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HEALTH AND DISABILITY COMMISSIONER

Te Toihau Hauora, Hauātanga

ANNUAL REPORT

for the year ended 30 June 2004

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

5 October 2004

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 2004.

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

Introduction

This report covers my fourth year as Health and Disability Commissioner and discusses the following key features of the 2003/04 year:

- Complaints and quality
- Continued progress in clearing the backlog
- Review of the Act and Code
- Trial by media
- International work
- HDC Consumer Advisory Group

Complaints and Quality

A decade has passed since the New Zealand Parliament legislated for a Health and Disability Commissioner, an independent agency designed to "facilitate the fair, simple, speedy, and efficient resolution" of complaints about the quality of health care and disability services. Most complaints are resolved swiftly and with minimal intervention, and the minority of complaints that proceed to a formal investigation are used to promote systems learning or to instigate remedial steps, if necessary.

Complaints offer a window of opportunity to improve health services. However, evidence is emerging that complaints are not necessarily the treasure trove that quality improvement gurus would have us believe. Instead of providing reconciliation and closure, complaints can have toxic effects on patients and health professionals, and may perhaps more accurately be described as "toxic treasure".

The first major review of the HDC complaints system, by Cull in 2001, reported that injured patients found the process "confusing, cumbersome, difficult to access and costly, both financially and emotionally". HDC's 2004 survey of complainants using its investigation services shows that only 46% were satisfied overall with the fairness of the process (in contrast to 80% of providers). It is perhaps not surprising that a system that upholds (by breach finding) only 43% of investigated complaints leaves complainants dissatisfied — although the parties who experience advocacy report much higher levels of satisfaction (86% of complainants and providers, in the 2003 survey). However, the investigation results indicate a failure to meet complainant expectations.

Research reported in the *NZMJ* in July 2004 indicated a significant immediate emotional impact on doctors and long-term reduction of trust in their patients, and suggested that doctors, although usually vindicated and rarely "named and blamed", also have a very negative view of the complaints process. Doctors' attitudes towards complaints were also revealing. A disturbing 31.5% of respondents did not agree that "most complainants are normal people" — a figure strongly at variance with my own experience of the sort of people who complain to HDC (who include many health professionals) — and only 34% felt they learnt from the complaint. However, whatever the pitfalls of the current system, doctors rightly perceive that patients need a voice for their concerns, and that the alternative of malpractice suits would be far worse.

Clearly, complaints need to be handled with care, to minimise the risk of toxic effects on patients and health professionals, and to maximise the potential for learning. Arguably, the very notion of complaint is unhelpful, conjuring up images of whingeing consumers. In practice, many complainants simply have questions about their care and/or are unhappy about poor communication, and the "right to an explanation" would be a more apt (and less pejorative) description.

Achieving a sense of completion at the end of the complaints process is important for both the provider and the complainant. Effective complaints resolution provides closure and, if possible, healing of the consumer–provider bond. Complaint handling techniques such as the use of advocacy or mediation, with the opportunity for facilitated face-to-face meetings of the parties, can enable healing that is denied by paper investigations.

Changes resulting from the Health and Disability Commissioner Amendment Act 2003 (in effect from 18 September 2004) will significantly enhance the Commissioner's power to deal with complaints appropriately, and should reduce duplication of process and enable early resolution. The new legislation seeks to ensure a balance between resolution for individuals and protection of the public. It makes explicit the Commissioner's power to deal with complaints in the most appropriate way, and introduces more flexibility in the options available. After receiving a complaint, the Commissioner will be required to make an initial assessment, including preliminary enquiries if necessary, to decide what action, if any, to take — the Commissioner can decide to take no action, if action is "unnecessary or inappropriate". As well as the option of referring the matter to an advocate for low-level resolution, there will be a new option of referring the matter to a provider for resolution, or calling a mediation conference, without the need for formal investigation.

Patients and health professionals have a shared interest in the provision of good quality care. But clinicians are fallible and work in complex systems where mistakes are inevitable and miscommunication is rife. Patients are remarkably forgiving when things go wrong or communication is inadequate, but when sufficiently aroused will voice their complaints. My hope is that the law changes will reduce the toxic effect of current complaints processes on complainants and providers — and help HDC achieve its statutory mandate of "the fast, simple, speedy, and efficient resolution of complaints".

Continued Progress in Clearing the Backlog

This year the number of new complaints remained fairly static (1,142 compared to 1,159 last year), but the Office has made further progress in clearing the backlog of open files. The number of investigation files has reduced from 500 (in 2000) to 200 (in 2004). The more complex and difficult files, which are time-consuming to investigate, are being handled more efficiently, with files open for longer than 18 months down from 20% of total files in 2000 to just 4% currently. The overall tally of open files was reduced to an all-time low of 347 at 30 June 2004.

These improvements are the result of the continued hard work of HDC staff. Greater use of advocacy and intervention by HDC's complaints assessors have improved the speedy low-level resolution of complaints. Overall, 59% of all files are closed within three months.

By focusing on early resolution we have achieved a 49% drop in the number of formal investigations (down to 179 for the 2003/04 year). The percentage of breach findings in completed investigations has increased to 43% (from 32%), reflecting more detailed initial assessment of whether a complaint raises concerns that warrant investigation. However, there has been a significant 40% drop (down to 18) in referrals to the Director of Proceedings, consistent with HDC's rehabilitative approach.

Review of the Act and Code

As required under our statute, HDC undertook a Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights, and reported to the Minister of Health. The Report was tabled by the Minister in Parliament on 25 August 2004.

The review process started in November 2003 when invitations were sent to key stakeholders seeking preliminary feedback on the operation of the Act and Code. Those comments, together with my own views as Commissioner, were compiled in a consultation document, which was distributed in February 2004. The consultation document canvassed a wide range of issues, including the changes under the HDC Amendment Act 2003, and a number of key provisions were highlighted for discussion.

During March and April 2004, submissions were again invited from interested organisations and individuals, as well as from the public at large as part of a nationwide consultation process. Release of the consultation document coincided with national and local media releases announcing the reviews. The HDC free phone 0800 number was available for those wishing to request information or to make an oral submission. The consultation document was also posted on the HDC website and received 1,908 hits during March and April 2004.

In addition to the invitation for submissions, feedback on the Act and Code was obtained during a series of meetings. Public meetings were held throughout the country and were advertised beforehand by public notice and local media releases. Māori and Pacific Island focus group meetings were also held.

Sixty-three submissions were received in response to the consultation process. Many of the submissions applauded the work of HDC and supported the changes coming into effect in September 2004. Other common areas of discussion included access to HDC services by disabled consumers, alternative structures for HDC advocacy services, the recent amendment to Right 7(10), whether consumer responsibilities should be included in the Code, and whether the Code should include a right to access services. A number of submissions also made operational suggestions, which have been, or will be, adopted by the Commissioner.

The submissions were analysed and incorporated into the Commissioner's Report, which was presented to the Minister of Health on 30 June 2004. The Report confirms that, overall, the Act and Code are operating effectively. I have, however, suggested that reviews of the Act and Code occur less frequently, that the Act reflect the Office's current practice of honouring Treaty principles, and that the Code be amended in relation to research involving consumers who are not competent to consent.

The recommended changes to the Act and Code will not come into effect unless the Government decides to adopt the recommendations.

Trial by Media

Stories of medical misadventure and patients' death or disability continue to attract media interest. Notwithstanding the growing understanding of the complex nature of adverse events in health care — and the fact that individual negligence is seldom the sole contributory factor — injured patients and their families often focus on a single health professional involved in their treatment. Despite the willingness of many providers to disclose mistakes and say sorry, and the availability of publicly funded complaints mechanisms (advocates and HDC), a minority of disgruntled patients are quick to contact the media. There is a growing tendency for the media to publicly identify health professionals accused of negligence — even before they have had an opportunity to put their case and have the matter adjudicated. This is a disappointing trend, since premature publicity creates the impression of a "guilty professional" and adds to the stress experienced by the individual under investigation. Equally regrettable is the media's willingness to be used by complainants who seek to put public pressure on HDC to reverse a provisional finding.

New Zealand faces a serious health workforce shortage. One of the factors cited by doctors giving up practice is hostile media publicity. In fact, most media reporting of health is positive. The media has a legitimate role in reporting concerns about the quality of health care. But reporters should aim for fairness and balance in their stories. HDC will continue to strive to protect the privacy of patients and health professionals in our handling of complaints and investigations. We publish

non-identifying investigation reports on our website (www.hdc.org.nz). We have an eight-year track record of non-disclosure (even in the case of a breach report, where a public interest argument in favour of disclosure can be made).

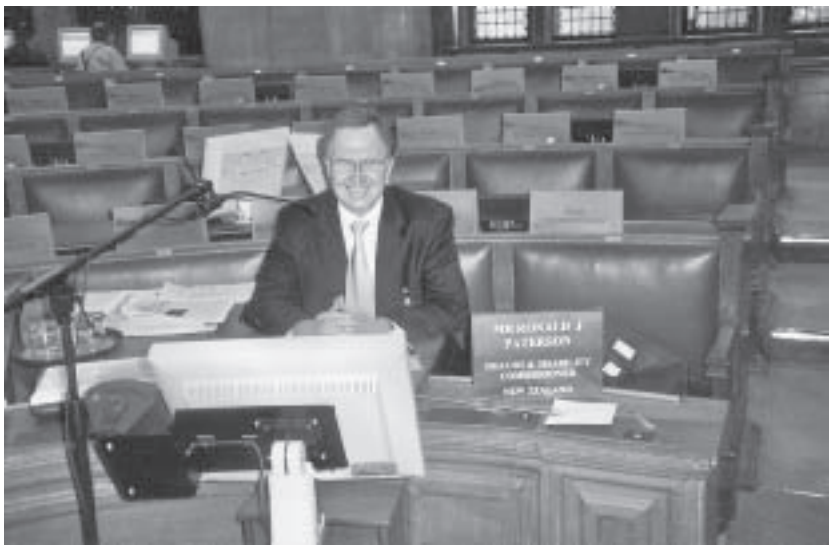
Disciplinary cases are in a different category. Here, there has usually been an investigation by HDC, a finding that the health professional breached the Code of Patients' Rights, and a decision by the Director of Proceedings that the matter warrants disciplinary proceedings. Parliament has signalled (in the Medical Practitioners Act 1995 and the new Health Practitioners Competence Assurance Act 2003) that disciplinary hearings must generally be held in public. Currently, only a tiny number of doctors face disciplinary charges before the MPDT (10–20 a year) and recent cases favour name suppression until the Tribunal makes its decision (*Director of Proceedings v I*, High Court Auckland, Frater J, 20 February 2004) and even occasionally following a guilty finding (*Director of Proceedings v M*, MPDT No 296/04/118D, 23 August 2004). There is an important public interest in transparency and accountability in disciplinary proceedings, and name suppression following a guilty verdict should be reserved for truly exceptional cases.

International Work

There is increasing interest internationally in New Zealand's unique combination of state-funded compensation for medical misadventure (via ACC) and resolution of complaints by independent advocates and the Health and Disability Commissioner. In January 2004, I presented evidence in Manchester, England, to the judiciary inquiry into the notorious GP Harold Shipman, who killed 215 (probably 260) of his patients. New Zealand's legally enforceable Code of Patients' Rights, the right to complain, and the system of co-regulation (ie, registration and competence matters regulated by registration authorities; complaints and discipline by an independent Commissioner) was of great interest to the Inquiry Judge, Dame Janet Smith.

In March 2004, HDC hosted the Australasian State Health Care Complaints Commissioners to a two-day meeting in Auckland. HDC attends six-monthly meetings with the Australian Commissioners, and benchmarking exercises and informal feedback suggest that New Zealand's complaints resolution and educational initiatives are recognised as leading-edge.

In February 2004 I was appointed by Australian Health Ministers to chair a review of the system for assessment of overseas-trained surgeons — specifically, the assessment processes of the Royal Australasian College of Surgeons. Australia, like New Zealand, faces a surgical workforce shortage, and the review seeks to balance the competing demands of access to services (especially for rural and regional consumers) and maintenance of high quality surgical standards.



Presenting at the Shipman Inquiry, January 2004

In June 2004, I was invited to present a paper on "New Zealand's No-fault System" to the Academy Health Conference in San Diego. This is the leading health services researchers' meeting in North America, and was an excellent opportunity to showcase the New Zealand model of health and disability complaints resolution.

Australasian State Health Care Complaints Commissioners meeting in Auckland, March 2004

HDC Consumer Advisory Group

The HDC Consumer Advisory Group has met three times since the inaugural meeting in June 2003. The group provides valuable advice and feedback to the Commissioner on strategic issues. Members also provide input on submissions made by HDC.

Members are Huhana Hickey, Evan McKenzie, Beverley Osborn, John Robinson, Barbara Robson and Ana Sokratov. Judi Strid departed the group on her appointment as Director of Advocacy, and was replaced by Kim Robinson. Kim is a Policy Analyst for the Deaf Association of New Zealand. He is involved in Human Rights advocacy at national and international levels for Deaf persons, and has represented the New Zealand Deaf Community through various central and local Government advisory groups.

Acknowledgements

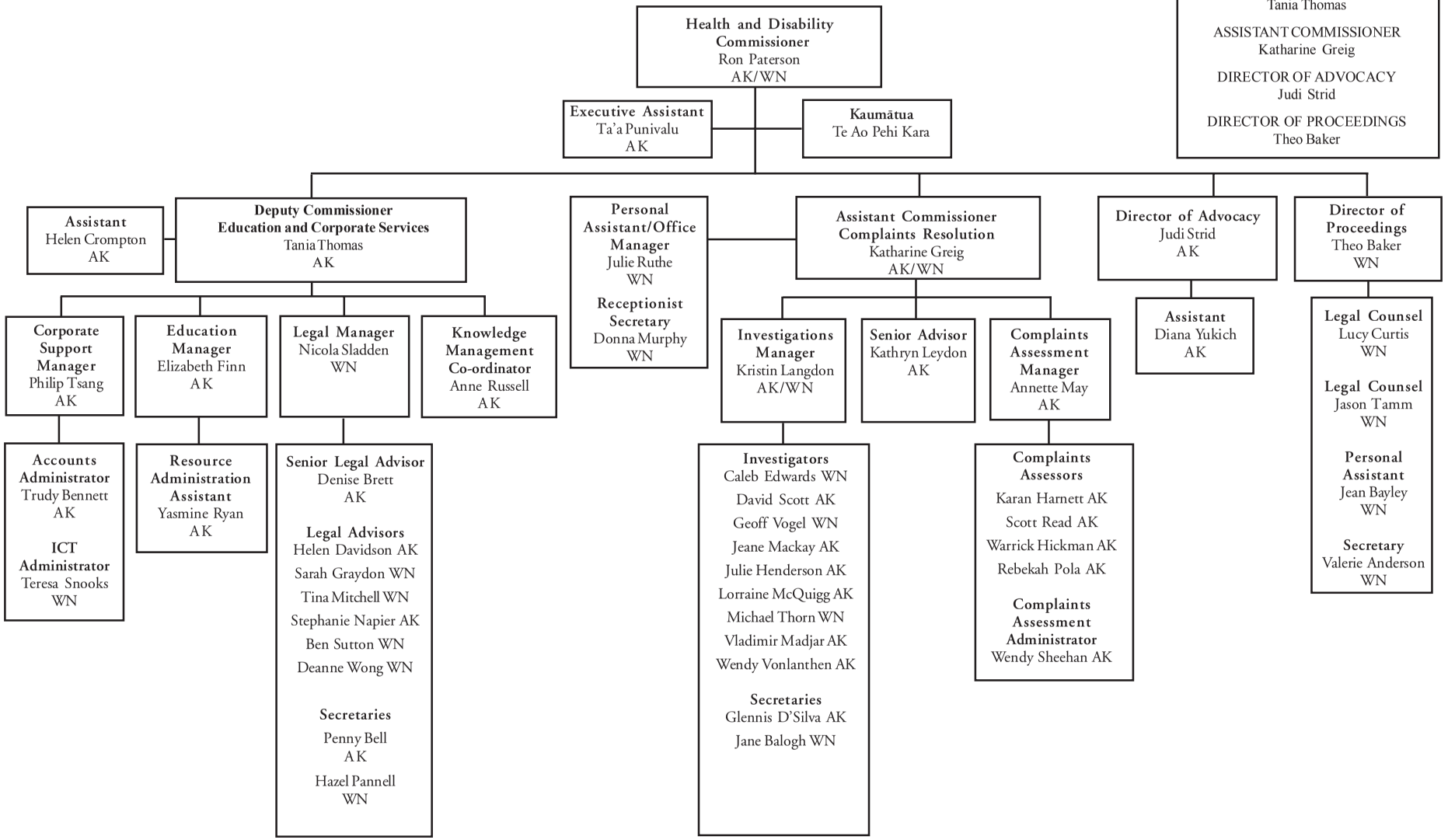
The year marked the departure of long-term Investigations team leader Kathryn Leydon, who has played a vital role in HDC's complaints assessment and investigative work since 1996. Corporate Services Manager John Berridge also departed after three years' loyal service to the organisation (2001–03).

Key changes to the Senior Management Team were the appointment of Tania Thomas as Deputy Commissioner, Education and Corporate Services, and of a new Director of Advocacy, Judi Strid, who brings a wealth of consumer advocacy experience to HDC. Tania has overseen significant improvements in advocacy services during her time as Director (2001–04). Morag McDowell resigned as Director of Proceedings at the end of 2003, after two and a half years in a tough role in which she displayed professionalism and achieved excellent results. Former Proceedings Counsel, Theo Baker, took office as Director of Proceedings in January 2004.

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 2003/04.

Health and Disability Commissioner

Organisation Chart — 30 June 2004



Report of the Deputy Commissioner — Education and Corporate Support

Deputy Commissioner, Tania Thomas

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

Introduction

The Health and Disability Commissioner's Office has embraced the notion of continuous learning. We have challenged ourselves and moved out of our comfort zone, we have acquired new knowledge, and have experimented in working in new ways. We have completed a reorganisation of our teams and our processes because we wanted to create an exciting work environment and to stimulate our staff to go beyond the usual to discover better, more effective ways of doing things.

New Look Structure

We now have a Corporate Support division, which provides the Commissioner's complaints resolution function with human resource advice, legal advice, technological systems and organisational planning and budgeting processes to support their core work. We also have an Education/Knowledge Management division, which develops and compiles up-to-date, consistent and leading-edge learning resources for internal education and external education of consumers, providers and professional bodies.

These two divisions are led by a new role — the Deputy Health and Disability Commissioner, which encompasses responsibility for responsiveness to disability issues and partnership with Māori. In addition to this change we have shared leadership responsibility among more people across more levels within HDC. HDC managers are pushing to create relationships amongst our staff that are trusting and challenging, supportive and provocative, visionary and practical, so that we can continue to find better solutions to resolving complaints.

High Stakes Work

The Commissioner and his staff often have to face and manage anger, outrage, blaming, sadness, crying, aggressiveness, questions about their ability, evasiveness, and personal attacks from some complainants and providers. The expression of these emotions is understandable. There is a lot at stake for complainants and health and disability providers when a complaint has been made. For complainants, we become involved in their lives because they may feel powerless or violated in a very personal way. For providers, their reputation is on the line.

There is also a lot at stake for HDC, as our reputation is shaped by how well we handle ourselves under the pressure of working with people who are often upset, regardless of the "rights" or "wrongs" of a particular situation. HDC seeks to accomplish exceptional results, and this requires the

Commissioner's team to work with impartiality, objectivity and composure at all times. This approach requires us to identify and nurture "best-in-class" qualities within our functions and processes.

Māori

The Commissioner's Office has continued to develop tools and knowledge to enable staff to work more appropriately with Māori.

HDC staff contact with Māori can be through enquiries, the complaints assessment process, the investigation process, arranging a mediation, or through a presentation or educational interaction. In all these situations it is important for staff to feel comfortable and able to offer services that will support completion of the process; for example, offering the opportunity for karakia, and ensuring Māori know that support people are welcome and that speaking Māori is supported. A competency training plan for working with Māori has been developed for all HDC staff, and is about to be implemented. This work continues to be supported by HDC's kaumātua, Te Ao Pehi Kara, and a range of Māori advisors and trainers.

HDC is looking forward to adding to its information resources by publishing a guide to using HDC's services for Māori to support the newly designed brochure in Māori on the Code of Rights.

Disability

An implementation plan for the New Zealand Disability Strategy has been approved by the Ministry of Disability Issues and has been implemented. The plan focuses on building staff capability in working with people with disabilities, and providing consumers with a disability with improved access to information and greater promotion of their rights and how to enforce them. HDC is also a member of the "Mainstream" programme, which is a public sector, supported employment programme for people with disabilities.

Successful resolution of complaint through mediation

Mr A was admitted to a hospital Emergency Department after injuring himself in a car accident that morning. On assessment his main complaint was abdominal and back pain. X-rays of his back and neck showed no fractures and he was discharged around 5pm. Mr A's condition deteriorated and he was re-admitted to the Emergency Department at 10pm with pain in the kidney region and symptoms of shock. He was re-assessed and discharged home with pain relief and treatment for a urinary tract infection. Four days later he deteriorated markedly with disorientation, increased abdominal and back pain, and weakening of his legs. He was admitted to Intensive Care and received treatment for a contusion of the small bowel. Mr A continued to have intermittent complaints of back pain but another X-ray showed no fracture. However, a further X-ray and CT imaging taken a few days later indicated a fractured spine. Mr A experienced increasing heaviness in his legs and subsequently developed paraplegia.

This serious complaint concerned the standard of care Mr A received at the hospital. The primary issue was the failure of hospital medical staff to diagnose the fracture, which left Mr A paralysed. The complaint also concerned pain management, nursing care, and communication.

The Commissioner commenced an investigation and, after reviewing the hospital's response, referred the matter for expert orthopaedic advice. The advisor considered that, overall, the care Mr A received was satisfactory. Mr A's fracture was not displaced at the time of initial X-ray investigation and was therefore hidden from view. The advisor stated that this was an exceptionally complex case, and that Mr A had received good management and well documented, compassionate care.

In light of the expert clinical advice, and the unresolved communication concerns, the matter was considered appropriate for mediation. As Mr A's family were of Māori descent the Commissioner engaged a Māori mediator with knowledge of cultural issues. The family and the District Health Board were provided with a copy of the expert advice prior to the mediation conference to guide them in their discussions.

The mediation conference resulted in a successful outcome. This included a written apology by the Board to Mr A and his whānau, as well as the instigation of a process to restore his mana. In their letter of apology, the Board commented that the mediation was a learning experience for all involved, and that the knowledge would be applied for the benefit of all patients.

Report of the Director of Advocacy

Director of Advocacy, Judi Strid

Introduction

It has been a busy year for the advocacy service. I wish to acknowledge the dedication, commitment and expertise of the advocates, managers and Trust members from the three advocacy service organisations that provide the nationwide advocacy service. I also wish to acknowledge the inspiring leadership of Tania Thomas, the former Director of Advocacy, who left during this period to take up the position of Deputy Commissioner. Tania has put in place a model of advocacy that is consumer-centred, collaborative and well placed to achieve successful low-level resolution.

The surveys and feedback from consumers continue to show that advocacy is a very effective approach for resolving complaints. Advocacy offers consumers access to immediate information about options, as well as assistance to resolve complaints in a manner that also seeks to identify opportunities for learning and making improvements to services. The training and education sessions provided by advocates continue to be in high demand and receive positive responses.

The opportunity for supported face-to-face meetings with providers enables consumers to talk to their health or disability provider about their concerns. Common themes continue to emerge from complaints. Although most complaints are about standards of care, it is often the communication issues and attitudes consumers encounter that make it difficult for them either to approach a provider on their own or resolve the matter satisfactorily. Consumers continue to articulate their wish for providers to listen, to involve them in discussions about their concerns, to provide the information they need, and to support their decisions. Consumers want to feel respected. They want their ideas and opinions valued. Being respected nurtures self-confidence and is more likely to generate a willingness to work together collaboratively — an environment all providers should be aiming to achieve.

Advocates have observed that many complaints could have been avoided if the communication between provider and consumer had been more effective and expectations better managed.

Advocates achieve resolution in the vast majority of complaints by demonstrating respect in personal interactions with consumers and providers. This creates a positive environment in which people feel more able and motivated to express themselves. This in turn can lead to both parties taking a chance on trying something new to resolve the issues at hand and therefore opening up the potential for learning from the situation. Respectful relationships make it easy to do the right thing. Respect for people is contagious and advocates will continue to infect as many people as possible.

Advocacy in Action

Advocates continue to look for opportunities to raise the profile of advocacy, identify areas where information and education is needed, establish and maintain community links and networks, and be proactive in ways that could help enhance the quality and effectiveness of service delivery.

In some areas advocates participate in the orientation of new staff in provider organisations, including some District Health Boards (DHBs). Advocacy services report a more productive working relationship with provider staff where advocacy has been included in the orientation programme and the role of advocates is better understood. One service manager was invited to participate in discussions about the development of the complaints procedure for a Primary Health Organisation (PHO) as well as the review of the complaints process for the local District Health Board. A number of the larger provider organisations have invited advocates to be part of their planning committees and other forums where there have been opportunities for discussion on the Code and the provision of consumer-centred services.

On receipt of a complaint, an advocate offers the consumer or complainant options for resolving the issues themselves or with advocacy support. Strengths-based advocacy is practised to assist the consumer to find the most appropriate way forward for his or her set of circumstances. This may include coaching consumers to handle the issue themselves (where appropriate) — an option that a number of consumers appreciate. Many say that once they have the options explained to them, they are able to "get on with it".

Consistent with the aim of low-level resolution, the option of addressing the complaint directly with the provider concerned is always discussed. A verbal response or explanation from the provider is often the best way of resolving concerns quickly. Processes an advocate may assist a consumer with include meeting with or writing to providers, accessing medical records or other information related to the health or disability service, or formulating a formal complaint to the HDC.

Self-advocacy

Mrs A was provided with verbal and written information about advocacy and the Code after relaying the following: On a number of occasions she and her doctor had discussed the probability that she would need to be commenced on an antihypertensive. At a consultation her blood pressure was noted, yet again, to be high, and the doctor advised that it was now time to start the treatment. They again discussed her reluctance to commence treatment, but she agreed to do so. Mrs A was told the name of the medication being prescribed and she asked about possible side effects. The doctor told her she would know if she experienced any and she should return if she did. Mrs A then requested the same information from the dispensing pharmacist, who advised that it is not the pharmacy's normal practice to provide such information about the medication.

Mrs A was very disturbed about not being able to get the information and contacted the local advocate to reaffirm her rights. As a result of her concerns and discussions with the advocate, Mrs A decided to seek a second opinion from a specialist and contacted her GP's nurse to organise a referral letter. Within the hour her doctor had phoned her, having recognised her distress, and asked to meet with her later the same day. Mrs A's advocate offered to support her, but Mrs A felt able to proceed alone. She reported back to the advocate that the meeting had gone well and she had received the information she required. The doctor apologised for the distress caused and assured her that he would support her in obtaining a second opinion.

Enhancing Advocacy

Advocacy services have a commitment to quality improvement and professional development. We are moving towards advocacy practice based on competencies, a clearly defined scope and Code of Practice and, eventually, a formally recognised training programme with a national qualification. This will formalise what constitutes best practice and should be an effective way to achieve consistency and improved understanding of an advocate's role. This commitment is reflected in the comments made by consumers, and also in the high level of activity achieved.

The advocacy service organisations are working to implement recommendations from a recent Structure Review Report. This includes taking steps to work positively with providers and focus more clearly on achieving resolution. Improving professional relationships has resulted in an increasing number of providers seeking advocacy input into their complaints procedures and processes, as well

Back from left: Tony Daly (Manager, Advocacy Services South Island Trust, ASSIT); Maria Marama (Manager, Health Advocates Trust, HAT); Stacy Wilson (Manager, Advocacy Network Services Trust, ADNET). Seated from left: Judi Strid (Director of Advocacy); Diana Yukich (Assistant to the Director of Advocacy)

as an increased willingness to provide consumers with information about the advocacy service. This is a positive approach by providers in meeting their obligations under the Code.

Professional development and regular regional training for advocates continues to be a focus for building capacity, knowledge, skills and expertise. Improving services for Māori has been a priority. Advocates have participated in Te Reo and tikanga training, with opportunities for Māori advocates to attend workshops on the development of services for Māori. One service is implementing recommendations following an independent cultural audit.

Senior Advocate and Advocate Supervisor roles have been developed to acknowledge the skills of experienced advocates, to formalise a process of support for staff, and to focus on the effectiveness of advocacy practice. One service has implemented a "Staff Burn Out Programme" and a specific focus on quality assurance activities.

Nationwide Advocacy Service

The nationwide advocacy service comprises 41 advocates and three managers, who work within three separate advocacy service organisations (ASSIT, ADNET and HAT) contracted to provide health and disability consumer advocacy services. Eight of these people work full time and 36 are part time. Although collectively providing services to the entire country, the advocates are physically located in the following areas: Northland, Auckland, Thames, Tauranga, Hamilton, Te Kuiti, Whakatane, Rotorua, Gisborne, Turangi, New Plymouth, Napier, Wanganui, Palmerston North, Masterton, Wellington, Christchurch, Invercargill, Dunedin, Timaru, and Nelson.

All advocates can be contacted through a local or 0800 number and there is a free fax number so that deaf consumers can make contact.

Training

There has been a commitment during the year to develop effective education programmes on rights and advocacy. Our aim is to increase the awareness of consumers, providers and professional bodies on the benefits of low-level resolution, so that consumers are willing to exercise their rights and providers implement practices and processes that enable compliance with the Code. This has been done by providing programmes to train community advocates as well as coaching advocates and carers so that self-help becomes a valid option.

The advocacy services have developed "Train the Trainer" education packages for consumer representatives, to support consumer advocacy and education about the Code of Rights within

Training for providers

The staff of an organisation that provides services in a series of residential homes for disabled people were keen to explore ways to better respect consumer rights and to help consumers self-advocate. An advocate led a two-day training workshop for 16 staff to equip them to help residents to recognise their rights and to know how to self-advocate. Comments from the participants included:

"It has made me look deeper into different things that I do at work as she [the advocate] looked at it from an outsider's point of view."

"I have attended other workshops on this subject but never have I got as much from it as I have this time."

community groups. "Train the Trainer" education packages have also been tailored to the needs of disability groups, and specifically designed for providers to support them in the development of their own education packages about compliance with the Code. An increasing number of advocates now have the expertise to train others who provide advocacy.

One service provided a social work student placement for an eight-week period, during which time the student obtained an insight into the work of advocacy and the Commissioner's office.

Presentations, Education and Networking

There has been an increasing focus over the past year on providing education and presentations to the disability sector to ensure consumers with disabilities are aware of their rights and what options are available to them if they have concerns about a disability or health service. A number of initiatives have been developed to improve the links between advocacy and the disability community, and enhance our approach to disability issues, for example taking a holistic approach when assisting particularly vulnerable consumers such as those with complex disabilities.

A number of staff participated in promotional interviews on various radio stations, covering both official languages of New Zealand. One advocate regularly contributes to a Pacific Island station, in her native tongue.

Participation and involvement in local networks is required of all advocates. Developing relationships and mechanisms for ongoing liaison with local groups, organisations and agencies enables advocates to be well linked to their communities and in touch with local issues, and generates a trust in their ability to work effectively when resolution is needed.

Advocates report that networking is an effective means of sharing information, and learning about new initiatives and changes within the health and disability sector. Gaining insight into provider organisations' complaint processes, in particular who is aware of the complaints, the nature of the complaints, and the responses, has also been a helpful step.

Trends

Over the past year there has been a much greater demand for advocates to provide sessions for providers with a specific focus. Sometimes this has been prompted by an accreditation process. The most common topics have been informed consent, advance directives, and "Not for Resuscitation" orders.

Rural consumers continue to be less inclined to raise issues. Advocates consider that this relates to the low level of services available in small rural communities compared with urban areas, as well as a reluctance to complain about people they know. There continue to be numerous complaints about the lack of information and communication issues. Misunderstandings over what is meant by "treatment" and "rehabilitation" are common.

Advocates are contacted by prisoners who need assistance with the prison health service. Helpful working relationships have been established with Prison Inspectors and prison health staff.

The northern region has had an increase in contact from migrant communities with complaints about general practitioners. There has been an increase in the number of complaints received from people with physical and intellectual disabilities, and about the services provided by rest homes.

Some DHB complaints processes and lack of staff backup have caused significant delays in the resolution of complaints. Advocates report on a regular basis that providers are not responding within the timeframes outlined in the Code. Some require constant reminders of their duty to respond to complaints within the required timeframes.

Lack of discharge planning to ensure that support is appropriate continues to be a feature of many complaints relating to the discharge of older people. A significant number of enquiries still relate to concerns about ACC and WINZ. Advocates note that the most effective way to resolve complex complaints is to bring the parties together at a meeting.

ASSIT, the South Island service, has responded to 2,580 requests for information, a 14% increase on the previous year. 88.8% of complaints have been resolved or partially resolved at a low level. Of the 1,554 people who used an advocate to help with their complaint, 87.8% came directly to the service. 12.11% chose to approach HDC in the first instance. 65% of complaints were made by the consumer, 32% by a third party, and 3% came as formal referrals from the Commissioner.

29% of the complaints brought to ADNET for assistance were made as a result of the consumer/complainant having had direct contact with an advocate or the advocacy service; 23% were as a result of a provider suggesting advocacy; and 20% resulted from friends and family suggesting advocacy support. The remaining 28% of referrals came from a variety of sources such as other agencies, the Commissioner, advertising, etc. 81% of people chose advocacy in the first instance, and the remaining 19% took their complaints directly to HDC.

After receiving information from an advocate only 1% of ADNET's enquiries were escalated to a complaint. An analysis of the workloads of ADNET advocates over the past year showed that 276 enquiries and 151 complaints were managed per FTE (full-time equivalent position). In addition, advocates were proactive in the educational field, delivering 59 education sessions per FTE and networking with 93 organisations per FTE.

83.5% of complaints managed by the northern service, HAT, were resolved or partially resolved at a low level. 91% were resolved in less than three months and 99% in under six months. 9% were unable to achieve low-level resolution and 7.5% were referred to HDC.

Most complaints made to ASSIT were from people over 60 years of age, compared with ADNET, which received most from people in the 40–60-year age group.

Overall Consumer Response to Advocacy

When consumers were asked to rate the advocacy process, the role and skill of the advocate, and whether they received the help they needed, an average of 80% found advocacy beneficial. Some consumers, however, commented on the advocate's lack of power to effect changes such as facilitating access to services. Many suggestions for how things could have been done better actually related to the actions of providers and other parties. Those in custody, for example, were dissatisfied at the lack of choice and access to the services they needed. Some felt more could be done to make providers accountable for their actions. The following comments provide typical examples of the feedback from consumers.

Sorting the consumer–provider relationship

Mr A, a man in his mid-twenties, contacted advocacy services with concerns about being spoken to "as if he was a child" by his community support worker. He has lived with his disability all his life and until recently lived with his parents. He said that the support worker made reference to him making a friend "that may not be suitable" and he said it sounded "just like his mother". He has lived in supported housing for two years and feels he is able to choose his friends.

A meeting was held between Mr A, an advocate, and the support worker and his supervisor. Mr A was able to articulate how it had made him feel to be spoken to like a child. It was agreed that Mr A would continue with the support worker because he "got on most of the time" and the situation would be reviewed in three months' time.

Consumer's desire to live independently

Over the last 12 months an advocate has had ongoing contact (four separate complaints) with Mr A, a young man who has cerebral palsy. He is in his early twenties and requires 24-hour care. He lived at home with his family, and two family members were paid to provide personal care to him. He had been having ongoing difficulties with the care they provided, and had concerns about the way the family treated him. Mr A felt they were very over-protective, and wanted to leave home and live independently.

The advocate met with Mr A several times to explore how he might raise his concerns with the family. Initially Mr A felt unable to do so himself, so the advocate continued to visit each time he contacted her. During this time the advocate coached and mentored Mr A in knowledge of the Code of Rights and how he could exercise his rights effectively. The advocate also reiterated her support of him in actions he might take in resolving his issues.

The advocate encouraged Mr A to utilise other support people or agencies in his life. These included his Case Support Worker at CCS, who contacted him daily and arranged counselling to assist and support him in dealing with his development and self-confidence.

Over a period of time, Mr A finally felt able to meet with his family and providers to address his issues and concerns. The advocate attended as support. At this meeting Mr A was able to articulate his key issue and, consequently, now lives independently.

The advocate has continued to provide support and information to Mr A on issues involving his new caregivers and provider organisations. She recognises Mr A's growth and development in knowing his rights and how to exercise them.

"The advocate was on our side … in a supportive and advisory role; we could not have managed without her."
"Support invaluable — kept me focused."
"Has opened many doors that had been shut."
"Advocate fine and supportive but has no teeth to do anything like getting nurses disciplined or doctors struck off."
"Provided clarity and information."
"I was so impressed with the support I received; I wish I had known of this help before."
"Advocate understood problem and working together we got a solution."
"Set the wheels in motion."
"Professional, kept discussions on track."

While advocates constantly strive to empower consumers and teach them skills to resolve problems if faced with a similar situation, many feel they would not have achieved resolution if the advocate had not been involved.

"Situation was resolved calmly because of the presence of the advocate."
"Would still seek advocacy support and advice. I really don't think the health professionals would take a person's issues seriously."
"The support enabled me to gather my strength to take charge of the situation."

Consumers had the following comments when we asked what could have been done better:

"Did a good job but no teeth."
"Reduce the provider response time."
"It would have been good to have an apology from the nurse rather than the general manager — the nurse was the one who did it."
"A letter from hospital management would have been nice."

Overall Response to Educational Presentations

Overall there was a 92% level of satisfaction with education sessions provided by advocates. Consumers and providers were asked to comment on whether the information was helpful and improved their understanding of Code rights, whether the presentation was relevant and met their needs, whether there were opportunities for participation, and whether they know how to contact an advocate.

Report of the Director of Proceedings

Director of Proceedings, Theo Baker

Introduction

Whilst the number of referrals received from the Commissioner this year was fewer than last year, it has nonetheless been a very full and active year for the proceedings team. Not only was there an increase in hearings from the previous year, but several high-profile cases have attracted media attention. Medical Practitioners Disciplinary Tribunal hearings such as the disciplinary charges against Mr Breeze, Dr Fisher and Dr O'Flynn have been in the public eye. In the meantime, the Proceedings Team and briefed counsel have been engaged in prosecuting and settling many other matters.

Statistics

This year there were 18 referrals resulting in 21 Director of Proceedings files. The outcome of the referrals is contained in Table 1. This compares with 30 referrals resulting in 62 files in 2002/2003. A referral from the Commissioner is based on a complaint. One complaint may involve more than one provider. Proceedings files are provider-based.

The large number of referrals in the previous year is reflected in the hearing statistics found in Table 2 (overleaf). Of a total of 20 disciplinary charges laid against 19 registered health professionals, 16 were upheld. Two successful prosecutions were overturned on appeal and two are awaiting appeal hearings. One appeal has been adjourned part-heard.

Six appeals from the Medical Practitioners Disciplinary Tribunal were heard by the District Court this year. There were three appeals on interlocutory matters (two interim name suppression and one application for an adjournment). One case where the District Court granted interim name suppression on appeal was unsuccessfully appealed by the

Table 1: Action taken in respect of referrals to Director of Proceedings in 2003/2004

	No of Cases
No further action	
Dispensing technician	1
Medical practitioner	
General practitioner	3
Pharmacy	1
Pharmacist	2
Psychologist	1
s 49 decision in process	
Dentist	2
District Health Board	1
Medical practitioner	
General surgeon	
(3 complaints against 1 surgeon)	4
Hearings pending	
Discipline	
Dentist	1
Medical practitioner	1
Human Rights Review Tribunal	
Acupuncturist (1 hearing)	2
Counsellor	1
TOTAL	**20**

Table 2: Outcome of hearings in 2003/04

Provider	Successful	Unsuccessful	Outcome pending	Total
Discipline				
Chiropractor (2 charges arising from 2 separate complaints)	1			1
Dentist	1			1
Medical practitioner				
General practitioner	2*			2
General surgeon	2			2
Obstetrician/gynaecologist	2	1		3
Orthopaedic surgeon		1		1
Medical Officer Special Scale (psychiatry)	1			1
Psychiatrist		1		1
Nurse				
General	2			2
Midwife	1	1		2
Pharmacist	2			2
Psychologist (registered)	1			1
Appeals				
Interlocutory		3		3
Substantive	2		1	3
TOTAL	**17**	**7**	**1**	**25**

Note: Of the successful prosecutions against medical practitioners, 2 remain subject to appeal.
*Overturned on appeal.

Director in the High Court. Because of the significant implications of that decision on future name suppression decisions (on both interim and permanent bases), leave is currently being sought to appeal to the Court of Appeal.

Human Rights Review Tribunal

This year no Director of Proceedings cases were heard by the Human Rights Review Tribunal, but three matters (involving a total of four providers) were settled without the need for a hearing. One of those matters is discussed in the case study *Director of Proceedings v Matthews.*

As can be seen from Table 3 (opposite), on 30 June 2004 there were 11 providers facing proceedings before the Human Rights Review Tribunal. Two matters had been allocated hearing dates before the end of the calendar year, while five other matters were awaiting hearing.

Of these, two have been the subject of disciplinary charges. Section 50(5) of the Health and Disability Commissioner Act 1994 provides that where the conduct has been the subject of disciplinary proceedings, the Tribunal must have regard to the findings of the disciplinary body and to any penalty imposed in those proceedings. Therefore, where disciplinary proceedings are contemplated, it is desirable to have these heard first. The decision whether to issue proceedings before the Human Rights Review Tribunal is then deferred.

As a consequence, matters that have been referred in one year may not be heard in the Human Rights Review Tribunal until the following year, or even later.

Director of Proceedings v Matthews

In contrast to cases where there was an obvious breach of ethical standards, based on a sexual relationship, this case highlighted the serious consequences that a blurring of professional boundaries can have on the therapeutic relationship. While counselling the complainant, Mr Matthews was her colleague, her friend and her business partner. It was the Director's case that the care provided to the complainant was compromised by this crossing of boundaries.

Mr Matthews is an unregistered psychologist, and so there is no jurisdiction to lay a disciplinary charge before the Psychologists Board.

For many years the complainant had experienced obsessive compulsive disorder, depression and anxiety disorder. She was referred to a health provider organisation. She was initially under the care of a psychologist and a psychiatrist, who prescribed the antipressant medication Prozac (a serotonin reuptake inhibitor) and Anafrinil (a tricyclic).

Following a panic attack, the complainant started to see Mr Matthews as her therapist. She consulted him fortnightly and then weekly.

Over time, the complainant became involved with the organisation as a volunteer group co-ordinator. Later, the complainant was employed by the organisation on a three-month trial basis. Mr Matthews and she worked closely together, co-facilitating group therapy sessions, and became colleagues. He continued to counsel her.

By then, there had also developed a close friendship between the parties. Mr Matthews provided the complainant with his cell phone number and encouraged her to ring him at any time. He told her that he had special feelings for her, that he was fond of her and that he loved her as a friend. She was also very fond of him.

The complainant's depression gradually worsened and she became dependent and reliant on Mr Matthews. She would contact him often.

On several occasions Mr Matthews tried to terminate the therapeutic relationship over the telephone, but on each occasion the complainant begged him to continue as her therapist and the counselling continued. Her condition deteriorated and she became progressively more depressed.

On about four occasions the complainant became suicidal and on other occasions, she experienced suicidal ideation.

Mr Matthews, the complainant, her husband and another colleague entered into partnership to establish a private clinic. The complainant and Mr Matthews worked together at the clinic until he told her that he did not want to continue their clinical relationship or business relationship. Throughout that period the complainant's depression failed to improve. Despite the complainant's initial wish to continue the friendship, it also soon ended. The complainant was devastated by these events.

By consent, the Human Rights Review Tribunal made a declaration that Mr Matthews had breached Rights 4(1), 4(2) and 4(4) of the Code (HRRT Decision No 9/04, 16 April 2004).

Table 3: Providers facing proceedings before the Human Rights Review Tribunal at 30 June 2004

Provider	Proceedings being drafted	Proceedings filed awaiting response/ fixture	Set down for hearing	Successful hearing awaiting damages award	Settled awaiting final orders	Total
Acupuncturist*			1	1		2
Counsellor	1				1	2
District Health Board		1				1
Medical practitioner		1	1			2
Registered nurse**	1				1	2
Rest home licensee**					1	1
Social worker		1				1
TOTAL	**2**	**3**	**2**	**1**	**3**	**11**

*One acupuncturist faces two claims arising from different complaints.

**There is one claim against a registered nurse and rest home, arising from the same complaint.

Director of Proceedings v Rama

This year the Director of Proceedings successfully prosecuted Auckland dentist Dr Natu Rama for the third time. On 10 November 2003 the Dentists Disciplinary Tribunal found Dr Rama guilty of an act detrimental to the welfare of the patient (pursuant to s 54(1) (b) of the Dental Act 1988). On this occasion Dr Rama did not appear to answer the charge. Having received submissions on penalty, the Tribunal ordered that Dr Rama be suspended for three months, commencing 1 May 2004. Following expiry of the suspension, he must practise under supervision for a period of 12 months.

In a previous disciplinary hearing in 2002, the Tribunal found Dr Rama guilty of an act that was detrimental to the welfare of his patient when he installed a temporary bridge of an unacceptable standard, and guilty of professional misconduct in failing to follow up the incomplete dental care, in circumstances where he had made no personal contact with the patient after fitting the temporary bridge, had cancelled six appointments, without providing any relief for her pain, and had failed to refer her on to another dentist.

Earlier in 2003, Dr Rama had pleaded guilty to a charge that he had committed an act that was detrimental to his patient's welfare. He accepted that he had inadequately prepared a tooth for a bridge; that while fitting a definitive bridge, he had adjusted natural teeth and had failed to remove excess cement; had failed to communicate that the bridge was not permanent and that the patient would require follow-up care; and failed to arrange such follow-up care.

In the most recent case, the patient consulted Dr Rama knowing that she had extensive decay in her teeth, and not having visited a dentist in some years. Between 10 December 1998 and the end of January 1999, Dr Rama completed a treatment plan including an extensive root canal and crown treatment, for which the patient paid $7,000.

When the patient consulted another dentist in June 2000, it transpired that caries remained in tooth 27. It had been present at the time Dr Rama was treating her, but he had not discussed it with her or treated it. The preparation for the root canal of teeth 11 and 12 was inadequate and there were inadequate crown margins on four teeth, the margins being described as "grossly deficient", with gaps that could be measured in millimetres. The defects were described by the Tribunal as serious and exposed the complainant to risk of further decay, gingivitis, periodontal disease and coronal microleakage. The crowns completed on teeth 11, 12, 23 and 25 needed to be re-done. Further, Dr Rama had failed to keep adequate or legible notes of her care.

Tribunal Survey

Postal surveys of the seven Tribunals with which the proceedings team had dealings between 1 July 2003 and 30 June 2004 were undertaken. Five responses were received and the feedback was largely favourable, with expectations being met or exceeded in most cases.

One respondent was less satisfied with the drafting of a charge. Drafting charges can sometimes prove quite challenging. There needs to be sufficient detail to inform the defendant of the allegations, but there can be a tendency for a charge to become somewhat cumbersome if it is "over-particularised". The feedback from the respondents is very helpful and every effort is made to ensure that the standard of drafting is consistently high.

The survey results revealed that counsel were professional, well prepared and clear in written and oral communication. Interlocutory matters were well written, researched and presented. All respondents found that the staff of the proceedings team were polite, responsive to their needs and timely in their response.

Topical Issues

Sexual Relationships with Patients and Clients

It is notable that a large proportion of referrals this year (5 out of 18) concerned sexual encounters between health care providers and consumers (see Table 4 opposite). The relationships were consensual, but unethical. Two of this year's successful disciplinary hearings concerned such relationships. In all cases the providers were men and the consumers were women.

Table 4: 2003/04 referrals concerning sexual relationships between patients and clients

Provider	No action	Awaiting hearing	Successful prosecution	Total
Chiropractor			1	1
Medical practitioner	1		1	2
Psychologist	1			1
Counsellor		1		1
TOTAL	**2**	**1**	**2**	**5**

Over the four years since 1 July 2000 there have been 14 matters involving such allegations referred by the Commissioner to the Director of Proceedings. The number of referrals about counsellors was 3, chiropractors 2 (2 separate complaints against one practitioner), medical practitioners 4, nurse aide 1, psychologists 2, social worker 1, support worker (mental health) 1. Action was taken in respect of 10 of the 14 cases. Two of those are waiting to be heard. In the remaining eight, the Director of Proceedings was successful, but one is subject to an appeal.

The reasons for taking no action have usually related to the wishes of the consumer. The consumer's position is not determinative, and on occasion proceedings have been issued despite the consumer's wishes and without her involvement. Much will depend on the evidential sufficiency of the case in the absence of the consumer's testimony. In none of the above cases has an unwilling consumer been summonsed to give evidence. Paradoxically, it is often in the interests of mentally unwell consumers to spare them the trauma of a hearing, and yet this group represents the most vulnerable section of the community who require the most protection. The balancing of the individual consumer's interests against the wider public interest can be a challenging task for the Director, and all efforts are made to address public safety.

Of the 14 cases, in all but one the relationship has not been denied, but in most cases the providers have sought to minimise their responsibility by pointing to their own vulnerability and stress. In many cases there is an apparent inability to appreciate the damaging effect of their actions on the consumer, and the fact that the quality of future relationships with health care providers has been compromised for that consumer as a result of the breach of trust. It appears that a number of these health care providers (both registered and unregistered) have little true appreciation of the reason such a relationship is unethical, and are unaware of the profound effect such a relationship can have on a consumer — especially where there is a known legacy of sexual abuse.

Changes for Proceedings

Personnel

The departure of Morag McDowell from the position of Director of Proceedings required some adjustment for the Proceedings Team. As Legal Counsel, it was a privilege to work with such a tireless perfectionist and consummate professional. With her determination and spirit she ably led the Proceedings Team through some demanding times, leaving her mark on the quality of prosecutions. As Director of Proceedings, I will endeavour to maintain her high standards.

In April we were fortunate to have Lucy Curtis join us as Legal Counsel, the team returning to its full complement of three lawyers and two support staff.

Proceedings team: (Back row from left) Jean Bayley (Personal Assistant), Jason Tamm (Legal Counsel), Lucy Curtis (Legal Counsel); (Front row from left) Theo Baker (Director of Proceedings), Valerie Anderson (Secretary)

Procedural

From 18 September 2004, section 49 of the Health and Disability Commissioner Act 1994 is amended so that in the process of deciding whether to issue proceedings, the Director of Proceedings is no longer required, under the Act, to ascertain the wishes of the complainant or to give the provider a further opportunity to be heard. This latter requirement has at times caused a delay as the Director has endeavoured to act fairly in providing the practitioner that opportunity. The process has sometimes become protracted by meetings in person, affording the practitioner further time to instruct counsel, or accommodating counsel's commitments. The decision-making process pursuant to section 49 will therefore be streamlined with the amendments.

Under the Health Practitioners Competence Assurance Act 2003, from 18 September 2004 all new disciplinary charges will be heard by the one disciplinary body, the Health Practitioners Disciplinary Tribunal, with appeals to the High Court.

The proceedings team looks forward to adapting to these changes and is committed to ensuring that the transition runs as smoothly as possible.

Conclusion

As we approach a new era in disciplinary proceedings, there are still a number of cases that will be heard in familiar territory. Before the end of November there are five hearings set down, three disciplinary matters to be heard in the current respective jurisdictions, and two HRRT proceedings. In addition, five HRRT matters await hearing dates, three substantive appeals await fixtures, and one appeal has been adjourned part-heard.

I wish to acknowledge the high standard of advocacy and advice provided by briefed counsel. Their expertise and public-spirited attitude contributes significantly to the work of the proceedings team.

I am also grateful for the dedication of my team — Jason, Jean, Lucy and Valerie. In the year ahead, the Proceedings Team will continue to focus on the delivery of high quality proceedings with minimal delays.

Complaints Resolution

Assistant Commissioner, Katharine Greig

Introduction

Complaints Resolution comprises two teams: the complaints assessment team, based in Auckland, and the investigation team based in Auckland and Wellington. Katharine Greig, Assistant Commissioner, heads this pivotal area of the organisation.

2003/04 was another successful year for Complaints Resolution. A fundamental role of the Commissioner is to facilitate the "fair, simple, speedy, and efficient resolution of complaints" (section 6 of the Act). Consistent with this, Complaints Resolution had three key targets this year. The first was to decrease the number of open complaint files, which was achieved with 347 open complaint files at 30 June 2004. The second was to continue to focus on resolving matters at the lowest appropriate level, which is reflected in the number of matters resolved without investigation, and in the low number of investigation files open at the end of June — 200. The third was to ensure that complaints are resolved as speedily as possible, while maintaining quality and fairness. The significant progress in improving timeliness can be seen by comparing the figures as at 30 June 2004 with the figures four years ago.

Table 1: Number of open complaint files

	2003/2004	2002/2003	2001/2002
Open at year start	367	546	634
New during year	1,142	1,159	1,211
Closed during year	1,162	1,338	1,299
Open at year end	347	367	546

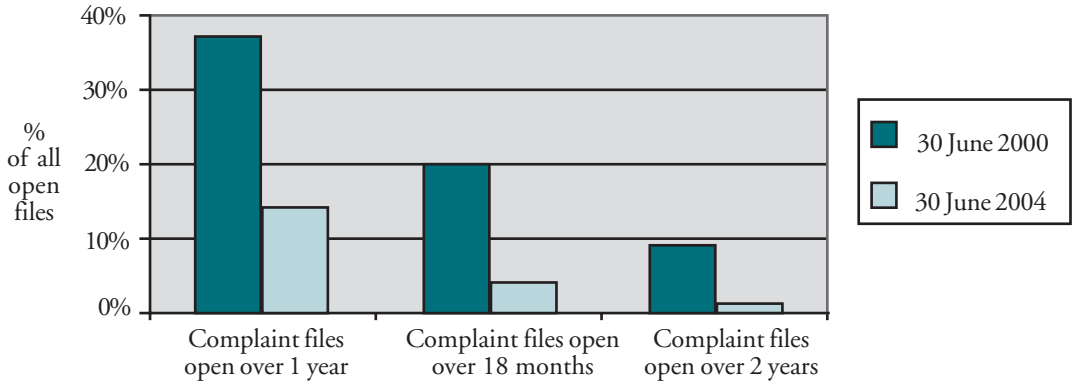


Figure 1: Timeliness of complaints resolution

Complaints Resolution underwent significant change in terms of structure and personnel over the last year, following a review of the organisation. The Complaints Resolution management team now comprises Katharine Greig, Assistant Commissioner, Annette May, Complaints Assessment Manager, and Kristin Langdon, Investigations Manager. These new positions recognise the need for strong internal leadership, the increasing level and complexity of work undertaken by the complaints assessment team, and the need to ensure efficient management and national consistency in the day-to-day management of the investigations function.

Complaints Assessment Team

2003/04 was a productive and challenging year for the complaints assessment team, comprising staff based in Auckland and led by Annette May. The team was responsible for closing 984 of the 1,162 complaint files closed in 2003/04. Ninety-one percent of the files were closed within six months.

As part of the organisational review, the "enquiries" team was renamed "complaints assessment", as the work of the team is broader than enquiries. In most cases, this team is the first point of contact for complainants approaching the Office, either by phone or in writing. The team also plays an important front-end role in liaising with providers about whom complaints have been made, and maintaining effective working relationships with a number of external organisations to ensure that complaints are handled appropriately — including the registration bodies, the Privacy Commissioner, Coroners, District Inspectors of Mental Health, the Ministry of Health, and other government agencies.

Because of the volume and complexity of the work of the complaints assessment team, and the increased focus on resolving complaints at the lowest appropriate level, the team increased from four full-time staff to six (including the new position of Complaints Assessment Manager). Some roles were reconfigured during the year, and processes streamlined to improve quality and responsiveness.

Enquiries

The public can contact the complaints assessment team from anywhere within New Zealand by telephoning our toll free line (0800 11 22 33) between 8am and 5pm, Monday–Friday, by visiting our website (www.hdc.org.nz), or by emailing the Office at hdc@hdc.org.nz. Such enquiries are managed by the complaints assessment team.

Most people who make enquiries do so by telephone. In 2003/04 there were 7,070 verbal enquiries taken, which is similar to last year (7,206). Most enquiries are dealt with by providing verbal information on the options available for resolving complaints, the role of the Office, and how to complain. Wherever possible, callers are directed to other agencies that can assist them if the matter is not within the Commissioner's jurisdiction. A large number of callers (1,196) were referred to advocacy for assistance.

Enquiries often reflect topical issues, including media stories. Over the last year, high-profile media coverage of investigations where the provider has been publicly identified by the complainant or other interested parties, and the establishment of Primary Health Organisations, are examples of issues that have prompted a number of calls to the complaints assessment team.

Written responses to enquiries (categorised as "formal responses") increased from 193 in 2002/03 to 237 in 2003/04. This year, for the first time, we set a target of completing 85% of formal responses within one month, and achieved a result of 81%, despite higher than anticipated demand.

Complaints

In the year ended 30 June 2004 HDC received 1,142 complaints, a slight drop from the 1,159 in the previous year.

Table 2: Action on enquiries

Action taken	2003/2004	2002/2003
Contact		1
Escalated to complaint	18	12
No response required	102	66
Outside jurisdiction (access, date, funding, ACC)	731	770
Outside jurisdiction — referred to another agency	158	329
Provided formal response	237	193
Provided information on HDC and complaints process	946	*
Provided verbal information	2,789	4,523
Provided verbal and written information (including requests for brochures)	198	179
Referred to advocacy	1,196	526
Referred to another agency (including district inspector, prison inspector and professional body)	789	34
Referred to another internal department (eg, legal, education)	169	30
Open	13	16
Total	**7,346**	**7,751**

* Not previously recorded.

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 may be made verbally or 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 registration body must not take any action on the complaint until notified by the Commissioner that the complaint is not to be investigated further under the Health and Disability Commissioner Act 1994 (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 (42%), relatives (31%), health professional bodies (11%), and advocacy services (5%). Complaints from health consumers far outweighed complaints from disability services consumers. The registration bodies that referred the most complaints were the Nursing Council, the Medical Council, the Pharmaceutical Society, and the Psychologists Board.

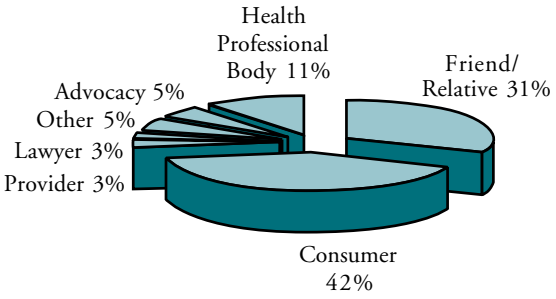


Figure 2: Source of complaints received 2003/04

Types of provider subject to complaint

The 1,142 complaints received involved 1,408 providers (see Table 4 on pages 26–27). For the year ended 30 June 2004 the types of provider most commonly complained about were:

Individual Providers		**Group Providers**	
General Practitioners	34%	Public Hospitals	56%
Nurses	8%	Rest Homes	11%
Psychologists	6%	Pharmacies	6%
General Surgeons	6%	Prison Service	4%
Dentists	5%		

Initial complaints assessment

Initial handling of complaints is undertaken by the complaints assessment team. A complaints assessor, responsible for initial management of all new complaints, identifies any matters that do not fall within the Commissioner's jurisdiction, in consultation with a member of the legal team. These complaints are responded to as a priority, and we endeavour to find alternative avenues for assistance where possible. This is one of the initiatives undertaken recently to streamline assessment processes.

A "triage team" is responsible for assessing all complaints received (other than matters identified as outside jurisdiction) and recommending to the Commissioner how best to handle each complaint. This team, which is convened by the Complaints Assessment Manager, includes a complaints assessor, the Investigations Manager, the Director of Advocacy, and a legal advisor. Meetings are held regularly with the aim of assessing complaints within five working days of receipt. Prior to assessment, the complaints assessment team gathers information to assist the triage team to make a prompt recommendation on the most appropriate way to handle the complaint. This usually involves telephone contact with the consumer or complainant, and obtaining relevant documents.

Currently a complaint within the Commissioner's jurisdiction can be referred to advocacy, investigated or, in limited circumstances, no action taken. If it is not clear what action should be taken by the Commissioner, further information from either the parties involved, or another agency or third party, is sought to assist decision making. In-house legal advice is sought when necessary.

Complaints referred to another agency, outside jurisdiction, or no action taken

A complaint file may be closed at an early stage if the Commissioner has no jurisdiction, or decides to take no action. Matters that do not come within the Commissioner's jurisdiction include access or funding issues; events that occurred prior to July 1996; and matters where there is no apparent breach of the Code (section 35 of the Act).

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 occurred means that an investigation is not practicable or desirable; the subject matter of the complaint is trivial; the complaint is not made in good faith; the person alleged to be aggrieved does not want any action taken; or there is another adequate remedy. In 2003/04, 275 complaints were closed using section 37(1), compared to 240 last year (see Table 3 opposite).

Many files are closed under sections 35 and 37(1) after obtaining further information from the parties involved, including the provider. The Commissioner is then able to make a balanced decision, based on all of the information that is provided, as to what action is appropriate.

Complaints resolved without investigation

In 2003/04, 282 complaint files were closed without investigation as a result of the complaint being withdrawn (101), or being resolved by the Commissioner (62), through advocacy (73), or by agreement of the parties (46). This represents a quarter of all files closed last year, and reflects the Commissioner's focus on low-level resolution of complaints where possible.

Table 3: Complaints referred to another agency, outside jurisdiction, or no action taken

	2003/2004	2002/2003	2001/2002
Outside jurisdiction[1]	256	186	193
Referred to a health professional body[2]	88	92	93
Referred to the Privacy Commissioner	16	20	29
Referred to Human Rights Commission	2	2	2
Referred to Ombudsman	0	1	2
Referred to ACC	32	39	44
Referred to the Ministry of Health	15	32	44
Referred to a District Inspector	17	25	24
Referred to another agency	1	2	6
No action[3]	275	240	200
Total	**702**	**639**	**637**

1 Outside jurisdiction relates to access or funding, events that occurred before 1996, or decisions under section 35 of the Act.
2 Chiropractic Board, Dental Council, Medical Council, Medical Laboratory Technologists Board, Nursing Council, Opticians Board, Pharmaceutical Society, Physiotherapy Board, Podiatrists Board, Psychologists Board.
3 No action taken under section 37(1) of the Act, and no investigation commenced.

The case study below illustrates a serious complaint resolved without a formal investigation.

Case study: Serious complaint successfully resolved without formal investigation

Mrs A, an insulin-dependent diabetic who also had low-grade non-Hodgkins lymphoma, arrived at a Public Hospital Emergency Department by ambulance at 10.10am with a history of right leg pain and a fall at her home that morning.

On arrival, Mrs A was immediately triaged and allocated a triage code 3, indicating she needed to be seen by a doctor within 30 minutes. Mrs A was not reviewed by a doctor until 4.00pm that afternoon. The records show that on examination Mrs A had hypotension, confusion, renal failure, and sepsis secondary to cellulitis/gangrene of her right leg. She was admitted to the Intensive Care Unit and managed for multi-organ failure until a decision was made to withdraw treatment nine days later.

Following Mrs A's death, the District Health Board commissioned an external review to determine whether the care and treatment provided to her in the Emergency Department met an acceptable standard. The review was headed by a senior nursing consultant and an emergency medicine consultant from separate District Health Boards. The review concluded that the care and treatment provided to Mrs A did not meet an acceptable standard and made a number of recommendations designed to improve the systems and processes in the Emergency Department.

Ms B, Mrs A's daughter, was involved in the external review. Following its completion she contacted the Commissioner, concerned about whether the recommended changes had been implemented.

On receipt of Ms B's enquiry the Commissioner wrote to the District Health Board requesting specific advice on the actions it had taken to give effect to the recommendations. The District Health Board responded promptly and in detail providing an "Action Plan", which clearly set out the recommendations and changes needed, how the changes would take place, who was responsible for them, and the dates for completion. The Action Plan showed that seven months after completion of the review a number of the recommended changes had been implemented and the majority were in process.

The Commissioner wrote to Ms B, providing her with a copy of the Action Plan and explaining some of the specific initiatives being developed in the Emergency Department. These included an electronic patient management system and structural changes to the layout of the department. Ms B advised the Commissioner that she was very happy with the outcome and hoped that the situation that had contributed to her mother's death would be unlikely to occur again. The file was closed without need for any further action.

Due to the quality of the external review, and the willingness of the District Health Board to implement the recommendations, a potentially serious complaint was resolved without formal investigation.

Table 4: Types of provider subject to complaint

Individual provider (registered medical practitioners)	2003/2004	2002/2003	2001/2002
Anaesthetist	6	5	12
Cardiologist	1	2	4
Cardiothoracic surgeon	0	1	3
Dermatologist	4	12	13
Ear/Nose/Throat specialist	1	2	9
Emergency physician	1	0	1
Endocrinologist	0	1	1
Gastroenterologist	1	0	0
General practitioner	256	243	271
General surgeon	45	37	34
Geriatrician	3	1	1
House surgeon	5	2	3
Medical officer	5	4	4
Neurologist	2	3	3
Neurosurgeon	3	1	1
Obstetrician/Gynaecologist	22	31	44
Occupational medicine specialist	5	5	11
Oncologist	1	0	4
Ophthalmologist	3	6	14
Orthopaedic surgeon	18	18	29
Otolaryngologist	4	0	0
Paediatrician	4	9	14
Pathologist	1	1	3
Physician	34	33	26
Plastic surgeon	7	4	7
Psychiatrist	26	23	24
Public health specialist	1	0	0
Radiologist	8	10	6
Registrar	14	26	20
Sports medicine specialist	0	1	–
Urologist	11	7	9
Subtotal (medical practitioners)	**492**	**488**	**571**

Individual provider (other than medical practitioners)	2003/2004	2002/2003	2001/2002
Acupuncturist	2	2	2
Alternative therapist	0	1	3
Ambulance officer	1	2	0
Audiologist	1	0	0
Caregiver	1	4	6
Chiropractor	6	13	5
Counsellor	6	8	6
Dental nurse	0	0	1
Dental technician	6	5	8
Dentist	41	57	50
Dietician	0	1	1

Individual provider (other than medical practitioners)	2003/2004	2002/2003	2001/2002
Laboratory technologist	0	0	1
Midwife	37	41	30
Naturopath	3	2	0
Needs assessor	0	1	1
Nurse	60	68	43
Occupational therapist	4	3	5
Optician	1	0	0
Optometrist	2	2	3
Oral surgeon	2	4	4
Osteopath	2	5	1
Other providers	15	6	11
Pharmacist	21	30	24
Pharmacy technician	1	1	1
Physiotherapist	7	6	10
Podiatrist	0	2	1
Psychologist	43	33	23
Psychotherapist	0	2	0
Rest home manager	2	0	3
Social worker	6	0	2
Speech language therapist	1	0	1
Subtotal (other individuals)	**271**	**299**	**246**
Total (all individual providers)	**763**	**787**	**817**

Group provider	2003/2004	2002/2003	2001/2002
Accident and medical centre	9	7	8
Accident Compensation Corporation	20	1	2
Ambulance service	4	8	3
Dental provider	2	2	7
Disability provider	8	11	10
Educational facility	1	2	0
Government agency	5	0	0
Intellectual disability provider	8	3	6
Laboratory	2	2	3
Medical centre	28	17	20
Other group provider	21	13	19
Pharmacy	38	40	30
Prison service	28	27	28
Private medical hospital	7	11	13
Private surgical hospital	11	18	11
Public hospital	359	355	353
Radiology service	7	4	7
Rehabilitation provider	6	2	5
Rest home	69	67	56
Trust	12	6	10
Total group providers	**645**	**596**	**591**

From left: Katharine Greig (Assistant Commissioner) and Kristin Langdon (Investigations Manager)

Investigations

Investigation Team

The investigation team comprises nine investigators and two support staff based in Auckland and Wellington, led by Kristin Langdon, who was appointed to the position of Investigations Manager in January 2004.

Investigation Process

If a complaint requires investigation, the Investigations Manager allocates responsibility to an individual investigator. However, team members work closely together, and with in-house legal advisors, to ensure the quality and consistency of investigations. The investigation process is independent and impartial and subject to the rules of natural justice. Considerable emphasis is placed on ensuring that investigations are procedurally fair and efficient.

Complaints Investigated

In the year ended 30 June 2004, 178 complaints were resolved after or during an investigation, with 200 investigations open at the end of the year. The number of investigations closed in 2003/04 is lower than the previous year, when 345 matters were closed after or during investigation. This in part reflects the Commissioner's emphasis on resolving complaints at the lowest appropriate level, which results in most matters now assigned for investigation being complex. It also reflects a lower number of investigation staff over the full year, in comparison with previous years.[1]

Closure of old files, while striving for timely investigation of new complaints, has continued to be a strong focus this year, and the results have been pleasing. 90% of investigations were completed within two years of the date the complaint was received (improved from 80% last year) — with only three files older than two years open as at 30 June 2004. 74% of investigations were concluded within 18 months of the date of receipt (improved from 60% last year) and 43% were completed within 12 months of the date of receipt (improved from 35% last year).

1 This year saw the resignation of two senior investigation staff members who have made a significant contribution to the organisation. Kathryn Leydon, most recently team leader of the Auckland investigation team and then Senior Advisor, left after nine years. Steve Anthony, team leader of the Wellington investigation team, left after three years. We thank them for their contribution. Elizabeth Finn, one of our investigators, was appointed Education Manager.

Table 5: Complaints investigated

Complaints investigated[1]	2003/2004	2002/2003	2001/2002
Breach (referred to Director of Proceedings)	18	27	28
Breach (not referred to Director of Proceedings)	59[2]	86	62
No breach	56[3]	148	144
Resolved by mediation	10	23	28
No further action taken	35[4]	61	72
Total	**178**	**345**	**334**

1 A single complaint/investigation may result in more than one provider being found in breach.
2 Includes breach reports and breach letters.
3 Includes no breach reports and no breach letters.
4 Complaints where no further action was taken under section 37(2).

In 2003/04, in 35 cases in which an investigation was commenced, the Commissioner decided it was not necessary or appropriate to take further action, having regard to all the circumstances of the case. Ten investigations were concluded by successful mediation — with mediation being proposed as an option in other cases, but declined by the complainant.

Mediation is an important tool available to the Commissioner for the resolution of complaints. Currently it is available only once an investigation has been commenced (section 61 of the Act), but with amendments to the Act from 18 September 2004, mediation will be an option at any time after a complaint has been received.

This year, considerable work has been undertaken on updating guidelines for mediators, developing written information about mediation for parties to a complaint, developing criteria for the appointment of mediators, and appointing a panel of suitably qualified, accredited and experienced mediators.

Assistant Commissioner Katharine Greig represented the Office on a working party of representatives from public sector agencies that offer mediation services within a statutory framework.[2]

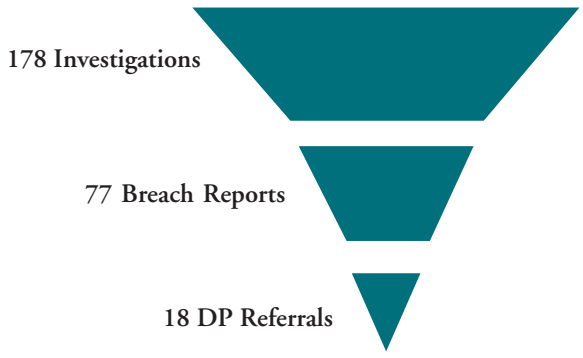


Figure 3: Outcome of investigations 2003/04

2 The working party was initiated by the Human Rights Commission with the idea of establishing a network of public sector mediators. The purpose is to build collaboration amongst agencies that offer statutory alternative dispute resolution in order to improve services offered to the public. The working party organised an inaugural Public Sector Mediators forum held in Wellington in December 2003. Feedback from those who attended was overwhelmingly positive and it is hoped the forum will become an annual event.

Table 6: Individual providers found in breach of the Code/referred to the Director of Proceedings

Provider	2003/2004		2002/2003	
	Breach finding	Referred to DP	Breach finding	Referred to DP
Acupuncturist	2	2	0	0
Ambulance officer	1	0	2	0
Anaesthetist	1	0	4	2
Caregiver	0	0	4	2
Chiropractor	2	1	1	1
Counsellor	2	1	1	0
Dentist	5	3	4	1
Dermatologist	0	0	1	0
Emergency physician	1	0	2	0
General practitioner	33	3	50	8
General surgeon	11	4	9	2
House surgeon	0	0	5	0
Medical officer	0	0	2	1
Midwife	4	0	7	3
Naturopath	1	0	0	0
Neurologist	1	0	0	0
Neurosurgeon	1	0	0	0
Nurse	8	0	22	9
Obstetrician/Gynaecologist	2	0	7	4
Oncologist	1	0	0	0
Ophthalmologist	0	0	4	1
Oral surgeon	1	0	1	0
Orthopaedic surgeon	0	0	1	1
Osteopath	2	0	0	0
Other health provider	1	0	4	2
Otolaryngologist	0	0	2	0
Paediatrician	1	0	0	0
Pathologist	0	0	2	0
Pharmacist	17	4	11	5
Pharmacy technician	3	1	2	1
Physician	1	0	6	0
Physiotherapist	1	0	1	0
Plastic surgeon	1	0	0	0
Psychiatrist	1	1	1	1
Psychologist	1	1	0	0
Radiologist	1	0	0	0
Registrar	1	0	10	0
Rest home licensee	2	0	1	0
Rest home manager	0	0	3	2
Social worker	1	1	2	2
Total	**111**	**22**	**172**	**48**

In 133 cases the investigation was concluded by the Commissioner reporting his formal opinion in a written report. In 56 matters the Commissioner formed the opinion that the Code had not been breached. In these cases the evidence gathered during the investigation established that the matters complained of did not give rise to a breach of the Code; that the provider acted reasonably in the circumstances (which is a defence under clause 3 of the Code); or that there was insufficient evidence to establish the complaint.

Breach of the Code

In 77 cases the Commissioner formed the opinion that a breach of the Code had occurred. This represents 43% of the 178 investigations — an increase from 33% in the previous year, and reflective of the fact that investigation is increasingly reserved for more serious matters that cannot be resolved at the assessment stage. Key themes in the majority of breach opinions continue to be poor communication, failure to give adequate information, inadequate standard of care, and poor record-keeping.

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.

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, notifies the registration body of 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 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 the parties.

Table 7: Group providers found in breach of the Code/referred to the Director of Proceedings

Provider	2003/2004		2002/2003	
	Breach finding	Referred to DP	Breach finding	Referred to DP
Accident and medical centre	2	0	2	0
Ambulance services	3	0	2	0
Dental provider	0	0	1	0
Disability provider	0	0	1	0
Hospice	0	0	1	0
Medical centre	2	0	5	2
Other provider group	2	0	3	2
Pharmacy	11	2	10	4
Private hospital	3	0	9	5
Public hospital	21	5	28	6
Rest home	6	0	13	4
Total	**50**	**7**	**75**	**23**

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 unless the matter is referred for prosecution.

In 18 of the 77 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. The 18 matters included 22 breaches by individuals and 7 breaches by a group provider. The referrals represented 23% of breach reports (24% last year).

Feedback

Throughout the year the Commissioner receives informal feedback from consumers and providers and those involved in the complaints resolution process, such as expert advisors. A postal survey of complainants and providers involved in the investigation process is also undertaken to obtain formal feedback. Feedback — both informal and formal — is an essential source of information for measuring satisfaction and improving our performance.

"Informal" Feedback

Set out below are some of the comments received in correspondence during the year.

- "The purpose of this letter is to convey our appreciation at the manner in which you and your staff dealt with the complaint concerning our son, which of course you are no longer pursuing as explained in the referred letter. Apart from the very professional approach adopted, we were very impressed and comforted by the ever present empathy in all your communications, written and verbal."
- "Thank you so much for the sensitive way you handled [my husband's] complaint. I am very pleased to have a result — a positive one at that. [My husband] would have been very happy."
- "I was most impressed with the content and format of the report which covered fairly and accurately my unpleasant journey. With the information from other professionals and hospitals included, I can now see the complete picture and all my doubts, concerns and queries fall into place."
- "If I may say so, I am most impressed by the care and accuracy of the reports making complex clinical cases readily understandable to all parties."
- "We have … nothing to fear from the complaints process, where common sense and a sharp eye for the clinical reality are very much in evidence in recent cases."

Satisfaction Surveys

To assist the Commissioner to ascertain the level of satisfaction with fairness of the Commissioner's processes, and to identify areas in the investigation process that need improvement, a postal survey was undertaken of a sample of complainants and individual providers involved in investigations completed between 1 July 2003 and 30 June 2004.

Complainant survey results

Eighty-six complainants were surveyed, with a 41% response rate.

- 80% were satisfied with communication about both the process and the progress of the investigation;
- 80% were satisfied with response times to phone messages and written communication;
- 87% found our staff polite to deal with;
- 72% found the reasons for the final decision clear;
- 65% of respondents were satisfied their view was heard in a fair and unbiased way;
- 46% of respondents were satisfied with the overall fairness of the investigation process.

Comments from complainants

- "I would have liked to have received information on the final outcome. That is — what was the outcome of [the doctor's] appearance before the Medical Council of New Zealand. Also, what steps have been taken to ensure that the Commissioner's recommendations to the [DHB] have been implemented."
- "Realise that people do not make complaints against hospitals and the medical profession without just cause and quite often decline to do so for fear of retribution."
- "The whole complaint was handled very sensitively."
- "I have no complaints about the way in which HDC handled my complaint or the investigation process."
- "The letters informing me about the investigation were clear and concise which was very good."
- "I know it is difficult, but by not having the expertise to investigate and having to rely on independent opinion has its own weakness. Using someone who has come up through the same system makes it very difficult to investigate the system itself."
- "I think there should be more time paid to an individual in very complex cases even if it warrants meeting instead of letters and phone calls."
- "Independent opinion should be someone outside the system, ie overseas."
- "My son and I would like to thank you all for taking the time to sort out our case very efficiently."
- "The investigation was detailed and [HDC] should continue doing what it does very well."

Individual provider survey results

One hundred and forty-three providers were surveyed, with a 59% response rate.

- 83% were satisfied with communication about both the process and progress of the investigation;
- 81% were satisfied with response times to phone messages and written communication;
- 93% found our staff polite to deal with;
- 90% found the reasons for the final decision clear and easy to understand;
- 77% were satisfied their view was heard in a fair and unbiased way;
- 81% were satisfied with the overall fairness of the investigation process.

Comments made by providers

- "Keep getting the expert opinions that are independent. In all the comments below I seem to be negative but I am grateful for a thorough investigation."
- "If possible speed up the whole process to minimize stress to all parties."
- "Get both parties together before HDC starts formal investigation. It may save a lot of time and energy and long wait for the parties involved."
- "Need to possibly have the parties talking to each other like with a mediator."
- "Continue with personal interviews — I personally found this very beneficial as this allowed a focus on what was required. The questions were specific which allowed a direct response."
- "Keep those subject to a complaint informed a little more regularly as the investigation is in progress."
- "HDC needs to have a method of screening out and dismissing trivial complaints."
- "Provider should be given a list of support agencies to whom they can turn for advice during this process."
- "Reinforce constantly that providers have rights as well as responsibilities."
- "I thought it was very thorough. Could perhaps encourage early dialogue between complainant and respondent."
- "Speed up the process."
- "Overall I believe the process works well."

District Health Board survey results

Twenty-one District Health Boards (DHBs) were surveyed, with a 52% response rate.

- All respondents found our initial letters easy to understand;
- All respondents were satisfied with contact response times to phone messages and written communication;
- 91% of respondents found our staff polite to deal with;
- The majority of respondents said it would be helpful if HDC re-introduced quarterly status reports on all complaints involving their organisation.

Comments made by DHBs included:

- "Be understanding about reasons for delays in responses. Requests for information are taken seriously but can be hard to co-ordinate in a large organisation with limited resources."
- "Regular visits (every two years or so) of the Commissioner are helpful."
- "Keep resolving complaints at the lowest possible level."
- "From the DHB perspective, you are one of the best agencies we deal with in terms of communication and reports!"
- "We have noted improved complaint response times. Keep it up."
- "Be a little more specific when asking for policies and procedures — the general request is too broad, especially if we are not clear on what the apparent problem is."
- "More regular forums for those in DHB complaints person role."[3]

Summary

Over the past year there has been progress in areas identified for improvement in the last survey. This includes quicker responses to phone messages and written communications, and clearer communication about the process and role of HDC, time frames, and the progress of an investigation.

The survey responses highlighted the stress complainants and providers experience during the investigation process and the need for speedier investigations. More work will be done to assess how best to support the participants through an investigation and manage their expectations. It is pleasing to note that the majority of providers and complainants felt their own view was heard in a fair and unbiased way. It is unclear whether the negative view expressed by complainants about the overall fairness of the investigation reflects dissatisfaction with the outcome — given that only 43% of investigations end in a breach finding. More targeted questions are planned for next year.

Suggestions for more face-to-face discussions between parties affirm the Commissioner's commitment to using mediation more often as a tool for resolving complaints promptly.

3 A successful seminar for DHB complaints managers was held in March, with excellent attendance from around the country. The seminar provided a good opportunity for discussion of processes, feedback and networking.

Legal Services

Legal Manager, Nicola Sladden

Overview

Once again 2003/04 was a busy and productive year for the legal team. It was also a time of change.[1] I would like to thank the legal team for embracing the changes with professionalism and dedication.

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

Complaints Resolution

As reported last year, the legal team continues its involvement at the "front end" of complaint resolution. As well as providing advice to the complaints assessment team in the initial assessment phase, this involves liaison with consumers, providers, expert advisors, and a number of external organisations to ensure that complaints are handled appropriately. Over the course of the year the legal division has maintained effective working relationships with the registration bodies, the Ministry of Health, the Accident Compensation Corporation, the Human Rights Commission, and the Offices of the Coroner, the Privacy Commissioner, and the Chief Ombudsman.

A senior legal advisor is also part of the triage team, which assesses all new complaints. Legal review was provided on many investigation files, and legal advisors were involved in investigation planning and providing advice during investigations. In addition, legal advisors assumed responsibility for managing a number of complex investigations. From December 2003, Helen Davidson, a legal advisor, managed the Commissioner-initiated inquiry into the quality of the care provided by Tauranga surgeon Ian Breeze to a number of patients on whom he performed surgery.

1 As a result of the HDC restructure, responsibility for legal services within HDC moved to the Education and Corporate Services team under the leadership of Tania Thomas, Deputy Commissioner. This meant that the dual role previously undertaken by Katharine Greig was reconfigured. Katharine took over responsibility for Complaints Resolution as Assistant Commissioner, and Denise Brett, Senior Legal Advisor, acted as Legal Manager until Nicola Sladden commenced as Legal Manager in February 2004.

Legal team (back row from left): Deanne Wong (Legal Advisor), Denise Brett (Senior Legal Advisor), Ben Sutton (Legal Advisor), Stephanie Napier (Legal Advisor), Penny Bell (Legal Secretary); (front row from left) Sarah Graydon (Legal Advisor), Nicola Sladden (Legal Manager), Tina Mitchell (Legal Advisor)

Information Requests

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. This year, the Office extensively reviewed its policy on information disclosure, clarifying the situations when it is appropriate to withhold information. The Office adopts a policy of open disclosure in accordance with its obligations under the Privacy and Official Information Acts. However, the general policy is not to release information during the course of an investigation when it is considered that releasing it will prejudice the Commissioner's ability to secure the fair, simple, speedy, and efficient resolution of complaints (s 6).

Prosecution

This year saw a successful prosecution by the Commissioner under section 73 of the Health and Disability Commissioner Act. In the District Court in Manukau, Dr Rama, dentist, was found guilty on four charges of hindering the Commissioner in his investigation of a complaint, and fined $750 plus costs.

This is the first time HDC has issued proceedings in respect of a provider who has refused to provide information required under section 62 of the Act. Since then, further proceedings under section 73 have been commenced in respect of another dentist, as a result of his failure to provide information on three complaints currently under investigation.

It is hoped that these prosecutions will send a clear message to providers about the need to comply with their obligations to provide information. Failure by a provider to respond to a complaint can frustrate the ability to obtain evidence needed to form an opinion or, in matters referred to the Director of Proceedings, lay charges.

Human Rights Review Tribunal

This year HDC was involved in a hearing before the Human Rights Review Tribunal concerning access to the Tribunal for complainants who are either dissatisfied with the outcome of the procedures

of the Commissioner, or who otherwise claim that there has been a breach of their rights under the Code notwithstanding that the Commissioner has not found a breach. The Tribunal decided that it has no power to carry out a judicial review of the actions of the Commissioner and there was therefore no statutory basis for the complainants to bring their claim to the Tribunal (*Perfect v Bay of Plenty District Health Board*, HRRT Decision No 03/04, 4 March 2004).

Protected Disclosures

The Health and Disability Commissioner is an "appropriate authority" listed in section 3(a) of the Protected Disclosures Act 2000. Five protected disclosures were received, three about rest homes and two about disability providers. HDC dealt with the protected disclosures in accordance with its policy. One matter was referred to the Nursing Council, one to the Office of the Controller and Auditor General, and another to advocacy services. Two matters were transferred to the Ministry of Health.

Ombudsmen Investigations

During 2003/04 few complaints about Health and Disability Commissioner processes were made to the Office of the Ombudsmen under the Official Information Act 1982 and the Ombudsmen Act 1975, or to the Privacy Commissioner. A number of the complaints were resolved following clarification and referral back to the Commissioner's Office by the Chief Ombudsman or the Privacy Commissioner.

Submissions

This year the legal team was extensively involved with some key legislative reform processes relating to consumers' rights and the quality of health care, including the change to Right 7(10) of the Code, the development of the Health Practitioners Competence Assurance Act 2003 (HPCA), the Health and Disability Commissioner Amendment Act 2003, and the second review of the Act and Code (discussed below). HDC was also involved in the review of the ACC medical misadventure system. Nicola Sladden was on the steering group of the Medical Misadventure Review.

During the year the legal team also drafted submissions on a range of policy documents and proposed legislation relating to health and disability issues. In total 27 submissions were made. Feedback from recipients indicated that the submissions were relevant, concise and of a high quality. From 1 July 2004, key submissions on policy work will be posted on the HDC website.

Submissions included comments on:

- Medical Council Draft Statement on Disclosure of Harm
- Medical Council Draft Statement on Complementary, Alternative and Unconventional Medicine
- Medical Council Draft Statement on the Supervision of Doctors Working on Temporary or Probationary Registration
- Standards New Zealand — Draft Standard DZ8164, Standards for Day-Stay and Rooms/Office-Based Surgery and Other Procedures
- Human Assisted Reproduction Technology Bill; Assisted Human Reproduction Bill; and Supplementary Order Paper 80
- Dental Association — Code of Practice on Informed Consent
- Ministry of Health Draft Discussion Document — Review of the Regulation of Human Tissue and Tissue-based Therapies
- Ministry of Health Draft Document — Memorandum to Cabinet Social Development Committee

on the Public Health Bill: Specific proposals for communicable and non-communicable diseases following public consultation
- Ministry of Foreign Affairs and Trade Cabinet Briefing Paper — Optional Protocol to the Convention Against Torture
- Ministry of Justice Draft Cabinet Paper — Mandatory Pharmacological Treatment of Child Sex Offenders
- Ministry of Justice Draft Option Papers — Review of the Coroners Act 1981
- National Health Committee Discussion Document — HIV Screening in Pregnancy
- Mental Health Commission Draft Document — An Overview of the Anti-Discrimination Sector
- National Ethics Advisory Committee — Systems of Ethical Review of Health and Disability Research in New Zealand; Ethical Review of Observational Research, Audit and Related Activities
- Law Commission Discussion Paper — New Issues in Legal Parenthood

Review of the Act and Code

From November 2003 to June 2004, the legal team assisted the Commissioner to undertake an extensive review of the Act and Code. The Act requires the Commissioner to review the Act every five years and report to the Minister on whether any changes are necessary. The Code is reviewed every three years. A public consultation document was released for comment in February 2004. It canvassed a wide range of issues, including the changes that are imminent under the Health and Disability Commissioner Amendment Act 2003, and a number of key provisions were highlighted for discussion. The key issues that prompted responses were access to HDC services by disabled consumers, advocacy issues, Right 7(10), and including in the Code consumer responsibilities and a right of access to services. A number of submissions also made helpful operational suggestions, which have been, or will be, adopted by HDC.

The legal team assisted the Commissioner to consider the submissions and complete his report to the Minister, which was delivered on 30 June 2004 for tabling by the Minister in Parliament in August 2004. The Commissioner has recommended three changes to the Act and one change to the Code (discussed at pages 2–3).

Education

Education Manager, Elizabeth Finn

The key result areas for education in 2003/04 have focused on delivering information about HDC and the Code of Health and Disability Services Consumers' Rights to a wider range of consumers and providers. A variety of approaches have been used to achieve this.

Consumers

A highlight this year was the national Consumer Seminar, "Protecting Consumers' Rights: The Health and Disability Commissioner ten years on", organised to celebrate the tenth anniversary of the enactment of the Health and Disability Commissioner legislation. The seminar attracted over 140 attendees. The Governor-General, Dame Silvia Cartwright, delivered the keynote address and offered a personal perspective of the Cervical Cancer Inquiry 1988/89, reflecting on the Inquiry process, the women and doctors who gave evidence, the intense media interest, and her Report, which led to the establishment of HDC and the Code.

The Commissioner reflected on the first 10 years of HDC. Health journalist Rae Lamb spoke about her research on medical error in the United States, where despite the litigious environment and malpractice claims, open disclosure is the key to effective resolution, and sometimes averts court action.

Other presenters included Joanna Manning on the development of informed consent by HDC; Professor Peter Davis on the balance between complaints resolution and accountability; Dr Robin Youngson and Kay Hogan on lessons from the Caesarean section fire at Waitakere Hospital; a panel discussion on the role of consumer representatives (Barbara Robson, Sandra Coney, Judi Strid and Ana Sokratov); and updates on HDC from Tania Thomas, Katharine Greig, Theo Baker, and Nicola Sladden and Tina Mitchell.

Dame Silvia Cartwright

Providers

Consistent with HDC's motto of "learning, not lynching", during the year the Commissioner gave presentations throughout the country, addressing a diverse range of health professionals and provider groups. He delivered seminars to general practitioners in Oamaru, Christchurch, Queenstown and Auckland, and to specialist groups including neonatologists, obstetricians and gynaecologists, surgical registrars, cardiologists, psychiatrists, orthopaedic surgeons, dermatologists and mental health clinicians. He spoke to palliative care and hospice groups, and to final-year medical students at Otago and Auckland, and gave the May graduation address to the Faculty

of Medical and Health Sciences at the University of Auckland. He continued to publish regular articles in *NZ Doctor* and *NZ Family Physician,* using case studies to illustrate how practice problems arose, and to suggest how they could be avoided.

Targeted initiatives were offered for other provider groups. A national education seminar for District Health Board complaints-handling staff was held in March. Seminars for health professionals who provide expert advice or testimony to HDC were held in Auckland and Wellington, in response to a training needs survey. These initiatives were very well received and will be repeated in future years.

Initiatives for Māori, Pacific Islands and Disability Groups

Seminars targeted specially to the needs of Māori and Pacific Islands providers and consumers were held in Auckland. They were conducted respectively by Moe Milne (former kaiwhakahaere for HDC) and Rebekah Pola, who is Samoan and currently works at HDC as a complaints assessor. One seminar for consumers was conducted entirely in Samoan and provided information about the Code to a diverse group of Samoan people. Feedback from this seminar identified the pressing need for more information to be available in the languages of non-English-speaking communities. We are very grateful for the support of Moe and Rebekah in assisting us to reach these groups and raise their awareness of their rights under the Code. Regional seminars for disability consumers in Christchurch, Invercargill and Auckland were enthusiastically received.

Further Presentations

Requests for speakers have been received throughout the year from various groups. Advocates and HDC staff have provided educational sessions to community groups and societies, staff at rest homes, private hospitals and clinics, paramedic groups and students training to be health and disability service providers. A training session for advocates was also conducted.

Written Educational Resources

Delivery of educational material within the community far surpassed targets for the year, with over 461,000 items being dispatched — more than double the predicted quantity. Additional staff have been employed to meet the increased workload in a timely manner.

Following changes to Right 7(10) of the Code, educational leaflets were revised and reprinted.

Web-based Initiatives

Anonymised reports have been published on the HDC website (www.hdc.org.nz) throughout the year. A large number have been written up as case studies, comprising a summary of each complaint and the Commissioner's decision, with a link to the full report. A selection of case studies is being compiled into a compendium, which will provide a valuable resource for the education and guidance of providers.

Cases sent to the Director of Proceedings are withheld from the website until any further processes are complete. Once the case has been finalised, an addendum to the HDC report indicates the outcome and provides the result of any disciplinary proceedings. The report is then published on the website.

The sharing of investigation findings is an important part of our role of educating consumers and providers about the rights and responsibilities under the Code, and the lessons learned from particular cases. The website is proving an efficient means for disseminating information.

Financial Statements

Financial Commentary

Funding

The Office is funded from Vote Health. Total funding for this year was **$6,517,333** (excluding GST). A funding increase of **$430,223** has been approved for the year ended 30 June 2005.

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 **$101,832** and investments totalled **$1,330,000** at 30 June 2004.

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 2003/04 was **$92,808** offset by production costs.

Operating Deficit

In 2003/04 the Office budgeted for a deficit of **$578,348** and made a deficit of **$424,138**.

Expenditure by Type

Expenditure is summarised by significant categories below. Service contracts, staff costs and occupancy costs (collectively 76.76% of total expenditure in 2003/04) largely represent committed expenditure. Much of the remaining 23.24% ($1.66 million) is discretionary.

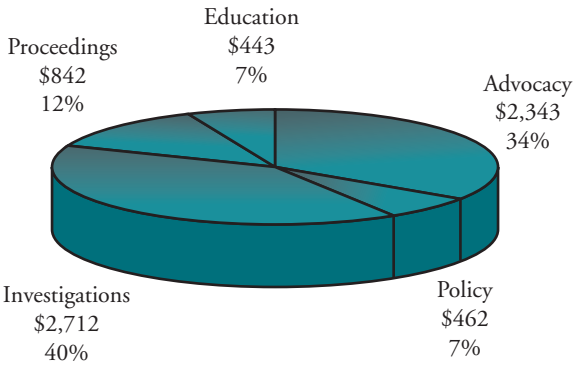
	03/04		02/03	
	$000	%	$000	%
Service Contracts	2,001	28.04	1,990	29.26
Audit Fees	7	0.10	9	0.13
Bad Debts Written Off	0	0.00	0	0.00
Staff Costs	3,129	43.85	2,997	44.07
Travel & Accommodation	176	2.47	126	1.85
Depreciation	262	3.67	270	3.97
Occupancy	348	4.88	193	2.84
Communications	491	6.88	567	8.34
Operating Costs	722	10.11	649	9.54
TOTAL	7,136	100.00	6,801	100.00

Figures GST exclusive

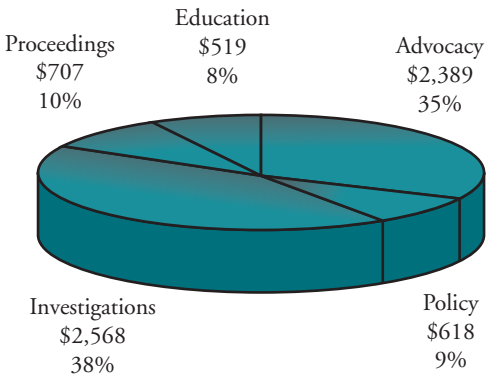
Expenditure by Output

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

Expenditure by Output 2003/2004 ($000s)



Expenditure by Output 2002/2003 ($000s)



Spending on Advocacy, slightly lower by $46,000, remained a significant commitment of resources at 34% (35% 02/03) of total expenditure. The Office continued to look for efficiencies in all areas.

2004/2005

For the coming year the Office has budgeted for a deficit of $220,569.

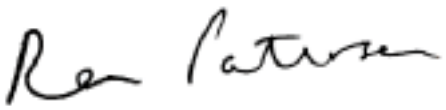
Statement of Responsibility

For the year ended 30 June 2004

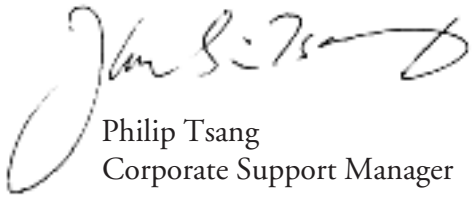
The Commissioner accepts responsibility for the preparation of the annual Financial Statements and the judgements used in them.

The Commissioner accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting.

In the opinion of the Commissioner the annual Financial Statements for the year ended 30 June 2004, fairly reflect the financial position and operations of the Health and Disability Commissioner.



Ron Paterson
Commissioner



Philip Tsang
Corporate Support Manager

5 October 2004

Audit New Zealand

AUDIT REPORT

TO THE READERS OF
HEALTH AND DISABILITY COMMISSIONER'S
FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2004

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, Mr F Caetano, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements of the Health and Disability Commissioner, on his behalf, for the year ended 30 June 2004.

Unqualified opinion

In our opinion the financial statements of the Health and Disability Commissioner on pages 46 to 60:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health and Disability Commissioner's financial position as at 30 June 2004;
  - the results of its operations and cash flows for the year ended on that date; and
  - its service performance achievements measured against the performance targets adopted for the year ended on that date.

The audit was completed on 5 October 2004, and is the date at which our opinion is expressed.

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

Basis of opinion

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

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

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements. If we had found material misstatements that were not corrected, we would have referred to them in the opinion.
Our audit involved performing procedures to test the information presented in the financial statements. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

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

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

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

Responsibilities of the Health and Disability Commissioner and the Auditor

The Health and Disability Commissioner is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements must fairly reflect the financial position of the Health and Disability Commissioner as at 30 June 2004. They must also fairly reflect the results of its operations and cash flows and service performance achievements for the year ended on that date. The Health and Disability Commissioner's responsibilities arise from the Public Finance Act 1989 and Health and Disability Commissioner Act 1994.

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and section 43(1) of the Public Finance Act 1989.

Independence

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

Other than the audit, we have no relationship with or interests in the Health and Disability Commissioner.

F Caetano
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Statement of Accounting Policies

For the year ended 30 June 2004

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) *Inventory*

Inventory is valued at the lower of cost and net realisable value.

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

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

(i) *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.

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

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

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

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

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

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

(l) *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 2004

Actual 02/03 $		Note	Actual 03/04 $	Budget 03/04 $
	Revenue			
6,148,444	Operating Grant Received		6,517,333	6,517,333
150,182	Interest Received		101,832	92,400
70,329	Publications Revenue		92,808	60,000
6,368,955	**TOTAL OPERATING REVENUE**		**6,711,973**	**6,669,733**
	Less Expenses			
1,989,836	Advocacy Service Contracts		2,000,789	1,985,905
9,000	Audit Fees		7,250	9,000
900	Fees Paid to Auditors for Other Services		0	0
0	Bad Debts Written Off		0	0
2,997,208	Staff Costs		3,129,004	3,237,276
126,025	Travel & Accommodation		175,810	144,986
269,510	Depreciation	4	261,941	263,931
192,751	Occupancy		348,445	336,992
567,366	Communications		491,125	535,450
648,684	Operating Costs		721,747	734,541
6,801,281	**TOTAL OPERATING EXPENSES**		**7,136,111**	**7,248,081**
(432,326)	**NET SURPLUS (DEFICIT)**		**(424,138)**	**(578,348)**

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

Statement of Financial Position

As at 30 June 2004

Actual 02/03 $		Note	Actual 03/04 $	Budget 03/04 $
	Crown Equity			
1,172,635	Accumulated Funds	1	748,497	697,422
788,000	Capital Contributed		788,000	788,000
1,960,635	**TOTAL CROWN EQUITY**		**1,536,497**	**1,485,422**
	Represented by			
	Current Assets			
47,586	Bank Account		31,403	50,000
1,670,000	Call Deposits		1,330,000	1,102,339
0	Prepayments		5,938	0
0	Inventory		20,970	0
23,868	Sundry Debtors		40,165	3,000
0	GST Receivable		0	0
1,741,454	**Total Current Assets**		1,428,476	1,155,339
	Non Current Assets			
743,980	Fixed Assets	3	539,465	502,568
743,980	**Total Non Current Assets**		539,465	502,568
2,485,434	**Total Assets**		1,967,941	1,657,907
	Current Liabilities			
24,269	GST Payable		58,619	48,204
500,530	Sundry Creditors	2	372,825	124,281
524,799	**Total Liabilities**		431,444	172,485
1,960,635	**NET ASSETS**		**1,536,497**	**1,485,422**

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 2004

Actual 02/03 $		Actual 03/04 $	Budget 03/04 $
2,392,961	Opening Equity 1 July 2003	1,960,635	2,063,770
(432,326)	Plus Net Surplus (Deficit) (Total Recognised Revenue and Expenses)	(424,138)	(578,348)
1,960,635	Closing Equity 30 June 2004	**1,536,497**	**1,485,422**

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

Statement of Cash Flow

For the year ended 30 June 2004

Actual 02/03 $		Note	Actual 03/04 $	Budget 03/04 $
	Cash Flow from Operating Activities			
	Cash was provided from:			
6,148,444	Operating Grant		6,517,333	6,517,333
168,143	Interest on Short Term Deposits		92,513	92,400
70,583	Revenue		86,605	45,000
6,387,170			6,696,451	6,654,733
	Cash was applied to:			
(6,417,602)	Payments to Suppliers and Employees		(6,950,829)	(6,919,149)
(30,432)	**Net Cash Flow from Operating Activities**	5	**(254,378)**	**(264,416)**
	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:			
(336,489)	Purchase of Fixed Assets		(101,805)	(133,245)
(336,489)	**Net Cash Flow from Investing Activities**		**(101,805)**	**(133,245)**
(366,921)	**NET INCREASE/(DECREASE) IN CASH**		**(356,183)**	**(397,661)**
2,084,507	Cash Brought Forward		1,717,586	1,550,000
1,717,586	Closing Cash Carried Forward		**1,361,403**	**1,152,339**
	Cash Balances in the Statement of Financial Position			
47,586	Bank Account		31,403	50,000
1,670,000	Call Deposits		1,330,000	1,102,339
1,717,586			**1,361,403**	**1,152,339**

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 2004

Actual 02/03 $	Note		Actual 03/04 $
	1	***Accumulated Funds***	
1,604,961		Opening Balance	1,172,635
(432,326)		Net Surplus (Deficit)	(424,138)
1,172,635		Closing Balance	**748,497**
	2	***Sundry Creditors***	
334,764		Trade Creditors and Accruals	190,454
62,120		PAYE	66,182
103,646		Annual Leave	116,188
500,530			**372,825**

3 *Fixed Assets*

	Cost $	*Accum Depn* $	*Net Book Value* $
03/04			
Computer Hardware	582,377	403,551	178,826
Computer Software	381,243	356,954	24,289
Communications Equipment	26,723	26,723	0
Furniture & Fittings	194,634	169,195	25,439
Leasehold Improvements	504,643	238,151	266,492
Motor Vehicles	42,280	42,280	0
Office Equipment	145,874	101,455	44,419
Total Fixed Assets	**1,877,774**	**1,338,309**	**539,465**
02/03			
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**	**1,345,942**	**743,980**

Notes to the Financial Statements

For the year ended 30 June 2004 — continued

Actual 02/03 $	Note			Actual 03/04 $
	4	***Depreciation***		**03/04**
106,547		Computer Hardware		97,349
53,367		Computer Software		49,168
0		Communications Equipment		0
11,342		Furniture & Fittings		11,982
77,602		Leasehold Improvements		79,255
0		Motor Vehicles		0
20,652		Office Equipment		24,187
269,510				**261,941**
	5	***Reconciliation between Net Cash Flow from Operating Activities and Net Deficit***		
(432,326)		Net Deficit		(424,138)
		Add Non-cash Items:		
269,510		Depreciation		261,941
		Movements in Working Capital Items		
97,962		Increase/(Decrease) in Sundry Creditors	(83,326)	
16,176		Increase/(Decrease) in GST Payable	34,350	
0		(Increase)/Decrease in Inventory	(20,970)	
286		(Increase)/Decrease in Trade Debtors	(6,978)	
0		(Increase)/Decrease in Prepayments	(5,938)	
17,961		(Increase)/Decrease in Interest Receivable	(9,318)	
132,384				(92,180)
0		Net Profit on Disposal of Assets		0
(30,432)		Net Cash Flow from Operating Activities		**(254,378)**

6 *Commitments*

(a) Advocacy Service contracts:
The maximum commitment for the 12 months from 1 July 2004 is $1,998,902.

(b) Premises Leases including leasehold improvements:

Auckland	$227,052 per annum until May 2008
Wellington	$76,000 per annum until April 2006

Actual 02/03 $	Note		Actual 03/04 $
	6	(c) Classification of Commitments	
2,278,669		Less than one year	2,301,954
302,801		One to two years	284,052
1,059,204		Two to five years	454,104
0		Over five years	0
3,640,674			**3,040,110**

7 ***Contingent Liabilities***

As at 30 June 2004 there were no contingent liabilities (02/03 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 Bank and sundry debtors.

Maximum exposures to credit risk at balance date are:

Actual 02/03 $		Actual 03/04 $
1,716,586	Bank Balances	1,361,403
23,868	Sundry Debtors	40,165
0	Inventory	20,970
0	Prepayment	5,938
1,741,454		**1,428,476**

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 Position.

Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument will fluctuate owing to changes in market interest rates. The average interest rate on the Health and Disability Commissioner's investments is 5.4%.

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 $6,517,333 (excluding GST) in operating grants from the Crown. There was no funding owing from the Crown at year end.

There were no other related party transactions.

10 *Employee Remuneration*

Total remuneration and benefits	*Number of employees*	
$000	**02/03**	**03/04**
100–110	1	1
110–120	1	2
170–180	1	0
180–190	0	1

The Commissioner's remuneration and allowances are determined by the Higher Salaries Commission in accordance with the Higher Salaries Commission Act 1977. The Commissioner's remuneration and benefits are in the $180,000 to $190,000 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 Deliver educational material to consumers and providers.	100% orders despatched within 5 working days of receipt of request.	461,274 units despatched in year, most within 5-day time line.
1.1.2 Publish case notes of key HDC opinions.	Case notes published on website within 3 months of key opinion.	93 case notes published on website within 3 months.
1.1.3 Publish a compendium of case notes.	Compendium published by 30 June 2004.	Publication of compendium deferred until December 2004.
1.2 Consumer Education		
1.2.1 Deliver an educational programme to the following consumer groups:	Each seminar evaluated and overall satisfaction of at least 60%.	
1.2.2 Consumers and consumer organisations.	One national seminar held by 30 June 2004.	Seminar held in Auckland. 100% satisfaction reported.
1.2.3 Disability services consumers and organisations.	Three regional seminars held by 30 June 2004.	Seminars held in Christchurch, Invercargill, Auckland. 100% satisfaction reported.
1.2.4 Māori consumers and organisations.	Three regional seminars held by 30 June 2004.	Seminars held in Auckland and Rotorua (2). 93% satisfaction reported.
1.2.5 Pacific Islands consumers and organisations.	Three regional seminars held by 30 June 2004.	Seminars held in Auckland (2) and Waikato. 93% satisfaction reported.
1.3 Provider Education		
1.3.1 Deliver an educational programme to the following provider groups:	Each seminar evaluated and overall satisfaction of at least 60%.	
1.3.2 General practitioner groups.	Five regional seminars held by 30 June 2004.	Target achieved. 99% satisfaction reported.
1.3.3 Health professionals who provide expert advice or testimony to HDC.	Two seminars held by 30 June 2004.	Target achieved. 94% satisfaction reported.
1.3.4 Māori providers.	One seminar held by 30 June 2004.	Target achieved. 100% satisfaction reported.
1.3.5 Pacific Islands providers.	One seminar held by 30 June 2004.	Target achieved; 87% satisfaction reported.

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 Contract deliverables are achieved:	Annual target 2003/04:	
Enquiries managed	6,343	8,081
Complaints managed	4,200	4,632
Education sessions	1,327	1,433
Networking contacts	1,399	1,942
2.2 Quality		
2.2.1 Deliver independent, high quality, consistent nationwide services to consumers during 2003/04.	60% of complaints will be resolved or partly resolved with advocacy.	81% of complaints resolved or partly resolved with advocacy.
	80% of a random sample of consumers satisfied with advocacy services.	80% of a random sample of consumers were satisfied with advocacy services.
	80% of a random sample of providers satisfied with advocacy process and professionalism of advocates.	Deferred pending enhancement of computer system to record data electronically.
2.2.2 Deliver high quality, consistent educational programmes to consumer groups and providers during 2003/04.	80% of consumers and providers participating in presentations and educational sessions report satisfaction with quality and content of delivery.	92% of those who participated in presentations and educational sessions reported satisfaction with quality and content of delivery.

Key Result Area 3: Enquiries and Complaints Management

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

Expected Performance and Standards	Target	Actual
3.1 Throughput targets		
3.1.1 Meet agreed throughput targets for handling enquiries.	Estimated 5,000 enquiries handled in 2003/04.	Enquiries handled: 7,333.
	85% of enquiries closed on day received.	96% of enquiries closed on day received.
	Estimated 170 written responses to enquiries regarding the Act and Code.	237 formal responses.

Expected Performance and Standards	Target	Actual
	85% of enquiries requiring written responses closed within 1 month of receipt.	81% closed in 1 month.
3.1.2 Meet agreed throughput targets for handling complaints.	Estimated 1,250 new complaints received in 2003/04.	1,142 complaints received.
	1,300 complaints resolved in 2003/04.	1,162 complaints resolved.
	For complaints not investigated: 90% resolved within 6 months of receipt.	91% resolved within 6 months.
	For complaints that are investigated: 50% resolved within 12 months of receipt.	43% resolved within 12 months. Target not achieved owing to backlog of older files.
	70% resolved within 18 months of receipt.	74% resolved within 18 months.
	90% resolved within 2 years of receipt.	90% resolved within 2 years.
3.2 Quality		
3.2.1 Ensure complaints are resolved in a fair and timely manner using transparent, robust and consistent processes.	60% of a random sample of complainants satisfied with fairness of investigation process.	65% of respondents satisfied their view heard in a fair and unbiased way.[1] 46% of respondents satisfied overall with fairness of investigation process.[2]
	60% of a random sample of providers satisfied with fairness of investigation process.	77% of respondents satisfied their view heard in a fair and unbiased way.[3] 81% of respondents satisfied overall with fairness of investigation process.[4]

1 This figure includes matters referred to mediation during an investigation.
2 This figure does not include matters referred to mediation during an investigation.
3 This figure includes matters referred to mediation during an investigation.
4 This figure does not include matters referred to mediation during an investigation.

Key Result Area 4: Proceedings

Objective: *Initiate proceedings in accordance with the Health and Disability Commissioner Act 1994.*

Expected Performance and Standards	Target	Actual
4.1 Timeliness		
4.1.1 Decide in a timely manner whether to issue proceedings.	100% of s 49 letters sent to providers and consumers within 8 weeks of receipt of investigation file from Commissioner.	100% compliance.
Statistics from here on are made on a provider basis. The 18 referrals since July 03 have resulted in 20 DP files.	100% of decisions (whether or not to issue proceedings) made within 8 weeks of receipt of relevant information.	100% compliance.
	100% of disciplinary charges or Human Rights Review Tribunal proceedings filed within 6 weeks of decision.	100% 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.	Survey completed. Respondents confirm high quality of proceedings.

Key Result Area 5: Policy Advice

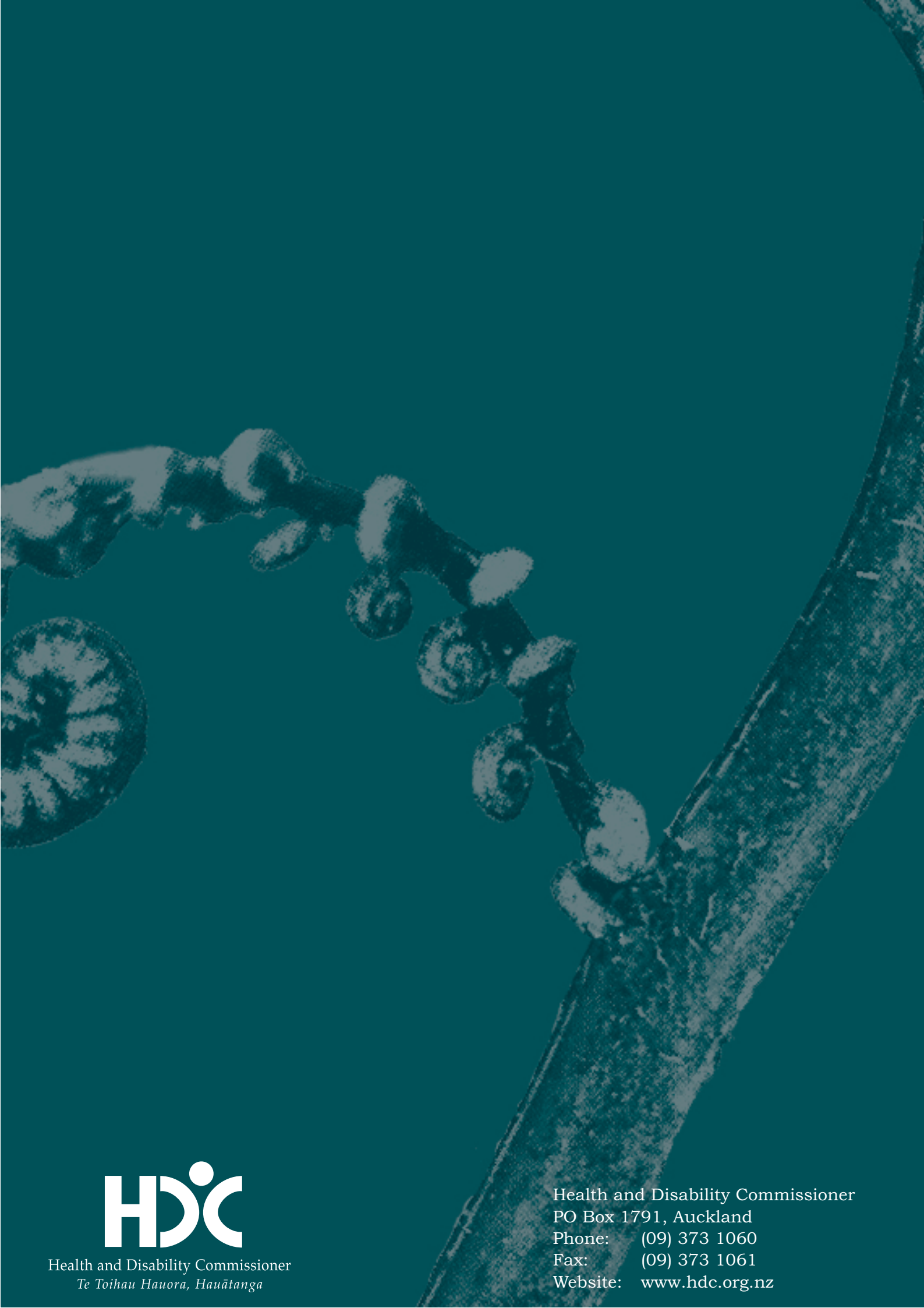
Objective: *Provide policy advice on matters related to the Code of Health and Disability Consumers' Rights and the Health and Disability Commissioner Act 1994.*

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.	96% of policy advice met deadline.
	Key stakeholders report high quality, relevant submissions.	Respondents reported that submissions were clear and well structured, relevant and useful.
5.2 Review of Act and Code		
5.2.1 Undertake review of HDC Act and Code of Rights and make recommendations to Minister of Health.	Complete consultation on revision of the Act and Code by 30 June 2004.	Review completed and Report sent to Minister on 30 June 2004.

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 Complete agreed human resources management and organisational development tasks arising from HDC reorganisation project.	New organisational structure approved and implemented by 31 December 2003.	Target achieved.
6.1.2 Complete agreed changes to human resources policies and procedures arising from staff workshops on organisational culture held in March/April 2003.	Agreed changes finalised by 31 December 2003.	Target achieved.
6.1.3 Introduce revised processes and practices culturally appropriate for Māori consumers and providers.	Revised processes and practices implemented by 30 June 2004.	Target achieved.
6.2 Information Technology		
6.2.1 Ensure that information technology systems are aligned to current and future business needs and reviewed annually.	User requirements for 2004/05 financial year identified by 31 March 2004. 2004/05 IT Plan finalised by 30 June 2004.	Target achieved. Target achieved.
6.2.2 Introduce enhancements to Enquiries and Complaints Database System and Proceedings Database System identified in the April 2003 analysis of users' requirements.	Enhancements developed and introduced by 31 December 2003.	Target not achieved. The remaining enhancements will be prioritised for completion in 2004/05.
6.3 Finance		
6.3.1 Manage the HDC Budget for the 2003/04 year.	Quarterly reports presented to Ministry of Health within time lines of 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 2002/03 Audit Report.	Gradings maintained or improved.	Target achieved.
6.3.3 Complete development and implementation of systems and documentation recommended in 2002/03 Audit Report.	Documentation completed by 31 March 2004.	Target achieved.
6.3.4 Develop Statement of Service Performance (SSP) and Statement of Financial Performance (SFP) for 2004/05 year.	Draft SSP and SFP submitted to Ministry of Health by 30 April 2004. SSP and SFP approved by Minister of Health by 30 June 2004.	Target achieved.



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