HEALTH AND DISABILITY COMMISSIONER

Te Toihau Hauora, Hauātanga

ANNUAL REPORT

for the year ended 30 June 2003

Health and Disability Commissioner
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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

14 October 2003

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 2003.

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 third year as Health and Disability Commissioner and discusses the following key features of the 2002/03 year:

- Learning from complaints
- Decline in medical discipline
- Continued progress in clearing the backlog
- Southland Mental Health Services Inquiry Report
- Open disclosure of adverse events
- HDC Consumer Advisory Group

Learning from Complaints

Consumer feedback and complaints about health care and disability services provide important information about the quality of care. Yet such information is not generally utilised by services in the same way as staff-reported incidents and other quality improvement strategies to generate change and improvement. Statutory complaint agencies have tended to investigate and resolve complaints with a primary focus on the issues for individual complainants. Investigations have focused on the minutiae of events and the local environment, with scrutiny of the judgement, skill and care of the providers involved. The outcomes of complaint investigation and resolution are not always translated into broader lessons for the community and the health and disability sector. The voice of consumers has not been used effectively to improve health and disability services. Yet consumers offer a unique perspective on the quality of care, and information from complaints and investigations needs to be considered alongside information from incident reports and other quality and safety reporting mechanisms.

As Commissioner, I have emphasised HDC's dual focus on complaints resolution and education. Prior to closure of a file, a check is made to ensure that any lessons learned from the individual case are being used to inform relevant parts of the health and disability sector. This is achieved by sending the relevant College or professional group, major employers (such as District Health Boards), and consumer groups anonymised copies of key decisions. Significant opinions and case notes are placed on the HDC website, www.hdc.org.nz/opinions. Although there is no clear evidence of the overall impact of dissemination of Commissioner findings, complaint investigations are increasingly being used as an "informer" for quality improvement, and to underpin systemic support and advocacy for consumers.

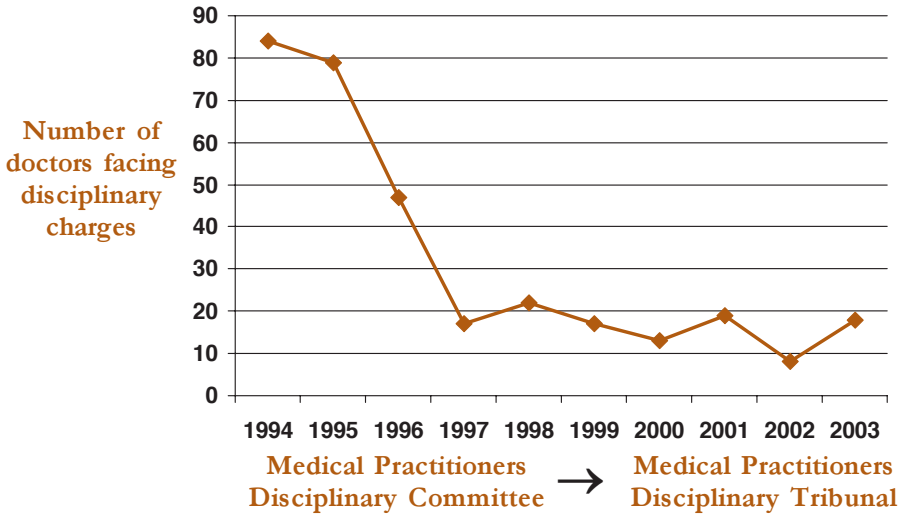
The recent publication by the Royal New Zealand College of General Practitioners of guidelines on "Managing Patient Test Results: Minimising Error" (2003) is a good example of learning from complaints. In light of HDC investigations that highlighted a failure by GPs to

follow up patient test results adequately (99HDC11494 and 00HDC07636), I drew attention to the topic in educational columns for *NZGP* (April 2001 and April 2002). This led to extensive discussion amongst GPs, and to consultation and debate led by the College. HDC contributed to the development of the guidelines that are currently being piloted. It is hoped that the result will be a clearer understanding of the extent of a GP's duty of care, and better follow-up for patients.

Decline in Medical Discipline

The myth that New Zealand doctors face one of the worst medico-legal/disciplinary environments in the world continues to be perpetuated by some medical and legal practitioners. In seeking improvements to the current system for compensating injured patients and handling complaints, we need evidence-based medico-legal policy and law. The evidence gives the lie to the dire claims.

The dramatic decline in medical discipline in New Zealand is highlighted by the chart below. The introduction of the Code of Health and Disability Services Consumers' Rights (the Code) and the Health and Disability Commissioner complaints system in 1996, combined with the implementation of competence reviews by the Medical Council, have resulted in a four-fold reduction in the number of medical practitioners facing disciplinary proceedings. The New Zealand system emphasises rehabilitation of practitioners, rather than punishment, and is consistent with modern understanding of the nature of error and the importance of a culture of learning to improve patient safety.



Continued Progress in Clearing the Backlog

HDC has increased its productivity and dramatically reduced the backlog of open files over the past three years, in the face of a steady volume of complaints. We ended the year with the lowest ever tally of open files (367 at 30 June 2003, compared with 564 at 30 June 2002), a 35% reduction in 12 months. Current investigation files have decreased from 364 to 174. In total a record 1,338 complaints were resolved.

Good progress was also made in improving the quality and timeliness of investigations. The challenge for the year ahead is to complete the majority of investigations within 12 months.

There is an ongoing tension between timeliness and fairness — in complex investigations multiple providers and legal processes can significantly delay completion. Overall, however, HDC's caseload figures compare very favourably with comparable jurisdictions in Australia.

There has been a gradual increase in the proportion of cases that result in a breach finding: from 24% (in 2000/01), to 27% (in 2001/02), to 33% (in 2002/03). This should not be interpreted as evidence of poorer quality care, but as a natural consequence of greater use of advocacy and other "low-level" resolution strategies, reserving investigations for cases where the allegations warrant investigation. The proportion of breach findings that are referred to the Director of Proceedings continues to fluctuate, with a decrease to 24% of breach reports in 2002/03 (compared to 31% the previous year).

Southland Mental Health Services Inquiry Report

A notable feature of the year was the release of the Southland District Health Board Mental Health Services Inquiry Report in October 2002. The report was the culmination of an extensive investigation over the previous 12 months, ably led by Assistant Commissioner Katharine Greig.

The report examined the care of Mark Burton, who was admitted to Southland Hospital's inpatient mental health unit on 10 February 2001 suffering from paranoid delusions. Mark Burton killed his mother on 31 March 2001, the day after being discharged from the inpatient unit. He was later found not guilty of murder by reason of insanity.

The report acknowledged the staffing shortages faced by a small geographically isolated mental health service, but concluded that these problems did not excuse the poor standard of care provided to Mark Burton. There were inadequate monitoring and control mechanisms to ensure that staff practised safely, that incident and risk management strategies were in place, and that policies and procedures were followed. Contact and co-ordination with Mark Burton's family was patchy and substandard, and discharge planning was scanty, ineffective and poorly co-ordinated. Possible indicators of persisting psychotic persecutory delusions were not explored or taken into account in a more cautious approach to treatment, and there was no comprehensive risk assessment before Mark Burton left the unit.

The Southland District Health Board and several individual providers were found to have breached the Code of Consumers' Rights. The case was referred to the Director of Proceedings, and disciplinary proceedings and Human Rights Review Tribunal proceedings are pending.

The report made wide-ranging recommendations to address individual and systems problems in the Southland mental health services. Good progress has been made in implementing the recommendations, and Southland's mental health services were recently accredited by Quality Health New Zealand.

Open Disclosure of Adverse Events

A promising development in the past year has been the move by Waitemata District Health Board to publish data on mistakes and near misses. This step is consistent with increasing recognition internationally of the need for open disclosure by hospitals (and clinical staff) of adverse events. The *Kennedy Inquiry* into Bristol Royal Infirmary Hospital in the United Kingdom (2001) referred to the "duty of candour" owed by health professionals, which is recognised in New Zealand by the patient's right to receive the information that a reasonable patient who has suffered an adverse event would expect to receive (Right 6(1) of the Code).

Published research by Radio New Zealand journalist Rae Lamb (*Health Affairs*, 2003) indicates that US hospital managers are reluctant to disclose adverse events (despite new safety standards mandating disclosure) for fear of malpractice lawsuits. The Accident Compensation system (which effectively bars medical negligence claims) should make open disclosure easier in New Zealand, and the experience of Waitemata District Health Board — with adverse events reported by the media in a responsible way — is an encouraging sign that valuable quality information can be made public without fear of recriminations. Canterbury District Health Board has begun reporting medication errors publicly, and it is hoped that other Health Boards will take up this initiative. New Zealand patients currently know more about comparative debt levels than quality in our public hospitals, and the time is right for much greater sharing of information.

HDC Consumer Advisory Group

In June 2003 an HDC Consumer Advisory Group was formed. The role of the group is to provide timely advice and feedback to the Commissioner on strategic issues, including:

- handling of consumer complaints about health and disability services
- how to improve the quality of health and disability services
- public interest issues where the Health and Disability Commissioner can take a lead
- policy issues raised by the Commissioner
- promotion and education.

The group meets three times a year. Members are: Barbara Robson, Chairperson of the Feilding and Districts Community Health Group for nearly eight years, with a strong record of advocacy for consumers and the community in both the health and disability sectors; Huhana Hickey (Waikato Iwi, ko Ngatitahinga hapu), National Māori Advisor for DPA (NZ) Inc, and the mother of a son with disabilities; Ana Sokratov (nō Ngāpuhi: Te Rarawa me Te Aupōuri), Consumer Consultant for Waitemata DHB Mental Health Services Group, with a background in rights-based law and health and disability advocacy; Beverley Osborn, a Methodist presbyter with a background in hospital and home-based health social work, and a close association with people in a number of the smaller communities of New Zealand; John Robinson, the National Manager of CanTeen, the New Zealand Teenage Cancer Patients Society; Judi Strid, a consumer advocate with particular interests in women's and children's health, and in increasing opportunities for consumer representation, participation and involvement; and Evan McKenzie, a disabled war veteran who for over 30 years has been committed to pursuing improved rights and entitlements for the intellectually disabled, Vietnam veterans and their families, and people who are seriously disabled through personal injury.

Acknowledgements

The year marked the departure of former Senior Investigator (Projects) Nicola Holmes, who ably led HDC through a major change project to redesign enquiries and complaints resolution processes.

Finally, I wish to record my thanks to all the staff at HDC, to our kaumātua, Te Ao Pehi Kara, and to everyone involved in advocacy services in New Zealand, for their dedication and support of our work in 2002/03.

Report of the Director of Advocacy

Director of Advocacy, Tania Thomas

E ngā mata-ā-waka o te motu, tēnā koutou katoa.
All groups throughout the land, greetings to you all.

Introduction

I would like to thank all the advocates, their managers and their Trusts for the positive and proactive approach they have taken in embracing the new direction for advocacy implemented in the middle of last year. An independent review carried out in November 2002 included focus group meetings with consumers and providers from around the country. The findings confirmed that advocacy services are heading in the right direction, with the aim of increasing the percentage of complaints resolved with advocacy.

Common themes were raised by both consumers and providers during the focus group meetings:

- Both value a relationship based on understanding, respect, and trust.
- Both groups appreciate a high degree of clarity regarding the complainant's issues and desired outcome prior to an interaction or meeting between the two parties.
- Both groups value the quality of the preparation the advocate provides prior to meeting.
- Both groups value the quality of listening and empathy displayed by advocates, and their ability to manage the emotional content of the complaint.
- Both respect a high level of professionalism and objectivity on the part of the advocate.
- Both appreciate input by the advocate at the meeting — subtle facilitation that keeps the complainant comfortable and ensures the discussion stays focused on achieving a resolution.
- Both would appreciate more follow-up after a meeting or interaction.
- Both want the advocate's attention to be focused on achieving a resolution.
- Both want the advocate to have a greater focus on ensuring that learning and change result from the interaction.
- Both see a need for specialist support for people with severe disabilities, and for additional support for the elderly.

The key goal of the advocacy complaints process is to achieve a resolution *for the consumer*. Within this process there are three key players: the complainant, the advocate, and the provider. The steps involved in achieving resolution include meeting with the provider or communicating in some form. Accordingly, for advocates to support the complainant and enable him or her to successfully negotiate this pathway, it is essential that they understand:

Case Study: Advocacy-assisted resolution of complaint against dentist

Mr A visited a dentist for treatment of a toothache. English is a second language for Mr A. He complained to HDC that the dentist did not tell him that the treatment included extraction of his bridge, which contained gold. The dentist threw away the bridge without telling Mr A. Further, the dentist did not provide him with adequate pain relief and he experienced extreme pain throughout the procedure. Mr A also complained that when he made a complaint about these matters he did not receive a clearly written response.

An advocate met with Mr A and arranged for an interpreter to assist with communication. The desired resolution sought was discussed, and also the actions Mr A was prepared to undertake. His preference was for a meeting with the dentist, and the advocate agreed to co-ordinate this and advise the provider of the details of the complaint and the resolution sought.

The advocate had a further meeting with Mr A to confirm arrangements and discuss strategies for the meeting. It was agreed that the advocate would note Mr A's issues on a whiteboard, then add the dentist's responses. The advocate would then summarise and confirm the responses accepted by Mr A.

At the meeting, the use of the whiteboard proved invaluable, and the notes clearly indicated that resolution had been achieved. This was confirmed by Mr A at the conclusion of the meeting. The dentist agreed to:

- reimburse the value of the gold contained in the bridge that was discarded;
- provide a verbal and written apology for the pain, discomfort and emotional effects of the treatment; and
- provide answers in writing to questions outlined in Mr A's letter of complaint to HDC.

Mr A was satisfied with the process and outcome of the complaint.

- the processes and systems under which providers operate, in particular how to work with the system to achieve a successful outcome;
- the basic processes of the health and disability services with which they interact, so they can manage the complaint resolution process and the complainant's expectations effectively; and
- the emotional impact of the complaint on the providers involved.

The key word is respect — respect for the providers and their systems, and recognition that achieving the best outcome for the consumer requires respect for, and working with rather than against, the people involved on the other side of the complaints process. This approach requires advocates to ensure they are on the side of the consumer, and are independent, and that by having a good understanding of provider systems and processes neither of these key roles is compromised.

The quality of the advocate's relationship with the provider can be a key to the quality, speed and efficiency with which the outcome is achieved. Key to building this relationship are understanding, trust, and respect. In response to the question "What most contributes to a good working relationship?", one provider stated: "Respect for each other and each other's roles, understanding the differences …" He then went on to explain: "[We're working] in a human system — the whole thing relies on the people and the relationships …"

The move towards improving the quality of the relationship between advocates and providers means advocacy practice needs to be constructively challenging as opposed to aggressively confrontational. Advocacy is a process that actively seeks change in providers' systems and/or practice. It supports providers to reflect on their response to the following questions:

- Have I been transparent in all my dealings with this consumer?
- How have I shown that I respect this consumer?
- How do I know I have communicated clearly?
- How have the consumer's ideas, skills and experiences been used in the decisions made in the management of this consultation/treatment/service?

- Have I heard the whole story?
- Have I considered the barriers that might be getting in the way of doing my job well?
- What have I done to include the consumer in the decision-making surrounding his or her issues?

At times, the transition by advocates to the new direction for advocacy services has been challenging, in particular the level of resources required and the length of lead-in time to complete the changes. However, despite this, advocates continued to work their way through the changes with professionalism and dedication to low-level resolution.

Highlights

- Presenting the New Zealand Health and Disability Services Consumer Advocacy model at the 4th National Health Complaints Conference in Canberra.
- Being invited to Hobart to present to the advocacy organisations contracted by the Commonwealth Aged Care Department.
- Spending time with the Mongolian Human Rights Commissioner while he was visiting New Zealand.
- Developing and successfully piloting a programme for raising awareness amongst providers who work with deaf consumers. The programme focuses on assisting providers to understand the practices required to ensure compliance with the Code of Rights when working with deaf people.
- Completion by Moe Milne of training of Māori advocates in the delivery of Māori provider and consumer education programmes about the Code of Rights, how it applies to Māori, and how Māori can best exercise their rights.

Around the Regions

The Health Advocates Trust (HAT), Advocacy Network Service Trust (ADNET) and Advocacy Services South Island Trust (ASSIT) have been actively involved in a wide range of initiatives during the past contract year.

Te Tiriti o Waitangi

- The Kaitutaki Tangata advocate role at HAT has been extended into the Northland/ Taitokerau region. This role is dedicated to working with Māori who have issues in the health and disability sector.
- Advocates from all regions have participated in te reo and tikanga Māori lessons to improve their fluency in Māori and their ability to work appropriately with Māori.
- A Kaitutaki Tangata role has been established by ASSIT and will concentrate on promoting the Code of Rights and the role of the advocate to Māori in te reo Māori.

Networks

- HAT has entered into two agreements with Work and Income New Zealand (WINZ) to be part of the Heartlands Programme. The aim of the programme is to provide services to rural areas that lack governmental or other organisations. Advocates visit the areas quarterly. The dates and times are advertised by WINZ.
- HAT has had input into the following groups: Auckland University of Technology Ethical and Advisory Committee, the Nursing Advisory Group at Manukau Polytech, Waitemata District Health Board Adult Advisory Group, and the Auckland Disability Provider Network.

Areas Commonly Reported on by Advocates

- Lack of effective communication and adequate information remains the underlying issue in almost all standard of care complaints.
- There appears to be an increase in the number of providers who do not respond to complaints within the required time frames and, as a result, consumers are accessing advocacy services.
- ACC clients who contact the advocacy service about their assessments often complain that they have not been properly examined by the assessor, and that the outcome of the assessment has been predetermined.
- There is a noticeable increase in requests for brochures and pamphlets around September/October, when quality audits are undertaken in many provider organisations.
- Two of the advocacy service organisations report that there is a high level of co-operation with prison health services staff across their regions.

Raising the Profile of Advocacy

- The general advocacy brochure has been translated into Arabic, Farsi, Somali, Amharic, Khmer and Burmese. The translations can be accessed on www.hdc.org.nz/advocacy/translatedbrochures.
- 08002SUPPORT (0800 2 787 7678) is a free fax line dedicated to providing access for consumers who may need support to make a complaint under the Code of Health and Disability Services Consumers' Rights. The service has been promoted to organisations and associations that provide services to deaf and/or speech-impaired consumers.
- Articles about advocacy and the role of advocates have been published in *Mana*, *Without Limits*, *The Decision Maker*, and *New Dialogue*.
- The educational presentation materials used by advocates have been updated to meet the needs of people who require an "easy read" format (eg, youth and the general public).

Advocate Development

- A national, three-day training conference was held in Wellington and was opened by the Minister for Disability Issues, Ruth Dyson. Topics covered included establishing networks; developing networks; interactive presentation techniques; strengths-based practice in complaints resolution; working with diversity; and working with Māori.
- Regional training has covered topics such as: stress management; the Coroners Act; the Protection of Personal and Property Rights Act; the Human Rights Act; the Privacy Act; the Treaty of Waitangi; peer supervision; addictive behaviours; advocates as facilitators; Māori cultural competency assessment; and resolution procedures.
- Three HAT advocates are completing tertiary studies and another six advocates are enrolled in the Certificate in Human Services.

From left: Stacy Wilson (ADNET manager), Tania Thomas (Director of Advocacy), Maria Marama (HAT manager), Ruth Dyson (Minister for Disability Issues), and Tony Daly (ASSIT manager), at the national training conference

Satisfaction Survey and Presentation/ Education Evaluation Results

Based on the feedback from consumers, providers and advocates, the consumer and provider satisfaction surveys were revised and implemented during 2002/03. The consumer and provider surveys used a rating scale from 1 to 7. Respondents were asked to select the rating that best fitted their view of the service provided by the advocate. The respondent could select a rating along a continuum from 1 (not at all) to 4 (to some extent) to 7 (to a very great extent).

A new survey was implemented for advocates. It identified issues and ideas for advocacy service managers and their Trusts to ensure advocates are supported in practising empowerment advocacy and in improving and developing their practice. This survey used the same rating scale as the revised consumer and provider surveys.

A presentation/education evaluation was used to identify improvements needed in the delivery and content of presentation and education sessions to providers and consumers.

Consumer Survey

Table 1 below outlines the average for each question, for the combined advocacy service organisations. The higher the percentage, the closer the rating is to a "7", ie, the more positive the respondent's view of the service provided by the advocate. Anything under "5" or 70% is viewed as needing improvement.

Consumers rated the advocacy process and advocate skill highly. Consumers felt that they could only move on to some extent, and they did not feel overly confident in being able to sort out a similar issue on their own without the assistance of an advocate.

Table 1: Consumer Survey

Questions Asked	Rating	%
Advocacy Process		
After you first spoke to an advocate, did you feel at ease?	5.8	83
Did the advocate explain his/her role to you?	5.8	83
Did the advocate help you get clear on your issues?	5.8	83
Were you given the help you needed during the process?	6.0	86
If you met with a provider, did the advocate support you when you most needed it?	5.5	79
Were your calls responded to promptly?	5.8	83
Advocate Skill		
Did you feel listened to?	6.3	90
Did you feel the advocate was on your side during the process?	6.1	87
Did you feel encouraged by the advocate?	5.7	81
Did the advocate understand your problems?	6.1	87
Resolution		
Do you feel that the best that could be done has been done?	5.0	71
Are you now able to move on?	4.8	69
If you were faced with a similar problem, could you sort it out by yourself?	3.9	56

Provider Survey

Table 2 below outlines the average for each question, for the combined advocacy service organisations. The higher the percentage, the closer the rating is to a "7", meaning that the respondent's view of the service provided by the advocate was positive. Anything under "5" or 70% is viewed as needing improvement.

Providers rated the advocates' approach and professionalism highly. Providers also rated highly their willingness to work again with an advocate in the future. However, there is room for improvement. Issues for advocates to address include managing consumer expectations, preparation to ensure resolution has a high chance of succeeding, and improving providers' ability and willingness to make changes to their processes, systems and practices following the resolution of complaints.

Table 2: Provider Survey

Questions Asked	Rating	%
Approach of the Advocates		
Did the advocate understand and respect your organisation's complaints system?	5.4	77
Do you have a positive relationship with the advocate?	5.8	83
Professionalism of the Advocate		
In your view, was the advocate able to take the part of the consumer *and* maintain an open and balanced view of the case?	5.3	76
Did the advocate maintain clear, professional boundaries throughout the case? (ie, not get emotionally involved in the case)	5.5	79
Did the advocate demonstrate respect towards all those involved in the case?	5.6	80
Did the advocate return your calls promptly?	5.3	76
Resolution		
To what extent did the advocate's actions support you and your organisation to resolve the case?	5.0	71
Were the advocate's actions consistent with a timely resolution of the case?	5.2	74
Did you have clarity regarding the consumer's issues prior to meeting with him/her or responding to his/her case?	4.4	63
Were the actions the consumer wanted you to take to resolve the case communicated to you prior to meeting with or responding to him/her?	4.2	60
If you met with the consumer, did the advocate allow him/her to lead the meeting, yet quietly facilitate a resolution of the case?	4.8	69
In your view, were the client's expectations realistic regarding what could be done to achieve a resolution?	4.2	60
Following a meeting or response, were you advised whether the case had been resolved satisfactorily and, if not, what the next steps would be?	4.9	70
In the Future		
How happy and willing are you to work with one of our advocates in the future?	6.0	86

Report of the Director of Proceedings

Director of Proceedings, Morag McDowell

Introduction

Once again it has been a busy and productive year for the Proceedings team. Although there were fewer hearings and Commissioner referrals than last year, the referrals involved more providers (62 as opposed to 44), resulting in a record number of working files for Proceedings. There have also been a number of high-profile cases, both referred to, and prosecuted/undertaken by, the Proceedings team over the past year.

The statistics for referrals, decision-making, and disciplinary hearings are outlined below.

Statistics

This year there were 30 referrals from the Commissioner, resulting in 62 Director of Proceedings files. An analysis of action taken in respect of those referrals is contained in Table 1 below.

Table 1: Action taken in respect of referrals to Director of Proceedings in 2002/2003

	No of Cases		No of Cases
Case concluded		**Hearings pending**	
Pharmacist (successful prosecution)	1	*Human Rights Review Tribunal*	
Hearings pending		Social worker	1
		Nurse	1
Discipline		Alcohol and drug counsellor	1
Medical practitioners		Rest home provider	1
Surgeons (orthopaedic/general)	2	**No further action**	
Obstetrician/gynaecologists	2	Corporate providers	5
Psychiatrist	1	Medical practitioners	
MOSS (psychiatry)	1	General practitioners	2
General practitioners	2	Anaesthetist	1
Nurses		Surgeon	1
Psychiatric	1	Ophthalmologist	1
Midwives	2	Pharmacists/Pharmacy	3
Aged care	2	Alcohol and drug counsellor	1
Dentist	1	Nurses	5
Chiropractor	1	**s 49 decision not yet made**	22
Pharmacist	1		
TOTAL			**62**

Eleven disciplinary cases were heard to completion within the year, including the first DP prosecution of a psychologist before the Psychologists Board. There was also one Human Rights Review Tribunal (HRRT) hearing (although two further claims settled prior to hearing). See Table 2 below for further details.

There were five appeals. Two were brought by the Director as appellant; in the others, the Director was respondent. One went to the Court of Appeal for consideration of the question whether the stillbirth of a baby (resulting from alleged deficiencies in medical care) amounted to personal injury to the mother, thereby entitling her to an ACC claim and precluding the claim of compensatory damages before the HRRT.[1] In that case the Court determined that the stillbirth did amount to personal injury and, accordingly, the Director cannot now pursue the claim for compensatory damages on the mother's behalf.

Table 2: Outcome of hearings

Provider	Successful	Unsuccessful	Outcome pending	Total
Discipline				
Psychologist	1			1
Nurses	2	1		3
Medical practitioners				
Radiologist		1		
Surgeon	1			
General practitioner (2 complainants)	1			3
Dentists	3			3
Pharmacist	1			1
HRRT				
Unregistered counsellors	2 (settled)			2
Acupuncturist			1	1
TOTAL	**11**	**2**	**1**	**14**

Tribunal Survey

A survey of Tribunals before which Proceedings are commenced was undertaken, seeking comment on a number of areas, including quality of charges/pleadings, submissions, preparation and presentation on interlocutory (pre-hearing) matters and substantive proceedings, and general responsiveness and professionalism of the Director's Office. It has been heartening to receive the results, which have been excellent, with the clear message that the Proceedings team is fully meeting, if not exceeding, expectations in all areas.

Any criticism has centred on the time it takes for charges/claims to be laid before the various Tribunals. This is largely due to the older files emerging from the Commissioner's Office as a result of the clearance of the backlog inherited by the present Commissioner. The requirement under the law to give providers a further opportunity to be heard (in relation to whether proceedings should be issued or not) also significantly contributes to the delay, as does the need to comply with discovery processes (where documents on the file are required to be disclosed to the provider).[2]

1 *Harrild v DP* (CA92/02) 25 June 2003.
2 Section 49 of the Health and Disability Commissioner Act 1994, which grants providers the opportunity to be heard prior to the Director making his/her decision, will be repealed when the Health and Disability Commissioner Amendment Act 2003 comes into force in September 2004.

Notwithstanding the realities and process issues outlined, I am conscious of the need to avoid delays so far as possible and will continue to endeavour to do so.

Director of Proceedings team (from left): Theo Baker (Legal Counsel), Morag McDowell (Director of Proceedings), Jean Bayley (Personal Assistant), Jason Tamm (Assistant Legal Counsel)

Topical Issues — Name Suppression

One of the most topical and difficult issues faced in recent times has been interim name suppression, particularly in relation to medical practitioners. In determining whether it is "desirable"[3] to suppress a doctor's name, the Tribunal is required to balance competing public and privacy interests. It is my view that the Director should represent the public interest in such applications.

The public interest resides in open, transparent proceedings and freedom of speech. There may also be specific public interest factors such as the need to publish the practitioner's name to avoid suspicion falling on others, or to protect the public against repeat offending.

Privacy interests usually put forward by the practitioner in support of a suppression application can include the adverse effect that publication could have on his/her reputation, practice and patients, and family members. A further factor for consideration is the presumption of innocence and the possibility that a practitioner will suffer ongoing adverse consequences from name publication, even if later found "not guilty" of the charge.

Case Study: *DP v Gorringe*

A significant case undertaken by the Director in 2002/03 related to Dr Richard Gorringe, a general practitioner who practises complementary medicine. Dr Gorringe was charged in relation to his care and treatment of two complainants. There were two charges alleging professional misconduct in relation to his undue reliance on an alternative diagnostic tool — Peak Muscle Resistance Testing (PMRT) — to the exclusion of adequate medical assessment and tests. The patients were diagnosed with unorthodox diagnoses (for example, paraquat poisoning, intra-cellular brucellosis, cytomegalo-virus toxin and electro-magnetic radiation sensitivity). Patient A actually had chronic eczema; Patient B was eventually diagnosed with fibromyalgia. These charges also covered informed consent issues and exploitation.

A third charge alleged disgraceful conduct in respect of Patient A, and Dr Gorringe's failure to provide her with appropriate treatment in the face of her clear clinical deterioration.

All charges and all particulars (excepting those laid alternatively) were upheld. The Tribunal determined that PMRT was not a plausible, reliable or scientific technique for making medical decisions and that reliance on it to make diagnoses to the exclusion of conventional and/or generally recognised diagnostic/investigatory techniques was unacceptable and irresponsible.

The Tribunal also found that Dr Gorringe's persistence with Patient A's treatment regime despite its manifest lack of success was grossly irresponsible and unconscionable and amounted to disgraceful conduct.

Dr Gorringe was censured, struck off the medical register, and ordered to pay costs.

Case 02/89D may be viewed at www.mpdt.org.nz.

3 Medical Practitioners Act 1995, s 106.

In the Medical Practitioners Disciplinary Tribunal there is a noticeable trend for interim name suppression to be granted more often than not. In two recent appeals to the District Court interim name suppression was granted to the medical practitioners concerned. Moreover, a recent ruling by one member of the MPDT has suggested that the statute[4] should be interpreted to the effect that interim name suppression must be granted in all cases prior to the actual hearing of the charge. In my view, there is certainly room for further judicial consideration of these issues in the future.

Conclusion

In my past two reports I have commented on the expected (significant) workload for the upcoming year. This year is no exception. Already ten disciplinary hearings have been heard since 1 July 2003, and two District Court appeals. A further five hearings have been set down before Christmas, including the disciplinary hearings arising from the Commissioner's Inquiry into Southland District Health Board's Mental Health Services.

The team continues to have as its focus the delivery of high quality proceedings with minimal delays.

A further objective is to provide training and education to the Commissioner's investigation teams regarding evidential requirements and quality investigation tools/skills.

Finally, I would like to convey a public thank you to my hardworking team (Theo, Jean, Jason, and Val), who have worked above and beyond the call of duty to deliver the excellent results outlined in this report.

Case Study: Dudley Stace — unregistered counsellor

The Human Rights Review Tribunal is a useful forum for setting standards for unregistered health professionals. The Tribunal may issue a declaration that the conduct complained of amounted to a breach of the Code of Consumers' Rights and make an order restraining the conduct.

In this case, proceedings were issued against Mr Stace, a drug and alcohol counsellor, for engaging in a sexual relationship with a current client, failing to provide adequate and appropriate treatment for his client, and failing to refer her to a specialised sexual abuse counsellor. These proceedings were settled with the payment of damages for pecuniary loss, exemplary damages, a declaration, and a restraining order.

Between July 1996 and August 1998 Mr Stace counselled the client on a one-to-one basis. The client had sexual abuse and alcohol issues. A sexual relationship commenced in February 1997 and continued until the therapeutic relationship was terminated in 1998. During that period the client paid a total of $7,000 for counselling sessions, which were occasionally conducted at her home. In addition to the sexual relationship Mr Stace failed to keep notes of the sessions, did not plan a course of treatment for the client, and did not apply appropriate therapeutic methods. Nor did he have any expertise in the treatment of sexual abuse, and he failed to refer the client to an appropriately qualified counsellor.

4 Medical Practitioners Act 1995, s 106.

Enquiries and Complaints Resolution

Assistant Commissioner, Katharine Greig

Enquiries and complaints resolution comprises three teams: an enquiries team based in Auckland 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.

2002/03 was a successful year for the enquiries and investigation teams. Our target for 30 June 2003 was 400 open complaint files. We came in well under target at 367 open files. We resolved more complaints at an early stage and finished the year with only 174 matters under investigation — compared with 505 three years ago.

Enquiries Team

2002/03 was an extremely busy and productive year for the enquiries team, which is led by Annette May. The enquiries team deals with both enquiries[1] and initial handling of complaints.[2] Its work in both areas expanded over the last year. There was a significant increase in the number of telephone enquiries handled and, in line with the Office's focus on resolving complaints at the lowest appropriate level, the enquiries team was responsible for 904 of the 1,338 complaint file closures in 2002/03.

At the start of the year the enquiries team comprised four full-time staff — the team leader and three enquiries officers. To recognise the increasing workload of the team, particularly the ongoing emphasis on resolving complaints at the most appropriate level, the team was increased from four to five full-time staff. An enquiries administrator was recruited to take on administrative tasks, including database maintenance, filing, information gathering and general assistance for the team. A legal advisor from the Office's legal team was also seconded to assist the enquiries team four days a week. This secondment recognised both the increasing amount of work undertaken by the enquiries team and the complexity of some complaint files.

Enquiries

The public can contact the enquiries team from anywhere within New Zealand by telephoning our toll-free line (0800 11 22 33) between 8am and 5.30pm, Monday–Friday, by visiting our website (www.hdc.org.nz), or by emailing the team at hdc@hdc.org.nz.

1 An "enquiry" is defined as any contact with the Office that is not a complaint about the provision of a health care or disability service.
2 A "complaint" is defined as any allegation that a health or disability services provider is, or appears to be, in breach of the Code.

Enquiries range from people seeking information on the Commissioner's role or how to make a complaint, to queries about how a particular Code Right might be interpreted.

Most people who make enquiries do so by telephone. In 2002/03 there was a significant increase in enquiries taken on the 0800 line, with 7,206 verbal enquiries taken. 545 written enquiries were also received (a total of 7,751 enquiries). In the previous year the total number of enquiries (both written and verbal) was 4,311. The increase in verbal enquiries is attributable to an increase in call volume and in staff available to take calls and record enquiries.

Most enquiries are dealt with by providing verbal information, often including an explanation of the options available. Written information (pamphlets and educational material) may also be sent. Where appropriate, callers are referred directly to advocacy services. If the matter is outside the Commissioner's jurisdiction it is generally referred to a more appropriate agency.

Enquiries often reflect topical issues in the health and disability sector, and provide a valuable opportunity for the Commissioner to educate people on the Code. Such enquiries have become more sophisticated and complex as people have increased their knowledge of the Code. Written responses (referred to as "formal" responses) are regularly sent and copied to relevant agencies. Table 1 details the frequency with which the actions described were taken.

Table 1: Action on enquiries

Action taken	2002/2003	2001/2002
Contact	1	
Escalated to complaint	12	11
No response required	66	22
Outside jurisdiction	770	469
Outside jurisdiction — referred to another agency	329	61
Provided formal response	193	184
Provided verbal and written information	179	140
Provided verbal information	4,523	2,075
Referred to advocacy	526	141
Referred to another department (eg, legal, education)	30	7
Referred to another agency (eg, Age Concern, Ministry of Health)	34	27
Sent written information	1,072	1,161
Open	16	13
Total	**7,751**	**4,311**

Complaints

In the year ended 30 June 2003 the Commissioner received 1,159 complaints, 4% fewer than the 1,211 complaints received the previous year (see Table 2 and Chart 1 opposite).

Source of Complaints

Any person (not just the consumer) may make a complaint to the Commissioner if he or she believes 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

Table 2: Number of complaints open compared with previous years

	2002/2003	2001/2002	2000/2001
Open at year start	546	634	575
New during year	1,159	1,211	1,397
Closed during year	1,338	1,299	1,338
Open at year end	367	546	634

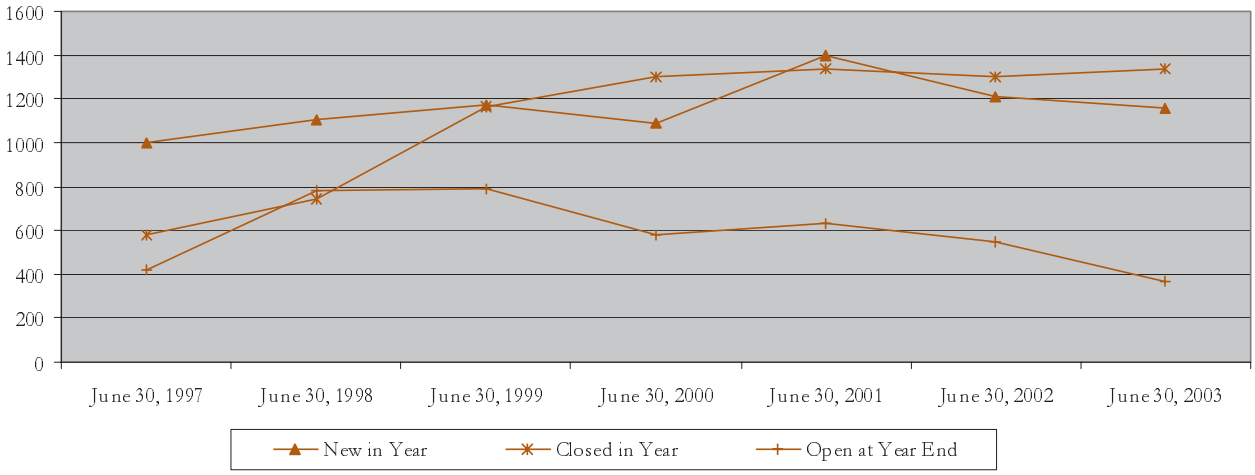


Chart 1: HDC complaints handling 1997–2003

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.

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.

Consistent with previous years, most complaints were received from individual consumers, relatives, health providers and the advocacy service (see Chart 2 below). Complaints from health consumers far outweighed complaints from disability services consumers. Also consistent with last year, the professional bodies that referred the most complaints were the Nursing Council, the Medical Council, and the Pharmaceutical Society (see Table 3 overleaf).

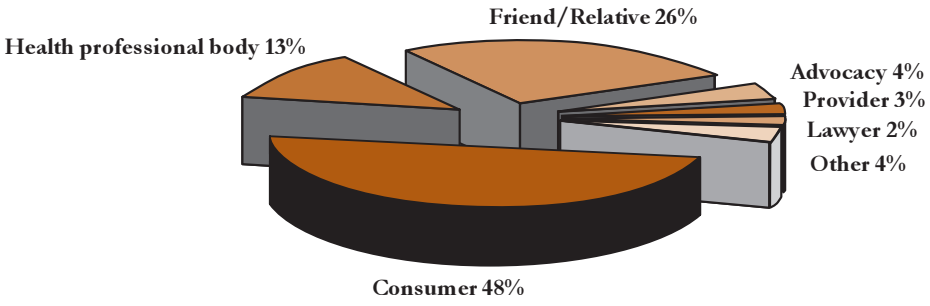


Chart 2: Source of complaints received 2002/03

Table 3: Complaints received

Source of complaint	2002/2003	2001/2002	2000/2001
Chiropractic Board	8	3	1
Dental Council	12	18	9
Medical Council	36	58	71
Nursing Council	46	22	26
Occupational Therapy Board	1	2	5
Opticians Board	2	1	0
Pharmaceutical Society	28	19	21
Physiotherapists Board	1	2	4
Pyschologists Board	13	11	13
Podiatrists Board	1	1	0
Other professional bodies	0	1	2
Subtotal (professional bodies)	**148**	**138**	**152**
Accident Compensation Corporation	6	16	7
Advocacy services	41	89	94
Coroner	3	2	1
Disability consumer	11	7	0
Disability provider	2	2	4
Employee	6	3	8
Friend	19	33	36
Health consumer	544	530	718
Health provider	38	22	34
Health regulatory body	0	3	3
Human Rights Commission	2	0	0
Lawyer	27	30	38
Member of Parliament	5	6	6
Member of public	12	12	4
Ministry of Health	2	8	5
Ombudsman	3	0	0
Police	2	3	2
Privacy Commissioner	0	2	0
Professional association	11	19	5
Relative	277	286	279
Other	0	0	4
Subtotal (other sources)	**1,011**	**1,073**	**1,245**
Total	**1,159**	**1,211**	**1,397**

Types of Provider Subject to Complaint

The 1,159 complaints received involved 1,383 providers (see Table 4 overleaf). For the year ended 30 June 2003 the types of provider most commonly complained about were:

Individual providers		**Group providers**	
• General practitioners	31%	• Public hospitals	60%
• Nurses	9%	• Rest homes	11%
• Dentists	7%	• Pharmacies	7%
• Midwives	5%	• Private hospitals	5%

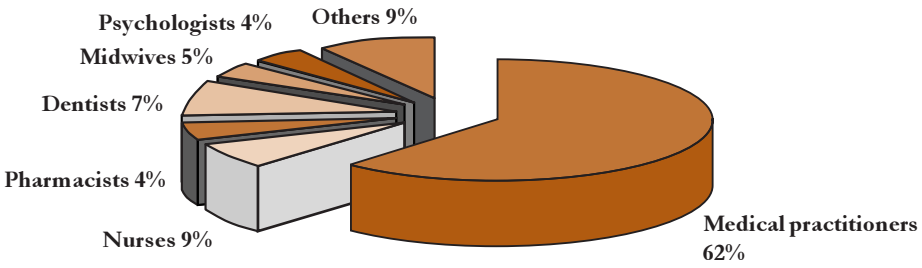


Chart 3: Providers subject to complaint 2002/03

Initial Complaints Assessment

Initial handling of complaints is undertaken by the enquiries team, which receives all new complaints. A triage team, convened by the enquiries team leader, recommends to the Commissioner how best to handle each complaint. This team 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.

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, the 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 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, p 22, details complaints that were outside jurisdiction, referred to another organisation, or on which no action was taken.

Table 4: Types of provider subject to complaint

Individual provider	2002/2003	2001/2002	2000/2001
Anaesthetist	5	12	9
Cardiologist	2	4	3
Cardiothoracic surgeon	1	3	4
Dermatologist	12	13	7
Ear/Nose/Throat specialist	2	9	2
Emergency physician	0	1	2
Endocrinologist	1	1	0
Gastroenterologist	0	0	1
General practitioner	243	271	397
General surgeon	37	34	51
Geriatrician	1	1	0
House surgeon	2	3	9
Medical officer	4	4	1
Neurologist	3	3	4
Neurosurgeon	1	1	0
Obstetrician/Gynaecologist	31	44	68
Occupational medicine specialist	5	11	5
Oncologist	0	4	4
Ophthalmologist	6	14	5
Orthopaedic surgeon	18	29	38
Paediatrician	9	14	15
Pathologist	1	3	3
Physician	33	26	46
Plastic surgeon	4	7	13
Psychiatrist	23	24	20
Radiologist	10	6	7
Registrar	26	20	17
Sports medicine specialist	1	–	–
Surgeon (specialty not noted)	0	0	3
Urologist	7	9	7
Subtotal (medical practitioners)	**488**	**571**	**741**
Individual provider (other than medical practitioners)	**2002/2003**	**2001/2002**	**2000/2001**
Acupuncturist	2	2	0
Aesthetician/Electrologist	0	0	1
Alternative therapist	1	3	1
Ambulance officer	2	0	0
Caregiver	4	6	5
Chiropractor	13	5	4
Counsellor	8	6	3
Dental nurse	0	1	0
Dental technician	5	8	16
Dentist	57	50	63
Dietitian	1	1	0
Laboratory technologist	0	1	1

Individual provider (other than medical practitioners)	2002/2003	2001/2002	2000/2001
Midwife	41	30	43
Naturopath	2	0	0
Needs assessor	1	1	0
Nurse	68	43	64
Occupational therapist	3	5	14
Optician	0	0	1
Optometrist	2	3	4
Oral surgeon	4	4	2
Osteopath	5	1	3
Other providers	6	11	21
Pharmacist	30	24	20
Pharmacy technician	1	1	1
Physiotherapist	6	10	24
Podiatrist	2	1	0
Psychologist	33	23	33
Psychotherapist	2	0	1
Rest home manager	0	3	2
Social worker	0	2	1
Speech language therapist	0	1	0
Subtotal (other individuals)	**299**	**246**	**328**
Total (all individual providers)	**787**	**817**	**1,069**

Group provider	2002/2003	2001/2002	2000/2001
Accident and emergency centres	7	8	12
Accident Compensation Corporation	1	2	2
Ambulance services	8	3	4
Dental providers	2	7	2
Disability providers	11	10	12
Educational facility	2	0	0
Intellectual disability organisations	3	6	2
Laboratories	2	3	4
Medical centres	17	20	23
Other provider group	13	19	36
Pharmacies	40	30	42
Prison services	27	28	14
Private medical hospitals	11	13	9
Private surgical hospitals	18	11	14
Public hospitals	355	353	351
Radiology services	4	7	1
Rehabilitation providers	2	5	9
Rest homes	67	56	73
Trusts	6	10	6
Total group providers	**596**	**591**	**616**

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

	2002/2003	2001/2002	2000/2001
Outside jurisdiction[3]	186	193	140
Referred to a health professional body[4]	92	93	116
Referred to the Privacy Commissioner	20	29	45
Referred to Human Rights Commission	2	2	7
Referred to Ombudsman	1	2	0
Referred to ACC	39	44	51
Referred to the Ministry of Health	32	44	44
Referred to a District Inspector	25	24	29
Referred to another agency	2	6	29
No action[5]	240	200	–*
Total	**639**	**637**	**461**

*Unable to access this data[6]

Complaints Resolved Without Investigation

In 2002/03, 354 complaints were closed without investigation as a result of the complaint being withdrawn, or being resolved by the Commissioner, through advocacy, or by agreement of the parties.

Complaints may be referred to an advocate either on receipt of a complaint or during an investigation. As in 2001/02, there was an increase this year in the number of complaints referred and resolved with advocacy assistance. This is consistent with the Commissioner's aim of resolving complaints at the lowest appropriate level.

Table 6: Complaints resolved or withdrawn

	2002/2003	2001/2002	2000/2001
Resolved by Commissioner	96	24	81
Resolved with advocacy assistance	109	97	77
Resolved by parties	50	77	78
Withdrawn	99	130	103
Total	**354**	**328**	**339**

3 Outside jurisdiction relates to access or funding, events that occurred before 1996, or decisions under section 35 of the Act.
4 Chiropractic Board, Dental Council, Medical Council, Medical Laboratory Technologists Board, Nursing Council, Opticians Board, Pharmaceutical Society, Physiotherapy Board, Podiatrists Board, Psychologists Board.
5 No action taken under section 37 of the Act, and no investigation commenced.
6 Over the past three years we have enhanced how we collect statistical information. Until 2001/2002 we did not report separately on no action under section 37 of the Act.

Investigation Teams

If a complaint requires investigation, it is allocated to one of two investigation teams, one in Auckland and one in Wellington. The Auckland team is led by Kathryn Leydon, Senior Investigator, and the Wellington team by Steve Anthony, Senior Investigator. An investigator is allocated responsibility for each complaint but team members work closely together, and with the Office's legal advisors, to ensure the quality and consistency of investigations.

Complaints Investigated

In the year ended 30 June 2003, 345 complaints were resolved after or during an investigation. The investigation process is impartial, independent and subject to the rules of natural justice. Considerable emphasis has been placed on ensuring that investigations are procedurally fair and efficient. To assist, a major change project was undertaken in 2001/02 to redesign enquiries and complaints resolution processes and to develop best practice. The re-engineered processes were implemented for all complaints resolution staff from 1 July 2002. They are better aligned with the fundamental role of the Commissioner to facilitate the "fair, simple, speedy, and efficient resolution of complaints" (section 6 of the Act).

The year saw a continuing strong focus on clearing old files, while striving for timely investigation of new complaints. The results have been very pleasing, with the number of open investigation files reduced from 364 at 30 June 2002 to 174 at 30 June 2003 — a reduction of 52% from last year. 82% of the investigations concluded were completed within two years of the date the complaint was received — with only nine files older than two years open at 30 June 2003. 35% of the investigations concluded were completed within 12 months of the date of receipt and 60% were resolved within 18 months of the date of receipt.

In 2002/03, in 61 cases in which an investigation was commenced the Commissioner decided that it was not necessary or appropriate to take further action, having regard to all the circumstances of the case. Twenty-three investigations were concluded by successful mediation.

Case study: Successful mediation following needle-stick incident

Mrs A was admitted to hospital suffering from severe migraine, and was prescribed morphine and Imigran. Imigran is administered using a dual cartridge system designed for self-use at home. Mrs A complained that a staff nurse unfamiliar with the device gave the injection from a previously used syringe. The hospital conceded that at the time there was no system in place to prevent the unsafe re-use of these devices.

The Commissioner commenced an investigation and, on receipt of the hospital's response, referred the matter to a mediation conference in an effort to resolve the complaint. The case was considered appropriate for mediation as, although there was disagreement about the precise details of the incident, constructive dialogue between the parties had occurred.

Mrs A and her husband attended the mediation conference, supported by a Health and Disability consumer advocate. The hospital was represented by its General Manager and Complaints Co-ordinator. Despite apparently irreconcilable positions, the parties managed to resolve the complaint.

The mediator commented that this was a particularly challenging mediation. The complainant insisted that the hospital recognise that the incident occurred, and the District Health Board was adamant that acknowledgement would not be forthcoming. The cycle of disagreement was effectively broken with the assistance of the advocate and the Complaints Co-ordinator, who drafted a written agreement acceptable to both parties. The agreement provided acknowledgement that the incident had occurred, but did not define precise parameters. It also provided for in-service training in relation to the device, and introduced a system of returning it to the hospital pharmacy after use, to eliminate the risk of re-use.

In this case, mediation facilitated not only resolution of the complaint, but also an improvement in the hospital's systems.

In 261 cases, the investigation was concluded by the Commissioner reporting his formal opinion in a written report. In 148 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.

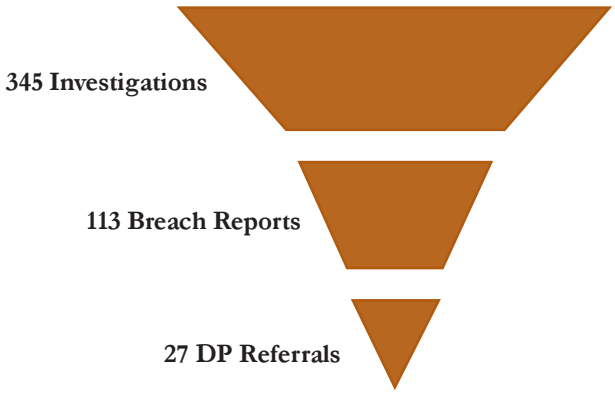


Chart 4: Outcome of investigations 2002/03

Breach of the Code

In 113 cases the Commissioner formed the opinion that a breach of the Code had occurred. This represents 33% of cases investigated in 2002/03 — an increase from 27% in the previous year. Inadequate information, poor communication, inappropriate clinical standards and sketchy record-keeping continue to be key themes in the majority of breach opinions.

In every case where the Commissioner found a breach of the Code he 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 of the report. In the minority of cases, specific remedial action (eg, a competence review by the Medical Council) was recommended.[7]

Table 7: Complaints investigated

Complaints investigated[8]	2002/2003	2001/2002	2000/2001
Breach (referred to Director of Proceedings)	27	28	26
Breach (not referred to Director of Proceedings)	86[9]	62	103
No breach	148[10]	144	122
Resolved by mediation	23	28	20
No further action taken	61[11]	72	286
Total	**345**	**334**	**557**

7 This useful remedial tool will be available for other health professional registration bodies when the Health Professionals Competence Assurance Act comes into force. Currently, the Medical Practitioners Act 1995 is the only health registration enactment that provides for review of competence.
8 A single complaint/investigation may result in more than one provider being found in breach.
9 Includes breach reports and breach letters.
10 Includes no breach reports and no breach letters.
11 Complaints where no further was taken under section 37.

Table 8: Individual providers found in breach of the Code/referred to the Director of Proceedings (around 28% of all individual providers investigated were found in breach of the Code in 2002/2003)

Provider	2002/2003		2001/2002	
	Breach finding	Referred to DP	Breach finding	Referred to DP
Ambulance officer	2			
Anaesthetist	4	2	4	2
Caregiver	4	2	2	
Chiropractor	1	1		
Counsellor	1		1	1
Dental nurse/technician	0		1	
Dentist	4	1	8	2
Dermatologist	1		0	
Emergency physician	2		1	
Gastroenterologist	0		2	2
General practitioner	50	8	41	6
General surgeon	9	2	10	6
House surgeon	5		6	1
Medical officer	2	1		
Midwife	7	3	12	1
Nurse	22	9	16	10
Obstetrician/Gynaecologist	7	4	14	1
Ophthalmologist	4	1	0	
Oral surgeon	1		0	
Orthopaedic surgeon	1	1	0	
Other health provider	4	2	1	1
Otolaryngologist	2		1	1
Paediatrician	0		3	
Pathologist	2		2	
Pharmacist	11	5	7	6
Pharmacy technician	2	1	0	
Physician	6		10	
Physiotherapist	1		1	
Psychiatrist	1	1	4	1
Psychologist	0		4	3
Radiologist	0		7	2
Registrar	10		2	1
Rest home licensee	1			
Rest home manager	3	2	3	2
Social worker	2	2		
Urologist	0		2	
Total	**172**	**48**	**165**	**49**

When an investigation is commenced into services provided by a registered health professional, the Commissioner advises the relevant registration body and, on completion of the investigation, advises the outcome and provides a copy of his final report. Other appropriate agencies, such as the relevant professional college or association (eg, the College of Midwives), or the Ministry of Health, are also sent copies of the report. Unless there is a specific need for

Table 9: Group providers found in breach of the Code/referred to the Director of Proceedings (around 31% of all group providers investigated were found in breach of the Code in 2002/2003)

Provider	2002/2003		2001/2002	
	Breach finding	Referred to DP	Breach finding	Referred to DP
Accident and emergency clinic	2		3	
Ambulance services	2		0	
Dental provider	1		0	
Disability provider	1		0	
Hospice	1		0	
Medical centre	5	2	3	1
Other provider group	3	2	4	1
Pharmacy	10	4	6	4
Private hospital	9	5	8	5
Public hospital	28	6	33	4
Rest home	13	4	6	2
Total	**75**	**23**	**64**	**17**

the agency to know the identity of the provider, the reports are sent in an anonymised form. Anonymised reports are also placed on the Commissioner's website at www.hdc.org.nz. This enables lessons to be learned, while preserving the anonymity of providers.

Unregistered health providers do not have registration bodies, nor in many cases relevant professional associations, and there is limited scope for the Commissioner to take effective action against such individuals.

In 27 of the 113 cases where the Commissioner formed the opinion that a breach of the Code had occurred, he 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 2003 but not received by the Director of Proceedings until after 1 July 2003, hence the Director's statement of having received 30 referrals (see p 11).) The 27 matters included 48 breaches by individuals and 23 breaches by a group provider. The number of matters referred represented 8% of complaints investigated, and 24% of breach reports (compared to 31% the previous year).

Satisfaction Survey Results

Postal surveys of complainants and providers who had participated in the complaints resolution process between 1 July 2002 and 28 February 2003 were undertaken. Three hundred complainant surveys were distributed with a 28% response rate. Two hundred and fifty-one independent provider surveys were distributed with a 37% response rate. Twenty-one District Health Boards were sent a provider survey and 19 responded, a 90% response rate.

The responses to the three surveys have provided valuable information. Important areas for improvement based on feedback from the surveys include:

- quicker resolution of complaints
- early advice about time frames for handling complaints processes and outcomes
- ensuring parties are kept informed of progress during complaints assessment and investigation
- clearer explanations to complainants of complaints handling decisions
- quicker responses to written correspondence.

The following sections outline the key findings from the DHB, individual provider and complainant surveys.

DHB Survey Results

- All DHB respondents found our initial letters easy to understand.
- All DHB respondents found the Office prompt at responding to telephone messages.
- All DHB respondents found our staff polite.
- 33% of DHB respondents found the Office quite slow at responding to written correspondence.
- 60% of DHB respondents found the bi-monthly updates kept them well informed on what was happening with complaints about their service.

The DHBs made the following comments and suggestions to improve the Office's processes:

- "We note the genuine effort to develop mutual trust between agencies — keep it up."
- "Keep up the open and clear communications. It is good to get phone calls on occasions where clarification is required or just to touch base."
- "More detail about progress of complaints would be useful."
- "All efforts to improve length of time taken to complete investigations would be appreciated."
- "It would be useful to start doing site visits to meet clinical staff to investigate complainants — the benefit of talking it through, to understand details in some cases would be better than letter writing."
- "I would like to add my own thanks to the whole team at HDC. The turnaround in time taken to resolve issues and the clearing of the backlog has been magnificent and benefited both patients and healthcare providers."

Independent Provider Surveys

- 98% of respondents found our initial letters easy to understand.
- 70% of respondents were satisfied with the information about time frames for handling complaints.
- 69% of respondents were satisfied with how well the Office kept them informed about what was happening with the complaint, with 15% of respondents being very dissatisfied.
- 10% of respondents were very dissatisfied with the promptness of our response to written communication, with 73% of respondents satisfied.
- 94% of respondents were satisfied with the promptness of our response to telephone messages.
- 96% of respondents found the staff polite.
- 80% 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.)
- 96% of respondents found the Commissioner's final decision easy to understand and 93% of respondents were satisfied they understood the reason for the final decision made about the complaint.
- 82% of respondents were satisfied overall with the fairness of the process, with 8% of respondents very dissatisfied.

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

- "The polite and non-judgemental contact is invaluable in soothing ruffled feathers."
- "When I was approached at first I was very shocked because I was sure I had done nothing wrong — the friendliness and support of your staff made it easy for me not to be too defensive about the whole process. I think the attitude of staff should remain open and friendly."
- "Peer opinion very relevant — I feel confident having my practice judged by someone in a similar situation."
- "Please keep us up to date with how things are going and please keep understanding the dismay and upset we feel that it is an unjustified complaint. Also the fear one can feel that

the complainee by some sort of mistake may be believed before us even without evidence — just because they have complained. You do feel very vulnerable."

- "As the 'accused' I feel the process made me 'guilty before charges' — it seems entirely 'pro-patient'. I was left for 18 months worrying about a vexatious bogus complaint — then told there was no case to answer. The patient and their lawyer should be reprimanded — that would be natural justice."
- "You had a job to do and I have no problems with that. The process did seem to take a long time. The manner in which the complaint was conducted was above reproach."

Complainant Survey Results

- 87% of survey respondents were satisfied the letters from the Office were easy to understand.
- 85% of respondents found the staff polite, respectful and good listeners.
- 25% of respondents were very dissatisfied with how they were kept informed about the time frames for handling their complaint; 64% were satisfied.
- 60% of respondents were satisfied with how well they were kept informed about what was happening with the complaint; 21% were very dissatisfied.
- 55% of respondents were satisfied with their view being heard in a fair and unbiased way; 41% were very dissatisfied.
- 56% of respondents were satisfied they understood the reason for the final decision made about the complaint; 33% of respondents were very dissatisfied.
- 41% of respondents were, overall, satisfied with the fairness of the process; 48% were very dissatisfied.
- 51% of respondents would not want to deal with the HDC in future.

Complainants made the following comments and suggestions to improve the Office's processes:

- "Remaining neutral. HDC does this well."
- "Listening to the complaint. Keeping complainant informed at all times. Keep up the respect, very important."
- "Keep communicating about the progress of the investigation."
- "Keep pressure on the practitioners to provide responses to the enquiries — specialist was constantly given deadlines to reply and ignored them or asked for longer — makes whole process very long and drawn out for all involved."
- "Very slow, needs to be sped up."
- "I think it would be good if you could actually speak to someone in person instead of just over the phone and corresponding."

Summary

The results from our second complainant and provider surveys have highlighted ongoing areas for improvement and identified ways of improving the survey to get more definitive feedback. Some respondents (both complainants and providers) remarked that the survey, often received some months after the complaint was closed, caused further and unnecessary stress. In 2003/04 complainants and providers will be surveyed closer to the time of the complaint being closed.

Further work needs to be done to identify whether there is a correlation between providers' and complainants' views of the fairness of the complaints handling process and investigation outcomes, in particular whether the higher numbers of providers than complainants reporting satisfaction with the fairness of the process is related to the higher percentage of investigation outcomes where complaints are not upheld. The survey highlights that the level of understanding of the final decision is lower for complainants than providers. Work will be done to identify how we can improve in this area.

Legal Services

Members of the Legal Team (back row from left): John Sneyd, Helen Davidson, Julie Ruthe, Marie van Wyk; (front row from left): Tina Mitchell, Katharine Greig, Nicola Sladden

Legal staff provide advice to the Commissioner, managers and other staff, spanning the range of functions and activities undertaken by the Office.

Complaints Resolution

As reported last year, 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. This includes providing advice to the enquiries team in the initial assessment phase, and liaison with consumers, providers, expert advisors, registration bodies, the Ministry of Health, and statutory officers, to ensure that complaints are handled appropriately.

A senior legal advisor is part of the triage team, which assesses all new complaints. One of the important functions of the legal advisor on the team is to provide advice on the interpretation of various aspects of the Health and Disability Commissioner Act and the Code of Rights. In addition, legal advisors provide advice during investigations. Legal review was provided on many investigation files, and legal advisors also assumed responsibility for managing a number of investigations. The Chief Legal Advisor, Katharine Greig, oversaw the major investigation into Southland DHB's mental health services, which was reported on in 2002.

Submissions

A wide range of policy documents and proposed legislation affecting the health and disability sector were reviewed by the legal team during the year, and over 20 submissions were made on key policy documents and proposed legislation. A significant submission was made to the Health Select Committee on the Health Practitioners Competence Assurance Bill. Other submissions included comments on the following:

- Mental Health Commission Draft Report — Mental Health Issues for Asians in New Zealand: A Literature Review
- Ministry of Health Discussion Document — Public Health Legislation; Promoting Public Health; Preventing Ill Health and Managing Communicable Diseases
- Health Select Committee — Human Assisted Reproduction Technology Bill; Assisted Human Reproduction Bill; Supplementary Order Paper 80
- Medical Council Draft Statement on the presence of a third person in a medical consultation
- National Health Committee — Discussion Document on Screening Appraisal Criteria
- Standards New Zealand — Draft Standards DZ81518, Home and Community Support Sector Standard, and DZ8156, Ambulance Services Performance Standards

- Ministry of Education — Privacy Law: Guidelines for GSE Staff
- Royal New Zealand College of General Practitioners — Draft Complaints Management Medico-Legal Resource and Occasional Paper — Managing Test Results

Feedback from recipients indicated timely, high quality and relevant submissions. Comments included:

- "An excellent standard as usual and very helpful" — Medical Council of New Zealand
- "Clear and well-structured — answered the questions that were asked in the letter well" — National Health Committee
- "Points made were of value and will assist in our rewording in some aspects of the Code [of Ethics]" — Dietitians Board
- "We would like to note that the submissions we receive from the Commissioner are always helpful and allow Standards New Zealand to ensure their documents continue to have a consumer focus and reinforce the important component of consumer rights. The submissions are consistently well-written and clearly describe recommendations and the reasons for these" — Standards New Zealand

Education

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. Conference papers were prepared and presentations delivered. Assistance was given in drafting articles for various publications, and the Chief Legal Advisor and staff addressed conferences and workshops throughout the year, including to consumer groups and health professionals.

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.

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 2002/03 fewer new complaints about the Health and Disability Commissioner processes were made to the Office of the Ombudsmen under the Official Information Act and the Ombudsmen Act, and to the Privacy Commissioner, than in previous years. Several complaints to the Ombudsmen were resolved following clarification and referral back to the Commissioner's Office by the Chief Ombudsman.

Protected Disclosures Act

The Health and Disability Commissioner is an appropriate authority listed in s 3(a) of the Protected Disclosures Act 2000. Only two protected disclosures were received in the last year. As required by the Protected Disclosures Act, the Health and Disability Commissioner has an internal procedure for receiving and dealing with information about serious wrong-doing forwarded by other organisations/individuals. The appropriate procedure was followed in both cases.

Education

Education Co-ordinator, Sarah Davies

Increased consumer education has been a highlight of the HDC education function this year. A number of new and significant consumer groups, for example New Zealand Cardiac Club, Challenge Trust, Peoplesfirst (IHC), have developed an educational relationship with the Office, leading to increased awareness of the Code of Health and Disability Services Consumers' Rights.

The launch of the Advance Directives in Mental Health Care and Treatment brochure took place in April at the Mental Health Commission Building Bridges Conference in Rotorua. The brochure was developed in conjunction with the Mental Health Commission and is an informative publication for mental health consumers.

Targeted education for providers was also a focus in 2002/03. A national education seminar for District Health Board complaints handling staff was held in March.

During the year the Commissioner gave presentations throughout the country, visiting Waikato Hospital, Wanganui Hospital, North Shore Hospital, Whakatane Hospital and Southland Hospital, and speaking to university classes on the consumer complaints system. The Commissioner addressed the Cardiac Society AGM and the Paediatric Society Annual Meeting. He continued to publish monthly articles in *NZGP*, recognising that 62% of complaints about individual providers relate to doctors.

In March the Director of Advocacy, Assistant Commissioner and senior investigators attended and presented at the 4th National Health Care Complaints Conference in Canberra.

Acting outside the square

HDC received a complaint about the death of a baby. The parents were Samoan and had been trying to conceive for many years. Finally IVF had been successful and the baby was seen as a gift from God.

The baby arrived at 26 weeks and, as a result of equipment failure in Neonatal Intensive Care, received 100% oxygen. Soon after, the baby developed *E coli* meningitis/sepsis and died. The parents believed that the death was directly linked to the oxygen incident. There had been a number of meetings between the parents and hospital staff following the baby's death but the family (and in particular the father) refused to accept the hospital's explanations. Eventually a complaint was made to the Health and Disability Commissioner.

We obtained expert advice. Our expert advised that care was appropriate, the meningitis/sepsis was a tragic but known complication, and the oxygen incident was clearly a result of equipment failure. The expert, who had worked in Samoa, offered to meet with the family to explain the circumstances. This meeting went ahead at the family's home and the family's GP also attended. The meeting was very emotional and went some way to assuring the father that the baby's death was not the result of negligence (although he was not entirely convinced). Feedback from the expert and family GP was positive.

Case Study: Inadequate monitoring of sedated patient

A complaint was made by a former Acting Director of Area Mental Health Services about a registered staff nurse. The complaint was on the basis that while the patient was in a locked seclusion room the registered staff nurse (1) did not enter the patient's room at any time during the night to undertake regular monitoring as instructed by medical staff; and (2) did not observe and report the patient's deteriorating condition to medical staff.

Mr A, a 41-year-old man with a mild intellectual handicap, was compulsorily admitted to hospital, sedated, and locked alone in a seclusion room for an extended period of time. The nurse was aware that Mr A had been asleep for most of the preceding 24 hours, had required nursing assistance to turn on the previous shift, had a poor intake of fluids, and had strained breathing when lying flat. The nurse did not go into the patient's room all night; all observations were done through the window. Mr A died, and the Coroner found that his death followed a period of immobility. The pathologist's findings of hypostasis and early pneumonia indicated that Mr A had almost certainly been lying still for some hours before his death.

The Commissioner noted that:

1 the nurse's assessment of where the balance between rest and observation should lie fell below the standard expected of a reasonable and competent nurse;
2 as an absolute minimum, the nurse was obliged to regularly carry out a meaningful assessment of Mr A's colour, breathing, position, activity and behaviour (as required by each of the relevant policies in place at the time);
3 careful and accurate observation was particularly important for this patient, in the light of concerns expressed during handover; and
4 had the nurse regularly monitored Mr A's condition during the early hours of the morning, it is likely that she would have been alerted to his deteriorating state of health.

The Commissioner also stated that although there was some inconsistency between the hospital's seclusion policy and the Ministry of Health Guidelines, consideration of the patient's best interests should be the nurse's first concern, and that guidelines and protocols are not a substitute for professional, clinical judgement, and need to be interpreted in the light of relevant circumstances. A nurse faced with apparently inappropriate or contradictory guidelines or protocols should seek guidance from a senior member of the team rather than risk compromising patient safety by rigidly following a document.

The Commissioner held that the registered staff nurse breached Right 4(1) of the Code in that she failed to provide the appropriate standard of care.

With regard to the public hospital, the Commissioner commented that it seemed apparent that Mr A should not have been in seclusion during the night, and expressed concern at the inconsistency between various seclusion policies, the paucity of new drug education, the lack of an ECG machine on the ward, the confusing clinical record format, and the delay in arrival of the resuscitation team. However, as the public hospital had since responded appropriately to the internal inquiry and inquest recommendations, to minimise the chance of harm to future patients, and given the length of time that had elapsed since the incident occurred, the Commissioner decided to take no further action in relation to any potential direct or vicarious liability on the part of the public hospital.

Case 02HDC08692 may be viewed at www.hdc.org.nz/opinions.

Anonymised HDC reports were published on the Commissioner's website throughout the year. Case notes of reports were introduced onto the website in June and provide an overview of each decision with a link to the full report.

In March a weekly bulletin was launched for HDC staff, advising of current publications and activities of heath and disability organisations. The bulletin provides increased awareness for staff and identifies opportunities to become more involved in the health and disability sector.

"Brown Bag Lunches" have become a regular event at HDC. Guest speakers offer in-house education on topics related to the health and disability sector, giving staff the opportunity to ask questions and meet people in the industry.

Te Ao Pehi Kara (kaumātua), Tania Thomas (Director of Advocacy), and Elaine Bycroft (Thames advocate).

Māori Initiatives within HDC

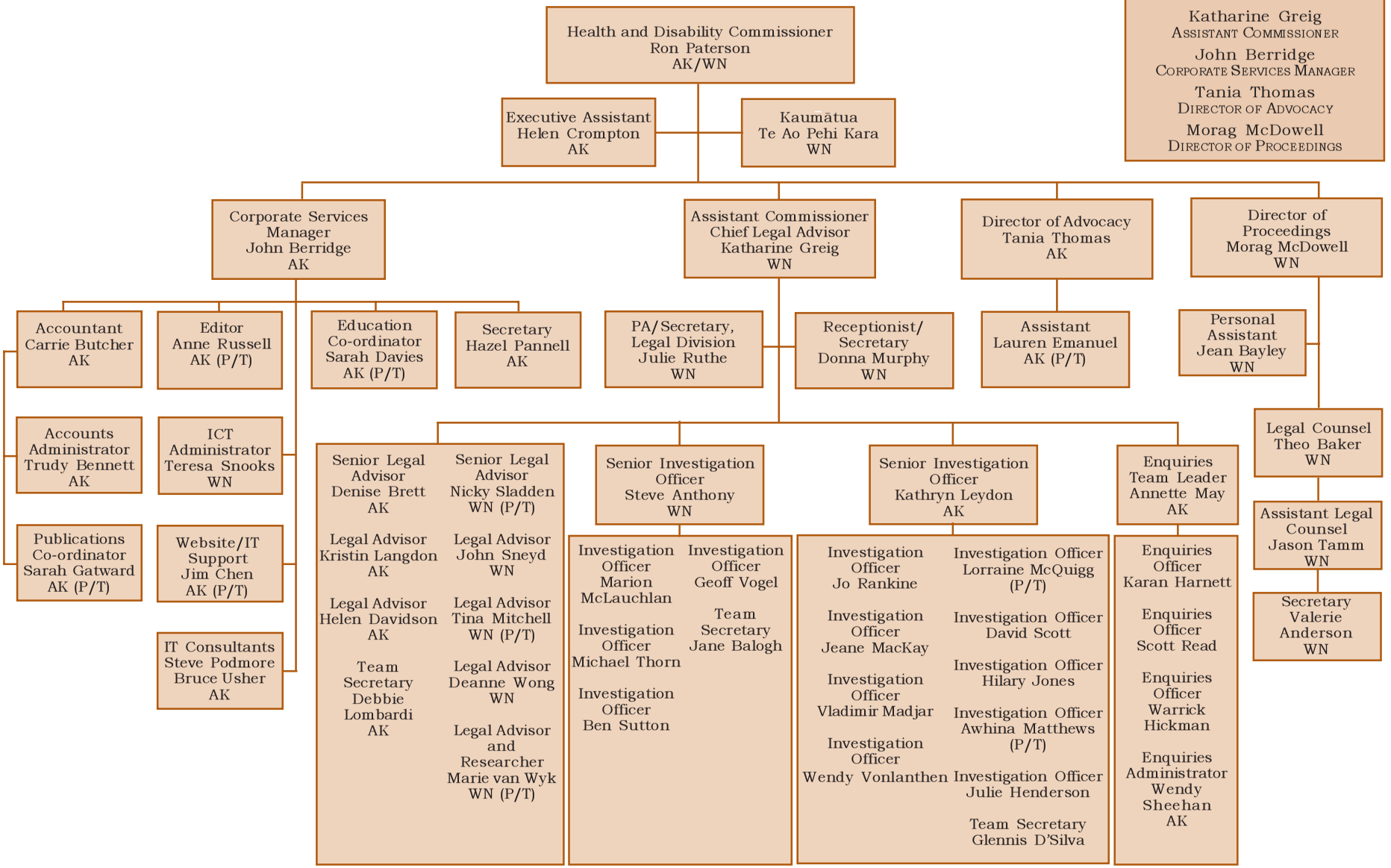
The Commissioner's Office has continued to increase the knowledge and skills of its staff so that they are better equipped to work with Māori. HDC staff:

- attended te reo Māori classes in both the Auckland and the Wellington offices of HDC. In Auckland HDC staff joined the Human Rights Commission (HRC) staff in their te reo lessons with Merimeri Penfold (a Human Rights Commissioner) and Bobby Newson (HRC's Kaiwhakarite). Wellington staff had their own tutor, Mereana Hond. Some staff also took advantage of the te reo tutorials on CD Rom;
- completed training in the "Māori World View" so that they could better understand the perspective of Māori in terms of their beliefs, values and culture. This training was led by Amster Reedy and Kataraina Pipi;
- have a desktop reference book, "He Tohu Arahi I te Mahi Tahi ki te Māori" — Guidelines for Working with Māori, developed by Moe Milne. Moe has previously been the Kaiwhakahaere (Cultural Advisor) for HDC, and we are very grateful for her continued support;
- began to learn two waiata especially written for the Commissioner's Office by Lee Morunga and Te Reotakiwa. The two waiata, "Te Wairua Māori" and "Te Wairua Tapu", will be used by HDC to support the Commissioner and his Office in settings where the occasion calls for a supporting song;
- have guidelines for collecting Māori ethnicity data to ensure appropriate information is available to HDC for service planning;
- celebrated Matariki, Māori New Year. This was the first time this event has been recognised in HDC.

HDC has developed:

- a Māori consumer education programme to assist Māori consumers to understand their rights under the Code and how they apply to Māori. The programme provides information to Māori consumers on raising concerns with providers who may also be relatives, and how the dynamic of whanaungatanga is a strength in complaints resolution. The programme, along with the Māori provider education programme, was delivered to groups in 2003;
- an interview process that ensures all candidates applying for work at HDC are fully conversant with, and actively supportive of, the special relationship afforded to Māori under the Treaty of Waitangi.

Organisation Chart (as at 30 June 2003)



Management and Administration

Corporate Services Manager, John Berridge

Organisation

The Health and Disability Commissioner continued to operate from the two offices located in Auckland and Wellington. As at 30 June 2003 there were 50 employees, of whom nine were in part-time positions, as well as three long-term contractors. The organisation chart as at 30 June 2003 is shown opposite.

The Commissioner and Director of Advocacy are based in the Auckland office, and the Assistant Commissioner and Director of Proceedings are located in Wellington. The Corporate Services Manager and administration are located in Auckland. The majority of the Legal team and the smaller of the two Investigation teams operate from the Wellington Office, and the Enquiries team is based in Auckland.

Management

The Strategic 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.

Monthly reporting of financial performance and position, as well as progress towards the targets of the Statement of Service Performance, continued as the basis for monitoring progress towards the goals and objectives of the Strategic Plan.

Human Resources

During the year there were a number of staff changes. In March, Nicola Holmes, Senior Investigator (Projects), who managed the Business Processing Re-engineering (BPR) Project to redesign enquiries and complaints resolution processes, moved on.

Alyson Howell temporarily managed the Education function pending the appointment of Erin O'Callaghan and later Sarah Davies in a new part-time Education Co-ordinator role.

A number of other appointments took place during the year, either replacing existing staff, including some on parental leave, or taking up newly established positions.

Overall staff turnover in the year was less than the previous year, and greater use was again made of part-timers and fixed-term appointments to provide the flexibility needed as the organisation managed a number of planned change initiatives.

Following on from the successful implementation of the BPR Project, an organisation restructure was commenced in May, and is due for completion by February 2004.

During the year, human resource management policies and procedures continued to be reviewed. A number of further improvements built on the previous year's introduction of four weeks' annual leave and 10 days' special leave for all staff.

Finance

The benefits of the new financial management software installed during the previous year were evident. In Audit New Zealand's Audit Report for the year ended 30 June 2002, the organisation's ranking was increased in two of the five assessment criteria. All five now rank as "good".

In November an application was made to the Ministry of Health for an increase in the annual operating grant. This was approved, and for 2003/04 there will be a 6% increase to $6,517,333 (exclusive of GST).

Information Systems

Development of the Office's network and information systems continued, and was extended to include the three advocacy organisations. Project-managed enhancements of both the Enquiries and Complaints Database Systems (ECDS) and the Proceedings Database Systems (PDS) commenced in May and are due for completion in late 2003. A similar but smaller revamp of the Advocacy Database System (ADS) began at the same time, and development was completed in late June.

Content of the present HDC website (www.hdc.org.nz) continues to be expanded, and the first case notes of the Commissioner's reports were published in June.

Case Study: Management of patient with terminal illness

Mr A, a 57-year-old Māori man, had consulted his general practitioner, Dr B, for many years about back pain. When Mr A's pain levels increased significantly Dr B prescribed various combinations of painkillers, but Mr A continued to experience pain. He was later found to have terminal cancer of the lung. Following radiation treatment he became very ill and his family took him to see Dr B, who diagnosed a chest infection, prescribed antibiotics, and arranged home care, but did not admit Mr A to hospital. A few hours later Mr A's family sought a second opinion from another general practitioner, who diagnosed pneumonia and arranged for Mr A's urgent admission to hospital. Mr A was actively treated for his pneumonia over a six-day period. He was due to be discharged home when he suddenly died.

Mr A's sister complained to HDC that Dr B had not fully investigated or adequately treated Mr A's pain and, when he became ill following radiation therapy, did not fully examine him or arrange for hospital admission.

Following an investigation the Commissioner considered that Dr B had appropriately investigated the causes of Mr A's pain and taken reasonable measures to manage his escalating pain in light of the diagnosis at the time. However, having recognised the possibility of a malignancy and made a referral to a hospital orthopaedic department, Dr B failed to follow up the referral to ensure it was being acted on. As a result, there was a delay in the diagnosis of Mr A's cancer and in the provision of adequate pain relief. The Commissioner reasoned that when Mr A became ill following radiation treatment, Dr B should have been alert to the increased risk of developing pneumonia, and should have performed a more thorough examination. Dr B stated that he did not admit Mr A to hospital as, in his experience, the overwhelming majority of Māori patients wish to stay at home with their whanau when terminally ill. The Commissioner commented that although it is commendable that Dr B took Mr A's ethnicity into account, it is not appropriate to make assumptions based on a patient's ethnicity that deprive the patient of an informed choice. Dr B has since reviewed his practice and attended a seminar on cultural differences.

Case 01HDC01078 may be viewed at www.hdc.org.nz/opinions.

Financial Statements

Financial Commentary

Funding

The Office is funded from Vote Health. Funding remained unchanged at **$6,148,444** (excluding GST) for this year. A funding increase of **$368,889** has been approved for the year ended 30 June 2004.

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 cashflow. Interest income for the year was **$150,182** and investments totalled **$1,670,000** at 30 June 2003.

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 2002/03 was $70,328 offset by production costs.

Operating Deficit

In 2002/03 the Office budgeted for a deficit of **$698,320** and reported a deficit of **$432,326**.

Expenditure by Type

Expenditure is summarised by significant categories below. Service contracts, staff costs and occupancy costs (collectively 76% of total expenditure in 2002/03) largely represent committed expenditure. Much of the remaining 24% (or $1.62 million) is discretionary.

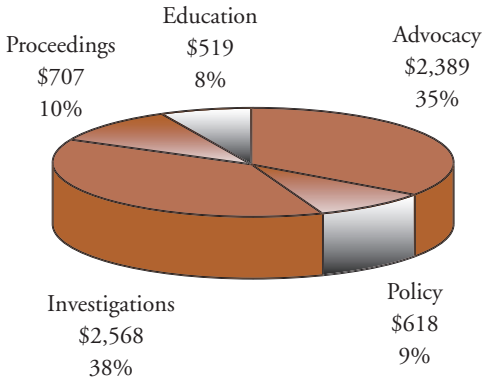
	02/03		01/02	
	$000	%	$000	%
Service Contracts	1,990	29.26	1,877	27.08
Audit Fees	9	0.13	9	0.13
Bad Debts Written Off	0	0.00	0	0.00
Staff Costs	2,997	44.07	3,075	44.37
Travel & Accom	126	1.85	206	2.97
Depreciation	270	3.97	185	2.67
Occupancy	193	2.84	317	4.57
Communications	567	8.34	484	6.98
Operating Costs	649	9.54	778	11.22
TOTAL	6,801	100.00	6,931	100.00

Figures GST exclusive

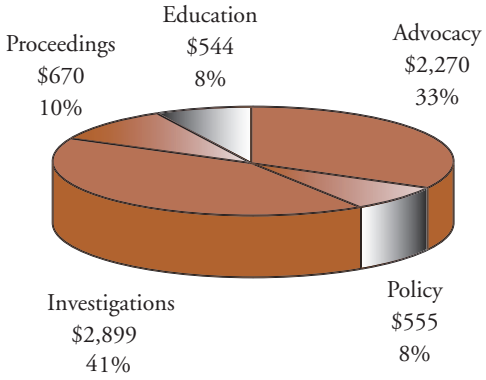
Expenditure by Output

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

Expenditure by Output 2002/2003 ($000s)



Expenditure by Output 2001/2002 ($000s)



Expenditure on Investigations was $2,568,000 ($2,899,000 in 01/02). Spending on Advocacy increased by $119,000, and remained a significant commitment of resources at 35% (33% in 01/02) of total expenditure. The Office continued to look for efficiencies in all areas.

2003/2004

For the coming year the Office has budgeted for a loss of $379,169.

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 2003.

Ron Paterson
Health and Disability Commissioner
14 October 2003

Audit New Zealand

REPORT OF THE AUDITOR-GENERAL

TO THE READERS OF THE FINANCIAL STATEMENTS OF THE HEALTH AND DISABILITY COMMISSIONER FOR THE YEAR ENDED 30 JUNE 2003

We have audited the financial statements on pages 42 to 59. 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 2003. This information is stated in accordance with the accounting policies set out on pages 42 and 43.

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 2003, 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 carried out an assurance-related assignment to review the Health and Disability Commissioner's performance measures. Other than this assignment, 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 42 to 59:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health and Disability Commissioner's financial position as at 30 June 2003;
  - 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 14 October 2003 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 2003

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 short-term 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 the lease 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 are 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 that cannot be identified in an economically feasible manner with a specific significant activity.

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

(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 2003

Actual 01/02 $			Actual 02/03 $	Budget 02/03 $
	Revenue			
6,148,444	Operating Grant Received		6,148,444	6,148,444
171,853	Interest Received		150,182	136,400
44,439	Publications Revenue		70,329	44,000
6,364,736	TOTAL OPERATING REVENUE		6,368,955	6,328,844
	Less Expenses			
1,876,839	Advocacy Service Contracts		1,989,836	1,987,000
9,000	Audit Fees		9,000	8,000
7,250	Fees Paid to Auditors for Other Services		900	0
0	Bad Debts Written Off		0	0
3,075,239	Staff Costs		2,997,208	3,109,582
205,821	Travel & Accommodation		126,025	175,038
184,751	Depreciation	**(Note 4)**	269,510	245,255
317,492	Occupancy		192,751	229,845
483,947	Communications		567,366	585,868
778,259	Operating Costs		648,685	686,580
6,938,598	TOTAL OPERATING EXPENSES		6,801,281	7,027,168
(573,862)	NET SURPLUS (LOSS)		(432,326)	(698,324)

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

Statement of Financial Position

As at 30 June 2003

Actual 01/02 $			Actual 02/03 $	Budget 02/03 $
	Crown Equity			
1,604,961	Accumulated Funds	**(Note 1)**	1,172,635	1,199,377
788,000	Capital Contributed		788,000	788,000
2,392,961	**TOTAL CROWN EQUITY**		**1,960,635**	**1,987,377**
	Represented by Current Assets			
34,507	Bank Account		47,586	50,000
2,050,000	Call Deposits		1,670,000	1,187,484
0	Prepayments		0	0
42,114	Sundry Debtors		23,868	2,000
0	GST Receivable		0	0
2,126,621	**Total Current Assets**		1,741,454	1,239,484
	Non Current Assets			
751,483	Fixed Assets	**(Note 3)**	743,980	1,006,353
751,483	**Total Non Current Assets**		743,980	1,006,353
2,878,104	**Total Assets**		2,485,434	2,245,837
	Current Liabilities			
8,093	GST Payable		24,269	40,906
477,050	Sundry Creditors	**(Note 2)**	500,530	217,554
485,143	Total Liabilities		524,799	258,460
2,392,961	**NET ASSETS**		**1,960,635**	**1,987,377**

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 2003

Actual 01/02 $		Actual 02/03 $	Budget 02/03 $
2,966,823	Opening Equity 1 July 2002	2,392,961	2,392,961
(573,862)	Plus Net Surplus (Loss)	(432,326)	(698,324)
(573,862)	Total Recognised Revenue and Expenses	(432,326)	(698,324)
2,392,961	Closing Equity 30 June 2003	**1,960,635**	**1,694,637**

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

Statement of Cash Flow

For the year ended 30 June 2003

Actual 01/02 $		Actual 02/03 $	Budget 02/03 $
	Cash Flow from Operating Activities		
	Cash was provided from:		
6,148,444	Operating Grant	6,148,444	6,148,444
202,282	Interest on Short Term Deposits	168,143	136,400
42,604	Revenue	70,583	44,000
6,393,330		6,387,170	6,328,844
	Cash was applied to:		
(6,672,133)	Payments to Suppliers and Employees	(6,417,602)	(6,693,818)
(278,803)	**Net Cash Flow from Operating Activities (Note 5)**	(30,432)	(364,974)
	Cash Flow from Financing Activities		
	Cash was provided from:		
0	Capital Contribution	0	0
0	**Net Cash Flow from Financing Activities**	0	0
	Cash Flow from Investing Activities		
	Cash was provided from:		
0	Sale of Fixed Assets	0	0
	Cash was applied to:		
(484,511)	Purchase of Fixed Assets	(336,489)	(393,049)
(484,511)	**Net Cash Flow from Investing Activities**	**(336,489)**	**(393,049)**
(763,314)	**NET INCREASE/(DECREASE) IN CASH**	**(366,921)**	**(758,023)**
2,847,821	Cash Brought Forward	2,084,507	2,084,507
2,084,507	Closing Cash Carried Forward	**1,717,586**	**1,326,484**
	Cash Balances in the Statement of Financial Position		
34,507	Bank Account	47,586	50,000
2,050,000	Call Deposits	1,670,000	1,276,484
2,084,507		**1,717,586**	**1,326,484**

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 2003

Actual 01/02 $	Note		Actual 02/03 $
	1	***Accumulated Funds***	
2,178,823		Opening Balance	1,604,961
(573,862)		Net Surplus (Loss)	(432,326)
1,604,961		Closing Balance	1,172,635
	2	***Sundry Creditors***	
309,086		Trade Creditors and Accruals	334,764
63,758		PAYE	62,120
104,206		Annual Leave	103,646
477,050			500,530

3 *Fixed Assets*

02/03	*Cost* $	*Accum Depn* $	*Net Book Value* $
Computer Hardware	810,095	572,669	237,427
Computer Software	367,854	307,786	60,068
Communications Equipment	26,723	26,723	0
Furniture & Fittings	195,235	159,759	35,476
Leasehold Improvements	504,643	158,896	345,747
Motor Vehicles	42,280	42,280	0
Office Equipment	143,092	77,830	65,262
Total Fixed Assets	**2,089,922**	**1,345,943**	**743,980**

01/02			
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 2003 — continued

Actual 01/02 $	Note			Actual 02/03 $
	4	***Depreciation***		**02/03**
81,370		Computer Hardware		106,547
32,526		Computer Software		53,367
0		Communications Equipment		0
12,820		Furniture & Fittings		11,342
40,106		Leasehold Improvements		77,602
0		Motor Vehicles		0
17,929		Office Equipment		20,652
184,751				269,510
	5	***Reconciliation between Net Cash Flows from Operating Activities and Net Surplus***		
(573,862)		Net Surplus		(432,326)
		Add Non-cash Items:		
184,751		Depreciation		269,510
		Movements in Working Capital Items		
85,930		Increase/(Decrease) in Sundry Creditors	97,962	
(34,232)		Increase/(Decrease) in GST Payable	16,176	
(2,063)		(Increase)/Decrease in Trade Debtors	286	
0		(Increase)/Decrease in Prepayments	0	
30,429		(Increase)/Decrease in Interest Receivable	17,961	
80,064				132,384
30,244		Net Profit on Disposal of Assets		0
(278,803)		Net Cash Flow from Operating Activities		(30,432)

6 ***Commitments***

(a) Advocacy Service contracts:
The maximum commitment for the 12 months from 1 July 2003 is $1,951,000.

(b) Premises Leases including leasehold improvements:
Auckland $226,800 per annum until March 2008
Wellington $76,000 per annum until March 2006

Note

6 (c) Rental agreements:

Telecommunications equipment
$42,630 per annum until January 2004

(d) Classification of Commitments

Actual 01/02 $		Actual 02/03 $
2,153,330	Less than one year	2,278,669
327,669	One to two years	302,801
1,084,338	Two to five years	1,059,204
0	Over five years	0
3,565,337		3,640,674

7 ***Contingent Liabilities***

As at 30 June 2003 there were no contingent liabilities (01/02 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.

Maximum exposures to credit risk at balance date are:

Actual 01/02 $		Actual 02/03 $
2,084,507	Bank Balances	1,716,586
42,114	Sundry Debtors	23,868
2,126,621		1,740,454

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.

Note

Fair Value

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

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 5.8%.

9 *Related Party*

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

During the year the Health and Disability Commissioner received $6,148,444 (excluding GST) in operating grants from the Crown. There was no other funding owing from the Crown at year end.

There were no other related party transactions.

10 *Exceptional Items*

An organisational restructure project commenced in May 2003 and is due for completion in December 2003. Two projects to enhance the Enquiries and Complaints database and the Advocacy database commenced in May 2003. All three are being project managed externally.

11 *Employee Remuneration*

Total remuneration and benefits	*Number of employees*	
$000	01/02	02/03
100–110	2	1
110–120	–	1
170–180	1	1

The Commissioner's remuneration and allowances are determined by the Remuneration Authority in accordance with the Remuneration Authority Act 1977. The Commissioner's remuneration and benefits are in the $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
1.1 General Education		
1.1.1 Provide appropriate educational material.	100% orders dispatched within 5 working days of receipt of request.	Target achieved. A total of 370,797 units were despatched in the year, all within the 5-day time line.
1.1.2 Update HDC website to improve quality and accessibility of information.	Website updated by 31 December 2003.	Target achieved; review of website content is ongoing.
1.1.3 Develop case notes of key HDC opinions.	Case notes published on website by 31 March 2003.	Target achieved.
1.2 Consumer Education		
1.2.1 Produce, in conjunction with the Mental Health Commission, a brochure explaining the use of advance directives by mental health consumers.	Brochure launched at MHC Building Bridges Conference in April 2003.	Target achieved; brochure is now included in HDC educational publications.
1.2.2 Deliver and evaluate educational programmes to disabled consumers.	Ten seminars delivered nationally to disabled consumer groups by 30 June 2003.	Target achieved.
	Not less than 60% satisfaction with seminars in survey of participants.	Target achieved; 85% satisfaction reported.
1.2.3 Publish, in conjunction with IHC, a "plain language" poster, brochure and guide to HDC and the Code.	Poster, brochure and guide developed by 31 December 2002.	Target achieved; documents are now included in HDC educational publications.
1.2.4 Deliver and evaluate an educational programme for Māori consumers.	Two pilot seminars held and revisions made to education programme by 31 December 2002.	Target achieved.
	Two further seminars held by 31 March 2003.	Target achieved.
	Not less than 60% satisfaction with seminars in survey of participants.	Target achieved; 100% satisfaction reported.

Expected Performance and Standards	Target	Actual
1.2.5 Deliver and evaluate an educational programme for Pacific Island consumers.	Two pilot seminars held by 31 December 2002.	Target not achieved. Despite considerable effort, a Pacific Island speaker was unable to be contracted.
	Not less than 60% satisfaction with seminars in survey of participants.	Target not achieved. See above.
1.2.6 Publish Code of Rights and Consumers' Guide to HDC for refugees on the HDC website in selected languages.	Code of Rights and Consumers' Guide published on website by 30 June 2003.	Target achieved.
1.3 Provider Education		
1.3.1 Deliver and evaluate one national educational seminar for District Health Board complaints handling staff.	Seminar held by 30 April 2003.	Target achieved.
	Not less than 60% satisfaction with seminar in survey of participants.	Target achieved; 100% satisfaction reported.
1.3.2 Deliver and evaluate one regional educational seminar for complaints handling staff of Māori providers.	Seminar held by 30 April 2003.	Target achieved.
	Not less than 60% satisfaction with seminar in survey of participants.	Target achieved; 100% satisfaction reported.
1.3.3 Deliver and evaluate one regional educational seminar for complaints handling staff of Pacific Island providers.	Seminar held by 30 April 2003.	Target not achieved. See 1.2.5 above.
	Not less than 60% satisfaction with seminar in survey of participants.	Target not achieved. See 1.2.5 above.

Key Result Area 2: Advocacy

Objective: *Operation of a New Zealand-wide advocacy service 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 Contract Compliance		
2.1.1 Compliance with Advocacy Service contracts and statutory Advocacy Guidelines is achieved.	100% compliance. Contracts agreed by 31 July 2002.	Contracts complied with.
Closed enquiries 6,343.	Targets agreed with Ministry of Health by 31 July 2002, including targets for Complaints Resolution and Education.	7,428 closed enquiries — 117% of annual target.
Complaints managed 4,200.		4,578 complaints managed — 109% of annual target.
Education sessions 1,327.		1,328 education sessions — 100% of annual target.
Networking contacts 1,399.		2,184 networking contacts — 156% of annual target.
	Independent quality review undertaken by 30 June 2003 confirms compliance.	Review completed.
2.2 Quality		
2.2.1 Deliver independent, high quality, consistent nationwide services to consumers during 2002/03.	60% of complaints will be resolved or partly resolved with advocacy.	74% resolved or partly resolved with advocacy.
	80% of a random sample of consumers satisfied with advocacy services.	81% of a random sample of consumers were satisfied with advocacy services.
2.2.2 Deliver high quality, consistent educational programmes to consumer groups and providers during 2002/03.	80% of a random sample of consumer groups and providers report that educational programmes improved their knowledge about the Code and services offered by advocacy.	89% of those who participated in educational programmes improved their knowledge of the Code and services offered by advocacy.

Key Result Area 3: Complaints Resolution

Objective: *Provide information in response to enquiries; assess and resolve complaints; and provide mediation services.*

Expected Performance and Standards	Target	Actual
3.1 Timeliness		
3.1.1 Meet agreed throughput targets for handling enquiries.	Estimated 4,000 enquiries handled in 2002/03.	Enquiries handled: 7,735. Target achieved.
	170 formal responses to enquiries regarding the Act and Code.	193 formal responses. Target achieved.
	85% of enquiries closed within 48 hours.	97% of enquiries closed within 48 hours. Target achieved.
3.1.2 Meet agreed throughput targets for handling complaints.	Estimated 1,300 new complaints resolved in 2002/03.	1,338 complaints resolved. Target achieved.
	90% of complaints resolved without investigation within 6 months of receipt.	90% resolved. Target achieved.
	50% of complaints resolved through investigation within 12 months of receipt.	35% resolved. Target not achieved owing to backlog of older files.
	60% of complaints resolved through investigation within 18 months of receipt.	60% resolved. Target achieved.
	80% of complaints resolved through investigation within 2 years of receipt.	82% resolved. Target achieved.
3.2 Quality		
3.2.1 Ensure complaints are resolved in a fair and timely manner using transparent, robust and consistent processes, and in accordance with Health Practitioners Competence Assurance Bill, when enacted.	Successful implementation of the re-engineered enquiries and complaints processes by 30 June 2003.	Target achieved.
	60% of a random sample of complainants satisfied with the fairness of the investigation process.	55% of respondents satisfied their view heard in a fair and unbiased way. 41% satisfied overall with fairness of investigation process.
	60% of a random sample of providers satisfied with the fairness of the investigation process.	80% of respondents satisfied their view heard in a fair and unbiased way. 82% satisfied overall with fairness of investigation process.

Key Result Area 4: Proceedings

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

Expected Performance and Standards	Target	Actual
4.1 Timeliness		
4.1.1 Decide in a timely manner whether to issue proceedings.	100% of files reviewed within 10 weeks of receipt of investigation file from Commissioner.	Targets not achieved owing to timing and complexity of referrals. 88% compliance.
Statistics from hereon are made on a provider basis. The 30 referrals since July 02 have resulted in 62 DP files.	Decision whether to issue proceedings made for 75% of files within 4 weeks of: final provider response; or final deadline given for provider response; or receipt of other relevant information required as a result of provider responses.	70% compliance.
	Decision whether to issue proceedings made for 100% of files within 6 weeks of: final provider response; or final deadline given for provider response; or receipt of other relevant information required as a result of provider responses.	80% compliance.
	100% of disciplinary charges or HRRT proceedings filed within 6 weeks of decision being made.	65% compliance.
4.2 Quality		
4.2.1 Undertake high quality proceedings in accordance with s 49(1) of the Act.	Survey of key disciplinary bodies and Human Rights Review Tribunal confirms that proceedings are of high quality.	Target achieved. Respondents report high quality proceedings.

Key Result Area 5: 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
5.1 Quality		
5.1.1 Provide high quality, relevant submissions on key policy documents and proposed legislation affecting the rights of health and disability services consumers.	All policy advice meets deadline set for submission.	Target achieved.
	Key stakeholders report high quality, relevant submissions.	Target achieved. Respondents reported high quality, relevant submissions, received by deadline.

Key Result Area 6: 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
6.1 Human Resources		
6.1.1 Maintain a happy and professional organisation.		
6.1.2 Take steps to measure and improve our organisational health.	Staff workshops on organisational culture completed by 30 September 2002.	Target achieved but with delay in deadline; workshops were completed in March 2003.
	Agreed changes to HR policies and procedures finalised by 28 February 2003.	Target not achieved because of delays in workshops.
	Participate in Deloitte Public Sector Salary Survey in February 2003.	Target not achieved; salary survey was not undertaken.
	Job evaluation of each new position undertaken as and when each position is established.	Target achieved.

Expected Performance and Standards	Target	Actual
6.2 Information Technology		
6.2.1 Ensure that Information Systems Strategic Plan (ISSP) is aligned to current and future business needs and reviewed annually.	2001 ISSP revised by 30 September 2002.	Target achieved.
	User requirements for 2003/04 financial year identified by 31 March 2003.	Target achieved.
	ISSP for 2003/04 finalised by 30 June 2003.	Target achieved.
6.3 Finance		
6.3.1 Manage the HDC Budget for the 2002/2003 year.	Quarterly reports to be presented to the Ministry of Health within the time lines of the Letter of Agreement.	Target achieved.
6.3.2 Maintain or improve the grading in each area of Financial and Service Performance Management specified in Audit NZ's annual audit report.	Gradings for 2001/2002 are: 1. Financial control systems — Good. 2. Financial management information systems — Good. 3. Financial management control environment — Satisfactory. 4. Service performance information and information systems — Good. 5. Service performance management control environment — Satisfactory.	Target achieved; two gradings of "Satisfactory" were upgraded to "Good".
6.3.3 Complete the development and implementation of systems and documentation recommended in our Audit Report for 2001/2002.	Documentation completed by 30 November 2002.	Target achieved.
6.3.4 Develop Statement of Service Performance (SSP) and Statement of Financial Performance (SFP) for 2003/2004 year and submit drafts to the Ministry of Health.	Draft SSP and SFP submitted by 31 May 2003.	Target achieved.

Health and Disability Commissioner
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