HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

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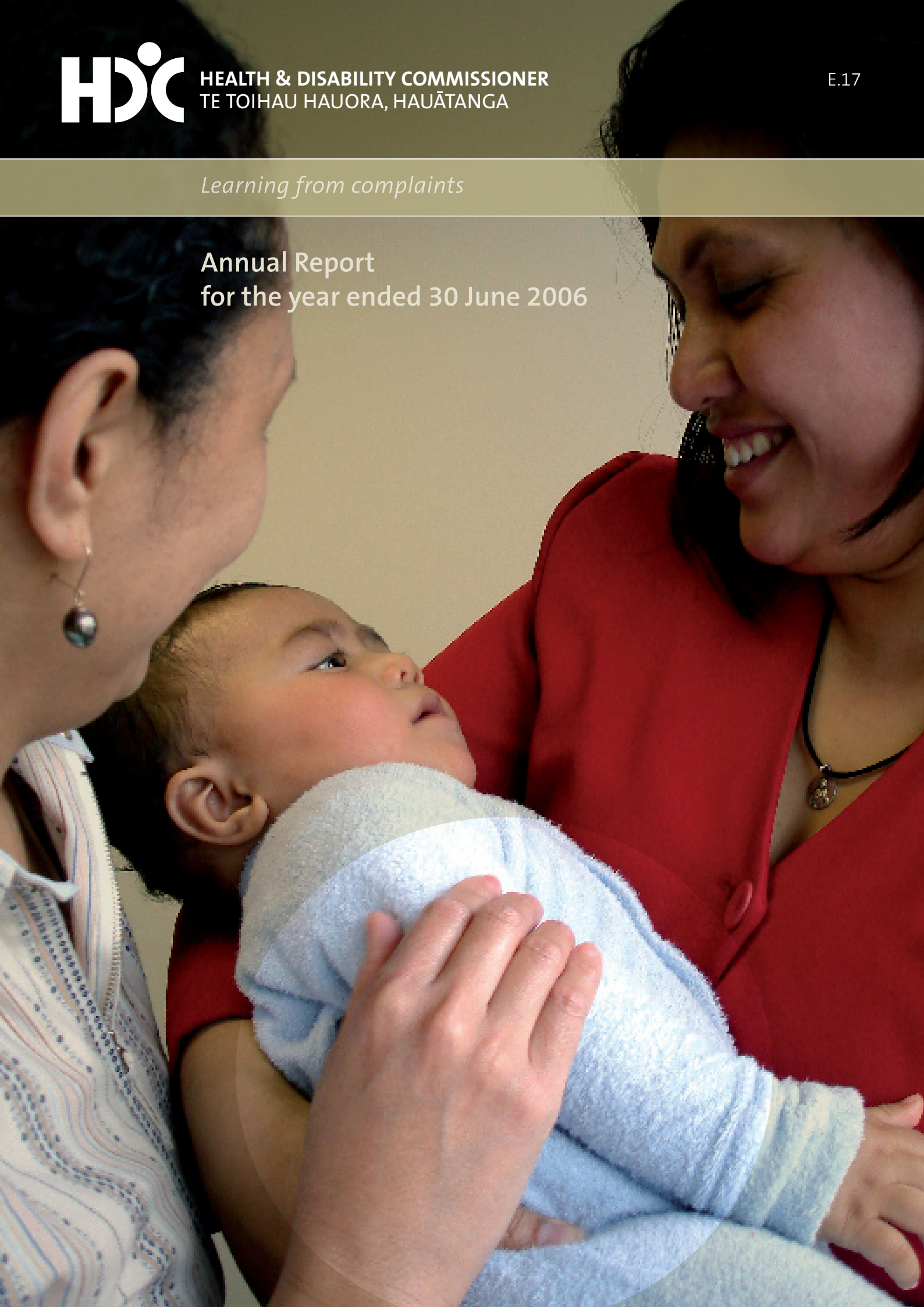
Learning from complaints

Annual Report
for the year ended 30 June 2006



CONTENTS

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

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

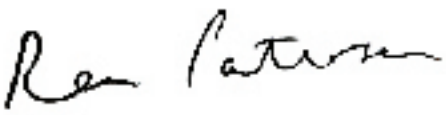
6 October 2006

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 2006.

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 sixth year as Health and Disability Commissioner and discusses the following key features of the 2005/06 year:

- Complaint outcomes
- Improving quality of care
- Patient safety
- Educational initiatives

Ron Paterson
Commissioner

Complaint Outcomes

Data from the past year show that HDC is achieving its statutory mandate of facilitating "the fair, simple, speedy, and efficient resolution of complaints". There was a slight drop in the volume of complaints received (1,076 compared with 1,124 last year), but the Office made further progress in reducing the number of open files. The overall tally of open files dropped to a record low of 279 at 30 June 2006, with only two files open just over 18 months.

The biggest change in recent years is that, in recognition of the fact that early resolution is usually in the best interests of both complainant and provider, fewer cases are concluded by a formal investigation (11% in 2005/06). Most complaints to HDC are speedily resolved by less formal means, after relevant information has been gathered and reviewed. Advocacy continues to be a remarkably effective means of resolution — this year 88% of 4,550 complaints received by the Nationwide Advocacy Service were partly or fully resolved with advocacy support, 91% within three months.

A total of 116 complaints were resolved after or during an investigation. One upside of fewer formal investigations is that the Office has greater capacity to undertake in-depth investigations that examine the individual and systemic factors contributing to an adverse event or complaint. The percentage of breach findings in completed investigations was 51%, compared with 41% the previous year. As in past years, most breaches of the Code related to deficiencies in assessment and treatment, lack of care co-ordination, poor communication and inadequate record-keeping.

It is also pleasing to report the high levels of satisfaction reported by parties surveyed following experience of the Office's investigation process. 78% of complainants who responded to HDC's survey (63 were surveyed, with a 40% response rate) were satisfied that their view was heard in a fair and unbiased way, compared with 82% of individual providers (115 were surveyed, with a 63% response rate). The similar figures are testament to HDC's even-handed approach, and in sharp contrast to the lopsided results in recent years; two years ago only 46% of respondent complainants were satisfied.

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 increase (from 14 to 19) in referrals to the Director of Proceedings (DP) for potential disciplinary or Human Rights Review Tribunal proceedings. In 2005/06 this equated to 32% of investigations that ended with a breach finding — up from 20% the previous year. Most cases that do lead to Tribunal hearings result in the DP's charges being upheld (eight of nine substantive hearings last year), a very high success rate that confirms further action was warranted.

Improving Quality of Care

Dr Marie Bismark published landmark research in February 2006 (undertaken at Harvard University and co-authored with Troy Brennan, David Studdert, Peter Davis and myself) on the "Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events" (*Qual Saf Health Care* (2006) 15:17–22). Bismark compared 398 HDC complaints relating to public hospital admission in 1998, with a nationally representative sample of non-complainants who suffered adverse events in the same year. The probability of complaint was found to increase steeply with severity of injury, and preventable injuries were much more likely to lead to a complaint than unpreventable ones. Bismark concluded that "complaints offer a valuable portal for observing serious threats to patient safety and may facilitate efforts to improve quality".

There is growing evidence that investigating systemic failures in care, and recommending improvements, is making a positive difference in the health and disability sectors. In November 2005, HDC highlighted the problem of medication safety in public hospitals, in an investigation of a tragic medication mix-up that contributed to the death of 91-year-old Eileen Anderson in Palmerston North Hospital (Opinion 03HDC14692). The decision has been widely used for teaching purposes in the health sector, and prompted one metropolitan DHB to write: "This DHB has taken the key messages from your review very seriously indeed. ... The measures we have put in place since receiving your report include: redesigning the drug chart so that the patient's name is handwritten; assigning a common area for patient records and drug charts in all wards; keeping the patient labels with the drug charts; and deploying a '10 rules of safe prescribing' document to all medical officers and senior nurses."

In another case, HDC's recommendation to eliminate two different pumps used to administer subcutaneous medication is being adopted nationally (Opinion 05HDC05278; see case note, p 36). In two other decisions, our investigations highlighted the importance of clarity in radiology and pathology reports, prompting the Royal College of Pathologists of Australia to agree to develop guidelines for consistency in the reporting of FNAs (fine needle aspirations). (See radiology Opinion 04HDC00031; and pathology Opinion 04HDC02992.)

An HDC investigation of delays in colposcopy services at North Shore Hospital (Opinion 03HDC15479) prompted an audit at Waitemata DHB, and in turn led the National Cervical Cancer Screening Programme to announce an audit of all DHBs' colposcopy services over the next two years. A major investigation of a baby's death at North Shore Hospital, and HDC recommendations for a review of the national maternity services access agreement, precipitated a full review of the current agreement (Opinion 04HDC04652). Problems in the emergency departments at Gisborne and Dunedin Hospitals were highlighted in two decisions (Opinions 04HDC04456 and 04HDC12081). In upholding a complaint of inadequate prioritisation of urology first special assessments at Southland DHB, HDC for the first time clarified the relative roles and responsibilities of specialists, GPs and DHBs in the contentious area of priority for elective services (Opinion 04HDC13909).

These cases (accessible on our website, www.hdc.org.nz) are part of a body of evidence of the use of complaints to improve the quality of health care. The new practice of naming public hospitals and district health boards found in breach of the Code (in reports that identify systemic concerns) has been a conscious decision to promote greater transparency and accountability in the publicly funded health system. The HDC decisions have been widely reported in the media and discussed in the health sector. Leading safety experts Alan Merry and Mary Seddon recently commended HDC on "a world-leading focus on addressing aspects of the system which contribute to patient harm, rather than only seeking to identify individual scapegoats when things go wrong" (*NZMJ*, 21 July 2006).

Patient Safety

There continue to be significant challenges to improve patient safety and the quality of care in hospitals and the community. The New Zealand Quality of Healthcare Study reported in 2001 that 12.9% of public hospital admissions were associated with an adverse event, ie, harm that is due to medical management rather than the disease process. Of these, approximately 10% were associated with serious harm, and 4% resulted in death. 30% of all adverse events were judged to be preventable. Furthermore, the costs of adverse events have been estimated to be $590 million per year. Thus 30 cents in every health dollar in New Zealand goes toward managing adverse events.

In contrast to the efforts of some other countries (notably Australia, the United Kingdom and the United States), progress in tackling the safety and quality of health care in New Zealand has to date been slow, patchy and unco-ordinated. A range of disparate activities is being undertaken, some at national level (under the umbrella of the "Improving Quality" strategy, 2003), and others by individual district health boards. As noted by Alan Merry and Mary Seddon, "our hospitals are not acceptably safe at present" and New Zealand has "not galvanized action at either the national or organizational level" to address this problem (*NZMJ*, 21 July 2006). The Health Select Committee has also highlighted the problem of adverse events and called for national action.

There is no national body equivalent to the newly established Australian Commission on Safety and Quality in Health Care to lead quality improvement efforts. The nearest equivalent in New Zealand is EpiQual, the National Health Epidemiology and Quality Assurance Advisory Committee established under the New Zealand Public Health and Disability Act 2000. To date, the Committee has had very little visibility in the sector, and is not yet a body that clinicians or consumer groups look to as leading safety and quality efforts nationally. It appears to have very little analytical and other support resources to do its work — in contrast to significant government investment in the Australian Commission.

Incident reporting systems (and their use) in New Zealand public hospitals are variable, and there is no national data collection and analysis, or rapid alert system, such as that undertaken by the National Patient Safety Agency in England. There is a clear need for district health boards to co-ordinate their efforts in introducing information systems to safeguard patients. Computerised medication administration systems are being looked at by some hospitals, but a national approach to their introduction has to date been lacking. The "Safe and Quality Use of Medicines National Strategy" launched in December 2005 by DHBNZ sets an excellent agenda, but the targeted initiatives need funding and co-ordination.

At the Rights to Health Conference in Samoa, where I spoke on the New Zealand experience of patients' rights legislation.

From left: Co-organisers Maria Kerslake, head of the Samoa Family Health Association, Margie Fepulea'i, GM for Pacific Health at Counties Manukau DHB, Esther Cowley, organiser of PACIFICA women.

As has been demonstrated by the successful "Save 100,000 lives" campaign in the United States, concerted and co-ordinated efforts can make tangible improvements in patient safety. There is an opportunity for New Zealand to make patient safety and quality improvement a key priority for government and the health sector in the year ahead.

Educational Initiatives

This year again saw a broad array of educational initiatives undertaken by HDC staff and advocates. A notable highlight of the year was the publication of *Case Notes of the Health and Disability Commissioner 2000–2004*, the first compendium of HDC case notes. It will be a valuable resource for researchers, consumer and provider groups, and the public.

Our website has been revamped, and continues to be frequently accessed by consumers, providers, and the media. Recent cases are usually reported by daily newspapers within 24 hours of posting on the website. Our widely circulated quarterly e-bulletin, *HDC Pānui*, provides regular updates on our work.

HDC staff and I deliver numerous conference presentations and talks to health professionals (including a wide range of trainee providers) throughout the country. In an effort to target Boards and highlight the patient safety challenge, over the past year I met with board members at Wairarapa, MidCentral, Nelson Marlborough, and West Coast DHBs, in addition to undertaking a dozen public hospital visits.

West Coast DHB meeting at Kaipo Marae, Bruce Bay, South Westland.

From left: Kevin Hague, Chief Executive, West Coast DHB; Ron Paterson; Ria Earp, Deputy-Director General Māori Health; and Professor Gregor Coster.

Consumer workshops in Auckland, Wellington and Christchurch provided vigorous feedback on our strategic direction, and support for HDC to be an effective "public watchdog" and to focus on disability issues. Under the leadership of Deputy Commissioner Tania Thomas, HDC is undertaking a range of disability initiatives. A key challenge is ensuring that disabled consumers can voice concerns without fear of retribution, and have the confidence to do so. A new "Speaking Up" programme is coaching consumers in the necessary skills.

Acknowledgements

Notable staff changes in the past year included the departure of energetic Investigations Manager Kristin Langdon, and the welcome appointment of a second Deputy Commissioner, Rae Lamb. I wish to record my thanks to all the staff at HDC, and to everyone involved in advocacy services in New Zealand, for their dedication and support of our work in 2005/06.

I note with sadness the death, in March 2006, of Te Ao Pehi Kara, HDC's kaumātua for the past 10 years. His wisdom, humour and desire to guide and help others will be greatly missed. Te Ao Pehi and his wife, Waiariki, have steadfastly worked with HDC to promote the Code and the rights of consumers. Te Ao Pehi provided insight into working with Māori and advocating for better health and disability services. Our love and support go out to his whānau — he was a great man with a great heart.

REPORT OF THE DEPUTY COMMISSIONER, EDUCATION & CORPORATE SERVICES

Ngā mihi mahana ki a koutou katoa.
Warm greetings to you all.

Our education role is about making change happen — changes in attitudes and practices are what we aim to achieve. We are passionate about safe, quality health and disability services, and we are not there yet.

Strong leadership is a crucial element for creating an agenda for change. We in the Commissioner's office have taken up the leadership challenge. We expect resistance, especially from those who are expected to change the most — and it makes us even more determined to motivate and organise others to act to achieve the vision we have for New Zealand's health and disability services and systems. We can't do it alone — we need to work together to achieve this goal.

Improvements in safety and quality will come about when lessons are learned from our successes and our failures. This is why an accessible, well used and highly responsive complaints system is so vital to gaining the changes we are seeking. It provides many of the lessons we need to learn, and offers an opportunity for social interaction with people who use health and disability services. The patients and clients of these services are their own best experts, and their input into the development, delivery and evaluation of the services they use can provide valuable information.

Tania Thomas
Deputy Commissioner,
Education & Corporate Services

The past year has been about meeting and spending time with consumers to get a better grasp of what matters to them and their communities. Our ability to understand their issues and respond appropriately still needs work in the area of disability, unlike the strides we have made in the health sector.

Consumer Voice

The regional consumer seminars held in 2005 were the start of what is now a regular feature of the Commissioner's annual calendar. The input from the many consumers we met with was both inspiring and instructional. In summary, there were five key issues raised across the seminars:

- *Consumer-centred approach* — the need for increased consumer participation in the development, delivery and evaluation of both HDC services and health and disability services. It is important that HDC partners informally and formally with consumer groups and organisations to increase the opportunity for regular and in-depth dialogue. There was a feeling that the office had gained considerable mana or respect amongst providers, but the same could not be said about consumers.
- *Increase in advocates* — this was seen as very necessary to reduce the negative effect of the power imbalance between well-resourced, well-educated, well-informed and well-connected providers and the consumers they serve. Advocates are one of the few ways vulnerable consumers can have their voices heard, and be supported to exercise their rights under the Code. An increase in advocates was also seen as an opportunity to provide much-needed specialised advocacy services for consumers who experience mental illness, deafness, or are unable to communicate easily, or who have an intellectual disability that makes it difficult to make their needs known and understood.
- *Focus on disability* — it was perceived that disabled people have been least served by the work of the Commissioner's office. This needs to be addressed by making our

recommendations more binding and ensuring that complainants are safe from retribution. The complaints process itself needs to be better understood, with a wider range of formats used to communicate information to disabled people. Consumers also wanted a quicker process for resolving complaints from people in residential care services or using personal care services in their own homes. The current auditing process for many disablility services was queried — consumers felt that it was a "tick box" approach and mainly paper driven rather than an in-depth, qualitative review of how the users of services felt about the quality of the service they were receiving. There was also a concern about using the term "low-level resolution" when discussing disability service complaints, as it was felt this phrase undermines the seriousness of such complaints, which in the main appear to be around a lack of respect and a generally poor attitude towards the needs and aspirations of disabled people to lead an "ordinary" life.

- *Profile and promotion* — consumers expressed a desire to have the Commissioner's office and its work more visible, being an effective "watchdog". Information about the work of the office needs to be available in more formats with an emphasis on simple language and more clarity (in practical, easy-to-understand terms) about what to expect as a user of the Commissioner's services. More stories with positive results need to be published to give consumers confidence.
- *Provider training* — consumers spoke about wanting provider training to be mandatory, in-depth and on-going, with consumer involvement. Providers needed to have a greater level of buy-in to providing safe, quality services that go beyond mere compliance with a set of standards. Change will only come about if providers are prepared to accept that consumers are their own best experts, and that their input into the services they receive is valuable and makes good business sense. These are largely changes in attitudes, values and beliefs, and will not take place without consistent training, development and reinforcement of provider practices. Consumers supported the need for well-trained and well-supported disability support workers. In the disability sector, unqualified caregivers work with people whose welfare is most at risk because they are very dependent on others.

Education

The past year has been characterised by increasing variety in the types of educational initiatives delivered and the formats used, as we reach out to greater numbers of consumers and providers.

Reaching Consumers in the Community

Information about HDC has been provided to the general community via local newspapers in five regions: Wellington, Rotorua, Taranaki, Gisborne and Auckland Central, reaching approximately 180,000 homes in total. Groups with a special focus have been targeted through material in publications such as *Family Care NZ* (for carers and families), *New Zealand Senior Style* (for seniors), *Without Limits* (for the disability sector), *Migrant News* (for immigrant communities), and the Samoan and Tongan directories. Information has also been broadcast via Planet FM to reach over 165,000 Aucklanders whose native languages are Tongan, Niuean, Fijian, Korean and Samoan.

The website remains an important source of information for consumers. The generic leaflet outlining the role of HDC, consumer rights and the complaints process, available on the website, has been translated in five more languages, bringing the total to 20 languages. Information about current issues of concern to consumers continues to be posted on the website. Articles discuss topics such as waiting times in accident and medical clinics, follow-up of test results, and receiving alternative health therapies.

New Resource for Disability Services Consumers

Elizabeth Finn (Education Manager) and Grant Cleland at a *Speaking Up* presentation.

HDC market research in 2004 recommended the inclusion of disabled people in the development and delivery of educational programmes. In response, the *Speaking Up* programme has been developed. This programme is designed to coach consumers in the skills needed to express their concerns about the services they receive, and to provide an opportunity for them to practise "speaking up" in a safe environment. The programme is delivered with two facilitators, one a disabled co-facilitator. A consultant with a disability (Grant Cleland, Creative Solutions, Christchurch) was involved in developing the session plan, and worked with the Education Manager as a co-facilitator in pilot sessions in Christchurch and Auckland. The programme will shortly be available for use by advocates nationwide.

Provider Education

While advocates still deliver the large proportion of provider education, HDC has received an increasing number of requests for presentations and educational sessions. Many are for providers undertaking postgraduate studies, particularly in the areas of quality and risk management.

The Health Practitioners Competence Assurance Act 2003 requires providers to maintain competence through ongoing training, and HDC is becoming involved in supporting providers, through their registration bodies and professional development groups, to meet these goals. Initiatives include both presentations and interactive training sessions. More than 96% of participants at these sessions reported overall satisfaction with the content, relevance and delivery of the sessions.

A series of educational sessions to support nurses working for the Department of Corrections was held at Waikeria Prison. The sessions addressed the difficulties of implementing Code-referenced practice in this challenging environment. By the end of the training, the nurses, all of whom attended as shift work allowed (some attending on their day off), demonstrated a good level of understanding of how difficult situations could be handled in line with the Code.

Publications

The demand for written resources, including leaflets and posters, continues: 386,807 items were dispatched during 05/06. The quarterly bulletin *HDC Pānui* (available on the website in English and Māori, and also disseminated to interested persons and groups via email) carries educational material including case studies and comment, and reports events of interest such as the three 2005 Consumer Seminars and the 2006 Mediation Seminar.

Focus on Disability

In the first half of 2006, the quality of residential disability services was a hot topic in the media, and led to three radio interviews and two television interviews fronted by the Deputy Commissioner, Education and Corporate Services. HDC was asked what it is doing about the poor state of services being delivered to disabled people.

Disability Focus initiatives continued to be implemented within the Commissioner's office, including the decision to create a Disability Services Portfolio managed with delegated authority by the Deputy Commissioner, Education and Corporate Services. HDC will continue to create more opportunities for dialogue about how to improve services for disabled people.

In 2003, the Commissioner established a Consumer Advisory Group that includes consumers with a disability. As a result of HDC's increased focus on disability, a specific Disability Consumer Working Group is to be established. This group will assist with finding solutions to issues raised around complaints resolution, and will provide direct input into the Commissioner's complaints resolution and education processes. The call from the 2005 consumer seminars for providers to take a more consumer-centred approach has led to a new project in 2006 — Best Practice in Consumer Centred Disability Service Provision.

The Commissioner has continued to implement our office's New Zealand Disability Strategy initiatives.

Employment at HDC

Staff employed by HDC who have identified themselves as having a disability have had many of their needs met through the provision of the following:

- telephone relay service
- NZ Sign Language interpreters or stenographers where appropriate
- NZ Sign language lessons for staff
- career coaching
- employee assistance programme
- opportunities to attend relevant conferences and network meetings.

Two hearing-impaired staff members attended the inaugural "Foundations for the Future Conference" (National Foundation for the Deaf) on 24–25 September 2005. Regular items of news and reports, including articles and updates from various sources in the disability sector, are posted on the internal email system. There is also an all-access disability support resource folder on-line for all staff.

Specialist advocacy

ASSIT (Advocacy Services South Island Trust), under contract to the Director of Advocacy, is commencing a specialist advocacy pilot that will work in partnership with the deaf community to improve access to information about consumer rights, self-advocacy, and how to obtain assistance to resolve complaints.

National Interpreting and Translation Project

The national interpreting and translation scoping project has a broad approach in recognition of the fact that consumers who encounter communication barriers do so in most aspects of life. HDC will take a leadership role and work collaboratively with other government agencies, including the Offices for Disability Issues and Ethnic Affairs, in this important area.

Resources

- A resource booklet entitled "Disability Issues" is now available to all staff. The purpose of this resource is to give HDC staff some guidelines on the use of language when interacting with disabled people.
- Both the Auckland and Wellington offices have a resource folder of information on disability issues, which is regularly updated as new material comes to hand. This was distributed in August 2005.
- The staff internal monthly newsletter "Highlights" includes a regular disability feature.

Consumer Advisory Group

The Commissioner's Consumer Advisory Group had two resignations in 2005. We farewelled John Robinson, the CEO of Canteen, a man well used to working with youth using health and disability services, and Beverley Osborne, a minister and a tireless worker with elderly people from the lower South Island.

Consumer Advisory Group

Back row from left: Ron Paterson (Commissioner), Barbara Robson, Evan McKenzie, Kim Robinson, Beverley Osborne.

Front row from left: Tania Thomas, Huhana Hickey, Ana Sokratov.

Māori Initiatives

Four Iwi who are located in the areas closest to our Auckland and Wellington offices have been approached and asked to work with the Commissioner's office and have responded positively. A formal partnership agreement will be implemented in late 2006 with the aim of HDC improving access for Māori consumers to its services and increasing training opportunities for Māori providers.

Conversion to International Financial Reporting Standards (IFRS)

For periods ending on or after 1 January 2007 New Zealand reporting entities will be required to apply New Zealand equivalents to International Financial Reporting Standards (NZ IFRS). NZ IFRS must be applied by every Crown Entity for accounting periods beginning on or after 1 January 2007. The Health and Disability Commissioner intends to adopt NZ IFRS for external reporting purposes for the Annual Report for the period commencing 1 July 2007.

To achieve the above timeframes and in order to publish its first NZ IFRS compliant financial statements for the year ended 30 June 2008, the Commissioner will be required to:

1. restate all of the 30 June 2006 closing balances in the statement of financial position, prepared under previous generally accepted accounting practice (NZ GAAP), to the new operating balances in the Balance Sheet as at 1 July 2006 under NZ IFRS; and
2. prepare NZ IFRS compliant financial information for the financial period commencing 1 July 2006 (to be used as comparative figures in the financial statements for the period commencing 1 July 2007).

The potential impact on the Health and Disability Commissioner's financial statements and accounting policies of adopting NZ IFRS is yet to be established, as the Health and Disability Commissioner has not yet completed its IFRS conversion project.

ORGANISATION CHART as at 30 JUNE 2006

SENIOR MANAGEMENT TEAM

Commissioner
Ron Paterson

Deputy Commissioner, Education & Corporate Services
Tania Thomas

Chief Legal Advisor
Nicola Sladden

Deputy Commissioner, Complaints Resolution
Rae Lamb

Director of Advocacy
Judi Strid

Director of Proceedings
Theo Baker

Health & Disability Commissioner
Ron Paterson
AK/WN

Kaumātua

Executive Assistant
Ta'a Punivalu
AK/WN

Director of Proceedings
Theo Baker
WN

Legal Counsel
Jason Tamm
WN

Personal Assistant
Lai Yin Wong
WN

Proceedings Secretary
WN

Director of Advocacy
Judi Strid
AK

Assistant
Diana Yukich
AK (P/T)

Health Advocates Trust (HAT)
Northland/ Auckland

Advocacy Network Services (ADNET)
Lower North Island

Advocacy Services South Island Trust (ASSIT)
South Island

Deputy Commissioner, Complaints Resolution
Rae Lamb
AK

Personal Assistant
Agnes Brown
AK

Complaints Assessment Manager
Annette May
AK

Senior Complaints Assessors
Warrick Hickman AK
Scott Read AK

Complaints Assessors
Richard Hanssens AK
Karan Harnett AK
Rebekah Pola AK
Jacqui Bozoky

Complaints Assessor (Triage)
Wendy Sheehan AK

Complaints Administrator
Michelle Lee AK (P/T)

Clinical Advisor
Stuart Tiller
AK (P/T)

Investigations Manager
Mark Evans
AK

Senior Investigator
Claire Campbell AK

Investigators
Nikki Deveraux AK
Jeane Mackay AK
Kanny Ooi AK
Matthew Pitt AK
David Scott AK
Wendy Vonlanthen AK

Liaison Investigator AK (P/T)

Secretary
Tracy Vela AK

Chief Legal Advisor
Nicola Sladden
WN (P/T)

Senior Legal Advisors
Sarah Graydon WN
Tina Mitchell
WN (P/T)

Legal Advisors
Sarah Pring
WN
Sarah Parker
WN

Secretary
Cassandre Cheung
WN

Deputy Commissioner, Education & Corporate Services
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Trudy Bennett
AK

REPORT OF THE DIRECTOR OF ADVOCACY

Kia ora tatou

I wish to acknowledge the hard work, dedication and commitment of all those involved in the three advocacy service organisations that collectively provide the nationwide health and disability advocacy service. The aim 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. This is a challenging and demanding endeavour, providing services to a diverse range of people in all parts of the country. The success of the advocacy service and the regard in which it is held within the community is due to the combined efforts of these people.

I also wish to acknowledge the Commissioner, Deputy Commissioner Tania Thomas, and Ministry of Health officials who have assisted my endeavours to obtain additional funding to strengthen the advocacy service.

Judi Strid
Director of Advocacy

Overview of the Year

The nationwide advocacy service is provided by three advocacy service organisations (ASOs), which have contracts with the Director of Advocacy. The service has a total of 47 staff, most of whom work part time out of 28 offices around the country, and who collectively make up a total of 34 FTEs (full-time equivalent positions). There are 34 advocates (26 FTEs), 3 kaitutaki tāngata/educators and 10 management/administration support staff.

The year has been very busy with the advocates achieving considerable success in networking and promoting consumer rights within their regions, providing information about self-advocacy and assisting consumers to resolve complaints. Consumers and providers continue to express a high level of satisfaction with the advocacy service and the opportunity to use a process that is very effective at resolving complaints at an early stage.

Service coverage continues to be a challenge in remote and isolated areas. Particular efforts have been made during the year to be as inclusive of remote communities as possible and to improve access to advocacy for consumers in these areas. The Chatham Islands were visited during the year to re-establish and maintain links to our most isolated area.

Professional Development and Quality Improvement

There is a strong emphasis within the service on quality improvement, supervision, mentoring and professional development, as well as the recognition that advocates should be setting a good example in these areas. Assessing the competence levels of advocates is an integral part of the service to ensure safe practice and to identify where additional training and support is required.

The year has seen the implementation of performance reviews based on national competencies, the implementation of the advocacy Code of Practice, piloting Māori cultural competencies, and further steps being taken to consolidate the development of an NZQA-based qualification in advocacy.

Who Uses the Advocacy Service?

Of those who used the advocacy service, 42% were male and 58% female. The greatest number of complaints were about services provided to people between the ages of 41 and 60 (32%). People aged between 26 and 40 make up the next largest group at 30%, followed by those aged 61 to 99 (27%).

Of those making complaints, 15% overall identified as Māori. This is likely to be an under-reporting of the real percentage, as ethnicity is not recorded for 19% of those who made complaints. Strategies have been put in place to improve this level of reporting, and a specialist advocacy pilot is in progress to identify ways of better responding to Māori. The Auckland and North region report a significant increase in contact with Pacific Islands people, as well as people from other ethnic groups, following a specific education and information campaign for Pacific and migrant communities. Half of the people using the service in this region identified as Pākehā New Zealanders (compared with 79% in the South Island), 20% as Māori, and 30% as from other ethnic communities.

How did People Hear about the Advocacy Service?

The three ASOs have once again received quite different responses to the question how people heard about the service. Overall, people tended to hear about the advocacy service from friends and family (25%), advocates (23%), advertising (23%), from a provider (17%), from HDC (5%), and the remainder from various other sources. However, as with the previous year, there is significant regional variation in relation to how people get to know about the service.

How did People Make Contact?

Overall, 67% of complaints to an advocate were made by consumers themselves, with the highest proportion in the South Island (74%); 31% of complaints were made by a third party, and 2% were referred by HDC. Referrals from the Commissioner continue to be a very small and declining percentage compared to complaints that come directly from the community. Only 3% of complaints to an advocate are referred on to HDC.

Enquiries and Complaints

The advocates managed a total of 8,649 enquiries and 4,611 complaints during the year. Overall, advocates were able to respond verbally to 74% of enquiries; 12% required both verbal and written responses; 7% were referred to another agency; and 5% were escalated to a complaint.

88% of all complaints were completely or partially resolved. Although most providers are well motivated to address problems and put matters right at an early stage, it is disappointing that advocates continue to report problems with provider complaint processes and delays in provider responses to complaints. However, despite this, 91% of complaints are closed within three months and 99% within six months.

Complaints have become more complex and take more time to resolve. In 2001 the average time spent on a complaint was three hours. This has now increased to an average of six hours.

Key Themes of Complaints

Although complaints to advocates often relate to more than one of the rights, standard of care continues to be the main concern — 41% overall. 13% of complaints relate to a lack of effective communication, and 11% raise informed consent issues. Unfortunately, concerns about complaint processes, and frustration with providers making early resolution difficult to achieve, has increased from 8% last year to 9%, and is up to 11% in the Auckland and North region. A further 9% of complaints relate to respect, dignity and independence, which are particular issues for disabled people. Although 5.5% over the whole country, matters relating to the right to the presence of support people is still an issue for South Island consumers at 9% of complaints.

Satisfaction with the Advocacy Service

80% of the consumers who participated in the satisfaction survey rated the advocate's skill and the advocacy process very highly. There were many excellent responses from consumers who were satisfied. Some consumers were disappointed that the advocate was unable to force the change they desired. The following are some consumer comments:

"What you do well is give everyone a chance to say how they feel and try and help them understand things a bit more clearly"; "very good at listening"; "someone who was there for me"; "I was immensely impressed"; "explained various options well"; "went the extra mile"; "I got the outcome I wanted"; "advocate was very knowledgeable, enthusiastic and concerned"; "clearly advised me of my rights"; "excellent service, very professional"; "I felt the advocate understood my situation."

Providers were asked about their awareness of the advocacy service, the approach used by the advocate, and whether the advocate acted in a professional manner. As it is important to have the co-operation of providers to achieve an early resolution, they were also asked about their willingness to work with advocacy again and whether they would recommend the services of an advocate. Overall, 84% of providers surveyed rated the advocacy service very highly. The highest ranking (89%) was on the professionalism of the advocates and willingness to use and recommend the service in the future. Some comments received from providers:

"The advocate was respectful, relaxed and non-intrusive"; "the advocate listened and facilitated well"; "served the consumer's interests thoroughly"; "absolutely great service"; "felt your advocate was able to draw out the issues in a very professional manner and allow the issue to be resolved to the consumer's satisfaction".

Education and Training

Education continues to be an effective way of increasing awareness of consumer rights and the role of advocates. 1,558 education and training sessions were provided during the year to consumers, consumer organisations, other advocacy services and a range of health and disability providers and provider organisations. 89% of survey responses rated the quality of the presentation, clarity of information, content and relevance as being of a high standard.

Education packages have been specifically developed for consumers, as well as for providers, to assist them to focus on implementing the rights in practice. The importance of this education cannot be underestimated as new staff continue to enter health and disability services. Some comments received:

"very good examples and explanations"; "clear and concise, well organised and well presented"; "session was open, relaxed, informative, met and exceeded expectations"; "engaging friendly speaker, kept it interesting"; "explained consumers' rights extremely well"; "information was very applicable and related to our setting".

Networking and Links

The advocates continue to develop new networks and foster links to existing ones. This keeps them in touch with local communities and raises the profile of advocacy and HDC. This is a particularly helpful approach for reaching very vulnerable consumers who would otherwise find it difficult to contact an advocate themselves. A total of 2,094 networking contacts were made during the year. A particular focus was on disability networks, residential facilities for people with disabilities, sole practitioners including complementary therapists, rest homes and other facilities for older people. Successful networking can often lead to education opportunities and improved understanding of consumer rights and provider responsibilities.

Responsiveness to Māori

We have a commitment to continually enhance Te Tiriti ō Waitangi relationships between Māori and the advocacy service, and to ensure that policies and processes are consistent with the values of Māori. Staff have continued to receive training, education, support and contact with resource people. Māori cultural competencies were introduced during the year and are being piloted to make sure the service is appropriate and safe. In addition, a specialist Māori advocacy pilot is in progress in the mid-lower North Island region to identify effective ways of providing advocacy services for consumers and whānau.

Kaititaki tāngata positions have been helpful in providing appropriate sources of education and information for Māori, as well as generating links with Māori communities. The support of local kaumātua has provided valuable support for advocates, assisted with implementation of the Māori competencies, and provided advice to advocacy organisations. Actions commenced during the year to extend the kaumātua network.

Responsiveness to Disabled People

The principles underpinning the New Zealand Disability Strategy are integral to the work of the advocacy service. During the year, disabled people were the main users of the advocacy service (56%).

Advocates focus on enhancing the abilities and skills of disabled people to maximise their independence and control of their world, and to make their own decisions. These are particular issues for consumers in residential care facilities, so advocates provide a home visiting service where required. Advocates have worked with Kimberley residents and their families to assist them with the deinstitutionalisation process and transition into local communities.

The service has a long tradition of supporting the parents of disabled children who seek help to advocate for their sons and daughters. They feel alienated by health and disability services that do not provide the required information and assistance. A joint project with Carers NZ has resulted in the development of a "Self Advocacy" information kit for inclusion in a national pack for carers.

The advocates attend disability forums and are well linked into disability networks. They supported a number of consumers preparing to tell their stories to the Mental Health Confidential Forum.

The advocates are developing expertise and specialised skills in particular areas. Assisting people with intellectual disabilities in forensic facilities is one example. A specialist advocacy pilot is in progress to explore how advocates can most effectively assist people in this situation.

Two pilots looking at partnering arrangements with the advocacy service and deaf communities in Christchurch and Wellington are also under way. The Wellington pilot will have a particular focus on deaf mental health issues and how advocates can best assist.

MAKE IT "CLICK"

A consumer wanted help with a complaint after fracturing her finger following a fall from her wheelchair when the mobility van she was in braked at an intersection. The Land Transport Safety Authority (LTSA) had been notified by the taxi company of advocacy involvement, as the company was concerned that it would be liable for the injury. During the meeting with the LTSA representative it became apparent that there is currently no law in New Zealand that requires a person being transported in a mobility van to be firmly secured. The taxi company now has a policy in place for the safe transport of people in wheelchairs. Other taxi companies have indicated their intention to adopt this policy.

WHEN A BIT OF A NUDGE CAN HELP

The mother of a child with a disability telephoned an advocate to say that she had been waiting five months to receive shoes for her daughter from an orthotic centre. Whenever she called the centre she was given "the runaround". The advocate telephoned the CEO of the service, who undertook to look into the matter. The CEO called the advocate the same day to advise that they had located the shoes and that they would be couriered to the client immediately. He also telephoned the child's mother to explain what had happened and to discuss any further arrangements for her daughter. She was very happy with the outcome and the speed with which the advocate had sorted out the problem.

Service Highlights

We recently celebrated 10 years of the Code and Advocacy under the Health and Disability Commissioner Act, with a number of advocates being recognised for 10 years of service. Senior advocate and assistant manager Linda Grennell (Ngāi Tahu) was elected National President of the Māori Women's Welfare League for three years. Advocate Pauline Wilson received the QSM for services to the Ashburton community.

The South Island ASO ran an independent pilot advocacy service for ACC claimants in the Christchurch area. ACC funded the pilot through the Director of Advocacy, and 106 claimants used the service in the first 10 months. The service is separate from the health and disability advocacy service, has its own 0800 number, and is in the process of being evaluated.

Ongoing complaints about needs assessment involving communication issues and co-ordination of care has led to a formal memorandum of understanding between one of the ASOs and a large needs assessment service. This step has been taken to work on ways to best assist consumers requiring needs assessment and associated support services.

Trends

Advocates have had greater contact with rest homes and residential facilities during the year. This is due to an increase in complaints as well as a concerted effort by advocates to increase their profile and availability through regular visits and education sessions.

Prison health services featured in a number of complaints to advocates. Inmates had problems with access to a doctor, dentist, nursing assessment, specialist diets and medication, as well as pain relief and medication dispensing issues. Inconsistencies in approach and access to care from one prison to another, and a lack of continuity of specialist care, caused concern for prisoners.

There were a greater than usual number of complaints about methadone services, with a number about one DHB service. These consumers said that they were reluctant to complain until the situation became really bad, as they feared that complaining might lead to removal from the programme. The problems included changes to regimes that were not communicated to consumers, as well as regimes that compromised employment and the ability to maintain a stable family life.

Large numbers of complaints were made about GPs and DHBs, including problems with complaint processes, particularly delays in responses. Some complaints were ignored, and it was disappointing that some consumers were asked to find another doctor after they made a complaint to a general practice.

Disabled people continue to be assessed as needing home help or attendant care, but problems finding someone to carry out these roles are not always communicated to

SUPPORT IS IMPORTANT

A consumer had issues with her mental health team after the previous meeting had not gone well. She had written a letter to her psychiatrist and case manager and was planning to give each of them a copy at her next appointment. She approached the advocacy service to see whether an advocate could attend this meeting as a support person, as she was feeling very anxious about it. The meeting went well and provided a good opportunity for the consumer to have her letter read. The doctor commented that she also felt that the previous meeting had not gone well, and stated how helpful the letter was, with the consumer's experiences written down. A full discussion took place, with the consumer feeling confident to tell her story and ask questions. The consumer felt the meeting had gone well and was happy and relieved. She was thankful that an advocate had been involved to give her the confidence to take action.

consumers. As there is a shortage of carers, consumers are reluctant to complain about the lack of continuity of care, untrained inexperienced carers, late arrivals and no shows, since they believe that making a complaint could risk the withdrawal of current services and result in them being left to fend for themselves.

Advocates note that even though treatment injury has replaced medical misadventure, a residual defensiveness amongst health professionals continues to make it difficult for consumers to get the help they need to make a treatment injury claim. Further training for health practitioners would help reduce the number of these complaints.

Time and travel costs continue to have a significant impact on rural advocates who cover large geographical regions. Travel is also a big issue for rural consumers who have to travel long distances to access services, with limited assistance options. They get frustrated when given appointment times that do not take public transport services into account, or when appointments are cancelled at short notice after travel and childcare arrangements have been organised. Advocates report that many are reluctant to complain because of the limited numbers of providers and alternative services, fear of reprisal, and the risk of the service being shut down if there are too many complaints.

FINDING A WAY FORWARD

A woman contacted the advocacy service concerned about her husband. He was an elderly man, living in a hospital since he had been resuscitated from "death" some months earlier. He had received good rehabilitation services and both were keen for him to return home. Although she felt she could look after him, she had found hospital staff very negative about the idea. She felt they were pushing her aside and that they would make sure it didn't happen. She told the advocate that she wanted hospital staff to show her what she needed to do to care for her husband, and how to carry out the simple physiotherapy exercises her husband needed to keep him as mobile as possible. The advocate located the physiotherapist and explained what the couple wanted. A plan was put in place for her to learn the exercises.

Several days later the woman rang the advocate to say that her husband was ready to come home, that the hospital would give him two nights' respite each week so that she could have a full day free of care, and that the manager of the ward was being very helpful in preparing them both for the man's successful move home.

The advocate did very little, but without that small intervention on their behalf it is unlikely that this outcome would have been achieved for this couple.

REPORT OF THE DIRECTOR OF PROCEEDINGS

Introduction

Overall, the number of referrals for this financial year was very similar to last year, but the concentration of eight referrals received during the three-month period from March to May, coupled with five hearings during that period, made for a busy close to the year. Again there have been successful outcomes in over 90% of Tribunal decisions.

Theo Baker
Director of Proceedings

Statistics

In the past year the Commissioner referred to the Director of Proceedings 19 health providers, of whom 10 were medical practitioners, with six of those being general practitioners. A decision to take no action was made in respect of one of those referrals (see Table 1 below). This is an uncharacteristically large proportion of referrals concentrated in the medical profession, but there is no evidence that it is the start of a trend.

Table 2 (overleaf) shows that there were 10 substantive hearings by the end of June 2006, but at the time of publication, six further hearings have taken place. Five of these cases involved general practitioners and one a nurse.

At least three further disciplinary matters are set down for hearing before the end of the calendar year. And, as can be seen from Table 3 (see page 19), there are six matters awaiting hearing in the Human Rights Review Tribunal (HRRT).

Of the 13 matters where a decision was made to issue proceedings, nine involved the laying of a disciplinary charge before the Health Practitioners Disciplinary Tribunal. There are five claims with the HRRT, with one practitioner facing proceedings in both jurisdictions.

Table 1: **Action taken in respect of referrals to Director of Proceedings in 2005/06**

Provider	No further action	Decision in process	Hearing pending	Hearing taken place	Total
Caregiver		1			1
Counsellor			1		1
Dentist				1	1
Medical practitioner					
General practitioner			6		6*
General surgeon	1	1	1		3
Urologist			1		1
Midwife	1				1
Nurse		2	1		3
Rest home			2		2
Total	**2**	**4****	**12**	**1**	**19**

* Five of these hearings will have taken place by the time the Annual Report is published.

** In three of these, the decision to issue proceedings was made after 30 June 2006. In the remaining one, the decision is still in process.

Table 2: **Outcome of hearings in 2005/06**

Provider	Successful	Unsuccessful	Outcome Pending	Total
Discipline				
Substantive hearings				
Dentist	1	1		2
Medical practitioner				
General practitioner	1			1
Psychiatrist	1			1
Surgeon	1			1
Nurse	4			4
Occupational therapist	1			1
Appeals				
Medical practitioner				
Surgeon	1			1
HRRT				
Substantive hearings				
Counsellor			1	1
Interlocutory hearings				
Psychiatrist	1			1
Total	**11**	**1**	**1**	**13**

It should be noted that sometimes when a decision is made to prosecute a registered health practitioner, the decision regarding the HRRT is put on hold. Some of the HRRT proceedings pending involve practitioners who have already faced a disciplinary charge in the previous financial year.

Rest Homes and Aged Care

Of the four successful prosecutions of nurses last year, recorded in Table 2, two involved the care of the elderly. Case notes for these decisions are on pages 20 and 22. In addition, last year two rest homes were referred by the Commissioner, and the three referrals of registered nurses involved breach findings for poor care of the aged.

Occupational Therapy Case

The prosecution of the occupational therapist referred to in the case note on page 21 was significant for two reasons. First, it was the first prosecution of an occupational therapist by the Director of Proceedings. More importantly, the Health Practitioners Disciplinary Tribunal found that a personal relationship that fell short of a sexual relationship amounted to professional misconduct. The Tribunal sent a strong message that professional boundaries must be carefully identified and maintained.

Name Suppression

Name suppression remains a point of contest and appeal. In February 2006 the High Court dismissed an appeal against the decision of the Health Practitioners Disciplinary Tribunal

Table 3: **Human Rights Review Tribunal cases in 2005/06**

Provider	Hearing pending	Outcome pending	Settled after proceedings filed	Total
Counsellor	1	1		2
Medical practitioner				
General practitioner	1			1
MOSS			1	1
Psychiatrist*	1			1
Nurse	1			1
Rest home	2			2
Total	**6**	**1**	**1**	**8**

*Referral from 2004/05.

SEXUAL RELATIONSHIP WITH SOCIAL WORKER

On 1 August 2006, the Human Rights Review Tribunal made orders by consent between the Director of Proceedings and Jacqueline Leighton.

At the relevant time Ms Leighton was a social worker employed by a Christian child and family support service. The consumer had a history of child sexual abuse and was suffering from chronic post-traumatic stress disorder, with ongoing relationship difficulties, an eating disorder, alcohol problems and recurrent depression.

In April 1999, the consumer's psychotherapist referred her to the service, and a social worker was assigned to assist the family. In April or May 2000, the consumer went into a residential programme. The service continued to support the family and in June 2000 Ms Leighton took over as social worker.

In August 2000, the consumer went home on leave for 3½ weeks. During this time the consumer and Ms Leighton became close, drinking alcohol together, and they formed a sexual relationship.

While the consumer was back in her residential programme, the two continued to have telephone contact and exchange cards. Ms Leighton closed the social work file during this period.

In November 2000, the consumer returned home and continued contact with Ms Leighton.

In December 2000, as a result of a friend's concern about the consumer's increased alcohol consumption, and the potential harm to the children if she drove under the influence of alcohol, Ms Leighton re-opened the service's file temporarily.

In February 2001, Ms Leighton started to work at another agency, where she commenced a relationship with a male colleague. In April 2001, she told the consumer that she wanted to discontinue her relationship with her because she did not love her and she wanted to pursue her relationship with her colleague.

The consumer was very distressed. She consumed a great deal of alcohol and attempted to commit suicide by taking an overdose of a sedative. She was taken to hospital and, upon recovering, she told her husband about her relationship with Ms Leighton.

It was agreed that there would be a declaration that Ms Leighton's conduct amounted to a breach of Right 4 of the Code of Consumers' Rights and that there would be an order restraining her from engaging in conduct of the kind that constituted the breach.

refusing permanent name suppression where a charge of professional misconduct had been upheld against a medical practitioner. The High Court held that "... the publication of names of persons involved in the hearing is the norm, unless the Tribunal decides it is desirable to order otherwise. Put another way, the starting point is one of openness and transparency, which might equally be termed a presumption in favour of publication." An appeal to the Court of Appeal is now pending.

These cases involve a balancing of the privacy interests of the practitioner (or any other person) against the public interest. The practitioner or defence counsel advance those privacy interests, while the prosecutor represents the public interest, which includes: matters of public safety; the public's interest in knowing the name of a practitioner accused of or found guilty of professional misconduct; accountability and transparency of disciplinary processes; freedom of speech; and the risk that other practitioners could be unfairly implicated if the practitioner is not named. It is the role of the Tribunal to consider the competing interests and decide whether or not it is desirable to grant name suppression.

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 Health Practitioners Disciplinary Tribunal
- the Human Rights Review Tribunal.

NEGLIGENT CARE OF ELDERLY PATIENT

Registered nurse Mr Geoff Henry pleaded guilty to a charge of professional misconduct arising from the professional services provided to an elderly patient who was receiving full-time private care from Medforce, the nursing agency of which Mr Henry was the Director and Manager. The patient was cared for in her own home for a period of 15 months, from August 2000 until November 2001. From mid-February 2001 to May 2001, the patient was cared for by caregivers during the day, with a registered nurse undertaking some night shifts; from the end of June 2001, no registered nurses were rostered on for any shifts. The patient developed ischaemic ulcers on her feet and significant pressure sores on her torso, from which she later died.

The Health Practitioners Disciplinary Tribunal found that: there was an inadequate nursing plan in relation to pressure areas, nutritional status, weight monitoring and pain management; the use of adequate or appropriate wound care products or equipment had not been ensured; there was inadequate assessment and monitoring of the patient's feet; and there was inadequate training of staff and involvement of a registered nurse.

In finding that cumulatively the particulars amounted to professional misconduct, the Tribunal noted that "Mr Henry, and others in his circumstances, must appreciate that when they accept the responsibility for caring for elderly, vulnerable patients there are minimum standards that must always be adhered to. The plight of the patient in this case, and the overall inadequacy of her care has been a source of considerable concern and distress to the Tribunal. That concern and distress is reflected in the Tribunal's unanimous decision that Mr Henry must be found guilty of professional misconduct."

At the time of the hearing, Mr Henry was no longer practising as a nurse. By way of penalty, the Tribunal imposed conditions for a period of three years, should Mr Henry return to practice: that he not practise as a sole practitioner in the aged-care sector, and that he undergo a competency assessment. A full copy of the decision can be found at www.hpdt.org.nz (22/Nur05/07D).

Surveys were sent to the respective chairs of the two tribunals, as well as to deputy chairs who had presided over hearings, and to the registrars and secretaries of the tribunals. Each profession has its own registrar, although in some cases that person covers more than one profession.

Accordingly seven surveys were sent, of which five were returned. Each survey contains a total of 16 questions covering areas such as timeliness, quality of evidence, and presentation of oral and written submissions. Looking at all areas, expectations were mostly met in 17% of the answers, they were fully met in 69%, and were exceeded in 14%.

The overall comments indicate that the Proceedings team continues to maintain a good relationship and profile with the tribunals. As in previous years, there was some concern about the drafting of charges, a matter about which I have spoken with the Chair. It is a difficult balance between a charge that on the one hand is cumbersome and over-complicated, but on the other may be insufficiently particularised, leaving the defendant uncertain of the precise manner in which his or her conduct is alleged to be deficient.

Conclusion

Thank you to the Proceedings team, who continue to work hard to maintain high standards, and to briefed counsel for their expertise and availability. The year ahead promises some interesting disciplinary prosecutions and Human Rights Review Tribunal proceedings.

BOUNDARY ISSUES AND OCCUPATIONAL THERAPIST

On 13 December 2005, the Health Practitioners Disciplinary Tribunal upheld a charge of professional misconduct laid against an occupational therapist, Ms Sonja Allen of Auckland. The Director of Proceedings alleged that Ms Allen had formed a personal relationship that was harmful and/or potentially harmful to the complainant, who was her client.

Ms Allen was employed by a District Health Board in a service that provided occupational therapy to persons who were also receiving mental health services. Ms Allen's role involved providing individual career counselling to clients and liaising with mental health care teams in respect of clients' needs.

The complainant's diagnosis was "anxiety/depressive/panic disorder". The complainant was comfortable engaging through email and so it was agreed with Ms Allen's supervisor that there could be some email correspondence, on the basis that they were to limit their email contact to the task and not to build up relationships.

However, Ms Allen later admitted that she and the complainant were in regular contact outside of work hours by email and MSN, often in the middle of the night, and often several times a night. The communications continued from mid-November 2002 to early May 2003, and the parties revealed a large amount of personal information to each other. They also met outside of work hours on two occasions. Ms Allen sent the complainant an email birthday card from overseas and brought back small gifts for him from her holiday.

The complainant developed feelings for Ms Allen and told her of this. When Ms Allen explained that these feelings were not reciprocated, the complainant was very upset. He sent her an email saying, "I am off to secure a length of rope for myself now." In May 2003, Ms Allen informed her team manager of the situation.

The Tribunal observed the difference in power between occupational therapists and clients, noting the professional fiduciary obligation on the occupational therapist to meet the needs of the client above his or her own needs. Further, because of the difficulty for an occupational therapist to maintain objectivity and professional judgement if a friendship develops, the quality of services provided to a client may be compromised and, if the friendship ends, the damage to the client may be quite severe.

The Tribunal ordered that for a period of three years from the date Ms Allen recommences practice, she must consult with and comply with any instructions or training given on boundary identification and maintenance. She was also ordered to pay $15,000 costs towards the prosecution.

INADEQUATE MANAGEMENT OF PATIENT'S BLOOD-GLUCOSE LEVEL

On 10 October 2005, the Health Practitioners Disciplinary Tribunal upheld a charge of professional misconduct laid against Naomi (Sally) Dale. It found that Nurse Dale had failed to adequately assess, monitor, evaluate and respond to Mr Bedford's changing blood-glucose levels; she had failed to provide adequate instructions to caregivers for the assessment, evaluation and response to Mr Bedford; and had failed to provide adequate and appropriate training to caregivers in respect of monitoring and responding to changing blood-glucose levels, recognising the signs of consciousness, and the administration of insulin.

The Tribunal ordered that Ms Dale practise only under the supervision of a registered nurse approved by the Nursing Council of New Zealand. She was also ordered to contribute $10,000 to the costs of the hearing and prosecution.

Mr Bedford suffered from Parkinson's disease, hypertension and postural hypotension, and was an insulin-dependent diabetic. Since 1998 he had lived at a rest home, during which time he had also experienced transient ischaemic attacks (TIAs).

Mr Bedford's blood-glucose levels were taken twice daily and his insulin was administered at 8am each day. During the period 17–21 September, Mr Bedford's morning blood glucose levels decreased to a level that is considered too low and in need of immediate raising.

During the evening of 20 September 2003, a senior caregiver telephoned Nurse Dale and described a fit that was different from Mr Bedford's usual TIAs, as well as a blood-glucose level of only 2.7mmol/L at tea-time. Nurse Dale instructed the caregiver to check Mr Bedford's blood glucose again, take his blood pressure, then call her back.

At approximately 8pm the caregiver rang Nurse Dale and advised her that Mr Bedford's blood-glucose level was now 2.5mmol/L. Nurse Dale advised the caregiver to give Mr Bedford some Milo and put up his bed rails to stop him falling out of bed.

At 7am and 8am on the morning of 21 September 2003, the caregiver on the morning shift measured Mr Bedford's blood glucose, which was 3.2mmol/L on both occasions. She then gave Mr Bedford his usual 20 units of insulin, thinking that this would increase his blood-glucose level.

At 9.30am the caregiver checked on Mr Bedford and found him to be a bit pale. She also observed that he was not really responding to her. She took his blood pressure, which was 160/110. She rang Nurse Dale and explained that Mr Bedford "wasn't really with it" and that his blood glucose was 3.2mmol/L. She advised Nurse Dale that she had given Mr Bedford his regular dose of insulin at 8am and that "he hadn't picked up".

Nurse Dale advised the caregiver to check Mr Bedford's level of consciousness by touching his eyelash to see if it twitched, and that if he responded in this way the caregiver should then give him some sugar. Nurse Dale advised the caregiver to then check Mr Bedford's blood glucose and to call back if she was not happy.

On observing Mr Bedford twitch when she touched his eyelash, the caregiver gave Mr Bedford a drink of Milo.

At 9.50am the caregiver re-checked Mr Bedford's blood glucose and found it was 1.1mmol/L. She rang Nurse Dale a second time, advised her of the reading and asked whether she should call an ambulance. Nurse Dale told her to take blood-glucose readings every 15 minutes.

The caregiver then took at least two further blood-glucose readings, the last of which was 2.0mm/L. The caregiver rang Ms Dale for a third time, advised her of the result, and told her that Mr Bedford was not really responding. Nurse Dale asked her to ring an ambulance, which was done immediately.

On arrival, the ambulance officer began treating Mr Bedford for hypoglycaemia by administering glucose intravenously. Mr Bedford was in a critical condition and was taken to Tokoroa Hospital before being flown to the intensive care unit of Waikato Hospital, where he was placed on a ventilator.

Mr Bedford did not respond to treatment, and the decision was made by his family to take him off the ventilator. He died on 24 September 2003.

COMPLAINTS RESOLUTION

Introduction

This is my first year in the role of Deputy Commissioner, leading the Complaints Resolution division. It has been a rewarding but challenging one, with many changes — not least of which was the decision to locate the whole division in Auckland from January 2006.

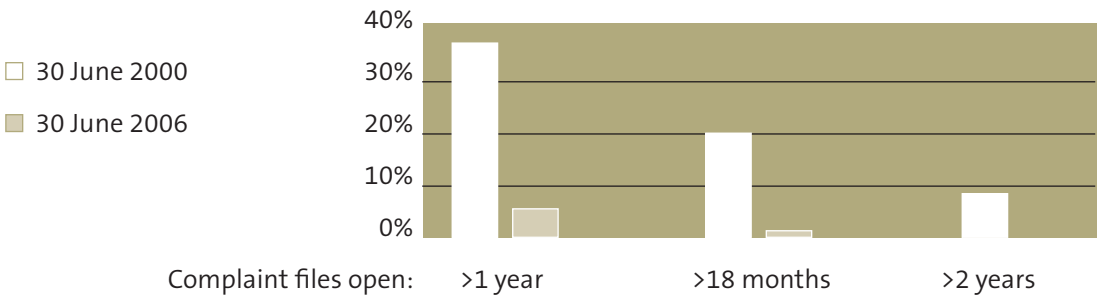
There are two distinct teams within Complaints Resolution — Complaints Assessment and Investigations. Their focus has once again been on resolving matters at the most appropriate level, reducing the number of older complaint files, and improving the timeliness of investigations while at the same time maintaining fairness and quality. It has been a very successful year on all counts. At 30 June 2006 there were 279 open complaints, a reduction of 11% in a year. Only 5% of these files were older than one year, compared with 12% a year ago. No files had been open two years. This is a significant achievement considering that 24 files had been open more than two years at this time four years ago. The emphasis on appropriate resolution is reflected in the number of matters resolved without formal investigation. 89% of complaints were handled using other approaches such as advocacy, mediation and referrals to other agencies.

Rae Lamb
Deputy Commissioner, Complaints Resolution

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

	2005/06	2004/05	2003/04
Open at year start	313	347	367
New during year	1,076	1,124	1,142
Closed during year	1,110	1,158	1,162
Open at year end	**279**	313	347

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



Complaints Assessment

Complaints Assessment Manager Annette May now leads a team of eight full-time assessors, an increase of one compared with a year ago. The team has grown in size in response to the greater number of files now being handled without formal investigation, and the increasing complexity of many of these files. This team was responsible for 928 of the 1,110 complaint files closed in 2005/06. Of these, 93% were closed within six months.

Complaints Assessment Team

All complaints and general enquiries are initially handled by the complaints assessors, who also carry a large file load of their own. They handle referrals to advocacy, play an important role in liaising with providers about whom complaints have been made, and work with external bodies to ensure that complaints are handled appropriately. These agencies include district health boards, registration authorities, District Inspectors, Coroners, and the Ministry of Health. In the past year, the signing of many letters has been delegated in order to streamline processes, give greater responsibility to staff, and reduce response times. Two senior assessors handle the most complex matters, and share responsibility for checking work. The team is assisted by a part-time in-house clinical advisor who reviews, and provides advice on, some files; a part-time administrative assistant; and a part-time contractor.

Enquiries

A toll-free telephone line (0800 11 22 33) allows the public to contact the complaints assessment team from anywhere in New Zealand between 8am and 5pm, Monday to Friday. Additionally, contact can be made by email (hdc@hdc.org.nz), and complaints may be submitted through an electronic complaint form on the website (www.hdc.org.nz). However, most enquiries are made by telephone. There were 5,099 enquiries last year, compared to 5,335 in 2004/05. Once again, the majority of these (1,538) were from people seeking information about how to lay a complaint, the options for resolving a complaint, and the role of the Office. There were also a significant number of calls relating to matters outside the Commissioner's jurisdiction. In these cases, efforts are always made to direct callers to the appropriate agency that may be able to help them.

There has been a significant increase in the number of enquiries categorised as "no response required" (168 compared to 88 last year). However, this primarily reflects the logging of calls needing transfer — these have been logged as part of a project to look at how to improve the HDC telephone system.

Written responses to enquiries (categorised as "formal responses") were sent to 166 enquirers, 81% within one month of receipt.

Complaints

In the year to 30 June 2006, HDC received 1,076 complaints, 48 fewer than in the previous year (1,124).

Any person who believes there has been a breach of the Code may make a complaint to the Commissioner. This means that the complainant may be a third party, such as another provider, or a relative or friend of the consumer. Complaints may be made verbally or in writing.

All complaints to statutory registration authorities, such as the New Zealand Medical Council, must be referred to the Commissioner in the first instance. The Commissioner is able to refer the matter back to the authority if there are competence or professional issues more appropriately handled by the authority.

Table 2: **Action on enquiries**

Action taken	2005/06	2004/05
Escalated to complaint	9	14
No response required	168	88
Outside jurisdiction (access, date, funding, ACC)	365	576
Outside jurisdiction — referred to another agency	133	118
Provided formal response	166	196
Provided information on HDC and complaints process	1,538	1,546
Provided verbal information	1,327	983
Provided verbal and written information (including requests for brochures)	30	105
Referred to advocacy	742	766
Referred to another agency (including District Inspector, prison inspector and professional body)	520	799
Referred to another internal department (legal, publications)	82	132
Open	19	12
Total	**5,099**	**5,335**

The Commissioner also has the power to commence an investigation on his own initiative.

Source of complaints
In 2005/06, as in previous years, most complaints came from individual consumers (48%), friends/relatives (30%) and registration authorities (9%). Once again, far more complaints were received from health consumers than from disability services consumers. The registration authorities that referred the most complaints to HDC were the Medical Council, the Psychologists Board, and the Dental Council.

Types of provider subject to complaint
The 1,076 complaints received in 2005/06 involved 1,361 providers (see Table 3 overleaf).

Figure 2: **Source of complaints received 2005/06**

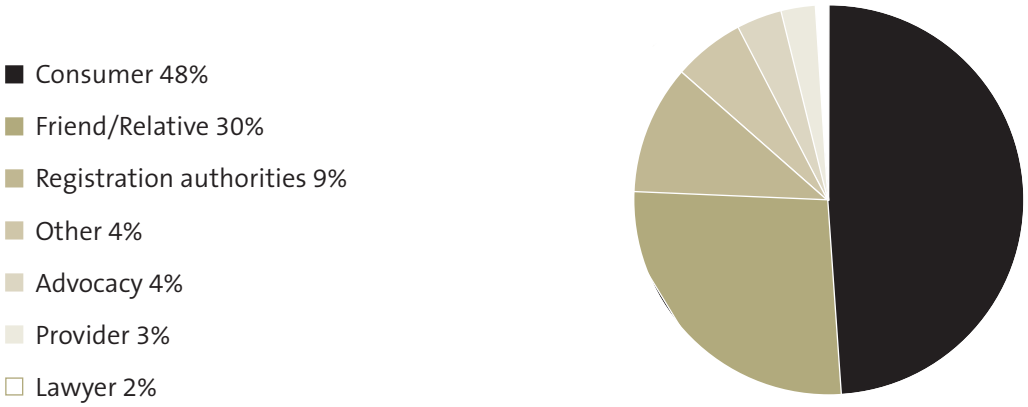


Table 3: **Types of provider subject to complaint**

Individual provider (registered medical practitioners)	2005/06	2004/05	2003/04
Anaesthetist	6	7	6
Cardiologist	1	1	1
Cardiothoracic surgeon	2	0	0
Dermatologist	2	3	4
Ear, Nose, Throat specialist/Otolaryngologist	3	7	5
Emergency physician	1	1	1
Endocrinologist	0	1	0
Gastroenterologist	0	2	1
General practitioner	204	244	256
General surgeon	22	26	45
Geriatrician	0	3	3
House surgeon	0	1	5
Medical officer	0	3	5
Neurologist	3	0	2
Neurosurgeon	1	2	3
Obstetrician/Gynaecologist	20	42	22
Occupational medicine specialist	8	0	5
Oncologist	3	0	1
Ophthalmologist	8	7	3
Orthopaedic surgeon	15	26	18
Paediatrician	7	9	4
Pathologist	1	3	1
Physician	27	28	34
Plastic surgeon	4	9	7
Psychiatrist	23	27	26
Public health specialist	0	0	1
Radiographer	1	1	0
Radiologist	9	11	8
Registrar	14	8	14
Sonographer	1	0	0
Sports medicine specialist	0	9	0
Urologist	4	13	11
Subtotal (medical practitioners)	**390**	**494**	**492**

Individual provider (other than registered medical practitioners)	2005/06	2004/05	2003/04
Acupuncturist	3	2	2
Alternative therapist	3	1	0
Ambulance officer	1	1	1
Audiologist	0	0	1
Caregiver	2	3	1
Chiropractor	8	13	6
Counsellor	5	6	6
Dental technician	4	4	6
Dental therapist	0	2	0
Dentist	57	30	41
Dietician	0	1	0
Key worker (mental health)	0	1	0
Massage therapist	0	2	0
Midwife	55	37	37
Naturopath	3	3	3
Nurse	65	58	60
Occupational therapist	8	5	4
Optician	0	0	1
Optometrist	0	1	2
Oral surgeon	3	2	2
Osteopath	4	2	2
Other providers	16	11	15
Pharmacist	18	24	21
Pharmacy technician	1	0	1
Physiotherapist	7	5	7
Podiatrist	3	4	0
Psychologist	38	24	43
Psychotherapist	1	0	0
Rest home manager	1	1	2
Social worker	2	2	6
Speech language therapist	1	1	1
Subtotal (other individuals)	**309**	**246**	**271**
Total (all individual providers)	**699**	**740**	**763**

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

Group provider	2005/06	2004/05	2003/04
Accident and emergency centre	9	8	9
Accident Compensation Corporation	19	7	20
Ambulance service	8	6	4
Dental provider	6	3	2
Disability provider	19	15	8
Educational facility	0	0	1
Government agency	9	6	5
Hospice	2	2	0
Intellectual disability organisation	5	4	8
Laboratory	2	1	2
Medical centre	39	31	28
Optometry	2	0	0
Other provider group	19	23	21
Pharmacy	23	21	38
Prison service	24	17	28
Private medical hospital	10	10	7
Private surgical hospital	13	11	11
Public hospital	363	382	359
Radiology service	7	4	7
Rehabilitation provider	6	8	6
Rest home	71	56	69
Trust	6	8	12
Total group providers	**662**	**623**	**645**

The types of provider most commonly complained about were:

Individual Provider		**Group Provider**	
General Practitioner	29%	Public hospital	55%
Nurse	9%	Rest home	11%
Midwife	8%	Medical centre	6%
Dentist	8%	Prison services	4%
Psychologist	5%		

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

	2005/06	2004/05	2003/04
Outside jurisdiction[1]	213	302	256
Referred to a health professional body[2]	77	65	88
Referred to the Privacy Commissioner	3	4	16
Referred to the Human Rights Commission	0	1	2
Referred to ACC	20	23	32
Referred to the Ministry of Health	4	13	15
Referred to a District Inspector	19	19	17
Referred to another agency	4	2	1
No action[3]	467	364	275
Total	**807**	**793**	**702**

1 Outside jurisdiction relates to access or funding, or decisions under section 40 of the Act.
2 Chiropractic Board, Dental Council, Medical Council, Midwifery Council, Nursing Council, Physiotherapy Board, Podiatrists Board, Psychologists Board.
3 No action taken under section 38(1) of the Act, and no investigation commenced.

Initial complaints assessment

When complaints arrive at HDC, an assessor responsible for the management of all new complaints identifies any matters that do not fall within the Commissioner's jurisdiction. This is done in consultation with the Complaints Assessment Manager, and any matters that are unclear, or borderline, are referred to the legal team in Wellington for review and advice. Priority is given to responding promptly to these complaints and being as helpful as possible. 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. In 2005/06, 147 complaints outside jurisdiction were closed, within an average time of one week.

Once jurisdiction has been established, new complaints are considered by a "triage" team, which makes recommendations to the Commissioner on how best to respond to each complaint. This team is convened by the Complaints Assessment Manager and includes the Deputy Commissioner, Complaints Resolution, the Director of Advocacy, the Investigations Manager, a senior investigator, and an experienced complaints assessor. Meetings are held every two days, with the aim of processing new complaints within five working days of receipt. Prior to these meetings, complaints assessors gather preliminary information such as registration details for the provider who is the subject of the complaint. In-house clinical or legal advice is also sought in relation to some complaints. In most cases, the triage team will require additional information such as a provider response and clinical notes in order to decide the most appropriate form of action.

Complaints resolved without investigation

In 2005/06, 89% of all complaint files were "closed" without a formal investigation. This reflects increased use of the wider range of resolution options available to the Commissioner following changes to the Act in 2004, and ongoing emphasis on finding the most appropriate level of resolution·

Each complaint is carefully assessed, and a considerable amount of information is generally obtained, reviewed, and analysed, before a decision is made on the most appropriate approach.

During the year, 187 complaint files were closed without investigation as a result of the complaint being withdrawn (22), or resolved by the Commissioner (39), through advocacy (58), by agreement of the parties (49), by mediation (5), or by the provider (14).

Under section 38(1) of the Act, the Commissioner may decide to take no action on a complaint where the length of time that has elapsed since the event complained of occurred means that an investigation is not practicable or desirable; the subject matter of the complaint is trivial; the complaint is not made in good faith; the person alleged to be aggrieved does not want any action taken; or there is another adequate remedy. In 2005/06, 469 complaints were closed using section 38(1) compared to 364 in the previous year.

Investigations

Investigations Team

The changes in the past year have impacted most on the investigations team. The decision to locate all of Complaints Resolution in Auckland meant that by January, the investigations team was no longer split across two centres. At the time of the reorganisation there were eight investigators and a secretary in Auckland, and three investigators and a secretary in Wellington. Bringing the team together in one office was intended to improve the quality, consistency and efficiency of complaints resolution. With fewer complaints going to formal investigation, the total number of full-time investigators was also reduced to seven, with one full-time secretary (complaints assessor numbers were increased).

Roles within the investigations team were also reviewed and, for the first time, a senior investigator was appointed. Additionally, a new position of Liaison Investigator was created, with responsibility for following up the Commissioner's recommendations to ensure they have been acted on by providers. This includes following up the referral of providers to the registration authorities for consideration of a competence review. The year also saw the resignation of the previous Investigations Manager, and the appointment of a new manager, Mark Evans.

Investigation Process

In line with the Commissioner's goal of resolving complaints at the most appropriate level, only complaints that allege a significant systems failure or departure from standards by individual providers, or other serious matters that cannot be resolved at the assessment stage, are referred for formal investigation. This means that investigators are generally handling complex cases, often involving multiple issues and providers.

As the files come through from "triage", they are allocated to individual investigators by the Investigations Manager. The investigators are assigned a "buddy" on the file, and they work closely with each other, and the legal team, to ensure that the investigations are of the highest quality. Procedural fairness and impartiality are essential, while trying to progress the investigation in a timely manner.

Where complaints involve clinical matters, the Commissioner will generally ask a relevant independent expert for advice on the standard of care. The experts are nominated by their professional colleges according to set criteria, including being held in good standing by their peers.

A highlight this year was holding an expert advisors training day jointly with the Accident Compensation Corporation. It is the first time this has been done. Some expert clinical advisors

MEDIATION CONFERENCE: A TRAGIC CASE BUT MEANINGFUL OUTCOMES FOR FAMILY MEMBERS AND PROVIDERS

A young man aged 20 (of Māori descent and residing in a predominantly rural area) developed symptoms of severe neck and shoulder pain. Over a period of 10 days he was seen, or reviewed over the telephone, by four different general practitioners (three from the same medical centre). The patient was treated primarily for muscle spasm. He also underwent X-rays and blood tests, which showed no abnormalities. The patient subsequently developed coughing with associated bloodstained mucous. After a telephone consultation, a diagnosis of viral bronchitis was suggested. The patient's condition soon deteriorated and he was transferred urgently to hospital and diagnosed with septicaemia and pneumonia. He developed multi-organ failure and died in hospital shortly afterwards.

An independent expert advisor criticised aspects of the care provided to the patient. However, the condition was rare and had an unusual presentation, which made diagnosis difficult. These factors were compounded by a lack of continuity of care.

The Commissioner referred the matter to mediation, as it was felt that this would provide an appropriate forum in which to discuss the deficiencies in the patient's care that had been identified by the expert advisor, and also an opportunity to negotiate possible improvements in services — and healing and closure for whānau members.

On the day of the mediation, unexpected hurdles threatened to derail the proceedings. The mediator's flight was cancelled at the last moment, and a substitute flight touched down at a less convenient destination. Fortunately, the mediator was able to be collected en route by one of the doctors driving to the mediation. Unfortunately, the doctor's car broke down during the journey. Undaunted, the mediator hitchhiked on (while the doctor remained with his car) until he was met by a driver from the whānau.

The mediation reached a successful settlement, with an agreement that mistakes had been made with the patient's care, and that services would be carefully reviewed on both systemic and individual levels. The medical centre also agreed to provide a private letter of apology to the whānau, and publish a public apology in the local newspaper. In addition, the parties agreed to institute a process for random clinical audits and provide a contribution towards a memorial for the young man.

This case is a good example of a creative mediation resulting in significant quality improvements and resolution for the complainants. It also established a basis for ongoing dialogue between the parties.

work for both organisations, and it was an excellent opportunity to provide training, as well as guidance on the differences between the two agencies.

Complaints Investigated

A total of 116 complaints were resolved after or during an investigation, with 81 investigations ongoing at the end of the year. Once again, good progress was made in improving the timeliness of investigations and, for the first time, no investigation file was aged over two years at 30 June.

During the course of the year, 69% of non-complex investigations were completed within one year of assignment for investigation; 76% were completed within 18 months; and 93% within two years.

The significant drop in the overall age of complaint files means that the investigations team is well placed to further improve the timeliness of investigations in the coming

Table 5: **Complaints investigated**

Complaints investigated[1]	2005/06	2004/05	2003/04
Breach (referred to Director of Proceedings)	17	14	18
Breach (not referred to Director of Proceedings)	42[2]	57	59
No breach	9[3]	24	56
Resolved by mediation	6	7	10
No further action taken	42[4]	70	35
Total	**116**	**172**	**178**

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 38(2).

year. By 30 June 2006, only 5% of open complaint files had been with HDC for longer than 12 months, compared with the start of 2005/06 when 12% of files were more than a year old. Just six years ago, in 2000, 37% of files were older than a year.

Breach of the Code

The purpose of an investigation is, of course, to establish whether or not there has been a breach of the Code. In 59 cases, the Commissioner formed the opinion that a breach of the Code had occurred. This represents 51% of the 116 investigations, and compares to 41% last year.

Many of the cases involved more than one individual provider, and some involved organisations as well. Once again, key themes included inadequate standard of care, poor record-keeping and communication, and failure to give adequate information and gain informed consent.

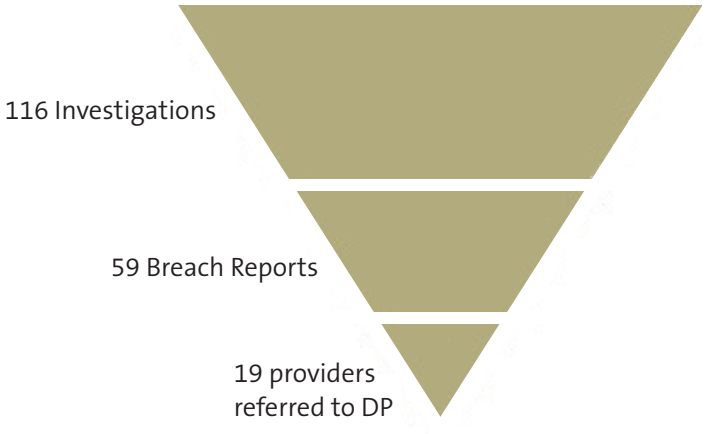
In every case, the Commissioner reported his opinion to the parties and recommended actions such as an apology, and a review of practice by the provider.

Where a registered health professional was investigated, the registration authority was notified at the beginning of the investigation and also informed of the outcome. In a minority of cases, a competence review of the provider was recommended.

Sometimes other specific recommendations have been made (see the Graseby pumps case study on page 37). The Commissioner's recommendations are intended to ensure that lessons are learned from the events, and that steps are taken to prevent similar occurrences. For this reason, copies of the reports are also sent to relevant agencies such as the Ministry of Health and District Health Boards, as well as professional bodies, who are encouraged to share the lessons with their members. Anonymised copies of key opinions are also placed on the HDC website.

In 17 of the 59 cases where the Commissioner formed the opinion that a breach of the Code had occurred, he referred a provider/s to the Director of Proceedings to consider whether further proceedings should be taken. Seventeen individual providers and two group providers were so referred. The referrals represent 32% of breach reports (an increase from 20% last year).

Figure 3: **Outcome of investigations 2005/06**



Mediation Seminar

In May 2005 HDC held a seminar on mediation of health complaints for invited representatives of consumer and provider groups, lawyers and mediators. Speakers included leading US mediation expert Professor Edward Dauer and New Zealand researcher Dr Marie Bismark, together with a consumer and provider who had experienced HDC mediation. Key lessons from the day included the potential for "patient safety mediations" (where learning from individual mediations is disseminated in the sector) and for much greater use of mediation to resolve complaints.

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:

- "My thanks and appreciation to [the investigator] ... for the professional and thorough manner in which he conducted this in depth investigation. His calm and approachable personality helped to relax my staff and myself during the onsite interviewing process and as a result he was easily able to obtain the required information."
- "Your letter was reassuring that ordinary people can expect a level of professionalism in Health Care Professionals in New Zealand. Your letter really meant a lot to me."
- "I would like to thank you and your staff for the consideration taken over our complaint ... The outcome as far as we are concerned is absolutely satisfactory and your department thankfully handled it with tact and diplomacy. We are indeed grateful to you for your care and assistance."
- "I would like to take this opportunity to thank you for your very supportive handling of our recent tragic mix up. I feel that we can now practise medicine with a lot more confidence knowing that our careers are unlikely to be destroyed by a mistake which leads to tragic results. I have no doubt that the new process is going to have a lot of positive advantages in terms of educating everyone and encouraging people to be more open with their errors."

Table 6: **Providers found in breach of the Code and referred to the Director of Proceedings**

	2005/06		2004/05	
Provider	**Breach finding**	**Referred to DP**	**Breach finding**	**Referred to DP**
Anaesthetist	2	0	1	0
Caregiver	2	1	0	0
Counsellor	1	1	1	0
Dentist	3	1	7	5
Dietician	1	0	0	0
ENT specialist/Otolaryngologist	1	0	1	0
General practitioner	22	6	21	1
General surgeon	5	3	6	0
House surgeon	1	0	0	0
Massage therapist	1	0	0	0
Medical officer	3	0	0	0
Midwife	9	1	6	0
Neurosurgeon	1	0	1	0
Nurse	15	3	13	5
Obstetrician/Gynaecologist	5	0	3	0
Occupational therapist	0	0	1	1
Orthopaedic surgeon	2	0	0	0
Other health provider	1	0	1	1
Pharmacist	6	0	7	1
Pharmacy technician	0	0	1	1
Physician	2	0	0	0
Physiotherapist	1	0	0	0
Psychiatrist	1	0	3	2
Psychologist	0	0	1	0
Radiologist	3	0	3	0
Registrar	3	0	2	0
Rest home	5	2	6	2
Rest home manager	0	0	1	0
Urologist	2	1	0	0
Total	**98**	**19**	**86**	**19**

- "The Commission was unique in its ability to obtain a complete perspective of all aspects ... I appreciated the understanding you depicted, impartially, towards all those involved. Nobody deliberately set out to cause harm. I trust that they also appreciate that this case has achieved, in the end, a positive difference. Undoubtedly many people — patients, families and the medical profession — will increase their vigilance and personal responsibility."

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 2005 and 30 April 2006.

Complainant survey results

Sixty-three complainants were surveyed, with a 40% response rate.

- 96% found our staff polite to deal with;
- 88% were satisfied with response times to telephone messages and written communications;
- 93% were satisfied with communication about the process and progress of the investigation;
- 94% found the reasons for the final decision clear;
- 89% found the Commissioner's final decision easy to understand;
- 78% were satisfied that their view was heard in a fair and unbiased way;
- 74% reported being able to move on.

Comments from complainants

- "I thought the Commissioner determined and understood the fairly complex background well and obtained very good technical expertise in order to arrive at a decision."
- "Once you had all relevant information to hand, you acted promptly. Not your fault that there were delays in receiving information."
- "At all times (phone conversations & interviews & letters) we were taken seriously listened to carefully & with courtesy. Importantly my 86-year-old mother was never treated as a nuisance or lacking mental capacity as often happens to the elderly."
- "HDC, as with ACC have all the right processes in motion — maybe simply to keep the complainant happy, but I believe they both need to go one step further, and do more, in my case, instructing my surgeon to alter his ways."
- "Feel the matter was dealt with very well and efficiently. Nothing further would or should have been added."

Individual provider survey results

One hundred and five providers were surveyed, with a 63% response rate.

- 97% found our staff polite to deal with;
- 88% were satisfied with response times to telephone messages and written communications;
- 87% were satisfied with communication about the process and progress of the investigation;
- 88% found the reasons for the final decision clear;
- 89% found the Commissioner's final decision easy to understand;
- 82% were satisfied that their view was heard in a fair and unbiased way.

Comments made by providers

- "You were thorough in investigation. The whole process is educational as clearly I have learnt from gaps in the care & it has been a learning experience for me."
- "The case was reviewed in a neutral manner. The time frame was very stressful and no support given."
- "Dealing with the complaint promptly and investigating the complaint quickly and came to a decision quick as possible and kept up with written communication."
- "You were fair. I have to admit I had not expected this as a first time subject of complaint."
- "Investigated the claim completely. Talking to all those people involved and getting submissions — also asking the right questions."
- "I wonder if matters of professional judgment should be separated from conduct issues."
- "The HDC was very balanced in the way it dealt with complaints raised against me. I felt I was treated fairly and both parties had adequate opportunities to air their view. Like the nice balanced approach."

MAKING A DIFFERENCE — THE OUTCOME OF ONE RECOMMENDATION

The Commissioner received a complaint from the Police on behalf of the family of a woman who died while receiving palliative care at home for end-stage lung cancer.

The woman's death followed the administration of an overdose of morphine by a palliative care nurse. The overdose was not confirmed as the cause of death, and the Police decided that there was not a criminal case to answer, but asked the Commissioner to investigate whether any professional negligence was involved.

The morphine was administered subcutaneously, using a Graseby pump. The Commissioner found that the nurse had inadvertently set the pump to deliver 20mm of diluted medication per hour instead of 2mm per hour. She was found in breach of the Code.

A factor contributing to the error was confusion about the operation of two different types of Graseby pump. There were two in use in the region, a "green" one, which delivered medication at millimetres per 24 hours, and a "blue" pump set at millimetres per hour.

To reduce the risk of error, the Commissioner recommended that where practicable, palliative care services move towards using one type of pump for the administration of subcutaneous medication.

The recommendation was sent to all district health boards, Hospice New Zealand, and the Society of Palliative Medicine. They were subsequently contacted to see what follow-up action they had taken.

Only six of the 21 DHBs reported that they were still using two types of pump, and they were either phasing out one model, or had responded to the recommendation by instituting tighter protocols, new labels, or training to reduce the potential for error.

All DHBs indicated that they had carefully considered the concerns raised by the Commissioner, and had drawn them to the attention of appropriate staff.

The Society of Palliative Medicine supported the Commissioner's recommendation, and Hospice New Zealand advised its members of the risks involved in holding and using different types of the pump. It asked the manufacturer to consider developing a standard pump with a single scale setting. The company, Graseby International, replied that this would be considered as part of its product development process.

The Commissioner's report (05HDC05278) can be viewed on the website at http://www.hdc.org.nz/files/hdc/opinions/05hdc05278nurse.pdf.

District Health Board survey results

Twenty-one DHBs were surveyed, with a 67% response rate.

- 100% found our staff polite to deal with;
- 92% were satisfied with response times to telephone messages and written communications;
- 100% were satisfied that the quarterly complaint status report kept the DHB satisfactorily informed on all HDC complaints within their service.

Comments made by DHBs

- "Nothing! Keep up the good work."
- "Not aware of anything. Thanks for the great work done by the HDC office in promoting a stronger customer focus in the health sector."
- "Having investigators available for informal discussions about difficult cases."
- "It would be good if HDC could provide an annual seminar to present to the sector learnings arising from complaints received, and sector responses made, during the past year."

Summary

The figures represent an extremely busy year in complaints resolution, with tremendous progress in meeting internal and external targets to ensure that HDC delivers the "fair, simple, speedy, and efficient resolution of complaints". The challenge for the new year is to continue to improve the quality of the complaints resolution work, as well as the timeliness of our investigations.

Investigations Team

Back row from left: Matthew Pitt, David Scott (Senior Investigator), Mark Evans (Investigations Manager), Jeane Mackay, Tracy Vela (Investigations Secretary).

Front row from left: Kanny Ooi, Nikki Deveraux, Wendy Vonlanthen, Claire Campbell (Senior Investigator).

COMPLAINT RESOLUTION THROUGH COLLABORATIVE EDUCATIVE MEANS

A mother complained about the treatment her 16-year-old son, B, received when he attended an Accident and Medical Clinic. He was feeling unwell and was limping, with a painful and swollen toe and ball of his foot. The patient's mother felt that he had been bitten by a spider. The affected area was white and surrounded by a much larger red and heated area.

B saw four different GPs, and a number of possible diagnoses were explored, including gout and arthritis. The doctors were dismissive of Mrs B's assertion that her son had been bitten by a spider, and some of the providers contacted were unaware that there were poisonous spiders in New Zealand. When Mrs B wrote to HDC, B was still unable to play sport, and his family remained unsure about what had caused his health problems. The lapse in time also meant that it was too late to administer any antivenom. Part of the complainant's motivation for the complaint was her wish that education on venomous fauna in New Zealand be distributed widely.

The Clinical Director of the clinic responded to the family's complaint by sending out educational material on indigenous venomous fauna (such as poisonous spiders) in the clinic's bulletin, which is distributed to locum doctors and shareholding GPs in the clinic region.

The Commissioner's clinical advisor reviewed B's care and the provider responses. Both he and the Commissioner agreed that the family's concerns were valid. They noted that a doctor has a duty of care to seek out correct information for a patient, and should contact a knowledgeable colleague for advice where there is uncertainty. Although a spider bite as the cause of B's symptoms remained speculative, the symptoms were consistent with that possibility, and the GPs should have sourced accurate information from either the local hospital emergency department or the National Poisons Centre.

The Commissioner considered that the complaint highlighted important issues and provided opportunities for learning. He wrote to the Clinical Director, drawing attention to a Ministry of Health pamphlet on venomous spiders in New Zealand (Code 1424). He also requested a copy of the material produced and circulated in the clinic region.

In addition, the Commissioner sent anonymised details of the complaint to the Medical Council of New Zealand, the Royal New Zealand College of General Practitioners, the New Zealand Faculty of the Australasian College for Emergency Medicine, and the New Zealand Accident and Medical Practitioners Association (AMPA), requesting that they update him as to their current knowledge, awareness, and training practices regarding venomous spiders in New Zealand, and the treatment of bites, and consider producing new educational material and articles.

The following educational outcomes occurred as a result of the complaint:

- the New Zealand Faculty of the Australasian College for Emergency Medicine wrote to the Commissioner outlining the knowledge about management of venomous bites and stings that trainees and fellows are required to possess;
- anonymised details of the decision were placed on the AMPA website;
- an article on spider bites was produced for the *Journal of the Accident and Medical Practitioners Association* (JAMPA) (Vol. 3 (No. 1) 2006); and
- an article on managing spider bites appeared in the November/December 2005 issue of the RNZCGP *Pulse* magazine.

LEGAL SERVICES

Overview

2005/06 was a busy and productive year for Legal Services. I would like to thank the legal team for their professionalism and commitment over this period. The year brought change. Roles within the team were reviewed, resulting in the promotion of the Legal Manager to Chief Legal Advisor. Two legal advisors, Tina Mitchell and Sarah Graydon, were promoted to senior legal advisor roles to assist with the management of legal files. The year also marked the departure of some longstanding and highly regarded members of the team — in particular, Denise Brett, Senior Legal Advisor, and Helen Davidson, Legal Advisor.

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

The changes to the ACC scheme, the abolishment of personal injury by medical misadventure as a basis for ACC cover, and replacement of treatment injury came into effect on 1 July 2005. The legal team has participated in meetings with ACC and other stakeholders in relation to the implementation of the ACC guidelines for reporting the risk of harm.

The legal team also led the development of an information-sharing agreement between the Commissioner and the Dental Council, a protocol on the interface between the Director of Advocacy, the Director of Proceedings and the Health and Disability Commissioner, and a charter of legal services for internal guidance. Internal clients were surveyed on the quality of our services. Feedback indicated that legal advice was timely, relevant, concise, and of a high quality.

Complaints Resolution

The legal team continues its involvement in complaints resolution work, providing advice, and liaising with consumers, providers, expert advisors, and external organisations. Legal advisors assumed responsibility for managing a number of complex complaint files.

From time to time, complainants or providers may contact the Commissioner's Office with concerns about the Commissioner's decision on a complaint. Such concerns may be about the accuracy, outcome or fairness of the decision. The legal team considers such requests, obtains further information, and advises the Commissioner on what action is appropriate — for example, whether the file should be reopened, or whether aspects of the decision or the Commissioner's process need to be explained to the person who has raised the concern. The closed-file review policy was reviewed and updated during the year to clarify the process for reviewing the Commissioner's preliminary assessment decisions. It remains relatively rare for files to be reopened.

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 yet important aspect of the legal division's workload.

Before proceeding to investigate a complaint, the Commissioner notifies the relevant parties of the details of the complaint (which usually involves sending a copy of the complaint) and the subject matter of the investigation. It is the Commissioner's usual policy not to release further information in the initial investigatory stage (for example, witness statements), as to do so may allow an individual to tailor his or her response and so compromise the fair, simple, speedy, and efficient resolution of the complaint. This view is consistent with the Privacy Commissioner's decision in *Commissioner of Police v Ombudsman* [1988] 1 NZLR 385.

Prosecution

This year saw a further prosecution taken by the Commissioner under section 73 of the Health and Disability Commissioner Act. The prosecution related to a psychiatrist who was under investigation and refused to provide required information.

It is regrettable that a small number of providers 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. Only one protected disclosure was received this year. It related to the workload of nurses in a ward of a hospital, and the impact of that workload on medication errors, the standard of documentation and incident reporting. Three ongoing protected disclosures were also dealt with. Of these, two involved mental health service providers, and one related to radiology services. As at 30 June 2006, there were no ongoing protected disclosures.

Ombudsmen Investigations

During 2005/06, 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. Most of the complaints were resolved following clarification and referral back to the Commissioner's Office by the Chief Ombudsman or the Privacy Commissioner.

The Chief Ombudsman considered a complaint from a consumer about the Commissioner's decision to take no action on the consumer's complaint about a medical practitioner when ACC had found there had been a medical error. The Commissioner's decision had been made on the basis that the amount of time that had elapsed would make an investigation impracticable, and because there were no public safety issues that required investigation. The Chief Ombudsman concluded that the HDC decision-making process was fair and that the decision not to investigate was reasonable.

Submissions

One of the functions of the Health and Disability Commissioner is to make public statements in relation to any matter affecting the rights of health and disability services consumers. During the year, the legal team drafted submissions on a range of policy documents and proposed legislation relating to health and disability issues. In total, 47 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.

Financial Commentary

Funding

The Office is funded from Vote Health. Funding increased from $6,948,444 to $7,214,222 (excluding GST) for this year. A funding increase of $339,778 has been approved for the year ended 30 June 2007.

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 $195,745 and investments totalled $2,070,000 at 30 June 2006.

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 2005/06 was $72,329 offset by production costs.

Operating Surplus

In 2005/06 the Office budgeted for a deficit of $267,754 and made a surplus of $102,000.

Expenditure by Type

Expenditure is summarised by significant categories below. Service contracts, staff costs and occupancy costs (collectively 79.6% of total expenditure in 2005/06) largely represent committed expenditure. Much of the remaining 20.4% (or $1.51 million) is discretionary.

	05/06		04/05	
	$000	%	$000	%
Service contracts	2,125	28.8	2,012	28.6
Audit fees	12	0.1	12	0.2
Staff costs	3,327	45.1	3,376	47.9
Travel & accommodation	195	2.6	168	2.4
Depreciation	181	2.5	218	3.1
Occupancy	420	5.7	371	5.2
Communications	551	7.5	453	6.4
Operating costs	569	7.7	437	6.2
Total	**7,380**	**100.0**	**7,047**	**100.0**

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 2005/2006 ($000s)**

- Complaints Resolution* $3,038 (41%)
- Advocacy $2,431 (33%)
- Proceedings $745 (10%)
- Policy $528 (7%)
- Education $638 (9%)

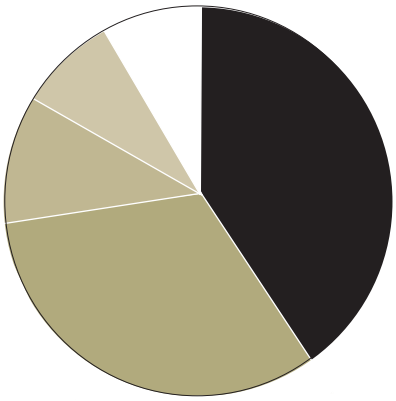
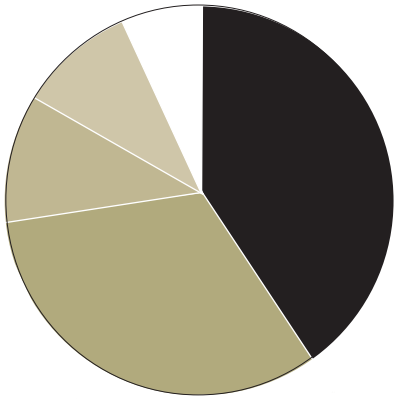


Figure 2: **Expenditure by output 2004/2005 ($000s)**

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



Expenditure on Complaints Resolution was $3.038 million ($2,885 in 04/05). Spending on Advocacy was $2,431 ($2,326 in 04/05). Outputs consumed very similar resources year on year. The Office continued to look for efficiencies in all areas.

2006/2007

For the coming year the Office has budgeted for a deficit of $258,042.

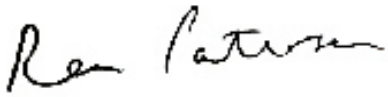
*In previous years this output was called “Investigations”.

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 2006.



Ron Paterson
Commissioner

Tania Thomas
Deputy Commissioner —
Education and Corporate Services

6 October 2006

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

AUDIT REPORT

TO THE READERS OF THE HEALTH AND DISABILITY COMMISSIONER'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2006

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, John Scott, 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 2006.

Unqualified Opinion

In our opinion the financial statements of the Health and Disability Commissioner on pages 46 to 66:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health and Disability Commissioner's financial position as at 30 June 2006;
  - 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 6 October 2006, 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 2006. 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.

John Scott
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 2006 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 6 October 2006 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) *Property, Plant & Equipment*
Property, plant & equipment are stated at their historical cost less accumulated depreciation.

(c) *Depreciation*

Property, plant & equipment 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) *Sundry Debtors*
Sundry debtors are stated at their estimated net realisable value after providing for doubtful and uncollectable debts.

(f) *Inventory*
Inventory is valued on a FIFO basis at the lower of cost or net realisable value. Inventory is the brochures and publications HDC distributes to the public or sells to health service providers.

(g) *Operating 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/special 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. An additional policy per New Zealand International Reporting Standards (NZIFRS) re special leave accrual has been adopted. All policies have been applied on a basis consistent with the prior period.

STATEMENT OF FINANCIAL PERFORMANCE for the year ended 30 June 2006

Actual 2004/2005		Note	Actual 2005/2006	Budget 2005/2006
	Revenue			
$6,948,444	Operating Grant Received		$7,214,222	$7,214,222
$152,080	Interest Received		$195,744	$60,000
$73,038	Publications Revenue		$72,329	$60,000
$7,173,562	**Total Operating Revenue**		**$7,482,295**	**$7,334,222**
	Less Expenses			
$2,012,233	Advocacy Service Contracts		$2,124,645	$2,107,386
$11,500	Audit Fees		$12,000	$9,000
$3,376,232	Staff Costs		$3,327,046	$3,339,287
$168,207	Travel & Accommodation		$195,254	$150,635
$217,638	Depreciation	**4**	$181,381	$180,689
$370,675	Occupancy		$419,748	$456,397
$452,721	Communications		$551,546	$727,587
$437,330	Operating Costs		$568,675	$630,995
$7,046,536	**Total Operating Expenses**		**$7,380,295**	**$7,601,976**
$127,026	**Net Surplus/(Deficit)**		**$102,000**	**($267,754)**

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

STATEMENT OF FINANCIAL POSITION as at 30 June 2006

Actual 2004/2005		Note	Actual 2005/2006	Budget 2005/2006
	Crown Equity			
$875,523	Accumulated Funds	1	$977,523	$209,100
$788,000	Capital Contributed		$788,000	$788,000
$1,663,523	**Total Crown Equity**		**$1,765,523**	**$997,100**
	Represented by Current Assets			
$34,879	Bank Account		$19,913	$51,000
$1,690,000	Call Deposits		$2,070,000	$456,793
$17,055	Prepayments		$19,249	$0
$17,791	Inventory		$14,665	$0
$96,524	Sundry Debtors		$39,127	$2,000
$1,856,249	**Total Current Assets**		**$2,162,954**	**$509,793**
	Non Current Assets			
$370,251	Property, Plant & Equipment	3	$493,246	$593,316
$370,251	**Total Non Current Assets**		**$493,246**	**$593,316**
$2,226,500	**Total Assets**		**$2,656,200**	**$1,103,109**
	Current Liabilities			
$59,635	GST Payable		$21,000	$0
$503,342	Sundry Creditors	2	$869,677	$106,009
$562,977	**Total Liabilities**		**$890,677**	**$106,009**
$1,663,523	**Net Assets**		**$1,765,523**	**$997,100**

Ron Paterson
Commissioner

Tania Thomas
Deputy Commissioner —
Education and Corporate Services

6 October 2006

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 2006

Actual 2004/2005		Actual 2005/2006	Budget 2005/2006
$1,536,497	Opening Equity 1 July 2005	$1,663,523	$1,264,854
$127,026	Plus Net Surplus/(Deficit) (Total Net Recognised Revenues and Expenses)	$102,000	($267,754)
$1,663,523	**Closing Equity 30 June 2006**	**1,765,523**	**$997,100**

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

Actual 2004/2005		Note	Actual 2005/2006	Budget 2005/2006
	Cash Flow from Operating Activities			
	Cash was provided from:			
$6,948,444	Operating Grant		$7,214,222	$7,214,222
$147,142	Interest on Short-term Deposits		$196,025	$60,000
$27,329	Revenue		$123,100	$60,000
$7,122,915			$7,533,347	$7,334,222
	Cash was applied to:			
($6,706,149)	Payments to Suppliers and Employees		($6,863,938)	($7,453,799)
$416,766	**Net Cash Flow from Operating Activities**	**5**	**$669,409**	**($119,577)**
	Cash Flow from Investing Activities			
	Cash was provided from:			
$0	Sale of Fixed Assets		$1,246	$0
	Cash was applied to:			
($53,290)	Purchase of Fixed Assets		($305,621)	($300,000)
($53,290)	**Net Cash Flow from Investing Activities**		**($304,375)**	**($300,000)**
$363,476	**Net Increase/(Decrease) in Cash**		**$365,034**	**($419,577)**
$1,361,403	Cash Brought Forward		$1,724,879	$926,370
$1,724,879	**Closing Cash Carried Forward**		**$2,089,913**	**$506,793**
	Cash Balances in the Statement of Financial Position			
$34,879	Bank Account		$19,913	$50,000
$1,690,000	Call Deposits		$2,070,000	$456,793
$1,724,879			**$2,089,913**	**$506,793**

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

Actual 2004/2005	Note		Actual 2005/2006
	1	**Accumulated Funds**	
$748,497		Opening Balance	$875,523
$127,026		Net Surplus	$102,000
$875,523		**Closing Balance**	**$977,523**
	2	**Sundry Creditors**	
$280,713		Trade Creditors and Accruals	$516,253
$72,480		PAYE	$68,056
$150,149		Annual Leave	$285,368
$503,342			**$869,677**

3 Property, Plant & Equipment

2005/2006	Cost	Accum Depn	Net Book Value
Computer Hardware	$631,273	$556,333	$74,940
Computer Software	$521,147	$389,738	$131,409
Communications Equipment	$26,723	$26,723	$0
Furniture & Fittings	$211,795	$189,671	$22,124
Leasehold Improvements	$606,536	$391,533	$215,003
Motor Vehicles	$42,280	$42,280	$0
Office Equipment	$162,807	$113,037	$49,770
Total Property, Plant & Equipment	**$2,202,561**	**$1,709,315**	**$493,246**

2004/2005			
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 Property, Plant & Equipment	**$1,926,197**	**$1,555,948**	**$370,251**

Actual 2004/2005	Note			Actual 2005/2006
	4	**Depreciation**		
$84,870		Computer Hardware		$68,132
$22,052		Computer Software		$10,731
$0		Communications Equipment		$0
$10,309		Furniture & Fittings		$10,141
$79,018		Leasehold Improvements		$74,705
$21,389		Office Equipment		$17,672
$217,638				**$181,381**

	5	**Reconciliation between Net Cash Flow from Operating Activities and Net Surplus/(Deficit)**		
$127,026		Net Surplus		$102,000
		Add Non-cash items:		
$217,638		Depreciation		$181,381
		Movements in Working Capital Items		
$135,384		Increase in Sundry Creditors	$372,680	
$1,016		Increase/(Decrease) in GST Payable	($38,634)	
$3,179		Decrease in Inventory	$3,125	
($51,423)		(Increase)/Decrease in Sundry Debtors	$50,771	
($11,117)		Increase in Prepayments	($2,194)	
($4,937)		(Increase)/Decrease in Interest Receivable	$280	
$72,102				$386,028
$416,766		**Net Cash Flow from Operating Activities**		**$669,409**

6 Commitments

(a) Advocacy Service contracts:

The maximum commitment for the 12 months from 1 July 2006 is $2,603,900.

(b) Premises Leases including leasehold improvements:

Auckland	$285,911 per annum until May 2008
Wellington	$88,000 per annum until April 2009

Actual 2004/2005	Note		Actual 2005/2006
	6	(c) Classification of Commitments	
$2,341,811		Less than one year	$2,981,345
$285,911		One to two years	$353,324
$285,911		Two to five years	$66,589
$0		Over five years	$0
$2,913,633			**$3,401,258**

7 Contingent Liabilities

As at 30 June 2006 there were no contingent liabilities (04/05 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:

$1,724,879	Bank balances	$2,089,913
$96,524	Sundry Debtors	$39,127
$17,791	Inventory	$14,665
$17,055	Prepayment	$19,249
$1,856,249		**$2,162,954**

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 7.2% (2005: 6.9%).

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 $7,214,222 (2005: $6,948,444) (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	
	2004/2005	2005/2006
$100–110,000	1	1
$110–120,000	0	1
$120–130,000	1	1
$140–150,000	1	1
$200–210,000	1	0
$210–220,000	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 $210,000 to $220,000 band.

11 Severance/Redundancy Payments

As part of an organisational review of the Commissioner, six redundancy payments were made in the year 1 July 2005 to 30 June 2006 totalling $46,603.

12 Indemnity Insurance

The Commissioner's insurance policy covers public liability of $19 million. Public liability includes cover for all amounts that the Commissioner becomes legally liable to pay as a direct compensation resulting from personal injury or damage to property, caused by an occurrence in connection with the organisation's operation. This also covers:

- General & Product Liability
- Association Liability
- Statutory & Employers Liability
- Landlord & Tennant Liability
- Plant & Machinery & Contents Liability
- Employee Personal Liability

Output Class 1: Service Delivery

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

- A nationwide, independent advocacy service promotes and educates consumers about their rights, and providers about their responsibilities, and assists consumers unhappy with health or disability services to resolve complaints about alleged breaches of the Code of Health and Disability Services Consumers' Rights, at the lowest appropriate level.
- The Commissioner responds to enquiries.
- The Commissioner assesses and resolves complaints.
- The independent Director of Proceedings initiates proceedings against providers.
- The Commissioner promotes and educates consumers, providers, professional bodies and funders about the provisions of the Code of Health and Disability Services Consumers' Rights.
- The Commissioner provides policy advice on matters related to the Code of Health and Disability Services Consumers' Rights and legislation that affects the rights of health and disability services consumers.

Output 1: Advocacy

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Enquiries managed: 7,400	30 June 2006	Target achieved 8,649 (117%).
2.	Complaints managed: 4,550	30 June 2006	Target achieved 4,611 (101%).
3.	Education sessions: 1,400	30 June 2006	Target achieved 1,558 (111%).
4.	Networking contacts: 1,500	30 June 2006	Target achieved 2,094 (140%).
5.	Deliver independent, high quality, consistent nationwide services to consumers during 2005/06, with 70% of complaints resolved or partly resolved with advocacy, 80% of a random sample of consumers satisfied with advocacy services, and 80% of a random sample of providers satisfied with the advocacy process and the professionalism of advocates.	30 June 2006	Targets achieved. On average, 88% of complaints resolved or partially resolved. 80% of consumers satisfied with advocacy services. 84% of providers satisfied with advocacy process and professionalism of advocates.
6.	Deliver high quality, consistent educational programmes to consumer groups and providers during 2005/06, with 80% of consumers and providers participating in presentations and educational sessions reporting satisfaction with quality of content and delivery.	30 June 2006	Target achieved (89%).

Output 2: Complaints Resolution

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Estimated 5,000 enquiries handled in 2005/06.	30 June 2006	5,099 enquiries handled.
2.	Estimated 180 enquiries requiring written responses handled in 2005/06.	30 June 2006	174 written responses handled.
3.	90% of enquiries closed on day received.	30 June 2006	Target achieved (94%).
4.	85% of enquiries requiring written responses closed within one month of receipt.	30 June 2006	81% of written responses closed within one month of receipt. A number of more complex enquiries required follow-up and therefore took longer than one month.
5.	Estimated 1,150 new complaints received in 2005/06.	30 June 2006	1,076 new complaints received.
6.	Estimated 1,200 complaints finalised in 2005/06.	30 June 2006	1,110 complaints finalised.
7.	90% of all complaints finalised within 12 months of receipt.	30 June 2006	Target achieved (93%).
8.	95% of all complaints finalised within 18 months of receipt.	30 June 2006	Target achieved (97%).
9.	100% of all complaints finalised within 2 years of receipt.	30 June 2006	99% of all complaints finalised within 2 years of receipt. Older investigation files were a priority, but two very complex investigations involving multiple parties took longer than expected to progress.
	For complaints not investigated		
10.	90% finalised within 6 months of receipt.	30 June 2006	Target achieved (93%).
	For complaints that are investigated		
11.	90% of non-complex investigations finalised within 12 months of assignment for investigation.	30 June 2006	Target not achieved (69%) as closing of older files took priority. Minister agreed to new target of 50% in quarter 3.
12.	90% of all investigations finalised within 18 months of assignment for investigation.	30 June 2006	Target not achieved (76%) — see explanation above. Target revised to 70% in quarter 3.
13.	100% of all investigations finalised within 2 years of assignment for investigation.	30 June 2006	93% of investigations finalised. Prioritising the conclusion of older files, and two very complex files, contributed to this result. Target revised to 95% in quarter 3.

Output 2: Complaints Resolution (continued)

	Performance Measure	Target Date	Actual
	Quality		
1.	85% of recipients of written responses surveyed are satisfied with the quality, relevance and helpfulness of the responses received.	30 June 2006	Target achieved (86%). (101 people surveyed, 42% (42) responded.)
2.	60% of complainants surveyed are satisfied with the fairness of the complaints resolution process.	30 June 2006	Target achieved (78%).
3.	60% of providers surveyed are satisfied with the fairness of the complaints resolution process.	30 June 2006	Target achieved (82%).

Output 3: Education and Promotion

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Deliver estimated 300,000 units of educational material.	30 June 2006	Target achieved (129%).
2.	Complete a satisfaction survey of website users accessing educational information and resources.	30 June 2006	Survey completed.
3.	Implement year 1 of external stakeholders' education plan.	30 June 2006	Completion of 14 out of 15 objectives within the plan achieved.
	Quality		
1.	100% of educational material orders dispatched within 5 working days of receipt of order form.	30 June 2006	99% of orders dispatched within 5 working days.
2.	80% of website users find the educational information and resources useful.	31 January 2006	92% of website users who responded to survey found the educational information and resources useful.
3.	100% of external stakeholder education plan implemented by agreed due dates.	30 June 2006	93% of annual target achieved. One remaining objective only partially completed owing to staffing shortage.
4.	80% of participants attending HDC seminars, educational sessions and presentations satisfied with content, relevance and delivery of session.	30 June 2006	Target achieved (97%).

Output 4: Proceedings

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Decide in a timely manner whether or not to issue proceedings.	30 June 2006	Target achieved (100%).
2.	Deliver high quality and fair proceedings throughout the process.	30 June 2006	Survey results confirm high quality and fair proceedings.
	Quality		
1.	100% of decisions on referral made within 8 weeks of receipt of file from Commissioner or further relevant information.	30 June 2006	Target achieved (100%).
2.	100% of tribunals satisfied that proceedings are of high quality.	30 June 2006	In 83% of all answers, expectations either fully met or exceeded. Expectations mostly met in remaining 17%.
3.	100% of consumers, providers and counsel for the provider offered an opportunity to provide feedback to the Director of Proceedings on the proceedings process.	30 June 2006	93% of consumers offered an opportunity to provide feedback to Director of Proceedings. (1 consumer not sent survey as terminally ill.) 60% of contactable providers offered opportunity to provide feedback. 100% of counsel for the provider offered opportunity to provide feedback to Director of Proceedings.
4.	100% of disciplinary charges or HRRT proceedings filed within 6 weeks of decision.	30 June 2006	87% achieved. Remaining 13% (2 cases) filed within 2 days after deadline.

Output 5: Policy Advice

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Estimated 40 submissions will be made in 2005/06.	30 June 2006	Target achieved (117%).
	Quality		
1.	100% of people receiving our submissions and policy advice rate satisfaction with high quality and relevance of our work.	30 June 2006	Target achieved (100%).
2.	100% of policy advice meets deadline set for submission.	30 June 2006	96% deadlines achieved. Two submissions did not meet deadline. In each instance the submission was late by only 3 days.

Output Class 2: Ownership Performance

HDC will continue to build capability and robust systems that meet our needs, are easy to use, and will assist us to carry out our work in a thorough and consistent manner across the following areas:

- Financial planning, monitoring and management.
- Information systems and technology management.
- Knowledge management.
- Human resources management.
- Legal services.
- Corporate support, for example, HDC's Implementation Plan for the New Zealand Disability Strategy and the work it does in increasing internal capability to work alongside Māori.

Output 1: Financial Management

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Maintain or improve grading in each area of Financial Service Performance Management in Audit New Zealand's 2005/06 Audit Report.	30 June 2006	Target achieved.
2.	Complete development and implementation of systems and documentation recommended in the 2004/05 Audit Report.	31 March 2006	Achieved. There were no items of significance raised at the end of the audit process.
3.	Revise HDC Finance Policy Manual.	30 September 2005	Finance Policy Manual revised.
	Quality		
1.	Grading maintained or improved.	18 December 2005	Target achieved; grading maintained.
2.	Documentation completed.	18 December 2005	Formal sign-off on management letter from auditor achieved.
3.	Revised Finance Policy Manual reviewed by Audit New Zealand.	18 December 2005	Achieved.

Output 2: Information Systems Management

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Implement year 2 of the Information Systems Strategic Plan (ISSP).	30 June 2006	Partially achieved. Case management system implementation delayed in order to find most appropriate system.
2.	Implement an Information Systems (IS) Service Level Agreement to guage effectiveness of HDC's maintenance and IS solutions programme.	30 June 2006	The service level agreement applies mainly to the new case management system, which has not yet been implemented.
	Quality		
1.	100% of year 2 ISSP implementation completed.	30 June 2006	Partially achieved.
2.	100% of users satisfied with implementation process.	30 June 2006	Implementation of new case management system did not occur; therefore users not yet surveyed.
3.	IS services achieves average rating of 6 on scale of 1–7 for services provided under service level agreement.	30 June 2006	Service level agreement not implemented. In process of completing needs analysis for new case management system.

Output 3: Knowledge Management

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Refine and implement year 1 of the Knowledge Management Strategic Plan.	30 June 2006	Partially achieved. Document management system implementation delayed.
2.	Revise HDC's brand profile (this includes the range of brochures, videos, booklets, CDs, posters, pocket cards and reports produced by HDC) and implement approved recommendations.	20 December 2006	Target achieved end of quarter 4.
3.	Develop and implement an external Communications Plan.	30 June 2006	Target achieved.

Output 3: Knowledge Management (continued)

	Performance Measure	Target Date	Actual
	Quality		
1.	100% of year 1 of Knowledge Management Strategy implemented.	30 June 2006	4 of 5 year 1 Knowledge Management Strategy objectives completed — 80% of annual target achieved.
2.	90% of website users satisfied with accessibility, content and ease of navigation on HDC's website.	30 June 2006	Survey to be implemented following launch of re-designed website.
3.	Approved branding recommendations implemented.	30 June 2006	Target achieved.
4.	Agreed recommendations from external Communications Plan implemented.	30 June 2006	No recommendations agreed as a result of the plan.

Output 4: Human Resources Management

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Implement year 1 of HDC's Capability Framework Plan.	30 June 2006	Target achieved (100%).
2.	Complete a staff survey to identify the level of satisfaction with the Capability Framework implementation.	31 March 2006	Survey not conducted as staff gave direct feedback via staff meetings and sought increased consultation on matters relating to competency framework, staff learning and development and matters pertaining to remuneration.
3.	Develop and implement an internal Communications Plan.	30 September 2005	Target achieved by quarter 3.
4.	Identify and implement processes to foster desired organisational culture.	30 June 2006	Target achieved.
5.	Define quality standards and develop benchmarks for workload management.	30 June 2006	Target partially achieved. A comparable data format for the purpose of benchmarking has been implemented with the Council of Australasian Healthcare Commissioners.

Output 4: Human Resources Management (continued)

	Performance Measure	Target Date	Actual
	Quality		
1.	Year 1 of the Capability Framework implemented by due dates.	30 June 2006	Target achieved.
2.	Implement agreed priority recommendations from the staff satisfaction survey on implementation of Capability Framework.	30 June 2006	Suvey not conducted as feedback from staff was given without the need for the survey.
3.	Managers, in consultation with staff, report at half-yearly management meetings an average rating of 6, on a scale 1–7, for the ease, timeliness and helpfulness of communication internally.	30 June 2006	A formal consultation process has not taken place. Despite this, feedback from staff on internal communication matters continues to be regular and constructive.
4.	Staff on-line survey rates 80% satisfaction with processes implemented to foster desired organisational culture.	30 June 2006	Survey has been deferred and will be completed in the 2006/07 year.

Output 5: Legal Services

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	100% compliance with agreed complaints resolution deadlines for responding to legal advice requests.	30 June 2006	90% compliance at year end.
	Quality		
1.	HDC's staff using legal services satisfied with quality of work.	30 June 2006	98% satisfaction with quality and relevance of advice.

Output 6: Corporate Support

	Performance Measure	Target Date	Actual
	Deliverables/Quantity		
1.	Develop strategic planning process that is inclusive of key stakeholder input.	20 September 2005	Target achieved.
2.	Complete Strategic Plan.	30 October 2005	Target achieved.
3.	Facilitate 6 inter-agency meetings.	30 June 2006	Target achieved
4.	Achieve quarterly and annual reporting deadlines.	30 June 2006	Target achieved.
5.	Implement year 2 of HDC's New Zealand Disability Strategy Implementation Plan.	30 June 2006	Target mostly achieved. More work to be completed on access to information.
6.	Implement HDC's revised Māori Initiatives Plan (based on the priorities identified in 2004/05).	30 June 2006	Target achieved.
7.	Facilitate 3 Consumer Advisory Group (CAG) meetings in 2005/06.	30 June 2006	Target achieved.
	Quality		
1.	90% of participants in strategic planning process satisfied with the process.	30 June 2006	No survey undertaken as response to HDC's invitation to participate in planning process low. Valuable information gained on how to better engage more people in process at review stage in 2007/08.
2.	Identify and implement 3 inter-agency joint initiatives that will benefit HDC.	30 June 2006	Target achieved — 3 joint initiatives in progress including signed Memorandum of Understanding with Mental Health Commission as leading agency on Multi Agency Plan.
3.	Six-monthly feedback from the Ministry of Health sought on adequacy of HDC's reporting.	30 June 2006	Target achieved.
4.	HDC's New Zealand Disability Strategy Implementation Plan reviewed by Office for Disability Issues.	30 June 2006	Target achieved.
5.	Formal, regular contact with Iwi in the main centres of New Zealand is established.	30 June 2006	Signing of 4 Iwi Memoranda of Understanding pending. Delay in sign-off owing to loss of HDC's kaumātua, Te Ao Pehi Kara, who passed away in March 2006.

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