HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

E.17

Learning from complaints

Annual Report
for the year ended 30 June 2011

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

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HEALTH and DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

3 October 2011

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 2011.

Yours faithfully

Anthony Hill
Health and Disability Commissioner

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

Vision

Champions of consumers' rights.

Wawata

Kai kōkiri i nga tika kai hokohoko.

Mission

Resolution, protection, and learning.

Whainga

Whakataunga, whakamaru me te akoranga.

COMMISSIONER'S REPORT

This first year as Commissioner has passed as rapidly as one might expect when 1,405 complaints are received, 5,401 enquiries are made, and 1,355 complaints are closed. This role is about people first. Each complaint is an opportunity to look across the system and we work knowing that those experiences translate to improvements.

We are drawn to the vision of a consumer-centred health and disability system — one that engages those whom it serves and their families as full participants in their care, one that provides seamless service within institutions, across providers, where teams work effectively to provide good care, one where we are open — transparent — with information about what happened (see Figure 1). The drivers of resolution, protection and learning see a constructive and effective approach in resolving complaints. I am constantly struck by the passion of the people I am fortunate to have working around me, the resilience of the consumers and the families with whom we deal, and the passion and the professionalism of many of the providers we deal with. I want, too, to acknowledge the tumult of Christchurch where we have seen, and continue to see, extraordinary resilience, commitment and contributions made by so many in the health and disability sectors within Christchurch and nationally to continue to provide care to those who need it.

Anthony Hill
Commissioner

Entity Performance

The Health and Disability Commissioner hit all its performance targets and delivered a small surplus this year. That is a very pleasing result. The long-term financial pressures remain, however, and work continues. Vacancies were a significant contributor to the budget performance. Staff worked extremely hard to cover vacancies during the period. However, necessary appointments have now been made to ensure capacity is maintained at a sustainable level. We have actively reduced costs in our accommodation sphere and continue to take a disciplined approach to organisational spend.

People

It has been a privilege to meet many people in the Health and Disability sectors this year. As Commissioner I have spoken at hospital grand rounds, university lectures, board and clinician meetings, consumer groups, conferences, and many other fora.

Within HDC, this year saw the departure of Deputy Commissioner Rae Lamb to take up a position as Aged Care Commissioner in Australia after a long and successful contribution to the HDC. We were fortunate indeed to welcome Theo Baker, Deputy Commissioner Complaints Resolution. Theo is an experienced senior legal practitioner and has experience in the public and private sectors in New Zealand and England.

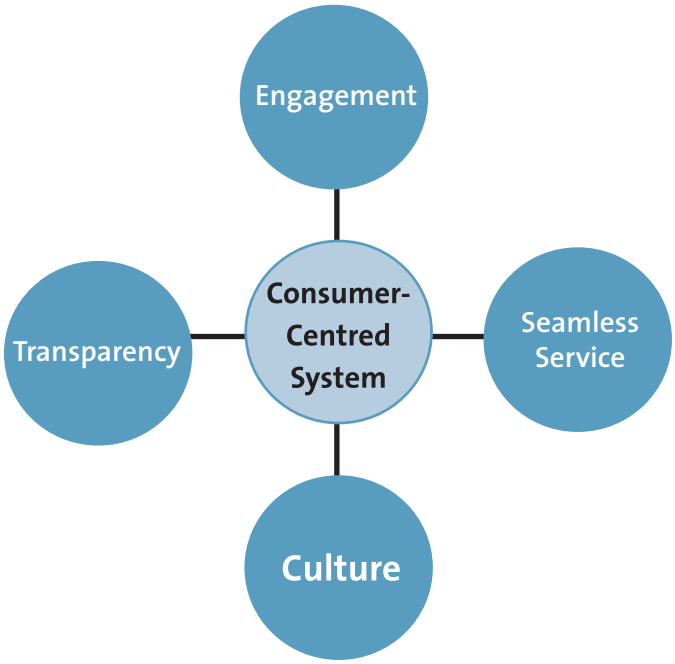
The Consumer Advisory Group continues to meet and contribute to the work of the HDC. I wish to particularly acknowledge Barbara Robson, co-convenor of that group, for the contribution and commitment that she has offered to me as Commissioner this year.

Making a Difference

One of the most common things a consumer says to me is: "I don't want this to happen to anyone else."

While our health and disability systems deliver good care a vast majority of the time, there are a significant number of cases where they do not. Often those cases involve a failure to get the basics right. When basic failures occur, people are harmed.

Figure 1: **A consumer-centred system**



At HDC we support the successful expression of a consumer-centred system.

The cases before us tell a story. Culture is critical — does "the way we do things around here" successfully engage the whole team caring for that consumer? In one case, an elderly gentleman suffered complications following surgery on his lower leg. Despite concerns being raised by family and staff, senior advice was not sought in time, and the patient suffered harm. In that case a failure to hand over, and a failure to act on expressed concerns, resulted in poor care. Three doctors were breached in that case, and a recommendation made to the provider to develop a culture in which the asking of questions and reporting of concerns is expected and accepted from all members of the multidisciplinary team.

A key aspect of successful resolution involves ensuring that the provider, the organisation, and the system have identified what went wrong and successfully learned from it, and that the system has been strengthened as a result. Throughout this report you will see examples of where change has occurred as a result of HDC involvement.

Disability

The HDC held one of the largest Disability gatherings in the country in December 2010, with the National Disability Conference — Making it Easy to Speak Up. This was a successful gathering of some 400 people and provoked some interesting conversations. Given the success of that conference we plan to hold a similar conference in 2012.

The Health Passport initiative continued in its progress with two district health boards (DHBs) implementing this pilot. The Health Passport makes it easier for health professionals to connect with and communicate with consumers with disabilities. Initial reports are highly favourable.

Two new educational resources were launched in the disability space — "Making it easy to put the Code into Action" and "Making Communication Easy".

Advocacy

The Nationwide Health and Disability Consumer Advocacy Service continues its important work in resolving complaints and providing information to consumers throughout New Zealand. In the report of the Director of Advocacy we see that:

- the service dealt with more than 10,000 enquiries — these can be face-to-face, telephone or email enquiries;
- on average 87% of complaints managed by advocacy were partially or fully resolved;
- advocates have made 4,238 rest home and 3,019 disability residential visits; and
- nearly 2,000 presentations and training sessions were given to consumers, providers and organisations.

These statistics are an impressive measure given that there are only 48 advocates throughout the country. The Advocacy service is a confidential free service to any person in New Zealand who wants to know about their rights when using a health or disability service.

Proceedings

The Director of Proceedings was successful in all cases that he took this year. There was one case of particular significance where the Human Rights Review Tribunal (HRRT) ruled that a community health coordinator pay $100,000 damages for financially exploiting a client — supporting the concept that exploitation of the vulnerable is totally unacceptable and will carry consequences.

Education

Prisons

Following the 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 healthcare to prisoners in line with their rights under the Code. ***Keeping safe with the Code***, a handbook for nurses working in prisons, has been developed and will be available for use as an educational tool for orientation of nurses new to the prison setting, and for longer serving nurses seeking to refresh their awareness of their responsibilities under the Code, and its implication for safe professional practice.

DHB reports

HDC continues to provide six-monthly reports to DHBs covering the numbers and types of complaints and the outcomes of closed complaints, making a total of 11 reports since January 2006. We continue to receive valuable feedback in response to the reports. DHBs report that the information is used for educational purposes, including discussion at Clinical Governance and service quality meetings, and in consumer feedback meetings.

Education for providers

In line with the requirements for general practices involved in Cornerstone Accreditation, HDC again provided Level One education sessions to practice staff (doctors, practice nurses and administration staff). Training sessions were held for staff at the Pukekohe Family Health Care Centre (Procare PHO), White Cross Healthcare, and Hutt Valley PHO. As well as many other specialised education presentations and workshops, medico-legal sessions were presented for a variety of audiences including a Medical Law Conference, Elder Law Conference, and over 450 nurses at the four regional NZNO Medico-Legal Forums.

Organisational Capability

At HDC our people are our greatest resource. The majority of HDC's staff possess professional qualifications and predominantly come from health, disability, or legal backgrounds. Together they bring to the organisation a wide range of skills in management, training, investigation, litigation, clinical practice, research and development, information technology, and financial management.

Equal Employment Opportunities

HDC respects the human rights of employees, and its Human Resources Manual recognises the need to provide equal opportunities for employment, promotion and training, both within the Office and through its recruitment processes. All staff involved in recruitment are made aware of the requirements of HDC's Equal Employment Opportunities policy, and it is part of new staff induction.

HDC's Equal Employment Opportunities policy states that HDC will ensure compliance with the New Zealand Disability Strategy by ensuring all disabled people employed by the Commissioner have the same employment conditions, rights and entitlements as everyone else, and that the Commissioner will give consideration to flexible work hours and the opportunity to work from home to ensure a suitable workplace for people with disabilities. HDC has a successful placement from Mainstream (a government-sponsored recruitment and vocational placement service for disabled people and Government/Crown Entity employers) and will continue to seek Mainstream placements in the future.

To raise awareness in the organisation of disability issues, the Disability Initiatives Manager presented to all staff on the history of disability issues in New Zealand and some of the issues facing disabled people today.

HDC has organised programmes throughout the year to celebrate Māori Language Week, Samoan Language Week, NZ Sign Language Week, and Matariki.

HDC is a member of the Equal Employment Opportunities Trust.

Workplace Profile

The Office of the Health and Disability Commissioner has 50 staff as at 30 June 2011, as follows:

- 38 females and 12 males
- 43 full-time positions and 7 part-time positions.

Of the six senior management positions, three were females and two were males, with one position vacant. Of the eight middle management positions, four were females and three were males, with one position vacant.

Although no data was collected this year on ethnicity or age, the Office benefits from a diverse workforce. For example, HDC has staff who are Māori, Samoan, Asian, Iranian, and English, among other ethnicities, whose ages range from early 20s through to over 60 years.

"Good Employer" Obligations

1. Leadership, accountability and culture

A new initiative this year to encourage staff engagement has been the formation of a Senior Leadership Forum, which the Commissioner has used to consult on strategy future planning, innovation at work, and performance enhancement. As well, staff forums are held in both offices each month for divisions to talk about their work and current issues, and to recognise staff and team successes, both personal and work-related. All staff are expected to attend

these forums. An all-staff conference was held in September, which had interactive sessions on "Innovation in the Workplace" and "Working Together".

2. Recruitment, selection and induction

HDC's recruitment policy and practices ensure the recruitment of the best qualified employees at all levels using the principles of Equal Employment Opportunities, while taking into account the career development of existing employees. Vacancies are advertised throughout the Office as well as externally, and employees are encouraged to apply for positions commensurate with their abilities. The Human Resources Manual and human resources policies are part of induction for new staff, and a "fresh eyes" interview for new staff is offered to gather feedback on how we can better support and induct new staff.

3. Employee development, promotion and exit

HDC policies support professional development and promotion, and HDC identifies training and development needs and career development needs as a formal part of the annual performance appraisal process. Self-development by employees is encouraged, and financial assistance or assistance in the form of time off during normal working hours may be granted by the Commissioner. Several staff have been given the opportunity to "act up" to cover vacant senior management roles and thereby further develop their management skills.

4. Flexibility and work design

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

5. Remuneration, recognition and conditions

HDC provides fair remuneration based on Equal Employment Opportunities principles. HDC recognises staff achievements in its internal newsletter "Highlights" and at monthly staff forums. The Long Service Leave policy was amended this year to entitle staff to one week's additional leave after each period of five years' continuous service (rather than just after the first five years), to further recognise the valuable contribution and commitment of long-standing members of staff.

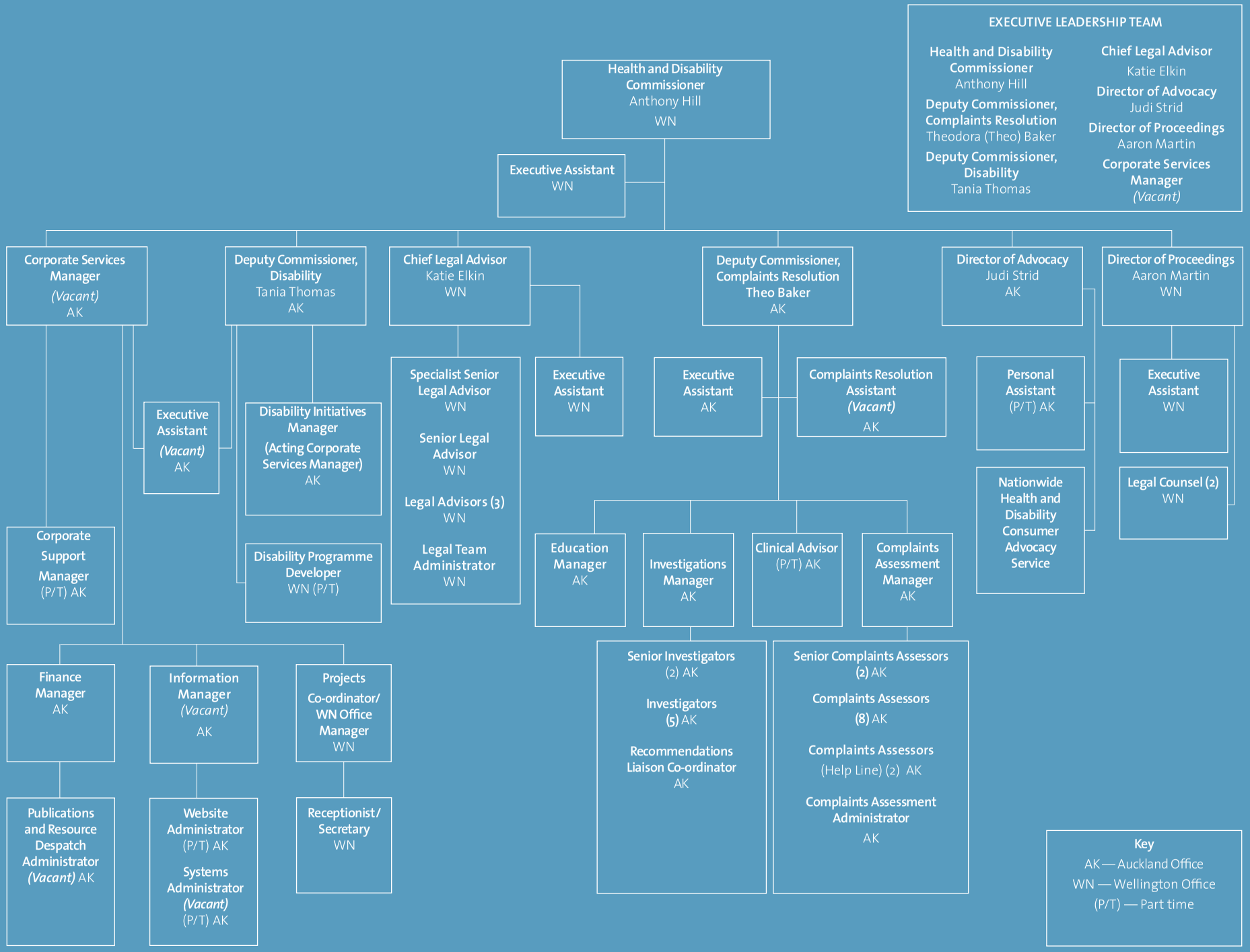
6. Harassment and bullying prevention

HDC has a Harassment policy and has zero tolerance for all forms of harassment and bullying. As well, HDC promotes and expects staff to comply with the State Services Code of Conduct.

7. Safe and healthy environment

HDC has an environment that supports and encourages employee participation in health and safety through its Health and Safety Employee Participation System and its Health and Safety Committee, which meets regularly. Health and safety is a regular agenda item at monthly staff forums, and hazards are actively managed in the office. Support is given to those staff with acknowledged disabilities by way of sign language interpreters, special equipment, and assistance to get to and from work. As well, HDC has a number of initiatives in place to promote a healthy and safe working environment, including sponsorship for health and wellness activities, Employee Assistance Programme incident and confidential counselling programme, provision of fruit in each office, and flexible hours.

ORGANISATION CHART as at 31 AUGUST 2011



COMPLAINTS RESOLUTION

HDC received 1,405 complaints and responded to 5,401 enquiries. The subject matter of the complaints received indicates that there is still some way to go before we can lay claim to a consistent and widespread consumer-centred approach in healthcare and disability support services. A large focus of our work is encouraging providers to make changes to their systems and processes to improve the quality of their care. This includes the encouragement of consumer participation in decisions about care.

The rationale for consumer-centred care is a sound one. A health or disability service provider who respects, listens to, and involves the consumer (and family and whānau where appropriate) is more likely to deliver a better service and be able to resolve any concerns at an early stage.

Theo Baker
Deputy Commissioner,
Complaints Resolution*

Resolution, protection and learning remain at the heart of HDC's work, and this year has been no exception. Despite fewer formal investigations, those conducted have brought about key changes in the health sector. This year 274 recommendations were made to individual and organisational providers resulting in significant changes to practice.

Survey results from complainants and providers who have participated in our process tell us that 81% agree that their complaints were taken seriously, and 73% were satisfied that we had managed the complaint well.

Open Complaint Files

We continue to strive for fair, speedy, simple and effective resolution of complaints. To this end, we have kept the number of open complaint files to a manageable level to prevent a backlog.

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

	2010/11	2009/10	2008/09
Open at year start	323	274	292
New during year	1,405	1,573	1,360
Closed during year	1,355	1,524	1,378
Open at year end	**373**	**323**	**274**

Complaints Closed

Each complaint is carefully assessed to determine the most appropriate way to fairly and promptly resolve it. Of the 1,355 complaints closed during the year, 89% were closed within six months of receipt, and 98% within 12 months. We have a number of ways to address complaints, as seen in Table 2.

*Ms Theo Baker joined HDC as Deputy Commissioner, Complaints Resolution, on 25 July 2011.

Table 2: **Complaints closed**

	2010/11	2009/10	2008/09
Outside jurisdiction (OJ)	83	131	132
Advocacy referrals	208	162	149
Formal investigation	27	51	109[1]
Referrals to other agencies	154[2]	359	184
Resolved by referral to providers	255	217	158
Resolved by mediation	5	5	4[3]
Section 38(1)	557	550	584
Withdrawn/Resolved by parties or Commissioner	66	49	58
Total complaints closed	**1,355**	**1,524**	**1,378**

1 In 2008/09 investigations resolved by mediation were reported separately in the mediation figures, whereas in subsequent years they were included in the investigations figures. (See Note 3.)
2 Includes Ministry of Health, ACC, Privacy Commissioner, District Inspectors, Human Rights Commission, District Health Boards as funders of services and registration boards.
3 Includes investigations resolved by mediation.

Complaints About Providers

Many complaints involve more than one provider. There were 2,078 providers complained about in 2010/11. Of these, 1,109 were group providers (organisations) while 969 were individual providers. Table 3 shows the types of provider most commonly complained about.

Table 4 shows that the primary issue in half of all complaints concerned treatment provided. Most complaints featured more than one issue. Common complaints include concerns about delays in service, diagnosis, the adequacy and appropriateness of treatment, complications and unexpected outcomes, co-ordination of care, and referrals to other services.

Table 3: **Providers most commonly complained about**

Group providers			Individual providers		
Public hospital	48%	(531)	General practitioner (GP)	31%	(301)
Medical centre (including GP clinics)	13%	(144)	Physician	7%	(71)
Rest home	9%	(102)	Midwife	7%	(71)
Disability provider	4%	(45)	Dentist	7%	(69)
A & E clinic	3%	(34)	Nurse	7%	(66)
Pharmacy	3%	(34)	Psychiatrist	4%	(40)
			Orthopaedic surgeon	4%	(40)

Table 4: **Complaints closed — nature of complaint**

Primary issue	No. of complaints closed	Percentage
Treatment	679	50.1
Communication	220	16.2
Professional conduct	74	5.5
Consent/Information	58	4.3
Disability/Other issues	57	4.2
Management of facilities	57	4.2
Medical records/Reports	54	4.0
Other	156	11.5

Issues around communication, consent, and information are also raised. Consumers complain about the attitude and manner of the provider, communication with families, the adequacy and accuracy of information, informed consent, and communication of test results.

Recommendations

One of the most critical parts of HDC's work is following up on the outcomes of complaints. In doing this, HDC is able to ensure that improvements have been made to services and there is a positive difference for consumers. This year 274 recommendations were made. There has been a high level of compliance with the recommendations (99%), regardless of whether or not the follow-up action was recommended on initial assessment of the complaint or following a formal investigation.

This year the Commissioner has audited completed recommendations to ensure provider compliance. This was done in a number of ways, including visits to sites and the production of documentary proof. There was 100% compliance of the 14 providers audited (11 group providers and three individuals).

PAEDIATRIC PRESCRIBING BY GP

A one-year-old child was seen by a GP in a multi-practitioner practice and diagnosed with an ear infection and prescribed antibiotics. Following a further presentation three days later, the antibiotics were changed and low-dose paracetamol prescribed. At a further appointment, the child was prescribed a higher dose of antibiotics (erythromycin). He developed a rash, and was diagnosed with a viral infection. Another doctor replaced the antibiotics with amoxicillin and prescribed antihistamines and creams. The child had been prescribed an excessive dose of erythromycin for his age and weight.

The GP was asked to review his practice for paediatric prescribing, and advise of any improvements made. He developed an electronic tool listing the most commonly prescribed paediatric medicines, and the appropriate doses according to the child's bodyweight. This was made available, via computer, to all doctors in the practice.

YELLOW ENVELOPE PROJECT

On admission to hospital, a rest home resident was unresponsive and had raised blood pressure. She was discharged back to the rest home after treatment, only to be readmitted the following day. At the hospital she suffered a fall, sustaining a spinal crush injury. She was discharged back to the rest home. The discharge summary did not include analgesia for pain relief, or changes in medications, and the family was unaware that a needs assessment of her level of care might be required. There was poor communication between the hospital, family and rest home.

The DHB was asked to advise the steps that could be taken to improve the quality of the discharge summary and communication between social workers and families prior to a patient's discharge from hospital.

The DHB developed a tool, called the Yellow Envelope project, to support the safe handover of clinical information from a residential care facility to hospital. The envelope contains documents, as well as a checklist of important handover information to be included when a resident is transferred to hospital or discharged home from hospital. The yellow envelopes were funded by the DHB and were distributed to all residential care facilities in its region. The yellow envelopes are placed in residents' files and transported with them whenever they are transferred between their facility and hospital.

MONITORING PATIENT HYDRATION LEVELS

A patient was admitted to hospital after dislocating her knee. She was otherwise well and the injury was managed conservatively. She began to feel increasingly sick over the next few days, with reflux and retrosternal discomfort. No treatment for nausea had been given. She developed a small amount of diarrhoea that worsened over ensuing days, delaying her planned discharge. The vomiting and diarrhoea worsened and the cause was thought to be possible infectious gastroenteritis. Isolation and IV fluids were ordered. However, the fluids were not commenced until the following day. The patient suddenly developed breathing difficulty and required oxygen and nebulisers. She was reviewed by a doctor but examination equipment (electronic blood pressure machine and pulse oximeter) was malfunctioning. The luer had been pulled out during a transfer, and an anaesthetist came to replace it. The patient subsequently deteriorated rapidly and resuscitation was required when she stopped breathing.

One of the issues identified was that there was no formal assessment of the patient's hydration status despite her ongoing nausea followed by vomiting and diarrhoea. The DHB was asked to provide information about any changes that have been made to ensure that patient fluid levels are monitored and maintained appropriately.

The DHB advised of two initiatives currently being undertaken by orthopaedic staff. A Preoperative Hydration Study was undertaken. This has resulted in improved communication between the theatre and ward staff. The previous practice of prolonged preoperative periods of nil-by-mouth has ceased. A Nil-by-Mouth project is also underway, involving both medical and nursing staff. The project is seeking to identify and institute processes to ensure proper hydration and nutrition in the postoperative period without compromising patient safety. The DHB is continuing to share information with the Commissioner about these projects, and the Commissioner will in turn ensure that other DHBs have an opportunity to learn from this information. These projects have the potential to provide valuable information for all medical staff on the hydration requirements for preoperative patients, and effects of inadequate hydration on postoperative patients.

COLLECTION AND TRANSFER OF CRYOPRESERVATION SAMPLES

A family complained that their newborn's placental cord blood was misplaced after it was collected for cryopreservation. The sample eventually arrived at the collection bank but was deemed unsuitable, owing to improper storage during transfer. The sample was to be used, if and when needed, to manage the father's severe haematological disorder. The family wanted to know how it was lost.

HDC pieced together the sequence of events, from information obtained from the three provider groups involved. The Commissioner asked the providers to coordinate a review of the referral, collection, and transfer of cryopreservation samples. The providers' review has resulted in development of a policy covering this. The coordination of collection and system improvements should ensure that these rare but important requests are handled in a more standard manner in future. The outcome of the review and an apology from the providers were welcomed by the family.

Advocacy referrals

An increased number of referrals were made to the Nationwide Health and Disability Consumer Advocacy Service. Complaints referred to advocacy often involve consumers who require assistance in communicating effectively with providers, or who are looking to strengthen their relationship with providers from whom they are likely to receive ongoing services.

Referrals to providers

There has been a steady increase in the number of referrals of complaints to the provider concerned. Many providers now have sound complaints-handling processes and have a genuine desire to work with complainants to resolve their concerns. Our case studies show that complaints managed directly between the provider and the complainant have a very good chance of being successfully resolved. Consumers are also offered advocacy support during the process. Providers are still required to report back to the Commissioner on how they have resolved the matter. The Commissioner has the discretion to reassess the complaint if it has not been appropriately addressed.

REFERRAL TO ADVOCACY RESOLVES COMPLAINT ABOUT A PHYSICAL EXAMINATION

A female patient complained to a hospital about a doctor who had performed an intimate examination without obtaining fully informed consent. Unhappy with the hospital's response, she contacted our office.

The Commissioner formally referred the complaint to advocacy. This provided the patient with the opportunity to meet directly with the doctor with the assistance of an advocate. The patient was able to explain why she felt her cultural needs and beliefs were not fully considered by the doctor before he performed the examination. The meeting also provided an opportunity for the patient to outline the psychological distress this experience caused her.

The patient received an apology at the meeting, and was also asked if she would be available to provide consumer advice in the implementation of cultural training at the hospital. A complaint resolution agreement was signed and an information pamphlet developed to fully inform patients of the procedures for internal examinations.

REFERRAL TO PROVIDER OF MENTAL HEALTH SERVICES REGARDING EMAIL ACCESS TO SERVICES

A concerned citizen complained to HDC that there was no facility to contact his local DHB's mental health service by email or through a website. He was unable to telephone and he wanted to advise the mental health service that a consumer he knew was threatening suicide. He eventually enabled the consumer to contact the crisis service and she was admitted to hospital. He asked HDC to look into the wider issue of means of communication with the mental health service by means other than telephone.

We formally referred the complaint to the DHB and asked it to work with the complainant and come up with a solution. The DHB responded advising that there was a National IT Strategy reviewing the capability of all DHB IT programmes, and the DHB would be working to upgrade its systems as part of this strategy. In the meantime, the DHB set up a dedicated email address for the psychiatric emergency team. The DHB's internet capability was also tested and found to be compatible with different browsers.

After receiving the DHB's response the complainant contacted HDC and was very happy with the role HDC had played.

Section 38(1) — closure

Section 38 is used to close complaints when no further action is required 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. Often a satisfactory outcome is achieved for the consumer in a more timely and responsive manner than would result from an investigation. This is particularly so where the provider has responded to the complaint and demonstrated learning and changes to practice as a result.

CRANIAL BLEED NOT DETECTED ON CT SCAN

A four-year-old girl was taken to a public hospital after she fell and hit her head. A CT scan was carried out, and she was discharged after the radiology registrar who read the scan found no evidence of bleeding within the skull. This diagnosis was confirmed by the radiology consultant the following day.

However, she continued to be unwell and developed swelling over the injury site. She returned to the hospital, where the same radiology consultant reviewed the CT scan again, and this time noted evidence of a small intracranial bleed. The girl's father complained to HDC about the original missed diagnosis.

The Commissioner asked an independent radiologist to comment on whether the intracranial bleed should have been diagnosed when radiology staff initially considered the young girl's CT scan. The expert advised that the quality of the images made diagnosing the condition more difficult, and offered suggestions for improving the quality of scans at the hospital. The DHB considered the advice and, in conjunction with its own departmental review, used it to change the way it scanned children with head injuries. This will help to improve services for future patients.

COMMUNICATION WITH FAMILY ABOUT A LOVED ONE'S PROGNOSIS

A family complained that they were given conflicting information by hospital staff about their family member's prognosis. Sadly, the woman died one week after being admitted to hospital with stomach pain, and one day after surgery. HDC obtained independent surgical advice, which confirmed that the woman's clinical management was appropriate. However, concerns remained about communication between staff and the family, and between hospital staff themselves. HDC asked the DHB to remind clinical staff who become involved in a patient's care of the importance of consulting with colleagues who have had immediate and significant involvement in caring for that patient. This is particularly important before delivering significant information about a patient's condition.

HDC received feedback on its decision from the husband of the deceased woman. Although he continued to dispute the version of events recounted by doctors at the hospital, he was grateful for the time and energy spent in an attempt to clarify what had happened. He said, "If there is a lesson to be learned from this … it is that accurate information must be made available in a timely manner by the person best qualified to provide it regardless of how distressing that information may be."

Investigations

Investigations remain an important tool for the Commissioner. The focus continues to be on allegations of significant breaches of ethical boundaries, moderate to severe departures from expected standards of care, public safety concerns, and the need for accountability. More importantly, however, is the potential for investigation findings to lead to significant positive changes being made to New Zealand's health and disability services.

An investigation involves a formal legal process, which can be time-consuming because of necessary procedural steps. As outlined, appropriate resolution, learning, and change are often achieved by other means. For these reasons the Commissioner's powers to investigate are used sparingly and where they can have greatest effect.

Other agencies, such as Coroners, are often already involved in cases, and so duplication of inquiries should be avoided. In these situations, close liaison with the relevant agency is maintained and the most appropriate one leads.

In deciding whether to investigate, the Commissioner also considers the provider's response, actions taken, and what changes have been made to address identified failings. Increasingly, providers are proactively undertaking their own investigations or reviews, often involving independent external reviewers, and will clearly identify their own failings and instigate remedial action.

The most serious cases 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. The Commissioner often makes recommendations on which the providers are obliged to report back, as outlined in case studies above. This year, 11 breach findings were made and four providers were referred to the Director of Proceedings.[1]

1 Two of these providers were involved in care to one consumer.

DELAY IN PROVISION OF SERVICES TO PATIENT WITH VASCULAR PROBLEMS

A woman complained about the care provided to her 79-year-old father by a public hospital. The man was referred to the emergency department with acute pain in his left leg and a cold, blue, left foot. He was diagnosed with impending ischaemia and admitted to hospital.

The man was initially under the care of a general surgeon, who recommended referral to a colleague, a general surgeon with an interest in vascular surgery ("the vascular surgeon"). Usually the operating surgeon would have been able to see the man within a few hours. A registrar advised the general surgeon that the vascular surgeon was on leave for two days. The general surgeon considered that the man's presentation was not critical, and so, rather than refer him to another DHB for a more urgent assessment, he considered that the man could stay in hospital for two days in order to see the usual vascular surgeon. The general surgeon examined the man the next day, and again the following day, when he expected that the vascular surgeon would have returned from leave. The general surgeon then found out that the vascular surgeon was not due back in the hospital for several more days. In the meantime, an angiogram revealed four aneurysms in the man's legs and abdomen. He remained in hospital for a further week, at which time the vascular surgeon assessed him and scheduled him for surgery a week later.

Following the surgery, the vascular surgeon monitored the man and was satisfied with his progress, but three days later the surgeon again went on leave. He did not hand over care to the on-call consultant. The man suffered complications but the significance of his symptoms was not appreciated by the registrar. After several days the man was referred to a vascular surgeon at another district health board, but his leg could not be saved and he required an above-knee amputation.

The Commissioner found that the first general surgeon breached Right 4(1) for failing to seek specialist advice within a reasonable time. The operating surgeon breached Right 4(5) for failing to adequately hand over care. The registrar breached Right 4(1) for failing to verify the information he provided to the first general surgeon about the absence of the operating surgeon, and failing to keep adequate records or adequately assess the patient.

The district health board was found to have adequate systems in place and was not found in breach of the Code. The district health board took reasonable steps to enable the three medical practitioners to provide safe services, and was not vicariously liable for their breaches. However, adverse comment was made about the failures of nursing and junior medical staff to report their concerns to the on-call consultant as the man's condition deteriorated, and the need to develop a culture in which the asking of questions and reporting of concerns is expected and accepted from all members of the multidisciplinary team. (Case 09HDC01146)

MISSED DIAGNOSIS OF ADVANCED COLORECTAL CANCER

A general practitioner treated a woman's symptoms of iron deficiency anaemia but did not undertake appropriate investigations to ascertain the cause of the anaemia. The expert advice was that the GP should have carried out an abdominal and rectal examination, and requested laboratory tests (mid-stream urine sample to exclude renal blood loss, and faecal occult bloods to exclude blood loss from the bowel). The GP should also have referred the woman for a gastroscopy when she presented with upper gastrointestinal tract symptoms and anaemia.

The Commissioner found that the GP breached Rights 4(1) and 4(4) of the Code of Health and Disability Services Consumers' Rights for failing to appropriately investigate and manage the woman's iron deficiency anaemia. He also breached Rights 4(1) and 4(4) of the Code for failing to examine her abdomen prior to diagnosing gastritis. The GP also breached Right 4(2) of the Code for failing to meet professional standards in terms of his documentation.

The Commissioner recommended that the Medical Council consider whether a review of the GP's competence was warranted. The Commissioner also referred the GP to the Director of Proceedings.

(Case 10HDC00253)

COMPLICATIONS FOLLOWING LAPAROSCOPIC HERNIA REPAIR

Over a period of 16 years, a woman had a number of laparoscopic surgeries performed by a general and laparoscopic surgeon to repair herniae in her groin and lower abdomen. After later surgeries she complained of various complications and pain which was not relieved by the analgesia the surgeon prescribed. The woman sought a second opinion and later had corrective surgery performed by another specialist, which immediately resolved her pain. The woman's sister complained on her behalf that the surgeon did not explore her symptoms adequately, did not accurately document her health problems, and treated her with a lack of respect during his examinations.

Over the period in which the woman had her surgeries, there were enormous advances in laparoscopic techniques to repair herniae. Her experiences reflected the learning taking place over this time. It was held that the surgeon provided surgery with reasonable care and skill and did not breach Right 4(1).

However, the Commissioner found that the surgeon was dismissive of the woman's concerns and disregarded the extent of the pain caused by his examinations. In doing so he failed to treat the woman with respect and breached Right 1(1). His failure to verify information about her and make her aware of his intention to share the information before he disseminated it to others, and his failure to maintain appropriate professional medical records, breached Right 4(2).

This case highlights the importance of treating patients with respect, communicating with them effectively, and recording consultations accurately and completely. It is also about the necessity, when a doctor transfers information about a patient to other doctors or agencies, that the information is correct, complete and accurate, and that the patient understands that the information is being sent, and knows the intended recipients.

(Case 09HDC01329)

PLACEMENT IN SECURE RESIDENTIAL CARE

A 43-year-old woman complained that she was detained in a secure rest home for more than a year without legal authority. The woman had been admitted to hospital in a confused state. She was physically unwell, and had a complex personal history which included severe psychological trauma, depression, and alcohol abuse. Psychiatric assessments diagnosed alcoholic amnestic disorder, in which memory is impaired. It was felt that the woman lacked capacity to make informed decisions about her care or her property and, accordingly, that an application for a personal order should be made under the Protection of Personal and Property Rights Act 1988 (PPPR Act). The woman had been chronically and intermittently homeless, and it was envisaged that she would be placed in an appropriate residential facility. The application was prepared but never filed with the court.

Three months later, the woman was discharged to a secure rest home that has a contract for the provision of age-related dementia care. It is also licensed to provide care to people under 65 years of age who require a secure environment. At this time there was only one other resident younger than 65. It was understood that the woman was legally required to remain in the rest home. The placement was authorised by and funded through a Needs Assessment and Service Co-ordination (NASC) agency.

On several occasions over the next few months the woman expressed her dissatisfaction with her accommodation and requested a more suitable placement. Following a multi-disciplinary team meeting, eight months after her admission, her GP recorded that she was inappropriately placed among older patients with dementia, but that she needed a secure placement as she had sourced alcohol on several occasions when opportunity arose. Around this time the woman also asked to live in the community. The home made several attempts to contact the agency about this request.

The woman's GP referred her to the DHB's mental health service, and to a community alcohol and drug service. She was assessed as not being sufficiently cognitively impaired to be in a secure unit, and as competent in relation to her personal care and welfare. In the course of efforts by staff from the alcohol and drug service to arrange access to a residential alcohol rehabilitation programme, it was learned that the PPPR Act order had never been filed, and that there was no legal requirement for the woman to remain in the rest home. Over the following two months, arrangements were made for her transition and, 14 months after her admission, she left the rest home.

Following investigation, the Deputy Commissioner found that the DHB had breached Rights 4(1) and 4(5) for failing to have adequate systems in place to deal with PPPR Act applications, failing to take sufficient or appropriate action in relation to the woman's discharge, and for poor communication and co-operation between staff and with other providers.

The NASC agency was found to be in breach of Rights 3, 4(1) and 4(5). It failed to verify the woman's legal status or to ascertain who could consent on her behalf, and who it should consult and communicate with in relation to her care. There was a lack of care and skill throughout the needs assessment/service coordination process, and there were deficiencies in communication and co-operation between staff, with the woman, and with other service providers.

The rest home was found to be in breach of Right 4(1). It also failed to verify the woman's legal status or to ascertain who could consent on her behalf, and who it should consult and communicate with in relation to her care. It did not take adequate steps to address the fact that she was inappropriately placed.

The NASC agency and the rest home were referred to the Director of Proceedings, who decided to take proceedings before the HRRT. Proceedings are pending.

(Case 08HDC20957)

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.

The Commissioner's office remains committed to encouraging health and disability services providers to put in place systems and processes that enhance consumer participation in decisions about their own healthcare and disability support services. Encouraging providers to think about ways of integrating consumers' perceptions and to find ways to work in partnership with consumers is a focus in our work.

Partnerships are about using both the professional's knowledge and the consumer's knowledge — allowing joint planning and decision-making around treatment, care, and disability support. It is about recognising the consumer as his/her own best expert in the experience of his/her impairment or illness.

Tania Thomas
Deputy Commissioner, Disability

It is about having a relationship that addresses differences of opinion with consumers, about collaborating with the consumer instead of always having to "take charge", being aware of how, as a provider, his/her own values and culture might interfere with providing unbiased assistance to consumers with different values or points of view.

The key message to the disability sector has been to promote inclusion of people with impairments and to encourage providers to improve the ways they seek feedback and input from people with impairments. Making sure disability services consumers and people with impairments who use health services are aware of how to complain or raise their concerns, who to complain to, how to get support to raise their concerns, having simple complaints-handling processes and dealing with issues as soon as practicable are all ways of encouraging feedback and input from consumers.

Disability-related Complaints Received

A total of 127 disability-related complaints were received between 1 July 2010 and 30 June 2011. These include all complaints received from disabled consumers (receiving health or disability services) and all complaints involving a disability service provider. The following is a statistical analysis of the complaints received showing the top five categories in each table.

Table 1: **Primary issue**

Issue	No. of Complaints	
Treatment	19	(15%)
Communication	13	(10%)
Management of facilities	11	(9%)
Access & funding	10	(8%)
Professional conduct	10	(8%)
Other	64	(50%)
Total	127	

Table 2: **Top five complaint key words**

Complaint Key Word	No. of Complaints
Inadequate care	25
Attitude/Manner	22
Inadequate treatment	19
Communication with family	12
Special needs not accommodated	12

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

Table 3: **Service category**

Service Category	No. of Complaints
Rest home care	29 (23%)
Residential care services	18 (14%)
Other disability services	17 (13%)
Specialist equipment services	11 (9%)
Home care	10 (8%)
Other	42 (33%)
Total	127

Table 4: **Complaint outcome (based on complaints closed)**

Outcome	No. of Complaints
Educational letter/follow-up	46 (38%)
Referred to provider for resolution	19 (15%)
Outside jurisdiction	17 (14%)
Referred to advocacy	15 (12%)
Referred to Ministry of Health	12 (10%)
Other	13 (11%)
Total	122

Accessibility and Responsiveness of HDC's Services

- HDC continues to promote its role through magazine advertisements, newsletters that are widely read by people in the disability sector, community notice boards, and regular emails to consumers and providers in our disability contacts database. A range of languages and accessible formats are used where appropriate.
- HDC provides useful information for the disability community on our website through weekly updates from the sector including the latest news and events. The information offered ranges from volunteering opportunities, the National Anthem in Sign Language, disabled people's access to earthquake assistance, to the Ministry of Health's new model for supporting disabled people.
- The Deputy Commissioner met with a number of consumer and provider groups in the disability sector, including: Complex Carers, IHC Children's Rights Seminar, Muscular Dystrophy Association of New Zealand Inc, Deaf Aotearoa New Zealand, CCS Disability Action, Taikura Trust, National Screening Unit, Mental Health Foundation, National Foundation of the Deaf, NZCare Group Ltd, NZ Disability Support Network, Northland DHB, TePou, ABI Rehabilitation, and medical students at the Auckland School of Medicine.

Deputy Commissioner, Disability, Tania Thomas, Disability Initiatives Manager, Hemant Thakkar, and Complaints Assessment Administrator, Michelle Smith, at Silent Camp (intensive weekend for New Zealand Sign Language students).

The Consumer Advisory Group — Front row, from left to right: (seated) Beverley Grammer, Anthony Hill (Commissioner), George Tripp, Ramari Maipi, and seated Pati Umaga. Second row, from left to right: Neil Hatcher, Martine Abel, David Corner, Barbara Robson, Molly Pihigia, Frances Hartnell, Suzy Stevens, David Talitu. (Absent: Fiona Pimm.)

- The Disability Initiatives Manager attended a number of forums organised by consumer groups and service providers in the disability sector. He has also made presentations on the Code for staff of disability service providers and carried out disability responsiveness training for tertiary students doing social work degrees at Unitec and MIT.
- Three of HDC's staff are learning New Zealand Sign Language and attended a Silent Camp run by the New Zealand Sign Language Teachers Association.
- Two meetings were held with HDC's Consumer Advisory Group. The group provided input into the development of the Health Passport initiative and the planning of the National Disability Conference.

Key Disability Initiatives

National Disability Conference

A National Disability Conference titled "Making it Easy to Speak Up" was held in December 2010 in Auckland. The conference was convened in response to members of the disability community voicing their desire for easy-to-understand, accurate, up-to-date information about their rights and ways to exercise those rights. Providers and consumers in the disability sector were also keen to socialise and network with peers and colleagues to share ideas.

Graeme Parish, President of People First Inc, at HDC's National Disability Conference.

Feedback from conference attendees confirmed that the aim of the conference was largely achieved. Networking opportunities were well received, and the range of topics covered was viewed as valuable, as were specific presentations on the rights of disabled people. Participants liked the opportunity they were given to be part of a practical session on peer support, and were impressed with the turnout of people, the mix of disabled people, and that disabled people were active presenters at the conference.

In addition to a great line-up of speakers from various government and non-government agencies, who provided useful information about their services, the conference participants had an opportunity to visit 30 display stands from various disability service providers. Other conference highlights included a heart-warming performance from the Edgewater College's Kapa Haka group and a riveting performance from the dancers from Touch Compass. The conference dinner provided some good humour and food for thought, compèred by motivational speaker Cam Calkoen and concluding with some great entertainment from sign singer Lorraine Butler and drummer Jaqui Barret, who encouraged all participants to try their drumming skills.

Participants acknowledge that there is much about the disability sector that works well — our plan is to contribute to the strengthening of the disability sector. The following are some of the comments made by conference participants, which we will build on at the next conference.

Consumers told us:

"One thing that I really like about disability services in New Zealand is...

- having a pacific disability information advice and support service
- networking with other people with disabilities
- that the power is now shifting to sit with families not services
- that there is a growing awareness that services must be provided holistically for the disabled person and those people caring for and supporting him or her
- the prospect for a change for the better ... real soon
- there is opportunity for volunteers to work alongside professionals to help make a positive difference in people's lives
- when it is delivered by people who have a willingness to understand the needs of individuals and deliver the service in a manner that embodies the principles of equity in rights and opportunities."

Professionals told us:

"I like working in the disability sector in New Zealand because...

- every day I get the opportunity to work with a great bunch of people
- I am passionate about my work. Work in the disability sector in New Zealand is very rewarding and it provides me a sense of great satisfaction
- I enjoy being able to assist students with disabilities and see their success at the end of their studies
- I enjoy supporting people to become as independent as possible so that they can access the community and live great lives
- I enjoy the challenge of being part of breaking down barriers to bring about positive changes within the disability sector
- I get to create opportunities for people with disabilities to enable them to be the drivers of their own destiny and to lead great lives
- the disability sector is a 'work in progress', it's exciting and incredibly challenging. Every day something happens, these 'happenings' in turn make my work fascinating."

As a result of this positive feedback from conference attendees the National Disability Conference will be held again in early 2012. There is no shortage of ideas for what to include in our next conference — more opportunities for participants to interact with the speakers is high on the list, along with greater opportunities for peer group discussions.

Health Passport

The Health Passport is a document designed to assist nursing, medical, and support staff to understand the care, communication, and support needs of people with disabilities. The Passport belongs to the disabled person, and is held, and updated, by him or her. The Health Passport concept is based on the Hospital Passport used in St George's Hospital, UK.

HDC is leading a process to implement the Health Passport in New Zealand hospitals. HDC worked with representatives from DHB disability advisory groups to contextualise the Passport for use in New Zealand, to develop the Passport document, and to plan the implementation. This was followed by a public consultation process. Documents were circulated widely amongst disability service users, service providers, consumer organisations, health professional bodies, DHBs, and other networks. Material was made available in various accessible formats, including plain language and NZ Sign Language. Feedback formats were email, fax, post, or telephone. A summary of the consultation feedback was compiled and posted on the HDC website, and key suggestions were incorporated in the draft document used for the pilot. As one mother put it, "I wish it had been available when my son needed Neurosurgery last year and was in hospital for 5 days. Although I explained my son's needs to the staff I found he was left to shower himself and generally all that I told them was largely ignored. I was regarded as an over anxious mother!"

The project requires an initial evaluation phase (the pilot), and Hutt Valley and Capital and Coast DHBs are currently trialling the Passport in their respective communities and hospitals. Evaluation and improvement add value to, and give confidence in, the product and process we bring to DHBs during implementation. HDC's interest as lead agency is to ensure that the Health Passport document responds as far as possible to the needs of those who use it, both service users and providers. At the completion of the evaluation phase, HDC intends to roll out the Health Passport initiative across all DHBs.

Educational Resources

Making Communication easy

This resource has been produced to identify some stereotypes that can distort understanding of impairment and have a negative impact on how we interact with people with impairments. It offers guidelines on the use of appropriate language associated with impairment, and is aimed at making it easy to communicate effectively with people with impairments.

Making it easy to put the Code into Action

This is a resource on the Code of Rights, for caregivers. It is designed to be a practical guide to the Code of Health and Disability Services Consumers' Rights for aged care and disability support workers by enhancing their understanding of the practical implications of those rights. It gives useful tips and concrete examples of actions that caregivers can take in their day-to-day work to respect and uphold consumer rights under the Code.

INEFFECTIVE COMMUNICATION ISSUES RESOLVED THROUGH MEDIATION

This case involves a 13-year-old girl who has cerebral palsy with cerebral, intellectual, and physical impairments. She also has hydrocephalus, which is controlled with a ventriculo-peritoneal (VP) shunt, a tube draining fluid from the ventricles in the brain to the abdomen for absorption and to relieve intracranial pressure. Her mother is profoundly deaf and communicates with the help of a sign language interpreter and whānau.

In September 2009, the mother took her daughter to an emergency department with vomiting, severe headache, increasing restlessness, and photophobia, which had been worsening throughout the morning. The girl was groaning loudly. Her whānau suspected a shunt malfunction. They waited nine hours before she was assessed by the neurosurgical registrar. She was admitted to the ward for observation.

The whānau later reported that the girl started "seizures" or "fitting" but the nursing staff said she was "restless" (her observations were normal). Her family told the staff that the movements were not normal, and the neurosurgical registrar was called, but nothing was done until she was assessed by a neurologist. Her family was told that the girl's condition was critical but nothing could be done until she stopped fitting. After 39 hours in hospital, the girl was rushed to emergency surgery to relieve the pressure on her brain.

The mother complained to HDC regarding the length of time they waited for her daughter to have effective treatment, and that the family were not listened to. They were also concerned about the girl returning to the same hospital and/or having to be admitted, and that sign language interpreters were unavailable at times to assist the mother to understand procedures and give consent.

HDC obtained expert advice from a neurosurgeon, who said that there was no major concern with the surgical care, but that the delay in the girl being assessed in the emergency department by a neurosurgical registrar was "rather unusual".

HDC then called a mediation conference, where the parties agreed to continue to work through the issues. As a result of the mediation, the DHB agreed to ensure that there were adequate up-to-date policies that reflected the DHB's obligations under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and the Health Information Privacy Code.

Further, the DHB undertook to ensure that all its staff were aware of, and trained in, the use of the policies. It made changes to some staff job descriptions and ensured that sign language interpreters were available to be contacted, or attend, when needed. The DHB also undertook to provide ongoing care to the girl, and set out a crisis plan and pre-arranged sign language interpreters for the mother.

REPORT OF THE DIRECTOR OF ADVOCACY

The Nationwide Health and Disability Consumer 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.

Judi Strid
Director of Advocacy

The high level of public awareness of the advocacy service is reflected in the high number of calls to the 0800 number. Since July 2010, there have been 29,284 calls, of which 92% of those made during normal business hours were answered. This number does not include the calls made directly to local advocates.

Enquiries

The advocacy service provides a very effective clearing house function with 10,401 enquiries managed for the year. As the focus of advocacy is on timeliness, it is pleasing that 95% of the enquiries were closed within two days and 98% within five days.

The highest percentage of enquiries is about how to make a complaint (18.5%), followed closely by the role of an advocate (18%). The next highest is requests for education sessions (9%). The remainder relate 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 (5.5%) 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 that they can deal with these matters themselves. In these situations, advocates are able to act as mentors.

Seventy-one percent of callers were provided with verbal and/or written information about advocacy and the Code of Health and Disability Services Consumers' Rights, and over 5% of callers were referred to other agencies such as the Office of the Privacy Commissioner, District Inspectors, WINZ, ACC, Human Rights Commission, Police, and the Office of the Ombudsmen. Close to 7% of enquiries were escalated to complaints, and over 6% resulted in a booking for an advocacy education session.

Complaints

The Advocacy service received 2,831 new complaints and brought forward 395 from the previous year, giving an overall total of 3,232. However, from a performance perspective, as complaints run over from one quarter to the next, reports run on a quarterly basis show a more accurate reflection of the actual workload. In line with historical reporting practice, this shows a total of 4,271 complaints managed by advocates.

Timeliness is a key aspect of achieving successful resolution of complaints. On average 85% of complaints were closed within three months and 98% closed within six months. On average 87% of complaints managed by advocacy were partially or fully resolved.

In 136 of a total of 315 resolution meetings, providers agreed to take post-meeting actions, which were recorded on the resolution agreement form. In all cases the provider completed the action within the agreed timeframe. This is the first year in which no providers have required a reminder from an advocate. 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.

Consumers continue to report difficulties arising from the decentralisation of DHB complaint processes to each department dealing with its own complaints, 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.

Complaints are classified according to the number of hours an advocate spends working with the consumer/complainant. During the past year, 36.8% were simple (up to 2 hours). This is down from 41% last year. Complaints classified as standard (2–8 hours) were up with 53.7% closed this year compared to 50% last year, 7.5% were complex (8–15 hours), up from 7%, and 2% of complaints were classified as taking more than 15 hours.

Source of complaints

A majority of complaints received about providers were made directly to advocates (57%), 20% used the 0800 number, and 10% called in to the local advocacy office or discussed their complaint with the advocate during an education or networking session. Eight percent contacted the advocate by letter, text, fax or email, and 5% were formal referrals from the Health and Disability Commissioner.

Complaints received directly from consumers accounted for 73% of complaints (up from 62%), and 27% (down from 35%) were from a third party such as family members, friends, and HDC. This reflects the proactive efforts of advocates to improve access to vulnerable consumers concerned about their care.

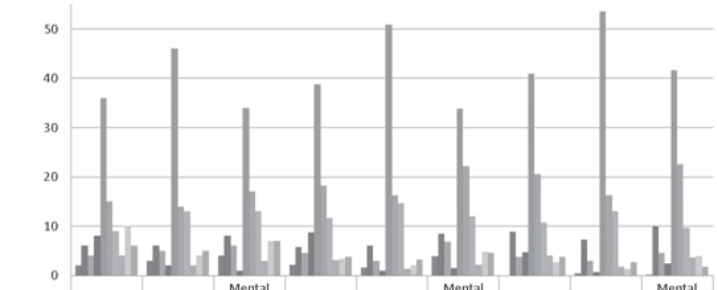
At 84%, the vast majority of complaints related to health service providers. The 16% relating to disability service providers is not reflective of consumers with impairments, as the statistics record the service used rather than the details about the consumer.

Complaint comparisons

It has been interesting to once again look at the similarities and differences between the nature of complaints about health (73%), disability (15%), and mental health services (12%). It is common for complaints to cover more than one particular right.

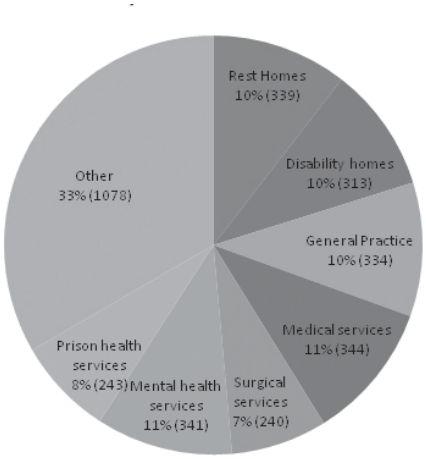
Complaints about respect (Right 1) are 7% for health, 9% for disability, and 10% for mental health. Complaints about dignity and independence (Right 3) have improved considerably from the 9% of complaints about disability service providers in the last reporting year, to 5%. Right 4 is clearly a major factor for all sectors — 41% of complaints involving disability services, 54% of health service complaints, and 42% of those involving mental health providers concerned the standard of care. The combined complaints about communication, information, and consent (Rights 5, 6, and 7) give a collective total of 36% for disability (up from 33%), 31% for health

Figure 1: **Complaints by sector and primary issue**



	Disability	Health	Mental Health	Disability	Health	Mental Health	Disability	Health	Mental Health
	08/09			09/10			10/11		
Rights	2	3	4	2.1	1.6	3.9	0	0.4	0.2
Right 1	6	6	8	5.8	6.1	8.4	8.9	7.2	9.9
Right 2	4	5	6	4.5	3	6.9	3.7	2.9	4.5
Right 3	8	2	1	8.7	1	1.5	4.7	0.7	2.4
Right 4	36	46	34	38.8	50.9	33.8	41	53.6	41.6
Right 5	15	14	17	18.2	16.2	22.1	20.6	16.3	22.5
Right 6	9	13	13	11.7	14.6	12	10.7	13	9.6
Right 7	4	2	3	3.1	1.4	2.1	4	1.8	3.6
Right 8	10	4	7	3.3	2	4.8	2.7	1.4	3.9
Right 10	6	5	7	3.8	3.2	4.5	3.7	2.7	1.8

Figure 2: **Complaint Categories 2010/11. The total number of complaints is 3,232**



providers, and 37% about mental health providers. The right to support (Right 8) continues to feature in just 3% of disability complaints, compared with 1% of health complaints and 4% of mental health complaints. Four percent of complaints about a disability service related to the complaint process (Right 10), compared with 3% about health services and 2% about the complaint processes used by mental health services.

Demographics

Most complaints come from female consumers (55.7%). Male consumers make up 38.9%, and people who describe their gender as other (eg, trans and intersex people) make up the remaining 5.4% of complainants.

Consumers under the age of 15 years account for 4% of complaints, with 16 such complaints being made by the consumer. Parents made 94 complaints, and 3 complaints were made by grandparents. At 34%, the highest number of complaints were made by people in the 41–60 year age group, followed by 25% from the 26–40 year age group, with 25% of all complaints being about consumers aged between 61–90 years.

Ropata Retirement Village residents in Lower Hutt enjoying an advocacy education session.

New Zealand Pākehā continue to bring the largest number of complaints (70%), with New Zealand Māori making 13% of the complaints. Complaints from Pacific Island communities accounted for 2.5% of complaints. The remainder of complaints are from a wide range of ethnic groups and include 162 people who declined to provide their ethnicity.

Residential Visits

Our advocates have been visiting rest homes for five years, and disability homes for four years. The purpose of the visits is to make it easy for residents to speak with an advocate, and to provide free education sessions for residents and whānau/family members as well as providers. The new DVD *Tell Someone*, which was specially designed as an education tool for advocates to help people with a learning or intellectual disability to understand their rights, continues to be extremely well received.

This was the first year of introducing a planned second visit to 50% of all rest homes and disability homes. The reason for this was to increase the focus on vulnerable consumers who would otherwise find it impossible or extremely difficult to seek the assistance of an advocate.

All 700 of the rest homes had at least one contact with an advocate, and 474 homes had at least two contacts. A majority (936 of 953) of disability homes had at least one contact with an advocate, and 556 had at least two contacts. Over the reporting year, there have been a total of 2,894 rest home and 3,019 disability residential visits by advocates.

Networking

Networking is an important way for advocates to establish a profile in their local communities so that they are well positioned to inform consumers of their rights and providers of their duties. Networking also helps the advocate to be well linked to their community and to stay up to date with developments in local services. This means that they know who to refer callers to if a matter is outside HDC's jurisdiction.

Networking and education are the key features of the role of the six specialist advocates. These advocates familiarise themselves with the different local issues across the country, and identify opportunities for letting these communities know about their rights, as well as raising their profile in a range of Deaf, refugee, and migrant communities.

Over the past year, advocates developed and maintained contact with 4,238 networks. Thirty-three percent of these non-residential networks had a disability focus, and 67% a health focus.

Of these, public interest groups made up 23% of the networks, 19% were with refugee/migrant groups, and 12% were with people with an intellectual or learning impairment. Fourteen percent were with older people's groups, 8% were with groups supporting people with a mental illness, with the remainder being spread across a variety of other groups including Māori, Asian and Pacific communities and provider groups.

Education and Training

Advocates presented a total of 1,936 education and training sessions to a range of consumers, providers, and organisations. The greatest numbers of requests were once again for basic information on advocacy, the Code, and HDC (58%). Requests for open disclosure training have continued, with advocates delivering 137 sessions over the past year. More than half of these sessions (54%) were carried out within the residential sector, 173 (9%) with the non-residential disability sector, and 64 (3%) with refugee/migrant communities. Including residential homes, 63% of education and training was provided to the disability sector.

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. The piloting of a programme in Auckland prisons designed for pre-release prisoners was very well received.

It is pleasing to see an increasing number of advocates being invited to present workshops to student nurses in training, as well as the success of joint education initiatives with HDC staff.

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.

Both the trainers and the in-house advocate trainers have found the annual refresher training programmes well worthwhile. The in-house trainers report the programmes as being very good preparation for them to train their colleagues.

A dedicated qualification for health and disability advocates was approved for the NZQA framework, so planning is underway to provide a competency assessment for the existing advocates. This will form part of a career pathway for health and disability advocates.

Lower Hutt advocate Sharon Downs showing the *Tell Someone* DVD to residents from a Laura Fergusson Trust residential home.

Highlights

The national focus on celebrating the anniversary of the launch of the Code of Rights on Code of Rights Day (1 July) continues to provide a real opportunity to attract 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. Many advocates had their displays and profile published in the local paper. Having an advocacy colleague on the front cover of the last annual report was a welcome way of acknowledging the work done by advocates to celebrate this special anniversary.

A number of advocates were pleased to be able to attend the HDC Disability Conference to provide information about the advocacy service and to offer support and assistance for those needing it. Those advocates who attended the conference gave it a high rating.

The national advocacy conference in Wellington provided an opportunity for advocacy personnel to meet the Commissioner (many for the first time) and to hear his vision for HDC. His ongoing interest and support of advocacy has been very much appreciated.

The Kaumatua Network was replaced with a new Puna Matauranga group as a way of providing more meaningful support and advice on Tikanga Māori. Members of this group work closely with each of the regional teams.

The positive response from providers and consumers about the *Tell Someone* DVD, along with the positive responses from people who hear the great care stories, continues to be a highlight.

Other highlights include:

- the provision of laptops, which are Skype capable to enable the Deaf advocates to provide peer support to each other, and the singing of the national anthem in NZSL at Parliament;
- the inclusion of an advocate in the mobile surgical unit video link to rural providers to enable them to be educated on the Code, Advocacy and HDC; and
- having the health and disability advocacy qualification formally approved by NZQA.

Satisfaction Results

By its very nature, the advocacy service provides a consumer-centred approach. It is therefore very important that we do this well and set a great example to providers. Surveys showed that 92% of consumers and 81% of providers are very satisfied with their dealings with the advocacy service. Ninety-three percent of consumers are very satisfied with the advocacy

Napier advocate Louise Grant with Summerset Rest Home resident Mr Tommy Taurima. Mr Taurima is a well respected kaumātua and a renowned songwriter of Ngāti Kahungunu descent.

process, 95% with the skill shown by the advocate, and 88% with the help they received in resolving the complaint. Ninety-three percent of consumers and 88% of providers said that they would recommend the service to others.

Ninety-one percent of consumers and providers are very satisfied with the education sessions provided by advocates.

Consumers make many positive comments about the advocate who assisted them. These include comments on the professionalism of the advocate, their knowledge and ability to listen and communicate well, as well as the understanding and empathy they showed. Consumers were pleased to have the advocate on their side, and commented on how this had given them the confidence to speak up about their concerns.

It is also important for providers to have confidence in the advocacy process. 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, and said that they would recommend the services to others.

The following are unsolicited comments about advocates:

> "Firstly many thanks for the valuable work you have done over the past year. This has included providing a supportive forum for the rangatahi to address any issues related to their rights whilst in treatment. They have stated that they are comfortable with your facilitation of this process and the clinicians have confirmed this through their counselling sessions. You have made our own processes more robust with your involvement in our service and we hope that you are able to carry on with this very positive contribution to our rangatahi's ongoing recovery as well as to this service in the future."

> "I wanted to pass on my sincere thanks for her efforts to resolve this issue on my behalf. From the outset I found her compassionate and very genuine in her concerns for my predicament."

> "I am so very impressed with the support and practical help I received from the advocate. I got splendid service and only wish I had been aware of this fine service much earlier."

In conclusion, I would like to once again acknowledge the dedication and commitment of all those involved with the provision of the advocacy service. It has been a difficult year with the sudden death of two advocates, as well as the untimely death of a valued Trust member. The camaraderie and support amongst advocacy personnel has played a significant role in enabling consumers to continue to receive a high quality professional service. The combined efforts of the advocates, managers and support staff, members of the National Advocacy Trust Board, and the new Puna Matauranga Group have all contributed to the provision of an excellent service for health and disability services consumers throughout the country.

Case Studies

The advocacy mantra that every complaint is an opportunity for learning and quality improvement encourages consumers to think of what could have made their experience better. It is also a challenge to providers to look at changes needed to ensure future consumers receive improved services. In this respect it is essential that the advocacy process adds value by supporting consumers to identify actions that will improve services, as well as helping them highlight service shortcomings.

The following case studies provide examples of how the advocacy process has enabled consumers to speak up and achieve results that have made a difference for them and, in some of the cases, future consumers.

CONCERNS ABOUT CARE IN A RESIDENTIAL HOME

An advocate was contacted by the mother of a consumer who has high needs, is non-verbal, and is fully dependent on the staff of the residential home in which she lives. The mother expressed concern that her daughter had been admitted to hospital as a result of not receiving her medication that prevents muscle spasm and grand mal seizures, and that this was not the first time she had been admitted as a result of her failing to receive the prescribed medication.

After initial discussions with the advocate, the complainant said she felt empowered enough to manage the complaint process without further advocacy support. The advocate followed up on the complainant's progress with her complaint, and was advised that she had not yet received a response from the provider. After further discussion, the complainant requested the advocate assist her to organise a meeting. Upon contacting the provider, it was decided that the meeting would be held the following day, as the new Area Manager would be in town.

The complainant, supported by the advocate, was able not only to address her concerns about medication, but also had the opportunity to discuss concerns relating to not being notified of serious issues, an evacuation plan, staff experience, and professionalism. As a result of the meeting, the complainant was able to receive feedback in respect of her medication concerns, and the manager also agreed to:

- educate staff on the purpose and function of the consumer's medication
- check the seizure protocol to ensure it is correct and that staff know what to do
- follow up and provide feedback to the complainant on the outcome of the consumer's recent X-rays
- determine the process for staff notifying/contacting the complainant when there are events, issues, etc, regarding her daughter
- provide a copy of the consumer's annual personal care plan to the complainant
- check the evacuation plan.

The complainant felt that it was a positive outcome. She believed that by having her concerns addressed, the overall standard of care would improve for all residents.

COMMUNICATION IN A PUBLIC HOSPITAL

Prior to undergoing a CT scan, a woman advised the attending nurse that from past experience she anticipated difficulty with inserting a luer in her arm. The woman was assured of the anaesthetist's skills. However, it took a painful 40 minutes to insert the luer, and the doctor was still holding it in place until the final second before the woman entered the machine.

The woman said that seconds into the scan she was in a lot of pain, with her arm swelling alarmingly. The attending nurses appeared to panic, not knowing what to do, and this further alarmed the woman. Two doctors were called in and they checked what had been done, but did not appear interested, and did not explain what was causing the pain and said that everything seemed to be all right.

The woman sought advocacy support to make her complaint to the hospital. After discussion with the advocate she chose to have assistance with writing a letter of complaint. She was keen for the radiology department to look into their procedures for dealing with patients who anticipate problems.

The woman was very satisfied with the response from the hospital. She said:

> "I feel that they treated the matter with the right amount of seriousness, they addressed all the issues that I mentioned and promised to have the right tools to cope with a similar event happening again ... I feel I can put it all behind me."

CONCERNS ABOUT A COMPULSORY TREATMENT ORDER

A young Kenyan woman telephoned the advocacy service with concerns about a Compulsory Treatment Order which required her to take medication in front of a public health nurse at her place of work.

Some months earlier she was diagnosed with TB and, as a result, she was referred to the Public Health Section for Communicable Diseases.

The woman was concerned that she was required to leave whatever she was doing to meet the nurse outside the grounds to receive the medication. She also felt that her privacy was being compromised, as her employer did not know that she had tested positive for TB.

The woman sought advocacy assistance to request that she be allowed to self-medicate or, alternatively, for the public health nurse to change the time she delivered the medication, so that the woman could receive it after work at her home.

At the request of the woman, the advocate sent an email to the Public Health section and asked that they reconsider their treatment order and allow the consumer to self-medicate. In response, the advocate received a call from the Registrar, who advised that she was going overseas for a week and would get in contact on her return.

As agreed, the Registrar telephoned on her return and advised that she would set up an appointment with the woman to do more tests in the hope that she would not need to take any further medication. The woman was elated with the response and attended the appointment. Following the appointment, the woman advised the advocate that she would require medication for only another month, and that as requested the medicine would be delivered to her at her home.

LACK OF RESPECT AT AN ACCIDENT AND MEDICAL CENTRE

A man went to his local accident and medical centre for treatment after binge drinking. The doctor who was treating him became very judgmental, telling him he was a "drug seeker", and writing this on the medical notes. The man had had previous treatment for binge drinking, and knew what worked for him. He was not seeking drugs and felt very offended by the doctor's attitude.

The man initially took his own action by writing a letter of complaint to the director of the accident and medical centre. After failing to get a response to his complaint, he contacted a local advocate. The man asked the advocate to write a letter to the director of the centre, on his behalf, to remind him of his responsibility in relation to Right 10 (the right to make a complaint and receive a timely response). A copy of the man's original complaint letter was included.

The man's letter of complaint outlined the following issues:

1. He felt that the doctor who had seen him was rude and disrespectful towards him, judging him as a "drug seeker" and writing this on his medical notes.
2. The doctor did not actually examine him.

The man also advised the outcome he was seeking:

- An explanation and apology for what had occurred.
- A refund of the $65 treatment cost, as the doctor had not examined or treated him.
- He wanted the words "drug seeker" removed from his medical notes.

The director of the medical centre responded in writing to the man with a sincere apology and an offer to meet in person, with the support of the advocate. The director said he had removed the drug-seeking behaviour caution from the system, and agreed to refund the fee for the man's visit.

The man decided not to meet as he was extremely happy with the written response. He thanked the advocate for the professional and empathetic way his complaint had been handled.

CONCERNS ABOUT THE STANDARD OF CARE IN A REST HOME

An advocate was approached by a family member with concerns about a parent in rest home care. When the advocate met with the consumer and complainant it was clear that the consumer did not want to make a fuss. However, he did authorise the complainant to pursue the issues after his death. A few months later, after he had passed away, the family contacted the advocate for help with their complaint. They had concerns about the care, record-keeping, staff training in clinical procedures, and the use of alternative therapies without consent.

The complaint was taken very seriously. The national manager of the rest home syndicate made a special trip to meet with the complainant. The complainant and other family members felt that the responses were detailed, investigations were thorough, the two levels of follow-up were appropriate, and that systems changes had occurred as a result of the complaint. They were grateful to the advocate for meeting the consumer, and for the ongoing support including during the resolution meeting. The family felt heard and able to move on.

EDUCATION SESSION FOR REFUGEES ON THE CODE OF RIGHTS

An advocate was invited to present an education session on the Code of Rights and the advocacy service to a women's refugee group. Within the group there were refugees who had been in New Zealand since 2000, including people who had spent a number of years in various refugee camps.

The advocate started with an overview of the Code, and then provided a more in-depth focus on Right 5, as communication can be a major barrier for refugees. The group became animated and expressed a lot of interest in this right, as many had experienced difficulties with health providers and wanted to share their experiences. Many had not been offered the services of an interpreter, and felt that their experience would have been better had this service been available. Some women felt disrespected and uninformed because of the language barrier and lack of interpreters.

The group felt that the advocate had empowered them with information about their rights, encouraging them to speak up, and providing them with contact details for the advocate if they want support.

EDUCATION SESSION FOR REFUGEES ON THE CODE OF RIGHTS

A woman from a refugee community visited the specialist refugee/migrant advocate, at her office, seeking support to make a complaint about poor communication and lack of respect by staff members at a clinic providing community health services.

The woman requested the advocate write to the manager of the service and advise him of her concerns. The letter was approved by the woman prior to being sent.

The woman received an apology from the manager on behalf of the service, and an assurance that her concerns had been discussed with staff.

When she returned to the clinic she could see a big difference. Communication had improved and the staff treated her with respect. She was very happy with the outcome and thanked the advocate for assisting her to exercise her rights.

REPORT OF THE DIRECTOR OF PROCEEDINGS

One of the ways our system is consumer-centred is that proceedings can be taken to publicly redress serious breaches of the Code of Health and Disability Services Consumers' Rights. This also provides a deterrent against similar breaches in future.

Rigorously analysing where things have gone wrong in a complex system is often enough to change future behaviour. People learn, and the system adapts. However, in instances of serious failure or where mistakes are repeated despite what should have been salutary past experience, accepted standards of practice need to be reinforced. In cases where there has been a serious departure from what those who work on the "frontlines" would regard as acceptable, proceedings vindicate consumers' confidence in, and respect for, health professionals.

I am again very grateful for the professionalism and dedication of my team and of the expert witnesses who have been involved in proceedings this year. Their sound analysis has resulted in meaningful outcomes being achieved for consumers in the cases taken.

Aaron Martin
Director of Proceedings

Statistics

The Director of Proceedings received four referrals during the year (in relation to four providers). The prosecution case has closed in a disciplinary proceeding against a general practitioner, and that matter has been adjourned after six hearing days to hear the defence case at the end of October 2011. There was one substantive hearing before the Human Rights Review Tribunal (HRRT) resulting in a very significant award of damages. Two HRRT cases (concerning the same rest home) were dealt with by the Tribunal "on the papers", without the

Table 1: **Action taken in respect of referrals to Director of Proceedings in 2010/11**

Provider	No. of providers	No further action	DP decision in progress	Proceedings pending	Proceedings concluded	Total no. of consumers involved
Shiatsu massage practitioner	1			1		1
General practitioner	1			1		1
Rest home	2			1	1	2*
Needs assessment service co-ordinator (NASC)	1			1		1*
Total	**5**			**4**	**1**	**4**

* One consumer is the subject of a claim against a rest home and a NASC.

Note: Table 1 records the Director of Proceedings' actions on referrals in the 2010/11 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 four referrals in the 2010/11 year (in relation to four providers).

need for a formal hearing. Two other cases were concluded by agreement without the Tribunal being asked to make any formal orders and are therefore not included in Table 2 below.

All proceedings concluded this year resulted in successful outcomes.

Table 2: **Outcomes in 2010/11**

Provider	Successful	Unsuccessful	Outcome pending	Total no. of providers	Total no. of consumers
HRRT					
Rest home	2			1	2
Nurse	3			1	3
Social worker	1			1	1
Total	**6**	**0**	**0**	**3**	**6**

Note: Two other cases (not shown in the above tables) were concluded by agreement without the Tribunal being asked to make orders.

SIGNIFICANT DAMAGES FOR FINANCIAL EXPLOITATION

In December 2010 the Human Rights Review Tribunal awarded $100,000 in damages against former community health coordinator Ms Parehe Nikau, for financially exploiting a client.

The claim established that Ms Nikau had accepted money and gifts totalling over $50,000 from her client (who has name suppression to protect her privacy). The Director also successfully claimed $30,000 compensation for humiliation, loss of dignity and injury to feelings, $20,000 for flagrant disregard of the client's rights, and $7,500 costs. The Tribunal made an order that Ms Nikau return two items of personal significance to her client.

Another social worker gave evidence of the effects these events have had on Ms Nikau's former client: increased use of acute respite services, more frequent medical reviews and a need for increased support and monitoring. The Tribunal heard that the client had put her complete trust in Ms Nikau and now felt insecure to such an extent that she had changed the locks on her doors. The exploitation happened at a time when the client was struggling to cope after her father's death and was very unwell.

The Tribunal's full decision is available at: http://www.nzlii.org/nz/cases/NZHRRT/2010/26.html

REST HOME RESPONSIBLE FOR DEFICIENCIES IN POLICIES, PROCEDURES AND STAFF TRAINING

In two decisions dated 12 May 2011 the Human Rights Review Tribunal made declarations that Norfolk Court Rest Home Limited (Norfolk Court) breached the Code of Health and Disability Services Consumers' Rights in relation to separate care of two different consumers. Both matters proceeded by way of an agreed summary of facts. The declarations were made by consent, the parties having resolved the issues of damages and all other matters (including in respect of costs) between themselves.

At the relevant time Norfolk Court had employed a registered nurse who was a recent graduate and lacked any gerontology nursing experience. When first employed, the nurse was to be the sole registered nurse at Norfolk Court despite not being suitably skilled or trained to be the sole person responsible for the provision of nursing services to residents. Norfolk Court failed to provide the nurse with sufficient mentoring, training and education to properly undertake her role. Norfolk Court accepted vicarious liability for the breaches of the Code by the registered nurse.

Norfolk Court did not have adequate policies and procedures in place for: resident assessment on admission; falls prevention; falls risk assessments; care planning; incident and accident reporting; doctors visits; communication/consultation with families; and continence management.

Norfolk Court did not ensure that its staff were adequately trained and familiar with the policies and procedures that were in place. It did not take reasonable steps to ensure that staff complied with these policies and procedures.

Consumer A (HRRT No. 45/10)

In the two years that Mrs A was resident at Norfolk Court, there were no recorded family meetings as part of the care planning process. Care plans that were made failed to include assessments for falls, pain or pressure risk. Mrs A suffered four falls between December 2008 and February 2009. She was later found to have a fractured ankle and a fractured hip. After each of these falls a new "falls risk assessment" should have been undertaken; however, no falls risk assessment was undertaken at any point. Despite being assessed by the registered nurse, no injuries were identified until six weeks after the hip fracture and one week after the ankle fracture when an X-ray was taken. Before this time, Mrs A was encouraged to mobilise and walk with her injuries despite complaining of ongoing pain and expressing reluctance to comply. Mrs A was in significant pain without adequate treatment for a period of four months, as the registered nurse failed to adequately assess Mrs A's pain and address it. Norfolk Court's pain management policy was inadequate.

Consumer C (HRRT No. 46/10)

Throughout Mr C's one-month stay at Norfolk Court the registered nurse made only two entries in Mr C's progress notes. There was no plan to manage Mr C's behaviours (including nocturnal wandering) to promote his safety prior to considering the use of medication.

Norfolk Court did not have in place policies and procedures for medical reviews. Mr C was put on a medication trial and was reported to be stumbling around the floor, falling at times. Mr C was given further medication and shortly afterwards was found attempting to jump off a balcony.

Mr C sustained injuries as a result of four falls during January 2009. He was not seen by the rest home doctor until after the third fall. He rapidly deteriorated and suffered two subdural haematomas and herniation of the brain. Mr C died in January 2009.

The Tribunal's full decisions are available at: http://www.nzlii.org/nz/cases/NZHRRT/2011/12.html and http://www.nzlii.org/nz/cases/NZHRRT/2011/13.html

The Director of Proceedings team: From left, Heléna Cook, Aaron Martin, Denise McElwain and Jason Tamm.

NURSE MANAGER/OWNER OF REST HOME LIABLE FOR BREACHES OF CODE

Ms Savita Mistry was the registered nurse/owner and manager of Birkenhead Lodge Retirement Home. She accepted that she had breached Right 2 of the Code of Health and Disability Services Consumers' Rights in relation to three different residents ("A", "B" and "C") in that:

(i) Between 1 January 2007 and 30 April 2008 "A" was charged $232.00 in respect of medicines purchased from a pharmacy for $98.80, without "A" having agreed to pay more than the cost of the medicines; and

(ii) "A" was charged $50.00 for an attendance by a podiatrist for which the attending podiatrist would have charged a maximum of $40.00 and for which in any event there was no clinical record of an actual attendance; and

(iii) Between 1 January 2007 and 30 June 2008 "B" was charged $970.00 in respect of medicines purchased from a pharmacy for $131.40, without "B" having agreed to pay more than the cost of the medicines; and

(iv) Between 30 August 2006 and 9 June 2008 "B" was charged $510.00 for attendances by podiatrists when there are records of only four attendances with an actual cost of no more than $160 (that is, a maximum of $40.00 each); and

(v) Between December 2007 and 29 April 2008 "C" was charged $75.00 a week for the benefit of residing in a larger room when she no longer occupied that room from December 2007; and

(vi) Between 13 June 2006 and 19 March 2008 "C" was charged $600.00 for attendances by a podiatrist when there are records for only three attendances with an actual cost of no more than $120 (that is, a maximum of $40.00 each); and

(vii) "C" was charged $60.00 for a consultation with a doctor on 4 March 2008, for which Birkenhead Lodge was not charged.

Right 2 of the Code provides:

> *Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.*

The Human Rights Review Tribunal was satisfied that Ms Mistry's conduct failed to comply with legal, professional, ethical and other relevant standards and, in particular, that she contravened Right 2 of the Code. The Tribunal made a declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994.

All other aspects of the relief claimed by the Director had been resolved between the parties.

The Tribunal's full decision is available at: http://www.nzlii.org/nz/cases/NZHRRT/2010/19.html

Statement of Responsibility for the year ended 30 June 2011

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 2011.

Anthony Hill
Health and Disability Commissioner

Hemant Thakkar
Acting Corporate Services Manager

3 October 2011

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Health and Disability Commissioner's financial statements and statement of service performance for the year ended 30 June 2011

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, Leon Pieterse, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and statement of service performance of the Health and Disability Commissioner on her behalf.

We have audited:

- the financial statements of the Health and Disability Commissioner on pages 41 to 61, that comprise the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health and Disability Commissioner on pages 62 to 66.

Opinion

In our opinion:

- the financial statements of the Health and Disability Commissioner on pages 41 to 61:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health and Disability Commissioner's:
    - financial position as at 30 June 2011; and
    - financial performance and cash flows for the year ended on that date.
- the statement of service performance of the Health and Disability Commissioner on pages 62 to 66:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects, for each class of outputs for the year ended 30 June 2011, the Health and Disability Commissioner's

- service performance compared with the forecasts in the statement of forecast service performance for the financial year; and
- actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 3 October 2011. This 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 our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and statement of service performance are free from material misstatement.

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.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health and Disability Commissioner's preparation of the financial statements and statement of service performance that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health and Disability Commissioner's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Health and Disability Commissioner;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Health and Disability Commissioner

The Health and Disability Commissioner is responsible for preparing financial statements and a statement of service performance that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health and Disability Commissioner's financial position, financial performance and cash flows; and
- fairly reflect its service performance.

The Health and Disability Commissioner is also responsible for such internal control as is determined necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

The Health and Disability Commissioner's responsibilities arise from the Crown Entities Act 2004 and section 15 of the Public Audit Act 2001.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you based on our audit. Our 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.

Leon Pieterse
Audit New Zealand

On behalf of the Auditor-General
Auckland, New Zealand

STATEMENT OF COMPREHENSIVE INCOME for the year ended 30 June 2011

	Note	Actual 2011 $	Budget 2011 $	Actual 2010 $
Income				
Revenue from Crown	2	9,170,000	9,170,000	9,170,000
Interest income		100,408	60,000	82,588
Other revenue	3	85,782	90,000	89,704
Total income		9,356,190	9,320,000	9,342,292
Expenditure				
Personnel costs	4	3,865,631	4,076,385	3,761,113
Depreciation and amortisation expense	9, 10	222,989	297,170	241,142
Advocacy Services		3,540,198	3,495,998	3,523,585
Other expenses	5	1,605,517	1,944,438	1,855,564
Total expenditure		9,234,335	9,813,991	9,381,404
Net surplus/(deficit) for the year		**121,855**	**(493,991)**	**(39,112)**
Total comprehensive income for the year		**121,855**	**(493,991)**	**(39,112)**

The accompanying notes form part of these financial statements.

Explanation of major variances against budget are provided in note 24.

STATEMENT OF FINANCIAL POSITION as at 30 June 2011

	Note	Actual 2011 $	Budget 2011 $	Actual 2010 $
Assets				
Current Assets				
Cash and cash equivalents	6	1,656,353	756,010	1,387,234
Debtors and other receivables	7	262,632	21,000	35,738
Prepayments		53,639	34,000	58,097
Inventories	8	20,034	30,000	28,173
Total current assets		1,992,658	841,010	1,509,242
Non-current assets				
Property, plant and equipment	9	189,868	238,624	291,741
Intangible assets	10	66,683	290,380	98,990
Total non-current assets		256,551	529,004	390,731
Total assets		**2,249,209**	**1,370,014**	**1,899,973**
Liabilities				
Current Liabilities				
Creditors and other payables	11	448,938	433,500	413,656
Employee entitlements	12	150,055	149,505	144,023
Total current liabilities		598,993	583,005	557,679
Non Current Liability Lease Incentive	13	186,067	0	0
Total non-current liabilities		186,067	0	0
Total liabilities		785,060	583,005	557,679
Net Assets		**1,464,149**	**787,009**	**1,342,294**
Equity				
General funds	14	1,464,149	787,009	1,342,294
Total Equity		**1,464,149**	**787,009**	**1,342,294**

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY for the year ended 30 June 2011

	Actual 2011	Budget 2011	Actual 2010
	$	$	$
Balance at 1 July	1,342,294	1,281,000	1,381,406
Amounts recognised directly in equity:			
Total comprehensive income	121,855	(493,991)	(39,112)
Total Net Recognised Revenues and Expenses	1,464,149	787,009	1,342,294
Balance at 30 June	**1,464,149**	**787,009**	**1,342,294**

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS for the year ended 30 June 2011

	Note	Actual 2011 $	Budget 2011 $	Actual 2010 $
Cash Flow from Operating Activities				
Receipts from Crown revenue		9,170,000	9,170,000	9,170,000
Interest received		102,328	60,000	84,826
Receipts from other revenue		68,458	90,000	134,081
Payments to suppliers		(5,123,540)	(5,421,905)	(5,379,445)
Payments to employees		(3,859,599)	(4,076,385)	(3,765,207)
Goods and services tax (net)		1,304	–	13,658
Net cash from operating activities	**15**	**358,951**	**(178,290)**	**257,913**
Cash Flows from Investing Activities				
Receipts from sale of property, plant and equipment		1,631	0	250
Purchase of property, plant and equipment		(31,256)	(101,700)	(66,427)
Purchase of intangible assets		(60,207)	(200,000)	(101,159)
Net Cash from Investing Activities		**(89,832)**	**(301,700)**	**(167,336)**
Net increase (decrease) in cash and cash equivalents		**269,119**	**(479,990)**	**90,577**
Cash and cash equivalents at beginning of year		1,387,234	1,236,000	1,296,657
Cash and cash equivalents at end of year	**6**	**1,656,353**	**756,010**	**1,387,234**

The accompanying notes form part of these financial statements.

1 Statement of accounting policies for the year ended 30 June 2011

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 2011, and were approved by the Commissioner on 3 October 2011.

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, 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:

Early adopted amendments to standards
The following amendments to standards have been early adopted:

NZ IFRS 7 Financial Instruments: Disclosures — The effect of early adoption of these amendments is that the following information is no longer disclosed:

- the carrying amount of financial assets that would otherwise be past due or impaired whose terms have been renegotiated; and
- the maximum exposure to credit risk by class of financial instrument if the maximum credit risk exposure is best represented by their carrying amount.

NZ IAS 24 Related Party Disclosures (Revised 2009) — The effect of early adoption of the revised NZ IAS 24 is:

- more information is required to be disclosed about transactions between HDC and entities controlled, jointly controlled, or significantly influenced by the Crown;

- commitments with related parties require disclosure; and
- information is required to be disclosed about any related party transactions with Ministers of the Crown.

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and that are relevant to HDC, are:

NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2014. HDC has not yet assessed the effect of the new standard and expects it will not be early adopted.

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 cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. The loss of service potential of inventory held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost (using the FIFO method) and net realisable value.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the 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 2011:

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.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the lease expense.

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 (2010 nil).

3 Other Income

	Actual 2011 $	Actual 2010 $
Sale of Publications	85,782	89,704
Total Other Revenue	**85,782**	**89,704**

4 Personnel Costs

	Actual 2011 $	Actual 2010 $
Salaries and wages	3,822,086	3,749,224
Employer contributions to defined contribution plans	37,513	15,983
Increase/(decrease) in employee entitlements (note 12)	6,032	(4,094)
Total Personnel Costs	**3,865,631**	**3,761,113**

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

5 Other Expenses

	Actual 2011 $	Actual 2010 $
Fees to auditor:		
Audit fees for financial statement audit	33,520	30,870
Staff travel and accommodation	108,295	92,298
Operating lease expense — premises	479,399	460,416
Operating lease expense — other	46,235	46,261
Advertising	39,072	91,928
Consultancy	124,559	238,186
Expert advice	116,489	121,646
Inventories consumed	72,812	184,418
Net profit on sale of property, plant and equipment	1,025	(250)
Communication	91,591	88,389
Computer costs	332,269	269,883
Other	160,251	231,519
Total other expenses	**1,605,517**	**1,855,561**

6 Cash and cash equivalents

	Actual 2011 $	Actual 2010 $
Cash on hand and at bank	26,353	27,234
Cash equivalents — term deposits	1,630,000	1,360,000
Total cash and cash equivalents	**1,656,353**	**1,387,234**

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% (2010 3.9%).

7 Debtors and other receivables

	Actual 2011 $	Actual 2010 $
Trade receivables	254,375	25,561
Other receivables	8,257	10,177
Less provision for impairment	0	0
Total debtors and other receivables	**262,632**	**35,738**

The carrying value of receivables approximates their fair value.

The ageing profile of receivables at year end is detailed below. All receivables greater than 30 days in age are considered to be past due. Included in trade receivables is the $223,280 lease incentive relating to the Auckland Office.

As at June 2011 and 2010, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2011 $	2010 $
Not past due	253,059	30,593
Past due 1–30 days	7,762	4,461
Past due 31–60 days	794	284
Past due 61–90 days	1,017	400
Past due > 91 days	0	0
Total	**262,632**	**35,738**

8 Inventories

	Actual 2011 $	Actual 2010 $
Publications held for sale	20,034	28,173
Total inventories	**20,034**	**28,173**

The carrying amount of inventories held for distribution that are measured at current replacement costs as at 30 June 2011 amounted to $20,035 (2010 $28,173).

9 Property, Plant and Equipment

Movements for each class of property, plant and equipment as at 30 June 2011 are as follows:

Cost	Comp hardware	Comms equip	Furn and fittings	Leasehold improve-ments	Motor vehicles	Office equip	Total
	$	$	$	$	$	$	$
Balance at 1 July 2010	830,338	26,723	199,918	672,057	40,889	185,615	1,955,540
Additions during year	13,218	1,687	4,581	3,654	0	8,116	31,256
Disposals during year	(2,931)	0	0	0	0	(1,249)	(4,180)
Balance at 30 June 2011	840,625	28,410	204,499	675,711	40,889	192,482	1,982,616
Accumulated Depreciation							
Balance at 1 July 2010	618,128	26,723	189,214	654,514	9,541	165,679	1,663,799
Charge for year	96,906	422	4,260	10,758	8,178	9,950	130,474
Disposals	(275)	0	0	0	0	(1,249)	(1,524))
Balance at 30 June 2011	714,759	27,145	193,474	665,272	17,719	174,380	1,792,749
Net book value 30 June 2011	**125,866**	**1,265**	**11,025**	**10,439**	**23,170**	**18,103**	**189,868**

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	(222)	(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	(1,473)	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**

10 Intangible Assets

Movements for each class of property, plant and equipment as at 30 June 2011 are as follows:

	Actual 2011 $	Actual 2010 $
Computer Software		
Balance at 1 July	978,449	877,290
Additions during the year	60,207	101,159
Disposals during the year	0	0
Balance at 30 June	1,038,656	978,449
Accumulated Amortisation		
Balance at 1 July	879,458	778,319
Charge for the year	92,515	101,140
Disposals	0	0
Balance at 30 June	971,973	879,459
Net book value at 30 June	**66,683**	**98,990**

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 2011 $	Actual 2010 $
Creditors	165,680	216,331
Income in advance	5,258	0
Accrued expenses	68,802	45,981
Lease incentive	37,213	0
Other payables	171,985	151,344
Total creditors and other payables	**448,938**	**413,656**

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 2011 $	Actual 2010 $
Current employee entitlements are represented by:		
Annual leave	148,315	143,187
Retirement and long service leave	1,740	836
Total current portion	150,055	144,023
Total employee entitlements	**150,055**	**144,023**

13 Non-Current Liability

	Actual 2011 $	Actual 2010 $
Lease Incentive Liability	186,067	0
Total Non-Current Liability at 30 June	**186,067**	**0**

Lease incentive relating to Auckland office at Level 10, 45 Queen Street for period 1 July 2012 to 9 June 2017.

14 Equity

	Actual 2011 $	Actual 2010 $
General funds		
Balance at 1 July	1,342,294	1,381,406
Total comprehensive income for the year	121,855	(39,112)
Total equity at 30 June	**1,464,149**	**1,342,294**

15 Reconciliation of Net Deficit to Net Cash from Operating Activities

	Actual 2011 $	Actual 2010 $
Total comprehensive income	121,855	(39,112)
Add/(less) non-cash items:		
Depreciation and amortisation expense	222,989	241,142
Total non-cash items	344,844	241,142
Add/(less) items classified as investing or financing activities		
(Gain) on disposal of property, plant and equipment	1,024	(250)
Total items classified as investing or financing activities	1,024	(250)
Add/(less) movements in working capital items		
Debtors and other receivables	(10,946)	73,847
Inventories	8,138	3,625
Creditors and other payables	9,859	(17,245)
Employee entitlements	6,032	(4,094)
Net movements in working capital items	13,083	56,133
Net cash from operating activities	**358,951**	**257,913**

16 Commitments and Operating Leases

Advocacy Service contracts

The maximum commitment for the 12 months from 1 July 2011 is $3,539,998 (2010: $3,539,998).

Operating leases as lessee

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

	Actual 2011 $	Actual 2010 $
Not later than one year	389,659	508,251
Later than one year and not later than five years	1,272,363	528,283
Later than five years	223,280	0
Total non-cancellable operating leases	**1,885,302**	**1,036,533**

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 office lease has been renewed with a new lease expiry date in June 2017 and the Wellington lease expires in April 2015.

17 Contingencies

Contingent liabilities

As at 30 June 2011 there were no contingent liabilities (2010 $nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2010 $nil).

18 Related Party Transactions and Key Management Personnel

Related party transactions

All related party transactions have been entered into on an arm's length basis.

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 has been provided with funding from the Crown of $9.170m (2010 $9.170m) for specific purposes as set out in its founding legislation and the scope of the relevant government appropriations.

In conducting its activities, The Health and Disability Commissioner is required to pay various taxes and levies (such as GST, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The Health and Disability Commissioner is exempt from paying income tax.

The Health and Disability Commissioner also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2011 totalled $0.1 million (2010 $0.1 million). These purchases included the purchase of electricity from Meridian, air travel from Air New Zealand, and postal services from New Zealand Post.

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 2011 $	Actual 2010 $
Salaries and other short-term employee benefits	899,313	931,750
Post-employment benefits	33,247	18,863
Other long-term benefits	0	0
Termination benefits	0	0
Total key management personnel compensation	**932,560**	**950,613**

Key management personnel include the six Executive Leadership Team members. At 30 June 2011 the Deputy Commissioner Complaints resolution position was vacant.

19 Employee Remuneration

Total remuneration paid or payable

	Actual 2011	Actual 2010
$110,000–119,999	1	1
$120,000–129,999	1	1
$150,000–159,999	1	1
$170,000–179,999	0	3
$180,000–189,000	1	0
$260,000–269,999	1	0
Total employees	**5**	**6**

During the year ended 30 June 2011, no employees received compensation and other benefits in relation to cessation (2010: $nil).

19a Commissioner's Total Remuneration

In accordance with the disclosure requirements of section 152 (1)(a) of the Crown Entities Act 2004, the total remuneration includes all benefits paid during the period 1 July 2010 to 30 June 2011.

		Actual 2011	Actual 2010*
Anthony Hill	Health and Disability Commissioner	$264,193	–
Ron Paterson	Health and Disability Commissioner	–	$192,113

*Ron Paterson resigned as Commissioner with effect from 31 March 2010.
*Anthony Hill took office as the Commissioner on 19 July 2010.

20 Events after the Balance Sheet Date

There were no significant events after the balance sheet date. Please note, however, that with effect from 1 July 2012, the advocacy and monitoring functions of the Mental Health Commission will be transferred to HDC.

21 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 2011 $	Actual 2010 $
Loans and receivables:		
Cash and cash equivalents	1,656,353	1,387,234
Debtors and other receivables	262,632	35,738
Total loans and receivables	**1,918,985**	**1,422,972**
Financial liabilities measured at amortised cost:		
Creditors and other payables	448,938	413,656
Total financial liabilities measured at amortised cost	**448,938**	**413,656**

22 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 Health and Disability Commissioner does not actively manage its exposure to fair value interest rate risk.

The average interest rate on the Health and Disability Commissioner's term deposits is 3.9% (2010: 3.9%).

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), and 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 of AA or better.

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 2011, 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 $8,150 (2010: $6,800) higher/lower. This movement is attributable to increased or decreased interest expense on the cash deposits. The contracted undiscounted amounts equal the carrying amounts.

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 $
2011			
Creditors and other payables — carrying amount (note 11)	448,938	0	0
Creditors and other payables — contracted cash flows (note 11)	448,938	0	0
2010			
Creditors and other payables — carrying amount (note 11)	413,656	0	0
Creditors and other payables — contracted cash flows (note 11)	413,656	0	0

23 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.

24 Explanation of Significant Variances against Budget

Statement of comprehensive income

HDC consumed 5.9% fewer costs than budgeted. $579,000 was saved on budget. This saving was spread over a number of areas including staff (one fewer senior management position for most of the year), depreciation (due to less capital expenditure) and operating costs (including lower systems consultancy and lower external legal advice).

Statement of financial position

Total assets are $879,000 higher than budget reflecting HDC's improved cash position compared to budget. Sundry debtors includes $223,280 relating to the Auckland Office's lease incentive. This incentive was negotiated as part of the renewal of the Auckland office lease. This money is yet to be received. Note that the entity reduced its office space and the price/sqm in negotiation for lease renewal — this would deliver material savings over the term of the lease.

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 $359,000 in surplus vs a $178,000 budgeted deficit. In addition, "cash from investing activities" is $210,000 lower than budget with fewer assets purchased than budgeted and cash on hand at the start or the year was $151,000 higher than budgeted.

Service Delivery

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

- The Commissioner assesses and resolves complaints.
- The Commissioner responds to enquiries.
- 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.
- 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 independent Director of Proceedings initiates proceedings against providers.

HDC carries out the above activities through four output classes: Complaints Resolution; Advocacy; Proceedings; and Education.

Output Class 1: Complaints Resolution

	Performance Measure	Target Date	Actual
	Complaints		
1.	An estimated 1,360 complaints are received.	30 June 2011	Target achieved. 1,405 complaints received.
2.	80% of complaints are closed within six months; 98% are closed within 1 year; and 100% are closed within 2 years.	30 June 2011	Target achieved. 89% (1,201 of 1,355) closed within six months; 98% (1,322 of 1,355) closed within 1 year; and 99.9% (1,353 of 1,355) closed within 2 years.
3.	A random sample of consumers and providers is conducted and high levels of satisfaction are reported on the timeliness and fairness of HDC complaints processes.	30 June 2011	Target achieved. A total of 189 consumers and providers responded to the survey, and 73% of the respondents agreed or strongly agreed that overall their complaint was managed well by HDC.
4.	Less than 1% of complaints are reopened after a closed file review.	30 June 2011	Target achieved. No complaint files were reopened.
5.	A sample of providers subject to recommendations following an investigation is reviewed and 25% of providers give evidence that HDC recommendations have been fully implemented.	30 June 2011	Target achieved. 14 providers subject to recommendations following an investigation were reviewed and 86% of providers gave evidence that HDC recommendations have been fully implemented.

Output Class 2: Advocacy

	Performance Measure	Target Date	Actual
1.	An estimated 3,800 complaints managed by advocates.	30 June 2011	Target achieved. A total of 4,271 complaints were managed by advocates.
2.	80% of complaints are closed within three months; 95% are closed within six months; and 100% are closed within nine months.	30 June 2011	Target achieved. 85% closed within three months; 98% closed within six months; and 100% closed within nine months.
3.	85% of complaints managed by advocacy are partially or fully resolved.	30 June 2011	Target achieved. 87% of complaints managed by advocacy were partially or fully resolved.
4.	Surveys of consumers and providers who have used/ dealt with the advocacy service will report high levels of satisfaction with the service and the skills of the advocate.	30 June 2011	Target achieved. Surveys showed that 92% of consumers and 81% of providers are very satisfied with the advocacy service overall. 91% of both consumers and providers are very satisfied with the education sessions provided by advocates.
5.	Advocates to have one contact with all rest homes and two contacts with 50% of rest homes.	30 June 2011	Target achieved. All (700) rest homes have had one contact from an advocate; and 68% of rest homes have had two contacts by an advocate. A total of 2,894 contacts were made to rest homes.
6.	Advocates to have one contact with all disability homes and two contacts with 50% of all disability homes.	30 June 2011	Target partially achieved. 98% (936 of 953) of disability homes have had one contact by an advocate; and 58% of disability homes have had two contacts by an advocate. A total of 3,019 contacts were made to disability homes.
7.	Advocates to have 3,000 networking contacts with consumers and providers (other than rest home and disability homes).	30 June 2011	Target achieved. Advocates have had 4,238 networking contacts with consumers and providers. A number of new specialist advocates are employed by the service, leading to a concentrated effort to establish contacts and networks.
8.	1,550 education sessions provided.	30 June 2011	Target achieved. 1,936 education sessions provided.
9.	180 case studies/Stories of Great Care are published.	30 June 2011	Target achieved. 180 case studies/Stories of Great Care have been published.

Output Class 3: Proceedings

	Performance Measure	Target Date	Actual
1.	80% of decisions are made within two months of receiving the referral.	During 2010/11	Target partially achieved. 60% (3 of 5) decisions made within two months of receiving the referral. The two cases where decisions were delayed concern care provided to the same consumer by two organisational providers. Both providers requested additional time over the Christmas/New Year holiday period in order to provide further information to the Director.
2.	Professional misconduct is found in 75% of disciplinary proceedings.	During 2010/11	There have been no concluded disciplinary proceedings.
3.	A breach of the Code is found in 75% of Human Rights Review Tribunal (HRRT) proceedings.	During 2010/11	Target achieved. A breach of the Code was found in 100% of HRRT proceedings.
4.	An award is made in 75% of cases where damages are sought.	During 2010/11	Target achieved. Claims for damages for six consumers went before the HRRT. Five of those six claims for damages were resolved by negotiated agreement. An award was made in 100% (1 of 1) of cases where the Tribunal was asked to determine damages.

Output Class 4: Education

	Performance Measure	Target Date	Actual
1.	Anonymised copies of the Commissioner's investigation reports are published on HDC's website within eight weeks of the report being signed off.	During 2010/11	**Target achieved. All investigation reports were published on the website within eight weeks of the report being signed off.**
2.	Produce informative and accessible educational resources, including: • Keeping Safe with the Code. • Getting the Best from your Health Provider. • Are You Committed to the Code?	30 June 2011	**Target achieved. Resource "Are you Committed to the Code?" was produced in December 2010 under the title "Making it easy to put the Code into action". Resources "Keeping Safe with the Code" and "Getting the Best from your Health Provider" are in draft and under consultation.**
3.	15% of educational materials are available in "Easy Read" format.	30 June 2011	**This activity has been postponed to 2011/12.**
4.	District Health Boards (DHBs) receive six-monthly complaint trend reports from HDC.	30 September 2010; and 31 March 2011	**Target achieved. All DHBs received complaint trend reports by 30 September 2010 and 31 March 2011.**
5.	100% of DHBs responding to the reports rate them as useful for improving the safety and quality of their services.	During 2010/11	**Target achieved. All DHBs responded that the reports were useful for improving the safety and quality of their services.**
6.	Develop and trial the Health Passport.	30 June 2011	**Target achieved. Two DHBs, Hutt Valley and Capital and Coast, commenced a pilot on 1 April 2011.**
7.	Provide 20 educational presentations with 100% of people requesting the presentation satisfied that the presentation met their expectations.	30 June 2011	**Target achieved. 38 educational presentations were provided and 100% of the people who requested presentations were satisfied that the presentation met or exceeded their expectations.**
8.	Provide two intensive provider education programmes with 90% of participants reporting that they are satisfied with the content and delivery of the programme.	30 June 2011	**Target achieved. Two intensive provider education sessions were provided and 100% of participants were satisfied with the content and delivery of the programme.**

(continued overleaf)

Output Class 4: Education *(continued)*

	Performance Measure	Target Date	Actual
9.	Promote public awareness of the Health and Disability Commissioner Act and Code of Rights.	30 June 2011	**Public awareness survey has been postponed to 2011/2012.**
10.	Provide an annual report on the impact of HDC's submissions with 95% of respondents satisfied with the quality of submissions.	30 June 2011	**Target achieved. A survey was conducted using a random sample of HDC submission recipients and 100% of the respondents were satisfied with the quality of submissions. A summary report of the impact of HDC's submissions is completed.**

Health and Disability Commissioner
PO Box 1791
Auckland

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

www.hdc.org.nz