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HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Pūrongo ā-Tau
Annual Report

mō te tau mutunga o te 30 Hune 2021

for the year ended 30 June 2021

He aha te mea nui o te ao?
He tangata, he tangata, he tangata

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

Ngā kaupapa
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Kupu Whakataki a te Kaikōmihana
Commissioner's foreword

Morag McDowell
Health and Disability Commissioner

Tēnā koutou

I'm pleased to present our latest annual report, which details HDC's performance on key functions and case studies for the year ended 30 June 2021. I took office as the Health and Disability Commissioner part-way through this financial year, on 7 September 2020, with my predecessor Anthony Hill leading our dedicated team for the first two months of the year.

As a new Commissioner, I'm mindful that we're living in a unique time where the health and disability system has been thrust to the front and centre of the public's consciousness. The system is continuing to respond well to the health crisis of the COVID-19 pandemic, and now a period of significant transformation is looming.

I am pleased to see that the key aim of the health reforms announced during this year is a more people-centred system. The Code of Health and Disability Services Consumers' Rights (the Code) is as important as ever in the context of crisis and transformation, and it is crucial that we maintain a focus on the needs of consumers in this environment.

Complaints can sometimes be viewed by the sector with apprehension, but they are an inevitable part of patient contact. They are a significant learning opportunity — a chance to understand the experience of consumers in a direct way that may not be captured elsewhere. They are a good reflection of what matters to consumers and their whānau. Although people have the right to complain under the Code, it can take a lot of motivation to make a complaint, as well as courage, particularly if people are reliant on the services they are complaining about.

> *Complaints reflect the issues consumers and their whānau care most about*

Complaints are on the rise

Similar agencies overseas are seeing rising complaint numbers, and HDC is no exception. This year we experienced a 14% increase in complaints, with a general trend of a 23% increase over the last five years. There are likely many reasons for this, including the pressure the health and disability system is under, as well as some people feeling more empowered to voice their concerns.

There has been a 130% increase in the number of cases being referred to my Investigations Team compared with the previous year. This is likely to reflect, in part, both the provision of health care to a population with more complex health needs and comorbidities, and the evolving technology and models of care.

> *14% increase in complaints received this year, 130% increase in the number of cases being referred to HDC's Investigations Team*

While we closed a record number of complaints this year, meeting demand is a constant challenge for the HDC. We are working to adapt our processes to meet the needs and expectations of consumers and their whānau, while also maintaining a trusted complaints resolution function that drives quality improvement across the sector. This year we also piloted a complainant experience survey to understand people's experience with our process, and will look to introduce this permanently from 2021/22.

COVID-19 complaints

We have been closely monitoring trends that appear across complaints relating to COVID-19. In 2020/21, complaints about COVID-19 reduced as restrictions eased. However, we continued to receive 10–15 complaints a month. The main issue raised related to delays in treatment following alert level restrictions, and pointed to a system already under pressure having to catch up to provide this care.

Complaints related to COVID-19 have increased significantly during the Delta outbreak and as the vaccine roll-out gained momentum. A number of these recent complaints relate to alleged misinformation about vaccination given to patients and the general public by a very small number of health providers. We will continue to pay close attention to people's concerns as they are brought to our attention and work with providers of services to resolve these in the most effective and appropriate way.

> *one of my key priorities is to strengthen HDC's own approach to equity*

Identifying systemic issues

This year I had the opportunity to look into multiple consumers' complaints regarding how medication brand changes are managed across the health system. This was an important matter for me as a new Commissioner because the complaints highlighted a systemic issue that carried ongoing risks for consumers.

I have included more details of this in the case study section of this report. The complaints pointed to a lack of clarity about who is responsible for communicating brand changes to consumers across the health system, and the importance of healthcare providers being informed appropriately, so that they can communicate these changes to their patients effectively and manage any risks.

I raised my concerns with the Director-General of Health and, as a result, a review is underway. I look forward to hearing the outcome of this work. As an organisation, we will continue to look for opportunities to highlight systemic issues on behalf of consumers.

Mental Health Commissioner

This year, the work led by former Mental Health Commissioner Kevin Allan was passed to the Mental Health and Wellbeing Commission under its broader wellbeing mandate. The creation of the new Commission was long supported by HDC, and I wish to thank Kevin Allan for his tireless work to monitor and advocate for improvements to mental health and addiction services on behalf of tangata whaiora over a number of years.

I note that in September 2021 the Ministry of Health launched *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*, and I welcome the development of a long-term plan to transform Aotearoa's approach to mental wellbeing and to fulfil the vision laid out in *He Ara Oranga*.

Addressing health inequity and promoting rights

There is strong commitment across the health and disability sector to address the prevalent inequities of our system in the transformation ahead. As Commissioner, one of my key priorities is to strengthen HDC's own approach to equity, honouring te Tiriti o Waitangi, and enhancing our contribution to an equitable health and disability system.

In particular, we have been working to strengthen our data collection, analysis, monitoring, and reporting of matters relating to equity, and have introduced improvements to the way we collect demographic information from consumers. We have introduced analysis of our ethnicity data into our six-monthly reports on complaints involving district health boards, and will continue to find ways to improve our processes and report on issues that arise for Māori and other people who are disadvantaged by the current system.

Alongside this, we are continuing to work with the Nationwide Health and Disability Advocacy Service to reach priority groups, including consumers and providers in Māori health, Pasifika, aged care, disability, and mental health and addictions.

It is a privilege to be Health and Disability Commissioner at such a pivotal time. My team and I look forward to championing the voices of consumers through the changes ahead.

Ngā mihi nui

Morag McDowell

Health and Disability Commissioner

1.0

Te arotake i te tau 2020/21
The 2020/21 year in review

Complaints received and closed by HDC and the Advocacy Service

HDC received
2,721 complaints

The Advocacy Service received
2,675 complaints

HDC closed
2,404 complaints
(the most complaints ever closed in a year)

The Advocacy Service closed
2,570 complaints

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

HDC and the Advocacy Service held **1,305** education sessions

The Advocacy Service made **3,794** visits and meetings with community groups and provider organisations

HDC held **4** complaints resolution workshops

In addition, HDC:

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 operates as an independent Crown entity — independent from government which enables the Office to be an effective and impartial guardian of consumers' rights.

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. 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.

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 mou ake** *Informed choice and consent*
8. **Tautoko** *Support*
9. **Ako me te rangahau** *Teaching and research*
10. **Mana to amuamu** *Right to complain*

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 2021, HDC received $13,370,000 from this appropriation to fund six output classes as set out in our Statement of Performance, and a one-off of $1,000,000 in funding from the COVID-19 Response and Recovery Fund to support us to respond to complaints arising from the impact of the COVID-19 pandemic.

Our executive leadership team as at 30 June 2021

Morag McDowell
Health and Disability Commissioner

Rose Wall
Deputy Health and Disability Commissioner, Disability

Kevin Allan
Deputy Health and Disability Commissioner

Greg Robins
Acting Director of Proceedings

Mark Treleaven
Associate Commissioner, Complaints Resolution

Jane King
Associate Commissioner, Legal

Dr Cordelia Thomas
Associate Commissioner

Jason Zhang
Corporate Services Manager

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 or not to take proceedings.

Education and analysis:
We use insights gained from complaints to influence policies and practice across the health and disability sector, and deliver education 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.

Mental health and addiction — monitoring and advocacy:
Previously, the Mental Health Commissioner monitored and advocated for improvements to mental health and addiction services. This role was transitioned from HDC to the Mental Health and Wellbeing Commission in February 2021.

3.0 Te whakarato i tā tātau rautaki *Delivering our strategy*

Four strategic objectives underpin HDC's Statement of Intent for 2020–2024:

1. Te whakatau amuamu
Resolution of complaints

One of our vehicles for the promotion and protection of consumers' rights is resolving complaints. Resolving complaints holds providers to account, encourages quality improvement, and promotes consumers' rights.

HDC has a statutory obligation to facilitate the resolution of complaints in a fair, simple, speedy, and efficient way. To assess impact in this area, we measure the timeliness of our process, with a target number of complaints to close each year and a measure of the age of open complaints.

In 2020/21:

- HDC received 2,721 complaints.
- HDC resolved/closed 2,404 complaints.
- HDC closed 64.8% of complaints within 3 months, 71.2% within 6 months, and 86.5% within 12 months.
- The Advocacy Service received 2,675 complaints.
- The Advocacy Service resolved/closed 2,570 complaints.
- The Advocacy Service closed 81% of complaints within 3 months, 98% within 6 months, and 100% within 12 months.
- 90% of consumers and 94% of providers who responded to surveys were satisfied or very satisfied with the Advocacy Service's complaints management process.
- HDC piloted a complainant experience survey this year, and will be introducing this on a permanent basis from 2021/22 onwards.

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

We aim to improve people's understanding of the Code and awareness of their right to complain. This is achieved through regular interactions with consumers and providers, and by providing specific advice, analysis, and educational initiatives.

HDC and the Advocacy Service provide education sessions, public statements, and reports on matters that affect the rights of health and disability services consumers.

In 2020/21:

- HDC responded to 1,997 enquiries, and the Advocacy Service responded to over 17,884 enquiries, helping people to understand their rights under the Code.
- HDC provided 31 educational sessions; of those surveyed, 92% of respondents were satisfied with these sessions.
- HDC delivered 4 complaints resolution workshops to providers; 97% of attendees provided feedback that they were satisfied with the workshops.

- HDC facilitated 4 regional seminars for people who use disability services; 100% of attendees who provided feedback reported that they were satisfied with the seminars.
- The Advocacy Service provided 1,274 education sessions; 89% of respondents were satisfied with these sessions.
- The Advocacy Service made 3,794 networking visits, with a focus on ensuring that vulnerable consumers and people not being served well by the system were made aware of the Advocacy Service and the Code.

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 both a local and a 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 2020/21:

- HDC made 492 recommendations for quality improvement
- Providers complied with 99.2% of HDC's recommendations
- HDC published 109 decisions on its website
- HDC provided district health boards (DHBs) with two six-monthly complaint trend reports; 100% of DHBs who responded to the survey said the reports were useful for improving services.

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 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 that proceedings are taken in circumstances that are well judged, and that the processes we initiate lead to a result that holds providers to account.

In 2020/21:

- HDC closed 123 investigations
- HDC found 106 breaches of the Code
- HDC referred 25 providers to the Director of Proceedings
- The Director of Proceedings filed six proceedings in the Human Rights Review Tribunal alleging a breach of the Code
- Two Health Practitioners Disciplinary Tribunal (HPDT) proceedings established professional misconduct, and a further two proceedings were filed

4.0 Te whakatutukitanga mō ngā mahi hira
Performance on key functions

HDC achieves its strategic objectives through six key functions:

4.1 Complaints resolution

Resolving complaints is one of the ways we promote and protect the rights of consumers of 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 available to us to help achieve this.

“14% increase in complaints received”

Complaints received and closed

HDC received 2,721 complaints in 2020/21 — a 14% increase on the number of complaints received last year, and a 23% increase over the past five years.

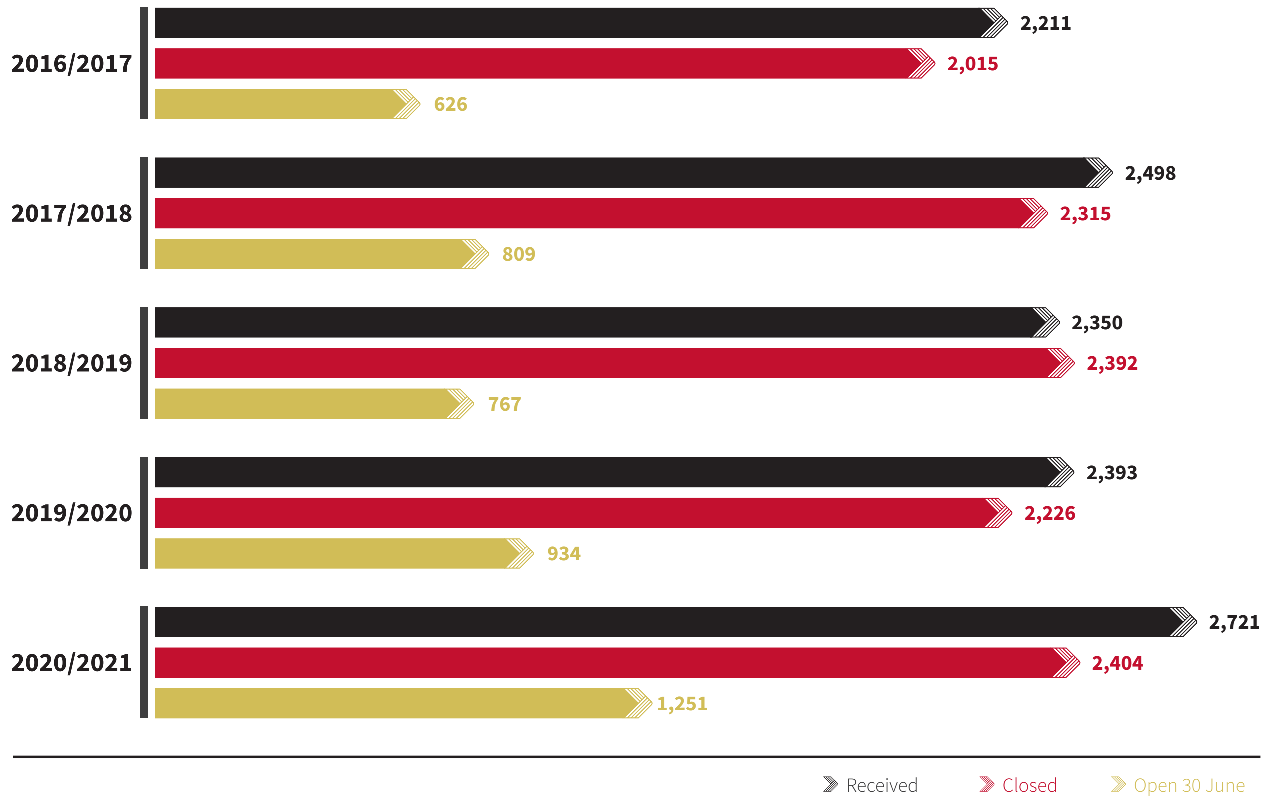
We have continued to adapt and respond to the challenges of the COVID-19 pandemic, further embedding the electronic processes set up in early 2020. We have continued to process a high volume of complaints throughout this period, with a total of 2,404 complaints resolved this year — an 8% increase on the number of complaints resolved last year. Overall, the number of complaints resolved has increased by 19% over the past five years.

The complaints being made by consumers are also increasing in complexity, which affects the time it takes to assess and investigate the issues involved. Overall, 1,251 complaints remain open as at 30 June 2021, which represents a 34% increase compared with last year.

In this climate, we continue to work hard to achieve timely resolution for people while ensuring that public health and safety risks are responded to appropriately. We are reviewing our processes to identify where efficiencies can be gained and resolution times reduced, while also maintaining fairness, equity, and commitment to our core function of promoting and protecting consumers’ rights.

“a total of 2,404 complaints resolved”

Figure 1: Number of complaints received and closed

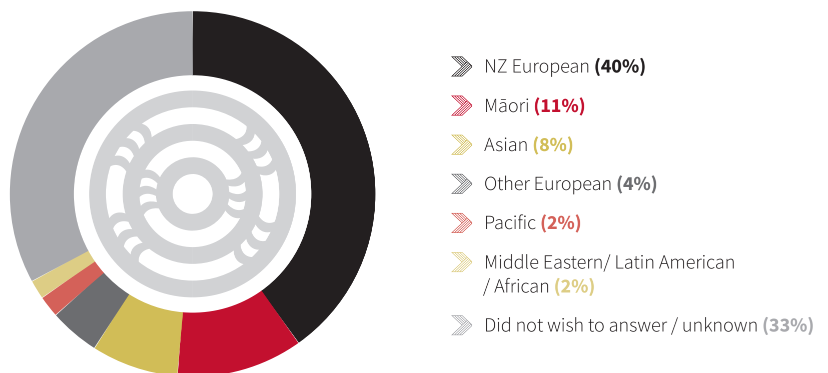


Whose care is complained about?

The demographics of consumers whose care was complained about in complaints received by HDC in 2020/21 are detailed below.

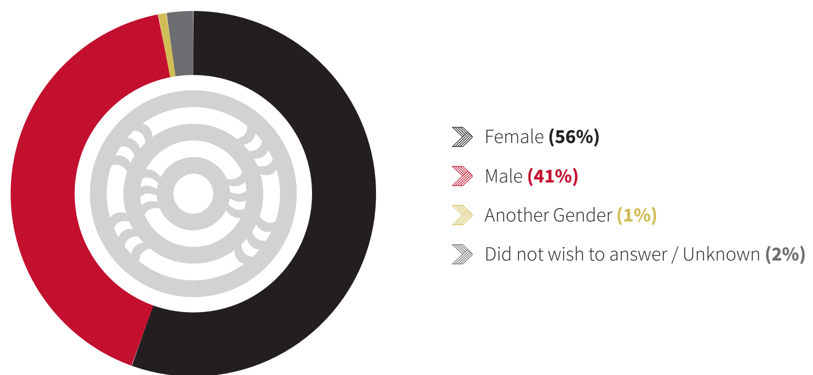
The majority of consumers identified as NZ European (40%) or Māori (11%). The ethnicity of consumers in complaints to HDC is similar to what is seen for complaints to the Advocacy Service; however, Advocacy receives a higher proportion of complaints from people who identify as Māori (23% vs 11%).

Figure 2: Ethnicity of consumers whose care was complained about in complaints received by HDC in 2020/21



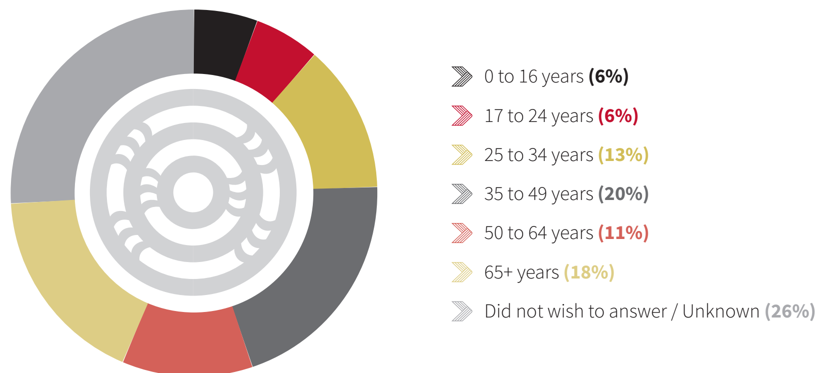
Women's care tends to be complained about at a slightly higher rate than men's care. This is similar to what is seen in other international jurisdictions and, while the reasons for this are not fully known, they are likely to be multifactorial. For example, complaints numbers can be driven by the amount of contact time with healthcare professionals, awareness among consumers of their rights and willingness to complain, and communication and quality of care issues.

Figure 3: Gender of consumers whose care was complained about in complaints received by HDC in 2020/21



The most common age groups for consumers in complaints to HDC are 35 to 49 years (20%) and over 65 years (18%). Generally this is similar to what is seen in complaints to the Advocacy Service.

Figure 4: Age of consumers whose care was complained about in complaints received by HDC in 2020/21



How we resolve complaints

HDC receives complaints through a variety of different channels: our website, post, email, or referral from another agency such as the Advocacy Service, the Coronial Service, or other professional regulatory bodies.

We have robust processes and systems in place to ensure fair and timely resolution of complaints, while complying with statutory and legal requirements.

Every complaint received is considered and assessed carefully to determine the most appropriate resolution pathway, based on the issues raised and evidence available. This process is thorough and can involve a number of steps, including obtaining a response from the provider involved, seeking independent clinical advice, and asking for further information from the complainant or other parties.

Once a complaint has been assessed, HDC decides on the most appropriate action to take, which may include:

Referring people to the Advocacy Service

- Referring the complaint to the Advocacy Service or to the provider to resolve the issue directly between the parties. Advocates can support consumers to maintain ongoing relationships with providers and achieve resolution outcomes at the point of service. In these situations, we set out clearly what is expected of providers in the resolution process, and both providers and advocates are required to report back to HDC on the outcome. It is open to HDC to take further action if the complaint cannot be resolved appropriately, or if the provider/s have failed to engage constructively.

Referring people to other agencies

- Referring the complaint to other agencies where the issues raised are more appropriately dealt with by that agency. For example, complaints about a provider's fitness to practise are better dealt with by their regulatory authority.

Deciding to take no further action

- The Commissioner can decide to take no further action on a complaint where the preliminary assessment indicates that the care provided or the provider's actions were reasonable in the circumstances, or the issues in the complaint can be reasonably addressed by other means.

Initiating a formal investigation

- In some cases, the Commissioner or Deputy Commissioner may decide to initiate a formal investigation of a complaint, which can result in the provider(s) being found in breach of the Code. Investigations focus on more serious departures from accepted standards of care, allegations of breaches of ethical boundaries, public safety concerns, and areas where there is potential for significant sector changes as a result.

Making recommendations for system improvement or educational comment

- The Commissioner or Deputy Commissioner can make recommendations for system improvement or educational comments designed to encourage providers to reflect on their practice and take away constructive learnings from the complaint. HDC then follows up with providers to ensure that they have complied with any recommendations made. Providers will typically be asked to provide evidence and supplementary information to assist HDC to evaluate the effectiveness of improvements and changes made. HDC's recommendations are nearly always complied with (99%).

The reason many complainants bring their concerns to HDC is to help to improve services so that others do not have the same experience as them. HDC encourages all providers to see complaints as an opportunity to learn, reflect, and improve.
In the 2020/21 year, HDC made recommendations for change or educational comments in response to 359 complaints, holding both providers and the system to account. HDC's recommendations continued to have a high compliance rate, with 99.2% of recommendations being complied with in 2020/21.

> *The most common reason people bring their concerns to HDC is to help improve services so that others do not have the same experience*

Table 1: Outcomes of complaints closed in 2020/2021

Outcome	*2020/21*
Investigation	*123*
Breach finding	106 25 providers referred to the Director of Proceedings
Referred to registration authority	0
No breach finding with adverse comment and recommendations	16
No breach finding	1
Other resolution following assessment	*2,169*
No further action with follow-up or educational comment	237
Referred to registration authority	37
Referred to other agency	52
Referred to provider	547
Referred to Advocacy Service	366
No action/no further action	823
Withdrawn	107
Outside jurisdiction	*112*
TOTAL	***2,404***

Issues complained about

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

The most commonly complained about primary issues have remained broadly consistent over the last four years. Inadequate/inappropriate treatment and missed/incorrect/delayed diagnosis are the most commonly complained about primary issues. In 2020/21, complaints primarily about inadequate assessments and delays in treatment increased.

When all issues raised in complaints are considered — not just primary issues — the most common complaint issue categories in 2020/21 were:

- Care/treatment (71%)
- Communication (66%)
- Consent/information (19%)
- Access/funding (15%)
- Medication (15%)

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

Primary issue	17/18	18/19	19/20	20/21
Inadequate/inappropriate treatment	220	222	199	228
Missed/incorrect/delayed diagnosis	235	209	194	205
Inadequate/inappropriate examination/assessment	106	81	103	144
Failure to communicate effectively with consumer	122	120	104	132
Disrespectful manner/attitude	129	138	125	127
Delay in treatment	81	66	89	127
Lack of access to services	105	118	115	97
Unexpected treatment outcome	119	94	109	92
Inadequate/inappropriate care (non-clinical)	90	92	80	89

This is broadly similar to what was seen in the previous year, although there has been a small increase in the proportion of complaints relating to consent/information issues from 14% of complaints received in 2019/20 to 19% of complaints in 2020/21.

Table 3: Commonly complained about organisations over last four years

Organisation type	17/18	18/19	19/20	20/21
DHB	997	986	1,004	1,099
Medical centre	578	493	534	595
Residential aged-care facility	144	130	169	151
Prison health services	101	91	110	112
Dental clinic	61	81	67	96
Pharmacy	63	58	59	70
Disability services provider	75	55	50	69
Home-care support services provider	72	49	63	81

Providers complained about

We receive complaints about both individuals and organisations (as defined below), with many complaints involving multiple providers. Organisations complained about have remained broadly consistent over time.

DHBs and general practices are the most commonly complained about organisations, with complaints about both of these providers increasing over the last four years (generally in line with the overall increase in complaints).

Compared to the previous year, there was a small decrease in residential aged-care facilities complained about in 2020/21. This may be attributed to a spike in complaints about these facilities during COVID-19 Level 4 restrictions in the previous financial year.

There was a small increase in the number of dental clinics, disability service providers, and home-care service providers complained about this year.

Individual providers

A number of factors can affect whether some types of individual providers are more likely to be listed on a complaint, including if the provider has a lot of patient contact time, and the degree to which they can be identified as responsible for the care provided.

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 midwives complained about, and a decrease in the number of orthopaedic surgeons complained about. There has been a decrease in the number of obstetrician/gynaecologists complained about in the last few years.

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

Occupation	*17/18*	*18/19*	*19/20*	*20/21*
General practitioner	335	321	300	308
Midwife	85	67	60	91
Dentist	38	51	60	58
Nurse	81	66	60	57
Psychologist	41	47	38	48
Psychiatrist	41	56	56	46
Internal medicine specialist	31	51	37	33
Orthopaedic surgeon	39	55	50	30
General surgeon	25	25	35	30
Obstetrician & gynaecologist	45	49	28	28

COVID-19 complaints

HDC has been monitoring the trends that appear across complaints relating to COVID-19. As at 30 June 2021, we had received 349 complaints related to COVID-19 since the beginning of the pandemic (February 2020).

As would be expected, complaints about COVID-19 reduced as restrictions eased during 2020/21. However, HDC continued to receive around 10–15 COVID-19 related complaints a month, and in 2020/21 HDC received a total of 197 complaints about COVID-19 related issues.

Common issues complained about in relation to COVID-19 in 2020/21 included:

- Lack of access to secondary care and/or delayed treatment
- Lack of access to primary care
- Care standards not being maintained during Alert Levels 3 and 4
- Inadequate infection control policies/procedures or failure to follow such policies
- Manner in which COVID-19 screening questions/policies were communicated
- Visitor restrictions and policies around support people
- Issues related to COVID-19 testing, e.g., access to tests, information about results, and informed consent for testing
- Issues related to the COVID-19 vaccine, e.g., access to vaccine, informed consent, and quality of care

We note that there has been a significant increase in complaints related to COVID-19 during the Delta outbreak and as the vaccine roll-out gained momentum. We will continue to pay close attention to people's concerns as they are brought to our attention and work with providers of services to resolve these in the most effective and appropriate way.

Investigations

HDC can carry out a formal investigation of a complaint in circumstances where an action is, or appears to be, in breach of the Code. The number of investigations carried out by HDC is increasing, with a significant increase in the number of complaints transferred to the Investigations Team in 2020/21, and a resulting rise in the number of formal investigations being initiated.

This year, 310 cases were transferred to the Investigations Team compared to 135 the previous year, representing an almost 130% increase.

> *130% increase in the cases transferred to our Investigations Team*

Investigation process

An investigation is an intensive and thorough process, which involves gathering evidence from all relevant parties, and often seeking independent clinical advice from an advisor with experience in the matters being investigated.

Following this evidence-gathering stage, the Commissioner or Deputy Commissioner produces a provisional opinion, outlining their findings on the care provided to the consumer/s, including whether or not the provider has breached the Code. Key parties to whom the report relates are given an opportunity to comment on the sections of the provisional opinion that are relevant to them, and they can make submissions in relation to any proposed adverse findings, or request amendment of any facts.

After careful consideration of these responses, the Commissioner or Deputy Commissioner forms their final opinion.

123 investigations were completed

In 106 of these investigations, HDC found that a consumer's rights had been breached.

Of these, 21 involved one or more providers being referred to the Director of Proceedings.

In the remaining 17 investigations completed, the provider was not found in breach of the Code. However, in many cases recommendations for change were made, to improve the quality of care.

> *123 investigations completed*

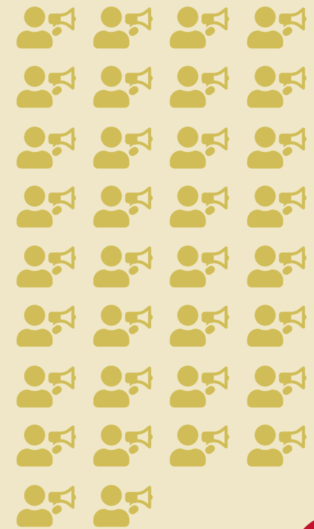
High compliance with recommendations

Recommendations for improvements and change are an important part of the outcomes for an investigation. Recommendations for systems improvements, training, education, supervision, and more, were made on almost all investigations (96%). We continued to observe a high level of compliance with our recommendations, with 99.2% compliance this year on recommendations made as part of both investigations and non-investigations.

4.2 Advocacy

The Director of Advocacy at HDC contracts with the National Advocacy Trust to provide and operate the independent Nationwide Health and Disability Advocacy Service (the Advocacy Service).

Advocates support people to resolve their concerns directly with their health and disability service providers, and promote the rights set out in the Code. They have a strong understanding of the health and disability sector, and substantial knowledge of their local communities.



2,675
complaints received

2,570
complaints resolved/closed

1,274
education sessions provided

3,794
networking visits made

Advocacy process

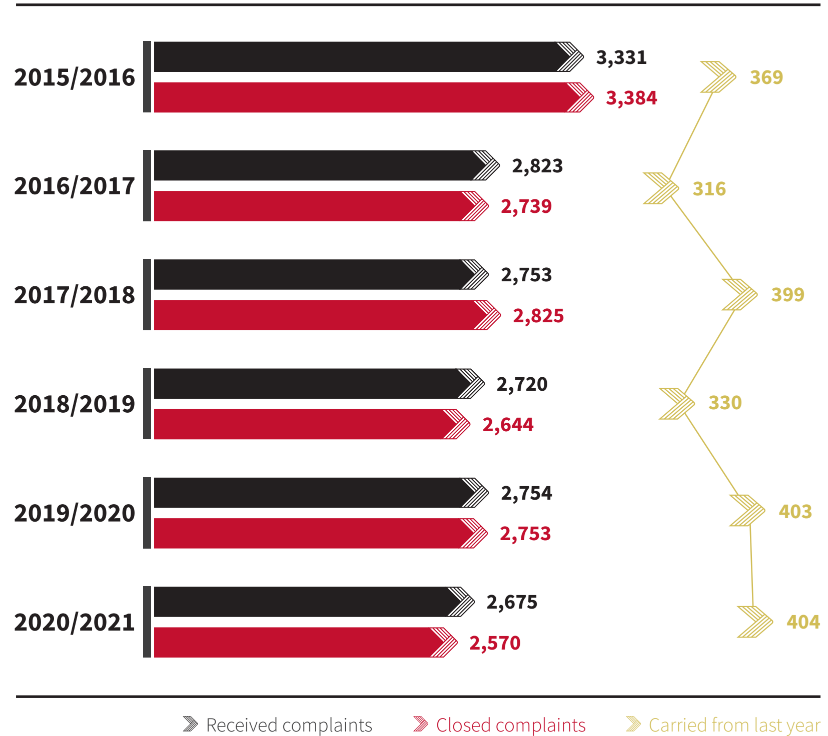
The Advocacy Service is critical to supporting HDC to achieve its strategic objective of independent, fair, simple, speedy, and efficient complaints resolution, and does this by facilitating early resolution between the parties.

The advocacy process can support people to rebuild relationships, which is particularly important when the relationship will be ongoing, such as with a GP or rest home. In some instances, just having the opportunity to talk things through and draft a complaint letter with an advocate enables people to achieve some personal reconciliation, and they may no longer need to make a formal complaint. The high resolution rate the Advocacy Service achieves reflects its consumer-focused approach and the commitment of providers to achieve early and effective resolution.

The service is accessible, and advocates are trained to support consumers who are culturally and linguistically diverse.

Complaints made to the Advocacy Service

Figure 5: Number of complaints received and closed by year

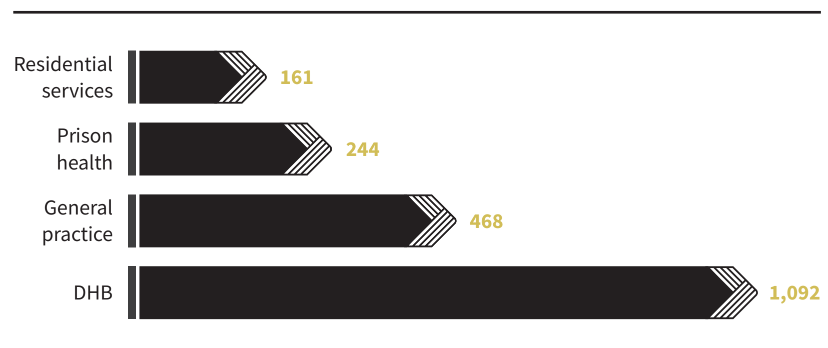


The service continued to survey both consumers and providers after their complaints were resolved/closed each month. Ninety percent of consumers who responded to surveys indicated that they were either very satisfied or satisfied with the service received from the advocate, and 94% of providers indicated that they were either very satisfied or satisfied.

Facilitating the speedy resolution of complaints while achieving good outcomes for consumers continues to be a focus for the service. Eighty-one percent of complaints were closed within three months of being received, 98% in six months, and 100% in nine months.

The types of provider complained about to the Advocacy Service is largely consistent with what is seen for complaints to HDC, with DHBs and general practices being the most commonly complained about provider type. As in previous years, Advocacy saw a higher proportion of complaints about prison health services than HDC.

Figure 6: Common complaints about providers to the Advocacy Service



COVID-19

While COVID-19 restrictions were in place for a relatively short period compared to previous years, this continued to shape the delivery of service for the Advocacy Service. The service has been agile through the various alert levels, and swiftly introduced a rapid telephone response process. Advocates have continued to work in a speedy and proactive way to support vulnerable consumers who are reliant on their service providers on a day-to-day basis.

Demographic trends

Demographic trends for complainants to the Advocacy Service are similar to those of previous years. Those aged between 41 and 60 years (36%), followed by those aged between 26 and 40 years (28%) make up the most complaints, and people who identify as female account for 59% of all complaints received.

New Zealand European and Māori were the most commonly identified ethnic groups for complainants to the Advocacy Service. Sixty-two percent of complaints received came from people who identified as New Zealand European, and 23% came from people who identified as Māori.

The demographics of consumers in complaints to the Advocacy Service is generally similar to what is seen for complaints to HDC. However, the Advocacy Service receives a higher proportion of complaints from consumers who identify as Māori (23%) compared to HDC (11%).

Figure 7: Complaints received by service type

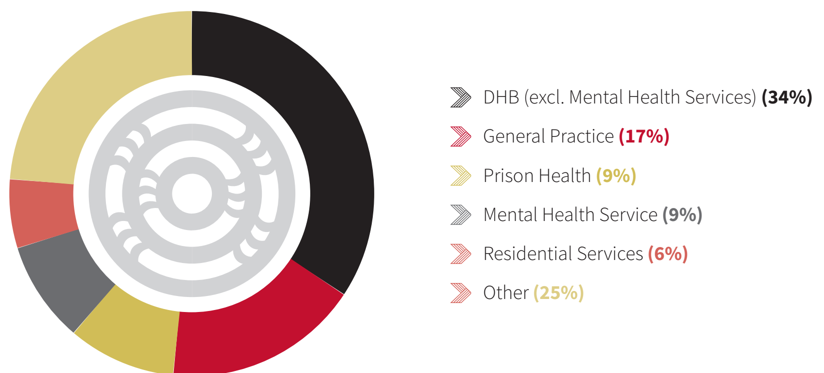


Figure 8: Ethnicity of people who make complaints to the Advocacy Service

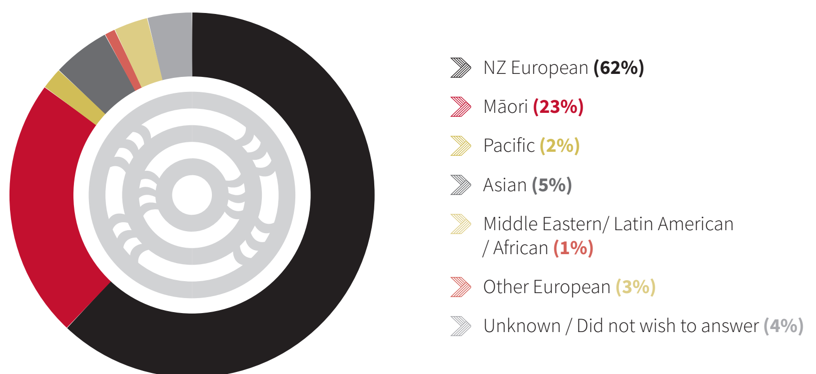
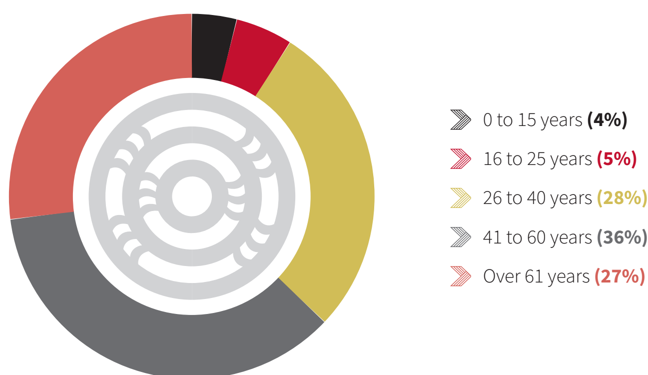


Figure 9: Age profile of people who make complaints to the Advocacy Service



Raising awareness of the Code

Advocates are responsible for raising awareness of the Code through education and promotional activities in the community. This year, advocates delivered 1,274 education sessions. The impact of COVID-19 and changing alert levels meant that providers and consumers were cautious about gatherings. This affected the delivery of some of the planned education sessions around the motu.

Part-way through the year, the Advocacy Service began to offer online education sessions to medical practices. This was then extended to all providers and consumers, with bookings available via the Advocacy Service website. In total, 69 education sessions were provided online, or a combination of some attending in person and others joining online.

Figure 10: Education sessions provided by year

Education sessions provided by advocates continue to be well attended and received. A total of 4,046 consumers and providers returned surveys; of those, 89% indicated that they were either satisfied or very satisfied with the education session provided. Groups where there were five or more participants made up 84% of all education sessions delivered.

Education sessions for priority groups

The Advocacy Service targets much of its educational activity at priority groups who are less able to self-advocate and/or experience worse health outcomes. This year, 46% (587) of education sessions were delivered to consumers and providers who have contact with Māori; Pacific peoples; refugee and migrant groups; disabled and Deaf communities; mental health and addictions services and support groups; disability and aged-care residential facilities and day-based programmes; and older people and their whānau and support, including home-care support services.

Of the 587 education sessions, 36% were delivered to groups associated with older people, 27% to mental health groups, and 16% to consumers or caregivers for those with disabilities. Overall, 89% of the 587 sessions delivered to priority groups were with consumers or consumer-focused groups.

This year, a total of 1,683 networking visits were also made by advocates, with 24% of these visits to an aged-care or residential disability service.

4.3 Proceedings

The Director of Proceedings has an independent statutory role. The Director takes proceedings against health and disability services providers in the Health Practitioners Disciplinary Tribunal | *Te Rōpū Whakatika Kaimahi Hauora* (HPDT) and the Human Rights Review Tribunal | *Te Taraipiunara Mana Tangata* (HRRT).

The Health and Disability Commissioner refers providers to the Director — a step usually reserved for the most serious breaches of the Code. The Director decides whether or not to take proceedings independently of the Commissioner.

The overall objective of the Director is to protect the public interest through holding practitioners to account, determining and upholding appropriate standards for healthcare providers, and promoting consumer confidence.

> *The HPDT considers cases of professional misconduct by a registered health practitioner, and has a range of penalties available, including a fine, conditions on practice, and suspension or cancellation of the practitioner's registration.*

> *The HRRT considers allegations of a breach of the Code against both registered and unregistered providers. Remedies include formal declarations of a breach of the Code, and in limited circumstances compensation is available.*

Proceedings taken by the Director

This year, the Director successfully prosecuted two health practitioners before the HPDT for professional misconduct, and filed proceedings in the HPDT against two further practitioners.

In addition, the Director filed six proceedings in the HRRT against providers (four against organisations or group providers and two against individual providers). As at 30 June 2021, decisions were awaited in each of these proceedings.

A case study on proceedings taken this year can be found in the case studies section of this report on page 36.

Referral numbers

This year, the Commissioner referred 23 providers to the Director of Proceedings arising from 21 complaints closed in 2020/2021. A further two providers were referred in respect of complaints closed by HDC at the end of the 2019/2020 year. A referral in respect of one provider was subsequently quashed by the High Court.

The total number of referrals is the highest since 2002/2003 and a significant increase on the number referred in recent years (typically around eight to twelve providers). The Director of Proceedings had 33 referrals in progress as at 30 June 2021.

The range of providers referred to the Director reflects the system-wide reach of the Code of Health and Disability Services Consumers' Rights.

Table 5: Referrals received in the 2020/21 year by provider type

Provider	*No. of referrals in 2020/21*
Rest home	6
DHB	4
Nurse	4
Doctor	3
General practice	3
Chiropractor	1
Podiatrist	1
Healthcare assistant	1
Social worker/mental health practitioner	1
Paramedic	1
TOTAL	***25***

4.4 Monitoring and advocacy — mental health and addiction services

Until 9 February 2021, the Mental Health Commissioner, Kevin Allan, was responsible for monitoring mental health and addiction services and advocating for improvements to those services.

The Mental Health Commissioner also made decisions on complaints about mental health and addiction services. These responsibilities were delegated to him by the Health and Disability Commissioner.

Ensuring a smooth transition to the Mental Health and Wellbeing Commission

The Mental Health and Wellbeing Commission Act 2020 was established in February 2021, establishing a permanent standalone commission that took on the Mental Health Commissioner's monitoring and advocacy function.

HDC has long supported the establishment of a Mental Health and Wellbeing Commission with a broader wellbeing mandate. Its ability to provide system-level oversight and hold the Government and other decision-makers to account are critical for the transformation of Aotearoa's approach to mental health and wellbeing, and to ensure that it remains an ongoing priority.

Throughout this year, the Mental Health Commissioner and his team met regularly with members of the initial and permanent Mental Health and Wellbeing Commission to share data, insights, and experience, including resources to support the development of the *He Ara Āwhina Service Level Monitoring Framework* and the *He Ara Oranga Wellbeing and Outcomes Framework.*

HDC will continue to consider and resolve complaints relating to mental health and addiction services, and to assess and respond to systemic issues arising from complaints. This will involve continued work with the new Commission, the Ministry of Health, and others on issues relating to mental health and addiction.

Supporting transformation

Following the release of *He Ara Oranga* in late 2018, the Government has been focused on implementing the recommendations and taking steps to transform New Zealand's approach to mental health and addiction.

Although the health system response to the COVID-19 pandemic has affected progress, this has also reinforced the need to do things differently to provide support for mental health and addiction issues and to promote wellbeing more broadly.

While the pandemic has undoubtedly increased the level of mental distress in our communities, the numerous iwi, community, whānau, and individual initiatives that emerged in the context of COVID-19 restrictions also offer lessons in how to promote wellbeing, and illustrate the power people have in contributing to collective wellbeing.

With reforms aimed at the whole health and disability sector on the horizon, there is a risk that the response to the New Zealand Health and Disability System Review | *Hauora Manaaki ki Aotearoa Whānui* will distract from the transformation in our approach to mental health and addiction. However, there is also a timely opportunity to model some of the sector changes the Government wishes to make more broadly in relation to mental health and addiction issues.

This year, up until 9 February, the Mental Health Commissioner and his team continued to provide advice and support to those tasked with bringing these recommendations to life. This included providing comment on the review of the Substance Abuse (Compulsory Assessment and Treatment) regime, and providing advice to the Ministry as it works on the repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act.

A long-term action plan for system transformation

In the Mental Health Commissioner's 2020 Monitoring and Advocacy Report,[1] Kevin Allan recommended that the Minister of Health work with colleagues to prepare an action plan, by 31 December 2020, to implement the *He Ara Oranga* agenda.

The Mental Health Commissioner called for a plan with clear vision, execution, and accountability, including identifying which minister and government agency will be responsible for leading it and coordinating its implementation. He also recommended that governance arrangements be developed with Māori, people with lived experience, providers, and other sector leaders to partner with government in the co-creation and implementation of the action plan.

The Mental Health Commissioner wrote to both Minister Hipkins[2] and Minister Little,[3] alerting them to his recommendations. He reiterated

[1] https://www.hdc.org.nz/news-resources/search-resources/mental-health/monitoring-and-advocacy-report-of-the-mental-health-commissioner-2020/

[2] https://www.hdc.org.nz/media/5537/mhc-letter-to-minister-of-health-july-2020.pdf

[3] https://www.hdc.org.nz/media/5664/mhc-letter-to-minister-of-health-november-2020.pdf

the need for a long-term action plan and early engagement from Māori, tangata whaiora, whānau, and service providers in its development. He noted that the Ministry's COVID-19 recovery plan, *Kia Kaha, Kia Māia, Kia Ora Aotearoa* provided a helpful foundation for this work.

Furthermore, prior to the transfer of his monitoring and advocacy function to the new Mental Health and Wellbeing Commission in February 2021, the Mental Health Commissioner penned an open letter to Minister Little[4] acknowledging the progress to date on a number of *He Ara Oranga's* recommendations, but noting the growing community concern about the lack of a transparent action plan to implement *He Ara Oranga* and provide a long-term plan to promote mental wellbeing. The Mental Health Commissioner reiterated the need for this plan to be designed in partnership with key stakeholders, and for the identification of the Minister and government agency responsible for leading this work. He also reinforced that regularly updated prevalence data was critical to support transformation and equity.

We note that the Ministry of Health launched *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* in September 2021, and we welcome the development of a long-term plan to transform Aotearoa's approach to mental wellbeing and to fulfil the vision laid out in He Ara Oranga.

Supporting consumers of mental health and addiction services

Increasing the prominence of consumers' rights in the mental health and addiction sector

He Ara Oranga stressed the need to give renewed prominence to the rights of consumers under the Code within the mental health and addiction sector. The inquiry recommended that HDC play a lead role in this, by undertaking specific initiatives to increase awareness of the Code among consumers, and respect and observance by providers (recommendation 22).

This year, HDC and the Advocacy Service partnered with tangata whaiora and their whānau, and providers, to identify opportunities to better support consumers of these services, and their whānau, to understand and act on their rights under the Code, and to increase providers' awareness of their obligations.

Through a series of conversations, hui, and feedback sessions, HDC and the Advocacy Service identified what is working well, key barriers and opportunities, and priorities for action. We heard that the Code needed to be brought to life — particularly through the voice of lived experience — and it needed to be better tailored to specific needs and contexts. We heard that fear of it having an impact on the services available, discrimination from society, and distrust were major barriers to consumers understanding and exercising their rights.

A range of options was discussed to address these barriers and increase awareness and respect for the Code in the mental health and addiction sector.

A programme of work is underway to provide more support to help people to understand their rights and how to make complaints, as well as to help providers to understand their responsibilities under the Code, and how to embed these into their day-to-day practice.

Strengthening the voice of tangata whaiora and whānau in the mental health and addiction system

He Ara Oranga stressed the need to place people at the centre of Aotearoa's response to mental distress, and to strengthen the voice and experience of consumers in mental health and addiction services.

Previously, in partnership with tangata whaiora, whānau, and providers, HDC commissioned the development of the Mārama Real Time Feedback tool (Mārama), to gather feedback about people's experiences of mental health and addiction services.

Since it was piloted in 2014, Mārama has collected feedback on over 41,000 experiences of care, with HDC providing stewardship since its inception.

With the transfer of the Mental Health Commissioner's monitoring and advocacy function, HDC wished to ensure that stewardship of Mārama was ongoing, and secured agreement from the Ministry of Health to take on responsibility for the tool from February 2021.

We thank everyone who has been involved in Mārama to date. HDC will maintain an interest in its success as part of the Mārama reference group.

[4] https://www.hdc.org.nz/media/5684/03-feb-mhc-letter-to-minister-of-health-february-2021.pdf

Upholding rights through complaints resolution

The Mental Health Commissioner also had responsibility for making decisions in relation to complaints to HDC about mental health and addiction services. This allowed him to connect the insights gained from complaints, and the recommendations made on individual complaints, with the wider monitoring and advocacy function.

HDC received 391 complaints about mental health and addiction services in 2020/21. This is the highest number of complaints ever received about these services. These 391 complaints represent a 33% increase on the 293 complaints received in the previous year, and a 58% increase over five years. The reasons for this increase are likely to be multifactorial, and may be a positive indication that mental health and addiction consumers feel more empowered to exercise their rights. It may also be indicative of the pressure on services, particularly in the context of the COVID-19 pandemic and the increasing public profile of mental health and addiction.

Similar to what was seen in 2019/20, when all issues complained about in relation to mental health and addiction services were considered, the most commonly complained about categories in 2020/21 were:

- Care/treatment (62%)
- Communication (61%)
- Professional conduct (22%)
- Facility issues (20%)
- Access/prioritisation (18%)
- Consent/information (17%)
- Medication (15%)

This is broadly similar to what was seen in the previous year, with the exception of professional conduct issues, which increased from being involved in 13% of mental health and addiction complaints in 2019/20 to 22% of complaints in 2020/21.

The most common issues complained about within these broad categories in 2020/21 were:

- Failure to communicate effectively with consumer (35%)
- Inadequate/inappropriate clinical treatment (24%)
- Inadequate/inappropriate examination/assessment (22%)
- Failure to communicate effectively with whānau (20%)
- Inadequate response to complaint by provider (17%)
- Lack of access to services (15%)
- Disrespectful manner/attitude (15%)

The issues complained about in 2020/21 are generally consistent with what has been seen in previous years.

The gender profile of tangata whaiora in complaints to HDC was evenly split between men (48%) and women (48%). This is in contrast to what is seen generally across all complaints to HDC, where women's care tends to be complained about at a higher rate. The most common age ranges for tangata whaiora were 35 to 49 years (23%) and 25 to 34 years (16%). Thirty-nine percent of tangata whaiora identified as NZ European, and 15% identified as Māori.

Māori tangata whaiora were more likely to raise concerns about communication with whānau, inadequate follow-up, discharge arrangements, and facility safety issues.

4.5 Education

HDC delivers education and training sessions to providers and consumers to equip them with a better understanding of their rights and obligations under the Code. This work is complemented by the Advocacy Service's role in promoting the Code through local networking and community-based education.

Complaint trend analysis

HDC has a unique lens on the system, with a focus on when things have not gone well in consumers' care. Our complaints data is grounded in the consumer experience, and reflects the issues consumers care about most.

We monitor trends that appear across complaints to target areas of concern within the sector. We regularly liaise with other agencies who have a responsibility for quality and safety about areas of systemic concern, to ensure that we all have a more complete picture of consumers' experience and are all using our functions to create change effectively.

During the year, HDC prepared a briefing to the incoming Minister of Health, which detailed the trends we see in complaints at a system-wide level. The briefing is available on the Beehive website.[5]

HDC also ensures that the learnings from complaints are communicated to the sector and the general public by publishing reports both on individual complaints and on trends that emerge across complaints. We have introduced a stakeholder newsletter to communicate key decisions and updates.

This year, we published 109 decisions where a provider was found in breach of the Code following a formal investigation.

We provided DHBs with two six-monthly complaint trend reports, which are available on our website[6]. The reports detail the issues and services complained about for all DHBs nationally, and for each individual DHB, allowing them to identify aspects of their care commonly at issue in complaints to HDC. The reports continue to be received positively, with 100% of DHBs who responded to a feedback survey stating that the reports were useful or very useful for improving services.

Education sessions

Education sessions also help to ensure that lessons from complaints are disseminated to the sector, particularly in regard to systemic issues of concern in complaints, and HDC's recommendations in these areas.

This year, we conducted 31 education sessions for a range of sector and consumer groups, including medical students, professional colleges, DHBs, aged-care staff, primary care staff, GreyPower, and a range of consumer organisations that advocate for people with particular health or disability conditions. We also presented at a number of health and disability sector conferences. Feedback from these sessions was positive.

Complaints management workshops

HDC also runs complaints management workshops, in line with our priority to improve providers' complaints management processes. We aim to increase the number of complaints resolved effectively by providers, improve consumer satisfaction with providers' responses to complaints, and encourage learning from complaints to improve quality of services.

This year, HDC conducted four complaints management workshops. Feedback continues to be positive, with between 92% and 100% of attendees who provided feedback reporting that they were satisfied or very satisfied with the sessions.

Education about the Health and Disability Commissioner Act and the Code, and the wider work of HDC is also delivered directly to consumers and providers through responses to formal enquiries. In 2020/21, HDC provided formal responses to 52 enquiries, in addition to the thousands of informal enquiries and telephone calls we received. The formal responses included providing information about informed consent and operation of the Code, the role of HDC, provider duties, and the application of the Code in different settings such as managed isolation and quarantine facilities.

Submissions

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.

This year, we made 22 submissions. Submissions were made on proposed legislation, including the review of the Health and Disability Services Standards and of the Retirement Villages Legislative Framework, and the proposed policies, procedures, codes of conduct or ethics, guidelines, and practice standards for health practitioners.

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[5] https://www.beehive.govt.nz/sites/default/files/2020-12/HDC.pdf

[6] https://www.hdc.org.nz/news-resources/search-resources/

4.6 Disability

The Deputy Commissioner, Disability — Rose Wall — is focused on increasing the awareness of disabled consumers about their rights under the Code, and ensuring that HDC is accessible and responsive to all people.

This year, education sessions were held for older people, disabled people, and their whānau in Wellington, Bay of Plenty, and Auckland, and at a National Youth Conference.

In a joint project with the Advocacy Service, we produced a collection of short video stories for people with learning disabilities. Each video tells a story about how people use disability support services and how they resolve any concerns they have. The videos are available on the HDC website[7].

To help people to engage with community-based health and disability services, HDC produced the educational booklet *Using Healthcare Services in the Community | He mahi tikanga Oranga mo te Kātoa.* The booklet contains tips on how to prepare for using community services, useful contacts, and a glossary of common words used in community health and disability service situations.

These resources work to deliver necessary information to consumers in a range of accessible formats, including New Zealand Sign Language and Easy Read formats, to empower people to have choice and control over their health and disability service needs.

Complaints received about disability services

The Deputy Commissioner, Disability recognises the importance of continuing to strengthen the safeguards in place for consumers of disability services, and promoting quality improvement. To that end, data from complaints is reviewed regularly to identify common issues and areas of concern, and information is shared with other agencies. Opportunities are also taken to increase public awareness of people's experiences, and bring about systems improvement where this is warranted.

This year, we received 124 complaints about disability services — a significant increase on the 95 complaints received last year.

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

- A lack of access to funding and services
- Individual support needs not being met
- A lack of effective communication with the consumer and their whānau, particularly regarding changes to support staff
- Inadequate service coordination, particularly in regard to staff rostering and staff attendance to shifts.

[7] https://www.hdc.org.nz/disability/disability-related-resources/

Home and community support services

Although the volume of complaints is relatively small — at 80 complaints in 2020/21 — it is almost double the number of complaints received in the previous year (41).

Complaints received about residential aged-care facilities

The Deputy Commissioner, Disability, Rose Wall, has responsibility for making decisions in relation to complaints to HDC about aged care.

People who receive residential aged-care services have particular vulnerabilities, and HDC pays close attention to the information received in complaints about those services. This year, HDC received 141 complaints about residential aged-care facilities — a decrease on the 161 complaints received last year.

Some of the most common issues identified by HDC on assessment of the complaints received this year were:

- Inadequate recognition/management of deteriorating conditions, including delays in escalating care for further review
- Inadequate assessment and management of challenging behaviours
- Inadequate falls risk assessment and management, including inadequate post-falls assessments
- Inadequate pain management
- Inadequate wound care, including inadequate assessment and monitoring
- Communication with consumers and whānau
- Inadequate care plans and documentation.

These issues remain similar to those found in the previous year, and highlight the complex nature of the support that is required to ensure that people's rights are complied with while maintaining their safety and wellbeing.

Aged Care Commissioner

Progress has been made towards establishing an Aged Care Commissioner within HDC. The role will elevate HDC's work to promote and protect the rights of people who receive aged-care services, and provide greater oversight and leadership in advocating for quality improvement across the sector. The Aged Care Commissioner will be located within HDC, as a Deputy Commissioner. Recruitment is underway, and we expect the Aged Care Commissioner to be in place in 2021/22.

5.0 Ngā mātai take | *Case studies*

01 Medication brand changes: highlighting systemic issues with ongoing risks to consumers

In 2020, HDC received a number of complaints from consumers raising concerns about Pharmac's decision to change the funded brand of lamotrigine, a medication used to treat epilepsy and bipolar disorder. Prior to the change, lamotrigine was available from Logem, Lamictal, and Arrow-Lamotrigine, and, after the change, from Logem only.

The previous Health and Disability Commissioner, Anthony Hill, carried out the initial assessment of these complaints, and the work was carried on by Morag McDowell from September 2020. As part of the process, a significant amount of information was obtained from consumers, prescribers, pharmacists, and Pharmac, and publicly available information was also considered.

It was found that a lack of clarity exists about who is responsible for managing and communicating brand changes to consumers, with a blurred line between Pharmac, prescribers, and pharmacists. Concerns were also raised about the potential for significant adverse effects for some consumers — many of whom may be particularly vulnerable — as a result of a medication brand change.

Mixed views and concerns were raised by different parts of the sector about their roles and responsibilities, with some GPs reporting that they do not consider it part of their role to inform patients of brand changes, and rely on pharmacists to communicate this to consumers at the time the medication is dispensed to them. Concerns were also raised about the relative inaccessibility of notifications about brand changes, which meant that some prescribers were unaware that they had happened.

The Commissioner took the step of writing to the Director-General of Health to outline her concerns, particularly as it is essential that healthcare providers are informed appropriately, so that they can communicate effectively with their patients and manage risks.

As a result, the Ministry of Health is undertaking a review of Pharmac's approach to communicating changes. HDC looks forward to the outcome of this work, so that the sector, and people receiving health services, have access to timely, consistent, and accurate information.

The Commissioner's letter and the Director-General of Health's reply are publicly available on the HDC website[8].

[8] https://www.hdc.org.nz/news-resources/news/commissioner-raises-concerns-with-the-director-general-of-health/

02 Informed consent: making recommendations for change and bringing issues to the attention of a professional body

In this case, a woman complained about not being fully informed about the fertility implications of procedures she underwent — a hysterectomy and bilateral oophorectomy (removal of reproductive organs).

HDC carried out a thorough assessment, with a particular focus on informed consent and the information provided on treatment options prior to the surgery. Following this, we made a number of recommendations to the health provider for improvement, including:

- Making it standard practice to inform all patients of the option to seek further advice from a fertility specialist, counsellor, or psychologist, before undergoing any surgery with possible fertility implications
- Amending the patient consent form to include reference to the patient having stated that they have been informed of their options, understand possible fertility implications, and are aware of their right to seek further advice
- Developing and providing a resource to all patients who are to undergo procedures with fertility implications, to outline the implications, options available to them, and where they can seek further information

As an additional step, we also brought the matter to the attention of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) to encourage the development of collaborative workstreams between obstetricians and gynaecologists and other specialists who can support women who are to undergo surgery with fertility implications.

03 Culturally appropriate care: making recommendations and tailoring our approach to meet the needs of whānau

A woman complained to HDC about the care her adult son received from a residential rehabilitation facility. He had suffered a severe traumatic brain injury following an accident, and now requires a high level of care.

The consumer's whānau were concerned that tikanga Māori was not respected in the provision of care, and that there was a lack of whānau engagement in decision-making and an absence of culturally appropriate policies.

During the course of HDC's assessment, it became apparent that the most appropriate way to achieve resolution was to facilitate a hui between the whānau, the provider, and HDC. The hui took place at the whānau's marae, and presented an opportunity for all parties to learn about the consumer, his whakapapa, and his connection to all those who have gone before him.

The provider acknowledged the shortcomings in the care provided, and sought help from the whānau to develop cultural safety for the provider. The whānau were happy and willing to assist in any way they could, and all parties felt that the hui led to a successful outcome. HDC also recommended that the provider:

- Consult with a cultural navigator or seek the guidance of a local kaumātua in the review of its cultural policy; and
- Provide training to all staff on the cultural policy, and ensure that it is followed effectively.

04 Mental health: referring a complaint to the advocacy process for support

A woman complained to HDC about the lack of adequate mental health support she was receiving from her DHB's mental health service. She was concerned that despite suffering a range of mental health symptoms, she had never received a definitive diagnosis and could not access community support services.

HDC considered the woman's complaint carefully and discussed resolution options with her over the telephone. With her agreement, HDC referred her complaint to the Advocacy Service for resolution.

An advocate supported the consumer to define her issues and focus on resolution outcomes that were achievable. Advice was given about seeking community support with mental health advocacy and peer support services, of which the woman had previously been unaware. A response was sought from the provider, which addressed her concerns around the care she had received, and also provided suggestions for alternative support and providers.

The advocate also helped the consumer to locate a copy of her Psychiatric Assessment Summary, which had been sent to her GP earlier in the year but she had never seen because she was no longer enrolled with the practice. The report helped the consumer to understand her diagnosis and recommended treatment plan.

05 Delays in care: referring a complaint to a provider to resolve directly with the consumer

A woman who had been diagnosed with Stage 2 myeloma (a type of blood cancer) complained to HDC about a delay in receiving her stem cell transplant procedure at her local hospital. She told HDC that the uncertainty around when she would be receiving treatment was causing undue financial stress and hardship for her family, and she was concerned that it would affect her employment.

HDC considered her complaint carefully, and felt that her concerns could be reasonably addressed directly with the provider. HDC wrote to the provider, sharing a copy of the complaint and setting out the expectations for resolution. The provider was asked to contact the consumer directly and ask whether she would like to meet to discuss her concerns, or if she would like to receive a written response.

The consumer opted to receive a written response, and a copy was shared with HDC, to ensure that the provider's response to her complaint was satisfactory.

The provider acknowledged that all patients should feel comforted and cared for, and offered an apology for the delay the consumer experienced. The provider gave a detailed explanation of what had caused the delay, and an outline of the steps taken to mitigate further instances of delay, and also provided the consumer with a letter that she could give to her employer to explain why she would require additional time off work.

She subsequently let HDC know she had been admitted for treatment and her complaint had been resolved to her satisfaction.

06 Investigation: resident of community living home suffers burns

A woman living with spastic quadriplegia, who does not communicate verbally, was a resident at an assisted living facility.

There were several oversights in the management of her continence products, including a delay in monitoring and replacing them for 12 hours. It was discovered that the continence product had leaked, and that she had sustained burns to both thighs.

There was also a lack of frequent pain assessments, inadequate medication administration, inconsistent documentation, a failure to seek timely medical review, and insufficient communication with the woman's welfare guardian.

Findings

Deputy Commissioner Rose Wall found that the facility did not provide services with reasonable care and skill, and in a manner that respected the woman's dignity.

The Deputy Commissioner also found that the Community Homes Manager — an enrolled nurse — failed to seek clinical advice from a registered nurse, and provided insufficient guidance to staff when the burns were reported to her.

Ms Wall noted: "My report highlights the importance of service providers having robust policies and procedures in place to support staff in caring for particularly vulnerable residents."

Recommendations

It was recommended that the service provider give evidence that earlier recommendations set out in the internal investigation have been implemented, and consider implementing a handover tool to ensure that accurate information is communicated among staff.

The provider was also asked to undertake a number of audits in relation to its medication administration records and continence product supplies, as well as to review its process in place for sourcing medical care.

Both the provider and the enrolled nurse involved were asked to provide a written apology to the woman, and the Nursing Council of New Zealand was asked to consider whether the enrolled nurse's competence should be reviewed.

The full report on case 19HDC01464 is available on the HDC website[9].

[9] https://www.hdc.org.nz/decisions/search-decisions/

07 Investigation: escalation of care for rest-home resident with cardiac symptoms

A woman in her late eighties was a rest-home resident and had a medical history that included coronary heart disease and COPD (a lung disease).

The woman began to experience pain in her shoulder and breast. Early the next morning, the caregiver became concerned and called the on-call registered nurse. The nurse instructed the caregiver to record the woman's blood pressure every hour and to call back if her condition deteriorated.

The nurse and the caregivers discussed the woman's condition by telephone on two further occasions, but the nurse did not assess the woman in person.

Later that morning, the nurse became concerned about the woman's blood pressure and instructed a caregiver to call a GP. However, a miscommunication between the rest home and the contracted and locum GPs meant that no GP attended the woman. During the afternoon, the nurse did not attend the woman to assess her, or call the rest home to monitor her condition.

That afternoon, the woman's son called an ambulance because the rest home had not done so. Subsequently, the nurse telephoned the woman's son and expressed her displeasure that he had called an ambulance.

The woman's son was concerned that an elderly woman with known heart problems had to wait for 14 hours for medical help. He stated: "[Rest-home owners] have a duty of care to those who we trust with our elderly, and those in need."

Findings

Deputy Health and Disability Commissioner Rose Wall found both the nurse and the rest home in breach of Right 4(1) of the Code. She considered that the instructions that the nurse gave to the caregiver were poor, and that the nurse did not provide medical intervention or arrange for it to be provided when it was required. When she became concerned about the woman's condition, the nurse did not conduct a face-to-face assessment of the woman. The nurse did not check whether the GP had arrived; and her communication with the woman's son was inappropriate.

The Deputy Commissioner also found that the rest home's procedure for obtaining GP assistance was inadequate; the nurse's workload and performance were not monitored effectively; the caregivers did not recognise the seriousness of the woman's condition, and failed to take steps to obtain urgent medical care; and the Emergency Policy was out of date.

Recommendations

The Deputy Commissioner recommended that the nurse attend training in cardiac management, communication with family members, and the responsibilities of a sole registered nurse at an aged-care facility.

The Deputy Commissioner noted that in response to HDC's recommendations, the rest home made a number of changes, including developing a plan for professional supervision for the nurse, providing training to caregivers, and updating the "When to Call 111" poster. The rest home, in conjunction with the nurse, provided HDC with an apology to the woman's family.

The Deputy Commissioner also recommended that the rest home provide additional training to caregivers, and review its processes for requesting GP assistance. In addition, she recommended that the local DHB consider continuing to monitor the care and services provided at the rest home.

The full report on case 19HDC00188 is available on the HDC website[10].

[10] https://www.hdc.org.nz/decisions/search-decisions/

08 Investigation: doctor’s failure to assess mental capacity of a dementia patient

A woman with dementia, and her partner, went to see the woman’s GP to complete a medical certificate certifying the woman’s mental capacity to appoint her partner as her enduring power of attorney (EPOA).

A person can make an EPOA only if they have sufficient mental capacity to understand what it is and what its effect will be. For patients, appointing an attorney or activating an established one are significant steps, as they can result in loss of autonomy or dignity.

“For patients, appointing an attorney or activating an established one are significant steps, as they can result in loss of autonomy or dignity.”

Although the Protection of Personal and Property Rights Act 1988 sets out the legal test for mental incapacity, it does not set out a test for capacity to appoint an attorney. However, a good guide is the common law test for competence — that a person must be able to understand the nature of decisions, foresee the consequences of those decisions, and communicate them.

In this case, the GP presumed that what was required was a letter to certify the woman’s lack of mental capacity to make decisions. The GP completed a medical certificate stating that the woman did not have mental capacity, but did not undertake a formal assessment of the woman’s mental capacity.

Subsequently, the woman’s partner returned to the medical centre and told the GP that the first certificate was not what his solicitor required. The GP contacted the solicitor for clarification, and concluded that she needed to certify that the woman did have the mental capacity to appoint an EPOA.

The GP completed a medical certificate confirming that the woman had mental capacity. The GP did this despite being of the opinion that the woman lacked the requisite mental capacity.

The woman went on to appoint her partner as her EPOA. Subsequently, the EPOA was activated, and the partner moved the woman to a rest home against the wishes of her children.

Findings

Health and Disability Commissioner Morag McDowell found that by failing to perform a formal assessment of mental capacity to appoint an enduring power of attorney, and certifying the woman’s capacity to appoint one contrary to her own opinion, the doctor failed to provide services to the woman that complied with legal and professional standards. The Commissioner found the GP in breach of Right 4(2) of the Code.

Recommendations

The Commissioner’s recommendations included that the doctor attend at least three seminars or courses on the topic of completing mental capacity documentation, arrange for peer review of the next three mental capacity documents she signs, and provide a written apology to the woman’s family.

“Doctors need to be familiar with the process and requirements for certifying whether a patient has the mental capacity to appoint an enduring power of attorney,” said Ms McDowell.

“I have recommended that the district health board consider creating an educational booklet for GPs to help them with their assessments.”

The full report on case 20HDC00126 is available on the HDC website[11].

[11] https://www.hdc.org.nz/decisions/search-decisions/

09 Investigation: delayed assessment of suicidal woman

A woman had a history of depression, post-traumatic stress disorder, and significant mental health issues. She had received compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 at the DHB.

The woman's GP made an urgent referral to the DHB's Mental Health Service for an assessment, owing to the woman's depression and suicidality. It was determined that she would be reviewed the following morning but, sadly, she died before any assessment was carried out.

Findings

Mental Health Commissioner Kevin Allan was critical that the DHB had seriously inadequate systems and processes in place at the time of the woman's referral. In particular, there was no formal process for triaging referrals, and e-referrals were managed by administrators without review by a clinician for up to 24 hours. Clinicians were also unable to access patient medical records easily, and they had to manage crisis calls in addition to their usual caseload.

"The DHB is responsible for the services it provides, and must ensure that appropriate systems are in place to support clinicians to carry out their roles," said Mr Allan. He considered that the inadequate systems and processes "contributed to the poor standard of care provided in this case, with the result that opportunities to assess the woman with the urgency required were missed".

Recommendations

The Mental Health Commissioner noted that since the events, the DHB had implemented a number of substantial changes, which should improve its service quality.

The Mental Health Commissioner recommended that the DHB update HDC on its newly developed mental health crisis service manual, conduct an audit of the current process for the management of incoming mental health referrals, and provide evidence of caseload reviews carried out for Mental Health Service clinicians and report on the effectiveness of those reviews. He also recommended that the DHB provide a written apology to the woman's family.

The full report on case 18HDC00078 is available on the HDC website[12].

Where to find help and support

If you need to talk to someone, you can free call or text any of these services at any time:

- Need to talk? **Call or text 1737** for support from a trained counsellor
- **The Depression Helpline:** 0800 111 757 or free text 4202
- **Healthline**: 0800 611 116
- **Lifeline:** 0800 543 354
- **Samaritans:** 0800 726 666
- **Youthline:** 0800 376 633 or free text 234 (8am–12am), or email talk@youthline.co.nz
- **The Lowdown:** www.thelowdown.co.nz or free text 5626
- **Kidsline (ages 5–18 years):** 0800 543 754
- **OUTline NZ:** 0800 688 5463 for confidential telephone support for the LGBTQI+ family, as well as their friends and families
- **Alcohol Drug Helpline:** 0800 787 797 or free text 8681
- **Gambling Helpline:** 0800 654 655 or free text 8006

In an emergency

If it is an emergency and you feel that you or someone else is at risk:

- Call **111** or
- Go to your nearest hospital emergency department (ED) or
- Call your local DHB Mental Health Crisis Team (CATT) **0800 611 116** and stay until help arrives.

If someone is unconscious, call an ambulance **(111)**.

[12] https://www.hdc.org.nz/decisions/search-decisions/

10 Director of Proceedings: proceedings filed by consent in the HRRT against the Department of Corrections regarding health care provided

Mr A, a person in prison, was hospitalised following a stroke and a heart attack. On discharge, the hospital prescribed him long-term clopidogrel (an anti-platelet medication or blood thinner). At the time of events, long-term clopidogrel was accepted first-line treatment for secondary prevention of stroke. If a patient stops taking clopidogrel or does not take it at all, there is an increased risk of serious heart conditions, stroke, or a blood clot in the legs or lungs. These conditions can be fatal.

After Mr A's hospital discharge, a GP at the prison transcribed Mr A's clopidogrel prescription for only one month in error, and entered it on Mr A's medication chart in the "short course medication" section (as opposed to the "regular medication" section). Some time later, a member of the prison health staff struck out clopidogrel on Mr A's medication chart, and then attempted to reinstate it by writing: "ERROR, crossed out by mistake." Three months later, Mr A was hospitalised with ischaemic heart disease (where plaque builds up inside blood vessels) and had four stents inserted in his heart. Only then was it was discovered that Mr A's clopidogrel had been stopped in error and that he had not been receiving it. Mr A started receiving long-term clopidogrel again. However, two months after his second hospital discharge, the clopidogrel was again stopped incorrectly. It was not until three months later, and after three further hospitalisations with a finding of significant coronary artery disease, that Mr A began receiving clopidogrel again.

The defendant accepted that cessation of Mr A's clopidogrel was a serious oversight that was perpetuated even after being picked up by the public hospital and despite many opportunities to identify and rectify the error. The defendant accepted that there were a number of failures by several prison health staff responsible for Mr A's care, indicating broader systemic issues for which, ultimately, the defendant was responsible. The defendant accepted that communication and documentation were seriously inadequate, and there were poor processes, a concerning lack of critical thinking, and poor compliance with policy by multiple providers, which contributed to Mr A not receiving his clopidogrel medication as intended. The defendant agreed that the care provided to Mr A fell well below the accepted standards.

The defendant accepted that its failures in care amounted to breaches of the Code, and the matter proceeded by way of an agreed summary of facts. The Tribunal was satisfied that the defendant had failed in the care it provided to Mr A, and issued a declaration that the defendant had breached Right 4(1) of the Code.

The decision is an important reminder that people in prison make up a unique and particularly vulnerable group. People in prison do not have the same choices or ability to access health services as a person living in the community, and do not have direct access to medication or to a GP. They are entirely reliant on prison health staff to assess, evaluate, monitor, and treat them appropriately.

The Tribunal's decision can be found on the Ministry of Justice website: www.justice.govt.nz.

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

Leadership

The Commissioner led the organisation with an Executive Leadership Team of two Deputy Commissioners, the Director of Proceedings, three Associate Commissioners, and a Corporate Services Manager. One Deputy Commissioner role was vacant during the 2020/21 year.

Our people

Our people are dedicated to upholding consumers' rights in their day-to-day work. We have a wide range of expertise, including in governance, leadership, investigation, policy, litigation, clinical practice, research, information technology, and financial management. Most HDC staff hold professional qualifications and have backgrounds in health, disability, or law.

As at 30 June 2021:

96 staff members (81 full-time equivalents)

Female **(82%)** Male **(18%)**

Full-time positions **(68%)** Part-time positions **(32%)**

We thank our people for their hard mahi and commitment to their work throughout the year — particularly given the difficulties posed by the COVID-19 pandemic and the significant increase in complaint volume and complexity.

Figure 11: HDC staff by ethnicity group

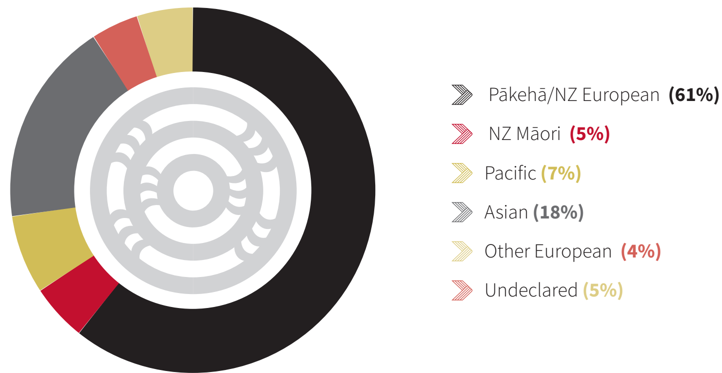
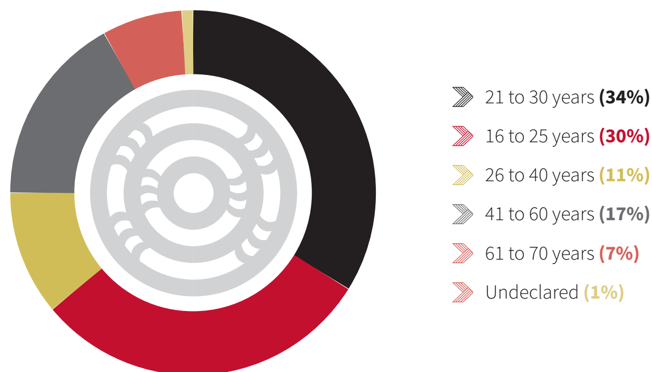


Figure 12: HDC staff by age group



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 throughout our operations. We are watching with interest the guidance from the Public Service Commission on gender and ethnicity pay-gap issues and will keep our policies and processes under review.

We require that all employees and other workers at HDC take responsibility to ensure that the objectives in the New Zealand Disability Strategy are put into practice. We employ staff with disabilities who, in addition to their primary role, provide valuable insight into the challenges faced by people living with disabilities. We support staff who disclose their disabilities to ensure that their needs are met, including providing special equipment.

In 2020/21, we organised programmes to recognise Mental Health Awareness, Te Wiki o te Reo Māori, New Zealand Sign Language Week, Pink Shirt Day, International Day of Persons with Disabilities, and Matariki.

Good employer obligations

Leadership, accountability, and culture

The Executive Leadership Team works 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 with regular opportunities to inform, share, and discuss current issues with staff.

Recruitment, selection, and induction

Our recruitment policy and practices ensure the recruitment of the best qualified employees at all levels using the principles of equal employment opportunities, while taking into account the career development of existing employees. Vacancies are shared with existing staff on a regular basis and they are encouraged to apply where appropriate. We also have a comprehensive induction programme for new staff that includes seeking their feedback to enable continuous improvement to the organisation.

Employee development and promotion

We support professional development and promotion. Our people's training, development, and career needs are formally identified as part of the performance review process, and we provide a structured training programme to support staff as they develop and progress in their roles.

Flexibility and work design

We continue to offer flexible working arrangements across the organisation, including supporting working from home, and flexible work times where possible. A number of staff work hours that enable them to study as well as gain valuable work experience.

Remuneration, recognition, and conditions

We provide fair remuneration that is linked to position accountability and market movement, and is based on equal employment opportunity principles. We recognise staff achievements at staff forums and events, and in newsletters. We also offer long-service leave in addition to standard leave under the Holidays Act 2003. This acknowledges the commitment, 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. We promote and expect everyone to comply with the State Services Standards of Integrity and Conduct.

Safe and healthy environment

We have several initiatives in place to ensure a healthy and safe work environment. Our people are supported to play an active role in health and safety through our Health and Safety Employee Participation System and the Health and Safety Committee, which meets regularly.

Health and safety is part of staff induction, and regular training is provided on evacuation processes for disabled staff. It is regularly on the agenda at staff forums and Executive Leadership Team meetings.

We maintain health and safety policies, and have in place an "Unsafe Visitor Process" if visitors threaten harm or show aggression towards staff. We also have VITAE confidential counselling services, offer influenza vaccinations, and provide sit/stand desks.

Since the initial COVID-19 restrictions, many staff have worked remotely for part of the week. We continue to support staff wellbeing, and health and safety for all staff working remotely, including buddy systems and video conferencing.

Processes and technology

Technology

A key component of our technology programme is protecting its systems from cyber risks. We use external experts to support and review the design of systems, and the ongoing monitoring and protection of IT operations. This year, a cybersecurity training programme was rolled out to all staff to raise awareness of the steps they can take to help reduce risks in this area.

We have provided additional training and support to help staff who work remotely. We have a paperless operating model, where possible. This ensures continuity of our essential services, including responding to complainants.

Our technology initiatives have enhanced our capability and efficiency, and assisted in keeping our costs down. We are continuing to work on new initiatives — for example, continued improvements to our database system, allowing more processes to be automated.

Sustainability

We work to reduce our impact on the environment and to save money, through the use of technology. We encourage the efficient use of resources, recycling, online meetings, public transport, and buying local, environmentally friendly products and services where possible.

Physical assets and structures

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

7.0 Tauākī whakatutukitanga *Statement of Performance*

7.1 Output Class 1: Complaints resolution

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2021

OUTPUT 1: Complaints resolution	*Actual 2021 $*	*Budget 2021 $*	*Actual 2020 $*
Revenue	8,193,061	8,200,000	7,558,317
Expenditure	7,959,203[3]	8,200,000	7,601,698
Net surplus/(deficit)	233,858	–	(43,381)

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 and 4.		2,721 complaints were received during the year. This represents a 14% increase on the previous year's volume (2020: 2,393). *Target achieved*
Assume 2,400–2,600 complaints will be received.	Close an estimated 2,400–2,600[1] complaints. The above figure includes an estimated 120–130 investigations.	2,404[2] complaints were closed during the year, including 123 investigations (2020: 2,226 complaints closed, including 133 investigations). Total number of open files at year end was 1,251 (2020: 934). *Target partially achieved*
	Manage complaints so that:	Age of open complaints at 30 June 2021:
	• No more than 20–22% of open complaints are 6–12 months old.	• 6–12 months old, 287 out of 1,251 — 22.94% (2020: 28.48%). Not achieved.
	• No more than 16–18% of open complaints are 12–24 months old.	• 12–24 months old, 233 out of 1,251 — 18.63% (2020: 17.56%). Not achieved.
	• No more than 2–4% of open complaints are over 24 months old.	• Over 24 months old, 45 out of 1,251 — 3.60% (2020: 3.21%). Achieved.

[1] HDC addresses complaints in a flexible and proportionate manner, ensuring that public health and safety risks are responded to while being mindful of the pressures on providers during the COVID-19 pandemic.

[2] This is HDC's highest ever yearly throughput, and HDC closed 8% more complaints than in the previous financial year.

[3] The variance was mainly arising from vacant positions. The Deputy Commissioner Complaints Resolution remained vacant for the full year.

7.1 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.	*Targets achieved* Between 1 July 2020 and 30 June 2021, compliance with quality improvement recommendations on 192 complaints was due to be reported to HDC by 186 providers. 488 out of a total 492 recommendations (99.2%) 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.	In the four cases of partial and non-compliance, HDC is considering next steps and options for three of the providers, whilst the other has been referred to the appropriate regulatory body. • 99.2% compliance (2020: 98.6%).

7.2 Output Class 2: Advocacy

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2021

OUTPUT 2: Advocacy	Actual 2021 $	Budget 2021 $	Actual 2020 $
Revenue	4,288,726[5]	4,089,000	4,010,438
Expenditure	4,166,312	4,089,000	4,033,456
Net surplus/(deficit)	122,414	–	(23,018)

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).		2,675 new complaints were received by the Advocacy Service in the year ended 30 June 2021 (2020: 2,754).
		Targets substantially achieved
Assume 2,600 to 3,000 complaints will be received.	Close an estimated 2,600 to 3,000[4] complaints.	For the year ended 30 June 2021, 2,570 complaints were closed (2020: 2,753)
		Targets achieved
	Manage complaints so that: • 80% are closed within 3 months • 95% are closed within 6 months • 100% are closed within 9 months	Complaints were managed so that: • 81% were closed within 3 months (2020: 79%). • 98% were closed within 6 months (2020: 99%). • 100% were closed within 9 months (2020: 100%).
		Targets 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.	90% (432 of 480) of consumers and 94% (157 of 167) of providers who responded to satisfaction surveys were satisfied or very satisfied with the Advocacy Service's complaints management process (2020: 93% of consumers and 93% of providers).

[4] Reduction reflects impact of COVID-19 pandemic.

[5] More funding was made to the National Advocacy Trust to assist with the Trust taking over the management of the HDC 0800 line, and to provide cost pressure support.

7.2 Output Class 2: Advocacy (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 2.2 — ACCESS TO ADVOCACY		
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 2,500[6] scheduled visits or meetings with community groups and provider organisations for the purpose of providing information about the Code, HDC, and the Advocacy Service. Such visits/meetings include aged-care facilities and residential disability services, with the emphasis on reaching vulnerable consumers and the family/whānau members who support them.	*Targets achieved* Certified aged-care facilities For the year ended 30 June 2021, 3,794 scheduled visits or meetings with community groups and provider organisations were carried out. 906 of these visits were to aged-care and residential disability facilities (2020: 3,705 visits or meetings, including 1,091 aged-care and residential disability facilities visits).
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 1,000[6] education sessions.	*Targets achieved* A total of 1,274 education sessions were provided (2020: 1,422).
	Consumers and providers are satisfied with the education sessions: • Seek evaluations on sessions with 80% of respondents satisfied.	*Targets achieved* 89% (3,590 of 4,046) of consumers and providers who responded to a survey were satisfied with the Advocacy Service's education session they attended (2020: 89% of consumers and providers).

[6] Reduction reflects impact of COVID-19 pandemic.

7.3 Output Class 3: Proceedings

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2021

OUTPUT 3: Proceedings	Actual 2021 $	Budget 2021 $	Actual 2020 $
Revenue	614,066	697,000	512,007
Expenditure	596,539[8]	697,000	514,946
Net surplus/(deficit)	17,527	–	(2,939)

Output and Assumptions	Performance Measures and Targets	Actual Performance[7]
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.	*Targets achieved* For the year ended 30 June 2021, professional misconduct was found in 100% (2 of 2) of disciplinary proceedings. Two further charges were filed in the HPDT for hearing in Quarter 2 2021/22 (2020: 100%, 1 of 1 professional misconduct proceedings was 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.	*Not measurable* For the year ended 30 June 2021, no HRRT proceedings have been concluded, but six proceedings were filed and decisions are pending in each (2020: 100%, 7 of 7 proceedings).
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.	*Not measurable* For the year ended 30 June 2021, no awards of damages were made. Five of the HRRT proceedings noted above included a confidential compensation component paid by agreement (2020: 100%, 9 of 9 proceedings).
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.	*Not measurable* For the year ended 30 June 2021, there were no cases in which a restorative approach was adopted (2020: 100%, 3 of 3 proceedings).

[7] Each proceeding filed by agreement represents lengthy correspondence between the Director, the provider, and the consumer or complainant, often requiring six to twelve months of negotiation. Twenty-five providers were referred to the Director of Proceedings in the financial year (more than double the number referred in recent years), and an increased number of HRRT and HPDT decisions is likely to follow in 2021/22 as a result.

[8] The variance was mainly arising from saving from travel restrictions and court cost recovery.

7.4 Output Class 4: Education

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2021

OUTPUT 4: Education	*Actual 2021 $*	*Budget 2021 $*	*Actual 2020 $*
Revenue	396,229	393,000	360,890
Expenditure	384,919	393,000	362,961
Net surplus/(deficit)	11,310	–	(2,071)

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% (8 of 8) of the DHBs who responded to an annual feedback form rated the complaint trend reports as useful for improving services (2020: 86%, 12 of 14).
Assist DHBs to improve their complaints systems (which contributes to achievement of Strategic Objective 3).	Provide two complaints resolution workshops for DHBs.	*Targets achieved* Two complaints resolution workshops for DHBs were held.
	Seek evaluations on the workshops, with 80% of respondents satisfied with the session.	92% (12 of 13) of respondents reported that they were satisfied or very satisfied with each session respectively (2020: 94.5%).
Assist non-DHB group providers to improve their complaints systems (which contributes to achievement of Strategic Objective 3).	Provide two complaints resolution workshops for non-DHB group providers.	*Targets achieved* For the year ended 30 June 2021, two complaints resolution workshops for non-DHB group providers were held (2020: two).
	Seek evaluations on workshops, with 80% of respondents satisfied with the session.	100% (19 of 19) of respondents reported that they were satisfied with each session (2020: 98.5%).

7.4 Output Class 4: Education (continued)

Output and Assumptions	*Performance Measures and Targets*	*Actual Performance*
OUTPUT 4.2 — INFORMATION AND EDUCATION FOR CONSUMERS AND PROVIDERS		
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 30 educational presentations. Consumers and health and disability service providers are satisfied with the educational presentations.	*Targets achieved* For the year ended 30 June 2021, 31 educational presentations were made (2020: 20).
	Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	For the year ended 30 June 2021, 100% of respondents who provided feedback (10 of 10) reported that they were satisfied with the presentations (2020: 100%, 20 of 20).
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 on the HDC website key Commissioner decision reports and related articles. Report on total number.	*Targets achieved* For the year ended 30 June 2021, 109 decisions relating to matters affecting the rights of consumers were published at ***www.hdc.org.nz*** (2020: 106). The Commissioner also made public statements regarding concerns about the management of medication brand changes across the health system, and in support of the official launch of the Mental Health and Wellbeing Commission.
OUTPUT 4.2 — OTHER EDUCATION		
Undertake analysis of relevant policies, standards, professional codes, and legislation and make submissions (which contributes to achievement of Strategic Objectives 2 and 3).	HDC makes at least 10 submissions.	*Targets achieved* For the year ended 30 June 2021, 22 submissions were made (2020: 39).
Respond formally 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).	At least 40 formal responses to enquiries provided.	*Targets achieved* For the year ended 30 June 2021, 52 formal responses to enquiries were provided (2020: 52).

7.5 Output Class 5: Disability

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2021

OUTPUT 5: Disability	*Actual 2021 $*	*Budget 2021 $*	*Actual 2020 $*
Revenue	587,845	576,000	528,244
Expenditure	571,066	576,000	531,276
Net surplus/(deficit)	16,779	–	(3,032)

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 "accessible software") educational resources for disability services consumers and disability services providers. At least two new educational resources will be available in accessible formats.	*Targets achieved* For the year ended 30 June 2021, two new educational resources were made available in accessible formats: • Using Healthcare Services in the Community • Video stories for people with learning disabilities

7.6 Output Class 6: Mental health and addiction services — monitoring and advocacy

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE 2021

OUTPUT 6: Monitoring and Advocacy	*Actual 2021 $*	*Budget 2021 $*	*Actual 2020 $*
Revenue	518,661[9]	668,000	651,032
Expenditure	503,857[9]	668,000	654,769
Net surplus/(deficit)	14,804	–	(3,737)

Output and Assumptions	*Performance Measures and Targets*	*Actual Performance*
OUTPUT 6.1 — MONITORING AND ADVOCACY		
Monitoring		
		Targets achieved
Monitor mental health and addiction services to identify potential improvements to services (which contributes to achievement of Strategic Objective 3).	Monitor and analyse issues and trends identified by HDC complaints and the Advocacy Service.	In 2020/21, HDC conducted analysis on the complaints received about mental health and addiction services over the 2019/20 financial year. This information is shared with key sector stakeholders, including the Initial Mental Health and Wellbeing Commission.
	Maintain engagement with key sector stakeholders and monitor sector performance information to keep informed about service issues and trends. Provide briefings to the Minister as required.	In 2020/21, HDC attended over 83 meetings and events with consumers and whānau, clinical, policy, and workforce leaders, and other stakeholders in the mental health and addiction sector. This included consumers' hui, site visits, and conferences (2020: 137). HDC's mental health and addiction monitoring and advocacy function was transferred to the new Mental Health and Wellbeing Commission on 9 February 2021.

[9] HDC's mental health and addiction monitoring and advocacy function was transferred to the new Mental Health and Wellbeing Commission on 9 February 2021.

7.6 Output Class 6: Mental health and addiction services — monitoring and advocacy (continued)

Output and Assumptions	*Performance Measures and Targets*	*Actual Performance*
OUTPUT 6.1 — MONITORING AND ADVOCACY (continued)		
Advocacy		
		Targets achieved
Advocate for improvements to mental health and addiction services (which contributes to achievement of Strategic Objective 3).	Make recommendations and educational comments to providers (and other organisations or individuals) when resolving complaints, to improve the quality of mental health and addiction services and complaints resolution processes.	HDC monitors providers' compliance with recommendations throughout the follow-up process by seeking evidence of the changes made. There were 48 quality improvement recommendations due in 2019/20.
	Monitor compliance with the implementation of recommendations: • 97% compliance.	For the year ended 30 June 2021, providers were: • Fully compliant with 100% of recommendations due this financial year (2020: 100%).
	Provide briefings or make recommendations or suggestions to any person or organisation in relation to issues or trends identified in HDC's monitoring of mental health and addiction services.	In 2020/21, HDC provided advice to the Initial Mental Health and Wellbeing Commission to support the development of a draft outcomes framework for the new Mental Health and Wellbeing Commission. This focused on what we have learned in developing and applying a monitoring framework for the mental health and addiction services. HDC also provided advice to support the Ministry of Health review of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017, including insights from complaints and sector engagement. HDC provided advice and support to the Ministry of Health in its review of Mārama Real Time Feedback prior to the Ministry taking over stewardship of Mārama in February 2021. HDC also progressed its consultation on implementing He Ara Oranga's recommendation to increase awareness of the Code by consumers of mental health and addiction services and observance and respect of the Code by providers (Rec 22).

7.6 Output Class 6: Mental health and addiction services — monitoring and advocacy (continued)

Output and Assumptions	*Performance Measures and Targets*	*Actual Performance*
OUTPUT 6.1 — MONITORING AND ADVOCACY (continued)		
Advocacy (continued)		
		Targets achieved The Mental Health Commissioner continued to advocate for an action plan to implement He Ara Oranga, and reported publicly on this issue. HDC wrote an open letter to the Minister of Health on the progress made towards transforming Aotearoa's approach to mental health and addiction and the critical challenges remaining, including the need for a long-term plan and prevalence data.

8.0 Ngā Tauākī Pūtea *Financial Statements*

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE FOR THE YEAR ENDED 30 JUNE 2021

	Notes	Actual 2021 $	Budget 2021 $	Actual 2020 $
Revenue				
Funding from the Crown		14,370,000	14,370,000	13,370,000
Interest revenue		18,450	50,000	50,164
Other revenue		210,138	203,000	208,573
Total revenue	2	14,598,588	14,623,000	13,628,737
Expenditure				
Personnel costs	3	7,841,524	8,387,000	7,922,958
Depreciation and amortisation expense	8,9	193,164	172,000	131,365
Advocacy services		3,680,260	3,481,000	3,481,010
Other expenses	4	2,466,948	2,583,000	2,171,581
Total expenditure		14,181,896	14,623,000	13,706,914
Surplus/(deficit)		**416,692**	**-**	**(78,177)**
Total comprehensive revenue and expense		**416,692**	**-**	**(78,177)**

Explanations of major variances against budget are provided in Note 17.

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2021

	Notes	Actual 2021 $	Budget 2021 $	Actual 2020 $
Assets				
Current assets				
Cash and cash equivalents	5	2,471,397	2,059,000	2,083,576
Receivables	6	6,105	30,000	13,139
Prepayments		65,349	50,000	46,092
Inventories	7	21,704	20,000	28,717
Total current assets		2,564,555	2,159,000	2,171,524
Non-current assets				
Property, plant, and equipment	8	283,257	228,000	221,918
Intangible assets	9	80,900	128,000	159,948
Total non-current assets		364,157	356,000	381,866
Total assets		2,928,712	2,515,000	2,553,390
Liabilities				
Current liabilities				
Payables	10	420,943	409,000	469,092
Employee entitlements	11	535,755	550,000	518,385
Total current liabilities		956,698	959,000	987,477
Non-current assets				
Payables	10	10,593	11,000	21,184
Total non-current liabilities		10,593	11,000	21,184
Total liabilities		967,291	970,000	1,008,661
Net assets		**1,961,421**	**1,545,000**	**1,544,729**
Equity				
Contributed capital	13	788,000	788,000	788,000
Accumulated surplus	13	1,173,421	757,000	756,729
Total equity		**1,961,421**	**1,545,000**	**1,544,729**

Explanations of major variances against budget are provided in Note 17.

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2021

	Notes	Actual 2021 $	Budget 2021 $	Actual 2020 $
Balance at 1 July		1,544,729	1,545,000	1,622,906
Total comprehensive revenue and expense for the year		416,692	-	(78,177)
Balance at 30 June	**13**	**1,961,421**	**1,545,000**	**1,544,729**

Explanations of major variances against budget are provided in Note 17.

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2021

	Notes	Actual 2021 $	Budget 2021 $	Actual 2020 $
Cash flows from operating activities				
Receipts from the Crown		14,370,000	14,370,000	13,370,000
Interest received		21,063	50,000	53,566
Receipts from other revenue		77,536[1]	58,000	69,359
Payments to suppliers		(5,979,684)	(5,970,000)	(5,572,652)
Payments to employees		(7,824,155)	(8,387,000)	(7,844,021)
GST (net)		(101,485)	-	93,793
Net cash from operating activities		563,275	121,000	170,045
Cash flows used in investing activities				
Receipts from sale of property, plant, and equipment		-	-	7,808
Purchase of property, plant, and equipment		(176,842)	(111,000)	(149,810)
Purchase of intangible assets		1,388[2]	(35,000)	(55,115)
Net cash used in investing activities		(175,454)	(146,000)	(197,117)
Cash flows from financing activities				
Receipts from capital contribution		-	-	-
Net cash from financing activities		-	-	-
Net increase/(decrease) in cash and cash equivalents		387,821	(25,000)	(27,072)
Cash and cash equivalents at beginning of the year		2,083,576	2,084,000	2,110,648
Cash and cash equivalents at end of the year	5	**2,471,397**	**2,059,000**	**2,083,576**

Explanations of major variances against budget are provided in Note 17.

The accompanying notes form part of these financial statements.

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

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

Notes to the financial statements

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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 2021, and were approved by the Commissioner on 6 December 2021.

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 NZD30m and 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 the 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.

COVID-19 impact disclosure

The COVID-19 pandemic did not have a significant impact on HDC during the financial year ended 30 June 2021 and, at this time, HDC does not expect significant impact in the future. HDC has considered that there is no material uncertainty that casts doubt on the organisation's ability to continue as a going concern.

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 2021 $	*Actual 2020 $*
Sale of publications	61,615	51,957
Advocacy Trust contribution to IT costs	136,322	140,908
Net gain on sale of property, plant, and equipment	-	7,808
Sundry revenue	12,201	7,900
Total other revenue	**210,138**	**208,573**

Asset disposals

During the year ended 30 June 2021, there were no net gains on disposals (2020: $7,808).

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 2021 $	Actual 2020 $
Salaries and wages	7,636,014	7,625,027
Employer contributions to defined contribution plans	188,140	218,994
Increase/(decrease) in employee entitlements	17,370	78,937
Total personnel costs	**7,841,524**	**7,922,958**

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 2021	Actual 2020
Total remuneration paid or payable:	*No. of employees*	*No. of employees*
100,000–109,999	4	2
110,000–119,999	1	2
120,000–129,999	2	-
130,000–139,999	1	4
140,000–149,999	1	-
150,000–159,999	1	1
160,000–169,999	2	2
170,000–179,999	-	1
180,000–189,999	1	1
200,000–209,999	-	1
230,000–239,999	2	-
240,000–249,999	1	-
250,000–259,999	-	2
290,000–299,999	1	-
380,000–389,999	-	1
Total	**17**	**17**

During the year ended 30 June 2021, no employee received compensation and other benefits in relation to cessation (2020: $57,565).

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 2020 to 30 June 2021, including all benefits, is set out below.

Name	Position	Term Started	Term Ended	Actual 2021 $	Actual 2020 $
Morag McDowell	Health and Disability Commissioner	7 Sep 20	-	298,201	-
Anthony Hill	Health and Disability Commissioner	19 Jul 10	30 Aug 20	92,994*	382,989

* This 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 2021 $	Actual 2020 $
Advertising	15,369	19,606
Audit fees	48,586	47,679
Clinical and legal advice	638,393	447,724
Communications & IT	606,786	475,564
Inventories consumed	73,870	50,904
Write-off on property, plant, and equipment	700	156
Operating lease expense	540,743	494,841
Policy and operational consultancy	75,126	115,392
Staff travel and accommodation	62,627	131,409
Other expenses	404,748	388,306
Total other expenses	**2,466,948**	**2,171,581**

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 2021 $	*Actual 2020 $*
Not later than one year	568,307	569,581
Later than one year and not later than five years	306,868	842,550
Later than five years	-	-
Total non-cancellable operating leases	**875,175**	**1,412,131**

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 (2020: two office leases and office equipment). The Auckland office lease expires in June 2023 and the Wellington lease expires in June 2022.

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 2021 $	*Actual 2020 $*
Cash on hand and at bank	1,471,397	1,083,576
Term deposits with maturities less than 3 months	1,000,000	1,000,000
Total cash and cash equivalents	**2,471,397**	**2,083,576**

While cash and cash equivalents at 30 June 2021 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is negligible.

As at 30 June 2021, the Health and Disability Commissioner holds no unspent grant funding received that is subject to restrictions (2020: 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 receivable allowance for credit loss in 2021 is $1,282 (2020: $2,232).

	Actual 2021 $	*Actual 2020 $*
Trade receivables	5,973	11,344
Less: allowance for credit loss	(1,282)	(2,232)
Other receivables	1,414	4,027
Total receivables	**6,105**	**13,139**
Total receivables comprises:		
Receivables from the sale of goods (exchange transactions)	6,105	13,139

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 2021 $	*Actual 2020 $*
Commercial inventories		
Publications held for sale	21,704	28,717
Total inventories	**21,704**	**28,717**

The write-down of inventories in 2021 amounted to $1,618 (2020: $626). There were no net write-down reversals in 2021 (2020: nil). No inventories are pledged as security for liabilities (2020: 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. 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%)

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 residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year end.

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 $	Communication equipment $	Furniture & fittings $	Leasehold improvements $	Motor Vehicles $	Office equipment $	Total $
Cost or valuation							
Balance at 1 July 2019	573,022	5,160	176,669	664,334	40,889	50,632	1,510,706
Balance at 30 June 2020	661,060	5,354	177,856	675,340	-	71,071	1,590,681
Additions	134,082	1,390	41,196	-	-	875	177,543
Disposals	(14,710)	-	(19,436)	-	-	(999)	(35,145)
Balance at 30 June 2021	780,432	6,744	199,616	675,340	-	70,947	1,733,079
Accumulated depreciation and impairment losses							
Balance at 1 July 2019	438,302	3,271	170,649	655,517	40,889	48,283	1,356,911
Balance at 30 June 2020	481,015	3,623	170,187	660,880	-	53,058	1,368,763
Depreciation expense	84,669	1,189	18,851	6,252	-	4,542	115,503
Disposals	(14,009)	-	(19,436)	-	-	(999)	(34,444)
Balance at 30 June 2021	551,675	4,812	169,602	667,132	-	56,601	1,449,822
Carrying amounts							
At 1 July 2019	134,720	1,889	6,020	8,817	-	2,349	153,795
Balance at 30 June 2020	180,045	1,731	7,669	14,460	-	18,013	221,918
At 30 June 2021	228,757	1,932	30,014	8,208	-	14,346	283,257

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 computer hardware, furniture, and office equipment that had reached the end of its useful life.

The net loss on all disposals was $700 (2020: $156).

There were no capital commitments for the acquisition of property, plant, and equipment at balance date (2020: 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 property, plant, and equipment are as follows:

	Acquired software $	*Internally generated software* $	*Total* $
Cost			
Balance at 1 July 2019	708,354	248,516	956,870
Balance at 30 June 2020/1 July 2020	763,468	248,516	1,011,984
Additions	(1,388)	-	(1,388)
Disposals	-	(248,516)	(248,516)
Balance at 30 June 2021	762,080	-	762,080
Accumulated amortisation and impairment losses			
Balance at 1 July 2019	553,842	248,516	802,358
Balance at 30 June 2020/1 July 2020	603.520	248,516	852,036
Amortisation expense	77,660	-	77,660
Disposals	-	(248,516)	(248,516)
Balance at 30 June 2021	681,180	-	681,180
Carrying amounts			
At 1 July 2019	154,512	-	154,512
At 30 June 2020/1 July 2020	159,948	-	159,948
At 30 June 2021	80,900	-	80,900

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 (2020: nil).

10. Payables

Accounting policy

Short-term payables are recorded at their face value.

Breakdown of payables and deferred revenue

	Actual 2021 $	Actual 2020 $
Payables under exchange transactions		
Creditors	101,662	90,992
Accrued expenses	161,264	109,793
Lease incentive	10,593	10,593
Total payables under exchange transactions	*273,519*	*211,378*
Payable under non-exchange transactions		
Taxes payable (GST, PAYE, and rates)	147,424	257,714
Total payables under non-exchange transactions	*147,424*	*257,714*
Total current payables	420,943	469,092
Lease incentives	10,593	21,184
Total non-current payables	10,593	21,184
Total payables	**431,536**	**490,276**

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 2021 $	Actual 2020 $
Current portion		
Annual leave	535,755	518,385
Total employee entitlements	**535,755**	**518,385**

12. Contingencies

Contingent liabilities

As at the reporting date there were no contingent liabilities (2020: nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2020: 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 2021 $	Actual 2020 $
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	756,729	834,906
Surplus/(deficit) for the year	416,692	(78,177)
Balance at 30 June	1,173,421	756,729
Total equity	**1,961,421**	**1,544,729**

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 2021 $	*Actual 2020 $*
Leadership Team		
Remuneration	1,798,009	1,919,424
Full-time equivalent members	7.98	8.50
Total key management personnel remuneration	**1,798,009**	**1,919,424**
Total full-time equivalent personnel	**7.98**	**8.50**

15. Financial instruments

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

	Actual 2021 $	*Actual 2020 $*
Financial assets measured at amortised cost		
Cash and cash equivalents	1,471,397	1,083,576
Term deposits with maturities less than 3 months	1,000,000	1,000,000
Receivables	6,105	13,139
Total financial assets measured at amortised cost	2,477,502	2,096,715
Financial liabilities measured at amortised cost		
Payables (excluding income in advance, lease incentive, taxes payable, and grants received subject to conditions)	262,926	200,784
Total financial liabilities measured at amortised cost	**262,926**	**200,784**

16. Events after the reporting date

On 17 August 2021, the New Zealand Government reinstated COVID-19 Alert Level 4 for the entire country. HDC has not been significantly impacted by the move to the Alert Level 4 as the remote working model was implemented during the initial COVID-19 outbreak.

17. Explanation of major variances against budget

Explanations for major variances from the Health and Disability Commissioner's budgeted figures in the statement of performance expectation are as follows:

Statement of comprehensive revenue and expense

Total expenditure

Personnel costs were lower than budget, mainly arising from vacant senior positions, including the Deputy Commissioner Complaints Resolution, which remained vacant for the full year.

Advocacy services costs were higher than budget as a result of additional contributions made to the National Advocacy Trust ("the Trust") to assist with the Trust taking over the management of the HDC 0800 line, and to provide cost pressure support.

Statement of financial position

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

Statement of 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 a result of fewer personnel costs incurred during the year compared to budget.

9.0 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 2021.

Morag McDowell
Health and Disability Commissioner

Jason Zhang
Corporate Services Manager

6 December 2021

10.0
Pūrongo ōtita
Audit report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Health and Disability Commissioner's financial statements and performance information for the year ended 30 June 2021

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, Lauren Clark, 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 52 to 69, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expense, 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 8 to 9 and pages 41 to 51.

In our opinion:

- the financial statements of the Health and Disability Commissioner on pages 52 to 69:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; 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 the Public Benefit Entity Standards Reduced Disclosure Regime; and
- the performance information on pages 8 to 9 and pages 41 to 51:
    - presents fairly, in all material respects, the Health and Disability Commissioner's performance for the year ended 30 June 2021, 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 6 December 2021. 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 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 it is necessary to enable the Health and Disability Commissioner 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 7, 10 to 40, 70 to 71 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.

Lauren Clark
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

He aha te mea nui o te ao?
He tangata, he tangata, he tangata

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

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