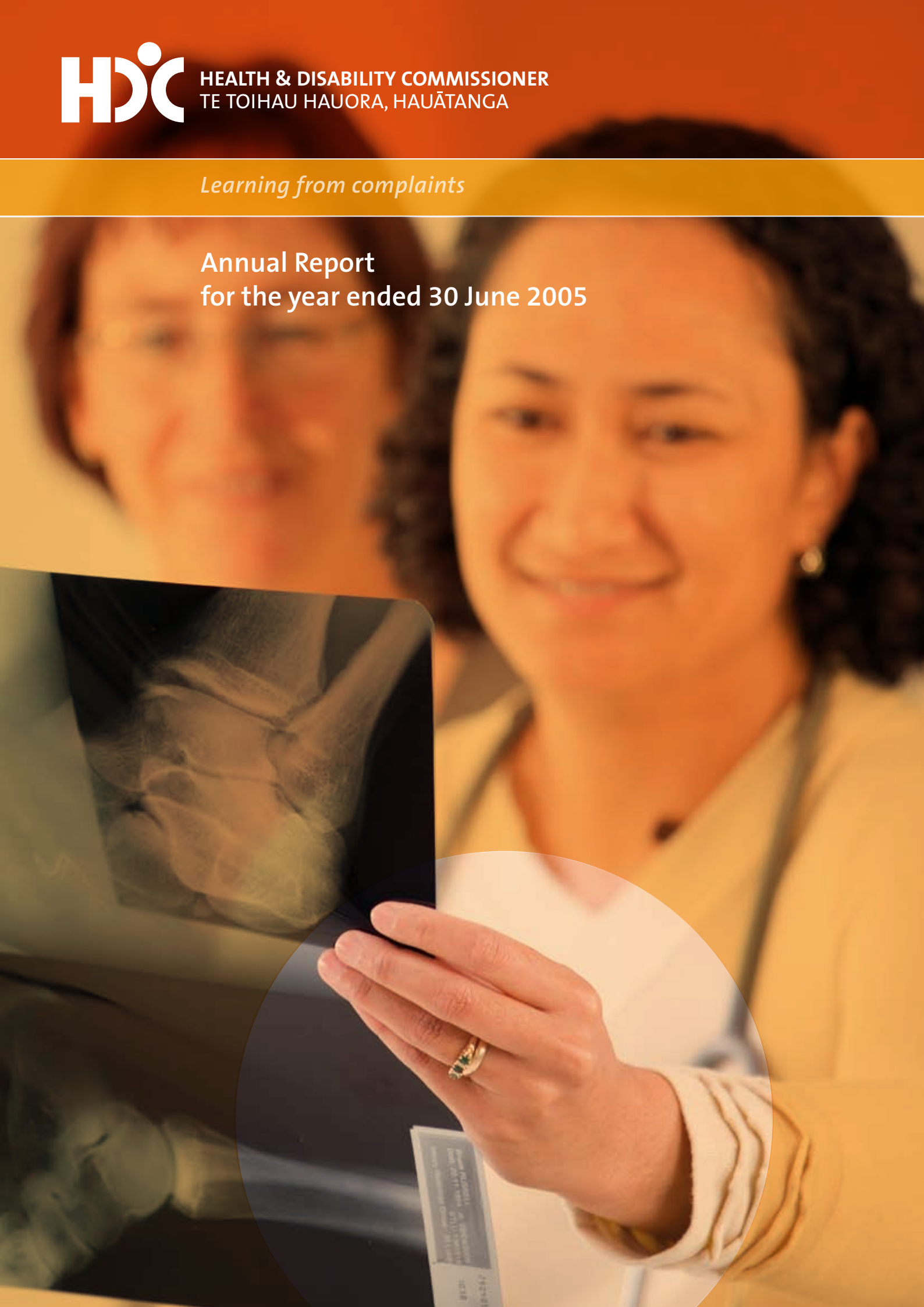
HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Learning from complaints

Annual Report
for the year ended 30 June 2005



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Presented to the House of Representatives Pursuant
to Section 198(1) of the Crown Entities Act 2004

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

7 October 2005

The Minister of Health
Parliament Buildings
WELLINGTON

Minister

In accordance with the requirements of section 198(1) of the Crown Entities Act 2004, I enclose the Annual Report of the Health and Disability Commissioner for the year ended 30 June 2005.

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 fifth year as Health and Disability Commissioner and discusses the following key features of the 2004/05 year:

- Early resolution of complaints
- Complaint outcomes
- Tauranga Hospitals Inquiry
- Educational initiatives
- International work

Ron Paterson
Commissioner

Early Resolution of Complaints

In September 2004 the Health and Disability Commissioner Amendment Act 2003 came into force, giving HDC new options to "facilitate the fair, simple, speedy, and efficient resolution" of complaints about the quality of health care and disability services. The new powers enhance the Commissioner's power to deal with complaints appropriately, help reduce duplication of process, and enable early resolution. After receiving a complaint, the Commissioner is required to make an initial assessment, including preliminary enquiries if necessary, to decide what action, if any, to take — with the option of taking no further action, if action is "unnecessary or inappropriate". In addition to the option of referring the matter to an advocate for low-level resolution, there are new options of referring the matter to a provider for resolution, or calling a mediation conference, without the need for formal investigation. The new legislation strikes a sensible balance between early resolution for individuals, and protection of the public in cases where notification to relevant authorities or full investigation is necessary.

Many complaints arising in general practice and public hospital settings are resolved directly with clinical staff and management. Most District Health Boards (DHBs) deserve recognition for their commitment to early resolution of complaints. The importance of open disclosure following an adverse event is a message that has been heard throughout the health sector, and is increasingly reflected by greater willingness to acknowledge shortcomings, apologise where appropriate, and take steps to remedy the situation. The recent changes to ACC's coverage of adverse medical events (with the move to a genuine "no fault" system from 1 July 2005, covering any "treatment injury"), combined with HDC's track record of fair processes and credible decisions, have contributed to a constructive medico-legal environment where providers have no legitimate reason to resort to defensive medicine or obstructive responses to complaints.

Most complaints to HDC are resolved swiftly and with minimal intervention: 57% within three months and 79% within six months of receipt of the complaint. These figures reflect the hard work and careful scrutiny of HDC complaints assessment staff. Only a minority (15%) of complaints proceed to a formal investigation of alleged individual or systemic failures.

Complaint Outcomes

This year the number of new complaints received by HDC remained fairly static (1,124 compared to 1,142 last year), but the Office made further progress in clearing the backlog of open files. The overall tally of open files dropped to a record low of 313 at 30 June 2005 (exactly half the backlog in March 2000), with 111 files under investigation (compared with 500 in 2000).

Achieving a sense of completion at the end of the complaints process is important for both the complainant and the provider. Effective complaints resolution provides closure and, if possible, healing of the consumer–provider bond. Advocacy continues to be a remarkably effective means of resolution — this year 82% of 4,448 complaints received by the Nationwide Advocacy Service were partly or fully resolved with advocacy support, 91% within three months. Advocacy and mediation (still an underutilised tool, with only seven investigations concluded by successful mediation last year) provide the opportunity for facilitated face-to-face meetings of the parties and can enable healing that is sometimes absent from paper-based investigations — although it is pleasing to report that 69% of surveyed complainants reported being able to "move on" at the conclusion of HDC's investigation of their complaint.

There remains an important place for formal investigation of concerns, and last year 172 complaints were investigated (including the major Tauranga Hospitals Inquiry, discussed opposite). In these cases, skilled investigators examine (with the aid of independent clinical advice) any lapses in care and communication, recommend any remedial steps, and share lessons with other health providers (such as DHBs and professional Colleges). This is consistent with HDC's emphasis on learning from complaints. Recent research confirms that "[i]n contrast to early opinions, later opinions demonstrate that the Commissioner sends clear signals of the expectations of the standard of quality, based on expert advice and current research" (Godbold, R and McCallin, A, "Setting the standard? New Zealand's approach to ensuring health and disability services of an appropriate standard", *Journal of Law and Medicine* (2005) 13: 125, 131).

Margaret Honeyman, Clinical Director of Mental Health, Ron Paterson, and Dave Davies, General Manager of Mental Health, at the Perspectives on Clinical Safety and Challenging Events seminar at Waitemata DHB in 2004

Most breaches of the Code related to deficiencies in assessment and treatment, lack of care co-ordination, poor communication and inadequate record-keeping. The percentage of breach findings in completed investigations was 41%, compared with 43% the previous year. There continues to be a correlation between investigation outcomes and reported satisfaction with HDC processes. The 2005 survey of complainants using our investigation services found 66% satisfied overall that their view was heard in a fair and unbiased way (a marked improvement from 46% the previous year), in contrast to 87% of surveyed providers (up from 81% last year).

Further proceedings are reserved for investigations that reveal major shortcomings in care or communication, or unethical practice. Over the past year, there has been a slight drop (from 18 to 14) in referrals to the Director of Proceedings (DP) for potential disciplinary or Human Rights Review Tribunal proceedings. In 2004/05 this equated to 20% of the investigations that ended with a breach finding — down from 23% the previous year, and consistent with HDC's rehabilitative approach. Most cases that do lead to Tribunal hearings result in the DP's charges

being upheld (9 of 11 substantive hearings last year), a very high success rate that confirms further action was warranted.

Tauranga Hospitals Inquiry

In February 2005 I concluded my Tauranga Hospitals Inquiry, which arose from complaints and public concerns about general surgeon Ian Breeze. The inquiry, ably led by legal advisor Helen Davidson, comprised two parts: first, separate investigations into whether Mr Breeze provided services of an appropriate standard to seven individual patients; and, secondly, a review of whether Mr Breeze's employers had taken adequate steps to respond to concerns about his practice and ensure that he was competent to practise surgery.

The second part of the inquiry highlighted the legal obligation of employers (in public or private) to monitor and maintain the competence of their employees, to protect patients. Employers of health practitioners need to have effective processes in place to enable them to respond decisively to any concerns about an employee's practice, in a co-operative and co-ordinated manner. Patient safety must be the paramount consideration. My report gives specific guidance to employers on the steps they should take in order to meet their obligations to provide safe care (www.hdc.org.nz/files/pageopinions/tauranga_hospitals_inquiry_anon.pdf).

Educational Initiatives

This year also saw a broad array of educational initiatives undertaken by HDC. A survey of 1,500 members of the public in November 2004 found that 72% were aware that health and disability services consumers have rights. This figure suggests an increasing awareness of consumer rights amongst the general public — in the last survey (in 1998) only 35% of service users knew they had rights. HDC's website was expanded during the year, and continues to be frequently accessed by consumers, providers, and the media. Recent cases are usually reported on by daily newspapers within 24 hours of posting on the website. HDC policy submissions, articles published in professional journals, and topical issue briefs (eg, on cataract surgery and informed consent to vaccines) are placed on our website for educational purposes.

HDC staff and I have delivered numerous conference presentations and talks to health professionals (including a wide range of trainee providers) throughout the country. Given the prevalence of complaints about care delivered in public hospitals, "grand round" lectures to hospital clinicians provide a valuable opportunity for education. Providers and consumers are always interested to hear from HDC about new developments (particularly any recent decisions), and a new quarterly e-bulletin, *HDC Pānui*, was introduced during the year to facilitate regular updates on our work.

As a result of my concerns about the detrimental impact of some media reporting of adverse events in health care, in December 2004 I convened a seminar for invited representatives of print, radio, and television media (journalists and editors), together with experienced consumer advocates and leaders from health professional and regulatory bodies. The day provided fascinating insights into the differing perspectives. Most participants recognised the legitimate public interest in reporting concerns about the quality of health care, but accepted the need for fairness, balance and respect for due process (avoiding harmful premature publicity). The seminar highlighted the unique role that HDC can play in tackling a thorny health or disability sector issue and bringing together a range of "opposing" interests.

HDC is also developing educational initiatives that target audiences in the disability sector, following consultation meetings with key stakeholders. One example is the Speak Up programme, an educational package for consumers aimed at empowering individuals to express their concerns, designed to be delivered with the support of a facilitator with a

disability. This is one of a number of actions taken by HDC in 2004/05, as part of our first implementation plan for the New Zealand Disability Strategy.

International Work

There is continued 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 July 2004, I represented New Zealand in New York at an international conference on Improving Quality of Healthcare, and in August I gave a keynote speech at the World Medical Law Congress in Sydney. In October the Deputy Commissioner gave a plenary address at the International Society for Quality in Healthcare conference in Amsterdam, and the Legal Manager presented on the New Zealand system at an International Symposium on Health Care Policy in Washington DC.

HDC participates in six-monthly meetings with the Australasian State Health Care Complaints Commissioners (in Melbourne in September 2004, and in Brisbane in March 2005). The meetings are a valuable opportunity for information sharing. Comparative data and informal feedback confirm that New Zealand's complaints resolution and educational initiatives are recognised as leading edge.

In 2004/05 I chaired two major Australian health system reviews. The first was 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 sought to balance the competing demands of access to services (especially for rural and regional consumers) and maintenance of high-quality surgical standards. My final report in March 2004 (www.surgeonsreviews.info/reviews/review_ots.htm) has been accepted by Australian Health Ministers, and a new assessment system is currently being implemented.

The second review examined the national arrangements for safety and quality of health care in Australia, and involved extensive consultation with clinicians, provider and consumer groups, health policymakers and funders. My final report in June 2005 (www.health.gov.au/internet/wcms/publishing.nsf/Content/health-sqreview.htm) has been endorsed by Health Ministers, with the announcement of the establishment of a new Australian Commission on Safety and Quality in Health Care.

Leading both reviews has provided a valuable opportunity to influence and learn from regulatory and other initiatives to improve the safety and quality of health care in Australia. It is hoped that some of the lessons from this work can be used to promote safe, high-quality health care in New Zealand.

Acknowledgements

The year marked the departure of Assistant Commissioner Katharine Greig, who joined HDC as Legal Manager in 1999 and, since 2000, oversaw the Office's handling of complaints. During that time, HDC significantly improved the timeliness and quality of our assessment and investigation of complaints, and halved the "backlog" of open files. Katharine's tireless efforts in complaints resolution, and her leadership of the Southland Mental Health Services Inquiry in 2002, are major legacies.

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 2004/05.

REPORT OF THE DEPUTY COMMISSIONER — EDUCATION & CORPORATE SERVICES

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

This is my first full year in the role of Deputy Commissioner Education & Corporate Services. The nature of our work at HDC requires us to work respectfully, and this involves a high regard for the uniqueness of individuals, families, groups and communities. It also means we have to consider how best we can share our resources, information, knowledge and skills, and how we can include people in the planning and development of our services. It means having to identify the power imbalances that exist in relationships so we can act to address them. It means being up-front and honest and transparent about what we are doing. Moreover, if this is how we expect our organisation to behave, HDC as an employer has to mirror these values in how it treats its staff.

Much of my role in the past year has been identifying processes and practices that will assist HDC staff to work in ways that support the philosophy we have for doing our work.

Tania Thomas
Deputy Commissioner — Education & Corporate Services

Two-way Communication with Consumers

One of the highlights for me this year has been working towards getting consumers to participate more actively in our work at HDC. A key outcome of the resultant Commissioner's Consumer Advisory Group meetings is the decision to hold three regional consumer seminars at the end of 2005.

While changes in HDC goals and practices promise potential benefits to consumers, it has become clear that consumers have been given only limited opportunity to contribute at the front-end of the decision-making. This omission has perhaps contributed to the significant number of consumers who have said they are not happy with their HDC experience, and the number who have said they would not use HDC again. In order to have buy-in on policy change, and to affirm that the correct decisions are being made, it is essential for consumers to have the opportunity to express their desires and priorities.

Changes have been made to improve the processes for making complaints against health practitioners and disability service providers, to ensure complaints are resolved expeditiously and fairly, with adequate communication between the various agencies involved. These changes have been introduced at an operational level, both for health service providers and within organisations such as HDC, and reflect a growing appreciation of the benefits of open disclosure and low-level resolution, and an understanding that complaints can be used more profitably to identify inadequacies in systems and practices and to improve the quality of those services, rather than to name, shame and blame providers.

Through the consumer seminars, HDC will engage consumers in a discussion about the way forward, to ensure consumer interests are being listened to and considered.

Education

I represented the Commissioner in Amsterdam at the 21st Conference of the International Society for Quality in Healthcare, where I spoke about the need for a no-fault compensation system to be complemented by a flexible and effective complaints system, such as the one under the Health and Disability Commissioner Act 1994. It affirmed for me that New Zealand

is a world leader in its commitment to health and disability consumer rights by having the Code of Rights in statute.

I also presented at District Health Board New Zealand's conference on Living Well with Chronic Illness. The importance of the quality of the relationship between the health professionals, the patient and his or her family and friends was stressed, and the positive difference it can make in the lives of those living with chronic illness was explored.

I took part in a panel at the International Health Priorities conference about health care as a human right. HDC is an advocate for consumer input and for consumers having the opportunity for meaningful dialogue with health care providers. Consumer voice is key to quality health care, and consumers are increasingly questioning decisions made by doctors.

Consumers are likely to find doctors' decisions around prioritising more acceptable if the criteria are fair and are based on clearly defined rights and common values. Being explicit about the criteria and making policy open for discussion means it is possible to explore differences in values.

Many consumers with scarce resources set priorities and make decisions around the best use of those resources, and sometimes these decisions are a matter of life and death. "Can I afford to get my son's asthma medication or should I pay the rent?", "Shall I get a warrant of fitness for the car or buy groceries?", "Shall I go to the dentist or pay the power bill?" Granted, those decisions are not made as often as the priority decisions made by health professionals and funders, but consumers can, with the relevant information, be part of the solution and can assist and advise on decisions about the allocation of health funding.

The On Small Shoulders conference I attended in support of children and youth who are caregivers for their parents, siblings and extended family members put a whole new perspective on the Code and how it applies to these very young and resourceful health and disability service providers.

Disability

HDC submitted its first implementation plan for the New Zealand Disability Strategy, for the 2004/05 year. The plan can be viewed at www.odi.govt.nz.

The many achievements include the following:

- A proactive staff recruitment programme is in place to focus on recruiting staff with disabilities. We had a successful placement using the government's Mainstream programme.
- The HDC website is being reviewed, with a particular focus on ensuring it is accessible to people with disabilities.
- An information pack was sent to all public libraries in New Zealand. It included an audio version of several HDC leaflets, aiming to cater in particular for those with visual impairment.
- A series of think tanks was convened, comprising 12 stakeholders in the disability sector. A report of these sessions identified three initiatives for development over 6–12 months, and three for implementation within the next three years. It outlined principles and methods for identifying target audiences, discussed prioritisation of initiatives, and recommended that criteria for ensuring initiatives are delivered in ways that are congruent with the cultural and other needs of disability consumers.
- A quarterly newsletter, *HDC Pānui*, is distributed in a variety of formats, and is also available on the Foundation of the Blind's telephone information service.

HDC put in place a relay telephone service for two of HDC's staff. The relay service has also been used by the Consumer Advisory Group. Many of the Commissioner's staff have taken the opportunity to learn New Zealand Sign Language.

Corporate Services

Corporate Services provide the platform for administering many of the systems and logistics that help HDC carry out its key role. This is achieved through fostering shared processes and practices that allow our separate areas of responsibility across the Commissioner's Office to maintain their separate and unique identities, while at the same time being able to co-operate and communicate in a way that ensures we are all contributing to the Commissioner's aims.

Human Resource Management

Our internal focus has been on developing human resource policies and practices that promote increased productivity and job satisfaction and enable a better balance between work and other activities, including voluntary work, leisure and personal development. We are not there yet, but we are working to develop a culture that asks, "How can we make it happen?"

Knowledge Management

We have implemented a knowledge management strategy within the Commissioner's office to better harness and disseminate the valuable learning we have gleaned from our work in complaints resolution. HDC is working more collaboratively, both internally and externally, and so it is crucial that we have access to fully integrated information that we can browse, explore and share. The information needs to be high-quality, accurate and appropriate to our needs and those of the people we serve. HDC has a role in contributing to the creation of new knowledge through collaboration and shared learning.

This commitment to accessibility has led to a review of the content and style of all our publications. We have also reviewed our website and begun work on redesigning the content and layout of the site. We received 260 responses to our online website satisfaction survey, which gave us information and ideas on how to make the website more accessible and user-friendly.

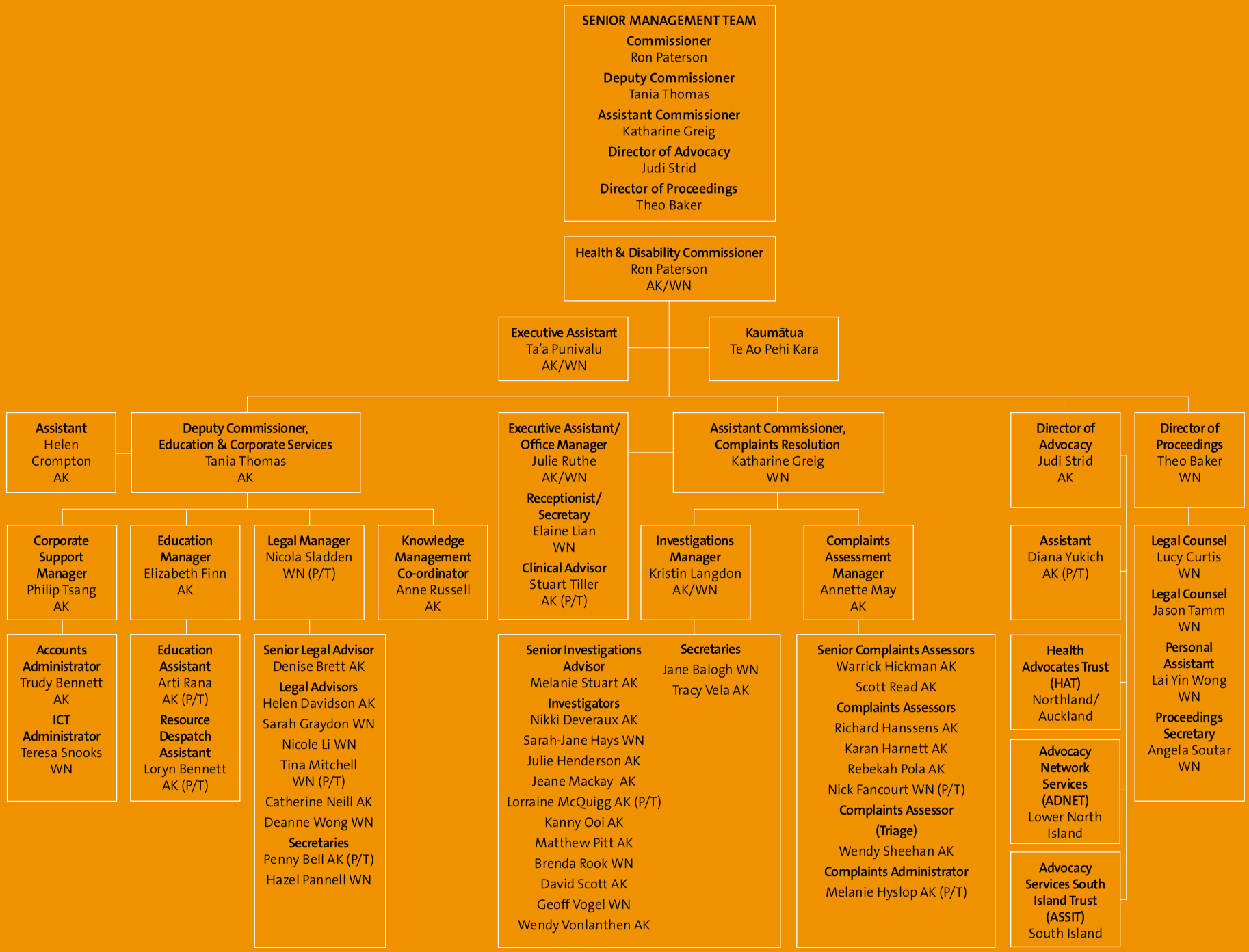
Information and Systems Technology

Doing business and working with a diverse range of people has required HDC to become e-enabled in a number of areas. For example, we have launched two web-based educational resources, introduced online ordering, established an online survey system, and completed the first draft of an online complaints process.

We have implemented a more sophisticated communication system for use by those of our staff who work offsite and who need remote access to their electronic documents and email.

HDC has made the decision to move towards outsourcing and sharing information system services. This will reduce the cost to HDC and improve our ability to obtain expert advice more readily, so that we are better able to use information technology to be more responsive to users' needs. HDC wants its staff to be able to seamlessly and easily connect to whatever information they need, whenever they need it, wherever it resides (digital and physical resources), and to use it effectively for research, learning, educating and administration purposes.

ORGANISATION CHART as at 30 JUNE 2005



REPORT OF THE DIRECTOR OF ADVOCACY

Kia ora tatou

I wish to acknowledge the hard work, dedication and commitment of the advocates, Trust members and other staff involved in providing the nationwide health and disability advocacy service. It is a challenge for the 44 personnel, most of whom work part-time, to provide services to a diverse range of consumer needs in all parts of the country.

The aim of the advocacy service is to promote and protect the rights of consumers by informing them of their rights and providing assistance to consumers wishing to resolve complaints about health and disability services providers.

Judi Strid
Director of Advocacy

Nationwide Health and Disability Advocacy Service

Structure

Although the service is provided under the Health and Disability Commissioner Act 1994, the Nationwide Advocacy Service is independent of the Commissioner. The Commissioner takes an impartial view, whereas advocates are on the side of the consumer, and the advocacy process is consumer-driven.

Three independent advocacy service organisations have contracts with the Director of Advocacy, who is also independent of the Commissioner. The advocacy service organisations are governed by community trust boards. The organisations that currently have contracts with the Director of Advocacy are:

- Health Advocates Trust (HAT), based in Auckland and covering the upper North Island;
- Advocacy Network Services Trust (ADNET), based in Wanganui and covering the mid- and lower North Island; and
- Advocacy Services South Island Trust (ASSIT), based in Christchurch and covering the South Island.

This year has seen changes with two of the service managers. We farewelled Stacy Wilson in February after seven years at ADNET, and welcomed back Lewis Ratupu as service manager. HAT manager Maria Marama went on maternity leave after the birth of her baby in April, and Hinurewa te Hau stepped in as interim manager.

Combined, the services consist of 30 advocates, plus four kaitutaki tāngata/educator positions, three service managers, three assistant manager/senior advocate/supervisor positions, and four administration staff, who work a total of 33.21 full-time equivalent positions.

The ability of consumers to access the advocacy service is particularly important. Advocates are based in 28 offices, stretching from Kaitaia to Invercargill, with five in the South Island. All advocates can be contacted through a local telephone number or an 0800 number. There is also email and a free fax number so that deaf consumers can make contact.

In areas where there is no advocacy office, particular effort is made to link with local networks to maintain a profile and to ensure consumers are able to contact an advocate and receive assistance when they need it. Regular visits are also made for networking and education sessions.

On the West Coast of the South Island, for example, a monthly clinic has been established at an independent site where consumers can make contact with or without appointment. This is in addition to the two days each month when education and training sessions are provided

in the area. Additional visits are made on a needs basis where an issue cannot be dealt with by telephone. An advocate also participates in the monthly DHB staff orientation to ensure all new staff are aware of the Code of Rights, their responsibilities to consumers, and how the advocacy service works.

Focus

Advocates aim to educate consumers and providers to shift the focus of health and disability services towards taking a more consumer-centred approach. Building relationships, promoting respectful dealings with all parties, and encouraging an approach that values and recognises complaints as quality improvement opportunities are effective ways of achieving this. A specific requirement is a commitment to strategies and actions that address the needs of Māori as tangata whenua. The focus of the New Zealand Disability Strategy is integrated into the planning and delivery of advocacy services.

There has been a particular effort over the past 12 months to identify ways the advocacy organisations can work more collaboratively to achieve a nationally consistent and high-quality consumer-centred advocacy service.

National guidelines, regular training and competency standards guide the professionalism, competence and practice of advocates, in addition to service delivery and performance management. It is important that the service sets a good example to demonstrate the benefits of learning and improving. Systems for continuous quality improvement are integrated through all levels of the service.

Education, Training and Networking

Education is a key part of an advocate's role. Advocates provide education sessions about the Code of Health and Disability Services Consumers' Rights to inform consumers about their rights, and providers about their responsibilities. They also promote the role of complaints as a way to improve the quality of services, and increase awareness of the role of advocacy and the benefits of low-level resolution. The new combined HDC/Advocacy leaflet, available in Māori and 13 other languages, promotes this approach and describes what consumers can expect when making a complaint.

Areas of Demand

There was a significant demand for training and education on the Code as residential facilities moved to accreditation under the Health and Disability Services (Safety) Act 2001. Of special interest were the topics of informed consent, advanced directives, and enduring powers of attorney. The importance of this education cannot be underestimated as new staff continue to take on health and disability service caring roles. Advocates are also keen to assist staff working in dementia units or with people who have a significant disability, so that staff members are proactive in making sure the rights of these very vulnerable consumers are respected.

The increase in requests from both providers and consumers for more specialised education has also continued. ADNET recorded that focused education with specialised training made up 12% of all education sessions delivered this year, compared with 5% last year.

Advocates have worked successfully with HDC staff to address specialised education and training requests. A number of advocates continue to have input into DHB staff orientation programmes, which ensures an ongoing focus on consumers' rights and an easier working relationship when the advocate is assisting a consumer with a complaint.

The kaitutaki tāngata role has been very successful in providing education sessions that are relevant to Māori. The role combines networking with Māori as an effective way of improving the profile of consumer rights and the advocacy service.

Evaluation and Feedback

As part of quality improvement, the advocates take part in training programmes to look at ways to enhance the quality of their own presentations. They are keen to try new and innovative ways to present and train people on rights, and look forward to the feedback from participants.

Consumers and providers rate these educations sessions highly. Using a scale where 1 is "not achieved" and 7 is "achieved to a very great extent", an average of over 90% of participants rated the content 6.35, and the facilitation, relevance, opportunity to participate and overall satisfaction as 6.40.

There was a total of 1,963 networking contacts over the year, as well as 1,452 education and training sessions.

HAT recorded that 78 of their 513 sessions had more than 20 people present, and 26 had over 40 attendees. The average length of the presentations was 62 minutes.

Feedback from attendees reflects the overall positive reception, highlighting an approach that is effective in its inclusiveness and positivity:

> **"Clear, concise and communicated well with group"; "Easy to understand format, very appropriate"; "Good interactive style"; "Well presented, friendly, informative"; "Easy to understand and explained things fully"; "Presented well, enjoyed the discussion"; "Pleasant, personable clear presentation"; "Encouraged class participation and so many of the people present participated"; "Answered questions, explained available options"; "Spoke clearly, message delivered informatively and questions answered well with clear examples".**

As always, however, some feedback provided constructive suggestions on how to improve delivery:

> **"Have more complaint examples"; "More exercises to add to video"; "I found pausing the video very hard to understand"; "Need more time to explore options"; "Make provider rights clear"; "Ask the class to come up with examples of a complaint to involve us right from the start".**

Assisting Consumers with Enquiries and Complaints

Enquiries

People contact an advocate or the advocacy service for a range of information and types of help. A total of 7,985 enquiries were made in the 2004/05 year. On average 69% of those making an enquiry were provided with verbal information, 21% with both verbal and written information, and 10% of enquiries were referred to another agency. Very few enquiries were escalated to a complaint.

It is of interest to know how consumers heard about the nationwide advocacy service. Of those who brought their complaint to an advocate, the greatest number overall (29%) had heard about the service from friends and family. This was also the most likely way a consumer in the South Island had heard about the service (41%). Overall, 21% had heard about the service directly from the advocacy service, and this was the most likely way that a consumer had heard about ADNET (34% of their contacts). Advertising accounted for 17% of enquiries, but was responsible for the greatest number of contacts with HAT (31%). Six

percent said they had heard about advocacy from HDC, 19% from a provider, and 8% from other sources.

Complaints Resolution

The information database does not collect data on how many consumers feel able to take their own action after speaking with an advocate, or how successful they were. However, advocates do report many examples where they coach consumers so that consumers are able to handle the issue themselves, an option that many appreciate. These consumers say that, once they have the options explained, they are able to "get on with it". This is not the case for many other consumers who feel disempowered or intimidated by their contact with the provider and request the assistance of an advocate.

Nationwide, the service managed 4,448 complaints. Of these, 67% were made by the consumers themselves and the remainder by a third party. An even greater number of South Island complaints came from consumers, and almost 88% approached the advocacy service in the first instance, with the other 12% going straight to HDC. One in every 661 people in the South Island took their complaint to an advocate.

Over 42% of the complaints were about appropriate standards, 13% were about effective communication, and 12% were about not being fully informed. Complaints about an unsatisfactory complaints process (Right 10) amounted to 8% — double the figure for last year. Of people who took a complaint to ASSIT, 9.5% had a problem with having a support person present, an issue less commonly complained of to the North Island services.

The greatest proportion of complaints were made by Pākehā New Zealanders (73% nationwide) and 60% of the complaints are made by females. Although not all people provide their ethnicity, about 16% stated they were Māori, and 2% were Pacific peoples.

The greatest percentage of complaints overall (32%) are about people aged 41–60 years who have received a health or disability service, although the majority of the complaints received by HAT concern those in the 26–40 age group (35% of all their complaints). This younger group totalled 30% of the complaints overall. People from the 61–99 years age group made up 28%, and this was the largest age group that made complaints to ASSIT (almost 34% of their complaints received).

Only 6% of the total complaints related to young people aged 16–25 years who had received a health or disability service, and a total of 4% related to those aged 15 and under. This is an area currently being reviewed to see how advocates can be more accessible to young people.

Advocacy is a very effective process for resolving complaints in a timely manner. As this is a consumer-centred process, the consumer chooses the most appropriate option. Of the 4,448 complaints managed by advocates, 82% were either resolved or partially resolved through advocacy. Sometimes consumers change their mind and withdraw a complaint or are unable to be contacted. If the provider does not wish to participate in resolving the matter, the consumer may choose to take his or her complaint to the Commissioner. ASSIT reported that 2.4% of unresolved complaints were taken to HDC, whereas 9.5% of consumers with unresolved matters withdrew or decided not to proceed. HAT reported 5% of unresolved complaints going to HDC.

Only a small proportion of complaints (less than 4% of the total complaints managed by advocates) came to advocacy from HDC, and that number represents a drop from the previous year.

Within three months of a complaint being made, 91.5% were closed; 99.1% were closed within six months.

Consumer responses to complaint resolution surveys show that the skill of the advocate and the advocacy process rate highly.

Sample of consumer comments

"I was very pleased to have their help"; "The service given to me by the advocate was very clear and reassuring"; "I had good support"; "Happy with the service provided"; "I was immensely impressed"; "I was treated with all the courtesy and help even though I had no wish whatsoever to meet the doctor concerned"; "The advocate we dealt with was professional in all areas"; "Once I shared my concerns with the advocate, who listened, encouraged, advised and followed up the load, the load got lighter"; "Yes they understood where I was coming from"; "My advocate has been very clear and constructive in helping me to assess the situation and take logical steps"; "Offered prompt and effective help"; "There couldn't have been anything else done better because it was all done efficiently, effectively and very sincerely"; "Very understanding and skilful"; "I wouldn't have got anywhere on my own, thank you".

Although the advocate is on the side of the consumer, it is important that providers have confidence in the advocacy process so that they will be willing to participate in the consumer's efforts to resolve the complaint.

Although providers were critical of consumer expectations, the high number of providers willing to work with the advocacy process again, and who would recommend the service to others, is heartening news for consumers as well as for the advocates.

Sample of provider comments

"The advocate demonstrated an extremely professional approach, maintained contact and clear communication through the process"; "Resolution was satisfactory"; "The advocate was very polite and gentle with the complainant. Communicated the process and progress well"; "Listening, understanding problem, helping complainant to voice their concerns clearly, always keen to work with consumers and providers to resolve complaints at advocacy level"; "Defusing anger and hostility"; "Established an environment that felt very safe and non threatening"; "I am very pleased with this service and am unsure as to what I could suggest to improve it".

Trends

Inadequate communication between consumers and providers, and by providers with each other, continues to be a common feature of complaints and the cause of difficult relationships leading to distressed consumers. Assisting with restoring communication and rebuilding relationships is a key focus for advocates working with consumers who need to have an ongoing relationship with a provider.

Advocates are expected to inform consumers about their right to complain (Right 10) and that they can expect their complaint to be taken seriously and dealt with appropriately in a timely manner. Whilst most providers make an earnest effort to resolve the complaint and can recognise the benefits of low-level resolution, it is of concern that advocates continue to report that some providers refuse to provide services to those who complain, and are unable to recognise the opportunity complaints bring to their service.

There has also been an increase in the number of complaints about providers taking far too long when dealing with complaints, and treating consumers/complainants disrespectfully. This also has an adverse outcome on the ability to manage complaints successfully at a low level. ADNET has observed that complaints about the provider's complaint procedure have increased from 3% of their complaints three years ago to 7% of their complaints over the past year.

Advocates in particular areas reported an increase in complaints related to the reduction of disability services, compounded by a lack of communication regarding the changes. A lack of co-ordination and agreement between local Needs Assessment Service Coordination services (NASCs) and providers also has an impact on services for consumers, often resulting in complaints. There has been an increasing number of enquiries and complaints from families with a disabled family member with complex care needs, where the family is finding it difficult to obtain the support, assistance and respite care they are entitled to.

People under 65 whose significant disability means they are unable to care for themselves have also come to the attention of advocates. Unable to live independently and in need of considerable care, these people are currently in aged care residential facilities. Advocates have been contacted by consumers, family members and staff as they believe this arrangement is under threat. The consumers are anxious that they may have to leave the current accommodation, along with its friendships and excellent care, and there is uncertainty about what will happen to them.

Advocates continue to receive complaints from prison inmates about a variety of issues relating to the quality of their care and treatments available in prison, as well as difficulties achieving specialist services owing to reliance on guards to accompany them for security requirements.

The cultural practices and attitudes of overseas-recruited doctors and nurses have been an issue in some health services. Advocates identify that these situations are educational opportunities, as overseas-trained practitioners are often not familiar with consumer rights and their responsibilities as a provider.

In conclusion, although the empowerment approach is effective in helping consumers become more actively involved in self-advocacy, many still like to have the support of an advocate, as they feel it goes some way toward addressing the "power imbalance" between themselves and the provider.

IMPORTANCE OF COMMUNICATION

An advocate was contacted by a consumer who is tetraplegic and lives independently in his own home. He requires 24-hour care.

The consumer had issues with two separate providers. One was the home support agency contracted by ACC to provide 24-hour care, and the other was a physiotherapist. The consumer was having ongoing difficulties with the home support agency, which he feared was going to withdraw services. He believed that the physiotherapist was providing the agency with information to support the withdrawal of services, and was concerned that he was going to be forced into rest-home care.

The advocate visited the consumer to listen to his concerns and explore options to assist him to resolve them. As a result of this discussion, the consumer requested and received a list from the providers about their concerns. He also arranged a meeting with the providers and accepted the advocate's offer of support at the meeting.

At the meeting the consumer was able to articulate his concerns about the care he was receiving, and the providers advised him of the expectations and protocols required of them as providers. The consumer was assured of ongoing services and support, and was happy with the outcome of the meeting.

He later contacted the advocate to advise of a further issue that had arisen with another provider, which he had been able to resolve successfully himself.

REPORT OF THE DIRECTOR OF PROCEEDINGS

Introduction

The work of the Commissioner and the Complaints Resolution team is evident in the decline in the number of referrals from the Commissioner for the past financial year. As the Commissioner cleared the backlog of open investigations between 2000 and 2003, the increase in referrals was marked. However, as the statistics below show, the past year has seen the proceedings team working at a steady pace, with successful outcomes in over 80% of Tribunal decisions.

Theo Baker
Director of Proceedings

Statistics

Table 1 shows the outcomes of referrals received between 1 July 2004 and 30 June 2005. (It does not include matters that were referred prior to 1 July 2004.) The 18 files that were opened arose from 15 referrals from the Commissioner. This will be the last time that one referral may result in more than one file being opened by the Director of Proceedings. Since amendments to the Health and Disability Commissioner Act 1994, effective from 18 September 2004, the Commissioner no longer refers a "matter", which may have involved more than one provider. Rather, individual providers are referred. This means that, in a case where the Commissioner has found that more than one provider has breached the Code, he may elect to refer selected providers to the Director of Proceedings.

The reduction in referrals in 2003/04 led to a predictable drop in hearings in the past year compared with the previous year (see Table 2, overleaf). In five of the six disciplinary hearings, the charges were upheld, as were the three appeals. The one Human Rights Review Tribunal (HRRT) proceeding, in respect of two complainants, was largely successful.

Table 1: **Action taken in respect of referrals to Director of Proceedings in 2004/05**

Provider	No further action	Decision in process	Hearing pending	Hearing taken place	Total
Dentist			3	2*	5
District Health Board	1				1
Medical practitioner					
Psychiatrist	1	1**			2
General practitioner		1			1
Nurse		3	2		5
Pharmacist	1				1
Pharmacy technician	1				1
Rest home		1			1
Social worker	1				1
Total	**5**	**6**	**5**	**2**	**18**

* These two charges were against the same dentist. In addition, there has been a third prosecution in respect of a referral received before 1 July 2004. Finally, there is another matter relating to this dentist in the hearings pending statistics.

** Decision made in July 2005 to take disciplinary action. HRRT proceedings on hold.

Table 2: **Outcome of hearings in 2004/05**

Provider	Successful	Unsuccessful	Total
Discipline			
Substantive hearings			
Dentist	3	1	4
Nurse	1		1
Psychiatrist	1		1
Appeals			
Medical practitioner			
General practitioner	1		1
Gynaecologist	1*		1
Surgeon	1*		1
HRRT			
Substantive hearings			
Acupuncturist	1**	1**	2
Interlocutory hearings			
Counsellor	1		1
Social worker	1		1
Total	**11**	**2**	**13**

* In these two cases some points were lost on appeal, but the substantive findings were upheld.

** These two cases involved only one acupuncturist, but two separate complaints. One complaint was only partially successful, the greater part of the claim not being upheld.

At present four disciplinary matters are set down for hearing before the end of the calendar year. Of those, one is a matter that was referred in the previous financial year. It arose from three separate complaints and is set down for hearing in September 2005. There are three other cases to be set down for hearing once the charges have been filed. Finally, as can be seen from Table 3, there are four matters awaiting hearing in the Human Rights Review Tribunal.

The first two prosecutions taken by the Director of Proceedings before the new Health Practitioners Disciplinary Tribunal were heard in June 2005. These hearings were in respect of the same dentist, and the charges were upheld. There are now no matters awaiting hearing before any of the disciplinary bodies established under any of the former registration acts.

Tribunal Survey

As in previous years, a postal survey was sent to the relevant disciplinary tribunals. In the past financial year, hearings had taken place before the following bodies:

- the Nursing Council
- the Medical Practitioners Disciplinary Tribunal
- the Dentists Disciplinary Tribunal
- the Health Practitioners Disciplinary Tribunal
- the Human Rights Review Tribunal.

Table 3: **Human Rights Review Tribunal cases in 2004/05**

Provider	Hearing pending	Successful prosecution	Unsuccessful prosecution	Settled after proceedings filed	Total
Acupuncturist		1*	1*		2
Counsellor	1			1	2
District Health Board				1	1
Medical practitioner					
MOSS	1				1
Psychiatrist	1				1
Midwife				1	1
Obstetrician				1	1
Social worker	1				1
Total	**4**	**1**	**1**	**4**	**10**

* These two cases involved only one acupuncturist, but two separate complaints. One complaint was only partially successful, the greater part of the claim not being upheld.

Accordingly five surveys were sent, of which three were returned. Expectations were "mostly met", but areas for improvement have been identified. As in previous years there was some concern about the drafting of charges. I have undertaken to meet with the relevant stakeholders in an effort to address any concerns.

In addition, in future, opportunities for feedback will be provided to complainants when a file is closed. Providers and their counsel will be surveyed as to the fairness of the process.

Other Developments

The Health and Disability Commissioner Amendment Act 2003 abolished the obligation on the Director of Proceedings to give providers a further opportunity to be heard before the Director decides whether or not to issue proceedings. Nevertheless, it is appropriate in some circumstances to invite or allow further comment. This has led to a slightly more fluid process upon referral, but the commitment to timeliness and fairness remains.

The lower number of referrals has enabled time to be spent on other projects. Expansions to the HDC website have now been made to include a schedule of upcoming hearings, and case notes of decisions once received. A list of Frequently Asked Questions also appears. A brochure about the role of the Director of Proceedings, which incorporates this material, has also been developed.

Compensation for Consumers

This year saw the first award of exemplary damages being made by the HRRT in an HDC case (see *Director of Proceedings v Fan*, overleaf). Comment has been made that the consumer groups consulted in the drafting of the Health and Disability Commissioner Act 1994 had expected that the Act would provide significantly greater opportunity for consumers to be compensated for breaches of the Code. On that note, a lawyer representing a consumer commented in correspondence to me: "Your comment in your letter on 11 February that there are comparatively few HRRT decisions under this legislation is not at all surprising given the restrictive approach your office apparently takes."

DIRECTOR OF PROCEEDINGS v FAN

On 25 February 2005 the Human Rights Review Tribunal issued two decisions in respect of two cases (heard together) involving health services provided by Mr Charlie Fan of Queenstown. Although both complainants' names have been permanently suppressed (and have therefore been referred to below as complainant "A" and "B", respectively), Mr Fan's application for permanent name suppression was declined.

In complaint A, the complainant alleged that in the course of an acupuncture treatment to "bring on" her period, the defendant rubbed her in the genital area. She made specific, detailed allegations about the manner in which he did this. The defendant denied this, but said that the complainant had requested that he check to see whether her period was coming and, although there was no clinical reason to warrant such conduct, he had acceded to her wishes and did so, using cotton wool and tweezers. Complainant A likewise denied that she had made this request and, further, gave evidence that she had a cervical stenosis, which meant that the onset of her periods was different from usual.

In complaint B, the complainant went to see the defendant about a problem with tinnitus (ringing in her ears). This had commenced while on her honeymoon following a loud air horn being blown directly into her ear.

The defendant diagnosed the problem as being "deficiency type" tinnitus (that is, a deficiency of qi in the kidneys) and concluded that it was caused by excess sexual activity. His treatment involved the teaching of breathing exercises as well as a moxibustion treatment close to the complainant's vagina. The complainant's evidence was that she did not understand why he was doing this. When the defendant touched her genitals, the complainant said, "I'm not comfortable with this." Mr Fan then told her to "pretend that he was a woman" and continued with the treatment.

In complaint A, the Tribunal declared that Right 1(2) of the Code had been breached in that the defendant did not provide complainant A with a covering that would have protected her personal privacy while the defendant checked to see whether her period had come, but not the more serious allegation of his having touched her genital area. The Tribunal gave a declaration that the Code had been breached but declined to award damages.

The Tribunal did, however, raise concerns about whether in undertaking an unnecessary examination the defendant had breached the Code, but it did not determine this issue as it was not specifically alleged as a breach in the Statement of Claim.

In complaint B, the Tribunal held that Mr Fan had breached Rights 1(2), 4(2), 5(1), 6(2) and 7(1) of the Code. It ordered Mr Fan to pay $5,000 in compensatory damages and $2,000 in exemplary damages. In a subsequent decision, dated 28 June 2005, the defendant has been ordered to pay costs of $22,000 and attend training in respect of the Code.

While it is acknowledged that only five claims have resulted in full substantive hearings before the Tribunal,[1] the assertion that this office takes a restrictive approach is not accepted. The reasons why there are few HRRT cases have been canvassed briefly in previous annual reports. The main reasons why so few cases are being heard by the Tribunal are as follows:

- Until 18 September 2004, the jurisdiction of HDC did not cover periods before 1 July 1996, so there has been a fairly brief opportunity for cases to be heard.
- Prior to 18 September 2004, the aggrieved person could not bring proceedings until the file had been to the Director of Proceedings (and there have been no cases brought by the aggrieved person after the Director took no action).
- The ACC statute-bar to civil claims for damages for personal injury by accident prevents a claim for damages under s 57(1)(a)–(c) of the Health and Disability Commissioner Act.

1 Two claims were heard together in the case of *Fan*.

- While a claim may still be made for punitive damages (also known as exemplary damages), a high threshold must be met for such an award to be made, and the sum involved is not likely to be great. Therefore the cost of bringing proceedings must be weighed against the prospects of success and the likely outcome.
- Public interest (that is, the safety and welfare aspects of complaints) in respect of registered health professionals is usually better served by bringing disciplinary proceedings.
- Sometimes the parties have already settled matters between themselves prior to a referral to the Director.
- The Director has on occasion settled matters prior to filing proceedings.
- The Director has often settled matters after filing proceedings. The proceedings have then been discontinued.
- The parties may have settled matters between themselves after proceedings have been filed. Orders have then been made by consent.

As a result of amendments to the Health and Disability Commissioner Act 1994, when the Commissioner finds a breach but does not refer the matter to the Director or Proceedings, an aggrieved person may now take his or her own case to the HRRT. It is possible that an increase in cases heard by the HRRT may therefore result.

Table 4 (overleaf) shows the outcomes of all referrals where HRRT proceedings have been possible. The small number of Tribunal hearings must be viewed in the context of these other cases.

Of all the reasons listed above as possible impediments to the pursuit of claims, the bar to civil proceedings for damages other than punitive damages is the most significant. Furthermore, the amounts of damages awarded in cases such as *Fan* (see case note) do not provide a strong incentive for issuing proceedings.

Finally, disciplinary proceedings do not fall within the ambit of the Sentencing Act 2002, which provides for payments to be made to the victims of offences. Nor is there provision in the Health Practitioners Competence Assurance Act 2003 for payments to be made.

Conclusion

In the year ahead I look forward to reviewing processes and practice in order to maintain a high quality of proceedings.

Proceedings team

Back row from left: Theo Baker (Director of Proceedings), Jason Tamm (Legal Counsel), Angela Soutar (Secretary)

Front row from left: Lai Yin Wong (Personal Assistant), Lucy Curtis (Legal Counsel)

Table 4: **HRRT outcome of all referrals to Director of Proceedings from 1 July 1996 to 30 June 2005**

	No of cases
Declaration made following a defended hearing, but no other remedy awarded	
Acupuncturist	1
General practitioner	1
Declaration and award made following a defended hearing	
Acupuncturist	2
Midwife	1
Cases where HRRT proceedings filed, but settled	
Counsellor	2
District Health Board	1
Midwife	1
Obstetrician	1
Psychologist	1
Registered nurse	1*
Rest home	1*
Cases where parties settled between themselves	
District Health Board	1**
Health trust	1**
Paediatrician	1
Cases unsuccessful	
Obstetrician	1***
Cases pending	
Counsellor	1
Medical practitioner	
MOSS	1
Psychiatrist	1
Social worker	1
Total	**21**

* Arising from the same complaint.

** Arising from the same complaint.

*** Claim withdrawn upon a Court of Appeal decision that the ACC statute-bar applied.

COMPLAINTS RESOLUTION

Introduction

The Complaints Resolution division, led by Assistant Commissioner Katharine Greig, comprises two teams: the complaints assessment team, based in Auckland, and the investigations team, based in Auckland and Wellington.

2004/05 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). The Complaints Resolution division successfully achieved its three key targets, which were based on section 6. The first target was to decrease the number of open complaint files. This was achieved with 313 open complaint files as at 30 June 2005, a reduction of 13% from last year's total of 347. The second target was to continue to focus on resolving matters at the lowest appropriate level, which is reflected in the number of matters resolved without investigation (85%), and in the low number of investigation files open at the end of June — 111 (200 last year). The third target 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 2005 with the figures at 30 June 2000.

Katharine Greig
Assistant Commissioner

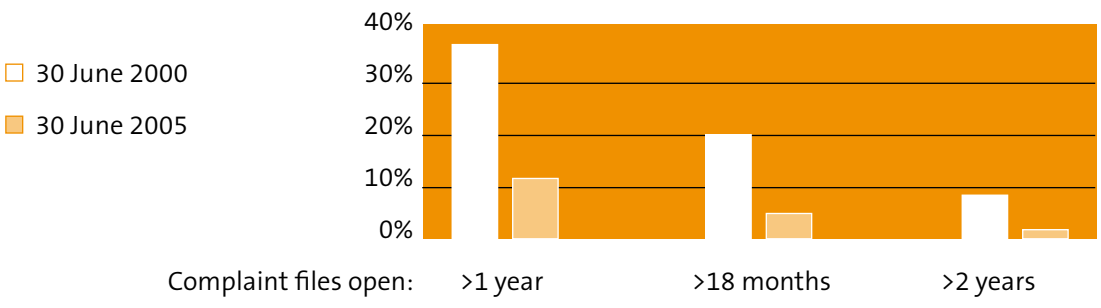
Complaints Assessment

The complaints assessment team, led by Complaints Assessment Manager Annette May, was responsible for closing 950 of the 1,158 complaint files closed in 2004/05 (82%). Of these, 93% were closed within six months.

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

	2004/05	2003/04	2002/03
Open at year start	347	367	546
New during year	1,124	1,142	1,159
Closed during year	1,158	1,162	1,338
Open at year end	313	347	367

Figure 1: **Timeliness of complaints resolution (% of all open files)**



Complaints Assessment Team

The complaints assessment team is the first point of contact with the Office for complainants and for general enquiries. It also plays an important role in liaising with providers about whom complaints have been made and in maintaining effective working relationships with external bodies to ensure that complaints are handled appropriately — for example, DHBs, registration authorities, District Inspectors, Coroners, and the Ministry of Health.

With an ongoing focus over 2004/05 on resolving complaints at the lowest appropriate level, the volume and complexity of the work done by the complaints assessment team has continued to grow. To reflect this, the team increased from six to seven full-time staff, two part-time staff members, and two part-time contractors. The team was assisted by a part-time medical advisor — a new position created at the start of the 2004/05 year.

Roles within the team were also reviewed: two complaints assessors were promoted to senior complaints assessor roles to assist with the increased complexity and volume of work, and a part-time administrator was appointed to manage the administrative work of the team. Processes were further amended to reflect changes in legislation (discussed elsewhere in this report) and 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.

Most people who make enquiries do so by telephone. Enquiries are generally 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.

In 2004/05 there were 5,335 verbal enquiries recorded, fewer than the 7,070 recorded the previous year. Interestingly, the category in which significantly fewer telephone calls were received was that of general queries, not related to health or disability services complaints or the work of HDC (1,243 fewer). Ninety-five percent of enquiries were responded to on the day they were received.

Written responses to enquiries (categorised as "formal responses") were sent to 196 enquirers and 83% were sent within one month.

Complaints

In the year ended 30 June 2005, HDC received 1,124 complaints, 18 fewer than in the previous year (1,142).

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 authorities, such as the Medical Council and the Nursing Council, must be referred to the Commissioner. The registration authority must not take any action on the complaint until notified by the Commissioner that the complaint is not to be investigated, or 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.

Table 2: **Action on enquiries**

Action taken	2004/05	2003/04
Escalated to complaint	14	18
No response required	88	102
Outside jurisdiction (access, date, funding, ACC)	576	731
Outside jurisdiction — referred to another agency	118	158
Provided formal response	196	237
Provided information on HDC and complaints process	1,546	946
Provided verbal information	983	2,789
Provided verbal and written information (including requests for brochures)	105	198
Referred to advocacy	766	1,196
Referred to another agency (including district inspector, prison inspector and professional body)	799	789
Referred to another internal department (legal, publications)	132	169
Open	12	13
Total	**5,335**	**7,346**

In 2004/05, as in previous years, most complaints were received from individual consumers (50%), friends/relatives (28%), and registration authorities (9%). As in previous years, far more complaints were received from health consumers than disability services consumers. The registration authorities that referred the most complaints were the Medical Council and the Nursing Council.

Types of provider subject to complaint
The 1,124 complaints received involved 1,363 providers (see Table 3 overleaf).

Figure 2: **Source of complaints received 2004/05**

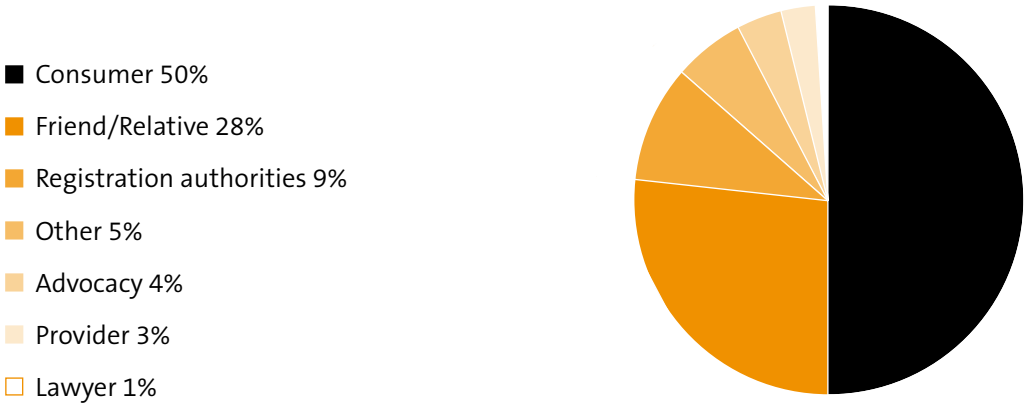


Table 3: **Types of provider subject to complaint**

Individual provider (registered medical practitioners)	2004/05	2003/04	2002/03
Anaesthetist	7	6	5
Cardiologist	1	1	2
Cardiothoracic surgeon	0	0	1
Dermatologist	3	4	12
Ear/Nose/Throat specialist	1	1	2
Emergency physician	1	1	0
Endocrinologist	1	0	1
Gastroenterologist	2	1	0
General practitioner	244	256	243
General surgeon	26	45	37
Geriatrician	3	3	1
House surgeon	1	5	2
Medical officer	3	5	4
Neurologist	0	2	3
Neurosurgeon	2	3	1
Obstetrician/Gynaecologist	42	22	31
Occupational medicine specialist	0	5	5
Oncologist	0	1	0
Ophthalmologist	7	3	6
Orthopaedic surgeon	26	18	18
Otolaryngologist	6	4	0
Paediatrician	9	4	9
Pathologist	3	1	1
Physician	28	34	33
Plastic surgeon	9	7	4
Psychiatrist	27	26	23
Public health specialist	0	1	0
Radiographer	1	0	0
Radiologist	11	8	10
Registrar	8	14	26
Sports medicine specialist	9	0	1
Urologist	13	11	7
Subtotal (medical practitioners)	**494**	**492**	**488**

Individual provider (other than registered medical practitioners)	2004/05	2003/04	2002/03
Acupuncturist	2	2	2
Alternative therapist	1	0	1
Ambulance officer	1	1	2
Audiologist	0	1	0
Caregiver	3	1	4
Chiropractor	13	6	13
Counsellor	6	6	8
Dental technician	4	6	5
Dental therapist	2	0	0
Dentist	30	41	57
Dietician	1	0	1
Key worker (mental health)	1	0	0
Massage therapist	2	0	0
Midwife	37	37	41
Naturopath	3	3	2
Needs assessor	0	0	1
Nurse	58	60	68
Occupational therapist	5	4	3
Optician	0	1	0
Optometrist	1	2	2
Oral surgeon	2	2	4
Osteopath	2	2	5
Other providers	11	15	6
Pharmacist	24	21	30
Pharmacy technician	0	1	1
Physiotherapist	5	7	6
Podiatrist	4	0	2
Psychologist	24	43	33
Psychotherapist	0	0	2
Rest home manager	1	2	0
Social worker	2	6	0
Speech language therapist	1	1	0
Subtotal (other individuals)	**246**	**271**	**299**
Total (all individual providers)	**740**	**763**	**787**

Table 3: **Types of provider subject to complaint** (continued)

Group provider	2004/05	2003/04	2002/03
Accident and emergency centre	8	9	7
Accident Compensation Corporation	7	20	1
Ambulance service	6	4	8
Dental provider	3	2	2
Disability provider	15	8	11
Educational facility	0	1	2
Government agency	6	5	0
Hospice	2	0	0
Intellectual disability organisation	4	8	3
Laboratory	1	2	2
Medical centre	31	28	17
Other provider group	23	21	13
Pharmacy	21	38	40
Prison service	17	28	27
Private medical hospital	10	7	11
Private surgical hospital	11	11	18
Public hospital	382	359	355
Radiology service	4	7	4
Rehabilitation provider	8	6	2
Rest home	56	69	67
Trust	8	12	6
Total group providers	**623**	**645**	**596**

The types of provider most commonly complained about were:

Individual Provider		**Group Provider**	
General Practitioner	33%	Public hospital	61%
Nurse	8%	Rest home	9%
Obstetrician/Gynaecologist	6%	Medical centre	5%
Midwife	5%	Pharmacy	3%
Physician	4%		
Psychiatrist	4%		

Table 4: **Complaints outside jurisdiction, referred to another organisation, or no action taken**

	2004/05	2003/04	2002/03
Outside jurisdiction[1]	302	256	186
Referred to a health professional body[2]	65	88	92
Referred to the Privacy Commissioner	4	16	20
Referred to the Human Rights Commission	1	2	2
Referred to the Ombudsman	0	0	1
Referred to ACC	23	32	39
Referred to the Ministry of Health	13	15	32
Referred to a District Inspector	19	17	25
Referred to another agency	2	1	2
No action[3]	364	275	240
Total	**793**	**702**	**639**

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, Midwifery Council, Nursing Council, Pharmacy Council, Physiotherapy Board, Podiatrists Board, Psychologists Board, Occupational Therapy Board.

3 No action taken under section 37(1) (section 38(1) after September 2004) of the Act, and no investigation commenced.

Initial complaints assessment

Initial handling of complaints is undertaken by the complaints assessment team. A complaints assessor, who is responsible for the 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 process, introduced in the 2003/04 year, has been very successful in ensuring the speedy and efficient handling of matters outside HDC jurisdiction. In 2004/05, 161 complaints outside jurisdiction were closed within an average time of one week. Feedback suggests that people have appreciated the prompt response and the constructive suggestions of alternative avenues for assistance.

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, an experienced investigator, 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. In-house legal or clinical advice is also sought where appropriate.

At the start of 2004/05 the Commissioner appointed a medical practitioner as a part-time clinical advisor. The clinical advisor has been particularly helpful in assisting the triage team to make timely recommendations on clinical matters within the advisor's expertise.

Complaints resolved without investigation

In 2004/05, 85% of all the complaints closed were closed without a formal investigation. This was consistent with the Commissioner's focus on the lowest appropriate level of resolution. Achieving this result required careful initial review of complaints, including obtaining clinical records and further information from complainants and, in a number of cases, responses from providers and early clinical advice. Once this information has been obtained, the Commissioner is able to make a balanced decision, based on all of the information available, as to what action is appropriate.

This year, 193 complaint files were closed without investigation as a result of the complaint being withdrawn (23), or being resolved by the Commissioner (63), through advocacy (57), by agreement of the parties (37), by mediation (1), or by the provider (12).

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

Under section 37(1) of the Act (after September 2004, section 38(1)), 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 2004/05, 364 complaints were closed using sections 37(1) or 38(1), compared to 275 closed in the previous year using section 37(1).

Since the amendments to the Act came into force in September 2004, the Commissioner has referred 38 complaints to providers for resolution. Of these referrals, 33 were to District Health Boards. In 11 cases, the complaints were successfully resolved. In a further 14 matters, the Commissioner decided on the basis of the information gathered to take no further action on the complaint. Two were not resolved and were referred for further action. A further 11 were still in progress at the end of the year.

In some cases referrals to providers have proved to be a very effective tool for resolving complaints. Providers have used a number of approaches to resolve complaints, including written apologies, meetings, and organising further treatment.

Three matters were referred to mediation without investigation using the new powers in the amended Act — with one matter resolved and two in progress.

Investigations

Investigations Team

The investigations team, led by Investigations Manager Kristin Langdon, comprises 11 full-time investigators, one part-time investigator, and two support staff. Staff are based in Auckland and Wellington.

There was a focus on training for investigation staff in 2004/05 — to extend the skills of both new staff and more experienced investigation staff.

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.

In line with the Commissioner's goal of resolving matters at the lowest appropriate level, only complaints that allege a significant systems failure or departure from clinical standards by individual providers, or other serious matters that cannot be resolved at assessment stage, are referred for formal investigation.

As a result, over the past two years the number of matters referred for investigation has decreased, and the matters referred are often complex with multiple providers and difficult clinical and organisational issues.

PROACTIVE RESPONSE TO ERROR IN MANAGEMENT OF INDUCTION

At 35 weeks' gestation, Mrs A's lead maternity carer referred her to the local public hospital for review of developing hypertension. Mrs A was seen in the maternal assessment unit, where her hypertension was noted and she was asked to return for a full examination by a consultant obstetrician, Dr B.

At the full examination, Mrs A's blood pressure remained high and a final review was planned at 40 weeks' gestation, with induction of labour at 41 weeks. However, because of a typographical error it was documented that Mrs A should be induced at 42 weeks. Accordingly, the final clinic visit was scheduled for 41 weeks plus one day.

No concerns were recorded at the final visit. Mrs A stated that she had previously asked a registrar about the confusion surrounding her induction date, but was informed that the notes were clear. The following day Mrs A went into spontaneous labour and gave birth to a stillborn baby.

Mrs A complained to the Commissioner that the typographical error and a lack of effective communication within the service led to her baby's death. Concerns were also raised about the quality of the records. The Commissioner sought a response from the DHB.

The DHB apologised for the error and acknowledged that it was directly responsible for the decision to allow Mrs A to go beyond the 41-week limit stipulated by Dr B. It was recognised that the semi-acute nature of the service, where patients may see a different doctor at each visit, increases the potential for miscommunication. The DHB advised that it is developing a "post-dates management" protocol to guide medical practice in maternal and fetal assessment units to ensure consistency and clarity of communication.

The DHB also acknowledged that the standard working sheets used for assessments were not adequate as they did not direct full documentation of all probable facets of a visit, which is crucial in ensuring continuity of care. Once the issue was identified, the sheet was re-designed.

Based on the DHB's honest and proactive response, the Commissioner decided not to investigate the complaint. He wrote to Mrs A outlining the changes that had been made within the unit, and the impact these would have on day-to-day practice. The Commissioner provided Mrs A with letters from the Chief Executive and Clinical Director acknowledging that the error had led to Mrs A not being induced by the agreed time. The letters confirmed that the changes to documentation and protocol had been fully endorsed and implemented.

Mrs A advised the Commissioner that, while the death of her baby was unbearable, the way in which her complaint was handled helped her a great deal. The honest and sensitive approach taken by the DHB, and the Commissioner, helped to resolve the complaint without formal investigation. This is a case in which a provider took full responsibility for what had occurred, and is a real example of "learning from complaints".

Complaints Investigated

In the year ended 30 June 2005, 172 complaints were resolved after or during an investigation, with 113 investigations open at the end of the year.

Good progress has been made on the timeliness of investigations — with 94% of investigations completed within two years (compared with 90% last year — with only two files older than two years open as at 30 June 2005); 86% of investigations concluded within 18 months (improved from 74% last year); and 47% closed within 12 months (improved from 43% last year).

It is anticipated that the number of investigations completed within 12 months will improve in the coming year as there is now no longer a backlog of older files, or investigation files waiting to be assigned.

In 2004/05, in 70 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.

In 22 cases in which an investigation was commenced, the Commissioner offered the complainant(s) the option of mediation as an appropriate form of resolution, based on information gathered during the investigation. This option was accepted in 18 cases, with four complainants not wishing to attend mediation. Seven investigations were concluded by successful mediation. Two mediations were unsuccessful with the remainder of the matters referred pending as at 30 June.

In 95 cases the investigation was concluded by the Commissioner reporting his formal opinion in a written report. In 24 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.

Table 5: **Complaints investigated**

Complaints investigated[1]	2004/05	2003/04	2002/03
Breach (referred to Director of Proceedings)	14	18	27
Breach (not referred to Director of Proceedings)	57[2]	59	86
No breach	24[3]	56	148
Resolved by mediation	7	10	23
No further action taken	70[4]	35	61
Total	**172**	**178**	**345**

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) (section 38(2) after September 2004).

Breach of the Code

In 71 cases the Commissioner formed the opinion that a breach of the Code had occurred. This represents 41% of the 172 investigations (compare 43% last year), 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 a registration authority) was recommended.

When an investigation is commenced into services provided by a registered health professional, the Commissioner advises the relevant registration authority and, on completion of the investigation, notifies the registration authority 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. Anonymised reports are placed on the Commissioner's website at www.hdc.org.nz. This enables lessons to be learned, while preserving the anonymity of the parties. Increasingly, the Commissioner's findings are reported by the media, who have been alerted by updates on the HDC website.

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 14 of the 71 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 14 matters included 17 breaches by individuals and 8 breaches by a group provider. The referrals represented 20% of breach reports (a decrease from 23% last year).

Figure 3: **Outcome of investigations 2004/05**

Table 6: **Individual providers found in breach of Code and referred to Director of Proceedings**

	2004/05		2003/04	
Provider	**Breach finding**	**Referred to DP**	**Breach finding**	**Referred to DP**
Acupuncturist	0	0	2	2
Ambulance officer	0	0	1	0
Anaesthetist	1	0	1	0
Chiropractor	0	0	2	1
Counsellor	1	0	2	1
Dentist	7	5	5	3
Emergency physician	0	0	1	0
ENT specialist	1	0	0	0
General practitioner	21	1	33	3
General surgeon	6	0	11	4
Midwife	6	0	4	0
Naturopath	0	0	1	0
Neurologist	0	0	1	0
Neurosurgeon	1	0	1	0
Nurse	13	5	8	0
Obstetrician/Gynaecologist	3	0	2	0
Occupational therapist	1	1	0	0
Oncologist	0	0	1	0
Oral surgeon	0	0	1	0
Osteopath	0	0	2	0
Other health provider	1	1	1	0
Paediatrician	0	0	1	0
Pharmacist	7	1	17	4
Pharmacy technician	1	1	3	1
Physician	0	0	1	0
Physiotherapist	0	0	1	0
Plastic surgeon	0	0	1	0
Psychiatrist	3	2	1	1
Psychologist	1	0	1	1
Radiologist	3	0	1	0
Registrar	2	0	1	0
Rest home licensee	0	0	2	0
Rest home manager	1	0	0	0
Social worker	0	0	1	1
Total	**80**	**17**	**111**	**22**

Table 7: **Group providers found in breach of Code and referred to Director of Proceedings**

	2004/05		2003/04	
Provider	**Breach finding**	**Referred to DP**	**Breach finding**	**Referred to DP**
Accident and medical clinic	1	0	2	0
Ambulance services	0	0	3	0
Dental provider	1	1	0	0
Medical centre	7	0	2	0
Other provider group	1	0	2	0
Pharmacy	8	1	11	2
Private hospital	5	0	3	0
Public hospital	18	4	21	5
Radiology	1	0	0	0
Rest home	6	2	6	0
Total	**48**	**8**	**50**	**7**

Feedback

The Commissioner receives both formal and informal feedback from consumers and providers involved in the complaints process.

Comments received in correspondence during the year include the following:

- "Thank you for all the hard work you put in with our case ... We both really loved the letter that the Commissioner sent to the hospital — as long as patients are treated better we will be happy."
- "Thanks for the full, frank, impartial and highly informative consideration of the issues I found so confusing. I am grateful."
- "We appreciate the helpful and constructive approach from your team."
- "Thank you for the letter and documentation you sent me with regards to my treatment of [a patient] earlier this year. ... With no previous experience of this sort of process, the fear of it caused me some weeks of distress and was no doubt the low point of my medical career. However, the documentation that you have sent me shows the process to be fair and considerate."
- "Your office remains one of the only offices that has the opportunity to look at both institutional process and individual practitioner behaviour and your report ultimately reflects this."

Satisfaction Surveys

To assist the Commissioner to ascertain the level of satisfaction with fairness of the Commissioner's process and to identify areas for improvement, a postal survey was undertaken of a sample of complainants and individual providers involved in investigations completed between 1 July 2004 and 30 April 2005.

Complainant survey results

Ninety complainants were surveyed, with a 36% response rate.

- 97% found our staff polite to deal with;
- 80% were satisfied with response times to telephone messages and written communications;
- 81% were satisfied with communication about the process and progress of the investigation;
- 75% found the reasons for the final decision clear;
- 81% found the Commissioner's final decision easy to understand;
- 66% were satisfied that their view was heard in a fair and unbiased way;
- 69% reported being able to move on.

Comments from complainants

- "Communication was clear and frequent. Staff were friendly and listened well."
- "The apology from the GP was the type written when you are forced to. We are not convinced that his practice will be modified to prevent it happening again to someone else."
- "I really appreciated the service and felt the investigation into my concerns was conducted in a fair and unbiased way in respect of both parties."
- "Any disappointment I have is the peer review process — one that must be inherently biased — and the fact that final decisions seem to rest on peer opinions. I am satisfied with the conduct of HDC staff."

Individual provider survey results

One hundred and nineteen providers were surveyed, with a 44% response rate.

- 85% found our staff polite to deal with;
- 78% were satisfied with response times to telephone messages and written communications;
- 83% were satisfied with communication about the process and progress of the investigation;
- 94% found the reasons for the final decision clear;
- 94% found the Commissioner's final decision easy to understand;
- 87% were satisfied that their view was heard in a fair and unbiased way.

Comments made by providers

- "I was very satisfied with the handling of this matter. Staff were polite, informative and responsive to my queries. I could not fault the way this matter was dealt with."
- "The investigation was very thorough, and the act of obtaining an independent expert opinion was appreciated. The opportunity to reply to a preliminary adverse finding, and the willingness of HDC to review that adverse finding, was appreciated and beneficial to the case. The ability of the HDC office to work through such a large amount of technical and medical information testifies to its quality of investigation."
- "Could have been faster although many delays were beyond HDC control."
- "HDC doesn't consider equally both sides of an 'argument'; it is biased for the complainant."
- "Things seem to have improved, although when you are on the receiving end of a complaint it seems to take forever. Most doctors would be pleased if this worrying, stressful time could be made as short as possible."

District Health Board survey results

Twenty-one DHBs were surveyed, with a 57% response.

- 100% found our staff polite to deal with;
- 96% were satisfied with response times to telephone messages and written communications;
- 91% were satisfied that the quarterly complaint status report kept the DHB satisfactorily informed on all HDC complaints within their service.

Comments made by DHBs

- "Written response times have improved over the last year — keep up the good work. Complaint investigators helpful and telephone responses prompt."
- "Keep improving turnaround times."
- "The quarterly reports have been very helpful. The website is excellent. You are providing an excellent service."
- "A key challenge to the sector is what are the flow on effects of some HDC rulings. For example, a range of College guidelines are becoming by default standards particularly when these are referred to in the HDC findings. Guidelines are not standards and the implications of them becoming standards needs to be well understood."

Summary

It is pleasing to see that continued progress has been made on response times to telephone messages and written communication, clear communication about the processes and role of HDC, time frames, and the process of investigation. The survey results confirm that most complainants and providers found the reasons for the final decision clear, and it is pleasing to note that 69% of complainants whose complaint was investigated report being able to move on after the investigation.

In response to last year's survey, a quarterly report has been re-introduced for DHBs. This year's survey results show that this initiative has been very well received.

CARE OF ELDERLY WOMAN WITH FRACTURED FEMUR

Mrs A, aged 89, was admitted to a rest home after a public hospital assessed that she required ongoing hospital care. Until then, Mrs A had lived on her own, with assistance from her daughter and paid home care. Mrs A's medical conditions at the time included Alzheimer's-type dementia, visual impairment, osteoporosis, and a proneness to falling (although she could walk with assistance). Following her admission, staff assisted Mrs A in all aspects of her day-to-day care.

Three months later, Mrs A was found to have a fractured right neck of femur. She was admitted to hospital for further assessment, and two days later hip replacement surgery was carried out. Mrs A's daughter, Ms B, said that the hospital informed her that her mother had had a significant fall. However, the rest home was unable to explain the cause of the fracture since none of the staff had seen Mrs A fall. Ms B was not satisfied with the rest home's inability to explain the fracture, and laid a complaint with the Commissioner.

Independent expert advice from a musculoskeletal radiologist indicated that Mrs A's fractured femur was caused by the loss of strength in her bones. However, the radiologist was unable to determine exactly when the fracture had occurred. Hip fractures are common in the elderly, but can be difficult to diagnose, and the time taken by the rest home to identify the fracture was not considered unreasonable.

The high level of care and concern the rest home provided to Mrs A was reflected in its records. This, coupled with the expert opinion, led the Commissioner to conclude that the care provided was appropriate.

A letter and a copy of the expert's report were sent to Ms B explaining the basis for discontinuing the investigation. Ms B responded positively, and expressed her appreciation to the Commissioner for the comprehensive explanation of her mother's fracture.

RESOLUTION OF SERIOUS COMPLAINT THROUGH COLLABORATIVE EDUCATIVE MEANS

Mrs X, a woman in her mid-fifties, had a busy and stressful business career. She travelled extensively and had several risk factors for cardiac disease — smoking, drinking, significant work stress, being overweight, and a family history of ischaemic heart disease.

Mrs X presented to a locum at the clinic of her GP (Dr Y) with an acute illness involving fever, chills, rigors, back pain and nausea. A chest X-ray was ordered and she was advised to continue with previously effective Panadol, and to return if urgent care was needed. Blood tests were compatible with a viral infection. When seen by her usual GP three weeks later she remained lethargic and was given a trial of weekly vitamin B_{12} injections for three weeks. Twelve weeks later she was seen by a nurse, who documented shoulder-blade pain, a tingling arm, vomiting, and normal breathing at rest. Dr Y visited Mrs X at home within an hour of the request. Her earlier pain across the back of her chest had settled, but she had fever and chills, tingling arms, no vomiting or diarrhoea or cough, and normal neurological observations. Dr Y's assessment was a viral infection. When seen two days later by another doctor at Dr Y's clinic, Mrs X reported that, although tired, she had no other complaints, and her back pain had resolved. Further blood tests were ordered to investigate possible malaria or other infections related to Mrs X's previous tropical travel.

At subsequent weekly visits to her GP, Mrs X reported ongoing tiredness and excessive sleeping. Mrs X had strong opinions on the management of her health. She initially declined Dr Y's offer of a specialist referral, but subsequently accepted one in response to pressure from her family and work colleagues. Sadly, Mrs X died from a cardiac arrest prior to the scheduled specialist review.

During the course of her illness, Mrs X was seen by at least three GPs and two nurses, none of whom investigated a possible cardiac aetiology for her symptoms. A post-mortem revealed extensive fresh and aged myocardial infarcts of the left ventricle complicating severe occlusive coronary artery atherosclerosis.

Mrs X's son corresponded with Dr Y, but was not entirely satisfied with the responses he received as to why his mother's heart problem was not diagnosed, and why Dr Y was unaware of her family history of heart disease. Mrs X's son wrote to the Commissioner seeking an independent review of Dr Y's care of Mrs X.

On review of the medical records, the Commissioner's independent clinical advisor advised that Dr Y had focused his diagnostic thinking on work stress and unusual (tropical) infection, particularly because of Mrs X's symptoms of fever and chills. In the advisor's opinion, Dr Y should have considered cardiac disease as a possible diagnosis. Although Mrs X did not present with significant chest pain, she presented with unusual fatigue and pains in her upper limbs and at the back of her chest — a point highlighted in a 2003 study cited by the Commissioner's advisor, which suggested that symptoms experienced by women suffering a cardiac ischaemic event were shown to differ from those experienced by men.[1]

The missed diagnosis and death of Mrs X provided a profound and tragic lesson for Dr Y in the varied presentations of angina. Dr Y instigated changes in his practice to proactively seek to disprove that patients with back/chest/abdominal pain have ischaemic heart disease.

It was agreed that the most appropriate resolution would be to report the valuable and broader educational message of this matter to GPs. An article on this case was subsequently published in *New Zealand Family Physician*.[2]

1 McSweeney, J C, et al, "Women's early warning symptoms of acute myocardial infarction", *Circulation* (2003) 108: 2619–23.

2 Tiller, S, "Missed diagnosis of myocardial infarction", *New Zealand Family Physician* (2005) 32(3): 199–200.

LEGAL SERVICES

Overview

Once again 2004/05 was a busy and productive year for Legal Services. I would like to thank the legal team for their 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 overview was provided on investigation files; educational materials were reviewed; and conference papers were prepared and presentations delivered.

Nicola Sladden
Legal Manager

As reported last year, the Health and Disability Commissioner Act of 1994 was amended to address a number of problems with the complaints process. The amendments came into effect in September 2004 and have streamlined the complaints mechanisms, giving the Commissioner greater flexibility to resolve complaints. The legal team provided briefings and advice to HDC staff in preparation for the changes.

The Health and Disability Commissioner has also been involved with the development and implementation of the Injury Prevention, Rehabilitation, and Compensation Amendment Act (No 2) 2005 (which came into effect on 1 July 2005). The Act set out changes to the ACC scheme, the main change being abolishing personal injury by medical misadventure as a basis for ACC cover, and replacing it with treatment injury. I represented the Health and Disability Commissioner on the steering group. Sarah Graydon was also involved in the consultation undertaken by the Accident Compensation Corporation (ACC) in relation to guidelines for reporting the risk of harm — another area where the ACC legislation has changed. The team has also worked with ACC to develop information and standard letters that ACC will use when informing claimants about the role of HDC — something it is now obliged to do when a claim for treatment injury is received. The legal team provided a general update to HDC staff on the amendments and their impact, as well as liaising with the Investigations Manager and Complaints Assessment Manager on the implementation of the changes.

I had an unparalleled opportunity to attend the launch of the World Alliance for Patient Safety in Washington DC on 27 October 2004, and then to present to international health policy thinkers on New Zealand's no-fault system and patient safety at the Commonwealth Fund International Symposium on Health Care Policy. On 8 and 9 November, I attended the Joint Commission on Accredited Healthcare Organisations sponsored conference on medical liability and preventing patient injury.

Complaints Resolution

The legal team continues its involvement at the "front end" of complaints 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 team has maintained an effective working relationship with the registration

authorities, the Ministry of Health, ACC, the Human Rights Commission, the Mental Health Commission, the Office of the Ombudsmen, and the Privacy Commissioner.

A legal advisor is also part of the triage team, which assesses all new complaints. Legal review was provided on many investigation files. Legal advisors were involved in investigation planning and in providing advice during investigations. In addition, legal advisors assumed responsibility for managing a number of complex investigations, including the Tauranga Hospitals Inquiry.

Information Requests

Many requests for information from complaint 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. The information disclosure policy was reviewed and updated during the year to clarify the situations in which it is appropriate to withhold information during the assessment or investigation of a complaint.

Prosecution

This year saw a further prosecution by the Commissioner under section 73 of the Health and Disability Commissioner Act. In the District Court in Manukau, Dr Aladdin, dentist, was found guilty on three charges of hindering and obstructing the Commissioner in his investigation of a complaint, and was fined $1,500 on each charge and ordered to pay costs.

It is regrettable that there continue to be providers who do not comply with their legal and professional obligations when involved in an investigation by the Commissioner. Delaying or refusing to provide information prolongs the process to the detriment of all parties. It is hoped that swift prosecution will send a clear message to providers about the importance of providing information in a timely manner.

Protected Disclosures

The Health and Disability Commissioner is an appropriate authority to receive protected disclosures, under the Protected Disclosures Act 2000. Six protected disclosures were received: two about rest homes, two about mental health service providers, one about pharmacy providers and one about radiology services. The Health and Disability Commissioner dealt with the protected disclosures in accordance with its policy. Three matters were transferred to the Ministry of Health. Three matters are ongoing.

Ombudsmen Investigations

During 2004/05 few complaints about HDC processes were made to the Privacy Commissioner, or to the Office of the Ombudsmen under the Official Information Act 1982 and the Ombudsmen Act 1975. 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

The legal team drafted submissions on a range of policy documents and proposed legislation relating to health and disability issues during the year. In total, 52 submissions were made. Feedback from recipients indicated that these submissions were relevant, concise, and of a high quality. Key submissions are posted on the HDC website.

EDUCATION

The key result areas for Education in 2004/05 have focused on delivering information about the Health and Disability Commissioner and the Code of Health and Disability Services Consumers' Rights in a more proactive manner, to a more targeted audience, and using a wider variety of delivery methods. This strategy has presented new and exciting opportunities for Education.

Elizabeth Finn
Education Manager

Increasing Awareness of Code Rights

During November 2004, Phoenix Research surveyed 1,500 New Zealanders over 15 years of age to establish New Zealand adults' level of awareness of HDC and the Code, and their knowledge and use of complaints services. The survey revealed that 72% of those asked were aware they have rights, 58% were able to name at least one right, and 38% could name two or more rights. The right to be treated with respect was the right cited most often (18% of those who knew they had rights); other rights commonly recognised were the right to information and the right to professional service and standards of care.

In HDC surveys conducted in 1997 and 1998, 29% and 35% of respondents, respectively, were aware of having rights; however, these surveys were conducted amongst service users, rather than in the general population. These consumer groups may have had a higher level of awareness than the general population. Therefore a result of 72% for the general population in 2004 indicates a significant increase in awareness over the past six years. Nonetheless, there is still much work to be done.

Targeted Consumer Education

In the past, HDC has identified key consumer and provider groups for active promotion of the Code, based on complaints information collected internally. In 2004/05, educational initiatives targeted those identified by market research as having the lowest awareness: people of Māori and Asian ethnicity, and those receiving social welfare benefits, including older people and consumers receiving mental health services. Consultation with key stakeholders in these groups has enabled discussion about the most effective ways to increase awareness within each specific target group, and educational initiatives are being developed accordingly. For example, a strategic initiative has been established through the Executive Council of Greypower and is under way nationwide.

Provider Education

The Commissioner has given presentations throughout the country, addressing a wide range of health professionals and provider groups, delivered conference presentations, and participated in seminars at District Health Boards and hospitals. He continued to publish regular articles in *New Zealand Doctor* and *New Zealand Family Physician*, using case studies to illustrate practice problems, and to suggest how they could have been avoided.

Trainee providers remain an important audience for educational sessions; general Code training has been delivered to a diverse range of trainee providers, including chiropractors, psychiatrists, pharmacists, midwives, doctors, counsellors, peri-operative and postgraduate nurses, paramedic and laboratory technicians, and also overseas-registered doctors seeking registration in New Zealand. There have been requests from other providers for more specialised training, on such topics as the use of restraint in dementia units, informed consent, and the use of advance directives in mental health. The participation of local advocates has been helpful in adding value and providing ongoing contact for providers in their area.

Proactive Approaches in the Disability Sector

In accordance with our New Zealand Disability Strategy Implementation Work Plan (see www.odi.govt.nz), HDC is developing educational initiatives that target audiences in the disability sector, both disabled consumers and people who provide services to people with disabilities. HDC commissioned research from Diversityworks to inform these initiatives, paying special regard to variation in impairment, socio-economic status and capacity/capability, and recognising tikanga Māori bicultural requirements and the cultural requirements of Pacific and other migrant communities.

Elizabeth Finn presenting to fourth-year pharmacy students at the University of Auckland

Educational Resources

HDC Pānui

On 30 June 2004, the first edition of a new quarterly bulletin was disseminated to over 600 readers by means of an email database. Issues are available as both Word and pdf documents, in both English and Māori, and to people in the Deaf community via the Telephone Information Service (TIS). *HDC Pānui* (which means "to speak aloud or publish — a public announcement") is also available on the website (www.hdc.org.nz). The bulletin contains information for consumers and providers, as well as educational case studies.

Web-based Initiatives

The website is assuming greater importance as HDC's public interface. The website is being improved so that it looks and feels more up to date, and the various website components are easier to access. Anonymised reports are published throughout the year, with many also presented in a summarised form as case studies, with a link to the full report. A survey of website users attracted 260 responses, 93.7% of which indicated that users found the reports informative and relevant.

The website is also being utilised as a vehicle for educational material. Recently posted items discuss cataract surgery, and address questions consumers may have about informed consent, especially in relation to vaccines.

Resources

There continues to be a high demand for written resources, with over 406,000 items dispatched during 2004/05. Two part-time staff attend to the invoicing and dispatch; 89% of orders were dispatched within five days. A new resource is being developed to provide information for consumers about HDC, the Code, and advocacy in a single leaflet, and will be available in English, Māori, and 13 other languages. The leaflets will be available for downloading from the website.

Financial Commentary

Funding

The Office is funded from Vote Health. Funding increased from $6,517,333 to $6,948,444 (excluding GST) for this year. A funding increase of $265,778 has been approved for the year ended 30 June 2006.

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 $152,080 and investments totalled $1,690,000 at 30 June 2005.

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 2004/05 was $73,038 offset by production costs.

Operating Surplus

In 2004/05 the Office budgeted for a deficit of $220,570 and made a surplus of $127,026.

Expenditure by Type

Expenditure is summarised by significant categories below. Service contracts, staff costs and occupancy costs (collectively 81.73% of total expenditure in 2004/05) largely represent committed expenditure. Much of the remaining 18.27% (or $1.28 million) is discretionary.

	04/05		03/04	
	$000	%	$000	%
Service contracts	2,012	28.55	2,001	28.04
Audit fees	12	0.17	7	0.10
Bad debts written off	0	0.00	0	0.00
Staff costs	3,376	47.91	3,129	43.85
Travel & accommodation	168	2.38	176	2.47
Depreciation	218	3.09	262	3.67
Occupancy	371	5.26	348	4.88
Communications	453	6.43	491	6.88
Operating costs	437	6.21	722	10.11
Total	**7,047**	**100.00**	**7,136**	**100.00**

Figures are GST-exclusive.

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

Figure 1: **Expenditure by output 2004/2005 ($000s)**

- Complaints Resolution $2,885 (40%)
- Advocacy $2,326 (33%)
- Proceedings $693 (10%)
- Policy $607 (9%)
- Education $536 (8%)

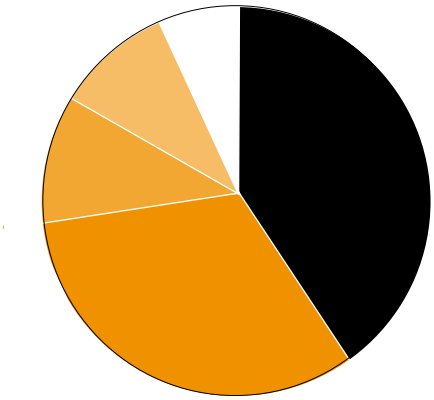
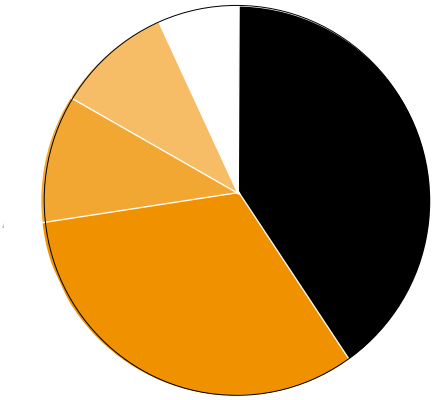


Figure 2: **Expenditure by output 2003/2004 ($000s)**

- Investigations $2,712 (40%)
- Advocacy $2,343 (34%)
- Proceedings $842 (12%)
- Policy $462 (7%)
- Education $443 (7%)



Expenditure on Complaints Resolution was the largest output class, at $2.8 million (40% of expenditure). Spending on Advocacy was slightly lower by $17,000. This reflects a change in the process and cost related to monitoring the advocacy service. Advocacy remained a significant commitment of resources at 33% of total expenditure. The Office continued to look for efficiencies in all areas.

2005/2006

For the coming year the Office has budgeted for a deficit of $267,754.

In terms of the Public Finance Act 1989:

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

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

3. We are of the opinion that these financial statements fairly reflect the financial position and operations of the Office of the Health and Disability Commissioner for the year ended 30 June 2005.

Ron Paterson
Commissioner

Tania Thomas
Deputy Commissioner —
Education and Corporate Support

7 October 2005

Audit New Zealand

AUDIT REPORT

**TO THE READERS OF THE
HEALTH AND DISABILITY COMMISSIONER'S
FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2005**

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 2005.

Unqualified Opinion

In our opinion the financial statements of the Health and Disability Commissioner on pages 46 to 62:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health and Disability Commissioner's financial position as at 30 June 2005;
  - 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 7 October 2005, and is the date at which our opinion is expressed.

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

Basis of Opinion

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

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements 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 our opinion.

The 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 our 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 2005. 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 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

Matters relating to the electronic presentation of the audited financial statements

This audit report relates to the financial statements of the Health and Disability Commissioner for the year ended 30 June 2005 included on the Health and Disability Commissioner's web site. The Health and Disability Commissioner is responsible for the maintenance and integrity of the Health and Disability Commissioner's web site. We have not been engaged to report on the integrity of the Health and Disability Commissioner's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information, which may have been hyperlinked to/from these financial statements. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and related audit report dated 7 October 2005 to confirm the information included in the audited financial statements presented on this web site.

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

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 2005

Actual 2003/2004		Note	Actual 2004/2005	Budget 2004/2005
	Revenue			
$6,517,333	Operating Grant Received		$6,948,444	$6,948,444
$101,832	Interest Received		$152,080	$61,222
$92,808	Publications Revenue		$73,038	$60,000
$6,711,973	**Total Operating Revenue**		**$7,173,562**	**$7,069,666**
	Less Expenses			
$2,000,789	Advocacy Service Contracts		$2,012,233	$2,025,617
$7,250	Audit Fees		$11,500	$9,000
$0	Fees paid to auditors for other services		$0	$0
$0	Bad Debts Written Off		$0	$0
$3,129,004	Staff Costs		$3,376,232	$3,264,087
$175,810	Travel & Accommodation		$168,207	$172,113
$261,941	Depreciation	4	$217,638	$230,563
$348,445	Occupancy		$370,675	$341,645
$491,125	Communications		$452,721	$606,226
$721,747	Operating Costs		$437,330	$640,984
$7,136,111	**Total Operating Expenses**		**$7,046,536**	**$7,290,235**
($424,138)	**Net Surplus/(Deficit)**		**$127,026**	**($220,569)**

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

STATEMENT OF FINANCIAL POSITION as at 30 June 2005

Actual 2003/2004		Note	Actual 2004/2005	Budget 2004/2005
	Crown Equity			
$748,497	Accumulated Funds	**1**	$875,523	$476,854
$788,000	Capital Contributed		$788,000	$788,000
$1,536,497	**Total Crown Equity**		**$1,663,523**	**$1,264,854**
	Represented by Current Assets			
$31,403	Bank Account		$34,879	$51,000
$1,330,000	Call Deposits		$1,690,000	$876,370
$5,938	Prepayments		$17,055	$0
$20,970	Inventory		$17,791	$0
$40,165	Sundry Debtors		$96,524	$2,000
$0	GST Receivable		$0	$0
$1,428,476	**Total Current Assets**		**$1,856,249**	**$929,370**
	Non Current Assets			
$539,465	Fixed Assets	**3**	$370,251	$474,005
$539,465	**Total Non Current Assets**		**$370,251**	**$474,005**
$1,967,941	**Total Assets**		**$2,226,500**	**$1,403,375**
	Current Liabilities			
$58,619	GST Payable		$59,635	$0
$372,825	Sundry Creditors	**2**	$503,342	$138,521
$431,444	**Total Liabilities**		**$562,977**	**$138,521**
$1,536,497	**Net Assets**		**$1,663,523**	**$1,264,854**

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 2005

Actual 2003/2004		Actual 2004/2005	Budget 2004/2005
1,960,635	Opening Equity 1 July 2004	1,536,497	1,485,423
(424,138)	Plus Net Surplus/(Deficit) (Total Recognised Revenues and Expenses)	127,026	(220,569)
1,536,497	**Closing Equity 30 June 2005**	**1,663,523**	**1,264,854**

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

Actual 2003/2004		Note	Actual 2004/2005	Budget 2004/2005
	Cash Flow from Operating Activities			
	Cash was provided from:			
$6,517,333	Operating Grant		$6,948,444	$6,948,444
$92,513	Interest on Short-term Deposits		$147,142	$61,222
$86,605	Revenue		$27,329	$60,000
$6,696,451			$7,122,915	$7,069,666
	Cash was applied to:			
($6,950,829)	Payments to Suppliers and Employees		($6,706,149)	($7,087,672)
($254,378)	**Net Cash Flow from Operating Activities**	**5**	**$416,766**	**($18,006)**
	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:			
($101,805)	Purchase of Fixed Assets		($53,290)	($202,000)
($101,805)	**Net Cash Flow from Investing Activities**		**($53,290)**	**($202,000)**
($356,183)	**Net Increase/(Decrease) in Cash**		**$363,476**	**($220,006)**
$1,717,586	Cash Brought Forward		$1,361,403	$1,146,376
$1,361,403	**Closing Cash Carried Forward**		**$1,724,879**	**$926,370**
	Cash Balances in the Statement of Financial Position			
$31,403	Bank Account		$34,879	$50,000
$1,330,000	Call Deposits		$1,690,000	$876,370
$1,361,403			**$1,724,879**	**$926,370**

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

Actual 2003/2004	Note		Actual 2004/2005
	1	**Accumulated Funds**	
$1,172,635		Opening Balance	$748,497
$(424,138)		Net Surplus/(Deficit)	$127,026
$748,497		**Closing Balance**	**$875,523**
	2	**Sundry Creditors**	
$190,454		Trade Creditors and Accruals	$280,713
$66,182		PAYE	$72,480
$116,188		Annual Leave	$150,149
$372,825			**$503,342**

3 Fixed Assets

2004/2005	Cost	Accum Depn	Net Book Value
Computer Hardware	$609,701	$488,421	$121,280
Computer Software	$386,357	$379,006	$7,351
Communications Equipment	$26,723	$26,723	$0
Furniture & Fittings	$205,582	$179,504	$26,078
Leasehold Improvements	$506,585	$317,169	$189,416
Motor Vehicles	$42,280	$42,280	$0
Office Equipment	$148,971	$122,845	$26,126
Total Fixed Assets	**$1,926,197**	**$1,555,948**	**$370,251**

2003/2004			
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**

Actual 2003/2004	Note			Actual 2004/2005
	4	**Depreciation**		
$97,348		Computer Hardware		$84,870
$49,168		Computer Software		$22,052
$0		Communications Equipment		$0
$11,982		Furniture & Fittings		$10,309
$79,255		Leasehold Improvements		$79,018
$0		Motor Vehicles		$0
$24,187		Office Equipment		$21,389
$261,941				**$217,638**

	5	**Reconciliation between Net Cash Flow from Operating Activities and Net Surplus/(Deficit)**		
($424,138)		Net Surplus/(Deficit)		$127,026
		Add Non-cash items:		
$261,941		Depreciation		$217,638
		Movements in Working Capital Items		
($83,326)		Increase/(Decrease) in Sundry Creditors	$135,384	
$34,350		Increase/(Decrease) in GST Payable	$1,016	
($20,970)		(Increase)/Decrease in Inventory	$3,179	
($6,978)		(Increase)/Decrease in Trade Debtors	($51,423)	
($5,938)		(Increase)/Decrease in Prepayments	($11,117)	
($9,318)		(Increase)/Decrease in Interest Receivable	($4,937)	
($92,180)				$72,102
$0		Net Profit on Disposal of Assets		$0
($254,378)		**Net Cash Flow from Operating Activities**		**$416,766**

6 Commitments

(a) Advocacy Service contracts:

The maximum commitment for the 12 months from 1 July 2005 is $1,998,900.

(b) Premises Leases including leasehold improvements:

Auckland	$285,911 per annum until May 2008
Wellington	$57,000 per annum until April 2006

Actual 2003/2004	Note		Actual 2004/2005
	6	(c) Classification of Commitments	
$2,301,954		Less than one year	$2,341,811
$284,052		One to two years	$285,911
$454,104		Two to five years	$285,911
$0		Over five years	$0
$3,040,110			**$2,913,633**

7 Contingent Liabilities

As at 30 June 2005 there were no contingent liabilities (03/04 Nil).

8 Financial Instruments

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

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

Credit Risk

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

Maximum exposures to credit risk at balance date are:

$1,361,403	Bank balances	$1,724,879
$40,165	Sundry Debtors	$96,524
$20,970	Inventory	$17,791
$5,938	Prepayment	$17,055
$1,428,476		**$1,856,249**

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 6.9% (2004: 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 $6,948,444 (2004: $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	
	2003/2004	2004/2005
$100–110,000	1	1
$110–120,000	2	2
$180–190,000	1	0
$190–200,000	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 $190,000 to $200,000 band.

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.	200,000 units	Target achieved. 406,243 units dispatched.
		100% orders dispatched within 5 working days of receipt of order form.	89% orders dispatched within 5 working days. Staffing based on projected volume of 200,000 units; not adequate to dispatch over 400,000 units and maintain 5-day target time frame for all orders.
1.1.2	Develop and implement survey of users of HDC website.	80% of users find case reports on HDC website informative and relevant.	Target achieved. 93.7% satisfaction reported.
1.2	**Consumer and Provider Education**		
1.2.1	Undertake market research to identify awareness and educational needs of consumers and providers.	Survey completed and findings reported to the Deputy Commissioner by end of December 2004.	Target achieved.
1.2.2	Prioritise, develop and implement initiatives to meet the identified educational needs of consumers and providers.	Priority needs identified by end February 2005.	Target achieved.
		Range of initiatives developed and implemented by end June 2005.	Target achieved.
1.2.3	Presentations and educational sessions delivered as part of consumer and provider education are evaluated by participants for content, relevance, quality of presentation.	Achieve 80% satisfaction.	97% satisfaction.
1.2.4	Facilitate national meeting with key stakeholders regarding media reporting of health and disability issues.	National meeting held by 15 December 2004.	Target achieved.
1.2.5	Implement educational objectives within HDC's NZ Disability Strategy plan.	Objective 1.1 (database) completed by end August 2004.	Delays due to slow responses. Achieved 30 September 2005.
		Objective 2.1 (case studies) completed by end March 2005.	Target achieved.

Key Result Area 1: Education (continued)

	Expected Performance and Standards	Target	Actual
1.3	**Promotional and Educational Materials**		
1.3.1	Review and revise all promotional and educational materials following anticipated changes to the Act and Code.	Review completed and revisions made by end of December 2004.	Target achieved.
1.3.2	Publish quarterly information bulletins for providers and consumers.	Bulletins distributed by: 30 September 2004 22 December 2004 31 March 2005 30 June 2005.	Target achieved.
1.3.3	Develop and implement two web-based educational initiatives.	Completed by 30 June 2005.	Target achieved.

Key Result Area 2: Advocacy

Objective
Operation of a New Zealand-wide advocacy service that assists health and disability services 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 2004/05:	
	Enquiries managed	7,400	7,985 enquiries managed. 108% of annual target.
	Complaints managed	4,665	4,448 complaints managed. 95% of annual target. Fewer enquiries were escalated to complaints.
	Education sessions	1,482	1,452 education sessions completed. 98% of annual target. Senior staff changes impacted on the ability to meet this target.
	Networking contacts	1,500	1,963 networking contacts managed. 131% of annual target.

Key Result Area 2: Advocacy (continued)

	Expected Performance and Standards	Target	Actual
2.2	**Quality**		
2.2.1	Deliver independent, high-quality, consistent nationwide services to consumers during 2004/05.	60% of complaints resolved or partly resolved with advocacy by 30 June 2005.	82% resolved or partly resolved with advocacy.
		80% of random sample of consumers satisfied with advocacy services by 30 June 2005.	Survey results reported 84% satisfaction with advocacy services.
		80% of random sample of providers are satisfied with the advocacy process and the professionalism of advocates by 30 June 2005.	2005 survey results reported 74% satisfaction with advocacy services. A new provider survey has been designed to better gauge satisfaction with advocacy.
2.2.2	Deliver high-quality, consistent educational programmes to consumer groups and providers during 2004/05.	80% of consumers and providers participating in presentations and educational sessions report satisfaction with the quality of the content and delivery by 30 June 2005.	Survey results reported 90% satisfaction with the quality of content and delivery of sessions provided by advocacy services.

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 5,500 enquiries handled in 2004/05.	5,323 handled.
		90% of enquiries closed on day received.	5,057 of 5,323 enquiries (95%).
		Estimated 180 written responses to enquiries regarding the Act and Code.	196 written responses.
		85% of enquiries requiring written responses closed within one month of receipt.	83% closed within a month of receipt. A number of complex enquiries required external input and took longer than a month to close.

Key Result Area 3: Enquiries and Complaints Management (continued)

	Expected Performance and Standards	Target	Actual
3.1.2	Meet agreed throughput targets for resolving complaints.	Estimated 1,250 new complaints received in 2004/05.	1,124 received.
		1,300 complaints resolved in 2004/05.	1,158 resolved. This figure is very close to the 2003/04 total of 1,162 resolved.
		For complaints that are not investigated:	
		90% resolved within 6 months of receipt.	93% resolved.
		For complaints that are investigated:	
		50% of investigations completed within 12 months of receipt.	47% completed within 12 months. Staff changes within the investigation team resulted in delays in the progress of some investigations.
		80% of investigations completed within 18 months of receipt.	86% completed.
		95% of investigations completed within 2 years of receipt.	94% completed. This target was not achieved owing to several unexpectedly complex files.
3.2	**Quality**		
3.2.1	Ensure complaints are resolved in a fair and timely manner using transparent, robust and consistent processes.	60% of complainants surveyed satisfied with fairness of investigation process.	66% of complainants who responded to the survey were satisfied with the fairness of the investigation process.
		60% of providers surveyed satisfied with fairness of investigation process.	87% of providers who responded to the survey were satisfied with the fairness of the investigation process.

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 decisions (whether or not to issue proceedings) made within 8 weeks of receipt of relevant information.	94.73% compliance. One decision made outside time frame owing to an administrative error in calculating a deadline. One decision deferred pending the outcome of a disciplinary proceeding on another matter.
		100% of disciplinary charges or Human Rights Review Tribunal (HRRT) 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 by 30 June 2005.	Three survey responses received. Two indicated that expectations were fully met or exceeded; one indicated areas for improvement.

Key Result Area 5: Policy Advice

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

	Expected Performance and Standards	Target	Actual
5.1	**Quality**		
5.1.1	Provide high-quality, relevant submissions on key policy documents and proposed legislation affecting the rights of health and disability services consumers.	All policy advice meets deadline set for submission.	100% of policy advice met deadline.
		Key stakeholders report high-quality, relevant submissions.	Target achieved. Respondents reported that submissions were clear, relevant and helpful.

Key Result Area 5: Policy Advice (continued)

	Expected Performance and Standards	Target	Actual
5.2	**Review of the Health and Disability Commissioner Act 1994 and the Code of Rights**		
5.2.1	Follow up any policy decisions made by the Minister in light of the 2004 Review of the Health and Disability Commissioner Act 1994 and the Code of Rights.	All policy decisions made by the Minister followed up by 30 June 2005.	Target achieved.

Key Result Area 6: Organisational Capability

Objective
Develop and improve the organisation's capability to perform its mission, 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	Identify and implement good management practices for the recruitment, induction, performance management and professional development of HDC staff.	Revised recruitment policies implemented by 20 December 2004.	Target achieved.
		Induction process revised and implemented by 15 February 2005.	Target achieved.
		Performance management system reviewed and revised system implemented by 30 June 2005.	Target achieved.
		Professional development and training plan developed by 30 May 2005.	Target achieved.
		Management training for HDC managers implemented by 30 June 2005.	Target achieved.

Key Result Area 6: Organisational Capability (continued)

	Expected Performance and Standards	Target	Actual
6.2	**Systems and Processes**		
6.2.1	Implement the revised Risk Management Plan for HDC.	Plan implemented by 20 November 2004.	Target achieved.
6.2.2	Implement year one objectives of a Ministry of Disability Issues approved HDC Disability Strategy Plan (Educational objectives within the plan are mentioned in KRA 1.2.5).	Year one objectives of the plan implemented by 30 June 2005.	22 out of 27 objectives were met (81%). This was the first year that HDC submitted an implementation plan for the NZ Disability Strategy, and some objectives were not realistic within the time frame. Additional work was done in areas not specified in the plan.
6.2.3	Establish and implement a formal communication plan with Iwi to ensure their input into the cultural appropriateness of HDC's services.	Plan implemented by 30 June 2005.	Target achieved.
6.3	**Information Technology**		
6.3.1	Implement year one of the IT Strategic Plan.	Year one of the IT Strategic Plan implemented by 30 June 2005.	Target achieved.
6.3.2	Complete enhancements to Enquiries and Complaints Database System and Proceedings Database System that are consistent with year one of the IT Strategic Plan and revised user needs completed in May 2004.	Enhancements completed by 30 June 2005.	Target achieved.
6.4	**Finance**		
6.4.1	Maintain or improve grading in each area of Financial and Service Performance Management in Audit NZ's 2003/04 Audit Report.	Grading is maintained or improved.	Target achieved.
6.4.2	Complete development and implementation of systems and documentation recommended in 2003/04 Audit Report.	Documentation completed by 31 March 2005.	Target achieved. On completion of the 2003/04 audit, the auditors found no significant issues to report, so nothing was required to be developed or implemented.

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