60 days	284	0
Past due 61–90 days	400	0
Past due > 91 days	0	0
Total	**35,738**	**87,900**

8 Inventories

	Actual 2010 $	Actual 2009 $
Publications held for sale	28,173	31,798
Total inventories	**28,173**	**31,798**

The carrying amount of inventories held for distribution that are measured at current replacement costs as at 30 June 2010 amounted to $28,173 (2009 $31,798).

9 Property, Plant and Equipment

Movements for each class of property, plant and equipment as at 30 June 2010 are as follows:

Cost	Comp hardware	Comms equip	Furn and fittings	Leasehold improve-ments	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 2009	782,589	26,723	196,970	670,532	40,889	185,837	1,903,540
Additions during year	60,471	0	4,431	1,525	0	0	66,427
Disposals during year	(12,722)	0	(1,483)	0	0	0	(14,427)
Balance at 30 June 2010	830,338	26,723	199,918	672,057	40,889	185,615	1,955,540
Accumulated Depreciation							
Balance at 1 July 2009	537,094	26,723	185,666	636,441	1,363	150,937	1,538,224
Charge for year	93,756	0	5,031	18,073	8,178	14,964	140,002
Disposals	(12,722)	0	(1,483)	0	0	(222)	(14,427)
Balance at 30 June 2010	618,128	26,723	189,214	654,514	9,541	165,679	1,663,799
Net book value 30 June 2010	**212,210**	**0**	**10,704**	**17,543**	**31,348**	**19,936**	**291,741**

Cost	Comp hardware	Comms equip	Furn and fittings	Leasehold improve-ments	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 2008	844,359	26,723	197,209	650,875	42,280	185,408	1,946,854
Additions during year	109,630	0	5,098	19,657	40,889	429	175,703
Disposals during year	(171,400)	0	(5,337)	0	(42,280)	0	(219,017)
Balance at 30 June 2009	782,589	26,723	196,970	670,532	40,889	185,837	1,903,540
Accumulated Depreciation							
Balance at 1 July 2008	626,111	26,723	185,951	588,417	42,280	135,442	1,604,924
Charge for year	82,056	0	5,052	48,024	1,363	15,495	151,990
Disposals	(171,073)	0	(5,337)	0	(42,280)	0	(218,690)
Balance at 30 June 2009	537,094	26,723	185,666	636,441	1,363	150,937	1,538,224
Net book value 30 June 2009	**245,495**	**0**	**11,304**	**34,091**	**39,526**	**34,900**	**365,316**

10 Intangible Assets

Movements for each class of property, plant and equipment as at 30 June 2010 are as follows:

	Actual 2010 $	Actual 2009 $
Computer Software		
Balance at 1 July	877,290	761,622
Additions during the year	101,159	115,668
Disposals during the year	0	0
Balance at 30 June	978,449	877,290
Accumulated Amortisation		
Balance at 1 July	778,319	633,639
Charge for the year	101,140	144,680
Disposals	0	0
Balance at 30 June	879,459	778,319
Net book value at 30 June	**98,990**	**98,971**

All software is acquired software.

There are no restrictions over the title of the Health and Disability Commissioner's intangible assets, nor are any intangible assets pledged as security for liabilities.

11 Creditors and Other Payables

	Actual 2010 $	Actual 2009 $
Creditors	216,331	249,596
Accrued expenses	45,981	40,083
Other payables	151,344	146,769
Total creditors and other payables	**413,656**	**436,448**

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

12 Employee Entitlements

	Actual 2010 $	Actual 2009 $
Current employee entitlements are represented by:		
Annual leave	143,187	147,117
Retirement and long service leave	836	1,000
Total current portion	144,023	148,117
Total employee entitlements	**144,023**	**148,117**

13 Equity

	Actual 2010 $	Actual 2009 $
General funds		
Balance at 1 July	1,381,406	1,423,554
Total comprehensive income for the year	(39,112)	(42,148)
Total equity at 30 June	**1,342,294**	**1,381,406**

14 Reconciliation of Net Deficit to Net Cash from Operating Activities

	Actual 2010 $	Actual 2009 $
Total comprehensive income	(39,112)	(42,148)
Add/(less) non-cash items:		
Depreciation and amortisation expense	241,142	296,670
Total non-cash items	241,142	296,670
Add/(less) items classified as investing or financing activities		
(Gain) on disposal of property, plant and equipment	(250)	(3,692)
Total items classified as investing or financing activities	(250)	(3,692)
Add/(less) movements in working capital items		
Debtors and other receivables	73,847	(73,798)
Inventories	3,625	(21,462)
Creditors and other payables	(17,245)	(40,177)
Employee entitlements	(4,094)	(11,284)
Net movements in working capital items	56,133	(146,721)
Net cash from operating activities	**257,913**	**104,109**

15 Commitments and Operating Leases

Advocacy Service contracts

The maximum commitment for the 12 months from 1 July 2010 is $3,539,998 (2009: $3,595,998).

Operating leases as lessee

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

	Actual 2010 $	Actual 2009 $
Not later than one year	508,251	537,412
Later than one year and not later than five years	528,283	942,463
Later than five years	0	94,071
Total non-cancellable operating leases	**1,036,533**	**1,573,946**

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

A portion of the total non-cancellable operating lease expense relates to the lease of these two offices. The Auckland lease expires in May 2011 and the Wellington lease expires in April 2015.

16 Contingencies

Contingent liabilities

As at 30 June 2010 there were no contingent liabilities (2009 $nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2009 $nil).

17 Related Party Transactions and Key Management Personnel

Related party transactions

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

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

Key management personnel compensation

	Actual 2010 $	Actual 2009 $
Salaries and other short-term employee benefits	931,750	967,000
Post-employment benefits	18,863	14,750
Other long-term benefits	0	0
Termination benefits	0	0
Total key management personnel compensation	**950,613**	**981,750**

Key management personnel include the six Senior Leadership Team members.

18 Employee Remuneration

Total remuneration paid or payable

	Actual 2010 $	Actual 2009 $
110,000–119,999	1	1
120,000–129,999	1	1
130,000–139,999	0	0
150,000–159,999	1	1
170,000–179,999	3	2
220,000–229,999	0	0
230,000–239,999	0	0
240,000–249,999	0	1
Total employees	**6**	**6**

During the year ended 30 June 2010, no employees received compensation and other benefits in relation to cessation (2009: $nil).

19 Events after the Balance Sheet Date

There were no significant events after the balance sheet date.

20 Categories of Financial Assets and Liabilities

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

	Actual 2010 $	Actual 2009 $
Loans and receivables:		
Cash and cash equivalents	1,387,234	1,296,657
Debtors and other receivables	35,738	87,900
Total loans and receivables	**1,422,972**	**1,384,557**
Financial liabilities measured at amortised cost:		
Creditors and other payables	413,656	436,448
Total financial liabilities measured at amortised cost	**413,656**	**436,448**

21 Financial Instrument Risks

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

Market risk

Fair value interest rate risk

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

The average interest rate on the Health and Disability Commissioner's term deposits is 3.9% (2009: 4.2%).

Cash flow interest rate risk

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

Credit risk

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

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

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

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

Liquidity risk

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

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

Sensitivity analysis

As at 30 June 2010, if the deposit rate had been 50 basis points higher or lower, with all other variables held constant, the surplus/deficit for the year would have been $6,800 (2009: $6,238) higher/lower. This movement is attributable to increased or decreased interest expense on the cash deposits.

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

	Less than 6 months	Between 6 months and 1 year	Between 1 and 5 years
	$	$	$
2010			
Creditors and other payables (note 11)	413,656	0	0
2009			
Creditors and other payables (note 11)	469,636	0	0

22 Capital Management

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

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

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

23 Explanation of Significant Variances against Budget

Statement of comprehensive income
In consultation with the Ministry of Health it was agreed that HDC operate with less revenue and less costs than was originally budgeted.

Statement of financial position
The lower than budgeted deficit per the Statement of Comprehensive Income flowed through to more cash on hand. This will enable the future prudential management of HDC's reserves in the forthcoming financial year.

Statement of changes in equity
As a direct consequence of the lower deficit, HDC's reserves are higher than budget.

Statement of cash flows
The lower deficit translated directly to "cash from operating activities" being in surplus vs a budgeted deficit. In addition, "cash from investing activities" was lower than budget with fewer assets purchased than budgeted.

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
	Complaints		
1.	An estimated 1,200 complaints are managed.	30 June 2010	**Target achieved. 1,524 complaints managed.**
2.	80% of all complaints closed within 6 months of receipt, and 95% closed within 12 months of receipt; no files aged over 2 years.	30 June 2010	**Target achieved. 89% of all complaints (1,361 of 1,524) closed within 6 months of receipt; 98% of all complaints (1,492 of 1,524) closed within 12 months of receipt. No file aged over 2 years.**
3.	Follow-up of recommendations confirms 100% compliance by providers.	30 June 2010	**Target partially achieved. 347 recommendations made from 1 July 2009 required compliance by 30 June 2010. 99% complied with: 88% (305) full compliance, 11% (38) partial compliance.**
4.	10% of group providers (organisations) subject to recommendations from HDC report systems changes to improve quality and safety of their service.	30 June 2010	**Target achieved. 45% (110 of 242) of group providers subject to recommendations as a result of a complaint have made systems changes. 23% (56 of 242) report having made significant systems changes.**
5.	Key stakeholders are provided with accessible information on any changes in services and processes as a result of any review recommendations being implemented.	Within 3 months of confirmation.	**As at 30 June the Commissioner had not received any decisions in relation to the Review of the Health and Disability Commissioner Act and Code of Rights.**

Output 2: Education and Promotion

	Performance Measure	Target Date	Actual
1.	Publish reports on the Commissioner's opinions following the completion of investigations within 8 weeks of the final report being signed off.	30 June 2010	**78% (22 of 28) reports eligible for publication were published within 8 weeks of final opinion being signed off. 4 reports not published within required timeframe await completion of proceedings or are subject to legal challenge; 1 report not published within required timeframe owing to changed process of including case notes; 1 report missed deadline.**
2.	DHBs receive 6-monthly complaint trend reports from HDC.	September 2009 and March 2010	**6-monthly trend reports sent to DHBs in April 2009 and January 2010. Report sent in January delayed owing to changes to HDC's database and need to develop new format for reporting information.**
3.	100% of DHBs that respond rate the reports as useful for improving the safety and quality of their services.	30 June 2010	**Target achieved. 100% of DHBs responded to January to June 2009 and July to December 2009 trend reports, and responses show on average 90% of DHBs found the information useful. The information was used for:** • **discussion in clinical governance meetings** • **discussion at service quality meetings** • **discussion at Consumer Feedback Committee** • **informing Clinical Council of issues identified** • **discussion at Senior Leadership Team and Clinical Board** • **informing Safety and Quality programme made available to staff via intranet** • **informing Complaints Review Committee** • **benchmarking and monitoring** • **teaching** • **education of staff regarding positive and timely management of complaints** • **customer service presentations.**

(continued overleaf)

Output 2: Education and Promotion (continued)

	Performance Measure	Target Date	Actual
4.	Publish a third edition of the "Stories of Great Care" booklet, showcasing good practices and processes.	30 June 2010	**Target achieved.**
5.	5% of all relevant educational materials are translated into "Easy Read" format and are available in html format via HDC's website.	30 June 2010	**Target achieved. Review of educational materials identified 24 resources; 14 (58%) are available in html format.**
6.	Convene 2 regional consumer seminars.	30 June 2010	**Target achieved. 3 regional consumer seminars held in Dunedin.**
7.	Provide 20 educational presentations to health and disability sector organisations.	30 June 2010	**Target achieved. 46 educational presentations provided.**
8.	Provide 2 intensive provider education programmes.	30 June 2010	**Target achieved. 2 intensive provider programmes delivered at Waikeria Prison and Otago Correctional Facility.**
9.	80% of participants who respond to seminar evaluations rate that they are satisfied with the usefulness of the seminar.	30 June 2010	**Target not achieved. Evaluation response rate too low to be useful.**
10.	100% of requestors of educational presentations rate that the presentations met their expectations.	30 June 2010	**Target partially achieved. 98% (45 of 46) of organisations requesting presentations rated that presentations met expectation. One requestor wanted more time for the presentation than was allocated.**
11.	80% of participants who respond to evaluations of intensive training rate that they were satisfied or very satisfied with the content and delivery of the programme.	30 June 2010	**Target achieved. On average 84% of participants who responded to the evaluation rated that they were satisfied or very satisfied with the content and delivery of the programme.**
12.	Provide an annual report on the impact of HDC's submissions.	30 June 2010	**Target achieved. Summary report of the impact of HDC's submissions completed.**
13.	Provide quarterly updates on the level of satisfaction with the quality of submissions.	30 June 2010	**Target achieved. 23 submissions made. 100% of those surveyed responded and were 100% satisfied with the quality of the submissions.**

Output 3: Advocacy Services

	Performance Measure	Target Date	Actual
	Advocacy Agreement		
1.	Administer compliance with Advocacy Services Agreements:		
	• 4,650–4,700 complaints managed.	30 June 2010	• **Target achieved. 5,606 complaints managed: 119–120% of annual target.**
	• 75% of complaints closed within 3 months.	30 June 2010	• **Target achieved. On average 89% of complaints closed within 3 months.**
	• 90% of complaints closed within 6 months.	30 June 2010	• **Target achieved. On average 99% of complaints were closed within 6 months.**
	• 80% of closed complaints either fully or partially resolved.	30 June 2010	• **Target achieved. On average 88% of complaints partially or fully resolved.**
	Rest home and disability home contacts		
2.	• At least 1 contact with all rest homes.	30 June 2010	• **Target achieved. Advocates contacted 697 rest homes (100% of total).**
	• At least 1 contact with all disability homes.	30 June 2010	• **Target achieved. Advocates contacted 884 disability homes (100% of total).**
	Education and training sessions		
3.	• 1,500 education/training sessions provided.	30 June 2010	• **Target achieved. 2,051 education/ training sessions provided (137% of target).**
	• 36 case studies or Great Care stories published.	30 June 2010	• **Target achieved. 144 case studies or Great Care stories published (100% of target).**
	• 2,000 networking contacts provided.	30 June 2010	• **Target achieved. 4,363 networking contacts provided (218% of target.)**

Output 4: Proceedings

	Performance Measure	Target Date	Actual
	Decision to prosecute		
1.	80% of decisions are made within 2 months of referral.	30 June 2010	**Target partially achieved. 56% (5 out of 9) decisions were made within 2 months of referral. The 4 deferred decisions relate to only 2 providers. Deferral in relation to one provider was in order to meet with family of deceased consumer; deferral in relation to other provider was to find suitable expert witness in ayurvedic medicine.**
	Compliance with directions		
2.	100% compliance with Tribunal/ Court directions.	30 June 2010	**Target achieved. 100% (39 out of 39) compliance with Tribunal/Court directions.**
	Successful proceedings		
3.	A finding of professional misconduct is made in 75% of disciplinary proceedings.	30 June 2010	**Target achieved. A finding of professional misconduct was made in 100% (7 of 7) of disciplinary proceedings.**
4.	A breach of the Code is found in 90% of HRRT proceedings.	30 June 2010	**Target achieved. A breach finding was made in 100% (2 of 2) HRRT proceedings.**
5.	An award of damages is made in 80% of cases where damages are sought.	30 June 2010	**Due to negotiated agreements being reached with providers, the Director of Proceedings did not need to seek awards for damages from the Tribunal.**

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