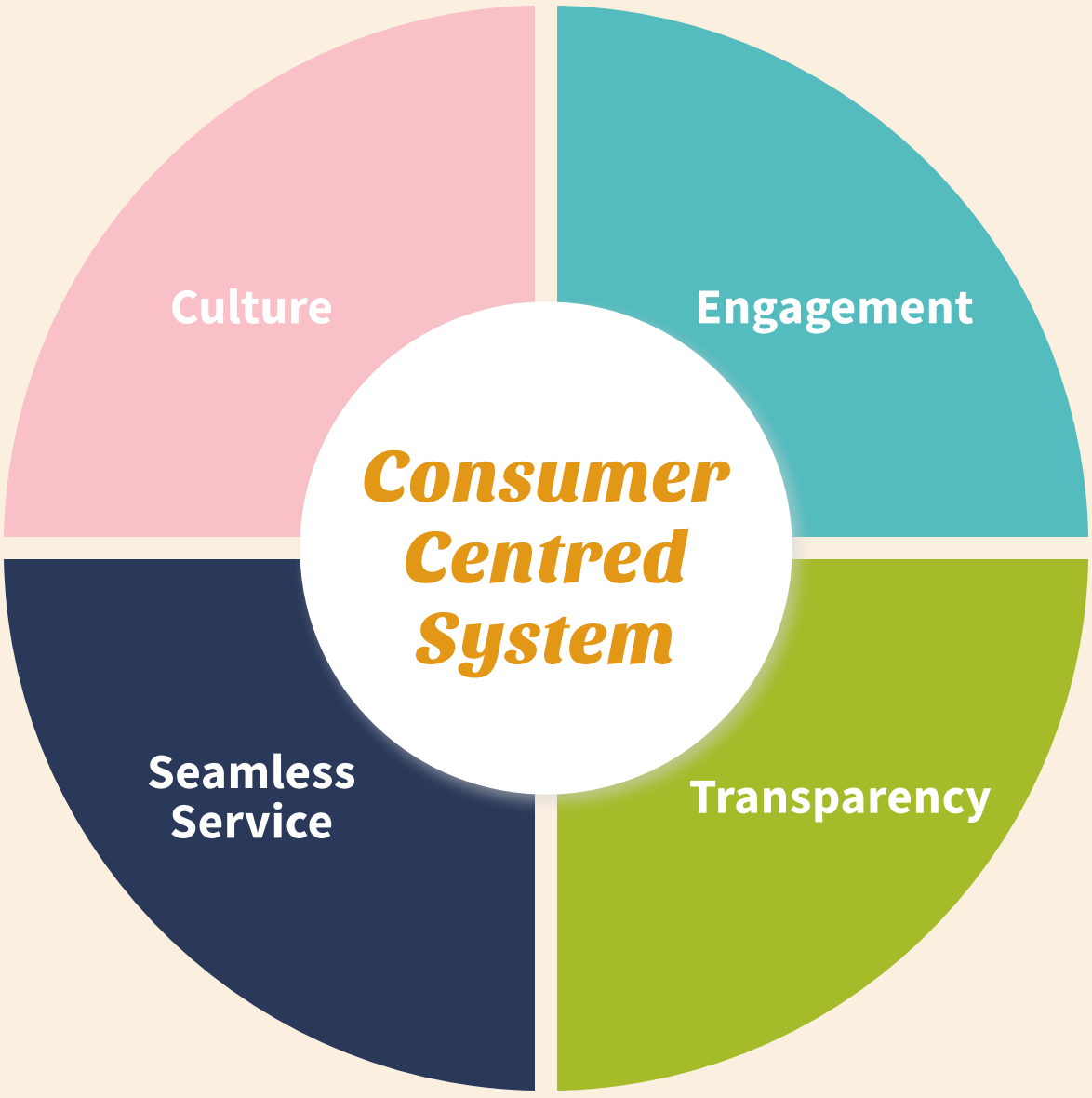
E.17

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

ANNUAL REPORT FOR THE YEAR ENDED 30 JUNE 2020


Culture
Engagement
Consumer Centred System
Seamless Service
Transparency

Contents

Presented to the House of Representatives pursuant to Section 150 of the Crown Entities Act 2004

Published by the Health and Disability Commissioner

PO Box 1791, Auckland 1140

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

15 December 2020

The Minister of Health

Parliament Buildings

WELLINGTON

Dear Minister

In accordance with the requirements of section 150 of the Crown Entities Act 2004, I enclose the Annual Report of the Health and Disability Commissioner for the year ended 30 June 2020.

Yours faithfully

Morag McDowell
Health and Disability Commissioner

PO Box 1791, Auckland, 1140, Level 10, Tower Centre, 45 Queen Street, Auckland, 1010, New Zealand
Ph: 09 373 1060, Fax: 09 373 1061, Toll Free Ph: 0800 11 22 33, www.hdc.org.nz

Commissioner's foreword

Morag McDowell

Health and Disability Commissioner

I took office as the Health and Disability Commissioner on 7 September 2020, so the activity contained in this report represents the work of my predecessor, Anthony Hill, and our very capable and dedicated team.

I take this opportunity to acknowledge Anthony and thank him for his 10 years of service. In his tenure, Anthony led the HDC to success in responding to a sustained rise in complaint numbers, while successfully continuing to champion the rights of health and disability services consumers in a complex and challenging environment, not least during the COVID-19 pandemic. I feel fortunate to be standing on the solid foundations set by Anthony, his predecessors Robyn Stent and Ron Paterson, and the HDC team, as I lead the organisation on the next phase of its journey. I would also like to acknowledge the contribution of Deputy Commissioner Meenal Duggal, who left HDC earlier this year.

Thanks to the HDC staff and members of the Executive Leadership Team for making the transition between Commissioners as seamless as it could be.

In March 2020, the final report for the Health and Disability System Review, Pūrongo Whakamutunga, led by Heather Simpson, was completed. In identifying the significantly different health outcomes for Māori, Pasifika, other ethnicities, people with disabilities, and aging and rural populations, it recommended system-level changes to achieve more equitable health outcomes. A core theme for the review — ensuring that consumers, whānau, and communities are at the heart of the health and disability system — reflects the HDC's own vision. The report, to my mind, challenges the HDC to reflect on how it can contribute to these important issues further, and in doing so reinforces the essence of the whakataukī from which the last lines are: *He aha te mea nui o te ao? Māku e kī atu, he tāngata, he tāngata, he tāngata!*

Moving forward, I am committed to considering equity issues as the HDC performs its core functions. This requires, among other things, that the HDC ensures that its own processes are accessible to, and appropriate for, consumers, and that complaints are resolved fairly, at the most suitable and proportionate level. The HDC must also meet its Te Tiriti o Waitangi obligations. Further, having observed in my past roles the effects of delay not only on consumers and providers, but also on the effectiveness of quality improvement measures, I am extremely mindful that our complaints resolution system must be as responsive as it can be. Lastly, we must not lose sight of the Commissioner's educational role: to speak out on matters related to the rights of health and disability services consumers and to be an effective watchdog. In the context of recent events, that function is as important as it has ever been.

In the paragraphs overleaf, Anthony Hill reviews the past year.

> "We must not lose sight of the Commissioner's educational role: to speak out on matters related to the rights of health and disability services consumers and to be an effective watchdog."

Anthony Hill

Former Health and Disability Commissioner

There is no doubt that 2019/20 has been a truly extraordinary year, with the COVID-19 pandemic presenting unprecedented challenges and uncertainties. I am proud to say that HDC has risen to meet these challenges, and it has been another successful year for us as we continue to promote and protect the rights of people who use health and disability services in New Zealand.

> “The story of the year just gone is one of rising to the challenge and not just meeting but exceeding expectations.”

HDC received 2,393 complaints in 2019/20. This is part of an ongoing upward trend in complaint volume, with numbers increasing by 22% over the last five years. Despite the dual pressures of increased volume and the COVID-19 pandemic restrictions, we maintained a high level of complaint closures in 2019/20, closing 2,226 complaints. HDC also completed 133 investigations — this marks a 30% increase on the number completed in 2018/19, and is a significant achievement.

COVID-19 response

When New Zealand went into Alert Level 4 lockdown, HDC moved swiftly and seamlessly to a remote working model. We made significant investments in our IT capability and trained and supported our staff to work remotely. We also made substantial changes to transition to a paperless operating model. All of these initiatives have enhanced HDC’s capability and efficiency, and will be of ongoing value.

Thanks to the smooth transition to remote working, we were able to continue delivering our essential service, addressing complaints and protecting the rights of people who use health and disability services. Throughout Level 4, HDC responded actively and appropriately to consumers and providers under pressure in a world no one could have dreamed of even a few months previously.

The independent Nationwide Health & Disability Advocacy Service (the Advocacy Service) immediately introduced a new rapid telephone response process during Alert Level 4, enabling advocates to continue to work proactively with vulnerable consumers. The Advocacy Service also took on operation of the HDC 0800 new enquiry line. This enables people to talk through their concerns easily with an advocate, and quickly understand the options for resolving their complaint.

Throughout the COVID-19 emergency response, HDC addressed complaints in a flexible and proportionate manner, ensuring that public health and safety risks were responded to while being mindful of the huge pressures on providers. We received 151 complaints related to issues arising from the COVID-19 pandemic in 2019/20, and we continue to monitor such complaints closely for patterns and trends. Common themes we’ve seen include inadequate communication around COVID-19 related policies, reduced or deferred access to care, inadequate infection control policies, issues related to visitor/support person policies, and inadequate access to testing for COVID-19.

We have been engaging with the sector and the Ministry of Health about the issues raised by the COVID-19 complaints we’ve received. In April 2020, we raised equity and patient safety concerns with the Ministry of Health regarding aspects of the COVID-19 response, including inconsistencies across the country in how DHBs applied the National Hospital Response Framework, and reduced health sector activity, levels of unmet need, and the importance of planning for demand.

Culture, leadership, and a system under pressure

As Commissioner I have been uniquely placed to see systemic issues in the sector. Over the past ten years, certain themes have recurred. This is a concern, and a salient reminder that we must stay vigilant in ensuring that people’s rights are protected.

Access to services and service delays have become an increasingly dominant theme. Certain themes recur, including: inadequate prioritisation systems (where patients are not prioritised according to clinical risk), inadequate planning for demand, cultures of tolerance emerging where delays are normalised, and a lack of collaboration between executive management and clinicians and/or inadequate responses by management to identified clinical risk.

I am also concerned by the geographical inequities in access to services that I see when I look across complaints. The sector must remain ever more attentive to these issues as it manages backlogs resulting from deferred access to care owing to the COVID-19 pandemic.

In the end, these cases often come back to issues of culture and leadership. Over the years I have seen deficiencies in culture express themselves in a number of ways, including:

- Systems that do not support staff to work well together, not allowing them to foster good collaborative working relationships and clear lines of communication
- The impact of hierarchy: environments where junior staff do not feel able to escalate care or discuss issues with senior staff appropriately, or are not listened to when they do
- Instances where a culture of tolerance emerges and the sub-optimal becomes normal

This is why I have focused on a system that supports cultures that embody transparency, consumer engagement, and seamless coordination, as they put consumers at the centre of services.

Informed consent

Informed consent, which lay at the heart of the Cartwright Inquiry, has continued to be a major theme in the complaints that have crossed my desk. Cases that embody these themes include:

- The gynaecologist who inserted an intrauterine device while a woman was under general anaesthetic, despite the fact that the woman had not provided informed consent for the procedure
- The GP who stopped a man's warfarin therapy without first discussing the risks and benefits of such an action with him
- The midwife who failed to recommend to a woman in labour that a specialist consultation was warranted
- The aged residential care facility that restrained a man using a lap belt without consent
- The orthopaedic surgeons who failed to inform a man undergoing surgery that human products would be used.

Late last year, we submitted a report to the Minister of Health recommending changes to the rules governing the circumstances when health and disability research can occur that involves adults who are unable to give informed consent. We consulted experts in the field and carried out a public consultation, asking a range of ethical and legal questions.

Currently, health and disability research involving adults unable to consent must, among other things, be in that person's "best interests", as required by Right 7(4) of the Code of Health and Disability Services Consumers' Rights (the Code). While this is an important safeguard for vulnerable people, there is a view that it creates barriers to potentially valuable low-risk research, meaning that some groups could be missing out on improvements and progress in health and disability services.

HDC's recommendations to the Minister included that the current "best interests" test in Right 7(4) of the Code remain for treatment and services, but to introduce a new test, with additional safeguards, for research involving adult participants unable to provide informed consent. The test would be that such research could take place only if it posed "no more than minimal foreseeable risk and no more than minimal foreseeable burden" to participants.

Additional safeguards include principles set out in the Code and elsewhere; enhancements to current ethics review and approval processes and governance systems; and monitoring of any changes that are implemented, with a particular focus on the outcomes for individuals.

If introduced, these changes would, with robust safeguards in place, allow some useful research to occur that currently is not permitted.

Mental health and addiction

This year, the Mental Health Commissioner released *Aotearoa New Zealand's mental health and addiction services: The monitoring and advocacy report*. The report offers an independent assessment of the state of services, and highlights the opportunity New Zealand has to provide global leadership in responding to mental distress and addiction.

The report makes a number of recommendations to the Minister of Health, including the development of a clear plan of action to deliver on the approach set out in *He Ara Oranga.* There has been significant progress since the last full report in 2018 — notably an increase in early support available, laying the foundations for the new Mental Health and Wellbeing Commission, and the Ministry of Health's investment in building its capability to provide stewardship and leadership. However, there is still a pressing need to improve services for people with complex and ongoing needs, including connections to wider social supports.

All the systemic issues above have been a feature throughout my tenure as Commissioner, but they become ever more urgent when the health system is under great pressure and operating under extraordinary circumstances.

The uncertainties ahead, for the economy, for the health and disability sectors, and for the world we will face, mean that the role of the HDC as an independent watchdog protecting and promoting the rights of all people using health and disability services is as vital as ever.

As I move on after a decade in the Commissioner role, I would like to thank all those who have contacted us to raise their concerns. It takes courage to complain, and each complaint contributes to a wider positive impact. Thank you also to those providers who have responded positively and openly to complaints, and shown a commitment to improving their services.

I am truly proud of the work HDC does and how we do it. The story of the year just gone is one of rising to the challenge and not just meeting but exceeding expectations. I would like to say a big thank you to the staff of HDC, who work hard every day toward making our vision of a consumer-centred health and disability system a reality. In handing over HDC to the new Commissioner, I feel confident that the organisation is in great shape to keep delivering in the months and years ahead.

1.0 The year in review

2,226 Complaints closed

2,615 Enquiries responded to

2,393 Complaints received

133 Investigations completed

30% More completed investigations compared to 2018/19

76% Closed within 6 months

99% Full compliance with HDC's quality improvement recommendations

20 Educational sessions

4 Complaints resolution workshops delivered

106 Decisions published

100%

of HRRT proceedings found a breach of the Code

of HPDT proceedings established professional misconduct

2,754 Complaints to Advocacy

2,753 Complaints closed

3,705 Networking visits and meetings

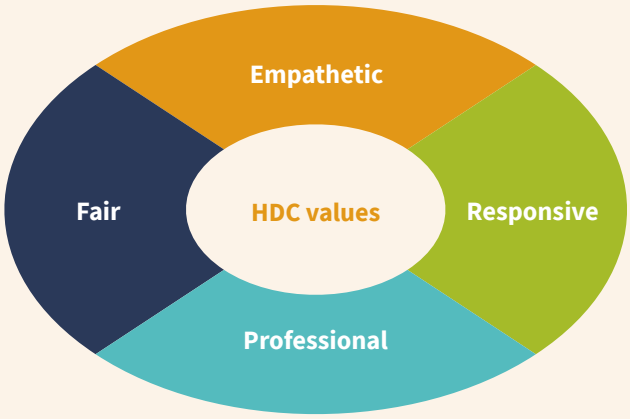
1,422 Education sessions provided

137

stakeholder events attended by the Mental Health Commissioner

2.0 Who we are

The Health and Disability Commissioner promotes and protects the rights of all people who use health and disability services, primarily by resolving complaints about infringement of those rights. HDC is independent from providers, consumers, and government policy, which enables us to be an effective and impartial watchdog.



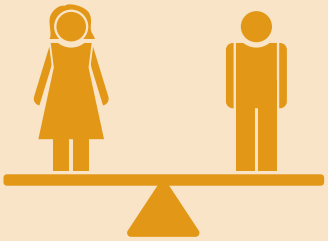
10 Consumers' rights

- **Respect** *Whakamana*
- **Fair treatment** *Manaakitanga*
- **Dignity & independence** *Tu rangatira motuhake*
- **Appropriate standard of care** *Tautikanga*
- **Effective communication** *Whakawhiwhitinga whakaaro*
- **Full information** *Whakamōhio*
- **Informed choice & consent** *Whakaritenga mou ake*
- **Support** *Tautoko*
- **Teaching & research** *Ako me te rangahau*
- **Right to complain** *Mana to amuamu*

The code

People's rights are set out in the Code of Health and Disability Services Consumers' Rights (the Code), which applies to all health and disability service providers.

HDC resolves complaints about infringement of those rights, holds providers to account, and uses the findings from complaints to improve quality of services, at both the individual and the wider systemic level.



What we do

Complaints Resolution

HDC's central function is to assess and resolve complaints. There are a number of options for resolving complaints, focusing on fair and early resolution.

Advocacy

The National Advocacy Trust, a charitable trust, is contracted to provide the Nationwide Health and Disability Advocacy Service (the Advocacy Service) to support people to resolve their complaints directly with providers, and to promote the Code through local networking and community-based education.

Proceedings

HDC can refer a provider found in breach of the Code to the Director of Proceedings (an independent, statutory role), who will decide whether or not to take proceedings against that provider.

Mental Health and Addiction — Monitoring and Advocacy

The Mental Health Commissioner monitors and advocates for improvements to mental health and addiction services.

Education and Analysis

HDC uses insights gained from complaints to influence policies and practice, including through submissions and strategic engagement. HDC also delivers education and training initiatives to improve providers' knowledge of their responsibilities under the Code.

Disability

The Deputy Commissioner, Disability has a particular focus on promoting awareness of, respect for, and observance of, the rights of disability services consumers.

HDC's funding

HDC is funded under the Monitoring and Protecting Health and Disability Consumer Interests Appropriation in Vote Health. This appropriation is intended to protect the rights of people who use health and disability services. This includes addressing the concerns of whānau and appropriately investigating alleged breaches of consumers' rights.

In the year ended 30 June 2020, HDC received $12,870,000 from this appropriation and an additional $500,000 from the Ministry of Health at the end of the financial year to fund six output classes as set out in the Statement of Performance. Despite a higher demand for HDC's services and the impact of COVID-19, HDC maintained a high output for complaints resolution (closing a record number of investigations) with a small financial deficit. HDC's budget was managed rigorously to cope within financial constraints and to focus on continuing to achieve more within our limited resources.

HDC's Executive Leadership

Morag McDowell
Health and Disability Commissioner

Kevin Allan
Mental Health Commissioner & Deputy Commissioner

Rose Wall
Deputy Commissioner, Disability

Mark Treleaven
Associate Commissioner, Complaints Resolution and Investigations

Kerrin Eckersley
Director of Proceedings

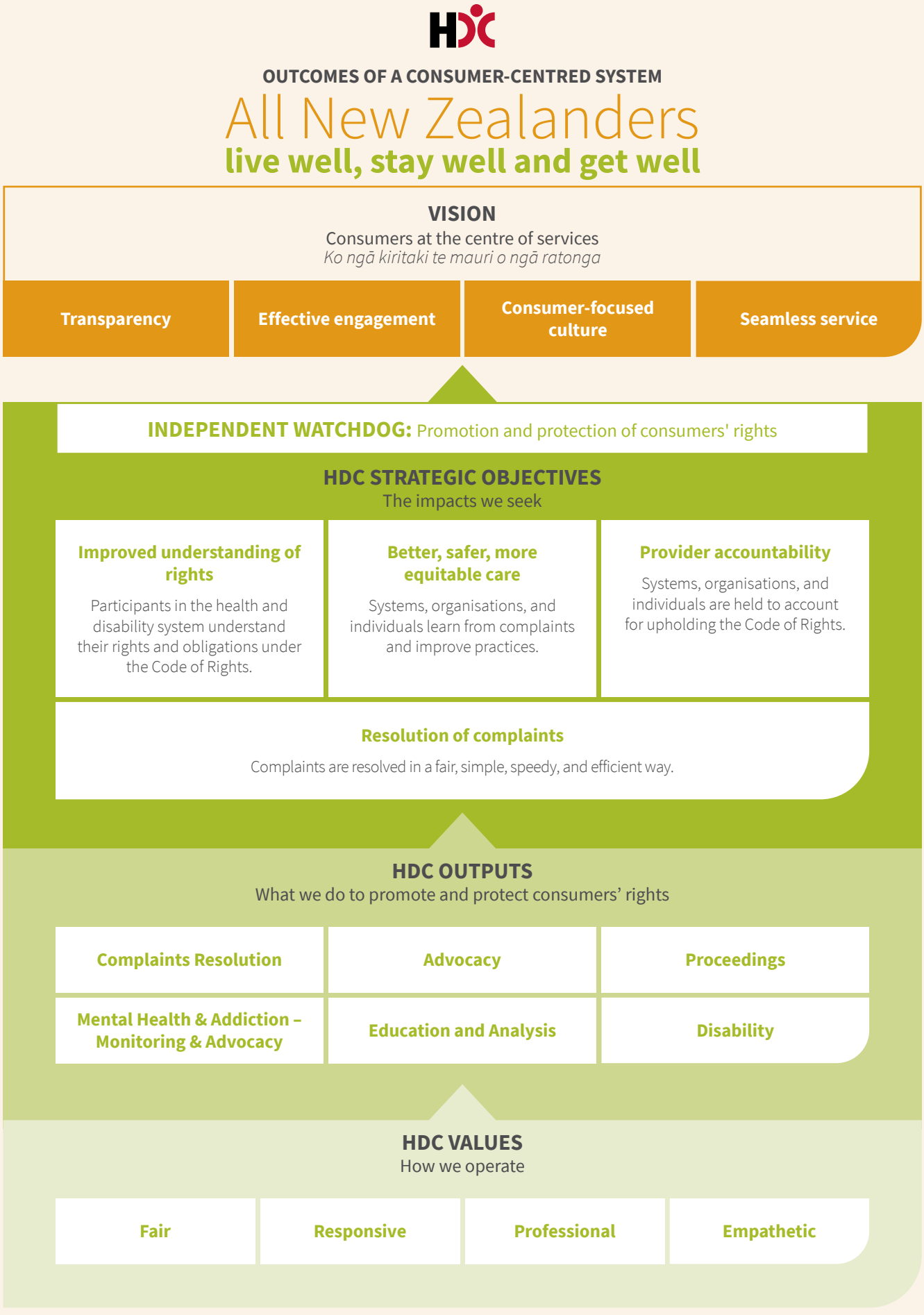
Jane King
Associate Commissioner, Legal

Dr Cordelia Thomas
Associate Commissioner

Jason Zhang
Corporate Services Manager

3.0 Delivering HDC's strategy

Figure 1: HDC's strategic objectives and vision



HDC's strategic objectives

HDC's vision is that consumers are at the centre of services — *ko ngā kiritaki te mauri o ngā ratonga.* Consumer-centred services are characterised by transparency, seamless coordination, effective engagement, and a consumer-focused culture. In this model, people are fully engaged in their own care. Communication with people and their families is clear and respectful, information is shared freely, and providers and services work effectively and respectfully together at all levels. In a consumer-centred system, the Code is upheld.

HDC's strategic intent is to promote and protect the rights of consumers as set out in the Code. Four strategic objectives underpin this:

1. **Resolution of complaints**
   Te whakatau amuamu

   HDC's primary vehicle for protecting 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, HDC measures the timeliness of its process, with a target number of complaints to close each year and a measure of the age of open complaints.

   In 2019/20:

   - HDC received 2,393 complaints
   - HDC closed 2,226 complaints
   - The Advocacy Service received 2,754 complaints
   - The Advocacy Service closed 2,753 complaints
   - 93% of consumers and 93% of providers who responded to surveys were satisfied or very satisfied with the Advocacy Service's complaints management process.
   - HDC closed 62% of complaints within 3 months, 76% within 6 months, and 89% within 12 months

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

   HDC aims to improve people's understanding of the Code and awareness of their right to complain. We achieve this through regular interactions with consumers and providers, and by providing specific advice, analysis, and educational initiatives.

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

   In 2019/20:

   - HDC responded to 2,615 enquiries, and the Advocacy Service responded to over 15,000 enquiries, helping people to understand their rights under the Code
   - HDC provided 20 education sessions; 100% of respondents were satisfied with these sessions
   - HDC delivered four complaints resolution workshops to providers; 94.5% of DHB workshop attendees and 98.5% of non-DHB group provider workshop attendees who provided feedback reported that they were satisfied with the workshops
   - HDC facilitated four 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 1,422 education sessions; 89% of respondents were satisfied with these sessions
   - The Advocacy Service made 3,705 networking visits, with a focus on ensuring that hard-to-reach and vulnerable consumers were made aware of the Advocacy Service and the Code

"Consumer-centred services are characterised by transparency, seamless coordination, effective engagement, and a consumer-focused culture. In this model, people are fully engaged in their own care."

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

HDC's work aims 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 2019/20:

- HDC made 773 recommendations for change
- Providers complied with 99% of HDC's quality improvement recommendations
- HDC published 106 decisions where a provider had been found in breach of the Code
- HDC provided DHBs with two six-monthly complaint trend reports, which the majority of DHBs said were useful for improving services
- The Mental Health Commissioner produced the mental health and addiction services monitoring and advocacy report

4. Provider accountability
Kia tika ngā mahi o ngā ratonga

Providers can be held to account in various ways — the simple fact that accountability mechanisms exist helps to drive change and quality improvement. The recommendations HDC makes hold providers to account for effecting 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 fact.

In 2019/20:

- HDC closed 133 investigations — a 30% increase on the number of investigations closed in the previous year
- HDC found 111 breaches of the Code
- HDC referred nine providers to the Director of Proceedings
- 100% (7 of 7) of Human Rights Review Tribunal proceedings found a breach of the Code
- 100% of HPDT proceedings established professional misconduct
- Resolution by negotiated agreement was achieved in 100% (9 of 9) of proceedings

“HDC's work aims to improve the quality of services at both a local and a wider sector level.”

4.0 Performance on key functions

HDC achieves its strategic objectives through six key functions:

4.1 Complaints resolution

Resolving complaints is central to HDC's role in promoting and protecting the rights of people who use health and disability services. HDC aims to resolve each complaint in a fair, simple, speedy, and efficient way, and we have a range of options available to us to achieve this.

Complaints received and closed

HDC received 2,393 complaints in 2019/20. This is part of an ongoing upward trend in complaint volume, with complaints increasing by 22% over the last five years.

HDC is an essential service, and in 2019/20 we had to adapt our operations quickly to respond to the challenges of the COVID-19 pandemic. We operated remotely during lockdown and made significant changes to transition our operating model to a paperless process.

Despite the challenges of the pandemic, HDC maintained a high level of complaint closures in 2019/20, closing 2,226 complaints. This included 133 investigations — a 30% increase on the 102 investigations closed in the previous year.

During the COVID-19 emergency response, HDC addressed complaints in a flexible and proportionate manner, ensuring that public health and safety risks were responded to while being mindful of the pressures on providers as a result of the pandemic. Balancing these priorities resulted in an increase in the number of open complaints at the end of 2019/20. HDC is working to ensure the timely resolution of complaints within the context of resource constraints and an increase in the volume and complexity of complaints received.

Complaints received and closed

Figure 2: Complaints received and closed from 1 July 2015 to 30 June 2020

How HDC resolves complaints

We receive complaints through various channels: our online complaint form, post, email, or referral from another agency (for example, the Advocacy Service or one of the Professional Registration Authorities). HDC has a number of processes and systems in place to ensure the fair and timely resolution of complaints while complying with statutory and legal requirements.

Our preliminary assessment process is thorough and can involve a number of steps, including: asking the provider to respond to the complaint and the concerns raised; seeking independent clinical advice about the standard of care; seeking information from other agencies; and asking the complainant and provider to comment on information gathered. HDC listens to every side of the argument, weighs up the evidence, and makes an impartial decision.

HDC has a wide discretion as to what action is taken after the preliminary assessment process is complete, including:

- Referring the complaint to the Advocacy Service or to the provider for direct resolution between the parties. Both the Advocacy Service and providers are required to report back to HDC on the outcome of these referrals, ensuring that people's concerns have been addressed appropriately.
- Referring the complaint to other agencies where the issues raised are more appropriately dealt with by that agency, e.g., often issues related to a provider's fitness to practise are dealt with more appropriately by their regulatory authority.
- The Commissioner may take no further action on a complaint where the preliminary assessment indicates that a provider's actions were reasonable in the circumstances, there are evidential issues that cannot be resolved, or the issues in the complaint have been addressed appropriately by other means. Often these decisions can be accompanied by recommendations for change or educational comment designed to effect positive change to the healthcare system. HDC then follows up with providers to ensure that they have complied with any recommendations made. Often providers are also asked to evaluate the effectiveness of any changes made.
- The Commissioner may decide to conduct a formal investigation of a complaint, which can result in the provider 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 positive change as a result. HDC's powers to investigate are used where they can have greatest effect.

Every complaint is an opportunity to learn, and the motivation for many complainants is to improve services so that what happened to them does not happen to someone else. HDC made 773 recommendations for change or educational comments in response to 271 complaints in 2019/20, and in this way held providers and the system to account for learning and taking preventative action, as well as protecting consumers' rights. HDC's recommendations have a high compliance rate, with 99% of recommendations being complied with in 2019/20.

Table 1: Outcome of complaints closed in 2019/20

Outcome	2019/20
Investigation	**133**
Breach finding	111
No breach finding — with adverse comment and follow-up	19
No breach finding with recommendations	1
No further action	2
Other resolution following assessment	**2,000**
No further action with recommendations or educational comment	235
Referred to other agency	58
Referred to registration authority	40
Referred to provider	425
Referred to Advocacy Service	317
No further action	815
Withdrawn	110
Outside jurisdiction	**93**
TOTAL	**2,226**

Complaints resolution during COVID-19 lockdown

HDC continued to receive and resolve complaints while New Zealand was under Alert Level 4 lockdown. In addition to the management of COVID-19-related complaints, we carefully considered how other complaints should be treated at a time when many providers of health and disability services were under significant pressure. With this in mind, we applied these guidelines under Alert Level 4:

1. The Code of Health and Disability Services Consumers' Rights continued to apply to health and disability services.
2. At this time providers should be focused on providing safe services.
3. This was a time of great concern for consumers and providers. HDC addressed complaints in a flexible and proportionate manner, ensuring that public health and safety risks were responded to while being mindful of the pressures on providers.
4. In practice, complaints raising urgent health and safety issues continued to be prioritised. The resolution of other complaints could be delayed owing to pressures on providers.

Complaints related to COVID-19

In 2019/20, HDC received 151 complaints related to the COVID-19 pandemic. We are monitoring these complaints closely, and the trends within these complaints are detailed on page 47 (Education section).

Issues complained about

Complaints made to HDC often include multiple issues. Each complaint received by HDC is categorised according to one primary issue (the issue of most importance to the consumer), and any number of other issues.

Commonly complained about primary issues in 2019/20

Table 2 below details the most commonly complained about primary issues in complaints over the last three years. Similar to what we've seen in previous years, "inadequate/inappropriate treatment/procedure" was the most commonly complained about issue in 2019/20, followed by "missed/incorrect/delayed diagnosis" and "disrespectful manner/attitude".

Table 2: Yearly comparison of the most commonly complained about complaint issue categories

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

Note: these categories reflect the issues as they are described by the consumer, and were not necessarily substantiated by HDC.

When all issues raised in complaints are considered — not just primary issues — the most common complaint issue categories in 2019/20 were:

- Care/treatment (67%)
- Communication (54%)
- Access/funding (15%)
- Consent/information (14%)
- Medication (13%)

These issues are broadly similar to what we saw last year.

Providers complained about

Complaints can be about individuals or group providers, and often multiple providers are named in a complaint. General practitioners (GPs) and district health boards (DHBs) provide most health care in New Zealand, and this is reflected in our complaints, with GPs being the most complained about individual providers, and DHBs the most complained about group providers.

Figure 3: Commonly complained about individual providers in 2019/20

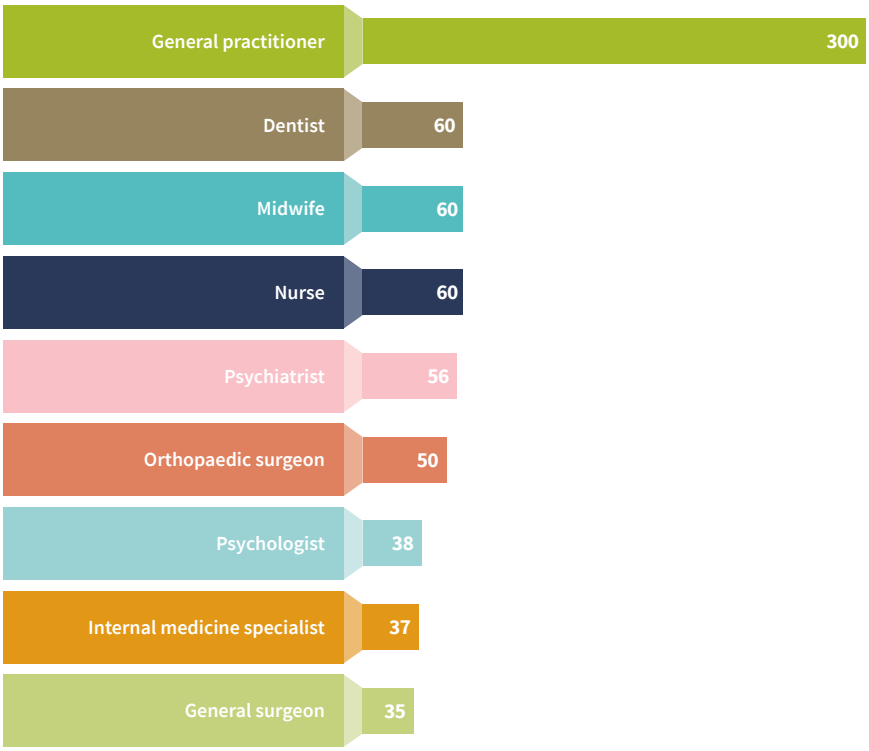
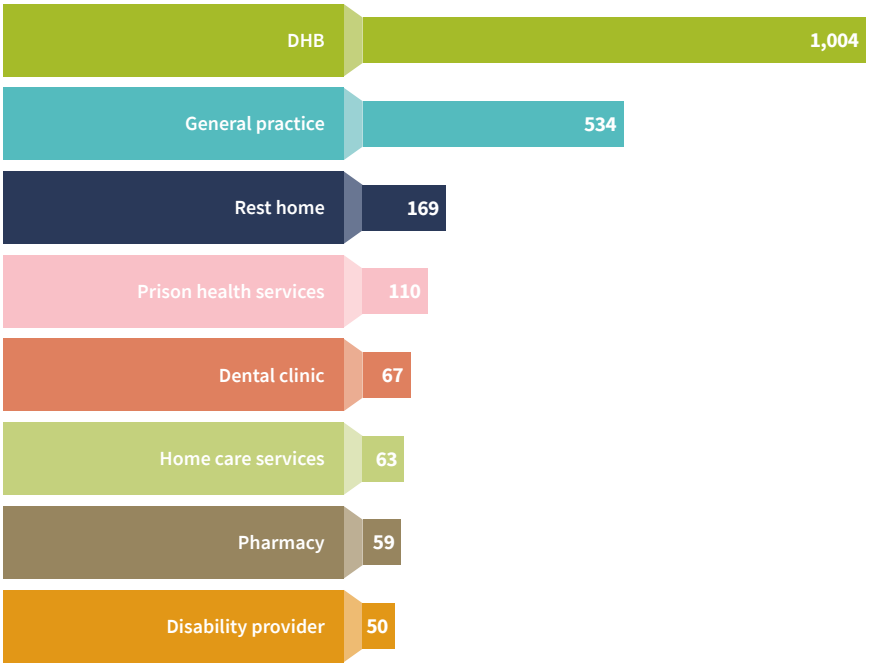


Figure 4: Commonly complained about group providers in 2019/20



EXAMPLES OF CASES CLOSED UNDER S38(1)

Improving procedures at a residential care home

A 37-year-old man with autism spectrum disorder went missing from residential care overnight.

He was found several hours later by Police. Although he was safe and well, the man's family raised concerns with HDC about how he was able to leave the home unnoticed.

The complaint prompted a thorough review of the incident. In its assessment, HDC was satisfied that the provider had worked constructively with the consumer's family to ensure that appropriate changes were made.

These changes included increasing security at the home, and ongoing education of staff. The case also led to the provider establishing a new specialist role for investigating complaints and facilitating quality improvement.

HDC recommended that the provider audit the plans of five current clients who utilise respite services, and review the training provided to staff. HDC asked the provider to report back with details of the actions taken, including the outcome of the audit and the results of the training review.

Improving follow-up for ophthalmology patients

A man complained to HDC about a delay in receiving a follow-up appointment from an ophthalmology clinic.

Following its assessment, HDC wrote to the DHB expressing concerns about deficiencies in the follow-up process for ophthalmology patients.

As a result, a number of important changes were implemented. These included tracking appointment requests through an electronic patient management system, and monthly audits to ensure timely follow-up.

EXAMPLE OF CASE REFERRED FOR RESOLUTION BETWEEN THE PARTIES

Clearer information for patients awaiting an appointment

A man complained about the communication he received from his DHB while awaiting the outcome of an orthopaedic referral.

The man was informed in writing that a decision had been made on his priority level, but no information about that decision was included.

On assessment, HDC decided to refer the complaint directly to the DHB for resolution between the parties, asking the DHB to provide the man with a detailed explanation of the decision.

In response to this referral, the DHB agreed that its acknowledgement letter to patients was too generic. The DHB noted that the letters needed to specify waiting times as well as other information relevant to the individual patient.

The DHB apologised to the man, provided him with an explanation regarding his priority level, and undertook to redesign its acknowledgement letters.

EXAMPLES OF RECOMMENDATIONS FOR CHANGE

Intensive care provided to newborn baby

The Health and Disability Commissioner found a DHB in breach of the Code for delayed treatment of a newborn baby with perinatal hypoxic-ischaemic encephalopathy and neonatal sepsis at a public hospital.

Staffing levels overnight at the hospital were inadequate, and staff showed a lack of critical thinking. Consequently, antibiotic treatment and EEG monitoring for hypoxic ischaemic encephalopathy were delayed; the baby was not assessed adequately; and staff did not document adequate medical records. The baby's condition deteriorated, and she died from an overwhelming infection.

Following an investigation, the Health and Disability Commissioner recommended that the DHB:

- Introduce an education programme for all neonatal intensive care unit (NICU) staff about the signs of possible infection, and about handover and documentation;
- Analyse the number of cot-side EEG monitoring units required;
- Review the staffing levels in the NICU;
- Review its procedure for "Early Onset Neonatal Infection Prevention"; and
- Provide a formal apology to the baby's whānau.

The Commissioner followed up with the DHB and found that all recommendations had been met.

Sexually inappropriate behaviour in a disability support service

A young man with an intellectual disability and autism was attending a vocational service. While at the service, another service user demonstrated aggressive and sexually inappropriate behaviour toward the man on multiple occasions.

While a number of serious events were documented, staff took little or no action to respond appropriately and minimise the risk of future harm. Consequently, the service failed to keep the man safe.

After an investigation, the Deputy Commissioner recommended that the vocational service, the area manager, and the service manager provide a formal apology.

The Deputy Commissioner also recommended that the service:

- Obtain independent advice to consider improvements that would ensure a positive organisational culture focused on continuous improvement and a zero tolerance approach to abuse;
- Ensure that adequate team and incident review meetings take place and requests and concerns from service users are recorded, tracked, and actioned;
- Audit vocational and residential services in the region for adherence to policies and procedures, and, where the results do not reflect 100% compliance, advise HDC of further improvements that could be made;
- Provide refresher training to relevant staff on the prevention and management of abuse, incident reporting, and leadership and promotion of a positive organisational culture; and
- Update HDC on the progress, effectiveness, and implementation of the recommendations from the national quality and safety review.

The Deputy Commissioner also recommended that the Ministry of Health and the Ministry of Social Development update her on the steps they have taken to ensure a zero tolerance approach to abuse within the disability support services they fund.

Management of a prisoner's medication

A prisoner was prescribed long-term clopidogrel (a medication used to reduce the risk of heart disease and stroke) after he was hospitalised following a stroke. He received the medication for only a month before it was stopped in error.

It was not until he was re-admitted to hospital several months later, after suffering a heart attack and having four stents placed in his heart, that he began receiving the clopidogrel again. However, after two months it was again stopped incorrectly, and it was not until several months later, after the man had been hospitalised a further three times, that he began receiving clopidogrel again.

Following an investigation, the Deputy Health and Disability Commissioner recommended that the Department of Corrections:

- Arrange for an independent external review of the level of GP cover provided at the prison;
- Report back to HDC on its project to implement an electronic medication administration system at the prison's health centre and its new process for medication self-administration signing sheets;
- Review a sample of recent discharges from hospital to the prison to ensure that appropriate care plans are in place;
- Report back to HDC on the medical officers' review of medication charts; and
- Provide a written apology to the man.

The Deputy Commissioner recommended that the pharmacy:

- Undertake a random audit of dispensing to the prison health centre to confirm that there was a current chart and prescription to support the dispensing;
- Develop an anonymised case study based on the report, use it as the basis for staff training, and share it with the Health Quality & Safety Commission (HQSC); and
- Provide a written apology to the man.

The Deputy Commissioner also recommended that Corrections and the pharmacy meet to discuss the report and any further issues, and report back to HDC.

Falls management and documentation at a rest home

A man complained about the care provided to his wife while living in a rest home.

His concerns related to quality of care around falls risk management and transfer to hospital.

HDC determined that while the care was largely appropriate, there were areas where the provider could make improvements, including the falls assessment tool used and the quality of clinical documentation.

HDC recommended that the provider implement a falls assessment tool that meets the recommendations of HQSC, and remind staff of the importance of ensuring that documentation follows a clinical reasoning format rather than a narrative reporting format.

The funding DHB and HealthCERT at the Ministry of Health were informed of the complaint and the issues raised.

Diagnosis of pulmonary embolism

A man in his early fifties was discharged from the Emergency Department (ED) of a public hospital with an undiagnosed pulmonary embolism.

During his time in the ED, he waited several hours for a medical assessment. The house officer who assessed him failed to consider pulmonary embolism as a diagnosis, and did not follow the DHB's Accelerated Chest Pain Pathway. The house officer was not supervised adequately by senior medical staff, and the man was not reviewed by senior medical staff before being discharged home. A few hours later, the man collapsed at home and was taken back to the ED by ambulance. However, he suffered a cardiac arrest and died.

Following an investigation, the Health and Disability Commissioner recommended that the DHB:

- Audit the ED waiting times to check whether times correlate to the triage code ascribed to patients;
- Provide an anonymised case study to staff for training purposes;
- Provide training to ED medical staff on diagnosis of pulmonary embolism, documentation, and supervision of junior staff;
- Provide a concrete plan for corrective action on the issues identified by the independent report commissioned by the DHB; and
- Apologise to the man's family.

Disclosure of complication following eye surgery

A woman underwent a corneal transplant to treat a progressive eye disease. She had undergone two previous corneal transplants, but both had failed.

During surgery, the ophthalmologist discovered that the donor corneal tissue had been treated with LASIK surgery, making it unsuitable for the transplant. The ophthalmologist decided to continue with the surgery using the donor tissue because there was a possibility that it could work, and he believed that waking the woman up would have risked her losing the eye permanently.

After the surgery, the ophthalmologist didn't disclose the issue to the woman for a further two weeks.

Following an investigation, the Health and Disability Commissioner recommended that:

- The Ministry of Health consider asking all clinics that perform corneal transplants to include this issue as a potential risk in the consent process;
- The ophthalmologist provide an apology to the woman for the delay in open disclosure; review HDC's "Guidance on Open Disclosure Policies" and identify areas for improvement in his practice; and provide HDC with an update on his communication with the Eye Bank regarding his newly discovered method of checking corneal tissue prior to surgery;
- The DHB consider updating its "Open communication (open disclosure)" policy to include guidance on what to do when a lead clinician is not available; and
- The Eye Bank consider the issues identified relating to the checking of corneal donor tissue, and consider trialling the use of optical coherence tomography machines to screen donor corneal tissue for previous laser surgery.

Communication systems at a DHB

A woman complained to HDC about communication issues at a DHB, including miscommunications around a decision to discontinue her treatment, and a lack of information regarding the impact of her condition on her ability to work.

In assessing the complaint, HDC was concerned about systemic issues at the DHB that contributed to the breakdown in communication.

HDC recommended that the provider develop new systems to ensure that patients are kept informed of decisions made about their treatment, and any limitations their condition will have on their lifestyle and employment.

HDC noted that while face-to-face consultation should be the primary means by which important information is communicated, this case together with the COVID-19 pandemic highlighted the need to develop alternative means of communicating with patients when face-to-face consultations may not be possible. The provider reported that it has increased its use of non-contact clinics (i.e., clinics via video-conferencing or telephone).

EXAMPLE OF CASE REFERRED TO ANOTHER AGENCY

In some cases, HDC refers complaints to other agencies where those agencies are better placed to consider the issues raised.

Referral to the Office of the Privacy Commissioner

A man was admitted to hospital with dehydration and was diagnosed with diabetic ketoacidosis. He questioned the accuracy of his clinical records regarding the admission.

The man also reported requesting his notes but not being provided with them. He sought to have his clinical records changed to reflect the treatment provided more accurately.

After assessing the complaint, HDC noted that the issues raised related to the man's health information privacy, and therefore referred the matter to the Office of the Privacy Commissioner.

Investigations

In around 5% of cases, HDC carries out a formal investigation of a complaint, which may result in a provider or providers being found in breach of the Code.

In an investigation, relevant evidence is collected from the consumer, the provider or providers being investigated, and third parties. Often we ask for independent clinical advice from a peer of the provider with experience in the matters being investigated. In some cases, we may need to seek clinical advice from several different speciality areas.

After all the evidence has been collected, the Commissioner or Deputy Commissioner forms a provisional opinion on whether or not the provider has breached the Code, and a report is drafted. At this point, the consumer has the chance to comment on the information gathered, and the provider has the chance to respond to any proposed adverse findings. After considering these responses, the Commissioner or Deputy Commissioner forms a final opinion.

This year, 133 investigations were completed — this is an increase of 30% from the previous year. In 111 of these investigations, HDC found that a consumer's rights had been breached, and recommendations for change were made in all these cases. In an additional 22 cases, the Commissioner or Deputy Commissioner did not find the provider in breach of the Code, but was critical of the care provided and made recommendations for change.

In 2019/20, nine investigations resulted in providers being referred to the Director of Proceedings to decide whether further legal action should be taken.

CASE STUDY

Lungs punctured during acupuncture treatment

A woman visited an acupuncturist for treatment for a left arm and wrist injury. She was also experiencing pain at the *jian jing* area on both sides of her shoulders, and shortness of breath.

The acupuncturist carried out acupuncture needling to the woman's *jian jing* points. Needling in this area has a known risk of pneumothorax (a collapsed lung). The needles were left inserted for approximately 30 minutes. The acupuncturist then rotated the needles "within 180 degrees" prior to removal.

When the needles came out, the woman experienced a sudden onset of chest pain and shortness of breath, while the acupuncture notes state that she began to experience a "stuffy" chest 10 minutes after the second adjustment, and slight chest pain.

After the appointment, the woman felt unwell and, once she got home, she lay down as advised by the acupuncturist. As she was suffering pain and numbness in her chest, her husband took her to an accident and medical clinic, and she was referred to hospital. Subsequently, the woman was diagnosed with two punctured lungs.

Findings

The Commissioner found the acupuncturist in breach of Rights 6(2) and 7(1) of the Code, as she failed to inform the woman of the risk of pneumothorax, including that the placement of the needles would be close to her lungs, or of the symptoms that could indicate a possible lung injury. This was information the woman needed to give informed consent for the acupuncture.

The Commissioner also found that it was more likely than not that the acupuncturist inserted the needles too deeply, and was critical that the acupuncturist retained the needles in the *jian jing* points. He considered that the acupuncturist did not take appropriate care, punctured both the lungs of her patient, and failed to recognise that her symptoms may have been caused by a pneumothorax. The Commissioner concluded that the acupuncturist did not provide services to the woman with reasonable care and skill, in breach of Right 4(1) of the Code.

Recommendations

The Commissioner recommended that the acupuncturist perform an audit to ensure that her patients had received appropriate information and provided written consent prior to treatment, and that she undertake further training on acupuncture needling techniques. He also recommended that the acupuncture clinic consider developing formal policies and procedures in relation to obtaining consent.

The Commissioner recommended that the New Zealand Acupuncture Standards Authority Inc and Acupuncture New Zealand circulate the case to their members as a learning opportunity.

(Case: 18HDC00442)

CASE STUDY

Return of body parts after surgery

A woman was admitted to hospital for a tonsillectomy, and asked to have her tonsils returned after her surgery.

The woman's request was documented on a preoperative checklist form, and both a nurse and a trainee anaesthetic technician knew about the woman's request. However, the woman's request was not raised again within the surgical team before surgery, and there was no space on the surgical consent form to record a patient's wishes regarding the return of tissue. Consequently, the surgeon was unaware of the woman's wishes.

After the surgery, the woman asked about the return of her tonsils, but they could not be found, despite a thorough search.

Findings

The Deputy Commissioner found the DHB in breach of Right 7(9) of the Code, which states that every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances that are removed or obtained in the course of a healthcare procedure.

The Deputy Commissioner acknowledged the significant personal and cultural importance of the matter for the woman, and concluded that her wishes should have been respected. The woman's request to have her tonsils returned was a patient-specific concern that should have been communicated to the circulating nurse, and also identified during theatre "time out" as part of the surgical safety checklist process.

The Deputy Commissioner noted the importance of DHBs having clear, robust processes that support the timely communication of relevant information. She found that there was a failure in effective communication and co-operation by the surgical team, in breach of Right 4(5) of the Code.

Recommendations

The Deputy Commissioner recommended that the DHB revise its policy for patient requests for the return of body parts, to reduce the reliance on staff passing on the information. It was also recommended that the DHB review its admission process, to ensure that patients who wish to have body parts returned have that request brought to the attention of the surgeon prior to surgery. The DHB was asked to undertake an audit of the use of the surgical safety checklist at the hospital.

(Case: 19HDC01234)

CASE STUDY

Inappropriate discharge and lack of respect for dignity

A man with a background of depression, anxiety, and alcohol abuse was admitted to the gastroenterology ward of a public hospital. He was treated for alcoholic hepatitis.

Around three weeks later he was discharged, despite remaining unwell and requiring ongoing medications, and having no suitable accommodation arrangements in place. The man was considered to be deliberately engaging in behaviour intended to prevent his discharge.

The man was escorted from the hospital by security staff and taken to a nearby bus stop while wearing hospital pyjamas. He remained at the bus stop for many hours. Members of the public and security staff raised concerns about his condition with the hospital's ED, but he was not reassessed by hospital staff.

Later that day, the man was taken to the ED waiting room, and police were called to remove him. He was issued a trespass notice and taken to a social service agency. While there his condition deteriorated further and he was returned to the hospital, where he died two days later.

Findings

In the Commissioner's view, given the man's unresolved medical and accommodation issues and his need for ongoing compliance with medication, it was not appropriate for him to be discharged. The Commissioner further noted that discharge to a bus stop should never happen, and was particularly concerned that there was a lack of effective response to the man's obvious need for help. The Commissioner found that the DHB failed to provide the man with services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner commented that there was a striking lack of compassion shown to the man in failing to take seriously the concerns raised by security staff and members of the public. The Commissioner found the DHB in breach of Right 3 of the Code for failing to respect the man's dignity.

In respect of this case, HDC's clinical advisor noted that "all patients deserve equal care regardless of personal circumstances", and that the failure of reasonable care in this case was due to a loss of concern for basic human dignity and a duty of care for all people, regardless of their behaviour or the underlying reasons for their illness.

Recommendations

The Commissioner made a number of recommendations to the DHB. These included that the DHB audit the operation of its trespass policy, and develop a protocol for the readmission of patients who re-present following discharge. He also recommended that the DHB apologise to the man's family.

(Case: 17HDC00497)

CASE STUDY

Assessment of a girl seen by multiple general practitioners

Over the course of just under a month, a young girl saw a doctor four times with symptoms including intermittent fevers, multiple sore joints with no confirmed history of injury, and weight loss.

Three of these four appointments were at the same medical centre. At her appointments, the girl was treated episodically, and when X-rays showed no musculoskeletal cause for her symptoms, the doctors did not seek further investigations to explore the cause.

After an appointment with her usual GP, she was taken to hospital. One week later she was diagnosed with acute rheumatic fever (ARF). She was kept in hospital on strict bed rest for several months.

Findings

The Commissioner found the medical centre in breach of Rights 4(1) and 4(5) of the Code for failures in relation to its care of the girl. The Commissioner acknowledged the difficulty in making the girl's diagnosis, as her presentation was unusual for ARF. However, the issue was not the failure to make the correct diagnosis earlier, but the failure to investigate the child's multiple deteriorating presentations, which meant that she was denied the opportunity for earlier diagnosis and treatment.

The Commissioner noted that the case highlighted the shortcomings of treating patients episodically, and the importance of critical thinking when a patient presents multiple times in a short timeframe, particularly when multiple providers are involved.

Recommendations

The Commissioner recommended that the medical centre prepare an anonymised case study on the girl's care for training all clinical staff, and consider facilitating a regular clinical meeting for review of patients who have seen multiple providers for the same or similar complaints over a short period, or in whom a diagnosis is proving elusive. The Commissioner also recommended that the medical centre apologise to the girl's family.

(Case: 19HDC00695)

CASE STUDY

Care provided to woman during pregnancy

At 33 weeks' gestation, a woman's Lead Maternity Carer (LMC) recognised that her fundal height (a measurement from the top of a woman's uterus to the pubic bone) was below that expected for her gestation, which could indicate issues with the baby's growth. The LMC ordered serial growth scans to monitor the baby's growth.

The LMC did not make a plan to manage the anticipated risks of intrauterine growth restriction (IUGR) or a small for gestational age (SGA) baby, and did not commence a customised growth chart to record the baby's growth. The growth scans showed discordant growth parameters, but the LMC and back-up LMC did not recognise this, and did not refer the woman to an obstetrician.

At 40 weeks' gestation, the back-up LMC ordered a repeat scan, which showed significant discord in growth parameters. However, the back-up LMC did not follow up the scan result, and the LMC did not recognise the risk of the declining centiles and discordant growth.

Eleven days later, the woman went into labour. On admission to hospital, an emergency Caesarean section was carried out for fetal distress. The baby was born in poor condition and was found to have suffered a stroke.

Findings

The Deputy Commissioner found that the LMC breached Right 4(1) of the Code for failing to make a plan to manage the risks of IUGR/SGA, including the use of a customised growth chart, after she recognised that the fundal height was below that expected for the gestation; for not recognising that the serial growth scans showed discordant growth parameters; and for not referring the woman to an obstetrician. The LMC was also found to have breached Right 4(2) of the Code for deficiencies in her documentation, and for not retaining a copy of the maternity records.

The Deputy Commissioner found that the back-up LMC breached Right 4(1) of the Code for not recognising that the serial growth scans showed discordant growth parameters, for not referring the woman to an obstetrician, and for failing to follow up the 40-week scan result.

Recommendations

The Deputy Commissioner noted the actions already taken by the Midwifery Council of New Zealand in reviewing the competence of the LMC, and recommended that the LMC attend further training on documentation and apologise to the woman. The Deputy Commissioner also recommended that the Midwifery Council of New Zealand consider whether any further action in respect of the LMCs was warranted.

The Deputy Commissioner will consult with the New Zealand College of Midwives and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) regarding collaboration on an education package for LMCs to provide guidance on the interpretation of ultrasound scan reports.

(Case: 17HDC01980)

4.2 Advocacy

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

36* **Advocates**

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

Received **2,754** complaints

Closed **2,753** complaints

Responded to over **15,000** enquiries

Provided **1,422** **education sessions**

Made **3,705** **networking visits**

* This number is approximate. The number of advocates fluctuated between 34 and 39 over the course of the year as vacancies were filled.

Nationwide Health & Disability Advocacy Service
Ngā Kaitautoko

The Advocacy Service complaints resolution process

The Advocacy Service is critical to achieving HDC's strategic objective of fair, simple, speedy, and efficient complaints resolution, by facilitating early resolution between the parties. 85% of the complaints managed by the Advocacy Service are considered by the complainant to be resolved or are withdrawn, and 79% of complaints are closed within three months.

Consumers are always at the centre of the Advocacy Service's complaints resolution process, with advocates guiding and supporting people to clarify their concerns and the outcomes they seek. This clarity enables the provider to write or speak effectively and directly to the complainant. Hearing each other's stories is an essential part of the advocacy process.

Often 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 a 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 achieving early and effective resolution.

COVID-19 response

The COVID-19 pandemic restrictions had a significant impact on advocates' ability to meet for networking, providing education sessions, and managing complaints. However, the Advocacy Service immediately introduced a new rapid telephone response process during Alert Level 4. This enabled advocates to continue to work in a speedy and proactive way with vulnerable consumers who were reliant on their service providers.

CASE STUDY

Communication around payment for medications

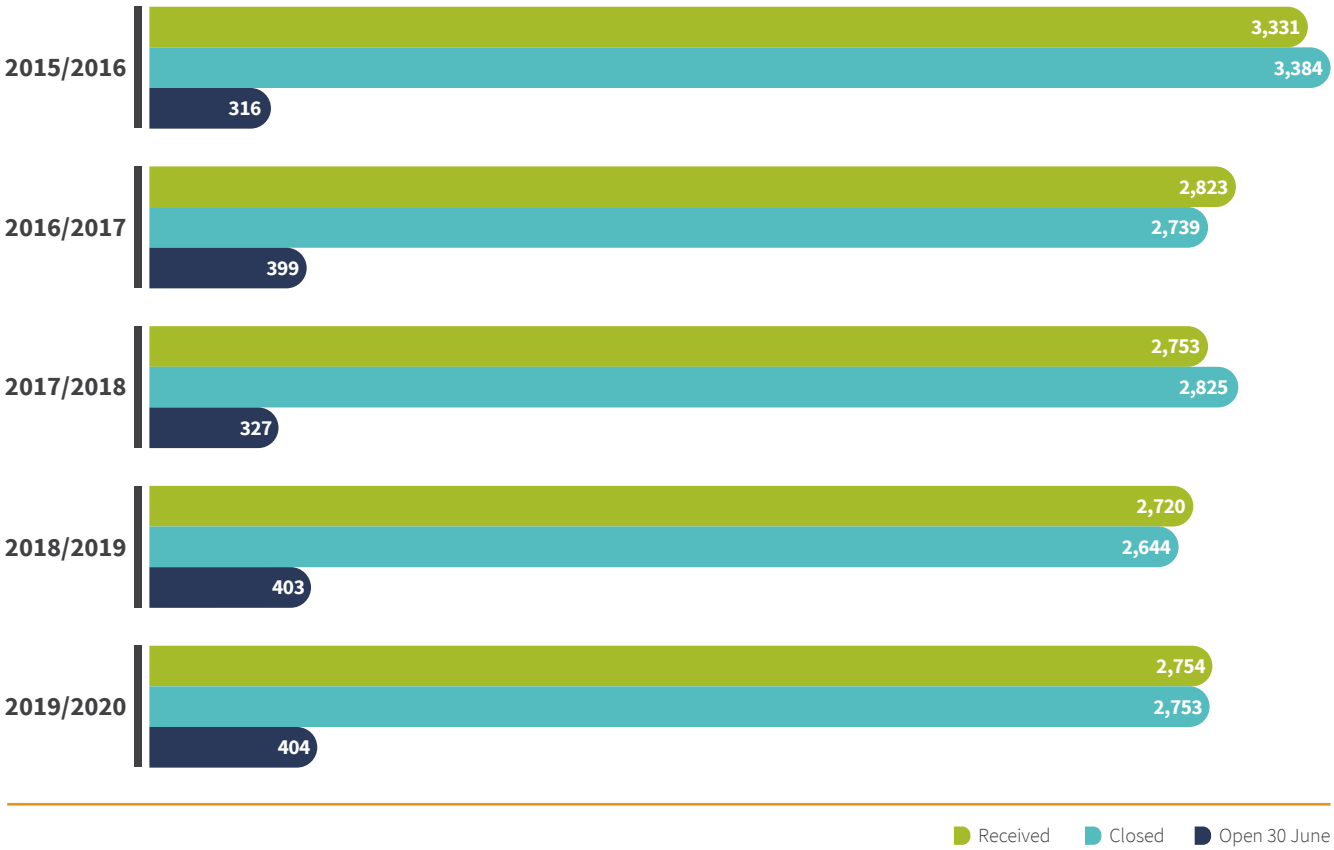
A man contacted the Advocacy Service with concerns about the lack of communication regarding his payment arrangements for his medication.

He had been embarrassed when a staff member had asked him to pay for his medication on the spot and he was unable to, so he left the service without it. As he needed his medications urgently, the advocacy rapid response process, which had been trialled in response to COVID-19, was explained. The man agreed that this process would work well for him, as he had difficulty with reading and writing.

After clarifying his specific concerns and outcomes, the advocate telephoned the provider, who gave an immediate response. The man was happy with the quick response and felt able to continue to receive services from the provider. He was also pleased that his feedback would provide learning opportunities for the provider around communication.

Complaints received and closed

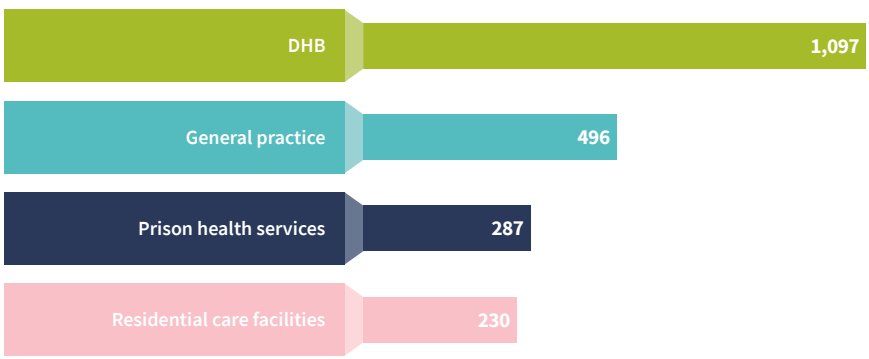
Figure 5: Complaints received and closed by the Advocacy Service between 1 July 2015 and 30 June 2020



Note: COVID-19 restrictions had an impact on the number of complaints still open as at 1 July 2020.

This year, the Advocacy Service received 2,754 complaints and guided and supported people to close 2,753. Of these, 79% were closed within three months, and 99% were closed within six months.

Figure 6: Providers commonly complained about to the Advocacy Service in 2019/20



The number of complaints about group providers to the Advocacy Service in 2019/20 is generally in line with what has been seen in previous years. Ninety-one percent of all complaints received by the Advocacy Service related to healthcare services, and 9% of complaints related to disability services. Similar to what is seen for HDC complaints, DHBs and general practices are the most commonly complained about provider types. The Advocacy Service does receive a slightly higher proportion of complaints about prison health services than HDC. Ten percent of all complaints to the Advocacy Service in 2019/20 related to mental health and addiction services, similar to the 12% seen by HDC.

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 (31%) make most complaints, and people identifying as female account for 59% of all complaints received. New Zealand European and Māori were the most commonly identified ethnicity groups for complainants: 62% of complaints received came from people identifying as New Zealand European, and 21% came from people identifying as Māori.

> “As a disabled client of the public health system, this advocacy service was fantastic. I was treated with respect, dignity, and kindness, and am thankful this service operates.”

Figure 7: Age of complainants to the Advocacy Service in 2019/20

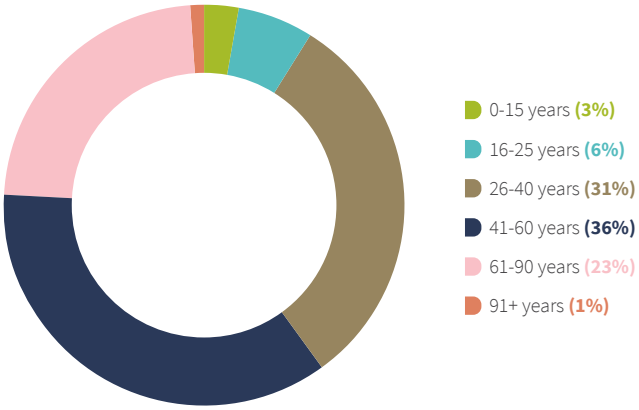
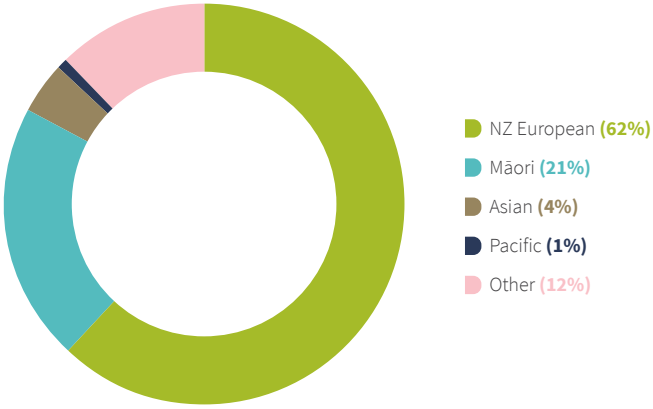


Figure 8: Ethnicity of complainants to the Advocacy Service in 2019/20



Reaching people and promoting the Code

Advocates work to ensure that they are accessible and familiar by networking with individuals, consumer-focused groups, and providers; by providing education sessions; and by distributing promotional materials in their communities.

Over the past year, advocates made 3,705 networking visits in their local communities, with a special focus on ensuring that hard-to-reach and vulnerable consumers, along with their whānau and carers, were made aware of the Advocacy Service and the Code. Networking helps advocates to build community knowledge and provide practical, up-to-date information, along with referrals to other services when necessary.

Advocates visit services that provide support to consumers who are least able to self-advocate and whose welfare may be most at risk. In particular, visits to aged-care and disability residential facilities, and to day-care centres, enable contact with residents who may otherwise find it impossible or extremely difficult to seek an advocate’s assistance. Advocates also use these visits to provide information and arrange education sessions for residents, whānau/family members, and providers. During 2019/20, advocates made 1,091 visits to residential services and a further 43 visits to non-residential facilities/services that provide day programmes and care.

Accessing the Advocacy Service

The Advocacy Service has an interactive website with information on how to contact a local advocate, online complaint forms, and a live chat option, and is promoted on the HDC website. The service also has a social media presence, and advocates distribute promotional leaflets, posters, and other resources in their communities. All promotional items, including the website, present advocacy information in an accessible format.

The Advocacy Service also operates an 0800 national call centre and now operates the HDC 0800 new enquiry line. This enables people to speak to an advocate easily, as the first option for talking through their concerns and understanding resolution options. During the 2019/20 year, staff managed over 15,000 public enquiries, covering a broad range of topics.

In addition, the Advocacy Service is promoted on the HDC website, and the service now operates the HDC 0800 new enquiry line. This enables people to speak to an advocate easily, as the first option for talking through their concerns and understanding resolution options.

Promoting the Code through education sessions

Advocates provide face-to-face education sessions to groups of consumers about their rights under the Code, and to groups of providers about their responsibilities and effective complaints management. These sessions are a great opportunity to discuss the Code in the context of the specific circumstances of the attendees, and for advocates to explain successful complaints management processes and the advocate's role.

In the 2019/20 year, advocates presented 1,422 education sessions. These were very well received, with 89% of attendees who responded to a survey reporting that they were satisfied or very satisfied.

Satisfaction with the Advocacy Service

People who contact the Advocacy Service often express frustration and anger about a situation. In some instances, being able to express their feelings to an advocate who listens, and to talk through the options available to them, may enable them to resolve their concerns. In other circumstances, the advocate will take an active role in supporting complainants to resolve their complaint with the person or organisation who provided the service.

Active advocacy can involve mentoring a person who wants to address their complaint directly with a provider, or writing letters and supporting complainants at meetings. Both complainants and providers have talked about the clarity advocates bring to the process, not only identifying issues but also providing guidance about what complainants need to help them to resolve their concerns. In 2019/20, 93% of consumers and 93% of providers who responded to satisfaction surveys said that they were satisfied or very satisfied with the Advocacy Service.

> "[My] advocate was so patient and understanding. She made me feel heard and I truly felt she was advocating on my behalf. It was a really good feeling having someone on my 'side' during this process. I appreciated her time and attention to my matter."

Nutrition planning for aged-care resident

A 96-year-old woman living in an aged-care facility was concerned about her weight loss, and felt socially isolated from other residents at meal times because of the challenges of her swallowing disorder.

The woman's daughter had tried to raise these issues with the rest home previously without success, and contacted the Advocacy Service.

The advocate supported the woman and her daughter in a meeting with the rest home team leader, chef, and diversional therapist. They discussed how best to ensure that the woman received a nourishing diet, taking into account that she had swallowing difficulties with textured food. The woman and her daughter were very happy with the outcome of the meeting, and it gave them confidence that the facility would provide the necessary diet and regular health checks to ensure that it was meeting the woman's needs.

Mentoring for self-advocacy

The Medical Council suggested that a woman contact the Advocacy Service for support with raising her concerns about how she was treated by her GP in a consultation.

The woman said that she had been contacted by her GP of many years to make an appointment to discuss her latest test results. However, during the consultation the woman lost confidence in her GP, as she felt that the GP made several mistakes, such as incorrectly referring to a history of a medical condition the woman did not have, and being critical of the sonographer who had carried out a scan.

After discussions with the advocate, the woman decided that the support she required from the Advocacy Service was mentoring to enable her to self-advocate. The advocate provided guidance and information throughout the process, from the initial letter to the GP through to resolution. The woman received what she considered to be a sincere letter of apology, an acknowledgement of her feelings, and an assurance that the same thing will not happen again. She thanked the advocate for the support, stating: "In uncharted waters it is so good having someone like you with knowledge and expertise to guide me."

Medication processes in prison

A man in a corrections facility contacted the Advocacy Service because, five days after being transferred from one facility to another, his medication had been stopped.

The man said that when he asked why his medication had been stopped, he was told by a nurse that it had "run out". He told the advocate that he had not received any communication prior to the medicine being unavailable, and was experiencing increased pain levels, anxiety, and difficulty sleeping.

With the man's agreement, a letter was sent to the health centre. In the response there was recognition that procedural changes were required and had in fact been made, including having GPs sign off medications in time for them to be re-stocked at the pharmacy, and that consumers should receive a letter informing them of any changes to their medication regimen.

The man was happy with the outcome, and was especially pleased that the changes implemented would improve the service for others.

4.3 Proceedings

The Director of Proceedings has an independent statutory role. The Director takes proceedings against health and disability services practitioners in the Health Practitioners Disciplinary Tribunal (HPDT) and/or the Human Rights Review Tribunal (HRRT).

The overall objective of the Director of Proceedings 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.

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

Proceedings taken by the Director

This year, the Director concluded seven proceedings in the HRRT. These all involved a formal declaration from the HRRT that providers had breached the Code. The cases in the HRRT involved failings by both group and individual providers. In addition, the Director resolved three matters by way of restorative justice, and successfully prosecuted a health practitioner before the HPDT for a serious breach of professional boundaries.

Referral statistics

During 2019/20, the Director of Proceedings had 27 referrals from HDC in progress, including nine referrals received in the course of the year.

Table 3: Referrals received in the 2019/20 year by provider type

Provider	No. of referrals in 2019/20
DHB	1
Disability service	1
Prison health service	2
Doctor	1
Mental health support worker	1
Pharmacist	1
Massage therapist	1
Rest home	1
TOTAL	**9**

CASE STUDY

Physiotherapist held accountable for breach of professional boundaries

The Director filed a charge against a physiotherapist in the HPDT alleging a breach of professional boundaries during a treatment session with a vulnerable female patient.

The charge

The charge related to the physiotherapist advising the patient to take off all of her clothes and/or failing to ask the patient to put some clothing back on when it was apparent that she was naked. The physiotherapist then proceeded to massage the patient's lower back, pelvic area, and upper and inner thigh areas despite the fact that she was naked; failed to drape the patient adequately during the massage; asked whether he could massage the patient's clitoral region; and engaged in a conversation with the patient that was of a sexual nature.

The charge also concerned a departure from professional standards of care in the treatment provided, specifically that the treatment was not appropriate at a first consultation for the condition the physiotherapist claimed he was treating (suspected muscle tension dysphonia (MTD) and breathing pattern disorder (BPD)).

The Tribunal's findings

In 2016, the patient suffered a traumatic brain injury requiring surgery. As a result of the injury, the patient experienced, among other things, changes to her voice and difficulty swallowing. She was referred to the physiotherapist for assessment. It was agreed that the assessment would take place in the patient's home. During the treatment session, the physiotherapist was alone with the patient. The physiotherapist first carried out therapy to the patient's vocal cords, which the patient found beneficial. Following a discussion about a previous lower back injury that had been aggravated by the patient's stay in hospital, the physiotherapist advised the patient that there was a connection between the lower back and the diaphragm and voice, and that a lower back massage might be helpful, to which the patient agreed.

The Tribunal found that at this time, the physiotherapist asked the patient to "take all of her clothes off". The patient questioned this, and the physiotherapist confirmed that she was to remove all of her clothing and put on a bathrobe. The patient changed as requested. The physiotherapist then asked the patient to remove her bathrobe and lie face down on a plinth. The patient covered herself with a towel.

The physiotherapist proceeded to massage the patient's lower back and the top of her buttocks, moving the towel so that he could massage directly onto her skin. The physiotherapist then advised the patient that, if she agreed, he would massage her "other side", and asked the patient to roll over so that she was lying on her back. The physiotherapist draped the patient with a towel from her shoulders to just below her crotch, and began to massage the patient's outer, middle, and inner thighs, which made the patient feel uncomfortable.

The Tribunal found that as the physiotherapist massaged the patient he moved the towel, leaving intimate areas of her body exposed. Further, the physiotherapist continued to massage higher up the patient's thigh and then asked if he could massage her clitoral region. The patient said no, and the massage ended.

The physiotherapist did not attend the Tribunal hearing but submitted witness statements for the Tribunal to take into consideration.

The Tribunal found that the particulars of the charge, with the exception of the particular relating to the post-treatment conversation, were established separately and cumulatively, and constituted malpractice, negligence, and conduct bringing discredit to the physiotherapy profession. The Tribunal was satisfied that each of the proven particulars warranted disciplinary sanction and amounted to professional misconduct.

Penalty

In determining penalty, the Tribunal concluded that the physiotherapist had taken advantage of the situation and of the patient's trust, and caused the patient significant distress. The Tribunal stated that the physiotherapist's behaviour "became increasingly concerning", and that he was "testing the boundaries as events unfolded to see how far he could go in his predatory conduct". The Tribunal cancelled the physiotherapist's registration.

The Tribunal's decision can be found at: **https://www.hpdt.org.nz/portals/0/1033Phys18420**

CASE STUDY

DHB held accountable for failing to provide services with reasonable care and skill

The Director filed proceedings by consent in the HRRT against a DHB regarding audiology services that the DHB provided to a young health consumer (Miss D).

Miss D was referred to the Audiology Department at Dunedin Hospital in July 2006 at two months of age. Despite being assessed five or six times between 2006 and 2010, and independent concerns being raised about her hearing, Miss D's severe hearing loss was not diagnosed until she was five years old.

Throughout the audiology assessments, the status of Miss D's hearing had not been established through appropriate audiological testing and cross checking, which had resulted in a significant delay in diagnosing her profound deafness. Miss D has been able to hear fully only since she was six years of age, with the assistance of hearing aids and a cochlear implant. She has required a lot of support and assistance with her academic progress, and is still several years behind her peers, both academically and socially.

The DHB acknowledged that its audiology services, facilities, and equipment at the time in question were suboptimal. Further, the DHB acknowledged that it failed to ensure that the sole charge audiologist was credentialled adequately, supervised appropriately, provided with peer support, and had his performance monitored. The DHB also acknowledged that a systemic failing contributed to Miss D not receiving care of an appropriate standard with regard to her hearing status.

The DHB accepted that its failures in care amounted to a breach of the Code, and the matter proceeded by way of an agreed summary of facts. The Tribunal was satisfied that the DHB failed to provide services to Miss D with reasonable care and skill, and issued a declaration that it breached Right 4(1) of the Code.

The Tribunal's full decision can be found at:
http://www.nzlii.org/nz/cases/NZHRRT/2020/5.html

4.4 Monitoring and advocacy — mental health and addiction services

The Mental Health Commissioner is responsible for monitoring mental health and addiction services and advocating for improvements to those services. He also makes decisions in relation to complaints about mental health and addiction services. These responsibilities are delegated to him by the Health and Disability Commissioner.

The Mental Health and Wellbeing Commission Act 2020 will come into force by February 2021, establishing a permanent standalone commission which will take on the Mental Health Commissioner's monitoring and advocacy function, within a broader wellbeing mandate. 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.

2
monitoring and advocacy reports
on the state of Aotearoa's mental health and addiction services

26
recommendations
to the Minister of Health for mental health and addiction system improvements

6 submissions & briefings
on Government policy and legislation

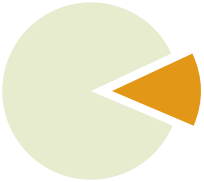
over 137
sector meetings and events
with consumers and whānau, clinical, policy and workforce leaders, and other stakeholders in the mental health and addiction sector

54
quality improvement recommendations
to services in response to complaints

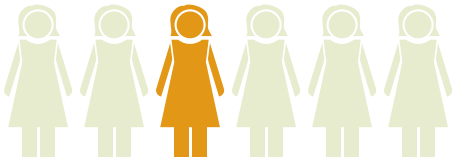
State of services reporting

1 in 5
New Zealanders live with **mental illness and/or addiction**

almost 1 in 3
Māori live with mental illness and/or addiction



12%
of New Zealanders will experience a **substance use disorder** at some stage of their lives



1 in 6
women experience **significant ante-/post-natal depression**

2 in 3
people in prison live with mental illness and/or addiction

Two reports on Aotearoa New Zealand's mental health services and addiction services were released in 2019/20 — an indicator update and a substantive monitoring and advocacy report.* This reporting brings transparency and accountability to the performance of services, and makes recommendations for improvement to the Minister of Health.

The Mental Health Commissioner found in his monitoring role that since 2018 significant progress has been made by Government to increase the focus on wellbeing, and to broaden support for people with mild to moderate mental distress and/or addiction needs. But there is much more to be done. There is a pressing need to improve support for people with complex and enduring needs, including connections to wider social supports, to partner with Māori, tāngata whaiora (people seeking wellness) and their whānau, and to engage people and communities in transformational system change.

New Zealand has a vital opportunity to shift from a service response to mental distress and/or addiction to a wellbeing system response, and, in doing so, can provide global leadership in promoting wellbeing. We have shown that we can do this with our collective wellbeing response to the COVID-19 pandemic. Taking the lessons learned from this approach and applying them to the pervasive mental health and addiction challenges our country faces could be a way forward.

*** https://www.hdc.org.nz/media/5397/hdc-mhas-monitoring-indicator-update-2019-report-web.pdf** and **https://www.hdc.org.nz/media/5517/hdc-aotearoa-new-zealands-mental-health-services-and-addiction-services-2020.pdf**

Some of the Mental Health Commissioner's findings and recommendations are highlighted below.

SUPPORTING TRANSITION TO A WELLBEING SYSTEM RESPONSE TO MENTAL DISTRESS AND ADDICTION

A key area of focus has been ensuring that the Government puts in place necessary systems and processes to support the transformational change for mental health and addiction services set out in *He Ara Oranga*, the 2018 report of the independent Inquiry into Mental Health and Addiction. In 2019/20, the Mental Health Commissioner recommended that the Minister of Health develop:

- An all-of-government, all-of-community plan to drive transformational change. There needs to be clear ownership of the plan within Government, and partnership with communities, to bring the collective response to life.
- A service-level action plan grounded in evidence and lived experiences to map out what it needs to achieve to deliver transformational services — so that funding decisions can be targeted, and the wellbeing workforce developed.

IMPROVING OUTCOMES FOR MĀORI

Outcomes for Māori continue to be worse than for other population groups. While it is positive to see a recent increase in funding for kaupapa Māori services, there is a continued need to ensure that all mental health and addiction services work for Māori and are culturally safe. Recommendations to the Minister of Health in 2019/20 included:

- That governance arrangements be established for Māori and other sector leaders to partner with Government in the co-creation of all-of-government, all-of-community and service-level plans; and
- To ensure that the health sector plan includes particular focus on ensuring that mainstream services succeed for Māori, as well as enabling and strengthening kaupapa Māori services and other Māori-led responses.

SUPPORTING MOTHERS AND BABIES TO HAVE THE BEST START

During pregnancy and in the first year after birth, women are at increased risk of developing or having a recurrence of mental health issues. Suicide is the leading single cause of maternal death in New Zealand, and Māori whānau are disproportionately affected. Routine screening and enhanced and better integrated support, particularly with infant services, is essential to promote the wellbeing of mothers and their children. Recommendations to the Minister of Health in 2019/20 included:

- When developing a maternity whole-of-system plan as part of the Child Wellbeing Strategy, the Government should implement:
  - A stocktake of current maternal mental health services to identify both the strengths of services and gaps or inequity in current services and skills in the workforce; and
  - A national pathway for accessing maternal mental health services, including cultural appropriateness, appropriate screening, and the development of integrated care pathways within a stepped care framework; and
- Ensure that substance-related and addiction issues and integration with infant services are an integral component of the maternity action plan.

ENSURING FOCUS ON ADDICTION

While co-morbidity is common, there are important differences in the drivers of, approach to, and experience of people with addiction that need to be taken into account as New Zealand transforms its approach to mental health. A broader approach to addressing substance-related issues is required, including reducing the stigma that can create barriers to people seeking help. Recommendations to the Minister of Health in 2019/20 included:

- Commit to and implement a public health programme aimed at promoting help-seeking, harm reduction, and destigmatisation for people who are experiencing harm from substance use; and
- Ensure that measures are taken to increase the number of addiction-specific peer support workers and consumer advisors within the mental health and addiction sector, particularly in DHBs.

CONTINUING TO ADDRESS THE NEEDS OF PEOPLE IN PRISON

Prisoners have some of the highest mental health and addiction needs in the country. While Corrections is making progress in improving its ability to address those needs, there are still areas of concern. Urgent action is needed to address the lack of forensic capacity, which has not kept up with the growing number and needs of the prison population.

Recommendations to the Minister of Health in 2019/20 included:

- Ensure that urgent action is taken to develop and implement strategies to improve forensic services, including workforce development, models of care, and access to culturally appropriate services and step-down supports.

SHOWCASING SUCCESS

The Mental Health Commissioner's monitoring and advocacy report also shone the spotlight on a number of initiatives around the motu that illustrate what is possible when people are willing to try a different approach.

Realising that standard healthcare delivery models were unlikely to reach those who would most benefit from a new treatment for Hepatitis C, Tū Ora PHO partnered with the Needle Exchange. Holding free monthly drop-in clinics at the Exchange with a nurse experienced in providing care to marginalised populations helped to build trust, remove barriers, and improve health outcomes for a high needs population.

A commitment to challenging standard practice and collaborating across disciplines and with those with lived experience has helped Auckland DHB to reduce its use of seclusion from 343 seclusion episodes in 2010 to record low levels — including months with no seclusion events — in 2020. With the number of seclusion events so low, each individual case can be reviewed, including by peer advisor de-briefs with

the tāngata whaiora, and with multi-disciplinary teams and whānau. Areas of support for the tāngata whaiora can be identified, as well as what can be done differently from pre-admission through to the seclusion event itself and after care.

With one of the highest levels of mental distress in the country and evidence of high need and poorer outcomes for Māori accessing mental health services, Hauora Tairāwhiti, in conjunction with community partners, developed an innovative bicultural kaupapa Māori response for people in distress. It applied indigenous mātauranga to reframe people's distress and find a way forward in their journey to wellness. Feedback showed that tāngata whaiora and whānau felt respected, validated, heard, and empowered, and that they valued the service. Delays and transition times decreased, there was a reduction in admissions to inpatient wards, and the use of compulsory treatment orders, particularly for youth (under 18 years), also declined.

Supporting transformation

Following the release of *He Ara Oranga* in late 2018, a significant focus for government has been the implementation of its recommendations and making the first steps to transform New Zealand's approach to mental health and addiction. In 2019/20, the Mental Health Commissioner and his team placed significant emphasis on providing advice and support to those tasked with bringing these recommendations to life.

SUPPORTING THE ESTABLISHMENT OF THE NEW MENTAL HEALTH AND WELLBEING COMMISSION

The new Mental Health and Wellbeing Commission will have a critical role in holding government and other decision-makers to account for the mental health and wellbeing of people in New Zealand. In 2019/20, the Mental Health Commissioner liaised frequently with the Ministry as it progressed the legislation to establish the new Commission, and made both written and oral submissions to the Select Committee. These submissions focused on ensuring that the new Commission is set up to succeed, with the necessary powers, independence, and make-up to perform its role.

In September 2019, the Initial Mental Health and Wellbeing Commission was set up to provide independent scrutiny of the Government's progress in improving New Zealand's mental health and wellbeing, and to develop advice for the permanent Commission, including a draft outcomes and monitoring framework. The Mental Health Commissioner and his team have liaised regularly with the Initial Commission since its establishment, sharing data, insights, and our experience in developing a monitoring framework for the sector.

CONTRIBUTING TO THE REVIEW OF THE MENTAL HEALTH ACT

The Mental Health Commissioner has long had concerns that the Mental Health (Compulsory Assessment and Treatment) Act 1992 is no longer fit for purpose. In his 2018 report, he recommended that the Ministry advise on the changes required to ensure that it aligns with the Code of Rights and current expectations about human rights, supported decision-making, and best practice in the provision of therapeutic health services. With the Ministry agreeing to repeal and replace the Act in response to *He Ara Oranga*, the Mental Health Commissioner and his team have been providing advice to the Ministry, including submitting on the draft revisions to Guidelines to the Act.

HDC's submission noted how important it is that those applying the Act, people subjected to it, and their whānau, are fully aware of the rights of consumers of health and disability services. It focused on the need for the Guidelines to strongly reinforce that the Code applies in full to the care of consumers of mental health services, even when under the Act, and that in situations where part or all of a Code right is overridden by the Act:

1. The other Code rights continue to apply;
2. Other Code rights become even more important and relevant; and
3. Systems and processes should be in place to uphold consumer rights to the greatest extent possible.

Supporting mental health and addiction consumers

Mental health and addiction consumers often share experiences of stigma and coercive practice. They can find it difficult to self-advocate, and have shared experiences of being ignored or dismissed when they do. In 2019/20, HDC and the Advocacy Service began a joint initiative 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 awareness among those providing such services of their obligations. Working with a group of people with lived experience from around the motu, HDC and the Advocacy Service have begun identifying what is working, as well as key barriers, opportunities, and priorities.

Upholding rights through complaints

As part of monitoring mental health and addiction services and advocating for their improvement, the Mental Health Commissioner has responsibility for making decisions in relation to complaints to HDC about mental health and addiction services. Insights gained from complaints are integrated with information gained through the monitoring function. This supports the Mental Health Commissioner to make quality recommendations for service improvement in relation to individual complaints. Each complaint provides a valuable opportunity to identify key learnings and promote best practice within the sector.

HDC received 293 complaints about mental health and addiction services in 2019/20. This is a small decrease on the 301 complaints received in the previous year, but is a 14% increase on the average number of complaints received over the last four years. Complaints about mental health and addiction services have increased by 28% over the past five years.

Similar to what was seen in 2018/19, when all issues complained about in relation to mental health and addiction services were considered, the most commonly complained about categories in 2019/20 were:

- Communication (63%)
- Care/treatment (58%)
- Consent/information (20%)
- Medication (19%)
- Access/prioritisation (16%)
- Facility issues (15%)
- Professional conduct (13%)

The most common issues complained about within these broad categories in 2019/20 were:

- Failure to communicate effectively with consumer (34%)
- Failure to communicate effectively with family (23%)
- Inadequate/inappropriate clinical treatment (22%)
- Inadequate/inappropriate examination/assessment (19%)
- Issues with involuntary admission/ treatment (15%)
- Lack of access to services (14%)
- Disrespectful manner/attitude (14%)
- Inadequate/inappropriate follow-up (14%)
- Inappropriate prescribing (13%)
- Inadequate coordination of care/ treatment (11%)

The issues complained about in 2019/20 are generally consistent with what has been seen in previous years, with the exception of complaints involving inadequate/inappropriate follow-up, which saw an increase in 2019/20 as compared to other years. Complaints involving inadequate follow-up were most often seen in relation to emergency mental health care.

It should be noted that these categories reflect the issues as they are described by the consumer, and were not necessarily substantiated by HDC.

Promoting service improvement

In 2019/20, the Mental Health Commissioner made 54 quality improvement recommendations to providers following a complaint, and providers were 100% compliant with all recommendations that were due to be completed in the 2019/20 year.

Recommendations made by the Mental Health Commissioner in 2019/20 picked up the themes of discharge planning, family engagement, emergency mental health care provided by ED, safety for consumers on the inpatient unit, and ensuring physical health equity for people who experience mental health and addiction issues (Equally Well). Some examples of these recommendations are set out below.

DISCHARGE PLANNING AND EQUALLY WELL

The Mental Health Commissioner undertook an investigation into the care provided to a man with mental and physical health issues. The Mental Health Commissioner found a number of inadequacies in the coordination of the man's care between a community mental health service, a Needs Assessment and Service Coordination (NASC) service, and two support organisations that were assisting the man to live in the community. The Mental Health Commissioner made a number of recommendations to the DHB designed to improve discharge planning and the care of mental health consumers with physical health issues, including that it:

- Implement robust policy documentation to ensure that when a person is to be discharged from a mental health and addiction service and there are multiple services involved, a multi-service meeting is held to determine the lead agency and confirm the support plan for the person;
- Undertake an audit of compliance with the community mental health service's discharge documentation requirements, focusing on obstacles to service delivery and criteria for re-referral to the service; and
- Familiarise NASC staff with the Equally Well consensus paper, to support them to enact this in the context of needs assessment and contracting services.

SAFETY ON THE INPATIENT UNIT

Following an investigation into the care provided to a man on an inpatient unit, including an episode of restraint, falls management, and the man's ability to access cannabis while in the unit, the Mental Health Commissioner made a number of recommendations to the DHB to improve the safety of the inpatient unit, including that it:

- Provide evidence that staff have undertaken refresher Safe Practice Effective Communication (SPEC) training (a course that supports best and least restrictive practice in mental health inpatient units), and undertake an audit of SPEC training records following these refresher sessions to ensure that records are being kept up to date;
- Review how to maintain adequate supervision in the High Care Unit where visibility and line of sight is a challenge;
- Consider whether to specify in the High Care Area practice guidelines the number of patients who should be in the High Care Area courtyard at one time;
- Consider including a specific requirement to assess and address addiction issues as part of treatment plans; and
- Consider system improvements to reduce access to illicit substances by mental health and addiction service inpatients, and ensure that it engages service users, families, and the wider mental health community and other relevant agencies in this work.

EMERGENCY MENTAL HEALTH CARE AND FAMILY ENGAGEMENT

Following an investigation into the care provided to a man by the ED of a public hospital and the DHB's mental health Acute Care Team, the Mental Health Commissioner asked the DHB to update HDC on the changes it had made since the event to improve the assessment of mental health patients in the ED.

This included providing information on: the implementation of a mental health assessment form for use by ED nurses; the training provided to ED staff regarding appropriate communication methods when assessing mental health patients; and any improvements made to the referral processes between ED and mental health services.

The Mental Health Commissioner also made a number of other recommendations to the DHB to improve family engagement during risk assessments, including that the DHB: provide a process for flagging significant historical risks with clear and, where possible, triangulated information; provide education to staff on the importance of obtaining family perspectives and the need to provide family with information and support; and conduct a random audit of documentation relating to mental health assessments to ensure that risks have been explored adequately and that attempts have been made to obtain collateral information from family.

CASE STUDY

Provision of methadone treatment to wrong client

A woman who had been prescribed a daily dose of methadone went to a pharmacy to consume her medication.

The pharmacist called out another patient's name, but thinking she heard her own name called, the woman followed him into the consultation room where she consumed someone else's dose of methadone. She also received further doses of the other patient's methadone to take away. The error was recognised quickly and rectified by the pharmacy.

Following the incident, the pharmacy manager stopped the woman's methadone service. The manager informed the woman's alcohol and drug case worker but did not discuss the issue with the woman before making the decision, in accordance with the New Zealand Practice Guidelines for Opioid Substitution Treatment.

Findings

The Mental Health Commissioner considered that the pharmacist should have done more to check the identity of the woman and, by not doing so, failed to comply with professional standards, in breach of Right 4(2) of the Code. The Mental Health Commissioner commented: "Methadone is a Class B controlled drug, and can cause death if the incorrect dose is dispensed. In my view, [the pharmacist] should have been more cautious given his lack of familiarity with the patients, particularly in light of the high risk of adverse effects."

The Mental Health Commissioner also noted that it is important that input from the consumer is sought prior to any decision to terminate a pharmacy's service to that consumer. He stated: "[M]ost patients who have received opioid substitution treatment have experienced stigma to some extent… I consider it essential that all patients who receive opioid substitution treatment are treated with a reasonable, non-discriminatory, non-judgemental and empathetic approach… [U]nilateral termination of services without any direct engagement with the consumer is likely to be based on incomplete information, and risks being unfair and unreasonable."

Recommendations

The Mental Health Commissioner recommended that the Ministry of Health review the New Zealand Practice Guidelines for Opioid Substitution Treatment to ensure that both the Code and the Pharmacy Council's Code of Ethics can be applied appropriately when a pharmacy stops services for a patient.

The Mental Health Commissioner also recommended that the pharmacist apologise to the woman. He recommended that the pharmacy:

- Arrange refresher training for its staff in relation to dispensing and administering methadone;
- Update its induction programme to include orientation to, and training on, its Standard Operating Procedures;
- Conduct an audit on errors or near misses in relation to the dispensing of methadone and on staff compliance with the Standard Operating Procedure in relation to methadone dispensing and consuming; and
- Report back to HDC on the outcome of the audit, including any actions taken by the pharmacy to improve its policies and practices as a result of the audit findings.

(Case: 18HDC00795)

4.5 Education

HDC undertakes a number of educational activities to improve providers' and consumers' understanding of Code rights, and to share learnings from complaints to support safety and quality improvements.

Education sessions

HDC delivers education and training sessions to providers to equip them with a better understanding of their obligations under the Code. This activity is complemented by the community-level education initiatives led by the Advocacy Service. These sessions also help to ensure that lessons from complaints are disseminated to the sector, by educating attendees on issues of concern in complaints, and HDC's recommendations in these areas.

Restrictions related to the COVID-19 pandemic had an effect on the number of education sessions HDC could undertake in 2019/20. Nevertheless, HDC conducted 20 sessions. These were delivered to a wide range of sector groups, including: medical students, professional colleges, pharmacy students, DHBs, nurses, primary care staff, and radiologists, as well as presentations at a number of health and disability sector conferences. Feedback from these sessions was positive, with 100% of respondents reporting that they were very satisfied or extremely satisfied.

In line with HDC's strategic priority to work with providers to improve their complaints management processes, HDC runs complaints management workshops. These workshops aim to increase the number of complaints resolved effectively by providers themselves, improve satisfaction with providers' responses to complaints, and encourage learning from complaints to improve quality of services. HDC conducted four of these workshops in 2019/20. Feedback continues to be positive, with between 89% and 100% of attendees who provided feedback reporting that they were satisfied or very satisfied with the sessions.

Education about the Act and Code and the work of HDC is also delivered directly to consumers and providers through responses to individual enquiries. In 2019/20, HDC provided formal responses to 52 enquiries, in addition to the thousands of informal enquiries and telephone calls we responded to. These responses included providing information about informed consent and operation of the Code, provider duties, and responding to enquiries about application of the Code during the COVID-19 lockdown.

Complaint reports

Every complaint is an opportunity to learn. HDC 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.

In order to disseminate the learnings from individual complaints, HDC publishes many of its decisions where a provider was found in breach of the Code. In 2019/20, HDC published 106 such decisions.

Trends and patterns that emerge across complaints are a rich source of learning, often identifying the systemic issues that can lead to complaints. With this in mind, HDC regularly monitors complaint trends.

In 2019/20, HDC provided all DHBs with two six-monthly complaint trend reports. 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. These reports continue to be received positively, with the majority of DHBs who responded to a feedback survey stating that the reports were useful or very useful for improving services.

The analysis of complaints data about types of adverse event can provide insights into the common contributing factors to those events. In order to capture these insights, HDC regularly publishes research reports with analyses of complaint data in particular areas of interest. In January 2020, HDC began an analysis of maternity complaints where deficiencies in the care provided were identified. A report detailing this analysis is expected to be published in 2020/21.

Trends in complaints regarding COVID-19

In 2019/20, HDC received 151 complaints related to COVID-19. These complaints are being monitored carefully for patterns and trends. Common issues complained about in relation to COVID-19 are:

- Inadequate infection control policies or failure to follow such policies;
- Lack of access to hospital care and/or deferred treatments/procedures;
- The manner in which COVID-19 screening questions and infection control policies were communicated to consumers by providers;
- Visitor restrictions and policies around support people, including communication with family about their relative's condition when they were restricted from visiting;
- Inadequate access to primary care;
- Care standards during Level 4 lockdown; and
- Inadequate access to testing for COVID-19 and/or delays in receiving test results.

HDC is liaising with the sector and the Ministry of Health about the issues HDC is seeing in complaints about COVID-19. For example, in April 2020 HDC raised equity and patient safety concerns regarding aspects of the COVID-19 response, including:

- Inconsistencies around the country in the ways DHBs applied the National Hospital Response Framework, including unwarranted inconsistencies in the degree to which services accepted GP referrals, variable service withdrawals, and inconsistent treatment of patients who had elective surgery cancellations; and
- Reduced health sector activity, levels of unmet need, and the importance of planning for demand (the consequences of which are particularly serious for those for whom early diagnosis and treatment is key to a successful outcome).

This letter is available on our website at **https://www.hdc.org.nz/media/5466/letter-to-minister-16-4-20.pdf**

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.

In 2019/20, HDC made 39 submissions. Submissions were made on proposed legislation, including the End of Life Choice Act and abortion reform, and comments were made on proposed policies, procedures, codes of conduct or ethics, guidelines, and practice standards for health practitioners.

Focus on equity

People in New Zealand have differences in health outcomes that are not only avoidable but are unfair and unjust. HDC is doing substantial work to strengthen our focus on equity, including in terms of data collection, analysis, monitoring, and reporting on matters relating to equity. We expect to be able to report on this in 2020/21.

> "Trends and patterns that emerge across complaints are a rich source of learning, often identifying the systemic issues that can lead to complaints."

4.6 Disability

Supporting disabled consumers

The Deputy Commissioner, Disability works to increase awareness among disabled consumers about their rights under the Code, and ensure that HDC is accessible and responsive to all people.

Education sessions

In 2019/20, HDC provided four education sessions for older people, disabled people, and their whānau. These sessions were received positively, with 100% of attendees who provided feedback reporting that they were satisfied or very satisfied. In response to COVID-19 restrictions, HDC has moved these presentations online, and a Powerpoint presentation in accessible formats is available on our website.

The Deputy Commissioner, Disability also produced a new resource booklet entitled "Going to Hospital", which is available on the HDC website. The plain language booklet is for people who are unfamiliar with public hospital services and want to learn more about what to expect as a patient. It offers tips on how to prepare for hospital, useful contacts, frequently asked questions, and a glossary of common words used in hospital situations, including some in te reo Māori.

Another key focus for HDC is empowering disabled consumers by enabling them to exercise choice, control, and supported decision-making. With this in mind, we revised the Health Passport booklets and guide book. The new versions are known as "My Health Passport", and are powerful tools for communicating with providers about consumers' individual support needs. In addition to updating these booklets, a new My Health Passport express version (a tri-fold brochure) has been developed. These documents work to inform the reader, delivering necessary information at the right time and addressing avoidable barriers arising from poor or non-existent communication.

HDC continues to work with the Ministry of Health and Capital & Coast DHB in preparing for the implementation of an online version of "My Health Passport", to make this helpful resource more easily accessible.

Complaints received about disability services

The Deputy Commissioner, Disability recognises the need to continue strengthening the safeguards in place for consumers of disability services, and to promote quality improvement. Complaints data is reviewed regularly to identify common issues and areas of concern, and this information is shared with other agencies. We also take opportunities to increase public awareness of people's experiences, and bring about systems improvement where necessary.

In 2019/20, HDC received 95 complaints about disability services — a similar number to the 92 complaints received in the 2018/19 year.

Common issues identified by HDC when assessing these complaints were similar to previous years, and include:

- A lack of access to funding and services;
- Individual support needs not being met; and
- A lack of effective communication with the consumer and their family/whānau, particularly regarding changes to support staff, and inadequate service co-ordination, particularly regarding staff rostering and staff attendance on shifts. These issues are of great importance to people who are reliant on this care.

Complaints received about residential aged-care facilities

People in residential aged-care services have particular vulnerabilities, and HDC pays close attention to the information we receive in complaints about those services. In 2019/20, HDC received 161 complaints about residential aged-care facilities — a significant increase on the 122 complaints received in 2018/19. Part of this increase can be attributed to the effects of the COVID-19 pandemic and the resulting policies and processes implemented by DHBs and residential aged-care facilities.

Some of the most common issues we identified when assessing complaints received this year were:

- Inadequate recognition, assessment, monitoring, and management of deteriorating conditions, and delay in escalating care for further medical review with other providers such as GPs;
- Inadequate falls risk assessment and management, including inadequate post-falls assessment;
- Inadequate pain management;
- Inadequate wound care, including assessment and monitoring;
- Poor communication with consumers and family/whānau; and
- Inadequate care plans and documentation.

HDC has paid close attention to residential aged-care services during the COVID-19 pandemic, recognising that this consumer group is particularly vulnerable, and that there has been a lack of visibility of the care being provided at this time. Complainants have raised concerns regarding:

- Visitor restrictions implemented by ARC facilities, and a lack of communication with family about the consumer's condition over the period these restrictions were in place;
- Adequacy of infection control policies and/or a failure to follow such policies; and
- Adequacy of care provided to residents of ARC facilities during the Level 4 lockdown period, including issues around staffing levels.

CASE STUDY

Processes for checking on a vulnerable client at home

This case highlights the importance of having adequate escalation policies and procedures when a consumer has safety requirements.

An elderly woman with co-morbidities and vision impairment was assessed as a high risk for falls. The woman lived on her own and required twice-daily cares and safety checks to be performed by a home-care support service. Her support plan included helping her with personal cares, oversight of her medication, home management tasks, and performing a safety check at each visit to ensure that she remained safe in her home.

One morning, the woman appeared not to be home for her morning support. The support worker telephoned the service, which followed the "client not at home" policy of calling the client and next of kin. When there was no response from anyone, they advised the support worker to move on.

The "client not home" process was followed a further two times, that evening and the following morning. Contact was made with a family member, who said that the next of kin were out of the country and requested a welfare check by the police. Meanwhile, a support worker returned later that morning and gained access using a spare key held by a neighbour. The woman was found lying in her bed, cold and unresponsive. She had suffered a cardiac incident and a stroke. An ambulance was called and she was transferred to hospital, where she passed away.

Findings

The Deputy Commissioner considered that the home-care support service failed to have a clear escalation policy in its "client not home" process and to identify different risks for individual clients. This resulted in the service failing to ensure the woman's safety, meaning that she was denied the opportunity for earlier medical care. Overall, the Deputy Commissioner found that the service did not provide services to the woman with reasonable care and skill, in breach of Right 4(1) of the Code.

Recommendations

The Deputy Commissioner recommended that the service:

- Train all staff on the updated "client not home" policy, and audit cases where the policy was applied, to assess its application and whether the desired outcomes were achieved;
- Develop an alert system so that individuals who require safety checks have their files flagged for special attention, and include a prompt in support plans to ensure that important information for emergencies is recorded; and
- Work with the DHB's Home and Community Support Services to develop a clear definition of a safety check.

The Deputy Commissioner also asked the service to apologise to the woman's family.

(Case: 19HDC01227)

CASE STUDY

Inadequate end-of-life care

Inadequate end-of-life care is a common issue seen across complaints about aged-care residential facilities. This case demonstrates the importance of ensuring that residents receive basic care, and that end-of-life care is planned appropriately to meet each resident's individual needs.

An elderly man requiring hospital-level care was admitted to an aged-care residential facility for end-of-life care. He was admitted with wounds on his legs, but his dressings were changed infrequently, he reported pain during dressing changes, and he experienced three falls.

During his time at the facility he became increasingly unwell. He lost weight, and this was not monitored by staff. He was not offered regular showers, his room was found to be dirty, and maggots were found on his toes. There were delays in arranging reviews by a GP and a podiatrist.

In his final days at the facility, his family raised concerns that his condition had deteriorated, and made a formal complaint, but there was no review or adequate response by senior staff.

Findings

The Deputy Commissioner found the facility in breach of Rights 4(1) and 4(2) of the Code. She considered that there were a number of failings by the facility, which resulted in an environment that did not support staff to undertake their roles adequately. Basic care the man should have received was lacking.

The Deputy Commissioner also found the clinical services manager at the facility in breach of Right 4(1) of the Code, as she did not provide appropriate oversight of documentation and care planning, and did not follow the facility's complaints policy when responding to the family's formal complaint.

Recommendations

The Deputy Commissioner made a number of recommendations to the facility, including that it:

- Report back to HDC on its corrective action plan;
- Audit the facility's compliance with protocols for reporting changes in a resident's condition to senior staff;
- Review its end-of-life care policies;
- Use the complaint as a basis for staff training; and
- Apologise to the man's family.

The Deputy Commissioner also recommended that the Nursing Council carry out a competence review of the clinical services manager, and that she apologise to the man's family.

(Case: 18HDC00700)

CASE STUDY

Professional boundaries between social worker and client

This case demonstrates the importance of service providers maintaining professional boundaries with consumers, and ensuring that there is adequate supervision, support, and guidance for individual workers.

A man living in a rehabilitation facility was preparing to move into his own home. The local DHB assigned a social worker to help him find suitable housing. Over a number of months, the social worker became more involved in the man's life, meeting with him daily to help with tasks like food shopping. She also visited him outside work hours.

A concern was raised that the social worker's relationship with the man had moved beyond a professional relationship. There was also concern that the man could become dependent on the social worker if the professional boundary was crossed.

Findings

The Deputy Commissioner found that the social worker did not seek any guidance from her supervisor on how to manage the situation, and did not ask for the man to be re-assigned to a different social worker. She failed to maintain professional and ethical boundaries, and did not keep accurate records.

The social worker also failed to adhere to the Social Workers Registration Board Code of Conduct and Core Competence Standards. Because of this, the Deputy Commissioner found that the social worker had breached Right 4(2) of the Code.

Recommendations

The Deputy Commissioner recommended that the social worker undertake a six-month mentoring and education programme with the Social Workers Registration Board, in relation to the Code of Ethics and with a focus on professional boundaries. The Deputy Commissioner also recommended that the Social Workers Registration Board consider undertaking a review of the social worker's conduct.

(Case: 19HDC01069)

5.0 Organisational health and capacity

Leadership

The Commissioner led the organisation with the Executive Leadership Team of two Deputy Commissioners (including the Mental Health Commissioner), the Director of Proceedings, three Associate Commissioners, and a Corporate Services Manager.

Staff

Our people are our greatest resource. HDC staff offer a wide range of expertise in areas including governance, leadership, investigation, policy, litigation, clinical practice, research, information technology, and financial management. Most staff hold professional qualifications and have backgrounds in health, disability, or law. This broad mix of skills and qualifications means that HDC is well placed to promote and protect the rights of health and disability services consumers.

Workplace profile

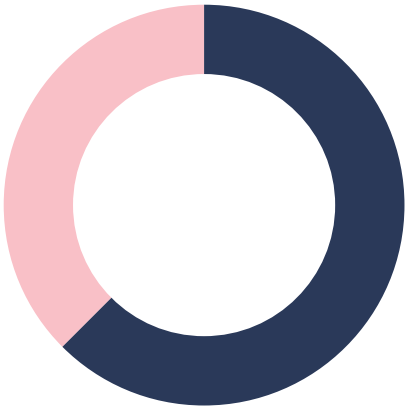
As at 30 June 2020, HDC had 86 staff members (75 full-time equivalents), as follows:

Figure 9: Gender of HDC staff

Females **(77%)**

Males **(23%)**

Figure 10: HDC staff in full-time and part-time positions



Full-time positions **(66%)**

Part-time positions **(34%)**

Equal employment opportunities

HDC promotes and maintains 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 business operation, including in the recruitment process.

HDC's policies require all employees and other workers at HDC to 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 sign language interpreters and special equipment.

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

In 2019/20, HDC organised programmes to enhance mental health awareness and to celebrate te reo Māori Language Week, Sign Language Week, 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. Our managers are responsible for leading a supportive, equitable performance culture. HDC holds regular staff forums in Auckland and Wellington to discuss and share current issues, and to recognise individual and team successes. During the COVID-19 lockdown, HDC held fortnightly video-conferencing forums for all staff to enhance communication and provide support through this challenging period. HDC conducted a brief survey to ask staff about their experiences of work during the COVID-19 lockdown period. The feedback we received indicated that staff engagement and productivity remained high and in some cases even improved through this time. Staff also indicated that they felt well supported.

Recruitment, selection, and induction

HDC's 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. When vacancies are advertised they are shared throughout the office, and employees are encouraged to apply for positions commensurate with their abilities.

HDC has a comprehensive induction programme and orientation plan for new staff. This includes an introduction to the team; an overview of the organisation's activities; information on policies, procedures and tools; and training as required. HDC also carries out a "Fresh Eyes" survey to obtain feedback from new staff members. This feedback supports continuous improvements to the organisation, helping to support staff and improve work practices.

Employee development, promotion, and exit

HDC's policies support professional development and promotion. Training and development needs and career development needs are formally identified as part of the performance appraisal process. Staff members develop a performance agreement with their manager that is tailored to their role, with clear objectives and a supporting development plan.

HDC also provides a structured training programme to support staff as they develop and progress in their roles. Professional development for employees is encouraged, and financial assistance and/or study leave may be granted by the Commissioner.

Flexibility and work design

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

Remuneration, recognition, and conditions

HDC provides fair remuneration that is linked to position accountability and market movement, and is based on equal employment opportunity principles. HDC recognises staff achievements at staff forums and through other channels such as the internal newsletter.

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

Harassment and bullying prevention

HDC has an "anti-harassment" policy and does not tolerate any forms of harassment or bullying. In addition, HDC promotes and expects staff to comply with the State Services Standards of Integrity and Conduct.

Safe and healthy environment

HDC supports staff to play a role in health and safety through its Health and Safety Employee Participation System and the Health and Safety Committee, which meets regularly. Health and safety is regularly on the agenda at staff forums and Executive Leadership Team meetings, and hazards are actively managed. In 2019/20, HDC reviewed and updated its policies associated with staff health and safety at work, and organised corresponding training for staff.

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

The COVID-19 lockdown meant a rapid transition to remote working for all staff. We implemented a range of measures to ensure staff wellbeing and health and safety at this time. These included frequent support from managers; buddy systems within teams; deployment of video-conferencing to all staff; regular all-staff video-conferences; and provision of external telephone/video-conference Employee Assistance Programme (EAP) services.

Process and technology

Technology: HDC adapted its operations quickly to respond to the challenges of the COVID-19 pandemic. We invested in our IT capability and implemented additional training and support to enable staff to work remotely and efficiently from April 2020. We also made significant changes to transition to a paperless operating model. This ensured that we were able to continue delivering our essential services, responding to complaints remotely throughout the lockdown period.

These initiatives have enhanced our capability and efficiency, and assisted in keeping our costs down. We continue to work on initiatives to bring further positive changes to the organisation. For example, in the last year we have continued to improve our database system, allowing some processes to become more automated.

Sustainability: HDC works to reduce its impact on the environment and to save money. The technological advances we've made this year feed into the achievement of our sustainability objectives. We also encourage staff to use resources efficiently and to recycle; we endeavour to buy locally as far as possible; we have increased the use of virtual meetings to save travel costs; we encourage staff to use public transport where appropriate; and we purchase environmentally friendly products and services where possible. In 2019/20, HDC sold two office vehicles, supporting the reduction of carbon emissions.

Physical assets and structures: HDC manages its assets cost-effectively. In 2019/20, HDC worked on a mini-refit for part of the Auckland office to improve the usability of work spaces. We maintain and care for our assets to ensure that we maximise their useful life.

6.0 Statement of performance

6.1 Output Class 1: Complaints resolution

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 1: Complaints resolution	Actual 2020 $	Budget 2020 $	Actual 2019 $
Revenue	7,558,317	7,127,000	7,307,281
Expenditure	7,601,698	7,635,000	7,150,890
Net surplus/(deficit)	**(43,381)**	**(508,000)**	**156,391**

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 3: see Section 3).		2,393 complaints were received during the year. This represents a 2% increase on the previous year's volume (2019: 2,350).
		Targets achieved
Assume 2,400–2,600 complaints will be received.	Close an estimated 2,200–2,300 complaints. The above figure includes an estimated 115—125 investigations.	2,226 complaints were closed during the year, including 133 investigations[1] (2019: 2,392 total complaints closed including 102 investigations).
		Total open files at year end were 934 (2019: 767).
	Manage complaints so that:	Age of open complaints at 30 June 2020:
	• No more than 20–22% of open complaints are 6–12 months old.	• 6–12 months old, 266 out of 934 — 28.48%[2] (2019: 20.8%) Not achieved.
	• No more than 16–18% of open complaints are 12–24 months old.	• 12–24 months old, 164 out of 934 — 17.56% (2019: 16.8%) Achieved.
	• No more than 2–4% of open complaints are over 24 months old.	• Over 24 months old, 30 out of 934 — 3.21% (2019: 4.7%) Achieved.

[1] This is a 30% increase on the 102 investigations closed in 2018/19, which resulted in an increase in the expenditure.

[2] HDC achieved the timeliness targets for files aged over 12 months. During the COVID-19 emergency response, HDC addressed complaints in a flexible and proportionate manner, ensuring public health and safety risks were responded to while being mindful of the pressures on the system. This has impacted our ability to meet targets for files aged 6—12 months. Additional ways were developed to support responsive, early and efficient complaints resolution. This is part of the ongoing continuous improvement focus and COVID-19 pandemic emergency response.

6.1 Output Class 1: Complaints resolution (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 1.2 — QUALITY IMPROVEMENT		
		Targets achieved
Use HDC complaints management processes to facilitate quality improvement (which contributes to achievement of Strategic Objective 2).	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.	Between 1 July 2019 and 30 June 2020, compliance with quality improvement recommendations on 278 complaints were due to be reported to HDC by 155 providers. Recommendations in relation to 274 of those complaints (98.6%) were fully complied with, and recommendations in relation to four were either partially or not 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 non-compliance, two providers were referred to the appropriate regulatory bodies and HDC is currently considering the next steps and options for the other two providers. • 98.6% compliance (2019: 99.3%)

6.2 Output Class 2: Advocacy

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 2: Advocacy	Actual 2020 $	Budget 2020 $	Actual 2019 $
Revenue	4,010,438	3,920,000	4,097,816
Expenditure	4,033,456	4,045,000	4,010,114
Net surplus/(deficit)	**(23,018)**	**(125,000)**	**87,702**

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).		2,754 new complaints were received by the Advocacy Service in the year ended 30 June 2020 (2019: 2,720). **Targets substantially achieved**
Assume 2,800 to 3,300 complaints will be received.	Close an estimated 2,800 to 3,300 complaints.	For the year ended 30 June 2020, 2,753 complaints were closed (2019: 2,644).
	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: • 79%[3] were closed within 3 months (2019: 83%) Target substantially achieved • 99% were closed within 6 months (2019: 99%) Target achieved • 100% were closed within 9 months (2019: 100%) Target achieved **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.	93% of consumers and 93% of providers who responded to satisfaction surveys were satisfied or very satisfied with the Advocacy Service's complaints management process (2019: 91% of consumers and 93% of providers).

[3] Transitioning to remote working practices in Q4 as a result of the COVID-19 pandemic lockdown had an impact on the number of complaints that could be dealt with by the Advocacy Service in Q4.

6.2 Output Class 2: Advocacy (continued)

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 2.2 — ACCESS TO ADVOCACY		
		Targets achieved
Network to promote awareness of the Code and access to the Advocacy Service in local communities (which contributes to achievement of Strategic Objective 4).	Advocates carry out 3,000 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.	**Certified aged-care facilities** For the year ended 30 June 2020, 3,705 scheduled visits or meetings with community groups and provider organisations were carried out. 1,091 of these visits were to aged care and residential disability facilities. (2019: 3,803 visits or meetings, including 1,239 aged care and residential disability facilities visits.)
OUTPUT 2.3 — EDUCATION AND TRAINING		
		Targets not achieved
Promote awareness of, respect for, and observance of, the rights of consumers and how they may be enforced (which contributes to achievement of Strategic Objective 4).	Advocates provide an estimated 1,600 education sessions.	A total of 1,422[4] education sessions were provided (2019: 1,681).
		Targets achieved
	Consumers and providers are satisfied with the education sessions: • Seek evaluations on sessions with 80% of respondents satisfied.	89% of consumers and providers who responded to a survey were satisfied with the Advocacy Service education session they attended (2019: 88% of consumers and providers).

[4] There was a reduction in education in Q4 as a result of restrictions during the COVID-19 pandemic alerts. Additional ways were developed to support responsive, early and efficient complaints resolution and the delivery of Code promotion and education. This is part of the ongoing continuous improvement focus and COVID-19 pandemic emergency response.

6.3 Output Class 3: Proceedings

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 3: Proceedings	Actual 2020 $	Budget 2020 $	Actual 2019 $
Revenue	512,007	588,000	570,318
Expenditure	514,946	630,000	558,112
Net surplus/(deficit)	**(2,939)**	**(42,000)**	**12,206**

Output and Assumptions	Performance Measures and Targets	Actual Performance[5]
OUTPUT 3.1 — PROCEEDINGS		
Professional misconduct is found in disciplinary proceedings (which contributes to achievement of Strategic Objective 3).	Professional misconduct is found in 75% of disciplinary proceedings.	**Target achieved** For the year ended 30 June 2020, professional misconduct was found in 100% (1 of 1) of disciplinary proceedings (2019: no professional misconduct proceedings were heard by the HPDT).
Breach of the Code is found in HRRT proceedings (which contributes to achievement of Strategic Objective 3).	A breach of the Code is found in 75% of HRRT proceedings.	**Target achieved** For the year ended 30 June 2020, a breach of the Code was found in 100% (7 of 7) of HRRT proceedings (2019: 100%, 3 of 3 proceedings).
An award is made where damages are sought (which contributes to achievement of Strategic Objective 3).	An award of damages is made in 75% of cases where damages are sought.	**Target achieved** Resolution by negotiated agreement was achieved in 100% (9 of 9) of proceedings (2019: 100%, 3 of 3 proceedings).
Where a restorative approach is adopted, agreement is reached between the relevant parties (which contributes to achievement of Strategic Objective 3).	An agreed outcome is reached in 75% of cases in which a restorative approach is adopted.	**Target achieved** For the year ended 30 June 2020, an agreed outcome was reached in 100% (3 of 3) of cases where a restorative approach was adopted (2019: no applicable cases).

[5] Nine cases that were resolved in 2019/20 fell into two different sub-categories. The actual number of cases resolved in 2019/20 is 11.

6.4 Output Class 4: Education

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 4: Education	Actual 2020 $	Budget 2020 $	Actual 2019 $
Revenue	360,890	346,000	430,406
Expenditure	362,961	370,000	421,195
Net surplus/(deficit)	**(2,071)**	**(24,000)**	**9,211**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.1 — INFORMATION AND EDUCATION FOR PROVIDERS		
		Target achieved
Monitor DHB complaints and provide complaint information to DHBs (which contributes to achievement of Strategic Objectives 2 and 4).	Produce six-monthly DHB complaint trend reports and provide to all DHBs.	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.	86% (12/14) of the DHBs who responded to an annual feedback form rated the complaint trend reports as useful for improving services (2019: 100%, 17 of 17).
		Target achieved
Assist DHBs to improve their complaints systems (which contributes to achievement of Strategic Objective 2).	Provide two complaints resolution workshops for DHBs.	Two complaints resolution workshops for DHBs were held.
	Seek evaluations on the workshops, with 80% of respondents satisfied with the session.	94.5% of respondents reported that they were satisfied or very satisfied with each session respectively (2019: 96%).

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.1 — INFORMATION AND EDUCATION FOR PROVIDERS (continued)		
		Target achieved
Assist non-DHB group providers to improve their complaints systems (which contributes to achievement of Strategic Objective 2).	Provide two complaints resolution workshops for non-DHB group providers.	For the year ended 30 June 2020, two complaints resolution workshops for non-DHB group providers were held (2019: two).
	Seek evaluations on workshops, with 80% of respondents satisfied with the session.	98.5% of respondents reported that they were satisfied with each session (2019: 92%).
		Targets not achieved[6]
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 4).	Provide 30 educational presentations. Consumers and health and disability service providers are satisfied with the educational presentations.	For the year ended 30 June 2020, 20 educational presentations were made (2019: 32).
	Seek evaluations on presentations with 80% of respondents satisfied with the presentation.	For the year ended 30 June 2020, 100% of respondents who provided feedback (20 of 20) reported that they were satisfied with the presentations (2019: 100%, 28 of 28).
		Target achieved
	Make public statements and publish reports in relation to matters affecting the rights of consumers: • Produce and publish on the HDC website key Commissioner decision reports and related articles. Report on total number.	For the year ended 30 June 2020, 106 decisions relating to matters affecting the rights of consumers were published at **www.hdc.org.nz** (2019: 56).

[6] No educational presentations were made in Quarter 4 as a result of restrictions during the COVID-19 pandemic alerts.

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 4.2 — OTHER EDUCATION		
		Target achieved
HDC engages in sector education through making submissions on relevant policies, standards, professional codes, and legislation (which contributes to achievement of Strategic Objective 4).	HDC makes at least 10 submissions.	For the year ended 30 June 2020, 39 submissions were made (2019: 24).
		Target achieved
HDC responds 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 4).	At least 40 formal responses to enquiries provided.	For the year ended 30 June 2020, 52 formal responses to enquiries were provided (2019: 53).

6.5 Output Class 5: Disability

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 5: Disability	Actual 2020 $	Budget 2020 $	Actual 2019 $
Revenue	528,244	551,000	573,597
Expenditure	531,276	575,000	561,321
Net surplus/(deficit)	**(3,032)**	**(24,000)**	**12,276**

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 4).	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.	**Target achieved** During the year ended 30 June 2020, two new educational resources, in accessible formats, were developed and posted on HDC's website: 1. Going to Hospital? — A booklet with information about what people can expect when they are engaging with public hospital services. 2. My Health Passport — HDC updated the Health Passport booklets and the Guide for Completing the Health Passport. These new versions are known as "My Health Passport" and "Guide for Completing My Health Passport". In addition to updating these booklets, a new My Health Passport express version (a tri-fold brochure format) has been developed. All of the resources are available in plain English and can be downloaded from HDC's website. Print copies are available on request. In addition, HDC also developed an online presentation for disabled people and their whānau to promote awareness of the rights of disability service users.

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

Financial Performance of Output Class

FOR THE YEAR ENDED 30 JUNE

OUTPUT 6: Monitoring and Advocacy	Actual 2020 $	Budget 2020 $	Actual 2019 $
Revenue	651,032	618,000	671,398
Expenditure	654,769	662,000	657,028
Net surplus/(deficit)	**(3,737)**	**(44,000)**	**14,370**

Output and Assumptions	Performance Measures and Targets	Actual Performance
OUTPUT 6.1 — MONITORING AND ADVOCACY		
Monitoring		
		Target achieved
Monitor mental health and addiction services to identify potential improvements to services (which contributes to achievement of Strategic Objective 2).	Monitor and analyse issues and trends identified by HDC complaints and the Advocacy Service.	In 2019/20, HDC prepared an analysis of 2018/19 complaint trends about mental health and addiction services.
	Maintain engagement with key sector stakeholders and monitor sector performance information to keep informed about service issues and trends.	In 2019/20, HDC attended over 137 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 (2019: 128).
	Provide briefings to the Minister as required.	In 2019/20, HDC analysed sector performance data and published research to underpin HDC's 2019 and 2020 Monitoring and Advocacy Reports.

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 2).	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 54 quality improvement recommendations due in 2019/20.
	Monitor compliance with the implementation of recommendations: • 97% compliance.	For the year ended 30 June 2020, providers were: • Fully compliant with 100% of recommendations due this financial year (2019: 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, including advice on the response to the inquiry into mental health and addiction.	In 2019/20, HDC met regularly with Ministry of Health officials to discuss implementation of recommendations from *He Ara Oranga*, particularly around the legislation to establish a new Mental Health and Wellbeing Commission and their work on the Mental Health Act. HDC also submitted on the Ministry's draft Mental Health Act Guidelines and both submitted and presented to the Health Select Committee on the Mental Health and Wellbeing Commission Bill. In 2019, in response to *He Ara Oranga*, HDC provided advice to the Minister of Health on what was needed to support sector transformation, including a statutory requirement for a mental health strategy and the information gathering powers required for the new Mental Health and Wellbeing Commission to perform its role effectively. The Mental Health Commissioner's 2020 Monitoring and Advocacy Report made 26 recommendations to the Minister of Health aimed at improving Aotearoa/New Zealand's response to mental health and addiction, and HDC met with the Minister of Health to brief him on the findings and recommendations of the report.

7.0 Financial statements

Statement of comprehensive revenue and expense for the year ended 30 June 2020

	Notes	Actual 2020 $	Budget 2020 $	Actual 2019 $
Revenue				
Funding from the Crown		13,370,000	12,870,000	13,370,000
Interest revenue		50,164	50,000	59,840
Other revenue	2	208,573	230,000	220,976
Total revenue		**13,628,737**	**13,150,000**	**13,650,816**
Expenditure				
Personnel costs	3	7,922,958	7,816,000	7,560,879
Depreciation and amortisation expense	8, 9	131,365	195,000	89,457
Advocacy services		3,481,010	3,481,000	3,485,310
Other expenses	4	2,171,581	2,425,000	2,215,819
Total expenditure		**13,706,914**	**13,917,000**	**13,351,465**
Surplus/(deficit)		**(78,177)**	**(767,000)**	**299,351**
Total comprehensive revenue and expense		**(78,177)**	**(767,000)**	**299,351**

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 2020

	Notes	Actual 2020 $	Budget 2020 $	Actual 2019 $
ASSETS				
Current assets				
Cash and cash equivalents	5	2,083,576	1,311,000	2,110,648
Receivables	6	13,139	30,000	18,902
Prepayments		46,092	50,000	39,166
Inventories	7	28,717	20,000	27,971
Total current assets		**2,171,524**	**1,411,000**	**2,196,687**
Non-current assets				
Property, plant and equipment	8	221,918	217,000	153,795
Intangible assets	9	159,948	126,000	154,512
Total non-current assets		**381,866**	**343,000**	**308,307**
Total assets		**2,553,390**	**1,754,000**	**2,504,994**
LIABILITIES				
Current liabilities				
Payables	10	469,092	452,000	410,861
Employee entitlements	11	518,385	480,000	439,448
Total current liabilities		**987,477**	**932,000**	**850,309**
Non-current liabilities				
Payables	10	21,184	18,000	31,779
Total non-current liabilities		**21,184**	**18,000**	**31,779**
Total liabilities		**1,008,661**	**950,000**	**882,088**
Net assets		**1,544,729**	**804,000**	**1,622,906**

Statement of financial position as at 30 June 2020 (continued)

	Notes	Actual 2020 $	Budget 2020 $	Actual 2019 $
EQUITY				
Contributed capital	13	788,000	788,000	788,000
Accumulated surplus	13	756,729	16,000	834,906
Total equity		**1,544,729**	**804,000**	**1,622,906**

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 2020

	Notes	Actual 2020 $	Budget 2020 $	Actual 2019 $
Balance at 1 July		1,622,906	1,571,000	1,330,750
Adjustment to accumulated surplus from the adoption of PBE IFRS 9		-	-	(7,195)
Adjusted balance at 1 July		1,622,906	1,571,000	1,323,555
Total comprehensive revenue and expense for the year		(78,177)	(767,000)	299,351
Balance at 30 June	13	**1,544,729**	**804,000**	**1,622,906**

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 2020

	Notes	Actual 2020 $	Budget 2020 $	Actual 2019 $
Cash flows from operating activities				
Receipts from the Crown		13,370,000	12,870,000	13,370,000
Interest received		53,566	50,000	60,439
Receipts from other revenue		69,359	85,000	77,980
Payments to suppliers		(5,572,652)	(5,851,000)	(5,486,610)
Payments to employees		(7,844,021)	(7,816,000)	(7,529,723)
GST (net)		93,793	-	(11,319)
Net cash from / (used in) operating activities		**170,045**	**(662,000)**	**480,767**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		7,808	-	-
Purchase of property, plant and equipment		(149,810)	(182,000)	(114,351)
Purchase of intangible assets		(55,115)	(50,000)	(6,500)
Net cash used in investing activities		**(197,117)**	**(232,000)**	**(120,851)**
Cash flows from financing activities				
Receipts from capital contribution		-	-	-
Net cash from financing activities		**-**	**-**	**-**
Net increase/(decrease) in cash and cash equivalents		**(27,072)**	**(894,000)**	**359,916**
Cash and cash equivalents at beginning of the year		**2,110,648**	**2,205,000**	**1,750,732**
Cash and cash equivalents at end of the year	5	**2,083,576**	**1,311,000**	**2,110,648**

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

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Notes Index

1. Statement of accounting policies

Reporting entity

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

The financial statements for the Health and Disability Commissioner are for the year ended 30 June 2020, and were approved by the Commissioner on **15 December 2020.**

Basis of preparation

The financial statements have been prepared on a going concern basis, and 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 requirements 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.

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 continually evaluated 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

COVID-19 did not have a significant impact on HDC during the financial year ended 30 June 2020, and HDC does not expect further significant impact. HDC has considered that there is no material uncertainty that casts doubt on the HDC'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 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 2020 $	Actual 2019 $
Sale of publications	51,957	65,162
Advocacy Trust contribution to IT costs	140,908	140,514
Sale of property, plant and equipment	7,808	-
Sundry revenue	7,900	15,300
Total other revenue	**208,573**	**220,976**

ASSET DISPOSALS

Two motor vehicles were disposed of during the year. The net gain on motor vehicle disposals was $7,808 (2019: nil).

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 2020 $	Actual 2019 $
Salaries and wages	7,625,027	7,309,447
Employer contributions to defined contribution plans	218,994	220,276
Increase/(decrease) in employee entitlements	78,937	31,156
Total personnel costs	**7,922,958**	**7,560,879**

Employee Remuneration

	Actual 2020 $	Actual 2019 $
Total remuneration paid or payable:		
100,000–109,999	2	1
110,000–119,999	2	1
120,000–129,999	-	3
130,000–139,999	4	1
150,000–159,999	1	1
160,000–169,999	2	1
170,000–179,999	1	1
180,000–189,999	1	1
200,000–209,999	1	-
250,000–259,999	2	3
380,000–389,999	1	1
Total Employees	**17**	**14**

During the year ended 30 June 2020, two employees received compensation and other benefits in relation to cessation totalling $57,565 (2019: $4,660).

COMMISSIONER'S TOTAL REMUNERATION

In accordance with the disclosure requirements of sections 152(1)(a) of the Crown Entities Act 2004, the total remuneration, including all benefits, paid to the Commissioner during the period 1 July 2019 to 30 June 2020 was $382,989 (2019: $386,024).

4. Other expenses

Breakdown of other expenses

	Actual 2020 $	Actual 2019 $
Advertising	19,606	20,293
Audit fees	47,679	46,786
Clinical and legal advice	447,724	527,480
Communications & IT	475,564	484,186
Inventories consumed	50,904	39,269
Write-off on property, plant and equipment	156	1,460
Operating lease expense	494,841	471,880
Policy and operational consultancy	115,392	99,700
Staff travel and accommodation	131,409	171,636
Other expenses	388,306	353,129
Total other expenses	**2,171,581**	**2,215,819**

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 2020 $	Actual 2019 $
Not later than one year	569,581	491,351
Later than one year and not later than five years	842,550	1,200,244
Later than five years	-	-
Total non-cancellable operating leases	**1,412,131**	**1,691,595**

The Health and Disability Commissioner leases two properties in Auckland and Wellington.
The non-cancellable operating lease commitment relates to the lease of these two offices and office equipment (2019: 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 2020 $	Actual 2019 $
Cash on hand and at bank	1,083,576	1,110,648
Term deposits with maturities less than 3 months	1,000,000	1,000,000
Total cash and cash equivalents	**2,083,576**	**2,110,648**

While cash and cash equivalents at 30 June 2020 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 2020, the Health and Disability Commissioner holds no unspent grant funding received that is subject to restrictions (2019: 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 2020 is $2,232 (2019: $4,980).

	Actual 2020 $	Actual 2019 $
Trade receivables	11,344	16,452
Less: allowance for credit loss	(2,232)	(4,980)
Other receivables	4,027	7,430
Total receivables	**13,139**	**18,902**
Total receivables comprises:		
Receivables from the sale of goods (exchange transactions)	13,139	18,902

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 2020 $	Actual 2019 $
Commercial inventories		
Publications held for sale	28,717	27,971
Total inventories	**28,717**	**27,971**

The write-down of inventories in 2020 amounted to $626 (2019: $836). There were no net write-down reversals in 2020 (2019: nil). No inventories are pledged as security for liabilities (2019: 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 balance 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
- 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 $	Communications equipment $	Furniture & fittings $	Leasehold improvements $	Motor vehicles $	Office equipment $	Total $
Cost or valuation							
Balance at 1 July 2018	537,089	7,145	169,099	656,393	40,889	61,520	1,472,135
Balance at 30 June 2019	573,022	5,160	176,669	664,334	40,889	50,632	1,510,706
Additions	106,805	841	10,240	11,006	-	21,073	149,965
Disposals	(18,767)	(647)	(9,053)	-	(40,889)	(634)	(69,990)
Balance at 30 June 2020	**661,060**	**5,354**	**177,856**	**675,340**	**-**	**71,071**	**1,590,681**
Accumulated depreciation and impairment losses							
Balance at 1 July 2018	443,387	4,536	160,719	652,563	40,889	58,409	1,360,503
Balance at 30 June 2019	438,302	3,271	170,649	655,517	40,889	48,283	1,356,911
Depreciation expense	61,323	999	8,591	5,363	-	5,411	81,687
Disposals	(18,610)	(647)	(9,053)	-	(40,889)	(636)	(69,835)
Balance at 30 June 2020	**481,015**	**3,623**	**170,187**	**660,880**	**-**	**53,058**	**1,368,763**
Carrying amounts							
At 1 July 2018	**93,702**	**2,609**	**8,380**	**3,830**	**-**	**3,111**	**111,632**
At 30 June 2019/ 1 July 2019	**134,720**	**1,889**	**6,020**	**8,817**	**-**	**2,349**	**153,795**
At 30 June 2020	**180,045**	**1,731**	**7,669**	**14,460**	**-**	**18,013**	**221,918**

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

The net loss on all disposals was $156 (2019: $1,460).

There were no capital commitments at balance date (2019: 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 that the asset is derecognised. The amortisation charge for each period is recognised in the surplus or deficit.

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

Acquired computer software
3 years (33%)

Developed computer software
3 years (33%)

Movements for each class of intangible asset are as follows:

	Acquired software $	Internally generated software $	Total $
Cost			
Balance at 1 July 2018	700,747	248,516	949,263
Balance at 30 June 2019/1 July 2019	708,354	248,516	956,870
Additions	55,114	-	55,114
Balance at 30 June 2020	**763,468**	**248,516**	**1,011,984**
Accumulated amortisation and impairment losses			
Balance at 1 July 2018	535,465	248,516	783,981
Balance at 30 June 2019/1 July 2019	553,842	248,516	802,358
Amortisation expense	49,678	-	49,678
Balance at 30 June 2020	**603,520**	**248,516**	**852,036**
Carrying amounts			
At 1 July 2018	**165,282**	**-**	**165,282**
At 30 June 2019/1 July 2019	**154,512**	**-**	**154,512**
At 30 June 2020	**159,948**	**-**	**159,948**

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 are no capital commitments at balance date (2019: nil).

10. Payables

Accounting policy

Short-term payables are recorded at their face value.

Breakdown of payables and deferred revenue

	Actual 2020 $	Actual 2019 $
Payables under exchange transactions		
Creditors	90,992	135,622
Accrued expenses	109,793	105,293
Lease incentive	10,593	10,593
Total payables under exchange transactions	211,378	251,508
Payable under non-exchange transactions		
Taxes payable (GST, PAYE, and rates)	257,714	159,353
Total payables under non-exchange transactions	257,714	159,353
Total current payables	**469,092**	**410,861**
Lease incentives	21,184	31,779
Total non-current payables	21,184	31,779
Total payables	**490,276**	**442,640**

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 2020 $	Actual 2019 $
Current portion		
Annual leave	518,385	439,448
Total employee entitlements	**518,385**	**439,448**

12. Contingencies

Contingent liabilities

As at 30 June 2020 there were no contingent liabilities (2019: nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2019: 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 2020 $	Actual 2019 $
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	834,906	542,750
Adjustment from the adoption of PBE IFRS 9	-	(7,195)
Adjusted balance at 1 July	834,906	535,555
Surplus/(deficit) for the year	(78,177)	299,351
Balance at 30 June	**756,729**	**834,906**
Total equity	**1,544,729**	**1,622,906**

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, 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 2020 $	Actual 2019 $
Leadership Team		
Remuneration	1,919,424	1,993,745
Full-time equivalent members	8.50	8.87
Total key management personnel remuneration	**1,919,424**	**1,993,745**
Total full-time equivalent personnel	**8.50**	**8.87**

15. Financial instruments

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

	Actual 2020 $	Actual 2019 $
Financial assets measured at amortised cost		
Cash and cash equivalents	1,083,576	1,110,648
Receivables	13,139	18,902
Investments — term deposits	1,000,000	1,000,000
Total financial assets measured at amortised cost	**2,096,715**	**2,219,550**
Financial liabilities measured at amortised cost		
Payables (excluding income in advance, lease incentive, taxes payable, and grants received subject to conditions)	200,784	240,916
Total financial liabilities measured at amortised cost	**200,784**	**240,916**

16. Events after the balance date

There were no significant events after the balance date.

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 REVENUE

The Ministry of Health provided an additional funding of $500,000 in June 2020 to fund the management and resolution of complaints.

TOTAL EXPENDITURE

Personnel costs were higher than budget, mainly due to an increase in employee holiday entitlements as a result of travel restrictions brought on by COVID-19.

Other expenses were lower than budget, owing to the rigorous management of the Health and Disability Commissioner's budget to cope with financial constraints.

Statement of financial position

Cash and cash equivalents were higher than budgeted due to the extra funding increase which was received from the Ministry of Health in June 2020.

Employee Entitlements were higher than budgeted owing to less leave taken by staff as a result of the COVID-19 pandemic.

Statement of equity

The closing equity balance was higher than budgeted owing to a higher than budgeted opening balance and a lower than budgeted deficit for the year.

Statement of cash flows

The higher net cash movement was mainly a result of the unbudgeted extra funding increase from the Ministry of Health and less expenditure incurred during the year compared to the budget.

8.0 Statement of responsibility

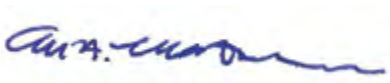
Statement of Responsibility

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 2020.



Morag McDowell
Health and Disability Commissioner

Jason Zhang
Corporate Services Manager

15 December 2020

9.0 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 2020

The Auditor-General is the auditor of the Health and Disability Commissioner. The Auditor-General has appointed me, David Walker, 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 67 to 87, that comprise the statement of financial position as at 30 June 2020, 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 55 to 66.

In our opinion:

- the financial statements of the Health and Disability Commissioner on pages 67 to 87:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2020; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards Reduced Disclosure Regime; and
- the performance information on pages 55 to 66:
    - presents fairly, in all material respects, the Health and Disability Commissioner's performance for the year ended 30 June 2020, 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;
- 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; and

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 15 December 2020. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to the impact of Covid-19 on the Health and Disability Commissioner. In addition, we outline the responsibilities of the Commissioner and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Emphasis of matter – impact of Covid-19

Without modifying our opinion, we draw attention to the disclosures about the impact of Covid-19 on the Health and Disability Commissioner as set out in Note 1 to the financial statements on page 74 and throughout the performance information on pages 55 - 66.

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 Commissioner for the financial statements and the performance information

The Commissioner is responsible on behalf of the Health and Disability Commissioner for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The 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 Commissioner is responsible on behalf of the Health and Disability Commissioner for assessing the Health and Disability Commissioner's ability to continue as a going concern. The 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 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 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 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 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 Commissioner is responsible for the other information. The other information comprises the information included on pages 1 to 54 and page 88, 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.

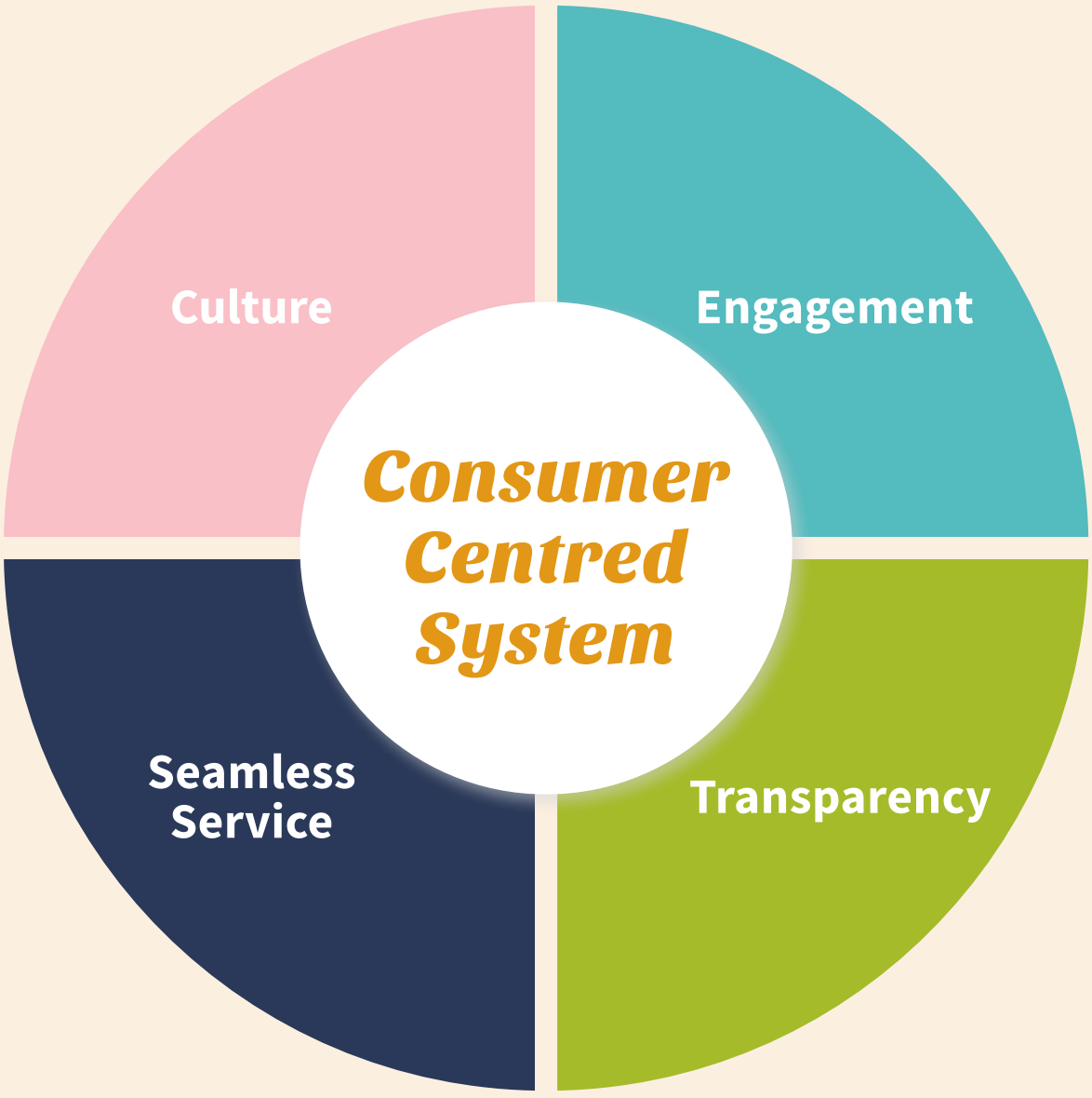
In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge 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.

Other than in our capacity as auditor, we have no relationship with, or interests, in Health and Disability Commissioner.

David Walker
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand


Culture
Engagement
Consumer Centred System
Seamless Service
Transparency

P O Box 1791
Auckland 1140

Level 10
Tower Centre
45 Queen Street
Auckland 1010

Ph: 09 373 1060
Fax: 09 373 1061
Toll Free Ph: 0800 11 22 33
www.hdc.org.nz