Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Annual Report
for the year ended
30 June 2002

Presented to the House of Representatives
Pursuant to Section 16 of the
Health and Disability Commissioner Act 1994

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

23 October 2002

The Minister of Health
Parliament Buildings
WELLINGTON

Minister

In accordance with the requirements of section 16 of the Health and Disability Commissioner Act 1994, I enclose the Annual Report of the Health and Disability Commissioner for the year ended 30 June 2002.

Yours faithfully

Ron Paterson
Health and Disability Commissioner

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Vision

The rights and responsibilities of consumers and providers are recognised, respected, and protected in the provision of health and disability services in New Zealand.

Te Whakataunga Tirohanga

Heoi ko ngā tika me ngā tikanga whakahāere a ngā kaiwhiwhi me ngā kaituku, arā, tūturu kia arongia motuhake nei, kia whakamanahia, a, kia whakamaruhia i roto i ngā whakataunga hauora me ngā whakataunga huarahi tauawhi i ngā momo hunga hauā puta noa i Aotearoa nei.

Mission

Our mission is to promote the rights and responsibilities of consumers and providers and to resolve complaints by fair processes and credible decisions to achieve just outcomes.

Te Kawenga

Koinei ra te kawenga motuhake a tēnei ohu, arā, ko te whakahou hāere i ngā tika me ngā māna whakahāere a te hunga Kaiwhiwhi me ngā Kaituku; hei whakatau i ngā nawe me ōna amuamu i runga i ngā whakaritenga tautika me ngā whakaaetanga tautika hei whakatau i ngā whakatutukitanga me ōna whakaputatanga.

Commissioner's Report

Commissioner, Ron Paterson

Introduction

This report covers my second full year as Health and Disability Commissioner and discusses the following key features of the 2001/02 year:

- Resolution, not retribution
- Clearing the backlog
- Learning not lynching
- Medical professionalism and patient safety
- Co-location with Human Rights Commission.

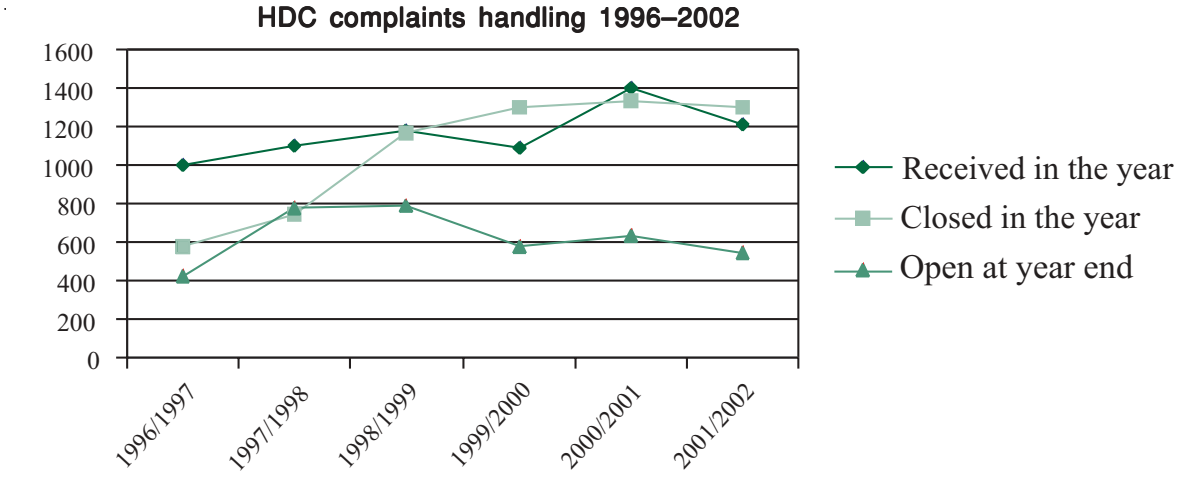
Resolution, not Retribution

The focus of the Health and Disability Commissioner's (HDC's) complaints resolution work continues to be resolution, not retribution. The outcome of complaints handled by advocacy services and the Commissioner's Office in 2001/02 confirms this emphasis. As reported by the Director of Advocacy, 76% of complaints closed by advocates last year had been resolved with advocacy assistance, or as a result of the consumer's own action after advocacy involvement.

Although 1,211 complaints were received by the Commissioner's Office, only 234 cases were concluded by an investigation and formal opinion on whether the provider breached the Code of Health and Disability Services Consumers' Rights (the Code). This is consistent with our aim of reserving investigation for the more serious allegations that merit investigation. Many complaints were resolved by the enquiries team through information provision or referral to another agency. Alternative resolution strategies such as referral to advocacy (up 26% over the previous year) or to mediation (up 40% over the previous year) are being used with good effect: the parties are able to sort out their differences face to face, and the process is much quicker.

A sustained effort to ensure the appropriateness and quality of investigations is resulting in more thorough and comprehensive reports, and a higher proportion of breach findings and referrals to the Director of Proceedings. Breach reports were issued in 27% of concluded investigations (up from 24%), and 31% of breach reports were referred to the Director of Proceedings for possible disciplinary and/or Human Rights Review Tribunal Proceedings (up from 21%). The Director of Proceedings appeared in 21 concluded disciplinary hearings, a major increase on the 10 hearings in 2001/02.

These figures should not be read as evidence of a greater focus on discipline; complaints that result in discipline still represent only 1–2% of all complaints received by HDC. But it is important for the public, and providers, to know that there is a place for accountability of providers within New Zealand's complaints resolution system. Recognition of the role that systems failures play in adverse events, and a quality improvement focus, does not remove the need for individuals to be held accountable for their own shortcomings in appropriate cases.



Clearing the Backlog

The above chart illustrates the Office's increased productivity and decreased backlog over the past two years, in the face of a record number of complaints. This year, for the second time in the history of the Office, we succeeded in having fewer files open at the end of the year than at the start of the year (546 at 30 June 2002 compared with 634 open at 30 June 2001). In total 1,299 complaints were resolved (down from 1,338 last year).

We were helped by a 13% fall in the number of complaints, from the record high of 1,397 in 2000/01 to 1,211 in 2001/02 (still the second highest annual volume to date). The more manageable intake enabled the Office to achieve a 14% reduction in the number of open files — "the backlog".

Equally pleasing was the continued progress improving the quality and timeliness of investigations. "Justice delayed is justice denied", and there are still too many standard and complex investigations that take more than 12 months to conclude. However, HDC's latest statistics compare very favourably with comparable jurisdictions in Australia.

Good progress has also been made in reducing the time taken to resolve complaints. Over the 2001/02 year, 69% of complaints were resolved within 6 months of receipt; 82% within 12 months; and 95% within 2 years. At 30 June 2002, 24 files remained open after 2 years,[1] and all were nearing completion.

Learning, not Lynching

In the face of the media pressure to name individual providers under investigation or subject to breach findings, I have continued to ensure that HDC's investigations and findings are confidential, but that appropriate authorities (notably registration bodies)

1 The oldest complaint, from 1997, was the subject of a largely unsuccessful application for judicial review by the provider (*Culverden Group Ltd v The Health and Disability Commissioner* (unreported), Glazebrook J, High Court, Auckland, M1143-SD00, 25 June 2001, discussed in last year's Annual Report). The provider appealed the decision, but subsequently discontinued the appeal, except as to costs. The further proceedings delayed completion of this matter. The Commissioner's final Opinion was that the provider failed to obtain the elderly consumer's informed consent to his admission to the rest home. The provider was asked to apologise to the consumer and refund the cost of the consumer's care. The Opinion may be viewed at www.hdc.org.nz/Opinion 97HDC9172.

are notified of the initiation and outcome of an investigation. I have maintained this approach because I believe that rehabilitation of providers (particularly health professionals and public hospitals) and improved patient safety are more likely to result from an emphasis on learning, not lynching.

It is perplexing that providers — especially doctors and nurses — continue to speak out about the "name, blame and shame" medico-legal environment in New Zealand, when the only official inquiry processes that identify providers under scrutiny are Coroners' inquests and disciplinary proceedings.

Doctors are clearly the providers most often singled out for complaint: 68% of complaints to HDC against individual providers in 2001/02. Doctors (and their legal advisors) are also the group who perpetuate the myth of New Zealand's harsh medico-legal environment. I have therefore continued to focus my personal education efforts on outreach to doctors. Last year, in addition to my monthly *NZGP* columns, I gave speeches to medical staff at Grey Hospital (Greymouth), Rotorua Hospital, Masterton Hospital, Whangarei Hospital, Palmerston North Hospital (the Combined Medical Staff Memorial Oration), Wairau Hospital, Nelson Hospital, Taranaki Hospital and Middlemore Hospital, on topics such as "Medical Complaints in New Zealand" and "The Supervisory Responsibilities of Specialists". Other key addresses to medical audiences were presentations to the Christchurch and Dunedin Schools of Medicine, the Royal Australasian College of Surgeons Annual Scientific Meeting, the Annual General Meeting of the Bay of Plenty branch of the New Zealand Medical Association, and the Annual General Meeting of the Canterbury Faculty of the Royal New Zealand College of General Practitioners.

A concerted effort has been made to ensure that investigation reports of educational value are anonymised, sent to the appropriate professional college or association, and placed on the HDC website, www.hdc.org.nz. The website has been reorganised and enhanced, and in the coming year case note summaries will be added to the Opinions database to make it more accessible and user-friendly.

Medical Professionalism and Patient Safety

In the past year, the New Zealand Medical Association and the Association of Salaried Medical Specialists have campaigned publicly for renewed emphasis on medical professionalism and less of a focus on external accountability mechanisms. To the extent that this campaign highlights the need for the internal morality of medicine to be recognised and supported, I endorse its aims. External regulation through health professional statutes and the Code needs to complement, but can never supplant, the central role of self-regulation and peer review.

One aspect of professionalism, however, is surely recognition of one's ethical responsibilities as a health professional, and of the overriding obligation to ensure the safety of patients (and the public). It has therefore been disappointing to note the approach taken on three key issues for patient safety in New Zealand:

- Opposition to the Accident Compensation Corporation (ACC) reporting accepted medical misadventure claims to the Medical Council — even though this would simply result in a confidential assessment by the Council of whether a competence review is necessary.
- Resistance to proposed mandatory reporting to registration bodies of concerns about a health professional's competence (the so-called "dob-a-doc" proposal) without any

acknowledgement that doctors currently have an ethical and legal responsibility to "protect-a-patient" by notifying an appropriate authority, if genuinely concerned.

- A cool response to Ministry of Health proposals to publish comparative public hospital morbidity and mortality data, even though individual doctors' performance data would not be published, and there is good research evidence of the effectiveness of publishing comparative data to improve organisational performance.

It is to be hoped that, during the forthcoming debates on the Health Practitioners Competence Assurance bill, the hyperbole about the "name, blame, and shame" medico-legal environment will be replaced by more thoughtful analysis of how best to improve current systems to protect the health and safety of members of the public, while supporting health professionals (and promoting professionalism).

Co-location with Human Rights Commission

Judge Silvia Cartwright's original vision (in the 1988 Report of the Cervical Cancer Inquiry) of the Health Commissioner's Office was of a statutory agency to protect patients' rights within the Human Rights Commission. Her vision reflected a view that saw patients' rights as an aspect of human rights.

The Office of the Health and Disability Commissioner has evolved along a somewhat different path over the past seven years, partly because the statutory framework of the HDC Act and Code seeks to promote and protect consumers' rights to quality health care and disability services, but does not recognise the right to access health or disability services.

The expiry of the original lease in the Auckland Office of HDC offered an opportunity to co-locate with the Auckland Office of the Human Rights Commission, to achieve several key objectives: to enable a collaborative and co-ordinated approach to common issues of concern for health and disability consumers; to improve our accessibility to the communities we serve; and to rationalise the use of office space and achieve cost savings through shared resources.

Chief Human Rights Commissioner Rosslyn Noonan and I were delighted to see our joint vision of co-located offices come to fruition with HDC's move to the 10th floor of the Tower Centre at 45 Queen Street, Auckland, on 20 May 2002. The Human Rights Commission occupies the 4th floor of the Tower Centre; reception, library, conference and meeting rooms are shared on the 10th floor.

We look forward to working more closely together in future, to better protect people with disabilities and everyone who uses health services.

Acknowledgements

The year marked the departure of long-serving Senior Investigator Siniua Lilo (1996–2001), who was a greatly valued leader of investigations in the Auckland Office, and a committed advocate for Pacific Island peoples.

Finally, I wish to record my thanks to all the staff of HDC, to our kaumātua, Te Ao Pehi Kara, and to everyone involved in advocacy services throughout New Zealand, for their dedication and support of our work in 2001/02.

Report of the Director of Advocacy

Director of Advocacy, Tania Thomas

Introduction

This is my first report of a full year as the Director of Advocacy. In partnership with the three contract advocacy service organisations, Health Advocates Trust (HAT), which covers Auckland and Northland, Advocacy Network Services (ADNET), which covers the central and lower North Island, and Advocacy Services South Island Trust (ASSIT), which covers the South Island, I have set a course for change. The new course seeks to move providers from being aware of the Code of Rights to being passionate and willing to comply with and implement the Code. The professionalism and competence of advocates is a key ingredient in assisting providers to move past the rhetoric of applying the Code.

Advocacy contractors have been asked to act with urgency to ensure that their services are culturally appropriate to Māori. Māori participation in the planning, delivery and evaluation of the advocacy services they provide is essential.

Contractors have also been asked to ensure that their services are accessible to consumers who traditionally do not use the advocacy service, and yet make up a significant percentage of New Zealand's population, for example Pacific Island peoples and people with disabilities.

From left: Tony Daly (Advocacy Services South Island Trust Manager), Stacy Wilson (Advocacy Network Services Manager), with advocates Elizabeth Love and Robert Srhoj.

Advocacy services have functioned under the Act for around six years. There are 39 advocates, mostly part time. The new direction for advocacy promotes greater use of consumer strengths and skills, community resources, and community advocates. It encourages networking and co-operation with other community groups in order to share some of the workload. Complaints are becoming more complex and, rather than being "one size fits all", advocates need to specialise and find ways to complement their resources from within communities. Where appropriate, advocates train consumers to take their own action; however, some consumers need intense, representational advocacy in order to achieve empowerment.

Advocates are required to assist consumers to deal with complaints directly with the provider, in situations that are often demanding, emotionally charged and confrontational. The new direction focuses on ensuring advocates have the skills and tools to work with solutions-focused methods as opposed to problem-solving methods. The traditional approach to change looks for the problem, makes a diagnosis and finds a solution — the focus is on what went wrong. Because we look for problems, we find them — by paying attention to problems, we emphasise and amplify them.

A strengths-based or solutions-focused approach looks for what works in the relationship with the provider, and guides the consumer to describe how he or she would prefer the relationship and/or service to be, based on previous positive experiences.

I would like to thank the advocates, the advocacy service trusts and managers, and the consumers and providers who have helped shape the new direction that has resulted from the independent review findings and consultation feedback during the past year.

I would also like to thank Te Ao Pehi Kara for his guidance and advice in the role of HDC's cultural advisor and kaumātua. He and his wife, Waiariki, have given their time very generously in supporting advocates and promoting the advocacy services.

The sections that follow outline key features from the 2001/02 year:

- Profile of advocacy consumers
- Outcome of complaints
- Consumer satisfaction ratings
- Independent review findings
- Advocate development
- Promotion of the advocacy services
- Advocacy highlights.

Advocacy Consumers

The following is a profile of advocacy consumers in 2001/02:

- 14% Māori
- 3% Pacific Island ethnicity, including Cook Islands, Nuie, Samoa and Tonga
- 1% Asian
- 1% Indian
- 41% New Zealand European
- 40% of other ethnicity or did not state their ethnicity.

Outcome of Complaints

During 2001/02, 3,712 complaint files were closed by advocacy services. The outcome of these complaints was:

- 49% (1,802) partly or fully resolved with the assistance of advocacy
- 27% (1,016) closed as a result of consumers taking their own action after involvement with advocacy
- 24% (894) either withdrawn, referred to HDC, or referred to another agency.

Complaints resolved with advocacy assistance or as a result of the consumer's own action after advocacy involvement therefore totalled 76% (2,818) of all closed complaints.

Consumer Satisfaction Ratings

HAT: 84% of consumers surveyed rated the service as good or very good.
ADNET: 83% of consumers surveyed rated the service as good or very good.
ASSIT: 84% of consumers surveyed rated the service as good or very good.

Independent Review Findings

The Review was completed in June 2002. It focused on identifying ways of enhancing the processes and outcomes of advocacy. Seven advocate focus groups and 15 consumer focus groups were held across the country. A number of improvements were identified as a result of the feedback received from participants. Many of these improvements have been included in the new advocacy service contracts for 2002–2004.

Strengthening advocacy services is a focus of the new contracts, in order to:

- increase the number of complaints resolved at a low level
- increase the number of consumers who feel empowered to take their own action to resolve their complaint
- resolve simple and standard complaints more quickly
- increase user-friendliness of advocacy services and access to communities who traditionally do not use the service
- increase the number of providers willing to participate in training to improve their ability to comply with the Code
- increase the number of providers willing to meet with consumers directly to listen to and resolve complaints.

Advocates' feedback from review findings

Advocates suggested improvement in the following areas:

- *Performance measures*: Advocacy performance measures need to assess the extent to which the intent of the Act is being implemented, support improved decision-making, and provide useful information regarding the future direction of the service. The way in which advocate performance is appraised, supported by supervision, and recognised needs to be included in the review of performance measures.

- *Role in prevention*: The role of prevention in advocacy needs to be emphasised. Prevention is about assisting providers to understand the ideal of complying with and implementing the Code, so that complaints are either reduced or eliminated because the service is meeting the needs of consumers. Additional support and a wider variety of educational tools need to be provided to advocates to assist in educating providers and consumers, and in networking and working with consumer and provider groups.

- *Implementation of empowerment advocacy*: Empowerment advocacy involves either assisting a consumer with self-advocacy or acting on a consumer's instructions. Empowerment is about choice — choosing one's own solutions to issues and concerns. Innovation is needed to ensure that the model of empowerment advocacy works well within the resources available.

Consumer feedback from review findings

Consumers listed the following areas as being of most importance to them:

- Advocate competence — being listened to, encouraged, and understood, and feeling that the advocate is empathetic.
- Advocacy process — at the point of initial contact with an advocate there is a need to clarify the advocate's role and expectations, and to define the issues. Consumers stated that they needed guidance in taking the steps required to reach resolution.
- Resolution — consumers need to feel that they have achieved the best outcome and that closure has been possible with the help of advocacy.
- At meetings with providers, consumers wanted advocates to support where necessary, keep the meeting on track, and help keep everyone focused on the issues.
- Consumers wanted calls responded to more promptly.
- Consumers wanted to be equipped by advocates to resolve their own concerns.

Tanya Wihongi, Kaikohe advocate, with her manager, Maria Marama, and the advocate for Wellington, Elisapeta Paia'aua, at the Advocates National Conference in Wellington.

Advocate Development

A national conference for advocates was held in Wellington in November 2001. "Finding a Way Through" was the theme for the conference, which was attended by all advocates and the HDC kaumātua, Te Ao Pehi Kara. The first day of the conference focused on "Expectations", and presentations were made by consumers and providers. Day two was based around "Models and Philosophy" and presentations ranged from raising personal awareness of disability to an introduction to Appreciative Inquiry — "A Strengths Based Approach".

Lauren Emanuel, Assistant to the Director of Advocacy

The final day of the conference was devoted to the theme of "Resolution". A plenary session and range of workshops concentrated on advocates achieving results for the wide range of consumers within their practice.

Māori Advocates' Training

In May 2002 a workshop for Māori advocates was held in Rotorua on the "Dynamics of Whanaungatanga". The workshop was attended by the Director of Advocacy, 13 advocates, and kaumātua Te Ao Pehi Kara. The focus of this training was to assist Māori advocates to understand the range of support networks available to Māori consumers, and to assist in identifying strategies for working with Māori consumers where the provider does not understand the cultural implications of a complaint.

Regional Advocate Training

Regional training took place in all advocacy service organisations between four and six times during the year. A wide range of topics was covered, for example:

- the new certification process for rest homes and hospitals
- mediation
- cultural training
- working with consumers who have a disability

Māori advocates pictured here with Lloyd Popata, a trainer in the Dynamics of Whanaungatanga (front row, second from left) and his wife, Rita Popata (middle row, fifth from left). Te Ao Pehi Kara, kaumātua for the hui, is seated on the far right of the middle row, and his wife, Waiariki, is second from the right in the middle row.

The new look advocacy brochure featuring advocates from the North Island.

- safety for advocates
- counselling versus advocacy
- dual diagnosis and mental health services
- District Inspectors' role with mental health consumers.

Promotion of the Advocacy Service

Advocacy advertising material has been revamped, with a new poster and a brochure featuring advocates from the Health Advocates Trust and Advocacy Network Services. We have received very positive feedback about the new poster and brochure — they stand out and have a "real kiwi" look. Bumper stickers have been produced for each advocacy region to use as give-aways.

Advocacy brochures translated into Samoan, Nuiean, Cook Island and Tongan were released in late 2001. Cantonese and Korean versions were placed on the Advocacy website in early 2002.

Highlights in Advocacy

Kaumātua initiative mid and lower North Island

Advocacy Network Services in the central and lower North Island established a regional group of seven kaumātua to advise on cultural issues and to provide support for evaluating advocacy services to Māori. ADNET also reported that 99% of Māori who responded to the consumer satisfaction survey stated that they were very satisfied with the cultural sensitivity of the service.

Moana Ola Project

The first phase of the Moana Ola Project was completed in February 2002. This project was aimed at consulting with Pacific Island peoples to identify strategies for improving awareness of the Code amongst Pacific Island providers and consumers, and for encouraging consumers to exercise their rights. The Moana Ola Project group was made up of advocates and external advisors from community and church groups and the Ministry of Pacific Island Affairs, representing Samoa, Tuvalu, Nuie, Fiji, Tokelau and Tonga.

The project group recommended:

- the development of a communication/education plan for use with Pacific Island consumers to aid the easy dissemination of information about the Act and the Code
- the establishment of a working relationship with the Ministry of Pacific Island Affairs and the 16 existing Pacific Island Community Reference Groups to assist with the consultation and implementation processes involved in increasing awareness in Pacific Island communities.

The project group developed a work plan to assist in the achievement of their recommendations. The work plan has been included in the Director of Advocacy's annual plan for 2002/03.

Two members of the Moana Ola project team, Caroline Westerlund (left) and Nina Kirifi-Alai.

South Island Advocacy 10th Anniversary

March 2002 marked the 10th Anniversary of advocacy services in the South Island. At an evening function in Christchurch, the Board of Advocacy Services South Island Trust celebrated the achievements of advocacy services in the Canterbury region and beyond, in the company of past and present advocates and Board members, the Minister for Disability Issues, Hon Ruth Dyson, the Commissioner, the Director of Advocacy, and a wide range of local consumers and providers.

Supporting Hillmorton Hospital residents

Advocacy Services South Island Trust had a busy time supporting residents following the sudden closure of Tupuna Villa at Hillmorton Hospital because of industrial action. For many of the residents this meant undergoing a needs assessment process, during which many longstanding issues of care were rectified and an opportunity provided for a new life outside the hospital.

Dr Parry inquiry

The adequacy of the advocacy services offered to Northland women following the complaints about Dr Graham Parry were brought into question before a parliamentary select committee. There was a clash of expectations of what the advocacy service could provide and what women wanted, for example:

- Some women were confused by the various complaints systems and wanted advocacy services to eliminate the need to deal with more than one organisation. Improved co-ordination of processes and information sharing amongst the various complaints agencies is needed, and considerable improvement has already taken place. If implemented, the recommendations from the Cull Report will also improve current processes.
- Some women have experienced considerable physical, emotional and financial hardship and feel that compensation has been inadequate. Advocates were unable to assist in obtaining further compensation. Issues revolve around ACC definitions and the criteria for rehabilitation compensation.
- Women wanted Northland Health to respond quickly, genuinely and comprehensively to the range of concerns raised, in relation to both their complaints about Dr Parry

and also regarding ongoing health services. Advocates found it difficult to persuade women to raise their concerns with Northland Health and had to contend with negativity about the hospital and its handling of previous high-profile cases.

- Events prior to July 1996 fall outside the Commissioner's jurisdiction, although advocates still sought to assist women in such cases.
- Advocacy could do little to assist women waiting for the outcome of their ACC claims, or to join in a proposed class action. Media coverage surrounding Dr Parry was intense, raising complainants' expectations of possible remedies available and thus making low-level resolution difficult. Despite these significant constraints, advocates supported individual women and managed to achieve partial resolution for some women who chose to work alongside an advocate.

Consumer Participation Steering Group for credentialling process

The Director of Advocacy has been a member of the Consumer Participation Steering Group established by the Ministry of Health with the aim of increasing the level of consumer participation in the credentialling process.

Green Lane Hospital babies' hearts

Many families throughout the country were supported by advocates following the news in February 2002 that Green Lane Hospital had retained babies' hearts. Support took several forms: assisting families through the initial stages of their shock and grief and helping them to obtain information; brokering or attending meetings with hospital authorities to find ways to lay their babies to rest; assisting families to meet with others in similar situations; and providing feedback to staff at Green Lane Hospital on the issues affecting the families involved.

Review of Advocacy Guidelines

The Advocacy Guidelines have been amended in consultation with a wide range of consumer groups and providers. The amended guidelines will enable advocacy services and individual advocates to understand more clearly what is required of them to effectively meet the requirements of the Health and Disability Commissioner Act 1994.

The amended guidelines now consist of a preamble outlining the aim of the Health and Disability Consumers' advocacy service, the philosophy underpinning the service, and three types of Advocacy Guidelines: Governing Guidelines, Advocate Practice Guidelines, and Advocacy Management Guidelines. The changes are designed to give greater clarity around specific areas of responsibility. The Governing Guidelines cover the Director of Advocacy, advocacy service providers and advocates; the Advocate Practice Guidelines guide the functions of advocates; and the Advocacy Management Guidelines guide advocacy service managers in the consistency and standardisation of advocacy policies and processes nationally. The amended guidelines will be submitted to the Commissioner for approval before the end of 2002.

Case Study: Advocacy and conflict over treatment of child

The advocacy service was contacted by telephone by the father of X, a 12-year-old boy diagnosed with Ewing sarcoma. X had commenced a course of chemotherapy and had received six treatments. He no longer wished to continue with treatment, and his parents supported his right to choose. The father wanted to know X's rights, and also the rights of parents. During the conversation it became apparent that the family needed urgent help, as X was due for his next treatment and the family had been advised that if necessary a court order would be sought to ensure continuing treatment. English was clearly a second language for the father, and the situation appeared serious. Arrangements were made to meet the family the same day.

X was present at the meeting along with other family members. He demonstrated a good command of the English language, and appeared to have a reasonable understanding of his condition and the treatment on offer. He made it very clear that he felt his views about further treatment should be considered.

The family had previously met with the health professionals involved in an effort to allay family concerns, and it was at the conclusion of the meeting that court proceedings were mentioned.

The issues for the family at that time were:

1. Information: The family was not convinced of the diagnosis and wanted an independent review. Secondly, the family had questioned the fact that X displayed no obvious symptoms such as pain or swelling, and the blood screens were clear. When the family queried this, they were told that it was "good" and "lucky".
2. Informed consent: The family were asked to sign a consent form for further chemotherapy and any "associated procedures deemed necessary". There had previously been mention of the need to amputate X's leg below the knee, and of a lung operation, and the family were afraid that these procedures would be carried out as "associated procedures deemed necessary". They asked for the "associated procedures" to be crossed out on the form and signed for chemotherapy only.
3. Communication: When X was taken back to the provider for a CT scan, the family expected that his chemotherapy would restart. However, the main provider was on leave and no arrangements had been made. X subsequently returned home.
4. Communication: The family had tried traditional Chinese medicine, acupuncture and naturopathy, and X had appeared to obtain relief. The family felt that it might be an option to continue with alternative therapies instead of further chemotherapy.

The advocate accompanied the family to a meeting with their lawyer later that day. It was decided that the best course of action was for the advocate to arrange a mediated meeting with the providers and the family, with the advocate to support them. Over the weekend, the advocate helped the family to clarify their issues, so they could be discussed openly in the mediated meeting. The advocate and an independent interpreter accompanied the family to the meeting with the providers.

The outcome of the mediation with advocacy support was that the family felt better informed of how X's diagnosis had been made. They were given supplementary reports and an explanation of the significance of the blood results. Further explanation was given about X's condition, the variation of symptoms experienced, and the reason why it would be inappropriate to take a second biopsy at that time (as the chemotherapy had already begun).

A range of treatment options were presented including chemotherapy and radiotherapy. At the conclusion of the meeting the provider advised the family that they would put a stay on the court proceedings pending a decision from the family within a reasonable timeframe.

Later that week an MRI scan was carried out, which showed that the cancer was small but still present. The provider offered the family the opportunity to obtain a second opinion from outside New Zealand, which they accepted. Following the offer of the second opinion and the appointment of legal counsel for all parties, further advocacy support was no longer necessary. X subsequently agreed to further treatment. The family are aware that they can return to the advocacy service at any time.

Case Study: Competent rural GP not in breach of the Code

The following case study involves a competent rural GP who failed to diagnose an extremely rare condition, but was found to have met all his responsibilities under the Code.

Ms A, an athletic woman in her forties living in a rural area, consulted Dr B for an insurance medical check. A full physical examination was normal, but a routine urine test revealed haematuria (blood in the urine).

A follow-up urine test a week later showed ongoing haematuria, so Ms A had blood tests, an ultrasound scan of her kidneys, and an intravenous pyelogram. All these tests were normal. Dr B consulted with a urologist and a nephrologist. Both specialists advised Dr B that Ms A, who was training for a marathon, was probably experiencing exercise-induced haematuria. Further tests showed that Ms A's haematuria resolved during an exercise break, but returned when she resumed exercising.

A few months later Ms A saw Dr B again complaining of shortness of breath, weight loss and persistent tiredness. She expressed concern that she might have sarcoidosis, as she had a family history of the condition. Dr B examined Ms A's chest and diagnosed a chest infection exacerbating Ms A's asthma. He prescribed antibiotics and an asthma inhaler and asked Ms A to return if her symptoms did not improve.

Ms A felt that Dr B was not taking her concerns seriously, and consulted another GP. Dr C arranged a repeat urinary tract ultrasound scan to investigate the ongoing haematuria. The ultrasound technician decided to check Ms A's heart (although Dr C had not requested this), and picked up a large mass in the left atrium.

Ms A underwent heart surgery and an 8cm by 5cm left atrial myxoma was removed. Ms A complained to HDC that Dr B had failed to diagnose the left atrial myxoma.

An independent rural GP advised that Dr B's examination, investigations and specialist consultations were all appropriate. The advisor stated that, in retrospect, Ms A's symptoms were consistent with a left atrial myxoma, but "a general practitioner would not be expected to diagnose the very rare condition of atrial myxoma. Neither myself, nor the two experienced colleagues I work with, have ever seen a case. Atrial myxoma is in many cases only diagnosed when serious complications occur, and it is indeed fortunate that the lesion was picked up by the experienced ultrasound technician."

The Commissioner's opinion, guided by the comments of the expert advisor, was that the GP provided health services to Ms A with reasonable care and skill and did not breach the Code. (Case 00HDC06335 may be viewed at www.hdc.org.nz/opinions.)

Report of the Director of Proceedings

Director of Proceedings, Morag McDowell

Introduction

This past year has been the busiest that the Proceedings team has faced since its inception. It was with some relief, therefore, that in June 2002 a third lawyer was appointed to the team. This was also my first year as Director of Proceedings and so, in addition to coping with the team's increased workload, there have been many new challenges. In this report I review the statistics relating to referrals, decision-making and disciplinary proceedings, and briefly describe process issues and challenges. Three disciplinary case studies are presented.

Statistics

This year there were 31 referrals culminating in 44 Director of Proceedings files.[1] This represents a 19.2% increase from 2000/01. An analysis of action taken in respect of those referrals is contained in Table 1 overleaf.

There has been a significant increase in the number of disciplinary proceedings this past year. Twenty-one hearings were concluded before the various disciplinary tribunals in the year (compared with ten concluded hearings last year). The outcomes and analysis of those hearings are outlined in Table 2 overleaf. Additionally, five matters were filed in the Human Rights Review Tribunal (HRRT). One was successfully settled (unregistered psychologist); the remaining four are awaiting hearing. On one of those four there have been ongoing interlocutory proceedings, including appeals to the High Court and Court of Appeal.

There were also four appeals from disciplinary findings in the course of the year. Two were substantive appeals.

There were three appeals on interlocutory matters, two of which related to name suppression.

Interestingly, in July 2001 criticism had been levelled by the Medical Practitioners Disciplinary Tribunal's chair, Wendy Brandon, at the dramatic reduction in the number of charges heard by the Tribunal since 1995. She implied unduly restrictive "gatekeeping" by the Health and Disability Commissioner in his failure to refer matters to the Director of Proceedings for prosecution, and reluctance by the Director of Proceedings to bring disciplinary proceedings before the Tribunal.[2] There has also been media comment of "errant doctor complaints slipping through [the] cracks"

1 HDC files are consumer/complaint based. Director of Proceedings files are provider based. Thus if a complaint relates to several providers, individual DP files are opened for those providers.

2 Brandon, W, "Complaints Against Medical Practitioners" [2001] NZLJ 249.

following David Collins QC's comments that it was surprising how few cases were now being referred to the Medical Practitioners Disciplinary Tribunal.[3]

The increasing number of referrals by the Commissioner to the Director of Proceedings over the past year suggests that criticism of an undue decline in discipline may have been premature.

Table 1: Action taken in respect of referrals to the Director of Proceedings during 2001/2002

Action Taken	No of cases	Total
No further action		14
Rest home	5	
Medical practitioner	6	
Nurse	1	
Psychologist	1	
District Health Board	1	
Section 49 process ongoing		18
Hearing pending		4
Acupuncturist (HRRT)	1	
Psychologist	1	
Dentist	2	
Hearing part heard		3
Medical practitioner (1 in respect of 2 complainants)	2	
Successful prosecution		4
Pharmacist	2	
Medical practitioner	2	
Unsuccessful prosecution		1
Medical practitioner	1	
TOTAL		**44**

Table 2: Outcome of disciplinary hearings

Provider	Successful	Unsuccessful	Total
Anaesthetist	1	1	2
Dental technician (same provider, 2 complainants)	2		2
Dentist	1		1
General practitioner	4	2	6
Midwife	1	1	2
Nurse	1		1
Obstetric/Gynaecology registrar (DP successful on appeal to District Court — now on appeal to High Court)	1		1
Ophthalmologist	1		1
Pharmacist	3	1	4
Psychiatrist	1		1
TOTAL	**16**	**5**	**21**

3 *The Press*, 19 September 2001.

In my view the increase in the number of prosecutions is related to a number of factors. Foremost, the HDC Office is "getting better" at investigation and providing higher quality evidence with which to prosecute. Secondly, the Commissioner has had a goal of closing the older, more serious investigations. These are now emerging at the other end of the Commissioner's process. Thirdly, the Proceedings team is also becoming more experienced in the jurisdiction, particularly in relation to the disciplinary thresholds and evidential requirements of the disciplinary bodies.

The outcomes speak for themselves. The success rate of the Office illustrates that frivolous or unwarranted charges are not being laid. Nevertheless, when compared to the number of complaints to the Commissioner, those cases that result in discipline still represent the tip of the iceberg at only 1–2%.

Case Study: Informed consent to eye surgery

Dr A, an ophthalmologist, was charged with conduct unbecoming a medical practitioner in relation to undertaking LASIK surgery without his patient's informed consent. He was also charged with inappropriately performing LASIK surgery on the patient's left eye, having been informed by the patient that the vision in her right eye was fluctuating following surgery on it.

The patient concerned had hyperopia (long-sightedness). She was referred to Dr A by her local ophthalmologist. Despite an attempt to make an appointment prior to surgery, staff at Dr A's surgery advised her that a pre-operative consultation was not necessary. The patient did receive a document setting out pre-operative and post-operative instructions. That document did not, however, set out any complications or risks associated with the proposed surgery. The patient did not receive the patient information booklet and information sheet about laser surgery usually sent out by the practice.

On three occasions prior to surgery, the patient phoned Dr A in order to discuss the up-coming surgery. She was unable to speak to Dr A directly.

On the day of the surgery the patient underwent a pre-surgery examination during which she was advised that after treatment her sight might be slightly under- or over-corrected. Dr A also advised that the long-term effects of the procedure were unknown. Once back in reception, the patient was asked to sign a consent form that she had not seen before while Dr A and his staff waited.

Following the surgery the patient experienced pain, and blurry and fluctuating vision. She phoned Dr A's surgery on five occasions prior to surgery on her other eye, but was unable to speak to him. On the date of the second surgery the patient told Dr A about her fluctuating and blurred vision. She was advised that the vision in her right eye would settle. LASIK surgery was performed on her left eye.

Over the following months the patient experienced fluctuating vision, blurriness and pain. Although the vision in her left eye had settled at the time of the hearing, she continued to have trouble with her right eye (some four years after the operation).

The Medical Practitioners Disciplinary Tribunal found Dr A guilty of conduct unbecoming a medical practitioner. He had failed to explain to the patient that the procedure was normally carried out on people with myopia (short-sightedness), and that when LASIK is performed on people with hyperopia it is usually not performed where the dioptre reading is more than +4 (the patient had dioptre readings greater than +8). Moreover, the consent form signed by the patient related to a different laser procedure and only referred to myopia. Having the patient read the consent form while the medical staff stood by waiting to perform the procedure did not afford the patient an adequate opportunity for her to raise any concerns, or decide whether to proceed with the operation.

Dr A had apologised to the patient and refunded her money. He had also made significant changes to his practice by not treating patients with hyperopia, and improving consent procedures. He was censured, fined $2,500 and ordered to pay 25% costs.

This case (No 01/85D) can be found on the MPDT website (www.mpdt.org.nz).

Processes

The HDC Act requires the Director of Proceedings to decide independently whether proceedings will be issued, either before the disciplinary bodies, the Human Rights Review Tribunal or both. There are statutory requirements that must be fulfilled prior to that decision-making. In particular, the consumer/complainant's wishes need to be ascertained, the provider must be given the opportunity to be heard, and the public interest must be considered.

I have found the necessity to give the provider a further opportunity to be heard an unusual requirement — particularly as it is very rare for the provider not to have responded at least once in the course of the Commissioner's investigation. I know of no other prosecution process that gives the alleged perpetrator of the conduct a further opportunity for response to the complaint *after* the investigation. It is also, without question, the most significant contributor to delay within the Proceedings' process. Reasonable time must be accorded to the provider within which to make a response. Additionally, it is not unusual for defence counsel to seek extensions of time for response, or disclosure, at the last minute, and sometimes further evidence is provided which needs further investigation or expert response.

Weighing the public interest is an important part of the decision-making process. This includes an assessment of public safety, community expectations, and individual accountability. Of course the likelihood of success, with reference to the disciplinary thresholds and matters of proof (bearing in mind that the cost of such proceedings is met by the public purse), is also a relevant consideration. The consumer's wishes are perhaps more determinative in relation to HRRT action than disciplinary proceedings. There have been cases where I have pursued disciplinary action when the consumer was not supportive of the proceedings (and the conduct could be proven without the necessity for the consumer to be a witness).

It has also been a challenge to identify and respond to the different processes adopted by the various Tribunals, Councils and Committees. These differences range from the manner in which the charge is drafted, to the actual procedure adopted in the hearing room.

Human Rights Review Tribunal

There has been public comment on the lack of proceedings taken before the HRRT by the Director of Proceedings. This comment fails to appreciate that the ability to seek compensatory damages in the HRRT is significantly curtailed by the statutory bar that operates if an aggrieved person has an ACC entitlement. Most "aggrieved persons" for the purpose of an HRRT claim have such entitlement. Moreover, the fact of entitlement is sufficient to preclude the action, and the Tribunal will not, of course, redress any perceived "shortfall" in the amount of compensation a person receives. If compensatory damages are prohibited, the hurdle of exemplary damages must be overcome (which in most cases is unrealistic). Additionally, a large number of consumers are not interested in pursuing HRRT claims, as they are motivated in their complaint not by the desire to get money, but simply to ensure that what happened to them does not happen to anyone else. In this situation, if the provider concerned is registered, disciplinary action is more likely to meet that motivation. Additionally, it is often the case that the public interest is better served by disciplinary, rather than HRRT, proceedings.

Case Study: Pharmacy dispensing errors

In 2001 my predecessor declined to take proceedings against a pharmacist who had incorrectly dispensed 20mg prednisone instead of 5mg. While the consumer concerned did take the medication, she suffered no lasting effects from the error. The matter was referred back to the Pharmaceutical Society, who brought their own prosecution against the pharmacist. In finding the pharmacist guilty of professional misconduct, the Disciplinary Committee described dispensing as the "lynchpin of community pharmacy" and stated that even one-off errors could amount to a disciplinary offence.

There were three dispensing error cases brought by this Office this year. One case involved two dispensing errors relating to cardiac medication and warfarin (which likely resulted in the consumer's admission to hospital). The other two cases related to the incorrect dispensing of warfarin — 5mg instead of 1mg, and warfarin being dispensed instead of prednisone. In both cases the consumers suffered serious adverse effects warranting hospital admission. The phamacists concerned were all fined and ordered to pay costs.

By contrast, a pharmacist's failure to assess the appropriateness of a prescription for codeine linctus for a seven-week-old baby was not considered a disciplinary offence. The prescription concerned did not specify whether the adult or paediatric strength should be dispensed, although the prescription clearly displayed the date of birth of the child. Adult strength codeine was dispensed (five times the paediatric dose) and the child was eventually admitted to hospital with codeine overdose. Notwithstanding that the Disciplinary Committee was satisfied that the pharmacist had breached the duty of care owed to the patient, and that the pharmacist admitted realising he was dispensing the adult dosage of codeine to a child, the Committee did not conclude that the conduct amounted to professional misconduct. This was because the pharmacist had "complied with the prescription", he was "inadvertently" led into making the error by the GP, and the incident was "one-off". It should be noted that the GP was also prosecuted and found guilty of professional misconduct.

Conclusion

The new year (2002/03) is also shaping up to be a busy one. There has been increasing media interest in the Commissioner's Opinions and the progress of disciplinary proceedings. This, in part, meets my objective of raising the profile of the Director of Proceedings' role and processes. In the past year I have endeavoured to clarify the role and educate the public (especially as it relates to the Commissioner's process) by responding where appropriate to media enquiry. I have also spoken publicly at a number of events including: a lecture to fifth year Auckland University medical students, the Best Practice Conference for Consumer Advocates, the IIR Medico-Legal Forum 2002, and the Legal Research Foundation's conference on Legal Issues in Mental Health. I will continue to make public comment where appropriate.

Other objectives for the upcoming year include further improvement to internal systems (precedents and data collection), and increased training and feedback to the Commissioner's investigation teams regarding evidential issues. Plans are under way to develop a training programme for expert witnesses, possibly in liaison with professional and other interested bodies. We will continue to strive to conduct professional and high quality disciplinary/HRRT proceedings.

Case Study: Dental treatment and follow-up

Dr X, a dentist, was charged before the Dentists Disciplinary Tribunal in relation to three particulars: his inadequate preparation of teeth for a bridge; installing a temporary bridge of unacceptable standard; and his failure to appropriately follow up the consumer's dental care by repetitively cancelling appointments and failing to refer her to another dentist for completion of the dental work.

The consumer had consulted Dr X after she had fractured a partial denture. She wanted a tooth implant. Dr X provided a quote for the installation of a three-unit bridge. While there was a dispute regarding the patient's understanding of the procedure she was to undergo, the charge did not canvas issues of informed consent.

In August 1998 the consumer underwent the preparation procedure for a bridge, and a temporary bridge was installed in her mouth on that occasion. She paid $1,700 up front for the dental work. A follow-up appointment was made for installation of the permanent bridge two weeks later.

The consumer was unhappy at what occurred at the appointment, as she believed she had undergone a procedure she had not consented to. Accordingly, on her return home and in subsequent days she spoke to the Dental Association and a consumer advocate for the purpose of determining how to address this issue with Dr X. After receiving advice she phoned Dr X's surgery on a number of occasions and, approximately one week after the appointment, wrote him a letter outlining her concerns.

The consumer was also distressed at the discomfort she felt following the procedure. Her teeth and gums were painful, and she was required to take ongoing pain relief. On the occasions she rang the surgery she advised the receptionist of her pain, but was unable to speak to Dr X personally.

The consumer's evidence was that over the following two months six appointments were cancelled at Dr X's instigation. These cancellations were disputed by Dr X, who admitted that three appointments were cancelled when he was overseas or unwell, but that thereafter the consumer had refused to attend any further appointments his receptionist attempted to make.

In October the consumer consulted several dentists in an effort to have her dental treatment completed. In December initial remedial work commenced. By this stage the consumer's gums were grossly inflamed and swollen.

In relation to the first particular, while the Tribunal was satisfied that the preparation of the consumer's teeth for a bridge was defective, such defects did not meet the threshold for disciplinary sanction. The Tribunal found that the temporary bridge was seriously defective (with gross overhangs, open margins, and unable to be cleaned), and that the defects in the bridge had caused the consumer's gingival inflammation and pain. It therefore concluded that in relation to this particular, Dr X was guilty of an act that was detrimental to the welfare of his patient.

The Tribunal also found Dr X guilty of professional misconduct in relation to the repetitive cancellation of appointments. In this respect the evidence of the consumer was preferred over the evidence of Dr X and his receptionist. Several factors were considered by the Tribunal to be relevant to this finding:

- Dr X had made no personal contact with the consumer after the August 1998 appointment.
- He failed to meet his professional responsibility to contact his patient and complete treatment — or re-evaluate the temporary restoration.
- He deliberately avoided returning the consumer's calls or meeting her in person.
- He cancelled six appointments without making any attempt to alleviate the consumer's pain or ensure her comfort.
- He failed to give the consumer the completed bridge.
- He failed to refer her to another dentist for completion of the work.
- He failed to refund her money.
- He failed to provide his records in a timely and reasonable manner.

At the time of writing, a penalty had not been handed down.

Enquiries and Complaints Resolution

Enquiries Team Leader, Annette May

Introduction

Enquiries and complaints resolution comprises three teams: an enquiries team and two investigation teams, one based in Auckland and one in Wellington. The leaders of these teams report to Katharine Greig, Assistant Commissioner, who heads this key area of the organisation.

2001/02 was an exciting and successful year for the enquiries and investigation teams. Our target deadline for 30 June 2002 was 600 open files, and we came in well under at 546. In line with our philosophy of resolving complaints at the lowest appropriate level, there have been fewer formal investigations.

There has been a slight increase in the number of referrals to the Director of Proceedings (DP). However, there is no evidence that the quality of health care has deteriorated; rather, the increase in referrals probably reflects the better quality of our investigations — more files now have a sound evidential basis for consideration of disciplinary action.

Enquiries Team

The enquiries team, led by Annette May, is the "front end" of our organisation. The team's work exemplifies our focus on resolving complaints at the most appropriate level. The team is based in Auckland and has four full-time staff.

The enquiries team draws on extensive knowledge about the role of the Commissioner and other agencies to assist callers in the most appropriate way. This year, the team participated in investigation training and undertook a full day of training at AUT on responding to enquiries from users of mental health services. A number of invited speakers have also educated the team on the role of other agencies, such as the Ministry of Health and District Inspectors, and close working relationships have been established.

Enquiries

An "enquiry" is defined as any contact with the Office that is not a complaint about the provision of health care or a disability service. Enquiries vary in nature from a caller needing information on the role of the Office, to an anaesthetist seeking advice on the interpretation of right 7(8) of the Code (the right to express a preference of provider).

Most people who make enquiries do so by telephone, although a number of people also "walk in" to the Auckland or Wellington Offices with an enquiry or write in with a specific question. The public can contact the Auckland-based enquiries team from anywhere within New Zealand by telephoning the toll-free line (0800 11 22 33) between 8am and 5.30pm Monday to Friday, by visiting our website (www.hdc.org.nz) or by emailing the team at hdc@hdc.org.nz.

During the year, 4,311 enquiries were received (1,000 more than last year), attributable to an emphasis on accurate recording of all enquiries and an increase in call volume.

The Enquiries and Complaints Database System (ECDS) records details of written and verbal enquiries and complaints. ECDS also provides an electronic record of investigation files, and allows the Commissioner to monitor trends.

Case study: Verbal information provided in response to a telephone enquiry

A caller telephoned seeking advice about the best organisation to look into a complaint concerning the failure of surgical equipment during a haemorrhoidectomy. After advising the caller to contact ACC to discuss lodging a claim, the Enquiries Officer consulted with a member of the legal team. Medsafe (Ministry of Health) was contacted and confirmed that it could potentially investigate this complaint. The caller was advised of this, and a follow-up email sent to Medsafe.

The vast majority of enquiries are dealt with by providing verbal information. This will often include an explanation of the options available.

The enquiries team will inform a caller if his or her enquiry is outside the Commissioner's jurisdiction. Over the last year the enquiries team improved its ability to liaise with, and refer callers to, other appropriate agencies.

Compared with last year, many more callers were sent written information (pamphlets and educational material — 27% compared with 13% last year).

Enquiries often reflect "live issues" in the health and disability sector, and provide a valuable opportunity for the Commissioner to educate people on the Code. Written responses (referred to as "formal" responses) are frequently sent and copied to relevant agencies.

Where appropriate, callers may be transferred directly to an advocacy service. (These calls are recorded as "advocacy referrals"; when callers are simply given information about advocacy these are recorded as "information provided".)

Table 1 opposite details the frequency with which each of these actions was taken. Calls of a general administrative nature are not included in the statistics.

Case study: Educational use of a formal response to an enquiry

A District Inspector wrote to the Commissioner asking about the application of the Code to the provision of electroconvulsive therapy. The Commissioner provided a formal response to the enquiry, explaining the relevant sections of the Code and enclosing a copy of an anonymised opinion finding a hospital in breach of the Code for failing to adequately co-ordinate the provision of electroconvulsive therapy. The formal response and anonymised opinion were later used as the focus of an educational session at a District Inspectors' conference.

Table 1: Action taken on enquiries

Action taken	2001/2002	2000/2001
Escalated to a complaint	11	21
No response required	22	29
Open	13	34
Provided formal response	184	171
Provided verbal and written information	140	118
Provided verbal information	2,075	1,732
Referred to advocacy	141	187
Referred to other department	7	1
Outside jurisdiction/referred to outside agency	557	379
Sent written information	1,161	639
Total	**4,311**	**3,311**

Complaints Received

A complaint is defined as any allegation that a health care or disability services provider is, or appears to be, in breach of the Code. In the year ended 30 June 2002 the Commissioner received 1,211 complaints, 13% fewer than the 1,397 complaints received in the previous year (see Table 2 below).

Table 2: Number of complaints open compared with the previous year

Complaint numbers	2001/2002	2000/2001	1999/2000
Open at year start	634	575	790
New during year	1,211	1,397	1,088
Closed during year	1,299	1,338	1,303
Open at year end	**546**	**634**	**575**

Source of Complaints

Any person (not just the consumer) may make a complaint to the Commissioner if he or she believes that there has been a breach of the Code. Complaints can be made verbally or in writing (in contrast to New South Wales where all complaints must be made in writing).

All complaints made to statutory registration bodies, such as the Medical Council and the Nursing Council, must be referred to the Commissioner. The health professional body must not take any action on the complaint until notified by the Commissioner that the complaint is not to be investigated further under the Health and Disability Commissioner Act (the Act), or that it has been resolved, or that it has been investigated and is not to be referred to the Director of Proceedings.

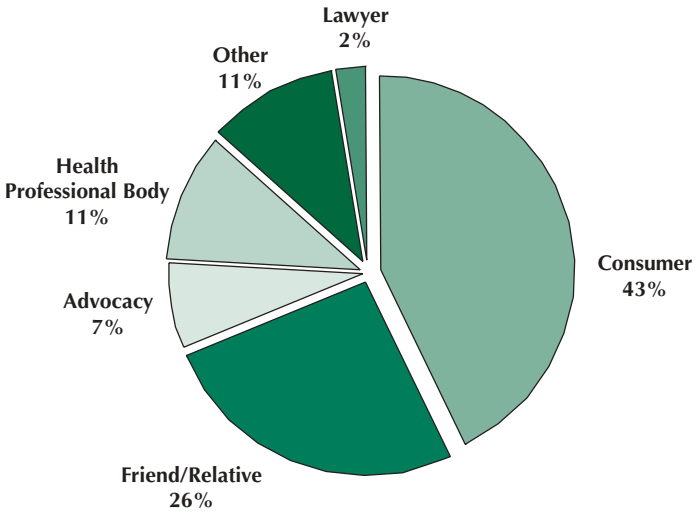


Chart 1: Source of complaints received 2001/02

Where concerns have been brought to the Commissioner's attention but no complaint has been laid, an investigation may be commenced on the Commissioner's own initiative.

The Commissioner is also authorised to receive disclosures under the Protected Disclosures Act 2000, and has done so on several occasions.

As in previous years, most complaints are received from individual consumers, relatives and the advocacy service (see Chart 1 above). Complaints from health consumers far outweighed complaints from disability services consumers.

In the year to 30 June 2002 the professional bodies that referred the most complaints were the Pharmaceutical Society, the Nursing Council, and the Medical Council. Each of these agencies referred fewer complaints than last year. In contrast, the Dental Council referred 18 complaints, twice as many as last year.

Case Study: Commissioner's initiative investigation into Southland mental health services

In October 2001, the Commissioner announced a significant inquiry into mental health issues. As a result of concerns about the quality of care provided to Mr Mark Burton by Southland District Health Board's inpatient mental health service, highlighted in a report commissioned by the District Health Board, the Commissioner began an own initiative inquiry into Mr Burton's care. In particular, the investigation considered whether Southland District Health Board or any of its employees breached Mr Burton's rights under the Code in relation to the following matters:

- ♦ contact and co-ordination with Mr Burton's family
- ♦ discharge planning, including formulation, implementation and review of discharge plans
- ♦ appropriateness of Mr Burton's discharge
- ♦ co-ordination with the community health teams.

At the request of Southland District Health Board, the investigation did not commence until after the conclusion of the Coroner's inquest. A team of independent advisors, headed by South Auckland psychiatrist Dr Murray Patton, interviewed staff in December 2001. A provisional opinion was issued in June 2002, and the final report will be released in October 2002. The report will be placed on the Commissioner's website (www.hdc.org.nz).

Table 3: Complaints received

Source of complaint	2001/2002	2000/2001	1999/2000
Chiropractic Board	3	1	2
Dental Council	18	9	8
Medical Council	58	71	42
Medical Laboratory Technologists Board	1	0	0
Nursing Council	22	26	8
Occupational Therapy Board	2	5	0
Opticians Board	1	0	3
Pharmaceutical Society	19	21	6
Physiotherapists Board	2	4	1
Psychologists Board	11	13	9
Podiatrists Board	1	0	0
Other professional boards	0	2	2
Subtotal (professional boards)	**138**	**152**	**81**
Accident Compensation Corporation	16	7	3
Advocacy services	89	94	40
Coroner	2	1	1
Disability consumer	7	0	1
Disability provider	2	4	2
Employee	3	8	5
Friend	33	36	14
Health consumer	530	718	748
Health provider	22	34	17
Health regulatory body	3	3	0
Lawyer	30	38	15
Member of Parliament	6	6	9
Member of the public	12	4	2
Ministry of Health	8	5	5
Police	3	2	3
Privacy Commissioner	2	0	0
Professional association	19	5	2
Relative	286	279	138
Other	0	1	5
Subtotal (other sources)	**1,073**	**1,247**	**1,007**
Total	**1,211**	**1,397**	**1,088**

Table 4: Types of provider subject to complaint

Individual provider	2001/2002	2000/2001	1999/2000
Anaesthetist	12	9	6
Cardiologist	4	3	1
Cardiothoracic surgeon	3	4	0
Dermatologist	13	7	5
Ear/Nose/Throat specialist	9	2	3
Emergency physician	1	2	0
Endocrinologist	1	0	0
Gastroenterologist	0	1	0
General practitioner	271	397	220
General surgeon	34	51	31
Geriatrician	1	0	0
House surgeon	3	9	4
Medical officer	4	1	0
Neurologist	3	4	3
Neurosurgeon	1	0	0
Obstetrician/Gynaecologist	44	68	26
Occupational medicine specialist	11	5	0
Oncologist	4	4	0
Ophthalmologist	14	5	6
Orthopaedic surgeon	29	38	33
Paediatrician	14	15	9
Pathologist	3	3	3
Physician	26	46	24
Plastic surgeon	7	13	4
Psychiatrist	24	20	16
Radiologist	6	7	2
Registrar	20	17	11
Surgeon (speciality not noted)	0	3	5
Urologist	9	7	11
Subtotal (registered medical practitioners)	**571**	**741**	**423**
Individual providers (other than registered medical practitioners)	**2001/2002**	**2000/2001**	**1999/2000**
Acupuncturist	2	0	0
Aesthetician/Electrologist	0	1	0
Alternative therapist	3	1	0
Ambulance officer	0	0	4
Caregiver	6	5	6
Chiropractor	5	4	8
Counsellor	6	3	1
Dental nurse	1	0	1
Dental technician	8	16	8
Dentist	50	63	39
Dietician	1	0	0
Laboratory technologist	1	1	1

Individual providers (other than registered medical practitioners)	2001/2002	2000/2001	1999/2000
Midwife	30	43	28
Naturopath	0	0	3
Needs assessor	1	0	0
Nurse	43	64	55
Occupational therapist	5	14	6
Optician	0	1	2
Optometrist	3	4	2
Oral surgeon	4	2	1
Osteopath	1	3	3
Other providers	11	21	75
Pharmacist	24	20	13
Pharmacy technician	1	1	1
Physiotherapist	10	24	8
Podiatrist	1	0	1
Psychologist	23	33	25
Psychotherapist	0	1	0
Rest home manager	3	2	2
Social worker	2	1	0
Speech language therapist	1	0	0
Subtotal (other individuals)	**246**	**328**	**293**
Total (all individual providers)	**817**	**1,069**	**716**

Group provider	2001/2002	2000/2001	1999/2000
Accident and emergency centres	8	12	9
Accident Compensation Corporation	2	2	10
Ambulance services	3	4	2
Dental providers	7	2	6
Disability providers	10	12	8
Intellectual disability organisations	6	2	2
Laboratories	3	4	1
Medical centres	20	23	16
Other	19	36	33
Pharmacies	30	42	28
Prison services	28	14	23
Private medical hospitals	13	9	15
Private surgical hospitals	11	14	20
Public hospitals	353	351	264
Radiology services	7	1	2
Rehabilitation providers	5	9	8
Rest homes	56	73	54
Trusts	10	6	10
Total group providers	**591**	**616**	**511**

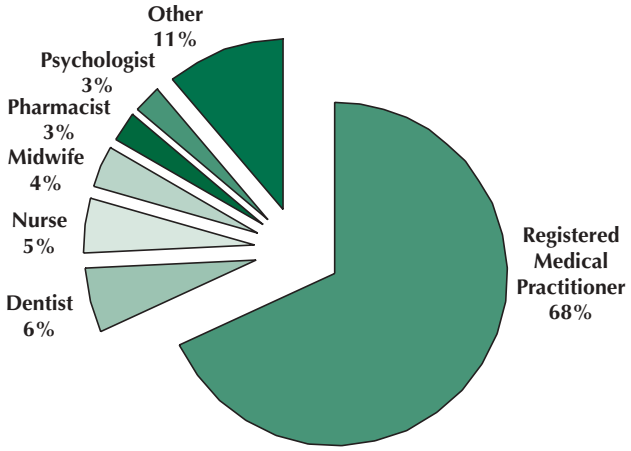


Chart 2: Providers subject to complaint 2001/02

Types of Provider Subject to Complaint

The 1,211 complaints received involved 1,408 providers. Table 4 (pages 30–31) sets out the numbers of complaints against categories of individual and group providers.

For the year ended 30 June 2002 the types of individual provider most commonly complained about were:

Individual providers		Group providers	
♦ General practitioners	33%	♦ Public hospitals	60%
♦ Obstetricians/Gynaecologists	5%	♦ Rest homes	10%
♦ Nurses	5%	♦ Pharmacies	5%
♦ Dentists	6%		
♦ Midwives	4%		

Initial Complaints Assessment

Complaints assessment team (from left): Kathryn Leydon (Senior Investigation Officer), Katharine Greig (Assistant Commissioner), Tania Thomas (Director of Advocacy) and Annette May (Enquiries Team Leader)

Initial handling of complaints is undertaken by the enquiries team. Complaints are then assessed by the Commissioner's assessment team — a panel of senior staff that includes a senior legal advisor, a senior investigator, the enquiries team leader and the Director of Advocacy. The team aims to assess complaints within five working days of receipt.

Each member of the team reviews each complaint file in full before the initial assessment meeting. At the meeting each new complaint is discussed and recommendations are made to the Commissioner on how best to handle each complaint.

Currently, a complaint within the Commissioner's jurisdiction can be referred to advocacy or investigated, or in limited circumstances the Commissioner may decide to take no action. Factors to be considered in the decision to take no action include the age of the complaint, the availability of another adequate remedy, and the wishes of the consumer (if a third party has laid the complaint).

If it is not clear whether there has been an apparent breach of the Code, the Commissioner may seek further information from the complainant, provider, or a third party to assist his decision-making.

Complaints Referred to Another Agency, Outside Jurisdiction, or No Action Taken

A complaint may be closed at an early stage if the Commissioner has no jurisdiction, or the Commissioner decides to take no action. Under section 37(1) of the Act, the Commissioner may decide to take no action on a complaint where:

- the length of time that has elapsed since the event complained of means that investigation is not practicable or desirable;
- the subject-matter of the complaint is trivial;
- the complaint is frivolous or vexatious or is not made in good faith;
- the person alleged to be aggrieved does not desire action to be taken; or
- there is another adequate remedy.

Table 5: Complaints outside jurisdiction, referred to another organisation, or no action taken

	2001/2002	2000/2001	1999/2000
Outside jurisdiction[1]	193	140	172
Referred to a health professional body[2]	93	116	72
Referred to the Privacy Commissioner	29	45	36
Referred to Human Rights Commission	2	7	5
Referred to Ombudsman	2	0	2
Referred to ACC	44	51	21
Referred to the Ministry of Health	44	44	11
Referred to a District Inspector	24	29	11
Referred to another agency	6	29	16
No action[3]	200	–*	–*
Total	**637**	**461**	**346**

*Unable to access this data[4]

1 Outside jurisdiction relates to access or funding, events that occurred before 1996, or decisions under section 35 of the Act.
2 Chiropractic Board, Dental Council, Medical Council, Medical Laboratory Technologists Board, Nursing Council, Opticians Board, Pharmaceutical Society, Physiotherapy Board, Podiatrists Board, Psychologists Board.
3 No action taken under section 37 of the Act, and no investigation commenced.
4 Over the past two years we have enhanced how we collect statistical information. Until this year we have not reported separately on no action under section 37 of the Act.

Complaints Resolved without Investigation

In 2001/02, 328 complaints were closed without an investigation as a result of the complaint being withdrawn, or being resolved by the Commissioner, through advocacy, mediation, or by the agreement of the parties.

Complaints may be referred to an advocate either on receipt or during an investigation where appropriate. There has been a significant increase in the number of complaints referred and resolved with advocacy assistance. This is consistent with the Commissioner's aim of resolving complaints at the most appropriate level.

Table 6: Complaints resolved or withdrawn

Complaints resolved or withdrawn	2001/2002	2000/2001	1999/2000
Resolved by Commissioner	24	81	0
Resolved with advocacy assistance	97	77	72
Resolved by parties	77	78	113
Withdrawn	130	103	42
Total	**328**	**339**	**227**

Investigation Teams

If a complaint requires investigation, it is allocated to one of two investigation teams, one in Auckland and one in Wellington. Each team is under the supervision of a senior investigator. The Auckland team is led by Kathryn Leydon and the Wellington team by Steve Anthony. An investigating officer is allocated to each complaint, but team members work closely together, to improve the quality and consistency of investigations.

Investigation officers bring a wealth of previous experience to their work at HDC. The investigation teams currently include people with clinical backgrounds in nursing, midwifery, social work, public health and medicine, and investigation backgrounds with the police, the army and other government organisations. Several investigators have a law degree.

Complaints Investigated

The investigation process is impartial, independent and subject to the rules of natural justice. In the last year, considerable effort has gone into ensuring that investigations are procedurally fair and efficient. There has also been a strong focus on clearing old files, while still striving for timely investigation of new complaints.

In 2001/02, in 72 cases in which an investigation had been commenced the Commissioner decided that it was not necessary or appropriate to take further action, having regard to all the circumstances of the case. A further 28 investigations were concluded by a successful mediation. Mediators have an excellent success rate in resolving complaints referred by the Commissioner. The number of successful mediations has doubled over the past two years, and there is scope for resolving significantly more matters through mediation in the future.

Case study: Successful mediation following complications of bowel surgery

Mr W was diagnosed with a bowel tumour and admitted to hospital for surgery. Dr L, a locum surgeon from Canada, removed the section of bowel containing the tumour and rejoined the bowel with a circular stapler. The operation was technically difficult, and Dr L had difficulty checking the anastomosis (join) because of the amount of blood.

Postoperatively, Mr W complained of increasing abdominal pain. The family told medical staff, but felt that their concerns were dismissed. Mr W's condition deteriorated and four days after the operation he needed admission to the Intensive Care Unit for ventilation. On the sixth postoperative day, a CT scan raised the possibility of a perforated bowel. After a delay of some 24 hours, Mr W went back to theatre for further surgery, revealing a pelvic abscess and a leaking anastomosis. Dr L drained the abscess and repaired the leak, leaving Mr W with a colostomy. Mr W remained in hospital for five weeks with further postoperative complications.

Mr W and his family wrote to the hospital, complaining about Dr L and seeking an explanation and an apology. The hospital told the family that Dr L had completed his three-month locum and returned to Canada. The family was unhappy with this response, and complained to the Commissioner.

An independent colorectal surgeon advised the Commissioner that "anastomotic leak is a well recognised but feared potential complication following a bowel anastamosis". He went on to say that, in view of the technical difficulties with the anastomosis, Dr L should probably have formed a colostomy at the original surgery. The advisor was also critical of Mr W's postoperative care, and the delay in taking Mr W back to theatre.

The Commissioner commenced an investigation, but was unable to contact Dr L. With the agreement of the parties, the Commissioner called a mediation conference in an effort to resolve the complaint. Mr W attended the conference with his wife and three children. The hospital solicitor and another surgeon represented the hospital. An independent mediator assisted the parties to come up with a simple agreement that everyone was happy with. The hospital acknowledged the family's concerns and apologised unreservedly for the distress caused to Mr W and his family. The hospital also stated that, in retrospect, it would have managed aspects of Mr W's care differently and agreed to take on board lessons learned from the case. The family agreed to allow the hospital to use details of Mr W's admission in staff training.

In 234 cases, the investigation was concluded by the Commissioner reporting his formal opinion in a written report. In 144 matters the Commissioner formed the opinion that the Code had not been breached. In these cases the evidence gathered during the investigation established that the matters complained of did not give rise to a breach of the Code; that the provider acted reasonably in the circumstances (which is a defence under Clause 3 of the Code); or that there was insufficient evidence to establish the complaint.

Breach of the Code

In 90 cases the Commissioner formed the opinion that a breach of the Code had occurred. This represents 27% of cases investigated in 2001/02 — an increase from 24% in the previous year. The majority of breach reports are characterised by three themes: inadequate information, poor communication, and sketchy documentation.

In each of these cases the Commissioner reported his opinion to the parties, and recommended actions. In the majority of cases the Commissioner recommended that the provider apologise for the breach of the Code, and review his or her practice in light

Table 7: Complaints investigated

Complaints investigated[5]	2001/2002	2000/2001	1999/2000
Breach (referred to the Director of Proceedings)	28	26	14
Breach (not referred to the Director of Proceedings)	62[6]	103	187
No breach	144[7]	122	283
Resolved by mediation	28	20	14
No further action taken	72[8]	286	205
Total	**334**	**557**	**703**

of the report. In a minority of cases, specific remedial action (eg, a competence review by the Medical Council) was recommended.

The Commissioner sends a full copy of each breach report to the relevant registration body. Breach findings against unregistered health professionals pose a particular challenge, as the Commissioner has limited scope to take effective action against such individuals. Other appropriate agencies, such as the relevant professional body, professional college or association (eg, the Royal New Zealand College of General Practitioners) or the Ministry of Health are also notified. Unless there is a specific need for the agency to know the identity of the provider, the reports are sent in an anonymised form. This enables lessons to be learned from adverse events, while preserving the anonymity of providers.

In 28 cases the Commissioner referred the matter to the Director of Proceedings to consider whether further action should be taken. (Three referrals were made by the Commissioner before 30 June 2002 but not reviewed by the Director of Proceedings until after 1 July 2002, hence the Director's statement of having received 31 referrals (see p 19)). The 28 matters included 49 breaches by individuals and 17 breaches by a group provider. This represented 8% of the complaints investigated, and 31% of breach reports (compared with 21% in the previous year).

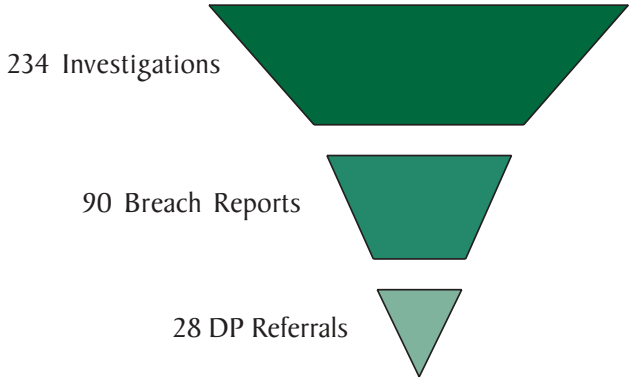


Chart 3: Outcome of investigations 2001/02

5 A single complaint/investigation may result in more than one provider being found in breach.
6 Includes breach reports and breach letters.
7 Includes no breach reports and no breach letters.
8 Complaints where no further action was taken under section 37.

Table 8: Individual providers referred to the Director of Proceedings (around 30% of all individual providers found to be in breach of the Code in 2001/02)

	2001/2002		2000/2001	
Provider	**Breach finding**	**Referred to DP**	**Breach finding**	**Referred to DP**
Acupuncturist	0		1	1
Anaesthetist	4	2	6	1
Caregiver	2		4	1
Counsellor	1	1	2	1
Dental nurse/technician	1		4	2
Dentist	8	2	3	
Dermatologist	0		3	
Emergency physician	1		0	
Gastroenterologist	2	2	0	
General practitioner	41	6	36	8
General surgeon	10	6	13	1
House surgeon	6	1	6	
Midwife	12	1	12	6
Neurologist	0		2	
Neurosurgeon	0		1	
Nurse	16	10	24	2
Obstetrician/Gynaecologist	14	1	13	1
Oncologist	0		1	
Ophthalmologist	0		3	2
Orthopaedic surgeon	0		4	
Other health provider	1	1	7	
Otolaryngologist	1	1	1	
Paediatrician	3		2	
Pathologist	2		1	
Pharmacist	7	6	9	3
Pharmacy technician	0		4	1
Physician	10		14	
Physiotherapist	1		0	
Psychiatrist	4	1	4	1
Psychologist	4	3	2	2
Radiologist	7	2	3	
Registrar	2	1	8	
Rest home manager	3	2	1	
Urologist	2		2	
Total	**165**	**49**	**196**	**33**

Table 9: Group providers referred to the Director of Proceedings (around 27% of group providers found to be in breach of the Code in 2001/02)

	2001/2002		2000/2001	
Group provider	**Breach finding**	**Referral to DP**	**Breach finding**	**Referral to DP**
Accident and Emergency Clinic	3		1	
Medical centre	3	1	4	
Other provider group	4	1	9	2
Pharmacy	6	4	10	3
Private hospital	8	5	3	
Public hospital	33	4	50	4
Radiology provider	1		0	
Rest home	6	2	6	
Total	**64**	**17**	**83**	**9**

Re-engineering of Enquiries and Complaints Processes

In July 2001 the Commissioner initiated a major change project, called Project Sherlock, to re-design the enquiries and complaint resolution processes and to develop best practice processes for HDC. Project Sherlock was ably led by Project Manager Nicola Holmes, supported by an enthusiastic team of staff.

Phase one of the project was a series of workshops run over a four-month period, involving all staff in the enquiries and complaints resolution processes, the Directors of Proceedings and Advocacy, and HDC mediators. The processes of other complaints organisations such as the Privacy Commissioner, the Human Rights Commission, and the Health Care Complaints Commission in NSW, Australia were compared. Proposed new processes were developed.

Phase two of the project tested the re-engineered processes through a rigorous six-month "pilot", involving 11 members of staff from each of the operational teams (enquiries, investigations and legal). Monthly quality audits were conducted and changes made. Having evaluated the pilot and completed revisions where necessary, the re-engineered processes were approved for national implementation on 30 June 2002.

The new processes are better aligned with the fundamental role of the Commissioner, to facilitate the "fair, simple, speedy, and efficient resolution of complaints" (section 6, HDC Act) and are intended to help HDC become the leading statutory complaints agency in Australasia.

Investigation training

The legal team provides all new enquiries and investigation staff with training on the Act, the Code, privacy, and the Protected Disclosures Act.

This year, all investigators took part in a training programme designed to improve the quality of investigations. The programme covered the following topics:

- Basic investigation skills
- Planning and managing an investigation
- Collection and protection of evidence
- Interviewing skills
- Understanding cultural issues
- Use of expert advisors
- Role of other agencies including the Ministry of Health and District Inspectors.

Senior Investigator (Projects) Nicola Holmes visited the Health Care Complaints Commission of New South Wales to share the experience of Project Sherlock and to learn about the best practice from the Australian state that has the most similar health complaints jurisdiction to New Zealand's. We are also working with the NSW Commission on an information technology project to enhance our database.

Complainant and provider satisfaction survey results

The Commissioner's Office for the first time surveyed complainants and providers who had participated in the complaints resolution process between 1 July 2001 and April 2002. Postal surveys were undertaken. A total of 202 complainant surveys were distributed with a 35% response rate. A total of 341 independent provider surveys were distributed with a 27% response rate. Twenty-one District Health Boards (DHBs) were sent a provider survey and 15 responded, a 71% response rate.

The poor response rate from complainants and individual providers is disappointing and has led to changes in the surveying process for next year. Future participants will receive more warning of a survey being distributed and will be better informed as to the purpose of the survey. Participants will receive their survey soon after file closure.

The responses to the three types of survey have provided valuable information. Key areas for improvement based on feedback from the surveys are summarised as follows:

- less delay in assessment and investigation processes
- clearer explanations of complaints handling decisions
- fuller summary explanation of proposed decisions about a complaint
- quicker responses to written correspondence
- early advice about timeframes for handling of complaints processes and outcomes.

The sections below outline the key findings from the DHB, Individual Provider and Complainant surveys.

District Health Board survey results

- 93% of DHB respondents found our initial letters "easy to very easy" to understand.
- All DHB respondents found the Office "prompt to very prompt" at responding to telephone messages.
- 27% of respondents found the Office quite slow at responding to written correspondence.
- 93% of respondents found the staff polite.
- 67% of respondents found that our bi-monthly updates kept them "well to very well informed" on what was happening with complaints about their service.

The DHBs were asked to comment on whether HDC could do anything differently that would facilitate implementation of the Commissioner's recommendations about their service. The following is a list of some of the comments:

- "Very good to be able to comment on the provisional opinion as this does give an opportunity to discuss viability of recommendations."
- "Areas of good practice could be recommended so organisations can have a mentor or use others' methods to prevent reinventing the wheel."
- "Some recommendations are already implemented by the time the Commissioner makes final opinion, because of the length of time taken to investigate."
- "Make them as reasonable and as relevant as possible."
- "So far we have found these to be clearly understood and reasonable."

Independent Provider Survey Results

- 85% of respondents found our initial letters and the reason for the Commissioner's final decision "easy to very easy" to understand.
- 43% of respondents were dissatisfied with the information about timeframes for handling complaints.
- 52% of respondents were dissatisfied with how well the Office kept them informed about what was happening with the complaint.
- 24% of respondents were very dissatisfied with the response to written communication.
- 55% of respondents were "quite satisfied" or "very satisfied" with our response to telephone messages.
- 74% of respondents found the staff polite.
- 67% of respondents were satisfied that their case was heard in a fair and unbiased way. (The providers surveyed included both those where a breach was found and those where no breach was found.)
- 35% of respondents would feel uncomfortable going through the HDC complaints process again, citing delays and stress.

Providers made the following suggestions to improve the Office's processes:

- "All I can say is that you handle it quite well in a non biased way and I'm quite grateful for everything. Keep up the good work."
- "Process appears to be fair, thorough and unbiased but frustrating because it seems to take so long."
- "Nobody likes having complaints against the service that they give, however we all have the right to complain and if improved service is the result then that's ok."
- "As the process takes a considerable time, it would have been helpful to be more fully informed about the process for investigation. Staff were particularly polite and helpful and this made the process much easier and helped to reduce the stress."
- "This process (even with a positive outcome) is very difficult to cope with. There is a huge emotional stress involved. I think your staff are aware of this. Perhaps more ongoing feedback would be helpful."
- "Your time frame was ridiculously slow in my opinion, for what I still believe was a frivolous complaint — expedite your time frame, as being on the receiving end of a complaint is most unpleasant."

- "Allow longer time frame to reply to letters. Sometimes patient notes have been transferred to other doctors' surgeries and it is difficult to retrieve them. Also discussion with specialist to clarify the situation may take time. Advice from lawyers also requires time."

Complainant Survey Results

- 88% of survey respondents found letters from the Office "quite easy" or "very easy" to understand.
- 43% of respondents found the reason for the final decision made about their complaint "very difficult" to understood.
- 78% of resopndents found the staff polite, respectful and good listeners.
- 30% of respondents were "very dissatisfied" with how they were kept informed about the timeframes for handling their complaint; 25% were "very satisfied".
- 28% of respondents were "very dissatisfied" with how they were kept informed about what was happening in their case; 24% were "very satisfied".
- 55% of respondents were either "quite dissatisfied" or "very dissatisfied" with the way their complaint was handled.
- 61% of respondents were "quite dissatisfied" or "very dissatified" with their view being heard in a fair and unbiased way.
- 59% of respondents would not want to deal with HDC in the future.

Chart 4 below is an aggregate of the responses in the above three areas. Changes will be made to the next survey to attempt to identify whether there is a correlation between a breach finding and complainants' responses that the complaints handling process is biased and unfair.

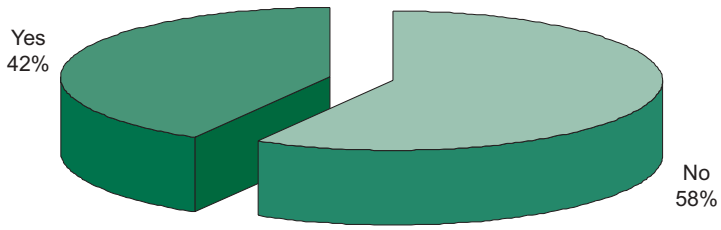


Chart 4: Complainant survey — "Overall, were you satisfied with the way your complaint was handled; was it in a fair and unbiased way; would you be happy to use HDC again in the future?"

Complainants made the following suggestions to improve our processes:

- "I was really pleased with the overall dealings and appreciated very much the sensitivity which I received. Thank you. My only regret was the final 'apology' letter I received from the surgeon — which to us had no emotions and was just a normal business letter. I felt quite unhappy about that."
- "Advocacy service very good. Investigation seemed lenient against people being complained against though."
- "Communication when huge time lapses before enquiry looked into. Get unbiased opinions to help look into the matter (not colleagues who have worked together)."

- "You might want to send this survey form once a case is closed. In my case, it has been some months now, I would have answered more accurately then."
- "Listen fairly to both sides of the story, rather than just the medical professionals. Their side was believed without question."
- "In certain instances it would be helpful to have a case officer sit down and talk with complainants rather than corresponding via letter. Furthermore, the investigation procedure of having another Medical Professional associated with the complaint to provide guidance/advice to HDC does little to inspire confidence and provide a perception of 'closing ranks'."

Summary

The results from our first complainant and provider surveys have highlighted areas for improvement. The survey results have also helped us to identify other types of question that will provide useful feedback. Some questions need to be posed to specific types of complainant, for example those who have had a complaint upheld versus those whose complaint was not upheld; those providers who have been found in breach versus those who have not. It is hard to resist the conclusion that the results — 78% of independent providers, compared with 39% of complainants, reported satisfaction with the fairness of the process — reflect the investigation outcomes of 73% upheld (breach report), and 27% not upheld (no breach or no further action report).

These initial survey results will provide a useful baseline against which to measure performance in future years.

Legal Services

Chief Legal Advisor, Katharine Greig

Overview

Legal staff in both the Auckland and Wellington Offices provide support and advice to the Commissioner, managers and other staff, spanning the range of functions and activities undertaken. Once again 2001/02 was a busy and productive year for the legal division.

Formal advice was provided to the Commissioner and staff on the interpretation of various aspects of the Health and Disability Commissioner Act 1994, the Code of Rights, and related legislation. Formal written responses were prepared to enquiries from the public and other agencies on the Act and Code, and many verbal enquiries were dealt with. A number of submissions on legislative and policy proposals were drafted; legal overview was provided on all investigation files; educational materials were reviewed; and conference papers were prepared and presentations delivered.

During the latter part of 2001, the Chief Legal Advisor, Katharine Greig, was extensively involved in management of the inquiry into Southland DHB's mental health services. In addition, most members of the legal team carried some investigation file load.

In line with the function of the Commissioner for the "fair, simple, speedy and efficient resolution of complaints", the legal division has become increasingly involved at the "front end" of complaint resolution. As well as providing advice to the enquiries team in the initial assessment phase, this involves liaison with consumers, providers, expert advisors, registration bodies, the Ministry of Health, and statutory officers, to ensure that complaints are handled appropriately.

Submissions

Submissions drafted by the legal division addressed a wide range of key policy documents and proposed legislation in the health and disability sector. Feedback from recipients indicated timely, high quality and relevant submissions. Thirty-eight submissions were made over the course of the year. Submissions included comments on:

- Draft Operational Standard for Health and Disability Ethics Committees, Ministry of Health
- Social Workers Registration Bill, Ministry of Social Policy
- Foreign Qualified Medical Practitioners Amendment Bill, Health Select Committee
- Draft NZMA Code of Ethics, New Zealand Medical Association
- Discussion Paper: Quality improvement strategy for public hospitals, Ministry of Health

- Submission to the Health Select Committee Inquiry into the adverse effects on women as a result of treatment by Dr Graham Parry, Health Select Committee
- Guideline for Microbiological Surveillance of Flexible Hollow Endoscopes: DZ 8149, Standards New Zealand
- Notification of Test Results, New Zealand Medical Association
- Sexual Boundaries Evaluation Report, Medical Council of New Zealand
- Draft Statement on Information and Consent, Medical Council of New Zealand
- Protecting the Intellectually Disadvantaged from Self Harm, Law Commission
- Draft Health (Screening Programmes) Amendment Bill and Cabinet Paper, Ministry of Health
- Draft Health Practitioners Competence Assurance Bill, Part 8, Ministry of Health
- Draft Code of ACC Claimants' Rights, Accident Compensation Corporation
- Draft Standards for the Wellbeing of Children and Adolescents Receiving Healthcare, Paediatric Society of New Zealand
- Medical Council's Statement of Every Doctor's Duty in an Emergency, Medical Council of New Zealand.

Liaison

Over the course of the year the legal division has maintained an effective working relationship with a number of external organisations, which enables consultation on individual files and clarification of our respective roles. These organisations include professional bodies and organisations, the Ministry of Health, the Accident Compensation Corporation, the Human Rights Commission, and the Offices of the Coroner, the Ombudsmen, and the Privacy Commissioner.

Registration bodies and Accident Compensation Corporation

In the interests of the safety of health and disability services consumers and to expedite the handling of complaints, the Health and Disability Commissioner has developed information-sharing protocols with registration bodies. Discussions are being held with the Medical Misadventure Unit of the Accident Compensation Corporation to develop a protocol, with agreement in principle.

Information requests and investigations

Many requests for information from investigation files were received during the year (made pursuant to the Official Information Act 1982 and the Privacy Act 1993). Responding to such requests is a time-consuming aspect of the legal division's workload.

During 2001/02 several new complaints about Health and Disability Commissioner processes were made to the Office of the Ombudsmen under the Official Information Act and the Ombudsmen Act 1975, and to the Privacy Commissioner. A number of the complaints were resolved following clarification and referral back to the Commissioner's Office by the Chief Ombudsman or the Privacy Commissioner.

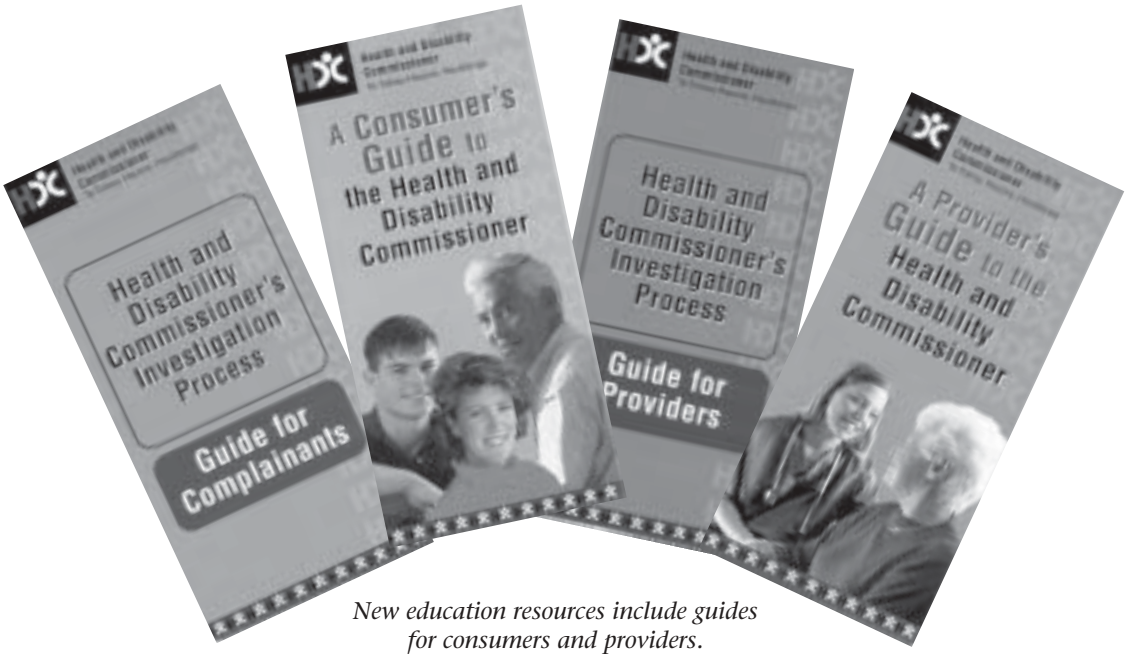
Education

This year has seen a targeted approach to educational initiatives, with a focus on government agencies that interface with the Commissioner's Office, and key groups of providers. Educational programmes were delivered to District Health Boards complaints staff, iwi and regional Māori service providers, the Accident Compensation Corporation, Work and Income New Zealand (WINZ), the Human Rights Commission (HRC), and the Department of Corrections.

The Commissioner has also continued to focus education on identified target groups of consumers. This included 38 programmes run in conjunction with the Disabled Persons Assembly Inc (DPA), and advocates across the country.

Notable Educational and Promotional Activities

- A range of new educational and promotional resources has been designed, produced and distributed. These include consumer and provider guides to the Health and Disability Commissioner's Office, and guides to the investigation process.
- The Commissioner's monthly column in the *NZGP*, a magazine for general practitioners, continues to provide a forum to address a wide range of topical issues affecting medical practitioners. Topics covered this year included medico-legal myths about complaints, the duty of candour under the Code, a 14-year-old's consent to a vaccine, receipt of the right medicine in a rest home, pitfalls of doctor shopping, and the crisis in New Zealand's rural general practitioner workforce. All the articles are available on the Commissioner's website (www.hdc.org.nz).
- A range of articles has been written and published in consumer and provider publications, including the *Consumer* and *Quality Health* magazines.
- The Commissioner's Opinions, with identifying features removed, have continued to be published on the Commissioner's website, for educational purposes.
- Senior managers and staff addressed several major conferences and workshops throughout the year, and the Commissioner gave keynote speeches at the Health Services and Policy Research Conference, the Australasian and New Zealand Medical Boards' Conference, and the first New Zealand Health Care Complaints Conference.
- Advocacy services continue to fulfil a vital educational role in informing providers and consumers about the Code and the role of advocates.
- The first pilot seminar for Māori health care providers was held in Kawakawa and included Māori mental health workers, alcohol and drug workers, community support workers, and administration and management staff. Two more seminars were subsequently held in Napier and Christchurch, with great success.
- Thirty-eight presentations about the Health and Disability Commissioner were made across the country to people with disabilities, in conjunction with the DPA.
- Pilot programmes about the Health and Disability Commissioner were conducted for government agencies that have an interface with the Commissioner, including ACC, WINZ and HRC.
- The Commissioner's internal newsletter, "Highlights", celebrated its first year. The monthly newsletter is aimed at informing staff and advocates of items of interest within HDC and advocacy services.



New education resources include guides for consumers and providers.

Educational Resources and Publications

In 2001/02 the Commissioner continued to provide a wide range of educational resources to consumer and provider groups. These are designed, first, to educate consumers about their rights under the Code and available avenues of support and complaint and, secondly, to provide information to providers regarding their obligations under the Code. This year 278,631 resources were distributed.

Educational resources distributed included:

- posters in English and Māori
- brochures in English and Māori outlining the Code in various forms, from the complete regulation to a short list of the ten rights
- leaflets providing information about advocacy services
- videos for consumers, available subtitled in Māori, Samoan, Tongan and Niuean
- a video for providers
- audio tapes containing information about the Code and advocacy services
- bilingual pocket cards with a summary of the ten Code rights in English and another language (these currently include Māori, Samoan, Tongan, Cook Island Māori and Niuean)
- Opinions, speeches, articles, media releases and other information of public interest. These were placed on the Commissioner's website, which continues to generate significant interest among consumers, providers, professional groups, the media, and the general public
- a range of formal responses by the Commissioner to enquiries relating to both Act and Code issues.

Education, Promotion and the Media

The Commissioner's public statements were widely reported in the print, radio and television media. The Commissioner appeared as a guest on consumer programmes such as the *Breakfast* show and *Fair Go*, and gave regular interviews to Radio New Zealand. Media enquiries

regularly request both comment from the Commissioner on issues of public concern, and information related to specific complaints under investigation.

Public statements that provoked debate during the year were:

- The Commissioner's decision to undertake an independent investigation into the quality of care provided to Mark Burton by Southland District Health Board's mental health service (see page 28).
- The Commissioner's comments on the revelations that Green Lane Hospital had retained body parts without parental knowledge or consent, and confirmation that the Human Tissue Act 1964 — not the Code — governs the retention and use of cadaveric tissue.
- The Commissioner's media release on the threatened strike action by Canterbury nurses, asking that the nurses reflect on their ethical responsibility not to abandon sick patients.
- The Commissioner's dialogue column in the *New Zealand Herald* about sex with patients, following a District Court decision that discipline was not warranted in a case where a doctor commenced a sexual relationship with his patient. The Commissioner criticised the ruling, stating that it was inconsistent with medical ethics and made a mockery of the zero tolerance policy for doctor and patient relationships.

Māori Initiatives within HDC

The Commissioner's Office undertook a number of key Māori initiatives in 2001/02. The Office now has in place:

- a staff development and training plan in Māori cultural awareness and development. The plan was developed in response to an independent cultural assessment carried out within the organisation. All HDC staff have attended a Māori cultural awareness induction training day in preparation for the new training plan
- a set of Māori cultural policies to guide the Commissioner's Office in implementing culturally appropriate processes and practices
- a set of guidelines for ensuring a Māori perspective is used when making submissions, developing policy and/or making comment on policy that impacts on Māori consumers and/or providers
- a database of Māori researchers, policy analysts and traditional healers for use in providing expert advice or assisting with submissions, policy development and comment

Te Ao Pehi Kara, HDC's kaumātua, and his wife, Waiariki, who are advisors to the Commissioner's Māori Initiatives Implementation Team.

- a database of iwi and Māori health and disability services providers to assist in developing and maintaining consultation, evaluation and feedback mechanisms with the Commissioner's Office and to ensure better coverage of promotional activities carried out by the Office
- a Māori provider education programme for use when promoting the Code
- a satisfaction survey format and process designed for use with Māori who use the Commissioner's service.

A cross-sectional implementation team within the Commissioner's Office has been established, including input from the Directors of Advocacy and Proceedings. The team has responsibility for implementing the initiatives listed above.

Case Study: Unsafe administration of ECT

Mr C had a history of treatment-resistant major depression. On the recommendation of Dr M, a psychiatrist, Mr C agreed to undergo ECT at a hospital on an outpatient basis. Dr M was aware that Mr C was taking the anticonvulsant Tegretol. Anticonvulsants make it more difficult to induce the seizure activity needed for effective ECT, but Dr M did not consider stopping or reducing Mr C's Tegretol.

Over the next month, four different training registrars at the hospital administered ECT to Mr C under the supervision of three different consultant psychiatrists. It was only after six high-dose treatments of ECT had failed to elicit adequate seizure activity that the ECT team discovered that Mr C was still taking Tegretol. The Tegretol was then discontinued before giving the final two ECT treatments.

Mr C's wife complained about the prolonged course of ECT and the failure to review Mr C's medications prior to treatment. An independent psychiatrist advised the Commissioner that Dr M, the prescribing psychiatrist, should have discontinued the Tegretol, if not prior to treatment, then certainly when it became clear that it was proving difficult to elicit seizures. The team administering the ECT also had a responsibility to review Mr C's medications prior to each treatment.

Dr M was found to have breached Mr C's right to have services provided with reasonable care and skill, by failing to discontinue his Tegretol before commencing ECT. Dr M acknowledged her oversight and apologised.

The hospital was also found to have breached Mr C's right to services of an appropriate standard, including the right to co-operation among providers to ensure quality and continuity of care. In particular, the hospital had failed to have policies and procedures in place to ensure an adequate medication review before ECT, and had failed to clarify the respective responsibilities of medical staff prescribing and administering ECT. The hospital confirmed that new guidelines had been put in place to prevent a similar problem recurring.

The Commissioner recommended that Dr M and the hospital review their practice and apologise to Mr C, and that the Royal Australian and New Zealand College of Psychiatrists distribute ECT guidelines to all District Health Boards. A copy of the Commissioner's report was sent to the Medical Council, the Ministry of Health, the Mental Health Commission, and the College of Psychiatrists.

The Commissioner received the following letter from Mr C and his wife: "We would like to thank you sincerely for the recommendations you made in your report which will, we hope, reduce significantly the likelihood of anyone else experiencing similar problems to those we encountered. Any improvements made in training and procedures can only benefit all involved, and your recommendations for increasing the information available to the public will be most welcome. Your report has provided as much as we could have wished for — now we can only hope that those involved will play their part.

Completion of your investigation allows us to put another part of this sad incident behind us … We trust that no other family has to go through the same experience that we have."

Case 00HDC07173 may be viewed at www.hdc.org.nz/opinions.

Management and Administration

Corporate Services Manager, John Berridge

Organisation

The Health and Disability Commissioner operates from two offices, located in Auckland and Wellington, with administration based in Auckland. As at 30 June 2002 there were 55 staff. Of these, 44 were full-time and 9 were part-time employees, and 2 were contracted. This equated to 48.2 full-time equivalents. Two employees were on parental leave. The organisation chart as at 30 June 2002 is shown on page 52.

The Commissioner and Assistant Commissioner are based in the Auckland and Wellington Offices respectively. The Director of Proceedings is Wellington based and the Director of Advocacy is Auckland based.

The majority of the legal team and the smaller of the two investigation teams operate from the Wellington Office.

Management

The Senior Management Team, consisting of the Commissioner, the Assistant Commissioner, the Directors of Advocacy and Proceedings, and the Corporate Services Manager, met regularly throughout the year. The Team was formed on the recommendation of Dr Jane Bryson in July 2001, as part of her Management Review of the organisation.

Reporting of financial performance and position as well as progress towards the targets of the Statement of Service Performance took place monthly, and provided the basis for regular review of the organisation's progress towards the goals and objectives set for the year.

Strategic Plan

A strategic plan for the four-year period 2002–2006 was developed in the course of the year. This incorporated and built on the Vision and Mission that were developed in 2001/02. It also provided a further opportunity for staff consultation, involvement and team building. The new plan was presented to staff and communicated to stakeholders in June 2002.

Human Resources

During the year there were a number of staff changes, significantly the appointment of Morag McDowell as the new Director of Proceedings. Pending her arrival on 9 July 2001, Matt McLelland was Acting Director of Proceedings on a temporary basis.

In September, Siniua Lilo, long-serving Senior Investigator, moved on. The two investigation teams in Auckland have been merged under the leadership of Senior Investigator Kathryn Leydon.

Denise Wilson, appointed Education Advisor in early 2001, resigned in April to return to the Auckland University of Technology. She was initially replaced by Alyson Howell in a contract role pending new appointments in the Education/Knowledge Management arenas. The Commissioner's Executive Assistant, Helen Crompton, took on the additional responsibility of Communications Advisor in March.

A number of other changes took place during the year, to improve internal processes, organisational performance and the throughput of complaints. A new position of Editor was trialled and then confirmed, with Anne Russell appointed to this role. Jim Chen was appointed to a part-time role of Website Editor.

The legal team was strengthened by the appointment of Kristin Langdon as an Auckland Legal Advisor, Dr Marie van Wyk as a Legal Advisor/Researcher, and Dr Deanne Wong as a Project Officer in the Wellington Office.

Overall staff turnover in the year was considerably less than the previous year, with greater use made of part-time and fixed-term appointments to provide the flexibility needed as the organisation managed a number of change initiatives. The most significant was the review and re-engineering of enquiries and complaints processes, Project Sherlock, discussed at page 38.

Human resources management policies and procedures were extensively reviewed and a number of significant improvements made in the course of the year. All staff now have four weeks' annual leave, and the entitlement for special leave has been increased to ten days.

Finance

New financial management software was installed to replace the dated accounting system that had been in use since the Office was first established.

Information Systems

Significant improvements were made to the Office's information systems this year, in line with the recommendations of the Information Systems Strategic Plan approved last year. The security of our information systems has been enhanced.

Internet access and external email were introduced. A number of other infrastructure developments were also implemented, resulting in an overall improvement in the speed and reliability of the network that supports both offices and the nationwide network of advocates.

The HDC website was extensively revamped, with an expansion in the content, and improvements in navigation and presentation based on surveyed user needs. The newly expanded site (www.hdc.org.nz) was launched in early July 2002. The Commissioner's Opinions have been reorganised, and improved search processes incorporated to assist researchers and other users. An initial trial of an intranet was also commenced in February, and further plans are being developed.

The Office continues to develop working relationships with the State Services Commission and kindred agencies, as well as participating in the promotion of e-government.

Auckland Office Re-location

On Monday 20 May the Auckland Office re-located to Level 10 of the Tower Centre at 45 Queen Street. This followed the expiry of the original lease in Quay Towers and a search for premises that would provide a more efficient and suitable environment for the increased numbers of staff.

Our new premises are co-located with the Auckland Office of the Human Rights Commission, with shared reception, library, and conference and meeting rooms.

A blessing of the combined premises was held on the morning of Monday 20 May.

The new reception area is shared by the Health and Disability Commissioner and the Human Rights Commission.

Staff of the Health and Disability Commissioner and the Human Rights Commission at the blessing of the new premises.

Organisation Chart (as at 30 June 2002)

Financial Statements

Financial Commentary

Funding

The Office is funded from Vote Health. Funding remained unchanged at **$6,148,444** (excluding GST) for this year and no change is expected for next year.

Investments

The Office invests surplus funds in term deposits lodged with creditworthy institutions. Deposits have a range of maturity dates to maximise interest income while maintaining cash flow. Interest income for the year was **$171,853** and investments totalled **$2,050,000** at 30 June 2002.

Publications

The Office produces a range of educational materials for use by the public and health and disability service providers. Members of the public receive these items free while providers are charged a modest amount to recover costs. Revenue from this source in 2001/02 was **$44,439** which was offset by production costs.

Operating Deficit

In 2001/02 the Office budgeted for a deficit of $659,121 and made a deficit of **$573,862.** For 2002/03 the Office has budgeted for a deficit of $698,229.

Expenditure by Type

Expenditure is summarised by significant categories below. Advocacy service contracts, staff costs and occupancy costs (collectively 75.94% of total expenditure in 2001/02) largely represent committed expenditure. Much of the remaining 24.06% (or $1.66 million) is discretionary.

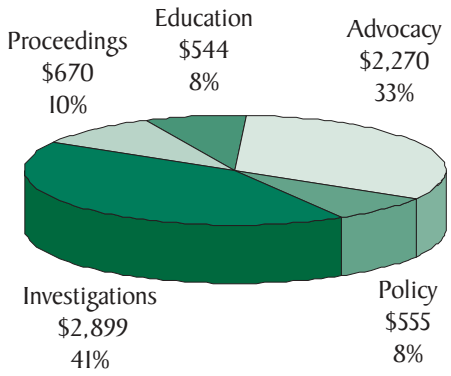
	01/02		00/01	
	$000	**%**	**$000**	**%**
Advocacy Service Contracts	1,877	27.05	1,827	26.73
Audit Fees	9	0.13	6	0.09
Bad Debts Written Off	0	0.00	0	0.00
Staff Costs	3,075	44.32	2,762	40.42
Travel & Accom	206	2.97	303	4.43
Depreciation	185	2.67	182	2.66
Occupancy	317	4.57	315	4.61
Communications	484	6.98	424	6.21
Operating Costs	785	11.31	1,015	14.85
TOTAL	$6,938	100.00%	$6,834	100.00%

Figures GST exclusive

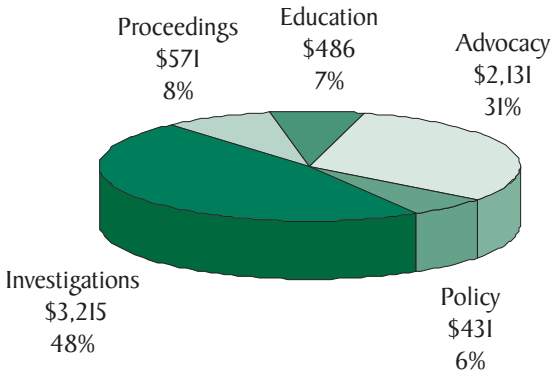
Expenditure by Output

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

Expenditure by Output 2001/2002 ($000s)



Expenditure by Output 2000/2001 ($000s)



Expenditure on Investigations was $2,898,821 ($3,215,190 in 00/01) and includes the Commissioner's Initiative: Southland District Health Board Mental Health Services investigation at $85,860. The number of investigations completed was down slightly from the previous year. Spending on Advocacy increased by $131,000, and remained a significant commitment of resources at 33% (31% 00/01) of total expenditure. The Office continued to look for efficiencies in all areas.

Statement of Responsibility

In terms of Section 42 of the Public Finance Act 1989:

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

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

3. I am of the opinion that these financial statements fairly reflect the financial position and operations of the Office of the Health and Disability Commissioner for the year ended 30 June 2002.

Ron Paterson
Health and Disability Commissioner
23 October 2002

Audit New Zealand

REPORT OF THE AUDITOR-GENERAL

TO THE READERS OF THE FINANCIAL STATEMENTS OF HEALTH AND DISABILITY COMMISSIONER FOR THE YEAR ENDED 30 JUNE 2002

We have audited the financial statements on pages 59 to 80. The financial statements provide information about the past financial and service performance of the Health and Disability Commissioner and its financial position as at 30 June 2002. This information is stated in accordance with the accounting policies set out on pages 59 to 60.

Responsibilities of the Health and Disability Commissioner

The Public Finance Act 1989 and Health and Disability Commissioner Act 1994 require the Health and Disability Commissioner to prepare financial statements in accordance with generally accepted accounting practice in New Zealand that fairly reflect the financial position of the Health and Disability Commissioner as at 30 June 2002, the results of its operations and cash flows and service performance achievements for the year ended on that date.

Auditor's Responsibilities

Section 15 of the Public Audit Act 2001 and Section 43(1) of the Public Finance Act 1989 require the Auditor-General to audit the financial statements presented by the Health and Disability Commissioner. It is the responsibility of the Auditor-General to express an independent opinion on the financial statements and report that opinion to you.

The Auditor-General has appointed Karen MacKenzie, of Audit New Zealand, to undertake the audit.

Basis of Opinion

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:

- the significant estimates and judgements made by the Health and Disability Commissioner in the preparation of the financial statements; and
- whether the accounting policies are appropriate to Health and Disability Commissioner's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with the Auditing Standards published by the Auditor-General, which incorporate the Auditing Standards issued by the Institute of Chartered Accountants of New Zealand. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements.

During the year, we reviewed the development of performance measures. Other than this service and in our capacity as auditor acting on behalf of the Auditor-General, we have no relationship with or interests in the Health and Disability Commissioner.

Unqualified Opinion

We have obtained all the information and explanations we have required.

In our opinion the financial statements of the Health and Disability Commissioner on pages 59 to 80:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health and Disability Commissioner's financial position as at 30 June 2002;
  - the results of its operations and cash flows for the year ended on that date; and
  - its service performance achievements in relation to the performance targets and other measures adopted for the year ended on that date.

Our audit was completed on 23 October 2002 and our unqualified opinion is expressed as at that date.

Karen MacKenzie
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Statement of Accounting Policies

For the year ended 30 June 2002

Statutory Base

The financial statements have been prepared in terms of Section 41 of the Public Finance Act 1989.

Reporting Entity

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

Measurement Base

The financial statements have been prepared on the basis of historical cost.

Particular Accounting Policies

(a) *Recognition of Revenue and Expenditure*

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

Expenditure is recognised when the cost is incurred.

(b) *Fixed Assets*

Fixed Assets are stated at their historical cost less accumulated depreciation.

(c) *Depreciation*

Fixed assets are depreciated on a straight line basis over the useful life of the asset. The estimated useful life of each class of asset is as follows:

Furniture & Fittings	5 years	Office Equipment	5 years
Communications Equipment	4 years	Motor Vehicles	5 years
Computer Hardware	4 years	Computer Software	2 years

The cost of leasehold improvements is capitalised and depreciated over the unexpired period of thelease or the estimated remaining useful lives of the improvements, whichever is shorter.

(d) *Goods and Services Tax*

All items in the financial statements are exclusive of GST, with the exception of accounts receivable and accounts payable, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

(e) *Debtors*

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

(f) *Leases*
The Health and Disability Commissioner leases office premises. These costs are expensed in the period in which they are incurred.

(g) *Employee Entitlements*
Annual leave is recognised on an actual entitlement basis at current rates of pay.

(h) *Financial Instruments*
All financial instruments are recognised in the Statement of Financial Position at their fair value.

All revenue and expenditure in relation to financial instruments is recognised in the Statement of Financial Performance.

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

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

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

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

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

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

(k) *Budget Figures*
The budget figures are those approved by the Health and Disability Commissioner at the beginning of the financial year.

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

Statement of Changes in Accounting Policies

There has been no change in Accounting Policies. All policies have been applied on a basis consistent with the prior period.

Statement of Financial Performance

For the year ended 30 June 2002

Actual 00/01 $			Actual 01/02 $	Budget 01/02 $
	Revenue			
6,148,444	Operating Grant Received		6,148,444	6,148,444
318,717	Interest Received		171,853	151,371
35,137	Publications Revenue		44,439	30,000
6,502,298	TOTAL OPERATING REVENUE		6,364,736	6,329,815
	Less Expenses			
1,827,225	Advocacy Service Contracts		1,876,839	1,866,000
5,520	Audit Fees		9,000	6,000
	Fees paid to auditors			
0	for other services		7,250	0
0	Bad Debts Written Off		0	0
2,761,838	Staff Costs		3,075,239	3,184,650
303,404	Travel & Accommodation		205,821	223,858
181,670	Depreciation	**(Note 5)**	184,751	221,914
314,862	Occupancy		317,492	333,889
424,372	Communications		483,947	494,371
1,015,045	Operating Costs		778,259	658,254
6,833,936	TOTAL OPERATING EXPENSES		6,938,598	6,988,936
(331,638)	NET SURPLUS (LOSS)		(573,862)	(659,121)

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

Statement of Financial Position

As at 30 June 2002

Actual 00/01 $			Actual 01/02 $	Budget 01/02 $
	Crown Equity			
2,178,823	Accumulated Funds	**(Note 1)**	1,604,961	2,362,616
788,000	Capital Contributed		788,000	788,000
2,966,823	**TOTAL CROWN EQUITY**		**2,392,961**	**3,150,616**
	Represented by Current Assets			
47,821	Bank Account		34,507	50,000
2,800,000	Call Deposits		2,050,000	3,063,993
0	Prepayments		0	0
70,479	Sundry Debtors		42,114	2,000
0	GST Receivable		0	0
2,918,300	**Total Current Assets**		2,126,621	3,115,993
	Non Current Assets			
358,238	Fixed Assets	**(Note 3)**	751,483	406,094
358,238	**Total Non Current Assets**		751,483	406,094
3,276,538	**Total Assets**		2,878,104	3,522,087
	Current Liabilities			
42,325	GST Payable		8,093	51,057
267,390	Sundry Creditors	**(Note 2)**	477,050	320,414
309,715	**Total Liabilities**		485,143	371,471
2,966,823	**NET ASSETS**		**2,392,961**	**3,150,616**

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

Statement of Movements in Equity

For the year ended 30 June 2002

Actual 00/01 $		Actual 01/02 $	Budget 01/02 $
3,298,461	Opening Equity 1 July 2001	2,966,823	2,966,823
(331,638)	Plus Net Surplus (Loss) (Total Recognised Revenues and Expenses)	(573,862)	(659,121)
2,966,823	Closing Equity 30 June 2002	**2,392,961**	**2,307,702**

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

Statement of Cash Flow

For the year ended 30 June 2002

Actual 00/01 $			Actual 01/02 $	Budget 01/02 $
	Cash Flow from Operating Activities			
	Cash was provided from:			
6,148,444	Operating Grant		6,148,444	6,148,444
251,915	Interest on Short Term Deposits		202,282	193,067
31,460	Publications Revenue		42,604	30,000
6,431,819			6,393,330	6,371,511
	Cash was applied to:			
(6,712,175)	Payments to Suppliers and Employees		(6,672,133)	(6,298,179)
(6,712,175)			(6,672,133)	(6,298,179)
(280,356)	**Net Cash Flow from Operating Activities**	**(Note 4)**	**(278,803)**	**73,332**
	Cash Flows from Financing Activities			
	Cash was provided from:			
0	Capital Contribution		0	0
0	**Net Cash Flow from Financing Activities**		**0**	**0**

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

Statement of Cash Flow

For the year ended 30 June 2002 — continued

Actual 00/01 $		Actual 01/02 $	Budget 01/02 $
	Cash Flow from Investing Activities		
	Cash was provided from:		
514	Sale of Fixed Assets	0	0
	Cash was applied to:		
(187,108)	Purchase of Fixed Assets	(484,511)	(274,110)
(186,594)	**Net Cash Flow from Investing Activities**	**(484,511)**	**(274,110)**
	NET INCREASE/(DECREASE)		
(466,950)	**IN CASH**	**(763,314)**	**(200,778)**
3,314,771	Cash brought forward	2,847,821	2,847,821
2,847,821	Closing Cash carried forward	**2,084,507**	**2,647,043**
	Cash Balances in the Statement of Financial Position		
47,821	Bank Account	34,507	50,000
2,800,000	Call Deposits	2,050,000	2,597,043
2,847,821		**2,084,507**	**2,647,043**

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

Notes to the Financial Statements

For the year ended 30 June 2002

Actual 00/01 $	Note		Actual 01/02 $
	1	***Accumulated Funds***	
2,510,461		Opening balance	2,178,823
(331,638)		Net Surplus (Loss)	(573,862)
2,178,823		**Closing balance**	**1,604,961**
	2	***Sundry Creditors***	
139,451		Trade Creditors and Accruals	309,086
59,739		PAYE	63,758
68,200		Annual Leave	104,206
267,390			**477,050**

3 ***Fixed Assets***

01/02	*Cost* $	*Accum Depn* $	*Net Book Value* $
Computer Hardware	681,867	466,123	215,744
Computer Software	312,238	254,419	57,819
Communications Equipment	26,723	26,723	0
Furniture & Fittings	178,593	148,417	30,176
Leasehold Improvements	472,255	81,293	390,962
Motor Vehicles	42,280	42,280	0
Office Equipment	113,960	57,178	56,782
Total Fixed Assets	**1,827,916**	**1,076,433**	**751,483**

Notes to the Financial Statements

For the year ended 30 June 2002 — continued

Note

00/01	*Cost* $	*Accum Depn* $	*Net Book Value* $
Computer Hardware	560,157	402,876	157,281
Computer Software	234,135	221,893	12,242
Communications Equipment	28,408	28,408	0
Furniture & Fittings	167,480	135,596	31,884
Leasehold Improvements	281,706	180,166	101,540
Motor Vehicles	42,280	42,280	0
Office Equipment	101,385	46,094	55,291
Total Fixed Assets	**1,415,551**	**1,057,313**	**358,238**

4 *Reconciliation between Net Cash Flow from Operating Activities and Net Surplus*

Actual 00/01 $			**Actual 01/02 $**
(331,638)	Net Surplus		(573,862)
	Add Non-cash items		
181,670	Depreciation		184,751
	Movements in Working Capital Items		
(64,988)	Increase/(Decrease) in Sundry Creditors	85,930	
2,688	Increase/(Decrease) in GST Payable	(34,232)	
(1,130)	(Increase)/Decrease in Trade Debtors	(2,063)	
0	(Increase)/Decrease in Prepayments	0	
(66,802)	(Increase)/Decrease in Interest Receivable	30,429	
(130,232)			80,064
(156)	Net profit on disposal of assets		30,244
(280,356)	Net Cash Flow From Operating Activities		**(278,803)**

Notes to the Financial Statements

For the year ended 30 June 2002 — continued

Note

5 *Depreciation*

		01/02
61,225	Computer Hardware	81,370
32,818	Computer Software	32,526
16	Communications Equipment	0
24,029	Furniture & Fittings	12,820
47,808	Leasehold Improvements	40,106
0	Motor Vehicles	0
15,774	Office Equipment	17,929
181,670		184,751

6 *Commitments*

(a) Advocacy Service Contracts:

The three performance based contracts which commenced on 1 July 1999 for a period of 24 months were extended for a further 12 months. The maximum commitment for the 12 months from 1 July 2002 is $1,951,000.

(b) Leases on Premises including leasehold improvements:

Auckland $255,156 per annum until March 2008
Wellington $ 63,333 per annum until March 2006

(c) Rental Agreements:

Telecommunications equipment
$42,630 per annum until January 2004

Notes to the Financial Statements

For the year ended 30 June 2002 — continued

Note

(d) Classification of Commitments

Actual 00/01 $		Actual 01/02 $
2,178,618	Less than one year	2,153,330
126,730	One to two years	327,669
233,868	Two to five years	1,084,338
0	Over five years	0
2,539,216		**3,565,337**

7 ***Contingent Liabilities***

As at 30 June 2002 there were no contingent liabilities (00/01 Nil).

8 ***Financial Instruments***

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

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

Credit Risk

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

Notes to the Financial Statements

For the year ended 30 June 2002 — continued

Note

Maximim exposures to credit risk at balance date are:

Actual 00/01 $		Actual 01/02 $
2,847,821	Bank Balances	2,084,507
70,479	Sundry Debtors	42,114
2,918,300		**2,126,621**

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

Fair Value

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

Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument will fluctuate owing to changes in market interest rates. The average interest rate on the Health and Disability Commissioner's investments is 6.0%.

9 *Related Party*

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

There were no other related party transactions.

Notes to the Financial Statements

For the year ended 30 June 2002 — continued

Note

10 *Exceptional Item*

The Auckland Office of the Commissioner relocated to new premises on completion of its lease. It is now co-located with the Auckland Office of the Human Rights Commission.

11 *Employee Remuneration*

Total remuneration and benefits	*Number of Employees*	
$000	*00/01*	*01/02*
100–110	1	2
120–130	–	–
160–170	1	–
170–180	–	1

The Commissioner's remuneration and allowances are determined by the Higher Salaries Commission in accordance with the Higher Salaries Commission Act 1977. The Commissioner's remuneration and benefits are in the $170,000 to $180,000 band.

Statement of Service Performance

Key Result Area 1: Education

Objective: *Educate health and disability services consumers, providers, professional bodies and purchasers about the provisions of the Code of Health and Disability Services Consumers' Rights and Advocacy Services.*

Expected Performance and Standards	Target	Actual
General Education		
1.1 Convey to the public units of educational resource in a range of appropriate languages with all requests for resources dispatched within 5 working days of receipt.	100,000 units.	278,631 units.
1.2 Develop multimedia resources describing how HDC handles complaints and enquiries covering advocacy, investigations, mediation and proceedings.	Proof copy distributed to sample audience of providers and consumers. Feedback used to refine final version for publication by 30 April 2002.	New provider and consumer guides, and new guides for complainants and providers under investigation developed for distribution in July 2002 and publication on HDC website.
1.2.1 Develop, print and distribute an HDC users guide.	Publish by 30 June 2002.	Target achieved.
1.2.2 Publish guide on HDC website.	Publish by 30 June 2002.	Ready for publishing.
1.3 Improve usefulness of website.	Improve usefulness and organisation of material on website by 30 June 2002.	Website reorganised and enhanced for launch in July 2002.
1.3.1 Improve organisation of material on website.		
1.3.2 Provide access to statistics on enquiries and complaints on the website.	Access to statistical data to be available by 30 June 2002.	Target achieved.
Targeted Education: Providers		
1.4 Develop, deliver and evaluate educational programmes for the following targeted groups of providers using HDC and ASO staff and/or contractors.	First pilot seminar for both DHB and non-DHB complaints staff to be delivered and evaluated by 30 June 2002.	Targets achieved. Pilot DHB seminar held at Counties Manukau DHB in June with evaluation of 82% satisfaction.

Expected Performance and Standards	Target	Actual
Target groups: • DHB and non-DHB complaints staff • iwi and regional Māori service providers based on the 12 current regions	First pilot seminar to selected iwi and regional Māori service providers to be delivered and evaluated by 30 June 2002. Not less than 60% satisfaction with content, delivery and effectiveness of presentations achieved in post-course evaluations by participants.	Pilot non-DHB seminar held for St John's in November. Informal evaluation only was undertaken; this was satisfactory. St John's later advised they intend to use this package again and add case studies from HDC website relevant to ambulance officers. Three iwi provider seminars completed in June, one each in Northland, Napier and Christchurch. Evaluations were 100%, 90% and 90% satisfaction respectively.
Targeted Education: Consumers 1.5 Develop, deliver and evaluate educational programmes for targeted groups of consumers using HDC and ASO staff and/or contractors. Target group: • People with disabilities.	Deliver 40 programmes by 30 June 2002. No less than 60% satisfaction with content, delivery and effectiveness of presentations achieved in post-course evaluations by participants.	38 programmes delivered with 100% satisfaction reported in survey.
Targeted Education: Government Agencies 1.6 Develop, deliver and evaluate educational programmes for targeted groups of government agencies that interface with HDC using HDC and ASO staff and/or contractors. Target groups: • ACC • Work and Income • Department of Corrections • Human Rights Commission	First pilot programme to be delivered to each group and evaluated by 30 June 2002. No less than 60% satisfaction with content, delivery and effectiveness of presentations achieved in post-course evaluations by participants.	ACC pilot programme held in June with 100% satisfaction reported. Work and Income pilot programme conducted in February. No formal evaluation undertaken but feedback positive. Department of Corrections programme undertaken by Advocacy. Human Rights Commission pilot programme conducted in June with 100% satisfaction reported.

Key Result Area 2: Advocacy

Objective: *Operation of a New Zealand-wide advocacy service from 1 July 2001 that assists health and disability consumers to resolve complaints about alleged breaches of the Code at the lowest appropriate level.*

Expected Performance and Standards	Target	Actual
2.1 During 2001/02 deliver a minimum of: • Enquiries closed — 6,848 • Complaints managed — 4,080 • Presentations to providers and consumers — 1,388 • Contacts with providers and consumers — 2,808	100% of volumes contracted to be delivered.	• Enquiries closed: 8,197 — 19% above annual target. • Complaints managed: 4,263 — 4% above annual target. • Presentations to providers and consumers: 1,754 — 26% above annual target. • Contacts with providers and consumers: 3,281 — 17% above annual target. • 2,574 (69%) of the 3,712 closed complaints for the year were partly resolved, resolved or resulted from consumers taking their own action after involvement with advocacy.
2.2 Deliver independent, high quality, consistent nationwide services to consumers and providers during 2001/02.	• 80% of a random sample of consumers will rank their satisfaction with advocacy services as satisfied to very satisfied.	• Achieved. 84% of consumers surveyed rated the quality of the advocacy service as good or very good.
	• 80% of a random sample of providers will rank advocacy presentations as having improved their knowledge of the Code and the services offered by advocacy.	• Not achieved. The entire provider survey process and presentation format has been changed and will be implemented in 2002/2003.
	• 60% of complaints will be resolved or partly resolved with advocacy.	• 1,802 (49%) of the 3,712 closed complaints year to date were partly resolved/resolved with advocacy. 1,016 (27%) of the 3,712 closed complaints resulted from consumers taking their own action after involvement with advocacy. Compilation of the outcomes "partly resolved/resolved with advocacy" and "consumer to take own action after involvement with advocacy" accounts for 2,818 (76%) of the 3,712 closed complaints.
	• An independent social audit will rank advocacy services as complying with the requirements of the Act against agreed criteria.	• The social audit, renamed the Enhancing Advocacy Review, was completed in June.

Key Result Area 3: Enquiries

Objective: *Provide information on the Health and Disability Commissioner Act, Code of Rights and Health and Disability Commissioner complaints resolution services to health and disability services consumers and providers who write to or telephone the Commissioner seeking information.*

Expected Performance and Standards	Target	Actual
3.1 To meet agreed throughput and quality targets for the year.	Estimated 3,500 enquiries handled in 2001/02.	Enquiries handled: 4,298 — 112% of target.
	160 formal responses to enquiries regarding the Act and Code.	184 formal responses — 115% of target.
	85% of enquiries closed within 48 hours.	94% of enquiries were closed.

Key Result Area 4: Investigations

Objective: *Assess and investigate complaints concerning breaches of the Code of Rights and provide mediation services as required.*

Expected Performance and Standards	Target	Actual
4.1 To meet agreed quantity standards.	1,552 new complaints processed in 2001/02.	1,211 new complaints were received 2001/02.
	60% of complaints closed within 6 months of receipt.	69% closed. Target achieved.
	75% of complaints closed within 12 months of receipt.	82% closed. Target achieved.
	85% of complaints closed within 18 months of receipt.	89% closed. Target achieved.
	95% of complaints closed within 2 years of receipt.	95% closed. Target achieved.
4.2 To ensure investigations are undertaken in a fair and timely manner using transparent, robust and consistent processes.	• Review and, as required, re-engineer investigation processes; test and implement re-engineered processes by 30 June 2002.	Achieved. Six-month pilot undertaken January to June 2002. New processes to be implemented from July 2002.

Expected Performance and Standards	Target	Actual
	• 80% of any random sample of complainants taken at any time in the year will rank their satisfaction with the fairness of the investigation process as satisfied to very satisfied.	• 42% of respondents were satisfied to very satisfied with the fairness of the investigation process.
	• 80% of any random sample of providers taken at any time in the year will rank their satisfaction with the fairness of the investigation process as satisfied to very satisfied.	• 67% of providers were satisfied to very satisfied with the fairness of the investigation process.

Key Result Area 5: Proceedings

Objective: *Initiate proceedings in accordance with the Health and Disability Commissioner Act.*

Expected Performance and Standards	Target	Actual
5.1 To decide in a timely manner whether to issue proceedings.	• 100% of files to be reviewed within 6 weeks of receipt of investigation file from Commissioner.	31 referrals (target based on consumer numbers). 21/31 reviewed within timeframe (68% of target). 4/31 as at 30 June remained to be reviewed but expected to be within timeframe. 6/31 outside timeframe (19%). 81% compliance.
Statistics from hereon are made on a provider basis. The 31 referrals since July 2001 have resulted in 44 DP files.	• Decision whether to issue proceedings to be made for 75% of files within 3 weeks of provider response, or within 3 weeks of final deadline given for provider response.	10/21 decisions made within timeframe (48%). This figure includes "No further action" taken on 4 files because of evidential insufficiency. 48% compliance.
Of the 44 DP files, decisions have been made on 21 files. Of remaining 23 DP files: 13/23 are presently in the section 49 process.	• Decision whether to issue proceedings to be made for 100% of files within 5 weeks of provider response, or within 5 weeks of final deadline given for provider response.	18/21 (86%) decisions made within timeframe. 3/21 (14%) decisions made outside timeframe. (Note: 2 of these files required further information to be sought following section 49 response received. In both cases the decision whether to issue proceedings was made within 1 week of receipt of that further information.) 86% compliance.

Expected Performance and Standards	Target	Actual
10/23 are new referrals awaiting commencement of section 49 process.	• 100% of disciplinary charges to be drafted and filed within 2 weeks of making decision to issue proceedings.	Decision was made to charge in disciplinary proceedings in 11/21 cases. 6/11 decisions drafted within 2 week timeframe (55%). Of 5 not within timeframe, legal and/or expert advice as to drafting of charge was sought on all 5 (which accounts for delay). 55% compliance.
5.2 To undertake proceedings in a fair manner.	• 80% of any random sample of consumers will rank their satisfaction with the process as satisfied to very satisfied.	Survey undertaken but did not provide reliable results.
	• 80% of any random sample of providers will rank their satisfaction with the process as satisfied to very satisfied.	Survey undertaken but did not provide reliable results.
5.3 Deliver professional, competent high quality proceedings.	Professional bodies/ disciplinary bodies will rank 80% of proceedings as high quality.	Formal consultation not undertaken; criteria for ranking required extensive consultation. Informal feedback from professional/ disciplinary bodies was very complimentary about quality of proceedings.

Key Result Area 6: Policy Advice

Objective: *Provide policy advice on matters related to the Code of Health and Disability Services Consumers' Rights and the Health and Disability Commissioner Act 1994.*

Expected Performance and Standards	Target	Actual
6.1 To maintain organisational capability to provide policy advice.	Provide submissions on key policy documents and proposed legislation affecting the rights of health and disability services providers.	Target achieved.
	All policy advice will meet deadline set for submission.	Target achieved.
6.2 High quality, relevant submissions.	Key stakeholders will report high quality, relevant submissions.	Target achieved. Respondents report high quality, relevant submissions, received by deadline set.

Key Result Area 7: Organisational Capability

Objective: *Develop and improve the organisation's capability to perform its mission, and in particular in the areas of human resources, information technology and finance.*

Expected Performance and Standards	Target	Actual
Human Resources		
7.1 Establish HDC as an "employer of choice" by instituting changes to present HR policies and practices based upon:		
7.1.1 Job evaluations and salary surveys for remuneration.	Initial job evaluations to be completed by 31 August 2001.	Job evaluations of all positions completed in June 2001.
7.1.2 Employee opinion surveys on organisational culture and conditions of employment.	Deferred until 2002/2003.	
7.1.3 Review and update present HR Manual.	Initial major update to be completed by 31 October 2001.	Major revision of HR Manual completed in June 2002.
7.2 Māori		
7.2.1 HDC and advocacy policies, processes and practices are consistent with the needs, values and beliefs of Māori.	80% of random survey of Māori participating in advocacy, investigations and proceedings report satisfaction with the way their needs, values and beliefs as Māori were met.	Survey completed but did not achieve adequate response rate.
7.2.2 All HDC staff and advocates receive training in the needs, values and beliefs of Māori.	Annual Performance Appraisals confirm that training has been received by 30 June 2002.	Target achieved — HDC staff and advocates received training in the needs, values and beliefs of Māori.
7.3 Provide continuing education for HDC staff on the HDC Act and Code and key concepts of health care law and ethics in New Zealand.	6 forums delivered by 30 June 2002.	Target achieved — 8 forums delivered.
7.4 Provide continuing education for ASO staff on the HDC Act, the Code and key concepts of health care law and ethics in New Zealand.	6 forums delivered by 30 June 2002.	Target achieved — 6 forums delivered.

Expected Performance and Standards	Target	Actual
Information Technology		
7.5 Implement IT infrastructure upgrade in line with HDC ISSP (Information Systems Strategic Plan).	To be implemented by 30 June 2002.	Target achieved. Computer Use policy implemented, external email and range of other infrastructure improvements introduced.
Finance		
7.6 Complete development of systems and documentation recommended in the 1999/ 2000 Audit Report.	To be completed by 31 December 2001.	Target achieved.
7.7 Complete any development of systems and documentation that might be recommended in the 2000/ 2001 Audit Report.	To be completed by 30 June 2002.	Target achieved.
7.8 Manage the HDC Budget as set out in the Letter of Arrangement.	All deliverables of the Statement of Service Performance will be in accordance with that document and achieved within the assigned budget.	Target achieved.