HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Pūrongo ā-Tau
Annual Report

mō te tau mutunga o te 30 Hune 2022
for the year ended 30 June 2022

Kotahi te kākano, he nui ngā hua o te rākau.

A tree comes from one seed and bears many fruit.

Ngā kaupapa
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Kupu whakataki a te Kaikōmihana Commissioner's foreword

Morag McDowell
Health and Disability Commissioner

He hōnore, he korōria
He maungārongo ki te whenua
He whakāro pai ki ngā tangata katoa
E ngā taonga huhua o te wā
Haere koutou, haere koutou,
Wakangaro atu raa.
E te iwi nui tonu
He mihi aroha ki a koutou katoa
Tēnā koutou, tēnā koutou, tēnā koutou katoa.

I am pleased to present the Health and Disability Commissioner's annual report for 2021/22. Not unexpectedly, this year was again dominated by the pandemic and its impact on the health and disability sector and our community.

These impacts have reverberated in my own office — reflected in an unprecedented 25% increase in the number of complaints from the previous year, and a trend consistent with the experience of complaints agencies internationally. Whilst the increased volume of work is itself significant, the diverse nature of COVID-19 complaints, particularly following the vaccination rollout, required close, day-to-day management as HDC formulated its approach to the often unique scenarios presented. I owe a debt of gratitude to my amazing team, who, despite the pressures, resolved 2,627 complaints for the year (including 121 investigations) — a 9% increase of closures from the previous year. Working in a complaints environment can be tough at the best of times, and I acknowledge the team's hard mahi, resilience and professionalism during this extraordinary year. Ngā mihi nui e te whānau.

At the start of the year we refreshed our strategic vision, which resulted in six areas of strategic focus, and associated workstreams. A critical value is to honour Te Tiriti o Waitangi in everything we do, with a view to increasing our internal cultural knowledge and competence of te reo and tikanga, strengthening our ability to recognise and respond effectively and appropriately to Māori complainants and complaints with a cultural dimension, and focusing on improving health outcomes for Māori in the health and disability system. To help us in that journey we welcomed Ikimoke Tamaki-Takarei (Waikato, Tainui) as our Kaitohu Mātāmua Māori (Director Māori) in May. He has already had an impact on our internal culture, and has initiated hui ā whānau (family meetings) with some of our existing complainants to better identify their needs in the resolution of their complaints. It's exciting to see

the opportunities presented by introducing a more flexible range of culturally appropriate processes, and the potential for their broader application in complaints resolution.

In 2021, the government announced its commitment to the establishment of an Aged Care Commissioner within HDC with a focus on advocating on behalf of older people and their whānau for better services in the health and disability system and providing strategic oversight and leadership to drive quality improvement in the aged-care sector. I was therefore pleased to announce the appointment of Carolyn Cooper, who joined us in March as Aotearoa New Zealand's first Aged Care Commissioner. Carolyn has spent the first part of her tenure establishing a designated team within HDC, including complaints assessors, investigators, principal advisors and cultural advisors. She also embarked on significant stakeholder engagement and, importantly, has been speaking to the sector on the serious issues associated with workforce shortages in aged residential care and home and community support services.

I am also very pleased to report the appointment of two new Deputy Commissioners this past year, Deborah James and Dr Vanessa Caldwell, which finally brought HDC to a full complement of statutory decision-makers, and a new Director of Advocacy, Tayyaba Khan. These key appointments have embedded strong leadership within the organisation.

Regrettably, despite best efforts, we have not been able to meet our timeliness targets, and there is a concerning growth of cases on hand. This is in no small part due to extraordinary growth of complaints volume these past two years, and other environmental context. HDC has not been immune to the impacts of the employee market, and, like many other businesses, we have had to grapple with the impact of the pandemic. In addition, the findings and recommendations of an Ombudsman report released in December 2020, which was critical of HDC's processes, saw an appropriate reconsideration of the threshold for referral of cases to our investigations team. This, together with the growing complexity and seriousness of complaints, has resulted in an increased number of investigations.

We are tackling these challenges head-on, although there is no quick solution, and we need to be both realistic and transparent about ongoing delay in our system. We have established two small, partly fixed-term teams in both our investigations and complaints assessment areas, with a focus on older complaints. In addition, we have trialled a number of process re-design changes (including, for example, looking to fast track investigations, and a modified triaging of new complaints), which have had some positive outcomes. We are continually looking for ways to improve our processes with a view to making them more efficient, but also more people-centred with a focus on early resolution. In this latter respect, the National Advocacy Service plays a valuable role, and many of our educational initiatives with providers have sought to reinforce the importance of them having effective in-house complaints resolution processes.

In addition to our complaints focus, we have sought to lend our voice, as the watchdog for consumers' rights, to various quality and safety

mechanisms. HDC is a member of the National Quality Forum (run by the Health Quality & Safety Commission), the Surgical Mesh Roundtable, the National Safer Prescribing and Dispensing hui, and the Mental Health and Addictions Multi-Agency Group. We routinely draw matters affecting consumers' rights to the attention of the appropriate agency, and/or leverage our powers to understand and improve patient safety. By way of example, this year we followed up with all public and private hospitals that offer surgical mesh procedures, on the extent to which they have been utilising co-designed information booklets available since 2019 for the purpose of informed consent. This information has been fed into the work of the Roundtable.

Of course, the importance of understanding consumer experience has assumed particular significance given the health and disability sector transformation. Even preceding that reform there was a significant increase in pressure in most parts of the health and disability system, and I am particularly mindful of the effect that such pressures have on communities, especially those already at risk of poor health outcomes and/or those that may be more vulnerable. Looking forward, HDC has a valuable role to play in monitoring the impacts of the reform, as well as the continuing environmental pressures, on consumer experience. In addition, whilst I am pleased to see one of the goals of the current health reform is a more people-centred system, and I acknowledge significant work is underway to better embed the consumer voice at all levels of that system, there must never be complacency about consumers' rights. Accordingly, our recent work has also focused on engaging with the new health entities to emphasise the key role of HDC in protecting and promoting those rights, and looking for opportunities to offer our insights on emerging issues that we see in the sector.

I wish to re-emphasise the privilege that it is to be the Health and Disability Commissioner. My team and I are steadfastly committed to championing the rights of health and disability services consumers, and contributing to the delivery of safe, high-quality care in Aotearoa, New Zealand.

Kia hora te marino, kia whakapapa pounamu te moana

Kia tere te karohirohi i mua i to matou huarahi

May the calm be widespread, may the ocean glisten like greenstone

May the shimmer of hope ever dance across our pathways

Ngā mihi nui

Morag McDowell
Health and Disability Commissioner

1.0

Te arotake i te tau 2021/22
The 2021/22 year in review

Complaints received and resolved by HDC and the Nationwide Health and Disability Advocacy Service (the Advocacy Service)

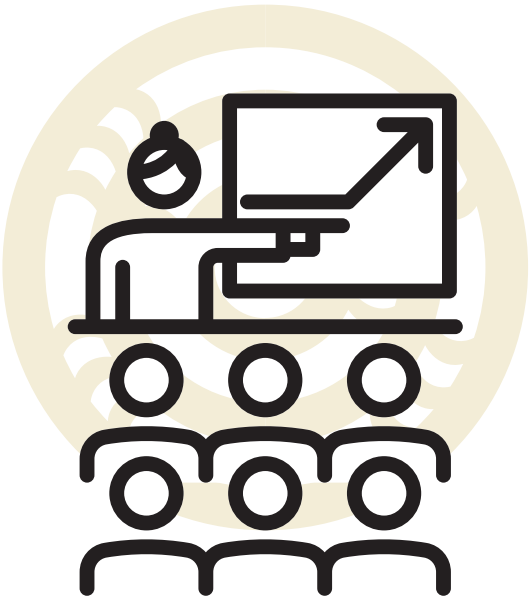
HDC received **3,413** complaints

The Advocacy Service received **2,971** complaints

HDC closed **2,627** complaints — a **9%** increase on the previous year

The Advocacy Service closed **2,922** complaints

Education and networking visits carried out by HDC and the Advocacy Service



HDC and the Advocacy Service held **881** education sessions (851 advocacy + 30 HDC)

The Advocacy Service made **3,304** visits and meetings with community groups and provider organisations

HDC held **5** complaints resolution workshops

In addition, HDC:

Resolved **82%** of complaints within nine months

Completed **121** investigations

Published **83** investigation decisions, which generated **233** media stories

Referred **15** providers to the Director of Proceedings

Received **2,482** enquiries

Undertook **239** engagements with key external stakeholders

Achieved **98%** compliance with quality improvement recommendations

2.0

Ko wai mātau
Who we are

The Health and Disability Commissioner (HDC) promotes and protects the rights of all people who use health and disability services.

HDC is an independent Crown entity — independent from government policy, which enables the Office to be an effective and impartial guardian of consumers' rights.

10
Consumers' rights

1. **Whakamana**
   Respect
2. **Manaakitanga**
   Fair treatment
3. **Tu rangatira motuhake**
   Dignity and independence
4. **Tautikanga**
   Appropriate standard of care
5. **Whakawhiwhitinga whakaaro**
   Effective communication
6. **Whakamōhio**
   Full information
7. **Whakaritenga mōu ake**
   Informed choice and consent
8. **Tautoko**
   Support
9. **Ako me te rangahau**
   Teaching and research
10. **Mana to amuamu**
    Right to complain

Ōu mōtika ina whakamahi koe i tētahi ratonga hauora, hauātanga rānei

Your rights when you use a health or disability service

The rights of people who use any health or disability service are set out in the Code of Health and Disability Services Consumers' Rights (the Code). This applies to all health and disability service providers.

HDC resolves complaints about the infringement of those rights, holds service providers to account, and uses the findings to improve the quality of services, at both the individual provider level and across the health and disability system.

Our funding

We are funded under the Monitoring and Protecting Health and Disability Consumer Interests Appropriation in Vote Health. In the year ended 30 June 2022, HDC received $16,270,000 from this appropriation to fund five output classes as set out in our Statement of Performance, and $800,000 to establish an Aged Care Commissioner within HDC.

Our functions

Complaints resolution:

we assess and resolve complaints from people about health and disability services.

Advocacy:

we contract the National Advocacy Trust to provide advocacy services to support people to resolve their complaints, and to promote the Code in the community.

Proceedings:

we can refer providers found in breach of the Code to the Director of Proceedings (an independent, statutory role), who will decide whether any proceedings should be taken.

Education and analysis:

we use insights gained from complaints to influence policies and practice across the health and disability system, and deliver educational initiatives to improve people's knowledge of the Code.

Disability:

the Deputy Commissioner, Disability has a particular focus on promoting the rights of people who use disability services.

Aged care:

the Aged Care Commissioner advocates on behalf of older people and their whānau for better services in the health and disability system, and provides strategic oversight to drive quality improvement in the aged-care sector.

Our executive leadership team as at 30 June 2022

Morag McDowell
Health and Disability Commissioner

Rose Wall
Deputy Health and Disability Commissioner, Disability

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

Carolyn Cooper
Aged Care Commissioner

Deborah James
Deputy Health and Disability Commissioner, Complaints Resolution

Ikimoke Tamaki-Takarei
Kaitohu Mātāmua Māori/Director Māori

Kerrin Eckersley
Director of Proceedings

Mark Treleaven
Associate Commissioner, Complaints Resolution

Jane King
Associate Commissioner, Legal

Dr Cordelia Thomas
Associate Commissioner

Jason Zhang
Corporate Services Manager

Tayyaba Khan
Director of Advocacy

3.0
Te whakarato i tā tātau rautaki
Delivering our strategy

HDC's purpose is to protect and promote the rights of consumers as set out in the Code of Health and Disability Services Consumers' Rights.

In 2021/22 HDC had a refreshed focus on honouring our responsibility under Te Tiriti o Waitangi in everything we do, including increasing our internal cultural knowledge and competence, strengthening our ability to respond effectively and appropriately to Māori complainants and focusing on improving outcomes for Māori in the Health and Disability system. This was supported by the appointment of a Kaitohu Mātāmua Māori (Director, Māori), who sits on our leadership team.

HDC's strategic work programme

In 2021/22, HDC developed a comprehensive strategic work programme to support our strategic objectives and enhance our contribution to an equitable system.

This work programme is focused on achieving the following outcomes:

- Honouring our responsibilities under Te Tiriti o Waitangi in all our mahi
- Having a people-centred complaints process
- Being an inclusive and culturally safe organisation
- Being an employer of choice
- Having an enhanced focus on rights promotion
- Ensuring we have a tangible system impact

Four strategic objectives underpin our strategic intent:

1. Te whakatau amuamu | Resolution of complaints

Resolving complaints holds providers to account, encourages quality improvement, and protects consumers' rights. We focus on the resolution of complaints at the lowest appropriate level, with the Advocacy Service assisting in supporting this early resolution at source.

In 2021/22:

- HDC received 3,413 complaints — an unprecedented increase of 25% on the previous year.
- HDC resolved/closed 2,627 complaints — up 9% on the previous year.
- HDC closed 71% of complaints within 3 months, 78% within 6 months, and 87% within 12 months.
- The Advocacy Service received 2,971 complaints.
- The Advocacy Service resolved/closed 2,922 complaints.
- The Advocacy Service closed 78% of complaints within 3 months, 97% within 6 months, and 100% within 12 months.

- 92% of consumers and 96% of providers who responded to surveys were satisfied or very satisfied with the Advocacy Service's complaints management process.
- HDC began trialling a hui ā whānau option for Māori consumers and whānau.
- HDC made cultural advice a routine part of the triage process.
- HDC introduced an option for people who would like cultural oversight and support with their complaint.
- HDC trialled a number of process redesign changes to increase efficiency while enhancing a more flexible, people-centred approach to resolution — for example, the introduction of new pathways to fast track investigations, a modified process for the triaging of new complaints, and working with the Advocacy Service to enhance our focus on early resolution.

2. Kia piki ake te māramatanga ki ngā tika | Improved understanding of rights

Promoting understanding of the Code is central to HDC's purpose and underpins everything we do. We also deliver a number of education initiatives to improve people's understanding of their rights and obligations under the Code. This work is complemented by the community-level education and networking sessions carried out by the Advocacy Service.

In 2021/22:

- HDC received 2,482 enquiries.
- The Advocacy Service received 19,711 enquiries, inclusive of the HDC 0800 line, helping people to understand their rights under the Code.
- HDC provided 30 education sessions; of those surveyed, 100% of respondents were satisfied with the sessions.
- HDC delivered five complaints resolution workshops to providers; 100% of attendees provided feedback that they found the sessions useful for improving complaints resolution.
- The Advocacy Service provided 851 education sessions; 88% of respondents were satisfied with the sessions.
- The Advocacy Service made 3,304 networking visits with community groups or provider organisations; 80% of these focused on vulnerable consumers and their whānau.
- HDC produced educational materials to assist consumers to understand their rights and providers to understand their responsibilities under the Code in the context of Assisted Dying. Information for consumers and whānau was published in five languages and is also available in an audio version.
- HDC produced a resource and quick guide for people receiving home and community support.
- In consultation with disabled people, HDC updated "My Health Passport", a tool for supporting disabled people to communicate their needs and preferences when engaging with services.

3. Kia piki ake te tauritenga o ngā āwhina me te haumaru | Better, safer, more equitable care

We aim to improve the quality of services at the local and wider sector level. We achieve this by making quality improvement recommendations and sharing lessons from complaints. In this way, people and the systems in which they work are held to account — individuals learn, systems improve, preventative action is taken, and consumers' rights are protected.

In 2021/22:

- HDC made 403 recommendations for quality improvement.
- Providers complied with 98% of HDC's recommendations.
- HDC published 83 decisions on its website, which generated 233 media stories.
- HDC undertook 239 engagements with key external stakeholders to promote the Code and share intelligence and insights relating to complaint trends.
- HDC provided district health boards (DHBs) with two six-monthly complaint trend reports; 100% of DHBs who responded to the survey said that the reports were useful for improving services.
- HDC made 26 submissions to government and other organisations in relation to the Code.
- An Aged Care Commissioner was established in HDC with a focus on advocating on behalf of older people and their whānau for better services in the health and disability system.
- HDC continued to strengthen our data collection, analysis and reporting of matters relating to equity and particularly Māori experiences of care.
- HDC contributed to the National Quality Forum, a multi-agency group designed to facilitate sharing of information on quality and safety issues and to better enable cross-agency collaboration.

4. Kia tika ngā mahi o ngā ratonga | Provider accountability

Providers of services can be held to account in various ways — accountability mechanisms help to drive change and quality improvement. The recommendations HDC makes hold providers to account for effecting quality improvements and change. For the most serious breaches of the Code, HDC refers providers to the Director of Proceedings to consider legal action. HDC seeks to ensure proceedings are taken in circumstances where the public interest requires, for example for reasons of public health or safety.

In 2021/22:

- HDC closed 121 investigations.
- HDC found breaches of the Code in 94 investigations.
- HDC referred 15 providers to the Director of Proceedings in respect of 18 complaints.
- The Director of Proceedings concluded 12 proceedings in the Human Rights Review Tribunal (HRRT) alleging a breach of the Code.
- The Director successfully prosecuted two health practitioners before the Health Practitioners Disciplinary Tribunal (HPDT) and filed proceedings against a further three.

4.0
Te whakatutukitanga mō ngā mahi hira
Performance on key functions

HDC achieves its strategic objectives through six key functions:

- **Complaints resolution**
- **Advocacy Service**
- **Aged care**
- **Disability**
- **Proceedings**
- **Education**

"In 2021/22, HDC received 3,413 complaints — an unprecedented 25% increase."

4.1 Complaints resolution

Resolving complaints is central to our role in promoting and protecting the rights of people using health and disability services. We aim to resolve every complaint in a fair, simple, speedy, and efficient way, and have a number of resolution options to help achieve this.

In 2021/22, HDC received 3,413 complaints — an unprecedented 25% increase on the number of complaints received the previous year, and well above the 2,600 complaints expected. This increase is largely attributable to a significant rise in complaints about COVID-19 issues.

This unexpected surge in complaints, as well as the impacts of the pandemic on HDC, has placed further pressure on the time it takes to assess and resolve complaints. This has resulted in a growth in complaints currently

under assessment. At the end of 2021/22, 2,037 complaints were under assessment — 63% more than the previous year. We are committed to addressing these delays, and continue to focus on ways of streamlining our processes and supporting early resolution where possible.

Despite these ongoing challenges, HDC closed a record number of complaints in 2021/22. The 2,627 complaints closed in 2021/22 represent a 9% increase on the previous year.

In addition, we introduced an option for people who would like cultural oversight and support with their complaint, made cultural advice a routine part of the triage process, and began trialling a hui ā whānau option for Māori consumers and whānau.

Figure 1. Number of complaints received, open and closed at year end

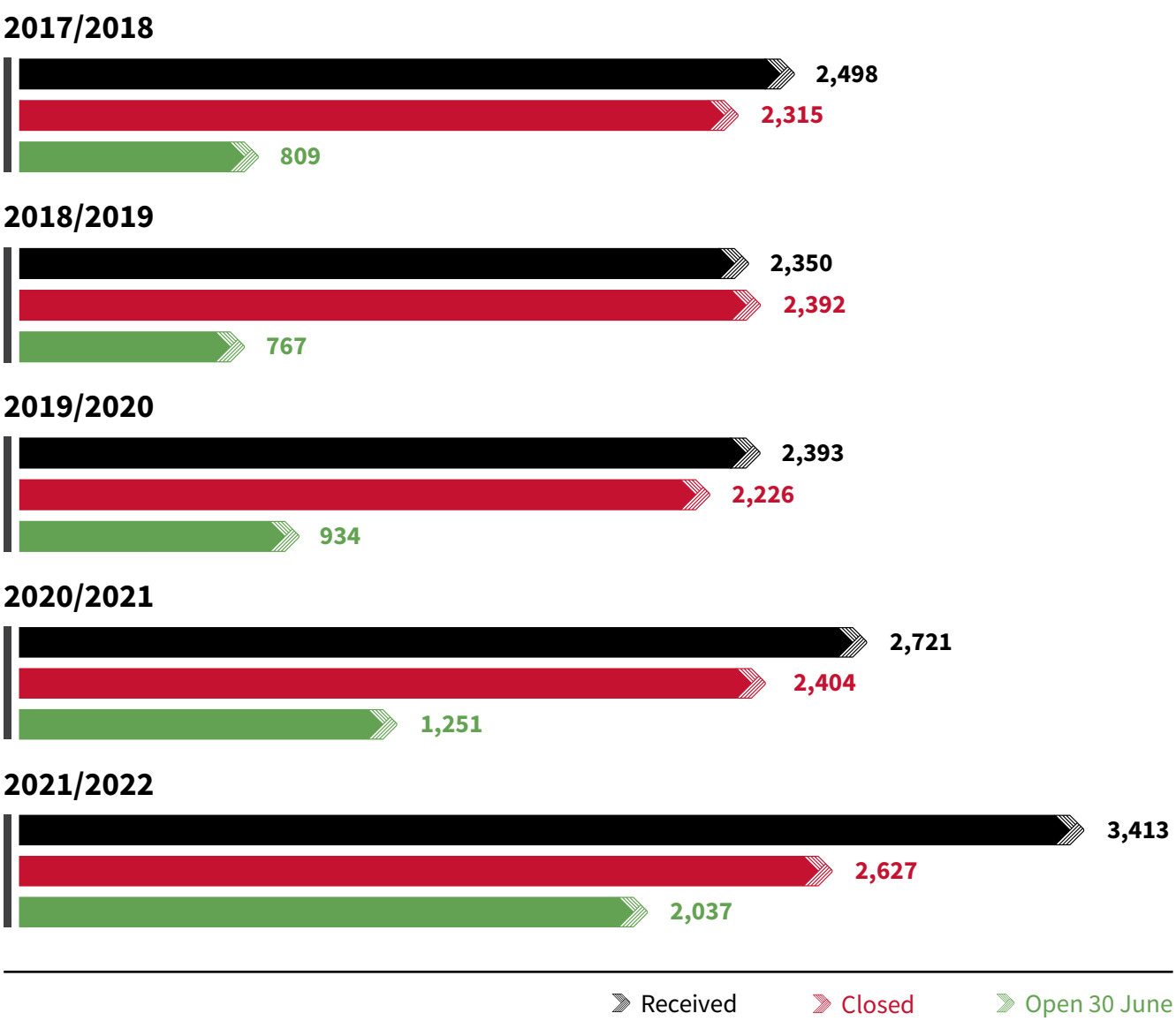


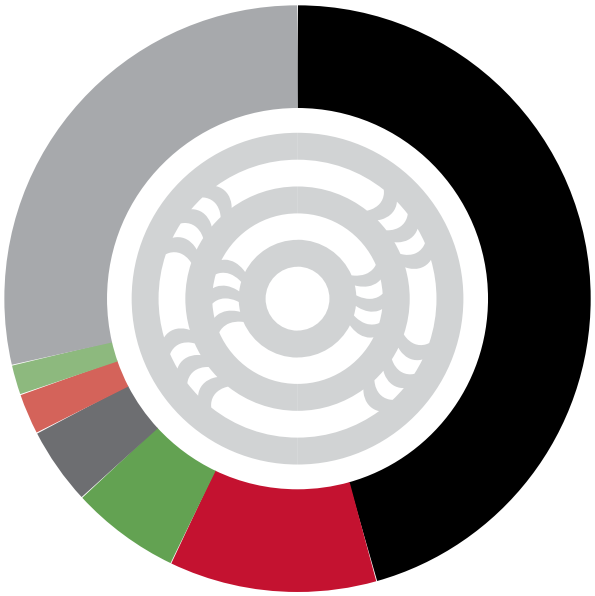
Table 1. Outcomes of complaints closed by HDC in 2021/22

Outcome	Number of complaints
Investigation	**121**
Breach finding	94 15 providers referred to Director of Proceedings for 18 complaints
Referred to registration authority	2
No breach finding with adverse comment and recommendations	12
No breach finding with recommendations	6
No breach finding	6
Withdrawn	1
Other resolution following assessment	**2,272**
No further action with follow-up or educational comment	194
Referred to registration authority	18
Referred to other agency	67
Referred to provider	578
Referred to Advocacy Service	448
No action/no further action	802
Withdrawn	165
Outside jurisdiction	**234**
TOTAL	**2,627**

Whose care was complained about?

The demographics of consumers whose care was complained about in 2021/22 are detailed below. These demographics are very similar to the previous year. Most consumers identified as NZ European (46%). This is similar to what is seen for complainants to the Advocacy Service, although the Advocacy Service receives a higher proportion of complaints from people who identify as Māori (22% vs 11%). HDC is committed to engaging with Māori and other communities who may experience barriers to understanding their rights under the Code, and access to HDC.

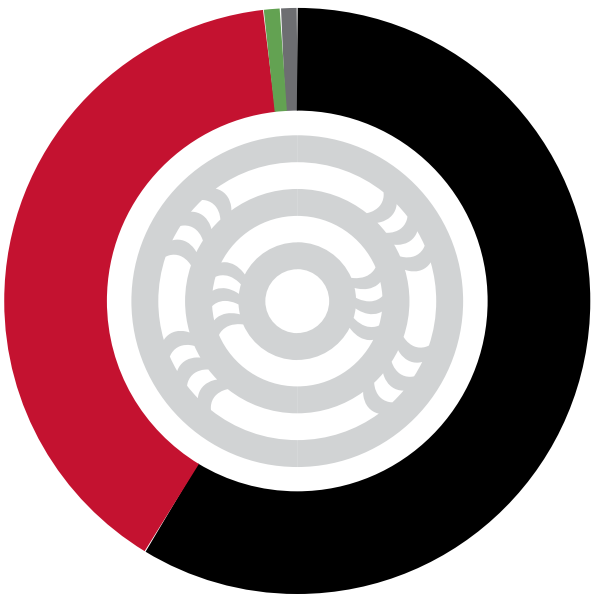
Figure 2. Ethnicity of consumers whose care was complained about in 2021/22



- NZ European **(46%)**
- Māori **(11%)**
- Asian **(6%)**
- Other European **(4%)**
- Pacific **(2%)**
- Middle Eastern/ Latin American / African **(2%)**
- Does not wish to answer / unknown **(29%)**

Women's care is complained about at a slightly higher rate than men's. This is similar to other international jurisdictions, and is consistent with the rate at which women access health services in comparison to men. Other factors can influence the higher rate of complaints from women, including the amount of contact time with healthcare professionals, awareness among consumers of their rights, willingness to complain, and communication and quality of care issues.

Figure 3. Gender of consumers whose care was complained about in 2021/22

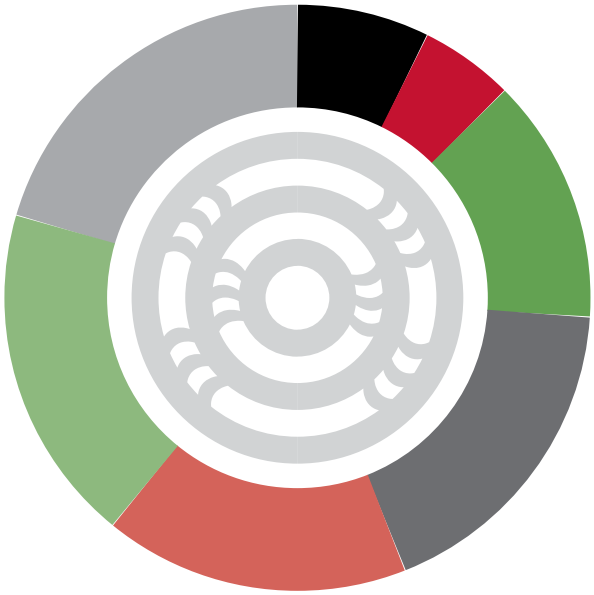


- Female **(59%)**
- Male **(39%)**
- Another gender **(1%)**
- Does not wish to answer/unknown **(1%)**

See overleaf for explanation.

The most common age groups for consumers in complaints to HDC are over 65 years (19%), 35 to 49 years (18%), and 50 to 64 years (17%).

Figure 4. Age of consumers whose care was complained about in 2021/22



- 0 to 17 years **(7%)**
- 18 to 24 Years **(5%)**
- 25 to 34 years **(14%)**
- 35 to 49 years **(18%)**
- 50 to 64 years **(17%)**
- 65+ years **(19%)**
- Does not wish to answer / unknown **(20%)**

Issues complained about

The complaints we receive typically comprise multiple issues. For statistical purposes, each complaint is categorised with one primary issue (generally the issue of most importance to the consumer) and multiple "complaint keywords".

The most commonly complained about primary issues have remained broadly consistent over the last four years, with inadequate/ inappropriate treatment and missed/incorrect/ delayed diagnosis generally being the most commonly complained about primary issues. Complaints primarily regarding "refusal to treat" significantly increased in 2021/22. This is due to a number of complaints HDC received about health and disability service providers' policies around vaccine and mask requirements. Complaints about "inadequate/ inappropriate care" also increased in 2021/22.

Table 2. Most common primary issues complained about over last four years

Primary issue	18/19	19/20	20/21	21/22
Inadequate/inappropriate treatment	222	199	228	186
Missed/incorrect/delayed diagnosis	209	194	205	240
Inadequate/inappropriate examination/assessment	81	103	144	144
Failure to communicate effectively with consumer	120	104	132	136
Disrespectful manner/attitude	138	125	127	163
Delay in treatment	66	89	127	116
Lack of access to services	118	115	97	119
Unexpected treatment outcome	94	109	92	90
Inadequate/inappropriate care	92	80	89	154
Refusal to treat	29	38	35	104

When all issues raised in complaints are considered — not just primary issues — the most common complaint issue categories in 2021/22 were:

- Care/treatment **(64%)**
- Communication **(56%)**
- Consent/information **(18%)**
- Facility **(18%)**
- Access/funding **(13%)**

This is similar to previous years, although in 2021/22 there was an increase in complaints involving facilities. This is likely due to an increase in complaints received about COVID-19-related policies/procedures (such as infection control policies or visitor restrictions).

Providers complained about

We receive complaints about individuals and organisations, with many complaints involving multiple providers. The type of organisation complained about has remained broadly consistent over time. DHBs and general practices have been the most commonly complained about organisational providers, with complaints about these providers increasing over the last four years (generally in line with the overall increase in complaints). The 2021/22 year saw an increase in complaints about home care and community support services, aged residential care facilities, and pharmacies.

Complaints about prison health services decreased compared to previous years. This is a similar number to what is seen in complaints to the Advocacy Service, although the Advocacy Service receives a higher proportion of complaints about prison health services than HDC.

"The 2021/22 year saw an increase in complaints about home care and community support services, aged residential care facilities, and pharmacies."

Table 3. Most common organisations complained about over last four years

Type of organisation	18/19	19/20	20/21	21/22
DHB	986	1,004	1,099	1,243
Medical centre	493	534	595	805
Aged residential care facility	130	169	151	183
Pharmacy	58	59	70	111
Home services provider	49	63	81	103
Dental clinic	81	67	96	86
Prison health services	91	110	112	73
Disability services provider	55	50	69	60

General practitioners are consistently the most commonly complained about individual provider, followed by midwives, nurses, and dentists. This year there was an increase in the number of psychologists, psychiatrists, internal medicine specialists, and obstetrician/gynaecologists complained about, and a decrease in the number of complaints about midwives and general surgeons.

Table 4. Commonly complained about individual providers over last four years

Occupation	18/19	19/20	20/21	21/22
General practitioner	321	300	308	364
Midwife	67	60	91	79
Psychologist	47	38	48	67
Psychiatrist	56	56	46	65
Dentist	51	60	58	64
Nurse	66	60	57	62
Internal medicine specialist	51	37	33	58
Orthopaedic surgeon	55	50	30	51
Obstetrician & gynaecologist	49	28	28	41
General surgeon	25	35	30	23

Ngā mātai take | Case study

Referral to provider

A consumer went to an urgent care clinic and, after being triaged, was asked to wait in the car for a consultation. The consumer was concerned about not having been made aware that there would be a lengthy wait time.

HDC considered that the provider was best placed to offer an explanation for the events and address the consumer's concerns, and referred the complaint directly to the provider.

The provider met with the consumer to discuss and explain the reasons for the delay. The provider apologised and outlined new measures to improve communication and wait times in future, including relocating triage nurses so that they are more accessible to patients; offering patients the opportunity to wait at home and be contacted closer to their consultation time; providing information sheets to patients waiting in cars, setting out processes and how to seek help; and investigating whether other local practices could see patients.

The consumer accepted the apology and the steps to improve the system.

(Case 22HDC00050)

Resolution with recommendations

While an in-patient at a mental health facility, a man who was receiving mental health care was transferred between wards regularly, and then was moved to a less secure mental health provider while COVID-19 restrictions were in place. The man's family was not concerned about the care provided at the facilities, but felt that the constant transfers were disruptive to the man's mental health, particularly his move to a less secure facility without adequate handover and without his belongings being transported with him. They wanted their complaint to bring awareness of these systemic issues and to prevent another healthcare consumer from having a similar experience.

Following a detailed assessment, HDC considered that the rate of movement between rooms and wards was unfortunate, but recognised the challenges faced by the provider in managing resources. HDC also acknowledged that the transfer and handover to the second mental health facility did not reflect good practice. In light of these findings, HDC made a number of recommendations for service improvement, including asking the provider to conduct an audit of the transfers of complex patients over the course of a month, and provide details of any steps taken to address the findings; provide evidence of remedial actions to address the flow of communication to other providers; create a plan to prevent a similar situation from happening again should there be another national lockdown; and formally apologise to the family.

The family was grateful to hear of the changes in place, and thanked HDC for its efforts.

(Case 20HDC01304)

4.2 Investigations

HDC may formally investigate a complaint where a provider's actions appear to be in breach of the Code.

Investigations tend to focus on more serious departures from acceptable standards or professional boundaries, public safety concerns, and significant systems or equity matters. An investigation is a comprehensive process and can result in a provider being found in breach of the Code. HDC's investigation process is largely conducted "on the papers" — generally, decisions are made on the basis

of gathered written information. During an investigation, relevant evidence is collected from the consumer, the provider or providers being investigated, and third parties. Often independent clinical advice is sought from an advisor or advisors. Advisors are peers of the provider complained about.

Following evidence gathering, the Commissioner or Deputy Commissioner produces a provisional opinion on whether or not the provider has breached the Code. Parties involved in the complaint are entitled to comment on sections of the provisional opinion relevant to them. This allows them to make submissions about proposed adverse findings, or to request an amendment of facts that form the basis of the opinion. After careful consideration of these responses, the Commissioner or Deputy Commissioner forms their final opinion.

The number of investigations carried out by HDC is generally increasing.

2021/22 year began with:

173 open investigations

163 investigations started over the course of the year

121 investigations completed, and 215 remained open at year end

"An investigation is a comprehensive process and can result in a provider being found in breach of the Code."

In 2021/22, 219 files were transferred to the investigations team — a decrease on the 310 complaints transferred in the previous year, but a significant increase on the 135 complaints transferred in 2019/20. This increase is attributed to a new cohorting system that identifies, at an early stage, whether a complaint warrants an investigation, to reconsideration of the investigation threshold,[1] and generally more complex issues being complained about.

In 2021/22, 121 investigations were completed. HDC determined that the consumer's rights were breached in 94 of these investigations. Fifteen providers were referred to the Director of Proceedings in respect of 18 complaints to consider whether further legal action should be taken.

Making recommendations for quality improvement is an important part of the outcome of an investigation. Quality improvement and resolution-related recommendations were made in 92% of investigations completed in 2021/22.

"Quality improvement and resolution-related recommendations were made in 92% of investigations completed in 2021/22."

[1] As a result of an Ombudsman's decision.

Information on risks of medication vital in informed choice and consent

A woman in her twenties became pregnant while taking Epilim (sodium valproate) for a mood disorder. Epilim places the fetus at high risk of developing serious birth defects, and can affect the way in which the child develops. The woman was concerned about the lack of information she received from the health professionals who cared for her at the DHB before and during her pregnancy. She said that the only specific risk she was informed of (after she became pregnant) was a 1–2% increase in neural tube defects like spina bifida, and she was concerned that this "massively" minimised the effects of exposure to Epilim in pregnancy.

Findings

The Deputy Commissioner considered that the locum psychiatrist who initially prescribed Epilim to the woman did not provide the information that a reasonable consumer in her circumstances would expect to receive at a critical point in her care. This included an explanation of the options available other than Epilim, and the specific risks of Epilim in pregnancy. The locum psychiatrist was found in breach of Rights 6(1)(b) and 7(1) of the Code.

The Deputy Commissioner considered the practice of psychiatrists using a letter to the client's GP rather than recording detailed clinical notes, and not having in place a policy for prescribing Epilim to women of childbearing age, were systemic factors at the DHB that contributed to the lack of information provided to the woman.

The Deputy Commissioner found that a midwife breached Right 4(2) of the Code for retrospectively amending the woman's antenatal records without indicating that the amendments were retrospective.

Recommendations

The Deputy Commissioner considered that the accessibility of information about Epilim could be improved, and recommended that relevant professional colleges circulate the Medsafe safety alert for Epilim to their New Zealand members, and communicate that when prescribing Epilim, clinicians should provide patients with written information about the risks in pregnancy, and discuss the risks, benefits, and necessary precautions to mitigate the risks, and confirm and document the patient's understanding of this.

The Deputy Commissioner asked Medsafe, ACC, and the Health Quality & Safety Commission to consider reproducing the current information booklet "Medicines for epilepsy, mental health, and pain can harm your unborn baby" in plain English and other languages to make sure it is as accessible as possible. The Deputy Commissioner also made a number of recommendations to the DHB, individuals involved, and relevant professional organisations, and recommended that the locum psychiatrist, the midwife, and an obstetrician (who had provided incorrect information) apologise to the woman.

(Case 19HDC00773)*

* This case can be found at: https://www.hdc.org.nz/decisions/search-decisions

Missed abnormal finding on X-ray

A woman in her sixties presented to an emergency department with stomach pain and nausea, and a chest X-ray was taken as part of the clinical investigations. The images were transferred to the hospital's radiology service, and there was a delay of 11 days before they were reviewed by a radiologist, who then sent them to an external radiology service for reporting. Although the subsequent radiology report described a significant abnormal mass on the woman's lung, the emergency department clinician who ordered the X-ray overlooked the comment, and no further action was taken until the radiology report was noted when the woman attended the emergency department again three years later. As a result of the delay, the opportunity to diagnose cancer at an earlier stage was missed. The woman's GP practice received the X-ray report and the radiologist's findings, but no clinician at the medical centre followed up this result or ensured that someone else had taken responsibility for following up the result.

Findings

The Commissioner considered that a delay of 11 days for the DHB to send the X-rays offsite for radiology reporting by a third party was unreasonable and increased the possibility of harm to the consumer. The Commissioner found that the DHB's failure to ensure that radiology reporting was completed in an acceptable timeframe amounted to a breach of Right 4(1) of the Code.

The Commissioner considered that the primary responsibility for taking further action on the radiology report lay with the emergency department clinician. In overlooking the reporting radiologist's comment about the significant abnormal mass and, consequently, failing to take any follow-up action, the clinician failed to provide services to the woman with reasonable care and skill, and breached Right 4(1) of the Code.

The Commissioner was critical that the woman's GP practice did not follow its own policies, and that safety-netting intended to prevent abnormal test results from being missed was not engaged, and another opportunity to follow up the abnormal X-ray result was missed.

Recommendations

The Commissioner recommended that the DHB audit compliance with its electronic results acknowledgement policy; update HDC on the changes made as a result of its serious adverse event review; report to HDC on the median reporting times for radiology results; consider whether improvements can be made to reduce delays in radiology reporting times; consider implementing a system to highlight all significant or abnormal test results to requesting clinicians; and apologise to the woman's family.

The Commissioner recommended that the emergency department clinician conduct an audit of radiology reports acknowledged by him. The clinician provided an apology to the woman's family.

The Commissioner recommended that the medical centre conduct an audit of test results ordered by third parties, to identify whether appropriate follow-up action is being taken and to assess compliance with its own policies.

(Case 20HDC00717)*

* This case can be found at: https://www.hdc.org.nz/decisions/search-decisions

Extraction of incorrect tooth

A man in his forties attended an appointment with a dentist to have his sore loose right front tooth removed. The dentist only briefly asked the man about the location of the tooth for extraction, and provided minimal information about the proposed treatment. As a result, the dentist mistakenly assumed that the man wanted a different tooth to be extracted, and proceeded to remove it. Encountering resistance, the dentist stopped the extraction mid-way, and realised that the wrong tooth was being extracted. The dentist asked the man to confirm which tooth he wanted removed, and, despite the man identifying another tooth, the dentist continued with the initial extraction without obtaining consent from the man. The dentist then extracted the correct tooth.

The man told HDC that the dentist did not explain the procedure in detail, including the risks of extraction. The man felt that his concerns were ignored by the dentist.

Findings

The Deputy Commissioner considered that the dentist did not obtain an adequate history from the man or conduct an appropriate clinical examination prior to proceeding with the extraction, and found the dentist in breach of Right 4(1) of the Code. The Deputy Commissioner also considered that the dentist did not provide adequate information to the man about his diagnosis or the options available for the management of his tooth, or about the plan to extract the first tooth. This was information that the man could reasonably have expected to receive in the circumstances, and the dentist was found in breach of Right 6(1) of the Code. The dentist was also found in breach of Right 7(1) of the Code for having extracted a tooth without consent. The Deputy Commissioner also found that the dentist did not maintain adequate and accurate records, or comply with the professional standards set by the Dental Council, in breach of Right 4(2) of the Code.

Recommendations

The Deputy Commissioner recommended that the dentist apologise to the man and undertake further training. She recommended that the Dental Council consider a review of the dentist's competence, and that the DHB undertake an audit of the dentist's recent tooth extractions, and use this case for educational purposes. The Deputy Commissioner referred the dentist to the Director of Proceedings.

(Case 21HDC00033)*

* This case can be found at: https://www.hdc.org.nz/decisions/search-decisions

Professional and ethical standards not met

A woman in her thirties had a 60-minute full body relaxation massage at a clinic. The clinic informed HDC that full body massages include massaging of the head, neck, shoulders, arms, back and legs, but not the front of the body. However, in this case, the massage therapist massaged the woman's breasts and lower abdomen.

Findings

The Deputy Commissioner considered that the massage therapist did not communicate with the woman adequately or provide her with the information to which she was entitled. He did not specifically mention his intention to massage her breasts and abdomen, and seek her consent to this. The Deputy Commissioner found the massage therapist in breach of Right 6(1) of the Code for failing to inform the woman adequately, and in breach of Right 7(1) of the Code, as without adequate information the woman was unable to give informed consent. The Deputy Commissioner also found that the massage therapist did not meet professional and ethical standards and breached Right 4(2) of the Code. In addition, the massage therapist did not take adequate steps to protect, maintain, or respect Ms A's privacy, in breach of Right 1(2) of the Code.

Recommendations

The Deputy Commissioner recommended that the massage therapist apologise to the woman and consider registering with Massage New Zealand to obtain peer support and professional development — particularly on acceptable standards of client care, practice, and ethics.

The Deputy Commissioner recommended that the massage clinic apologise to the woman; prominently display the Code of Rights and a complaint process; develop a client registration form for completion before a massage; implement a robust system for ensuring completion of the forms (and audit staff compliance over a three-month period); develop a policy outlining what a relaxation massage entails; encourage and support staff to register with Massage New Zealand (massage therapists are unregulated and not required to register with Massage New Zealand); provide all members of staff with an anonymised version of the opinion report; and ensure that its employee rule that under no circumstances should therapists touch the sensitive parts of the client's body is followed.

The Deputy Commissioner also recommended that every client is provided with clean and freshly laundered draping and bed linen, and that an audit of one massage a week over three months is undertaken by an appropriate person recommended by Massage New Zealand to ensure appropriate standards of hygiene.

The Deputy Commissioner referred the massage therapist to the Director of Proceedings.

(Case 20HDC01182)*

* This case can be found at: https://www.hdc.org.nz/decisions/search-decisions

4.3 Advocacy

Manaaki whenua, manaaki tangata, haere whakemua.

If we take care of the earth and take care of the people, we will take care of the future.

Advocates are critical to achieving HDC's mandate to promote consumers' rights and resolve complaints at the lowest appropriate level.

36
advocates

not inclusive of the 0800 call centre staff

22 **community-based offices**
from Kaitaia to Invercargill

Received
2,971
complaints

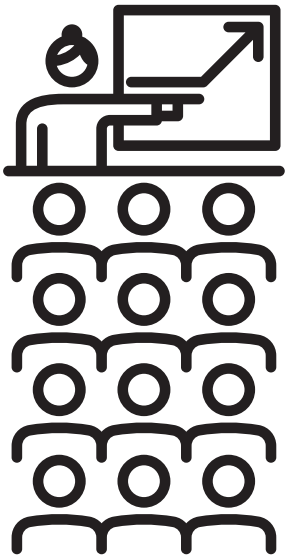
Closed
2,922
complaints

Responded to over
19,711
enquiries

Provided
851
education sessions

Made
3,304
networking visits

5,000
Facebook followers



Advocacy Service complaints resolution process

The Advocacy Service supports the fair, simple, speedy, and efficient resolution of complaints by assisting people to resolve their complaints directly with the provider. Creating space for the complainant and provider to hear each other is an essential part of the advocacy process.

The advocacy process can support people to rebuild relationships. This is particularly important when the relationship will be ongoing, such as with a GP or an aged residential care facility. In some instances, having the opportunity to talk things through and draft a complaint letter with an advocate enables people to achieve some personal reconciliation. Sometimes they may no longer feel that a formal complaint is necessary. The Advocacy Service achieves high resolution rates, reflecting its consumer-focused approach and the commitment of providers to achieve early and effective resolution.

Complaints

In 2021/22, the Advocacy Service received 2,971 complaints and closed 2,922 complaints. This was an 11% increase on the complaints received in comparison to the previous year.

"In 2021/22, the Advocacy Service received 2,971 complaints and closed 2,922 complaints. This was an 11% increase on the complaints received in comparison to the previous year."

Figure 5. Complaints to the Advocacy Service by year

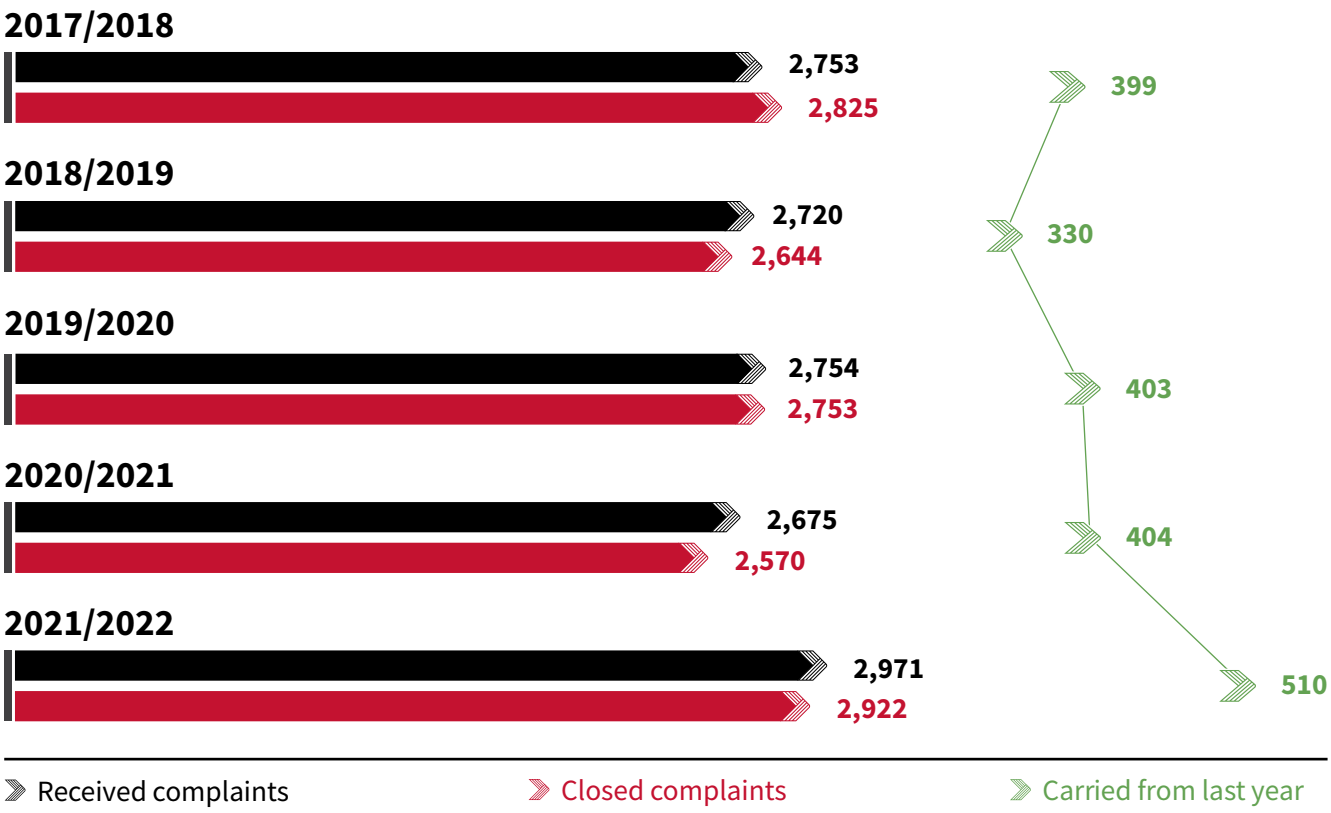
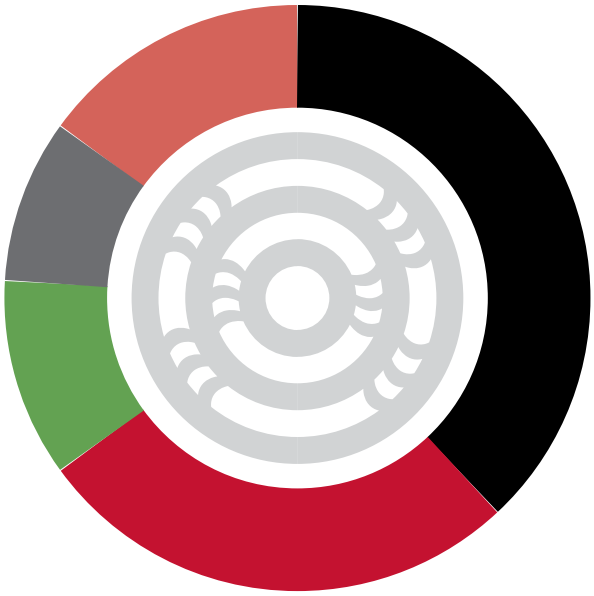


Figure 6. Complaints to the Advocacy Service by service type in 2021/22

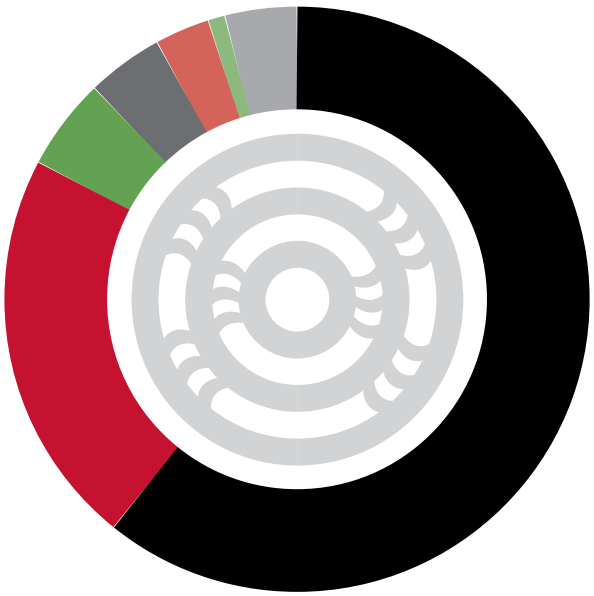


- DHB **(38%)**
- General practice **(27%)**
- Residential service **(11%)**
- Prison health services **(9%)**
- Others **(15%)**

Demographic trends

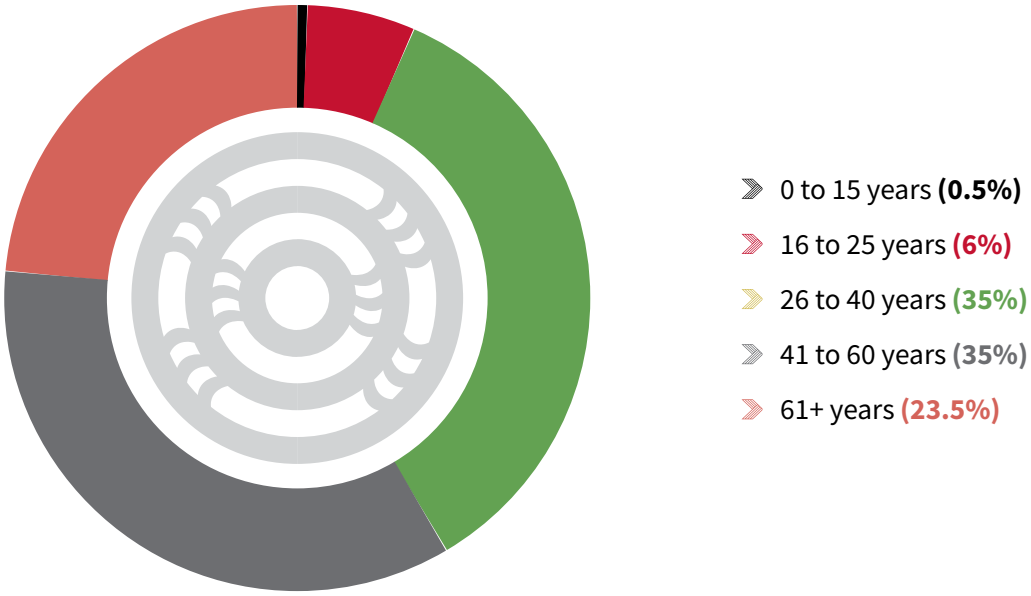
Demographic trends for complainants to the Advocacy Service remain similar to previous years. The most common age ranges for complainants to the Advocacy Service are 41 to 60 years (35%) and 26 to 40 years (35%). People identifying as female account for 59% of all complaints received. New Zealand European and Māori were the most commonly identified ethnicity groups for complainants: 61% of complaints received came from people identifying as New Zealand European, and 22% came from people identifying as Māori.

Figure 7. Ethnicity of complainants to the Advocacy Service in 2021/22



- NZ European **(61%)**
- Māori **(22%)**
- Asian **(5%)**
- Other European **(4%)**
- Pacific **(3%)**
- Middle Eastern/ Latin American / African **(1%)**
- Does not wish to answer / unknown **(4%)**

Figure 8. Age of complainants to the Advocacy Service in 2021/22



Raising awareness of the Code

Under the provisions of the Health and Disability Commissioner Act 1994, advocates are responsible for raising awareness of the Code through education and promotional activities. This is an important part of the work they do in our communities. As well as the education sessions, the Advocacy Service is funded to build and maintain relationships in the community to increase community understanding of the Code and avenues for complaint.

Advocacy support

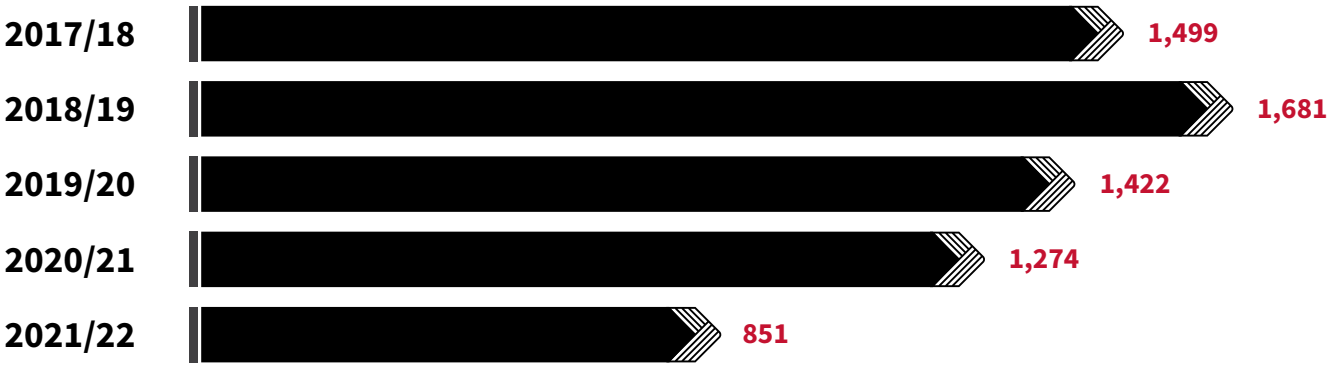
A woman complained to HDC about the lack of support she received from her GP and a crisis team when she was facing a mental health crisis. With the woman's consent, the complaint was referred to the Advocacy Service for supported resolution, as the woman was likely to require ongoing support from both providers. The advocate supported the woman to ask for a written response, including a detailed explanation of why certain actions were taken, and how the two services coordinated their care. The providers engaged with the process, and provided the woman with an explanation. A meeting with the crisis team was held to create a specific crisis plan, accessible to all relevant parties, to assist them to provide appropriate care to the woman the next time she required support. The woman agreed that her concerns had been resolved.

(Case 21HDC02275)

Education sessions

In 2021/22, COVID-19 restrictions had a significant impact on the delivery of the education functions of the National Advocacy Trust. During this period, the Advocacy Service saw a notable increase in contact from people in prison and those using home and community care support, and in contacts about GPs and aged residential facilities in relation to their policies and procedures.

Figure 9. Education sessions carried out by the Advocacy Service by year



4.4 Proceedings

In 2021/22, the Director successfully prosecuted two health practitioners before the HPDT for professional misconduct, and filed proceedings in the HPDT against three further practitioners.

The Director also concluded 12 proceedings in the HRRT against providers (10 against organisational providers and two against individual providers). At 30 June 2022, the Director was waiting for a decision from the HRRT for one other proceeding.

During 2021/22, the Health and Disability Commissioner referred 15 providers to the Director of Proceedings in respect of 18 complaints. The Director of Proceedings had 33 referrals in progress as at 30 June 2022.

The range of providers referred to the Director reflects the system-wide reach of the Code of Health and Disability Services Consumers' Rights. The Director is grateful to the staff and counsel of the Proceedings team for their mahi and dedication throughout another busy year.

Table 5: Referrals received by the Director of Proceedings in the 2021/22 year by provider type

Provider	No. of referrals
Psychiatrist	2
Osteopath	1
DHB	5
Nurse	4
Pharmacist	1
Massage therapist	1
Dentist	1
TOTAL	**15**

Ngā mātai take | Case study

In September 2015, Mr A presented at a hospital's emergency department with chest pain. Tests indicated that he had suffered a heart attack. Contrary to accepted guidelines, Mr A was admitted to a general medical ward for remote cardiac monitoring by the coronary care unit. Throughout his admission, nursing staff administered blood-thinning medications to Mr A. They also administered several sprays of glyceryl trinitrate (GTN) within a short timeframe to relieve his chest pain.* GTN can lower blood pressure, resulting in dizziness and fainting, and mobilisation soon after the use of GTN carries a risk of falling. Mr A's blood-thinning medication also increased his risk of falling. Despite this, nursing staff did not undertake a falls risk assessment for Mr A.

* GTN spray is used to relieve symptoms of angina by relaxing the blood vessels and allowing blood to flow more freely to the heart.

Shortly after GTN had been administered, Mr A needed the toilet. Nursing staff escorted him to the toilet but left him unattended. During this time, Mr A fainted and woke up on the bathroom floor. Nursing staff undertook a general visual check and assessed Mr A's vital signs, but did not perform a full physical assessment. Staff did not notice a lump on the back of his head, caused by hitting his head when he fell, until later. Mr A experienced low blood pressure, which triggered an Early Warning Score of 2. According to the hospital's recommended practice, this score required a medical review of Mr A within an hour, which did not occur. The overnight doctor did not review Mr A physically, despite two semi-urgent requests by nursing staff and Mr A's chest discomfort requiring GTN sprays, and despite Mr A having experienced an unwitnessed fall. Nursing staff did not advise the doctor that Mr A had hit his head when he fell, and the doctor did not review Mr A's clinical notes as part of his decision not to review Mr A.

There was poor communication between staff about Mr A's fall, particularly at the nursing and medical handovers. While incoming nurses were aware that Mr A had sustained an injury to his head, neither nursing nor medical staff told the incoming medical team, who understood Mr A to be a "heart attack" patient. Incoming medical staff did not review Mr A or the clinical notes adequately, and were unaware that Mr A had fallen and hit his head. The plan was to continue Mr A on his blood-thinning medication and transfer him to another hospital for an angiogram. Despite some nursing staff knowing that Mr A had fallen and hit his head, they did not undertake neurological observations, and continued to administer his blood-thinning medication. That evening, Mr A had a headache and felt dizzy when he stood up. Subsequently, nursing staff found that Mr A had vomited, was breathing abnormally, and was non-responsive. A CT scan revealed a massive brain bleed. Mr A received palliative care and, sadly, he died.

The DHB acknowledged that several failures during Mr A's admission resulted in the overall care being inadequate. The DHB accepted that the care provided to Mr A fell well below the standard expected of hospitals in New Zealand, and that there was a lack of attention to the basic aspects of monitoring, assessment, communication and critical thinking, and a failure to consider the care required by Mr A adequately. The DHB accepted that this was a collective failure of the system and the people operating in it, for which ultimately the DHB was responsible.

The DHB accepted that its failures amounted to a breach of the Code, and the matter proceeded by way of an agreed summary of facts. The Tribunal was satisfied that the DHB had failed to provide services to Mr A with reasonable care and skill, and issued a declaration that the DHB had breached Right 4(1) of the Code. The Tribunal's decision can be found at:

https://www.justice.govt.nz/assets/2021-nzhrrt-49-director-of-proceedings-v-taranaki-district-health-board.pdf

4.5 Aged Care

"The scope of the role is not limited to a particular age bracket, and covers all older people who access health and disability services."

This year saw a dedicated Aged Care Commissioner established within HDC, and Carolyn Cooper started in this role in March 2022. The role is designed to advocate for older people, and to provide strategic oversight and stronger sector leadership to drive quality improvement in the aged-care sector.

As a Deputy Health and Disability Commissioner, the Aged Care Commissioner is also a statutory decision-maker on complaints and formal investigations about care provided to older people, including whether their rights have been breached under the Code.

The scope of the role is not limited to a particular age bracket, and covers all older people who access health and disability services. These services are wide-ranging, including primary health care, general health services (including public hospital care), aged residential care facilities, and home and community support services.

The work programme in 2021/22 focused on the establishment of the role, including developing terms of reference for the role, recruitment, and building relationships with key stakeholders.

Complaints about aged-care services can be complex, as often they involve a series of events over a length of time. An aged residential care facility is also the older person's home.

In the 2021/22 year, HDC received 183 complaints relating to aged residential care facilities. This is the highest number of complaints ever received about this sector. Common complaint themes for the period were:

- Ineffective communication with consumers and their whānau
- Inadequate care and treatment
- Poor medication management
- Inadequate coordination and escalation of care

The following broader, systemic issues are also evident when looking across complaints received during the year:

- Cultural safety
- Capacity and capability of staff
- Dementia care management
- Skills and responsiveness of home care support staff
- Consumers' understanding of the care provided by retirement villages
- Mental health for older people

During the COVID-19 pandemic, HDC paid close attention to complaints about aged residential care and home and community support services, as this group was particularly vulnerable, with potential for the introduced restrictions to result in a lack of visibility over the care provided.

Complainants raised concerns regarding:

- The impact of COVID-19-related staff shortages and service disruptions in home and community support services on older people, including the services being withdrawn or reduced suddenly, inconsistencies in support worker availability, and difficulties in contacting the service.
- Visitor restrictions in aged residential care facilities — including the impact on the wellbeing of older people, inconsistencies in restrictions across aged residential care facilities, and a lack of communication with whānau about changing restrictions, and the condition of their loved ones over the period restrictions were in place.
- The impact of reduced staffing levels in aged residential care facilities on the standard of care provided to older people.

Monitoring and reporting framework

Gathering and monitoring data and information from older people, their whānau, and the sector will be key to driving system improvements in the care of older people. Developing a monitoring framework is therefore a current focus for the Aged Care Commissioner. This includes:

- Highlighting what is going well and the range of quality improvement initiatives in progress;
- Enabling the identification of key gaps, issues, emerging risks, and other areas in need of further attention or intervention; and
- Enabling collaboration with other agencies to ensure that we all use our levers where they can have the best impact to improve services for older people.

Engagement and consultation

A flexible, inclusive, person-centred approach to our definition of “older people” recognises the diversity of age-related services needed to maintain and improve the health, wellbeing, and quality of life for older people. This requires the development and implementation of a stakeholder engagement approach to reach and engage appropriately with people who may be less likely to raise concerns about their care. We must engage with older people and their whānau from all communities, and build effective relationships with advocacy groups and organisations across the aged-care sector. Forming partnerships with kaumātua, whānau, hapū and iwi will be a key focus.

Wider, and meaningful, engagement with a particular focus on Māori is vital to help us understand kaumātua and older people’s experiences of the health and disability sector, their concerns, and where they see opportunities for improvement.

Collective action

Several critical partners play an important role in delivering health and disability services. Ensuring delivery of quality services to enable older people to live safe, independent lives will help to ease pressure on the entire health system, and will enrich the lives of older people. Collective action by all critical partners and agencies in the health and disability system will lead to positive outcomes for older people.

Looking ahead

The Aged Care Commissioner is tasked with monitoring the responsiveness of the health and disability system to meet the needs of older people, with a particular focus on Māori. To support this, in 2022/23 she will look to establish key relationships and meaningful engagements with stakeholders, and to design a framework for monitoring and reporting on the performance of the sector. She has set a number of performance targets around these goals, and these will be reported in our annual report for 2022/23.

"A flexible, inclusive, person-centred approach to our definition of 'older people' recognises the diversity of age-related services needed to maintain and improve the health, wellbeing, and quality of life for older people."

Standard of care in aged residential care setting

An elderly woman was admitted to a rest home but did not receive her regular medications, including insulin, and died less than 24 hours after her admission.

This case highlights the importance of forward planning for new admissions, and of being vigilant when working with people who require medication in a timely way.

The Deputy Commissioner noted that registered nurses across many practice settings are key providers of clinical care for people with diabetes, and aged residential care settings are no exception.

The Deputy Commissioner considered that it was reasonable to assume that the health professionals involved in this consumer's brief episode of care were competent to recognise and manage her condition. The Deputy Commissioner found that the care provided to the woman fell short of acceptable standards in several areas. At least three of the four nurses involved in the woman's care failed to fulfil their clinical responsibilities and adhere to policies and procedures.

The Deputy Commissioner found the rest home in breach of Right 4(1) of the Code for failing to provide services with reasonable care and skill. The Deputy Commissioner also found two registered nurses in breach of Right 4(1) of the Code, and made adverse comment about the care provided by two further registered nurses.

Recommendations

The Deputy Commissioner recommended that the facility:

- Review its insulin administration policy to include guidance for staff when blood sugar levels are outside the usual parameters;
- Review the process of escalating GP contact attempts in situations where urgent medical review is requested;
- Introduce a GP follow-up deadline;
- Consider adding a reference section to the online note system for charting by GPs at admission or for pharmacy use in the event that a GP cannot be contacted; and
- Review its process for asking the local medical centre to chart residents' medications.

The Deputy Commissioner also recommended that the Nursing Council of New Zealand consider a review of the competence of two of the registered nurses involved in the woman's care.

(Case 19HDC01267)*

* This case can be found at: https://www.hdc.org.nz/decisions/search-decisions

4.6 Education and analysis

"Our complaints data is grounded in the consumer experience and can reflect the issues consumers care about most."

Our education initiatives and analysis of complaint trends are essential to our role of promoting greater understanding of the Code and contributing to quality and safety improvements in the health and disability system.

Complaint trend analysis

HDC has a unique lens on health and disability systems. Our complaints data is grounded in the consumer experience and can reflect the issues consumers care about most. To identify and leverage systemic change within the health and disability system, we monitor the trends that appear across complaints to target areas of concern.

We liaise regularly with other agencies with a responsibility for quality and safety, sharing intelligence and insights, identifying emerging trends, and, where appropriate, taking a collaborative approach to areas of shared concern.

HDC held 239 such engagements with key sector stakeholders in 2021/22. We also took part in the National Quality Forum — a multi-agency group designed to facilitate better information sharing of quality and safety issues, and to enable cross-agency collaboration.

HDC also ensures that insights from complaints are communicated to the sector and the general public by:

- Publishing key individual decision reports — 83 published in 2021/22;
- Working with the media to create greater public awareness of our decisions and the Code — for example, in 2021/22, 233 media stories were generated about HDC decision reports;

- Publishing a stakeholder newsletter to bring greater attention to our work in promoting and protecting people's rights under the Code;
- Giving presentations and delivering education sessions, both on the Code and on complaint trends;
- Using insights gained from complaints to influence policies and practice, including through submissions on policy and legislation;
- Producing reports into complaint trends; and
- Providing all DHBs with six-monthly reports outlining the trends in complaints nationally and individually — in 2021/22, DHBs continued to rate these reports as useful for improving quality and safety.

HDC is focused on strengthening our data collection, analysis, monitoring, and reporting of matters relating to equity, and in particular Māori experience of care. Currently we are reviewing our data collection to align with the new structures in the health system, and to ensure that we are collecting and sharing data and insights in ways that highlight inequities and support a system of learning and improvement.

In 2021/22, HDC continued to monitor the trends in complaints about COVID-19 closely — an overview of these trends can be found on page 42.

Education sessions

As well as sharing complaint trend information, systemic areas of concern, and lessons from complaints, we also deliver presentations to providers and consumers to improve people's understanding of their rights and obligations under the Code. This activity is complemented by the community-level education initiatives led by the Advocacy Service on behalf of HDC.

In 2021/22, HDC delivered 30 education sessions to sector and consumer groups. The sessions were given to a wide range of groups, including aged care, primary care, DHBs, consumer organisations, professional colleges, students across a range of health professions, and attendees at a number of health and disability sector conferences. Feedback from the sessions was positive, with people reporting improved understanding of HDC and the Code.

HDC also provides complaints management workshops to assist in improving early resolution pathways and to improve provider responses to complaints. We conducted five workshops in 2021/22. Respondents to a survey reported that they found the sessions useful for improving complaints resolution at their organisation.

Currently, HDC is developing online education for consumers and providers to ensure that our educational activities have wider reach and flexibility of approach.

Submissions and enquiries

Through making submissions, HDC advises on the need for, or benefit of, legislative, administrative, or other action to enhance protection of the rights of health and disability services consumers.

In 2021/22, HDC made 26 submissions. Submissions were made on proposed legislation, including the Pae Ora (Healthy Futures) Bill and the repeal and replacement of the Mental Health Act. HDC also submitted on several policy documents, such as the interim Government Policy Statement on Health, the code of expectations for health entities' engagement with consumers and whānau, Te Hiringa Mahara (the Mental Health and Wellbeing Commission's) Monitoring Framework, the Mental Health and Addiction System and Service Framework, the Department of Corrections' draft Disability Strategy, and various codes of conduct or ethics, guidelines, and practice standards for health and disability service providers. HDC also provided responses to select committees, including appearing before the Health Select Committee regarding a petition seeking the right to appeal HDC decisions. HDC's response to this petition, and the Committee's final report, can be found on the parliament website at www.parliament.nz.

Every year, HDC responds to thousands of enquiries from members of the public, and from providers and other agencies, which helps to improve understanding about people's rights under the Code. In 2021/22, HDC received 2,482 such enquiries.

Assisted dying

With the enactment of the End of Life Choice Act (EOLCA) in November 2021, HDC's scope was expanded to include assisted dying. The EOLCA overrides aspects of the Code in relation to assisted dying. HDC's focus has been on supporting consumers to understand their rights and providers to understand their duties under the Code in this new context.

In 2021/22, HDC published a range of resources about how the Code applies to assisted dying for consumers and providers. Resources for consumers (and their whānau) were published in five languages, as well as an audio version for people who are blind or have low vision. The Commissioner also presented on "Assisted Dying: Rights and Responsibilities" in a webinar hosted by the Ministry of Health to assist in preparing the sector for the enactment of the Act. A "Frequently Asked Questions" document was developed from the questions most commonly asked during the webinar, and this was published on the Ministry's and HDC's websites. Key messages were also reinforced in HDC's engagements with key stakeholders.

HDC engaged closely with the Ministry of Health about our educational activities to ensure that our promotional approach and alignment of key messages was consistent. HDC also developed tools for, and provided training to, National Advocacy Service staff to support their role in responding to enquiries and complaints and undertaking community-level education.

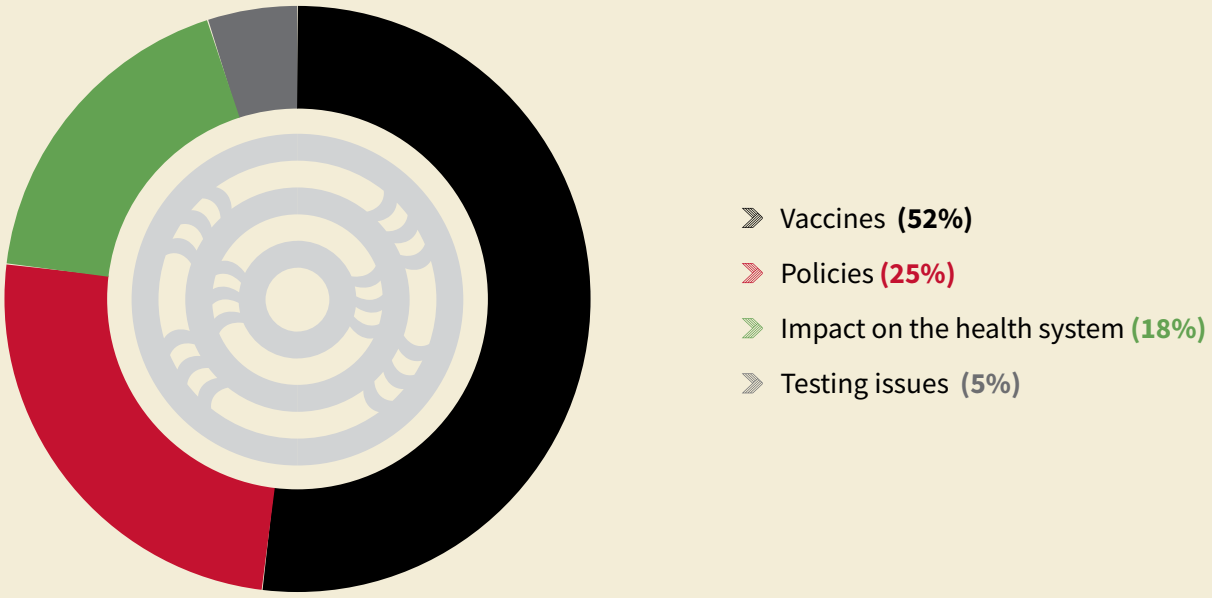
Trends in complaints regarding COVID-19

We have been monitoring trends that appear across complaints relating to COVID-19. In 2021/22, HDC received 879 complaints about COVID-19-related issues. This is a significant increase on the 212 complaints received in the previous year, and represents 26% of all complaints received by HDC in 2021/22.

Most COVID-19 complaints received by HDC in the 2021/22 year relate to the COVID-19 vaccine (52%). Other complaints relate to COVID-19-related policies (eg, infection control, visitor restrictions, mask requirements, etc) (25%), the impact of COVID-19 on the system (eg, delayed care, staffing, etc) (18%), and testing issues (5%).

As New Zealand's response to the pandemic has evolved, the profile of complaints has changed. We have seen complaints about the impact of COVID-19 on the health and disability system become more prominent in 2022, while complaints about vaccine-related issues have declined.

Figure 10. Issues raised in COVID-19-related complaints received by HDC in 2021/22



The most common specific issues raised by complainants to HDC in relation to COVID-19 in 2021/22 include:

- Refusal by health providers to treat unvaccinated people or people not wearing masks;
- Issues around streaming protocols (particularly seeing unvaccinated people in locations they felt did not uphold their right to dignity/personal privacy);
- Misinformation about COVID-19 and the vaccine provided by a small number of individual providers;
- Deferred or delayed access to services due to the impact of COVID-19;
- Standard of care provided by providers during COVID-19 outbreaks/restrictions (including impacts of reduced staffing on care standards);
- Lack of access to support people/visitors;
- Concerns about vaccine mandates;
- Consent processes for vaccines;
- Concerns around vaccine administration errors/technique or adverse reactions to vaccine;
- Concerns that consumers were communicated with in a disrespectful way by health providers due to their vaccine status;
- Testing issues — including access to testing, wait times, and delays in receiving test results; and
- Treatment of COVID-19.

4.7 Disability

The Deputy Commissioner, Disability has responsibility for ensuring tāngata whaikaha (disabled people) are aware of their rights under the Code, and for making HDC as accessible and responsive as possible to consumers' needs. Continuing to strengthen the safeguards in place for consumers of disability services, and promoting quality improvement, is also an important part of HDC's work.

COVID-19

The pandemic has presented a number of challenges over the past year, not least for tāngata whaikaha. Restrictions brought about by COVID-19 led to significant service disruption in some areas, and in some instances a lack of visibility of the care vulnerable consumers were receiving. A priority was to ensure tāngata whaikaha continued to receive the care and support to which they were entitled, and the health and disability services they received were of an appropriate standard. We have been paying particular attention to the concerns raised by consumers and their families/whānau about care, and in particular we have been highlighting to the home and community sector the risks of service disruption to vulnerable consumers who are reliant on community support services to live well and maintain their independence.

As we transition from the legacy of managing COVID-19 to living with the virus, we will continue to monitor the protections in place, and the concerns of tāngata whaikaha who receive health and disability services.

Complaints received about disability services

Disability-related complaints received by HDC are reviewed regularly to identify issues, emerging trends and areas of concern. Complaints are followed up and information shared with other agencies to encourage a common understanding of the difficulties disabled consumers are experiencing, and to facilitate a collaborative response. Opportunities are also taken to increase public awareness of people's experiences, and bring about service improvement where this is needed.

In 2021/22, HDC received 60 complaints about disability service providers.*

The common issues identified by HDC on assessment of these complaints were similar to previous years, and include:

- Inadequate and inappropriate care and support provided;
- Lack of access to services and subsidies/ funding;
- Failure to communicate openly, honestly and effectively with consumer and whānau;
- Special needs not accommodated; and
- Delay in treatment.

Home and community support services contribute to the overall health and wellbeing of many people and allow them to live a life of their choice, safely in their own homes, with independence. There was a concerning increase in the number of home care support providers complained about in 2021/22 as compared to previous years. HDC received 103 complaints in 2021/22 — a 27% increase from the 81 received in 2020/21. This is significant in the context of tāngata whaikaha as one of the primary consumer groups reliant on home care support in addition to older people.

Educational resources

Resources remain an important means by which HDC promotes awareness of the Code and informs consumers of their rights when accessing or using a health or disability service. To help people engage with community-based health and disability services, HDC developed the following online resources, to complement HDC's existing printed resources:

- **Are you receiving home support? webpage**
  A new webpage on the HDC website was created with the key points from each of the printed resources.
- **Home Support Quick Guide**
  Downloadable from the HDC website, this quick guide summarises the core messages from the printed resources and webpage, and key points to help people who are receiving care in their home.

Both resources use plain language and include contact details for emergency services, the Nationwide Health and Disability Advocacy Service, Whaikaha, the COVID-19 Disability Helpline, and HDC.

* The 60 complaints reported as being about disability services is based on the number of complaints categorised on HDC's complaints database as involving a 'disability provider' in the group provider field only.

Safety and wellbeing of vulnerable consumer

An adolescent boy with complex disabilities fell from the sling of a ceiling hoist while he was being transferred from his bed to a wheelchair by a support worker. After the fall, the support worker returned the boy to his bed without calling for assistance or assessing the boy for injury.

The incident was disclosed only when the boy's mother asked the support worker about her son's apparent distress. The boy was taken by ambulance to hospital, where he required further treatment.

Findings

The Deputy Commissioner determined that it was more likely than not that the support worker did not use the hoist correctly when attempting to transfer the boy, and the boy fell from the hoist and sustained the injury as a result. The disability service, as a healthcare provider, was responsible for providing services in accordance with the Code. The service's records showed that training and monitoring of the support worker's competency for moving and handling was up to date at the time of the accident.

The Deputy Commissioner found the support worker in breach of Right 4(1) of the Code for failing to provide services to the boy with reasonable care and skill. The Deputy Commissioner did not find the disability service in breach of the Code, but was critical that the service did not comply with its obligation to report the incident to the Health Quality & Safety Commission.

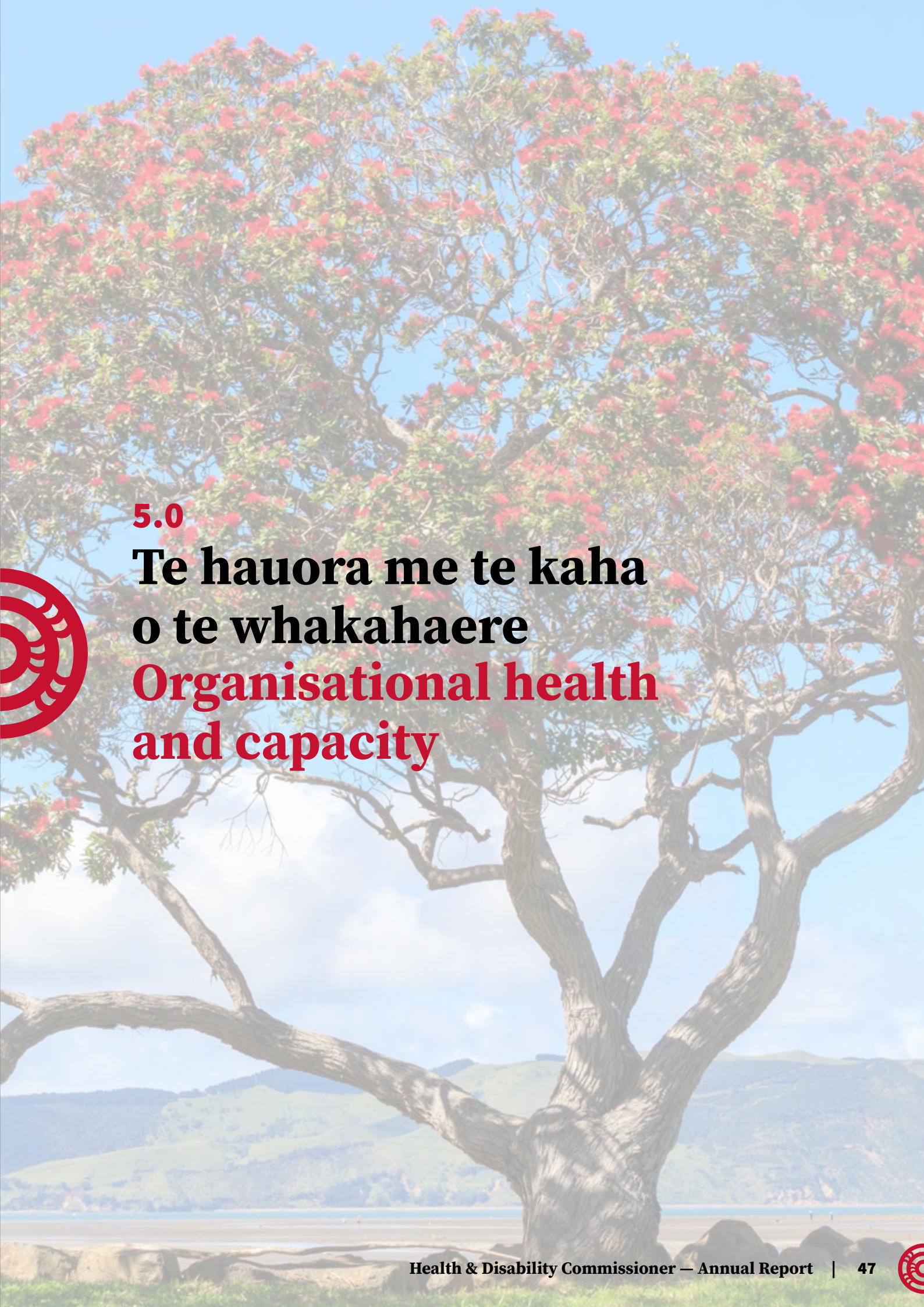
Recommendations

The Deputy Commissioner recommended that the support worker undertake further training in moving and handling, hoist use, and first aid.

The Deputy Commissioner recommended that the disability service report the accident to the Health Quality & Safety Commission and provide HDC with confirmation and evidence of the steps for improvement identified in response to the accident.

(Case 20HDC00931)*

* This case can be found at: https://www.hdc.org.nz/decisions/search-decisions



5.0

Te hauora me te kaha o te whakahaere
Organisational health and capacity

Leadership

Our organisation is led by the following groups:

- A Governance Group responsible for the strategic direction and work programme; and
- An Executive Leadership Team responsible for operational matters.

Our staff are committed to working collectively to promote and protect the rights of health and disability services consumers. Their expertise includes governance, leadership, investigation, policy, legal advice, litigation, clinical practice, research, information technology, communications, cultural advice, and financial management. Most staff hold professional qualifications and have backgrounds in health, disability, or law.

As at 30 June 2022, HDC had 121 staff members (106.71 full-time equivalents) comprising:

- Gender of HDC staff: females 81%, males 19% (2021: females 82%, males 18%)
- HDC staff in full-time and part-time positions: full-time positions 74%, part-time positions 26% (2021: full time 68%, part time 32%).

Equal employment opportunities

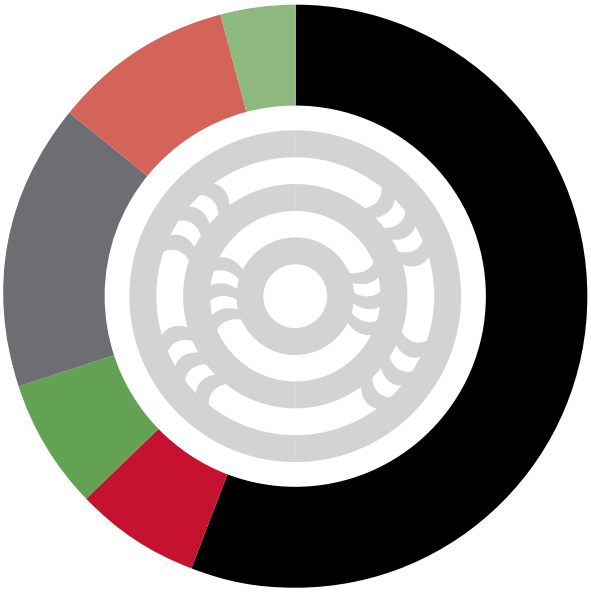
We promote and maintain equal employment opportunities. Our Good Employer and Equal Employment Opportunities Policy supports fair and equitable opportunities for employment, promotion, and training. The policy guides managers and staff to ensure that these commitments are integrated in the pre-employment recruitment process and throughout the employment cycle.

HDC employees and other workers must take responsibility to ensure that the objectives in the New Zealand Disability Strategy are put into practice. We employ disabled staff who, in addition to their primary role, are able to understand the diverse challenges of ableism. We support disabled staff to ensure that their needs are met, including providing workstation assessments, sign language interpreters, and special software and equipment.

We benefit from a diverse workforce with ethnicities including New Zealand European, Māori, Pacific, Asian, and others, and ages ranging from 20 years to over 60.

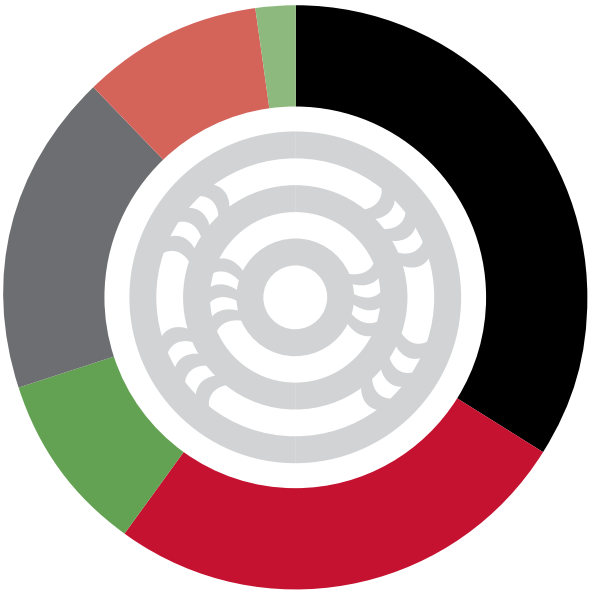
In 2021/22 HDC focused on resetting internal culture and laying the foundations for a more culturally appropriate and responsive organisation. HDC introduced weekly, whole-of-organisation karakia and waiata sessions; held workshops on Te Tiriti o Waitangi, equity and health for all staff; and introduced weekly drop-in sessions for staff to obtain cultural advice on any issue.

Figure 11. HDC staff by ethnicity group



- Pākehā/NZ European **(56%)**
- NZ Māori **(7%)**
- Pasifika **(7%)**
- Asian **(16%)**
- Other European **(10%)**
- Undeclared **(4%)**

Figure 12. HDC staff by age group



- 21 to 30 **(34%)**
- 31 to 40 **(26%)**
- 41 to 50 **(10%)**
- 51 to 60 **(18%)**
- 61 to 70 **(10%)**
- Undeclared **(2%)**

Good employer obligations

Leadership, accountability, and culture

Our staff work collaboratively to achieve HDC's strategic objectives, which align with the Minister's expectations and ultimately the government's priorities. Our managers are responsible for leading a supportive, equitable performance culture. The Commissioner provides all staff with regular updates via our "Mahi Tahi" newsletter and weekly karakia, and panui gathering to share current issues and recognise team achievements and successes.

Recruitment, selection, and induction

Our recruitment policy and practices ensure that the best qualified people are recruited using the principles of equal employment opportunities. We also provide career development for existing employees. When vacancies are advertised, they are shared throughout the office, and employees are encouraged to apply for positions commensurate with their abilities.

HDC implements a comprehensive induction and orientation programme for new staff. The topics include the oganisation's vision, mission and values, health and safety, cyber security and IT tool use, information management, privacy, staff wellbeing support, and role-specific training. We also carry out a "fresh eyes" survey to obtain feedback from new staff members for continuous improvements.

Employee development, promotion, and exit

We support professional development and promotion. Training and development, and career development needs are identified as part of the performance appraisal process. Staff members develop a performance agreement with their manager, which is tailored to their role and personal status, with clear objectives, performance measures, and a supporting development plan. Ongoing professional development for employees is encouraged, and financial assistance and/or study leave may be granted by the Commissioner.

We also provide acting-up and internal secondment opportunities to support staff development and retention. Some staff take the opportunities and then move into the role on a permanent basis following a recruitment process.

Usually, staff who leave HDC do so for further development or personal reasons, and may offer valuable feedback on their departure, which supports continuous improvements to HDC.

Flexibility and work design

We offer flexible working arrangements across the organisation. This includes supporting working from home with extra IT equipment and tools, and providing flexible work times where possible to support family and other commitments. Several staff work hours that enable them to study as well as gain valuable work experience. This year we recruited remote workers from regions outside Auckland and Wellington.

Remuneration, recognition, and conditions

We conduct regular research on market remuneration, and provide remuneration linked to position accountability and market movement. We recognise staff achievements in several ways, including at all-staff video conferences, directly by managers, and through other channels such as internal newsletters and our intranet.

We offer long service leave in addition to standard leave under the Holidays Act 2003. This acknowledges the commitment, dedication, and valuable contribution of our long-serving staff.

Harassment and bullying prevention

We have an "anti-harassment" policy and do not tolerate any forms of harassment or bullying. In addition, we promote and expect staff to comply with the State Services Standards of Integrity and Conduct.

Safe and healthy environment

We support staff to play a role in health and safety through the Health and Safety Employee Participation System and the Health and Safety Committee, which meets regularly. Health and safety is part of staff induction on day one. Regular training is provided on evacuation processes and the use of the evacuation chair for disabled staff. Health and safety is regularly on the agenda at staff forums and Executive Leadership Team meetings, and hazards are managed actively. We maintain health and safety policies, and also have an "Unsafe Visitor Process" for dealing with unacceptable and abusive communication and behaviour.

We have several initiatives to ensure a healthy and safe working environment. These include VITAE confidential counselling services; providing fresh fruit; offering influenza vaccinations; providing sit/stand desks at work; and organising Mental Health Awareness Week activities to support mental wellness.

Since the initial COVID-19 lockdown, many staff have continued to work remotely one or two days a week. We continue to ensure staff wellbeing and health and safety for all staff working remotely. This includes advice on workstation set-up and healthy work habits; extra IT equipment to support an ergonomic work set-up at home; frequent support from managers; buddy systems within teams; use of video-conferencing and regular all-staff video conferences; and provision of external Debriefing Line and Employee Assistance Programme (EAP) services to support staff in managing difficult calls.

Processes and technology

Technology

We are committed to providing staff with a secure, user-friendly and affordable ICT infrastructure. HDC uses external experts to assist with and review the design of systems, and for the ongoing monitoring and protection of IT operations from cyber risks. During the year, a refresher course of our cybersecurity training programme was rolled out to all staff to raise awareness further.

We have provided additional equipment and training support to enhance the ability of staff to work remotely. This supported our hybrid working model to become more seamless, which helps to ensure that we continue to deliver essential services and respond to complaints when working remotely.

Throughout the year we continued to work on initiatives to bring greater efficiency, such as the implementation of a secure file sharing solution, which allows us to exchange large files with external stakeholders. We refreshed our online complaint tool to make it more user-friendly and to strengthen data collection capability. We have continued to tweak our database system, where possible, to meet evolving process and reporting needs.

In 2021/22, we reviewed our existing applications and are currently preparing a business case for a new case management system, which will further enhance efficiency and support better stakeholder engagement and reporting analysis.

Sustainability

We work to reduce our impact on the environment and reduce costs. The technological advances we made this year feed into the achievement of our sustainability objectives. We also encourage staff to use resources efficiently and to actively recycle where possible, including e-waste. We endeavour to buy locally as far as possible, and have increased the use of virtual meetings to save travel costs. We purchase environmentally friendly products and services, where possible.

Physical assets and structures

We manage our assets cost-effectively. We continue to review the business requirement for the future and improve the usability of existing work spaces and physical resources. We maintain and care for our assets to ensure that we maximise their useful life.

6.0
Tauāki whakatutukitanga
Statement of Performance

6.1 Output Class 1: Complaints resolution

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2022

OUTPUT 1: Complaints resolution	Actual 2022 $	Budget 2022 $	Actual 2021 $
Revenue	9,989,201	10,020,000	8,193,061
Expenditure	9,647,657	10,120,000	7,959,203
Net surplus/(deficit)	**341,544**	**(82,000)**	**233,858**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 1.1 — COMPLAINTS MANAGEMENT		
Efficiently and appropriately resolve complaints (which contributes to achievement of Strategic Objectives 1, 3, and 4). Assume 2,400–2,600 complaints will be received.		3,413 complaints were received during the year. This represents a 25% increase on the previous year's volume (2021: 2,721).
	Close an estimated 2,400–2,600 complaints. The above figure includes an estimated 120–140 investigations.	**Target achieved** 2,627[2] complaints were closed during the year, including 121 investigations (2021: 2,404 complaints closed, including 123 investigations). Total number of open files at year end was 2,037 (2021: 1,251).

[2] This is HDC's highest ever yearly throughput, and HDC closed 9% more complaints than in the previous financial year.

6.1 Output Class 1: Complaints resolution (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
		Target not achieved
	Manage complaints so that: • No more than 22% of open complaints are 6–12 months old. • No more than 16% of open complaints are 12–24 months old. • No more than 4% of open complaints are over 24 months old.	Age of open complaints at 30 June 2022: • 6–12 months old, 663 out of 2,037 — 32.55% (2021: 22.94%). Not achieved. • 12–24 months old, 507 out of 2,037 — 24.89% (2021: 18.63%). Not achieved. • Over 24 months old, 124 out of 2,037 — 6.09%[3] (2021: 3.60%). Not achieved.

[3] HDC is actively addressing backlog and timeliness issues. However, unprecedented and unexpected increased complaints volume has impacted progress on complaints resolution timeliness.

6.1 Output Class 1: Complaints resolution (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 1.2 — QUALITY IMPROVEMENT		
Use HDC complaints management processes to facilitate quality improvement (which contributes to achievement of Strategic Objective 3).	Make recommendations and educational comments to providers to improve quality of services, and monitor compliance with the implementation of recommendations and encourage better management of complaints by providers.	**Target achieved** Between 1 July 2021 and 30 June 2022, compliance with quality improvement recommendations on 264 complaints was due to be reported to HDC by 225 providers. 395 out of a total 403 recommendations (98%) were fully complied with.
	Providers make quality improvements as a result of HDC recommendations and/or educational comments. Verify provider's compliance with HDC's quality improvement recommendations, with a target of 97% compliance.	Of the recommendations that were not fully complied with: five were due to the providers ceasing practice, two had been superseded with alternative recommendations, and the other was due to the provider not submitting evidence of completion despite consistent follow-up communication by HDC. 98% compliance (2021: 99.2%).

6.2 Output Class 2: Advocacy

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2022

OUTPUT 2: Advocacy	Actual 2022 $	Budget 2022 $	Actual 2021 $
Revenue	4,338,992	4,550,000	4,288,726
Expenditure	4,190,637	4,588,000	4,166,312
Net surplus/(deficit)	**148,355**	**(38,000)**	**122,414**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 2.1 — COMPLAINTS MANAGEMENT		
Efficiently and appropriately resolve complaints (which contributes to achievement of Strategic Objective 1).		2,971 new complaints were received by the Advocacy Service in the year ended 30 June 2022 (2021: 2,675).
		Target achieved
Assume 2,600 to 3,100 complaints will be received.	Close an estimated 2,600 to 3,100 complaints.	For the year ended 30 June 2022, 2,922 complaints were closed (2021: 2,570).

6.2 Output Class 2: Advocacy (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
	Manage complaints so that: • 80% are closed within 3 months. • 95% are closed within 6 months. • 100% are closed within 9 months.	**Target partially achieved** Complaints were managed so that: • 78%[4] were closed within 3 months (2021: 81%). Not achieved. • 97% were closed within 6 months (2021: 98%). Achieved. • 100% were closed within 9 months (2021:100%). Achieved.
Consumers and providers are satisfied with Advocacy's complaints management processes (which contributes to achievement of Strategic Objective 1).	Undertake consumer satisfaction surveys, with 80% of respondents satisfied with Advocacy's complaints management processes. Undertake provider satisfaction surveys, with 80% of respondents satisfied with Advocacy's complaints management processes.	**Target achieved** 92% of consumers and 96% of providers who responded to satisfaction surveys were satisfied or very satisfied with the Advocacy Service's complaints management process (2021: 90% of consumers and 94% of providers).

[4] Advocacy was experiencing delays in response from providers given the COVID-19 impact on the healthcare system at large. This was impacting the complaint closure time-frames.

6.2 Output Class 2: Advocacy (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 2.2 — ACCESS TO ADVOCACY		
		Target substantially achieved
Network to promote awareness of the Code and access to the Advocacy Service in local communities (which contributes to achievement of Strategic Objective 2).	Advocates carry out 3,500 scheduled visits or meetings with community groups and provider organisations for the purpose of providing information about the Code, HDC, and the Advocacy Service.	**Certified aged-care facilities** For the year ended 30 June 2022, 3,304 scheduled visits or meetings with community groups and provider organisations were carried out.[5]
	At least 75% of these visits and meetings are focused on vulnerable consumers (including those in residential aged care and disability services, inpatient mental health services, and prisons) and the family/whānau members who support them.	80% were focused on vulnerable consumers and the family/whānau members who support them. These include 947 aged-care and residential disability facility visits (2021: 3,794 visits or meetings, including 906 aged-care and residential disability facility visits).

[5] The COVID-19 regulations had an impact on the delivery of education sessions in-person and engagements with consumers and communities.

6.2 Output Class 2: Advocacy (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 2.3 — EDUCATION AND TRAINING		
Promote awareness of, respect for, and observance of, the rights of consumers and how they may be enforced (which contributes to achievement of Strategic Objective 2).	Advocates provide an estimated 1,500 education sessions.	**Target not achieved** A total of 851[6] education sessions were provided (2021: 1,274).
	Consumers and providers are satisfied with the education sessions: • Seek evaluations on sessions with 80% of respondents satisfied.	**Target achieved** 88% of consumers and providers who responded to a survey were satisfied with the Advocacy Service's education session they attended (2021: 89% of consumers and providers).

[6] The COVID-19 regulations had an impact on the delivery of education sessions in-person and engagements with consumers and communities.

6.3 Output Class 3: Proceedings

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2022

OUTPUT 3: Proceedings	Actual 2022 $	Budget 2022 $	Actual 2021 $
Revenue	597,815	702,000	614,066
Expenditure	577,375	708,000	596,539
Net surplus/(deficit)	**20,440**	**(6,000)**	**17,527**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 3.1 — PROCEEDINGS		
Professional misconduct is found in disciplinary proceedings (which contributes to achievement of Strategic Objective 4).	Professional misconduct is found in 75% of disciplinary proceedings.	**Target achieved** For the year ended 30 June 2022, professional misconduct was found in 100% (2 of 2) of disciplinary proceedings (2021: 100%, 2 of 2 professional misconduct proceedings heard by the HPDT).
Breach of the Code is found in HRRT proceedings (which contributes to achievement of Strategic Objective 4).	A breach of the Code is found in 75% of HRRT proceedings.	**Target achieved** For the year ended 30 June 2022, a breach of the Code was found in 100% (12 out of 12) of HRRT proceedings concluded (2021: no HRRT proceedings were concluded).

6.3 Output Class 3: Proceedings (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
An award is made where damages are sought (which contributes to achievement of Strategic Objective 4).	An award of damages is made in 75% of cases where damages are sought.	**Target achieved** For the year ended 30 June 2022, an award was made in 100% (10 of 10) of cases where damages were sought (2021: no awards of damages were made).
Where a restorative approach is adopted, agreement is reached between the relevant parties (which contributes to achievement of Strategic Objective 4).	An agreed outcome is reached in 75% of cases in which a restorative approach is adopted.	**Target achieved** For the year ended 30 June 2022, an agreed outcome was reached in 100% (4 of 4) of cases in which a restorative approach was adopted (2021: nil).

6.4 Output Class 4: Education

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2022

OUTPUT 4: Education	Actual 2022 $	Budget 2022 $	Actual 2021 $
Revenue	1,000,336	658,000	396,229
Expenditure	966,133	663,000	384,919
Net surplus/(deficit)	**34,203**	**(5,000)**	**11,310**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.1 — INFORMATION AND EDUCATION FOR PROVIDERS		
Monitor DHB complaints and provide complaint information to DHBs (which contributes to achievement of Strategic Objectives 2 and 3).	Produce six-monthly DHB complaint trend reports and provide to all DHBs.	**Targets achieved** Two six-monthly DHB complaint trend reports for each DHB were produced and provided to all DHBs.
	80% of DHBs who respond to an annual feedback form find complaint trend reports useful for improving services.	100% of the DHBs who responded to an annual feedback form rated the complaint trend reports as useful for improving services (2021: 100%).
Assist providers to improve their responses to complaints (which contributes to achievement of Strategic Objectives 1, 2, and 3).	Provide four complaints resolution workshops to providers, including webinars to increase the number of people reached. Report on total number of workshops provided and the approximate number of people who attended.	**Targets achieved** Five complaints resolution workshops for DHBs were held (2021: Two).
	Seek evaluations of the workshops, with 80% of respondents finding the session useful for improving complaints resolution.	100% of respondents found the session useful for improving complaints resolution (2021: 92%).

6.4 Output Class 4: Education (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.2 — INFORMATION AND EDUCATION FOR CONSUMERS AND PROVIDERS		
		Targets achieved
Promote awareness of, respect for, and observance of, the rights of consumers and how they may be enforced (which contributes to achievement of Strategic Objective 2).	Provide 20 educational presentations, including webinars to increase the number of people reached. Report on total number of presentations provided and the approximate number of people who attended.	For the year ended 30 June 2022, 30 educational presentations were made (2021: 31).
	Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	For the year ended 30 June 2022, 100% of respondents who provided feedback reported that they were satisfied with the presentations (2021: 100%).
	Develop and publish resources that promote awareness of the Code and avenues for complaints, with a particular focus on vulnerable consumers and the providers that serve them. Report on number of resources developed and intended audience/s.	For the year ended 30 June 2022, the following resources were developed: • Pertinent "assisted dying" information and guidance for both consumers and providers on the new health service related to the End of Life Choice Act 2019 • A website resource and a quick guide for people receiving home and community support services (HCSS) • The updated guides for complainants and providers, and the Learning from Complaints leaflet • An updated version of My Health Passport for disabled people

6.4 Output Class 4: Education (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
	Develop and implement an education strategy to assist with raising consumers' awareness of their rights and providers' awareness of their duties under the Code in respect of the End of Life Choice Act.	In 2021/22 HDC produced educational materials to assist consumers to understand their rights and providers to understand their responsibilities under the Code in the context of assisted dying. This included information in a number of languages and accessible formats for consumers and whānau, training for advocates to support community-level education, and information for providers, which was disseminated in presentations, articles, and on the website.
Respond to queries from consumers, providers, and other agencies about the Act, the Code, and consumer rights under the Code (which contributes to achievement of Strategic Objective 2).	Provide responses to queries as requested. Report on the total number and the breakdown by enquirer type.	For the year ended 30 June 2022, HDC had received a total of 2,482 enquiries, including 984 simple enquiries and 1,498 extended enquiries.
		Targets achieved
Make public statements and publish reports in relation to matters affecting the rights of consumers (which contributes to achievement of Strategic Objectives 2 and 3).	Produce and publish key Commissioner decision reports and related articles on the HDC website. Report on total number.	For the year ended 30 June 2022, 83 decisions relating to matters affecting the rights of consumers were published at www.hdc.org.nz (2021: 109).
	Work with the media to generate 50 media stories on HDC decision reports.	For the year ended 30 June 2022, 233 media stories had been generated.

6.4 Output Class 4: Education (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.2 — OTHER EDUCATION		
Engage with key sector stakeholders to promote the Code and share intelligence and insights relating to complaint trends (which contributes to achievement of Strategic Objectives 2 and 3).	Maintain engagement with key sector stakeholders. Report on number of engagements.	For the year ended 30 June 2022, HDC had undertaken 239 engagements with key external stakeholders.
	Provide briefings or make recommendations, suggestions, or submissions to any person or organisation in relation to the Code and/or issues or trends identified through complaints. Report on total number.	For the year ended 30 June 2022, 26 submissions were made (2021: 22).

6.5 Output Class 5: Disability

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2022

OUTPUT 5: Disability	Actual 2022 $	Budget 2022 $	Actual 2021 $
Revenue	573,396	568,000	587,845
Expenditure	553,791	572,000	571,066
Net surplus/(deficit)	**19,605**	**(4,000)**	**16,779**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 5.1 — DISABILITY EDUCATION		
Promote awareness of, respect for, and observance of, the rights of disability services consumers (which contributes to achievement of Strategic Objective 2).	Publish on the HDC website (and make accessible to people who use "accessibility software") educational resources for disability services consumers and disability services providers. Report on number of resources published.	**Targets achieved** For the year ended 30 June 2022, two new accessible resources were published on the HDC website to support consumers who use home and community support services. The resources focus on helping consumers to: • Set up a good relationship with their support worker • Manage their personal space • Manage situations and problems if they arise with their support worker

6.6 Output Class 6: Aged Care

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2022

OUTPUT 6: Aged Care	Actual 2022 $	Budget 2022 $	Actual 2021 $
Revenue	800,000	-	-
Expenditure	500,360	-	-
Net surplus/(deficit)	**299,640**	**-**	**-**

The 2021/22 Statement of Performance Expectations (SPE) did not have any measures related to Aged Care, as funding approval for the Aged Care Commissioner was received after the 2021/22 SPE was finalised. The actual expenditure includes initial establishment costs and an allocation of HDC's overheads. The new Aged Care Commissioner started her role on 14 March 2022.

7.0
Ngā tauākī pūtea
Financial statements

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE FOR THE YEAR ENDED 30 JUNE 2022

	Notes	Actual 2022 $	Budget 2022 $	Actual 2021 $
Revenue				
Funding from the Crown		17,070,000	16,270,000	14,370,000
Interest revenue		43,117	18,000	18,450
Other revenue	2	186,622	210,000	210,138
Total revenue		17,299,739	16,498,000	14,598,588
Expenditure				
Personnel costs	3	10,215,024	9,419,000	7,841,524
Depreciation and amortisation expense	8,9	222,523	209,000	193,164
Advocacy services		3,535,151	3,961,000	3,680,260
Other expenses	4	2,463,255	3,044,000	2,466,948
Total expenditure		16,435,953	16,633,000	14,181,896
Surplus/(deficit)		**863,786**	**(135,000)**	**416,692**
Total comprehensive revenue and expense		**863,786**	**(135,000)**	**416,692**

Explanations of major variances against budget are provided in Note 18.

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2022

	Notes	Actual 2022 $	Budget 2022 $	Actual 2021 $
Assets				
Current assets				
Cash and cash equivalents	5	3,775,647	2,458,000	2,471,397
Receivables	6	12,350	30,000	6,105
Prepayments		73,461	50,000	65,349
Inventories	7	13,438	20,000	21,704
Total current assets		3,874,896	2,558,000	2,564,555
Non-current assets				
Property, plant, and equipment	8	286,819	260,000	283,257
Intangible assets	9	26,194	51,000	80,900
Total non-current assets		313,013	311,000	364,157
Total assets		**4,187,909**	**2,869,000**	**2,928,712**
Liabilities				
Current liabilities				
Payables	10	606,612	565,000	420,943
Employee entitlements	11	756,090	600,000	535,755
Total current liabilities		1,362,702	1,165,000	956,698
Non-current liabilities				
Payables	10	-	-	10,593
Total non-current liabilities		-	-	10,593
Total liabilities		**1,362,702**	**1,165,000**	**967,291**
Net assets		**2,825,207**	**1,704,000**	**1,961,421**
Equity				
Contributed capital	13	788,000	788,000	788,000
Accumulated surplus	13	2,037,207	916,000	1,173,421
Total equity		**2,825,207**	**1,704,000**	**1,961,421**

Explanations of major variances against budget are provided in Note 18.

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 30 JUNE 2022

	Notes	Actual 2022 $	Budget 2022 $	Actual 2021 $
Balance at 1 July		1,961,421	1,839,000	1,544,729
Total comprehensive revenue and expense for the year		863,786	(135,000)	416,692
Balance at 30 June	13	**2,825,207**	**1,704,000**	**1,961,421**

Explanations of major variances against budget are provided in Note 18.

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2022

	Notes	Actual 2022 $	Budget 2022 $	Actual 2021 $
Cash flows from operating activities				
Receipts from the Crown		17,070,000	16,270,000	14,370,000
Interest received		39,012	18,000	21,063
Receipts from other revenue		49,647[7]	65,000	77,536
Payments to suppliers		(5,786,354)	(6,890,000)	(5,979,684)
Payments to employees		(9,994,689)	(9,419,000)	(7,824,155)
GST (net)		98,013	-	(101,485)
Net cash from operating activities		1,475,629	44,000	563,275
Cash flows used in investing activities				
Purchase of property, plant, and equipment		(166,989)	(148,000)	(176,842)
Purchase of intangible assets		(4,390)	(35,000)	1,388[8]
Net cash used in investing activities		(171,379)	(183,000)	(175,454)
Cash flows from financing activities				
Net cash from financing activities		-	-	-
Net increase/(decrease) in cash and cash equivalents		**1,304,250**	**(139,000)**	**387,821**
Cash and cash equivalents at beginning of the year		2,471,397	2,597,000	2,083,576
Cash and cash equivalents at end of the year	5	**3,775,647**	**2,458,000**	**2,471,397**

Explanations of major variances against budget are provided in Note 18.

The accompanying notes form part of these financial statements.

[7] The IT costs related to the National Advocacy Trust have been offset against the contribution from the National Advocacy Trust by the same amount.

[8] A credit note was received for software costs incurred in the prior year.

Notes to the financial statements

Notes index

1. Statement of accounting policies

Reporting entity

The Health and Disability Commissioner (HDC) has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for the Health and Disability Commissioner are for the year ended 30 June 2022, and were approved by the Commissioner on 13 March 2023.

The HDC was required under section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021, which extended the reporting timeframes in the Crown Entities Act 2004 by two months) to complete its audited financial statements and performance information by 31 December 2022. This timeframe was not met because Audit New Zealand was unable to complete the audit within this timeframe due to an auditor shortage and the consequential effects of COVID-19, including lockdowns.

Basis of preparation

The financial statements have been prepared on a going concern basis. The accounting policies have been applied consistently throughout the year.

Statement of compliance

The financial statements of the Health and Disability Commissioner have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

The financial statements have been prepared in accordance with PBE Standards Reduced Disclosure Regime (RDR). The criteria under which the Health and Disability Commissioner is eligible to report in accordance with PBE Standards RDR is that its total expenses are less than $30 million and it has no public accountability.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest dollar ($).

Summary of significant accounting policies

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below.

Goods and services tax (GST)

Items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the Statement of Financial Position.

The net GST paid to, or received from, the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

The Health and Disability Commissioner is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

Budget figures

The budget figures are derived from the Statement of Performance Expectations as approved by the Health and Disability Commissioner at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Health and Disability Commissioner for the preparation of these financial statements.

Cost allocation

The Health and Disability Commissioner has determined the cost of outputs using the cost allocation system outlined below:

Direct costs are costs directly attributed to an output. Indirect costs are costs that cannot be attributed to a specific output in an economically feasible manner.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation.

Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements, the Health and Disability Commissioner has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are evaluated continually and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are:

- Useful lives and residual values of property, plant, and equipment — refer to Note 8.
- Useful lives of software assets — refer to Note 9.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

- Leases classification — refer to Note 4.

2. Revenue

Accounting policy

The specific accounting policies for significant revenue items are explained below:

Funding from the Crown (non-exchange revenue)

The Health and Disability Commissioner is primarily funded from the Crown. This funding is restricted in its use for the purpose of the Health and Disability Commissioner meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

The Health and Disability Commissioner considers that there are no conditions attached to the funding, and it is recognised as revenue at the point of entitlement.

The fair value of revenue from the Crown has been determined to be equivalent to the amounts due in the funding arrangements.

Interest revenue

Interest revenue is recognised using the effective interest method.

Sale of publications

Sales of publications are recognised when the product is sold to the customer.

Sundry revenue

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date.

Breakdown of other revenue and further information

	Actual 2022 $	Actual 2021 $
Sale of publications	46,882	61,615
Advocacy Trust contribution to IT costs	135,260	136,322
Sundry revenue	4,480	12,201
Total other revenue	**186,622**	**210,138**

3. Personnel costs

Accounting policy

Defined contribution schemes

Employer contributions to defined contribution plans include contributions to KiwiSaver and the Government Superannuation Fund. The obligations to make employer contributions are recognised as an expense in the surplus or deficit as incurred.

Breakdown of personnel costs and further information

	Actual 2022 $	Actual 2021 $
Salaries and wages	9,772,991	7,636,014
Employer contributions to defined contribution plans	222,319	188,140
Increase/(decrease) in employee entitlements	219,714	17,370
Total personnel costs	**10,215,024**	**7,841,524**

Employee Remuneration

The Health and Disability Commissioner is a Crown entity and is required to disclose certain remuneration information in its annual reports. The information reported is the number of employees receiving total remuneration of $100,000 or more per annum.

Remuneration of employees over $100,000 per annum

	Actual 2022 $	Actual 2021 $
Total remuneration paid or payable:	**No. of employees**	**No. of employees**
100,000–109,999	4	4
110,000–119,999	1	1
120,000–129,999	3	2
130,000–139,999	1	1
140,000–149,999	3	1
150,000–159,999	1	1
160,000–169,999	-	2
180,000–189,999	2	1
210,000–219,999	1	-
220,000–229,999	1	-
230,000–239,999	1	2
240,000–249,999	-	1
260,000–269,999	1	-
290,000–299,999	-	1
360,000–369,999	1	-
Total	**20**	**17**

During the year ended 30 June 2022, no employee received compensation and other benefits in relation to cessation (2021: nil).

Commissioner's total remuneration

In accordance with the disclosure requirements of sections 152(1)(a) of the Crown Entities Act 2004, the total remuneration paid to the Commissioner during the year from 1 July 2021 to 30 June 2022, including all benefits, is set out below.

Name	Position	Term started	Term ended	Actual 2022 $	Actual 2021 $
Morag McDowell	Health and Disability Commissioner	7 Sep 20	-	369,100	298,201
Anthony Hill	Health and Disability Commissioner	19 Jul 10	30 Aug 20	-	92,994*

* Reflects a 15% temporary remuneration reduction (COVID-19) during the period 9 July 2020 to 30 August 2020.

HDC has taken association liability insurance cover during the financial year in respect of the liability or costs of commissioners and employees.

4. Other expenses

Breakdown of other expenses

	Actual 2022 $	Actual 2021 $
Advertising	16,805	15,369
Audit fees	52,292	48,586
Clinical and legal advice	355,336	638,393
Communications & IT	681,687	606,786
Inventories consumed	49,930	73,870
Write-off on property, plant, and equipment	-	700
Operating lease expense	566,637	540,743
Policy and operational consultancy	328,928	75,126
Staff travel and accommodation	33,437	62,627
Other expenses	378,203	404,748
Total other expenses	**2,463,255**	**2,466,948**

Accounting policy

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

Operating leases as lessee

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	Actual 2022 $	Actual 2021 $
Not later than one year	722,181	568,307
Later than one year and not later than five years	6,255	306,868
Later than five years	-	-
Total non-cancellable operating leases	**728,436**	**875,175**

The Health and Disability Commissioner leases two properties — one in Auckland and one in Wellington.

The non-cancellable operating lease commitment relates to the lease of these two offices and office equipment (2021: two office leases and office equipment). Both premises leases expire in June 2023.

5. Cash and cash equivalents

Accounting policy

Cash and cash equivalents include cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

	Actual 2022 $	Actual 2021 $
Cash on hand and at bank	2,275,647	1,471,397
Term deposits with maturities less than 3 months	1,500,000	1,000,000
Total cash and cash equivalents	**3,775,647**	**2,471,397**

As at 30 June 2022, the Health and Disability Commissioner holds no unspent grant funding received that is subject to restrictions (2021: nil).

6. Receivables

Accounting policy

Short-term receivables are recorded at their face value, less any allowance for credit loss.

In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery.

Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

There have been no changes during the reporting period in the estimation techniques or significant assumptions used in measuring the loss allowance.

The allowance for credit loss in 2022 is $2,395 (2021: $1,282).

	Actual 2022 $	Actual 2021 $
Trade receivables	9,226	5,973
Less: allowance for credit loss	(2,395)	(1,282)
Other receivables	5,519	1,414
Total receivables	**12,350**	**6,105**
Total receivables comprises:		
Receivables from the sale of goods (exchange transactions)	12,350	6,105

7. Inventories

Accounting policy

Inventories held for use in the provision of goods on a commercial basis are valued at the lower of cost (using the FIFO method) and net realisable value.

The amount of any write-down from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

	Actual 2022 $	Actual 2021 $
Commercial inventories		
Publications held for sale	13,438	21,704
Total inventories	**13,438**	**21,704**

The write-down of inventories in 2022 amounted to $364 (2021: $1,618). No inventories are pledged as security for liabilities (2021: nil).

8. Property, plant, and equipment

Accounting policy

Property, plant, and equipment consist of the following asset classes: computer hardware, communication equipment, furniture and fittings, leasehold improvements, motor vehicles, and office equipment.

Property, plant, and equipment are measured at cost less accumulated depreciation and impairment losses.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the Health and Disability Commissioner and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset, and are included in the surplus or deficit.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the Health and Disability Commissioner and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment at rates that will write off the cost of the assets to their estimated residual values over their useful lives. Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Leasehold improvements
3 years 33%

Furniture and fittings
5 years 20%

Office equipment
5 years 20%

Motor vehicles
5 years 20%

Computer hardware
4 years 25%

Communication equipment
4 years 25%

The residual value and useful life of an asset is reviewed annually, and adjusted if applicable.

Estimating useful lives and residual values of property, plant, and equipment

At each reporting date the Health and Disability Commissioner reviews the useful lives and residual values of its property, plant, and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant, and equipment requires the Health and Disability Commissioner to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by the Health and Disability Commissioner, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the surplus or deficit, and the carrying amount of the asset in the Statement of Financial Position. The Health and Disability Commissioner minimises the risk of this estimation uncertainty by:

- physical inspection of assets; and
- aligning estimates of useful lives to asset replacement programmes.

The Health and Disability Commissioner has not made significant changes to past assumptions concerning useful lives and residual values.

Movements for each class of property, plant, and equipment are as follows:

	Computer hardware	Comms equip	Furniture & fittings	Leasehold improve-ments	Office	Total
	$	$	$	$	$	$
Cost or valuation						
Balance at 1 July 2020	661,060	5,354	177,856	675,340	71,071	1,590,681
Balance at 30 June 2021	780,432	6,744	199,616	675,340	70,947	1,733,079
Additions	132,668	5,226	19,313	-	9,782	166,989
Disposals	-	-	(5,607)	-	-	(5,607)
Balance at 30 June 2022	**913,100**	**11,970**	**213,322**	**675,340**	**80,729**	**1,894,461**
Accumulated depreciation and impairment losses						
Balance at 1 July 2020	481,015	3,623	170,187	660,880	53,058	1,368,763
Balance at 30 June 2021	551,675	4,812	169,602	667,132	56,601	1,449,822
Depreciation expense	112,198	4,396	29,840	5,677	11,316	163,427
Disposals	-	-	(5,607)	-	-	(5,607)
Balance at 30 June 2022	**663,873**	**9,208**	**193,835**	**672,809**	**67,917**	**1,607,642**
Carrying amounts						
At 1 July 2020	180,045	1,731	7,669	14,460	18,013	221,918
At 30 June 2021/1 July 2021	228,757	1,932	30,014	8,208	14,346	283,257
At 30 June 2022	249,227	2,762	19,487	2,531	12,812	286,819

There are no restrictions on the Health and Disability Commissioner's property, plant, and equipment.

During the year, the Health and Disability Commissioner disposed of some furniture and fittings that had reached the end of their useful life.

The net loss on all disposals was nil (2021: $700).

There were no capital commitments for the acquisition of property, plant, and equipment at balance date (2021: nil).

9. Intangible assets

Accounting policy

Software acquisition and development

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development, employee costs and relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the maintenance of the Health and Disability Commissioner's website are recognised as an expense when incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use, and ceases at the date on which the asset is derecognised. The amortisation charge for each period is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Acquired computer software
3 years 33%

Developed computer software
3 years 33%

Movements for each class of intangible asset are as follows:

	Acquired software $	Internally generated software $	Total $
Cost			
Balance at 1 July 2020	763,468	248,516	1,011,984
Balance at 30 June 2021/1 July 2021	762,080	-	762,080
Additions	4,390	-	4,390
Balance at 30 June 2022	766,470	-	766,470
Accumulated amortisation and impairment losses			
Balance at 1 July 2020	603,520	248,516	852,036
Balance at 30 June 2021/1 July 2021	681,180	-	681,180
Amortisation expense	59,096	-	59,096
Balance at 30 June 2022	740,276	-	740,276
Carrying amounts			
At 1 July 2020	159,948	-	159,948
At 30 June 2021/1 July 2021	80,900	-	80,900
At 30 June 2022	26,194	-	26,194

There are no restrictions over the title of the Health and Disability Commissioner's intangible assets, nor are any intangible assets pledged as security for liabilities.

There were no capital commitments for the acquisition of intangible assets at balance date (2021: nil).

10. Payables

Accounting policy

Short-term payables are recorded at their face value.

Breakdown of payables and deferred revenue

	Actual 2022 $	Actual 2021 $
Payables under exchange transactions		
Creditors	172,560	101,662
Accrued expenses	190,682	161,264
Deferred lease incentive	10,593	10,593
Total payables under exchange transactions	373,835	273,519
Payable under non-exchange transactions		
Taxes payable (GST, PAYE, and rates)	232,777	147,424
Total payables under non-exchange transactions	232,777	147,424
Total current payables	**606,612**	**420,943**
Deferred lease incentives	-	10,593
Total non-current payables	**-**	**10,593**
Total payables	**606,612**	**431,536**

11. Employee entitlements

Accounting policy

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, and annual leave earned to, but not yet taken at, balance date.

Employee entitlements

	Actual 2022 $	Actual 2021 $
Current portion		
Annual leave	756,090	535,755
Total employee entitlements	**756,090**	**535,755**

12. Contingencies

Contingent liabilities

As at the reporting date there were no contingent liabilities (2021: nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2021: nil).

13. Equity

Accounting policy

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- contributed capital; and
- accumulated surplus or deficit.

	Actual 2022 $	Actual 2021 $
Contributed capital		
Balance at 1 July	788,000	788,000
Capital contribution	-	-
Balance at 30 June	788,000	788,000
Accumulated surplus		
Balance at 1 July	1,173,421	756,729
Surplus/(deficit) for the year	863,786	416,692
Balance at 30 June	2,037,207	1,173,421
Total equity	**2,825,207**	**1,961,421**

14. Related party transactions

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

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the Health and Disability Commissioner would have received in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Ministry of Health, Ministry of Inland Revenue, ACC, and New Zealand Post) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel compensation

	Actual 2022 $	Actual 2021 $
Leadership Team		
Remuneration	2,271,977	1,798,009
Full-time equivalent members	10.01	7.98

15. Financial instruments

The carrying amount of financial assets and liabilities in each of the financial instrument categories are as follows:

	Actual 2022 $	Actual 2021 $
Financial assets measured at amortised cost		
Cash and cash equivalents	2,275,647	1,471,397
Term deposits with maturities less than 3 months	1,500,000	1,000,000
Receivables	12,350	6,105
Total financial assets measured at amortised cost	**3,787,997**	**2,477,502**
Financial liabilities measured at amortised cost		
Payables (excluding income in advance, lease incentive, taxes payable, and grants received subject to conditions)	363,243	262,926
Total financial liabilities measured at amortised cost	**363,243**	**262,926**

16. Events after the reporting date

There were no significant events after the reporting date.

17. Impact of COVID-19

The COVID-19 pandemic contributed to a 25% increase in complaints during the financial year ended 30 June 2022, which put significant pressure on our staff.

The main impacts on HDC's financial statements due to COVID-19 are as follows:

Revenue

Revenue from the Crown was not impacted by the New Zealand COVID-19 response levels.

Expenditure

Personnel costs increased as a result of employing extra resources to manage the increase in complaints.

The employee entitlements balance has continued to increase as staff holiday plans have been impacted.

Other significant assumptions

There are no provisions made for the COVID-19 impact within the Statement of Financial Position.

There are no other significant assumptions being made concerning the future and no key sources of estimation uncertainty at the reporting date that pose significant risk of causing material adjustments to the carrying balances of assets and liabilities within the next financial year.

18. Explanation of major variances against budget

Explanations for major variances from the Health and Disability Commissioner's budgeted figures in the Statement of Performance Expectations are as follows:

Statement of Comprehensive Revenue and Expense

Total Revenue

Crown Funding was higher than budgeted due to the recognition of the new Aged Care Commissioner funding, which was approved after the 2021/22 Statement of Performance Expectations was finalised.

Total expenditure

Personnel costs were higher than budgeted, as a result of:

- additional resources employed to manage high incoming COVID-19-related complaints and the backlog from previous years; and
- the unbudgeted costs related to the Aged Care Commissioner, which was established in March 2022.

Advocacy Service costs were lower than budgeted as the National Advocacy Trust was transitioning to new leadership during the year, which delayed the implementation, and related costs, of several initiatives.

Operating lease expenses were lower than budgeted due to HDC's decision to delay the leasing of additional space for the Auckland office.

Clinical and legal advice costs were lower than budgeted due to delayed external advice requests due to the need to divert internal resources to increased complaint volume.

Statement of Financial Position

Cash and cash equivalents were higher than budgeted owing to the higher than budgeted surplus for the year.

Statement of Changes in Equity

The closing equity balance was higher than budgeted because of the surplus for the year.

Statement of Cash Flows

The higher net cash movement was mainly as a result of the funding received for the establishment of the Aged Care Commissioner.

8.0
Tauākī kawenga
Statement of responsibility

We are responsible for the preparation of the Health and Disability Commissioner's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Health and Disability Commissioner under section 19A of the Public Finance Act 1989.

We have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Health and Disability Commissioner for the year ended 30 June 2022.

Morag McDowell
Health and Disability Commissioner

Jason Zhang
Corporate Services Manager

13 March 2023

9.0
Pūrongo ōtita
Auditor's report

Independent Auditor's Report

To the readers of Health and Disability Commissioner's financial statements and performance information for the year ended 30 June 2022

The Auditor-General is the auditor of Health and Disability Commissioner. The Auditor-General has appointed me, René van Zyl, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health and Disability Commissioner on his behalf.

Opinion

We have audited:

- the financial statements of the Health and Disability Commissioner on pages 69 to 92 that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of the Health and Disability Commissioner on pages 11 to 13 and 54 to 68.

In our opinion:

- the financial statements of the Health and Disability Commissioner on pages 69 to 92:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2022; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards Reduced Disclosure Regime; and
- the performance information on pages 11 to 13 and 54 to 68:
    - presents fairly, in all material respects, the Health and Disability Commissioner's performance for the year ended 30 June 2022, including:
        - for each class of reportable outputs:

- its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and

- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 13 March 2023. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Health and Disability Commissioner and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of the Health and Disability Commissioner for the financial statements and the performance information

The Health and Disability Commissioner is responsible on behalf of the Health and Disability Commissioner for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Health and Disability Commissioner is responsible for such internal control as is necessary to enable them to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Health and Disability Commissioner is responsible for assessing the Health and Disability Commissioner's ability to continue as a going concern. The Health and Disability Commissioner is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the Health and Disability Commissioner, or there is no realistic alternative but to do so.

The Health and Disability Commissioner 's responsibilities arise from the Crown Entities Act 2004 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health and Disability Commissioner's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health and Disability Commissioner's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Health and Disability Commissioner.

- We evaluate the appropriateness of the reported performance information within the Health and Disability Commissioner's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Health and Disability Commissioner and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Health and Disability Commissioner's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health and Disability Commissioner to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Health and Disability Commissioner regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Health and Disability Commissioner is responsible for the other information. The other information comprises the information included on pages 2 to 10, 14 to 53, 93 to 94, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

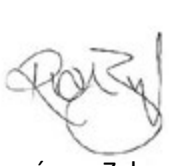
In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health and Disability Commissioner in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Deborah James was appointed as Deputy Health and Disability Commissioner, Complaints Resolution in August 2021. Prior to this, Deborah held the role of Sector Manager at the Office of the Auditor-General. During the audit period, there were appropriate safeguards to reduce any threat to auditor independence, as Deborah had no involvement in, or influence over, the audit of the Health and Disability Commissioner.

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



René van Zyl
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

He aha te mea nui o tea o?
He tāngata, he tāngata, he tāngata

What is the most important thing in the world?
It is the people, the people, the people

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