HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

E.17

Pūrongo ā-Tau
Annual Report
2024

MŌ TE TAU MUTUNGA O TE *30 HUNE 2024* | **FOR THE YEAR ENDED** *30 JUNE 2024*

Tuia tō mana kia māia
Tuia tō mauri kia mau

Horahia te mātauranga
Kia puta ko te māramatanga

Whakakotahi ai te wairua
Kia tipu, kia hua, kia puāwai ngā mahi

Haumi e, hui e,
Tāiki e!

Retain and hold fast to your mana, be bold, be brave
Be widespread with knowledge to empower understanding
By working together we will grow, flourish and prosper
Join all together, bind all together, let it be done!

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004
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Ngā kaupapa
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Te kupu takamua a te Toihau
Commissioner's foreword

MORAG MCDOWELL

Te kupu takamua a te Toihau

I am pleased to present the Health and Disability Commissioner's Annual Report for 2023/24.

Delayed access to care and workforce shortages continued to dominate public discourse and experiences this year. The impact of this on providers — who are striving to provide quality care in a system under considerable pressure — should not be underestimated. However, neither should the impact on people using services.

In this environment the Code remains of vital importance. The growing number of complaints to HDC — a 52% increase over five years — indicates increasing concern from people about their experiences of care. It should be acknowledged that complaints to HDC reflect a small proportion of the number of interactions that occur in the health and disability system each year. However, complaints often highlight the issues people care about most, and currently complaints to HDC reflect people's concerns about difficulties accessing care, inadequate communication in the context of delays, and the impact of workforce shortages on the standard of care.

In my view, the early resolution of complaints between complainant and provider, where appropriate, can result in the best outcome for everyone. We have been using our early resolution powers more flexibly to achieve timely resolution for the individual while also advocating for systemic change. In suitable cases this allows HDC to protect consumers' rights without the need for a full assessment and investigation. In 2023/24 we placed increased focus on supporting resolution between the parties (70% of complaints are now resolved this way), ensuring that HDC's resources are focused on those complaints that require HDC assessment and intervention.

> **I take this opportunity to thank the Advocacy Service for its work this year, and its commitment to ensuring that those people who face barriers to making complaints are supported to have their voices heard and their concerns addressed.**

The 3,628 complaints received by HDC in 2023/24 is the highest number of complaints ever received in a single year. This has undoubtedly placed us under significant pressure and has led to delays in the resolution of some of our complaints. While around 65% of the complaints we receive are closed within six months, more complex or serious complaints can take over two years to assess and resolve. I remain focused on reducing delays in our process, and in 2023/24 we implemented a plan to reduce our aging profile of complaints. Despite the unexpected ongoing volume increases, I am proud to say that we closed a record number of complaints this year.

We are greatly assisted by the Advocacy Service, which supports and guides people to resolve their concerns with their provider. I take this opportunity to thank the Advocacy Service for its work this year, and its commitment to ensuring that those people who face barriers to making complaints are supported to have their voices heard and their concerns addressed.

I have also been pleased to see HDC expand our use of tikanga-led resolution this year, including coordinating hohou te rongo (peaceful resolution) processes between complainant

and provider. These processes can both ensure a culturally appropriate resolution for Māori whānau and assist providers to improve their cultural capability.

HDC has a key role to play in quality and safety, and in the current environment of increasing complaints and system pressures, HDC has a focus on leveraging our intelligence to improve the system and consumer experience. As well as making hundreds of quality and safety recommendations in relation to individual complaints, we also published two important reports this year — the first monitoring report of the Aged Care Commissioner, and a report outlining the themes in complaints about residential disability support providers. These reports reflected consumer voice and experience and made multiple recommendations to improve the quality of care and support provided to disabled and older people. We will be taking a collaborative approach to working with the sector to monitor the implementation of our recommendations in these areas.

HDC has also developed robust processes to urgently escalate serious issues to those agencies that can take action. I have been encouraged by the quick and effective response to many of our concerns — emphasising both the importance of the consumer voice in creating change and the sector's commitment to patient safety and upholding rights.

I give my heartfelt thanks to my team. Despite the challenges we have faced, they remain

I have been encouraged by the quick and effective response to many of our concerns — emphasising both the importance of the consumer voice in creating change and the sector's commitment to patient safety and upholding rights.

dedicated to ensuring the consumer voice is heard, the health and disability system improves, and consumer rights are promoted and protected. Their passion and dedication have resulted in the successes laid out in this report, and I am incredibly proud of the work they have collectively achieved in service to New Zealanders.

HDC is, at its heart, a guardian of consumer rights, and it is important that we work to promote and protect people's rights in a myriad of ways. The review of our Act and Code is nearing completion, and I look forward to providing the Minister with our recommendations at the end of 2024. Looking forward to 2025, HDC will continue to support communities to understand and exercise their rights, and work to ensure the consumer voice is heard and has a tangible impact on the system.

Ngā mihi nui

Morag McDowell
Health and Disability Commissioner

Te kupu takamua a te Toihau

MORAG MCDOWELL

Te kupu takamua a te Toihau

He āhuareka ahau kia tāpaea te Pūrongo ā-tau a te Toihau Hauora, Hauātanga mō te tau 2023/24.

Ko te takaroa o te whai wāhitanga ki te manaakitanga me te tokoiti o te ohu mahi ka kaha kōrerotia tonutia e te marea me ngā wheako i tēnei tau. Ko te pānga mai o tēnei ki ngā kaiwhakarato — rātou e nanaiore ana ki te whakarato manaakitanga kounga i roto i tētahi pūnaha taumaha — me kaua e whakahāweatia. Engari anō hoki me kaua e te pānga atu ki ngā tāngata e whakamahi ana i ngā ratonga.

I te tēnei taiao he mea tino mātuatua te Tikanga Mōtika. Nā te piki haere o ngā amuamu ki a HDC — e 52 ōrau te pikinga i ngā rima tau nei — e tohu ana i te pikinga o te āwangawanga o ngā tāngata me ō rātou wheako mō te manaakitanga. Me mōhio e tātou ko ngā amuamu ki a HDC he ōwehenga paku nei o ngā pāhekoheko o roto o te pūnaha hauora, hauātanga i ia tau. Heoi anō, mā ngā amuamu ka mōhiotia ngā take nunui a ngā tāngata, ka mutu, ko ngā amuamu o āianei ki a HDC e whakaata ana i ngā āwangawanga o ngā tāngata mō te uaua o te whai wāhi mai ki te manaakitanga, me te āhua o te whakawhitinga kōrero mō te takaroa, me te pānga mai o te tokoiti o te ohu mahi ki te kounga o te manaakitanga.

Mōku ake, mā te whakataunga wawetanga o ngā amuamu i waenga i te kaiwhakapae me te kaiwhakarato, ina tika ana, ka puta mai he hua pai mō te katoa. E ngāwari haere ana ā mātou nei mahi kia tutuki pai te whakataunga mō te takitahi me te tautoko atu kia panonitia mai te pūnaha. I ngā kēhi tika ka āhei a HDC ki te tiaki i ngā motika o te kiritaki me te korenga e whakarite ai i tētahi aromatawai roa. I ngā tau 2023/24 ka aronui atu mātou ki te tautoko i te whakatau i waenga i ngā taha e rua (e 70 ōrau o ngā amuamu ka whakatauria pēneitia), me te ū mai kia aronui ngā rauemi a HDC ki ērā amuamu e whai ana i tā te HDC aromatawai me te whakataunga.

Ko ngā amuamu 3,628 i riro mai i a HDC i ngā tau 2023/24 ko te maha rawa atu o ngā amuamu i riro mai i tētahi tau kotahi. Nā konei kua noho taumaha mātou, me te aha, he takaroa te whakataunga o ētahi o ā mātou amuamu. Ahakoa ko te āhua 65 ōrau o ngā amuamu ka riro mai ka whakatauria i roto i te ono marama, ko ngā amuamu matatini, ngā mea taumaha ka rua tau kē pea hei aromatawai, hei whakatau. Ka aronui tonu ahau kia iti haere te wā hei whakatau, me te aha, i ngā tau 2023/24 i whakaritea e mātou he mahere kia iti haere tā mātou rārangi amuamu. Ahakoa te ohorere o ngā pikinga amuamu, he whakahīhī nōku ki te kī atu, ko ngā whakataunga o tēnei tau he mea o runga rawa atu.

He nui te taunaki o Ngā Kaitautoko, ko rātou kei te ārahi i ngā tāngata kia whakatauria ō rātou āwangawanga ki ā rātou kaiwhakarato. He tino mihi tēnei nāku ki Ngā Kaitautoko mō ā rātou mahi i tēnei tau, ā, me tō rātou kaingākaunui ki te tautoko i ngā tāngata e raru ana i ngā tauārai o te tuku amuamu kia rongohia ō rātou reo, kia whakatauria hoki ō rātou āwangawanga.

E harikoa ana hoki ahau i te kitenga mai o HDC e kaha whakamahi ana i te tikanga hei whakatau amuamu i tēnei tau, tae atu ki te whakahaere i ngā tukanga hohou te rongo i waenga i te kaiwhakapae me te kaiwhakarato. Mā ēnei tukanga ka ū ki tētahi whakataunga ā-ahurea mō ngā whānau Māori me te āwhina i ngā kaiwhakarato kia whakapai ake i ā rātou āheinga ā-ahurea nei.

He tino kawenga tā HDC ki roto ki te kounga me te haumaru, ā, i tēnei wā o te pikinga o ngā

I whakaata mai ēnei pūrongo i te reo me ngā wheako o te kiritaki, me te aha, he nui ngā tohutohu hei whakapai ake i te kounga o te manaaki me te tautoko i te hunga whaikaha me ngā kaumātua. Ko tā mātou e whai ake nei he mahi ngātahi me te rāngai hei aroturuki i te whakatinanatanga o ā mātou tohutohu i ēnei wāhi.

amuamu me te taumahatanga o te pūnaha, e aronui ana a HDC ki tō mātou mōhiotanga hei whakapai ake i te pūnaha me te wheako o te kiritaki. Āpiti atu ki ā mātou tohutohu mō te kounga me te haumaru e pā ana ki tēnā amuamu me tēnā amuamu, kua whakaputaina hoki e mātou ngā pūrongo mātuatua e rua i tēnei tau — ko te pūrongo aroturuki tuatahi mō te Toihau Tautiaki Kaumātua, me tētahi pūrongo e whakaatu mai ana i ngā ariā o ngā amuamu mō ngā kaiwhakarato tautoko kainoho whaikaha. I whakaata mai ēnei pūrongo i te reo me ngā wheako o te kiritaki, me te aha, he nui ngā tohutohu hei whakapai ake i te kounga o

te manaaki me te tautoko i te hunga whaikaha me ngā kaumātua. Ko tā mātou e whai ake nei he mahi ngātahi me te rāngai hei aroturuki i te whakatinanatanga o ā mātou tohutohu i ēnei wāhi.

Kua whakawhanake a HDC i ngā tukanga pakari kia tere te tuku atu i ngā tino take ki ērā pokapū e āhei ai te whakatau. He pai ki ahau te tere urupare me te mauritau o ngā urupare ki te nuinga o ō mātou nei āwangawanga — te mātuatua o te reo o te kiritaki me te ū o te rāngai kia haumaru te tūroro me te hāpai i ngā motika.

Ka mihi kau ake taku ngākau ki taku rōpū. Ahakoa ngā wero, ka ngākau nui tonu rātou kia rongohia te reo o te kiritaki, kia whakapai haere tonu i te pūnaha hauora, hauātanga, ā, ka hāpaingia ake ka tiakina hoki ngā motika o te kiritaki. Mā ō rātou ngākau whiwhita me ō rātou manawanui i tutuki pai ngā mea angitu e kōrerotia nei i tēnei pūrongo, ka mutu, he nui te whakahīhī ōku mō ngā mahi kua whakatutuki tahitia e rātou mō Ngāi Aotearoa.

Ko tā HDC, tōna tino mahi, hei kaitiaki o ngā mōtika o te kiritaki, ā, he mea nui kia kaha te mahi hei hāpai me te tiaki ngā motika o te tangata mā ngā tini huarahi. Kua tata mutu te arotakenga o tā mātou Ture me te Tikanga Mōtika, ā, kei te titiro whakamua ahau kia tukuna atu ā mātou tohutohu ki te Minita ā te mutunga o tēnei tau 2024. Hei ahu whakamua ki te tau 2025, ka tautoko tonu a HDC i ngā hapori kia mārama rātou kia meatia hoki e rātou ō rātou motika, ā, ka mahi hoki kia rongohia te reo o te kiritaki, ka mutu, e kitea ai te pānga mai ki te pūnaha.

Ngā mihi nui

Morag McDowell
Te Toihau Hauora Motuhake

1

Ko wai mātau
Who we are

The Health and Disability Commissioner (HDC) promotes and protects the rights of all people who use health and disability services. We do this through providing education and advocacy, contributing to quality and safety and by holding the system and providers accountable through the resolution of complaints.

> Ko koe, ko au
> Ko au, ko koe
>
> *You are I and I am you*

HDC is an independent Crown entity. Our independence from government and service provision enables HDC to be an effective and impartial guardian of consumers' rights.

HDC also contracts the National Advocacy Trust to provide the Nationwide Health and Disability Advocacy Service (the Advocacy Service) to support people to resolve their complaints directly with their provider and to undertake community-level promotion of the Code.

Our functions

Complaints resolution: HDC's core function for the protection of consumer rights is to assess, investigate and resolve complaints about the quality of care provided to people.

Promotion and education: HDC, together with the Advocacy Service, delivers educational initiatives to improve consumers' awareness of their rights and providers' knowledge of their responsibilities under the Code.

System monitoring and impact: HDC uses the insights gained from complaints to improve quality and safety and influence policies and practice across the health and disability system.

Focus populations: HDC has a focus on all people who use health and disability services, and our focus populations evolve over time. Noting our commitment to our responsibilities under Te Tiriti and to improve equity, as well as Government direction and our statutory obligations, currently we have placed a particular focus on the following population groups:

- **Māori: This work is supported by our Kaitohu Mātāmua Māori (Director Māori), who sits on our leadership team.**
- **Older people: The Aged Care Commissioner advocates for better health and disability services on behalf of older consumers and their family or whānau and provides strategic oversight to improve the care provided to older people.**
- **Disabled people | tāngata whaikaha: The Deputy Commissioner, Disability has a particular focus on promoting respect for, and observance of, the rights of disabled people | tāngata whaikaha when using health and disability services.**

Our funding

We are funded under the Monitoring and Protecting Health and Disability Consumer Interests Appropriation in Vote Health. In the year ended 30 June 2024, HDC received $19,701,000 from this appropriation to fund four output classes as set out in our Statement of Performance Expectations.

Our executive leadership team as at 30 June 2024

Morag McDowell
Health and Disability Commissioner
Te Toihau Hauora Motuhake

Rose Wall
Deputy Health and Disability Commissioner, Disability
Te Toihau Hauātanga Tuarua

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner
Te Toihau Hauora, Hauātanga Tuarua

Carolyn Cooper
Aged Care Commissioner
Te Toihau Tautiaki Kaumātua

Deborah James
Deputy Health and Disability Commissioner, Complaints Resolution
Te Toihau Tuarua, Whakatau Amuamu

Ikimoke Tamaki-Takarei
Kaitohu Mātāmua Māori
Director Māori

Courtney McCulloch[1]
Director of Proceedings
Pouārahi o Ngā Hāmenetanga

Mark Treleaven
Associate Commissioner, Complaints Resolution
Toihau Tūhono, Whakatau Amuamu

Jane King
Associate Commissioner, Legal
Toihau Tūhono, Ture

Dr Cordelia Thomas
Associate Commissioner
Toihau Tūhono

Jason Zhang
Corporate Services Manager
Pouwhakahaere Rangatōpū

Charmaine Pene
Director of Advocacy
Pouārahi Taunaki Motuhake

[1] *In July 2024, Courtney McCulloch resigned as Director of Proceedings. Jane Herschell was appointed to the role in August 2024.*

2

Ōu mōtika
The Code of Health and Disability Services Consumers' Rights

The rights of people who use health and disability services are set out in the Code of Health and Disability Services Consumers' Rights (the Code). The Code places corresponding duties on providers. These rights apply to all health and disability services.

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

In New Zealand's no-fault system for treatment injury, HDC is the key independent avenue for people to formally raise their concerns about health and disability services. We provide a critical layer of accountability and independence.

> Tuia tō mana, kia māia
>
> *Retain and hold fast to your mana*

10 Consumers' rights

1

Mana
Respect

2

Manaakitanga
Fair treatment

3

Tū rangatira motuhake
Dignity and independence

4

Tautikanga
Appropriate standard of care

5

Whakawhitinga whakaaro
Effective communication

6

Whakamōhio
Full information

7

Whakaritenga mōu ake
Informed choice and consent

8

Tautoko
Support

9

Ako me te rangahau
Teaching and research

10

Amuamu
Right to complain

3

Te whakarato i tā tātau rautaki
Delivering our strategy

HDC's vision is for the rights of people using health and disability services to be understood, upheld and protected. HDC has been working to ensure that honouring our responsibilities under Te Tiriti o Waitangi is central to everything we do.

Our strategic objectives

Being a culturally safe organisation

Diversity of age, ethnicity, gender identity, sexual orientation, disability, religion, and culture are all factors that contribute to people's experience of the health and disability sector. HDC provides an important platform for the consumer voice to be heard and for concerns to be raised and addressed. However, our ability to contribute to improved health outcomes within the health and disability sector relies on us ensuring that the way we operate is equitable, accessible, and culturally safe.

The ways in which HDC delivered on this strategic objective in 2023/24 included:

- Undertaking significant engagement with a diverse range of consumer groups to inform our review of the HDC Act and Code, with a particular focus on Māori and disabled people | tāngata whaikaha. Public consultation material is available in accessible formats, Māori, and plain English;
- Further expanding our use of tikanga-led approaches to complaints resolution;
- Establishing relationships with Māori health teams to improve culturally appropriate resolutions for Māori whānau;
- Undertaking regional engagements with Māori communities to support greater understanding of the Code and the role of HDC;
- Working with regulatory authorities to reinforce appropriate cultural standards of care and consider ways in which we can work together to resolve issues;
- Continuing to roll out our internal cultural education programme with a focus on mātauranga Māori, as well as improving our induction programme;
- Developing a disability strategy to support the rights of disabled people | tāngata whaikaha to be understood and upheld;
- Developing a work programme to ensure that staff have the necessary skills and knowledge in disability;
- Undertaking engagement across the country with a diverse range of older people to contribute to the Aged Care Commissioner's monitoring and quality improvement work;
- Working with our Consumer Advisory Group to develop an ingoa Māori for this group — Whakawaha — to better reflect the kaupapa of the group and its important role;

Te amorangi ki mua, te hāpai ō ki muri

Collective leadership enables success

- Revising our recruitment material to support recruitment of people with a strong understanding of disability;
- Updating key HDC resources into accessible formats, Māori, and plain English; and
- The Advocacy Service remaining focused on promoting the Code among priority communities, including people living in residential settings.

Having a timely people-centred complaints process

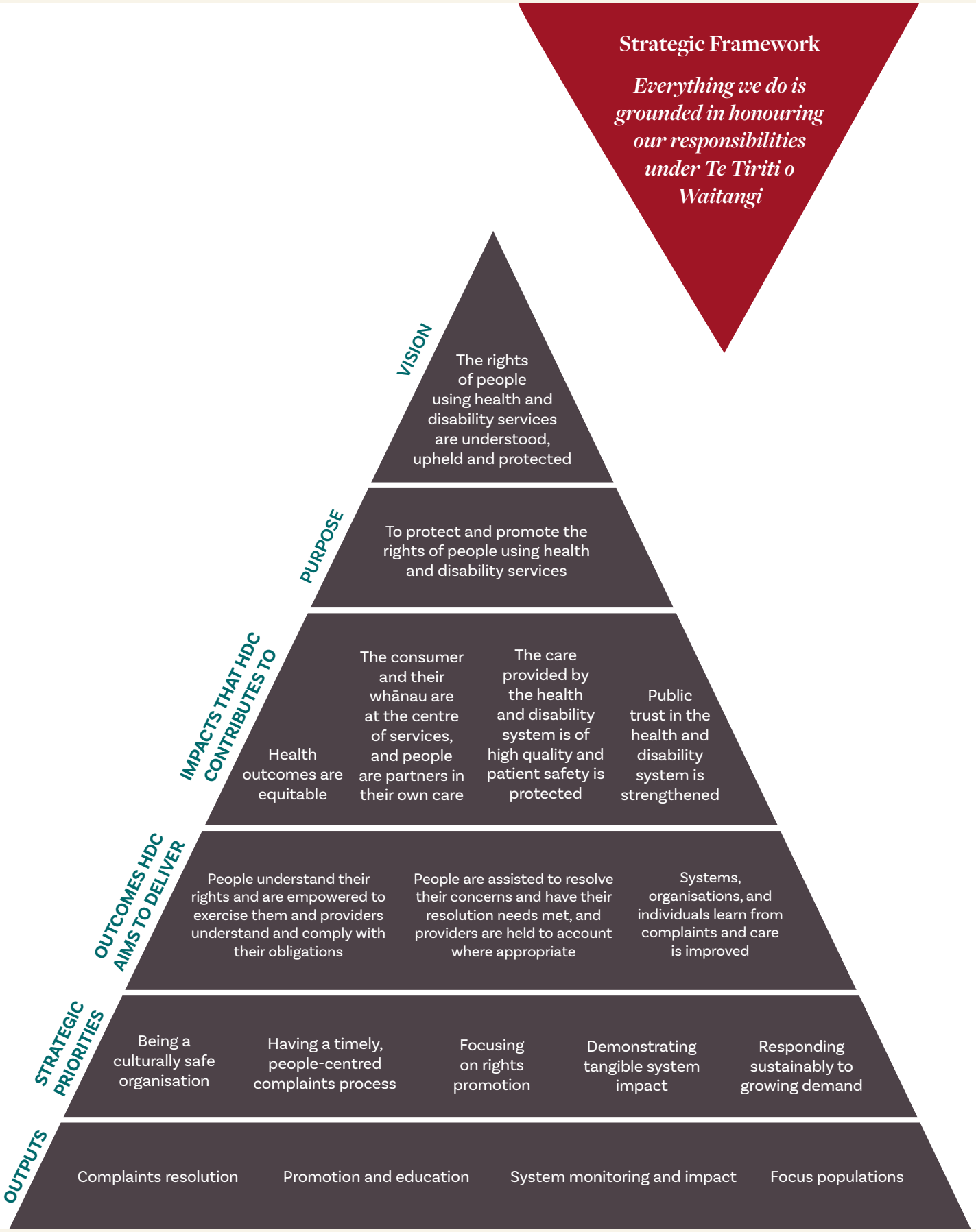
In the context of on-going increases in complaint volume in a resource-constrained environment, HDC has focused its complaints process improvement work on enhancing our use of early resolution pathways. This both supports the timely resolution of complaints and ensures that HDC's resources are concentrated on complaints where our powers can be used to greatest effect. Work to reduce our aging profile of complaints has also remained a key focus. Process improvement initiatives are detailed in the complaints resolution section.

We continue to monitor people's experience of our process through our complainant and provider experience survey, as well as feedback

We are committed to working with communities to raise their awareness and understanding of the Code, as well as improving providers' understanding of their obligations under the Code, ultimately to contribute to the upholding of people's rights and improved quality of care.

provided through other mechanisms (such as the review of the Act and Code). The analysis of this information is provided to our Executive Leadership Team and forms a central part of our process improvement work.

The Advocacy Service plays a vital role in the resolution of complaints between complainants and providers. In 2023/24 the Advocacy Service continued to support the timely resolution of complaints by closing most complaints within six months. They also undertook a significant amount of enquiry work assisting people to navigate the complaints system and providing


Strategic Framework
Everything we do is grounded in honouring our responsibilities under Te Tiriti o Waitangi
VISION
The rights of people using health and disability services are understood, upheld and protected
PURPOSE
To protect and promote the rights of people using health and disability services
IMPACTS THAT HDC CONTRIBUTES TO
Health outcomes are equitable
The consumer and their whānau are at the centre of services, and people are partners in their own care
The care provided by the health and disability system is of high quality and patient safety is protected
Public trust in the health and disability system is strengthened
OUTCOMES HDC AIMS TO DELIVER
People understand their rights and are empowered to exercise them and providers understand and comply with their obligations
People are assisted to resolve their concerns and have their resolution needs met, and providers are held to account where appropriate
Systems, organisations, and individuals learn from complaints and care is improved
STRATEGIC PRIORITIES
Being a culturally safe organisation
Having a timely, people-centred complaints process
Focusing on rights promotion
Demonstrating tangible system impact
Responding sustainably to growing demand
OUTPUTS
Complaints resolution
Promotion and education
System monitoring and impact
Focus populations

education in self-advocacy skills. HDC will be exploring how we can support work to improve the reach of the Advocacy Service in 2024/25.

Focusing on rights promotion

HDC is aware that there are communities who experience multiple barriers to accessing our services and who may not be empowered to exercise their rights. We are committed to working with communities to raise their awareness and understanding of the Code, as well as improving providers' understanding of their obligations under the Code, ultimately to contribute to the upholding of people's rights and improved quality of care.

The ways in which HDC delivered on this strategic objective in 2023/24 included:

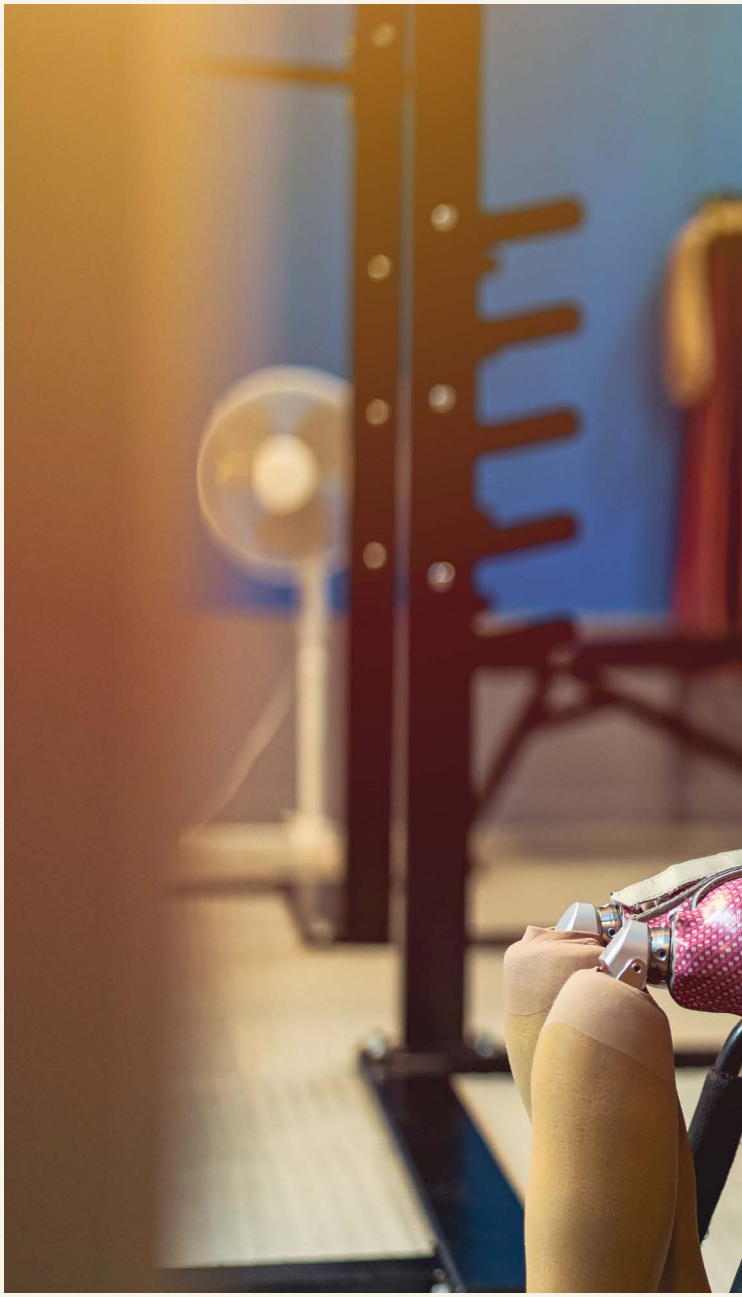
- Launching an animated video designed to raise people's awareness of their rights under the Code, which has garnered over 4,000 views;
- Increasing provider engagement with our education modules — with 8,399 providers accessing these modules in 2023/24;
- Delivering 43 educational presentations to providers and consumers to support their understanding of the Code, complaints management, and key themes in complaints;
- Using our Act and Code review as an opportunity to increase awareness and understanding of the Code and the role of HDC and the Advocacy Service;
- Funding the Advocacy Service to deliver 1,151 education sessions and 3,075 networking visits to raise awareness of the Code and avenues for complaint;
- The engagements undertaken by the Aged Care Commissioner with a diverse range of older people, including kaumātua. This raises understanding of the Code and avenues for complaint among older populations;
- Undertaking regional engagements to improve awareness and understanding of the Code among Māori communities; and
- Improving the accessibility of HDC's key resources on the Code and making complaints.

Demonstrating tangible system impact

HDC has a unique lens on the health and disability system — our intelligence is grounded in the consumer experience and can reflect issues not necessarily caught by other forms of error reporting (such as dignity, respect, and communication). Whether through the making of recommendations, sector engagement, or public and ministerial reporting, HDC ensures that the consumer voice is heard, urgent issues are escalated promptly, lessons from complaints are shared, and recommendations for change are made.

Ways in which HDC delivered on this strategic objective in 2023/24 included:

- Developing stronger processes to ensure that public safety and other urgent issues are escalated in a timely manner to those agencies who can protect patient safety;
- Increasing the use of our early resolution powers to achieve resolution for the individual consumer, while also contributing to systemic change;
- Publishing the first monitoring report of the Aged Care Commissioner, which set out 20 recommendations to improve the care provided to older people;
- Developing a report analysing five years of complaints about residential disability support and making several recommendations to improve the quality of support provided;
- Making 843 recommendations in relation to individual complaints to improve care quality and consumer experience;
- Maintaining a high compliance rate with our recommendations — 96% of providers complied with our recommendations in 2023/24;
- Publishing a report and associated dashboards outlining the themes in complaints about public hospital services;
- Continuing to work closely with the Registrar, Assisted Dying on complaints about assisted dying services, including providing reports outlining the trends in complaints to HDC;
- Undertaking significant stakeholder engagement to ensure that a collaborative approach is taken to sharing complaint trend information and monitoring associated action;
- Using insights from complaints to influence health strategy, policy, and legislation by making submissions;
- Undertaking public consultation on the review of the HDC Act and Code. Currently HDC has received 259 submissions;
- Publishing 107 investigation reports to share lessons from complaints and associated recommendations;
- Further increasing public awareness of HDC decision reports and other matters affecting consumer rights by working with the media to generate 1,440 media stories; and
- Participating in the National Quality Forum where HDC raises matters of concern emerging from HDC complaints.



Responding sustainably to growing demand

On-going increases in complaint volume (a 52% increase over five years) continue to place HDC under significant pressure. However, our work on increasing efficiencies means we also closed a record number of complaints in 2023/24. As noted, to allow us to respond to growing demand and prioritise our resources towards those complaints that require them, HDC focused on further increasing our use of early resolution pathways in 2023/24.

We have also implemented a plan to reduce the number of complaints currently under assessment and improve the timeliness of our process, with a focus on our older complaints. This plan has had a positive impact on the number of complaints closed that are aged over two years. However, reducing this cohort of complaints remains difficult as it begins to show the impact of a significant increase in complaints two years ago. This will remain an area of focus for HDC.

HDC's out-dated IT platform creates significant barriers to enhancing the efficiency of our process, as well as restricting our ability to improve complainant and provider experience of the process and undertake data analysis. A new case management system will increase efficiency and productivity, improve the transparency and responsiveness of our process, and allow us to better analyse and share our data. Such a system is a priority for HDC, and we will be exploring how we can invest in a new case management system in 2024/25.

In the meantime, we have focused on making improvements to our IT systems to enhance efficiency where we can, including by migrating our email system from Lotus Notes to Microsoft 365, implementing SharePoint to enhance collaboration and communication between staff, and moving to a new phone system that integrates better with other software.

We concentrated on our internal staff culture in 2023/24 by implementing a staff-led Tā Tātou Kawenata | Charter outlining shared expectations and shared understandings of ways of working together. We have also improved staff training, including by introducing a cultural capability component to our induction training programme and by undertaking a staff survey on how we can better support staff to engage with disability-related matters. A disability-related training programme will be rolled out to staff over the next year. We will also be rolling out an internal training programme to support staff understanding of quality and safety and making effective recommendations.

A new case management system will increase efficiency and productivity, improve the transparency and responsiveness of our process, and allow us to better analyse and share our data.

Code of expectations for health entities' engagement with consumers and whānau (code of expectations)

While the Pae Ora (Healthy Futures) Act 2022 does not require HDC to act in accordance with the code of expectations, we continue to ensure that the principles and intent of the code are built into our work. Some of the ways in which we did this in 2023/24 included:

- Using our complaints data to highlight the consumer and family and whānau voice in quality and safety;
- Publishing an analysis of complaints about residential disability support services to highlight the concerns of disabled people and their families and make recommendations to improve the quality of support;
- Publishing the Aged Care Commissioner's monitoring report and associated recommendations, which was informed by the voices of older people. The report made 20 recommendations to improve the care provided;
- Working with our Consumer Advisory Group to develop an ingoa Māori for this group — Whakawaha — to better reflect the kaupapa of the group and its important role;
- Continuing to prioritise engagement with Māori and disabled people | tāngata whaikaha in our review of the Act and Code, as well as those communities who are under-represented in complaints to HDC;
- Further expanding our use of tikanga-led approaches to complaints resolution;
- Continuing to monitor consumer and provider experience of our complaints process and using this information to prioritise and implement improvements;
- Contracting the Advocacy Service to undertake community-level promotion of the Code and mitigate the power imbalance by working with consumers to resolve complaints directly with the provider;
- Improving the accessibility of HDC's key resources on the Code and making complaints; and
- Making 843 recommendations on individual complaints to improve care quality and the consumer experience, and monitoring the implementation of these recommendations.

4

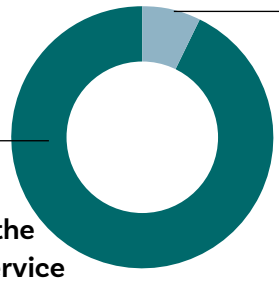
Te whakatutukitanga mō ngā mahi hira

Performance on key functions

Whāia te iti kahurangai ki te tūohu koe mehemea he maunga teitei

Pursue excellence

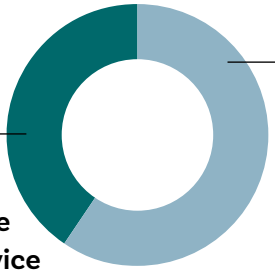
Enquiries received



1,645 enquiries received by HDC

20,518 enquiries received by the Advocacy Service

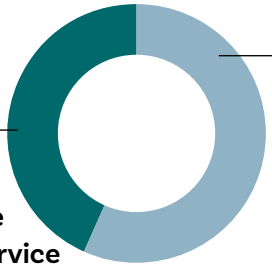
Complaints received



3,628 complaints received by HDC

2,455 complaints received by the Advocacy Service

Complaints closed



3,148 complaints closed by HDC, including 154 investigations

2,402 complaints closed by the Advocacy Service

4,226

education sessions and networking visits carried out by Advocacy (1,151 education and 3,075 networking sessions)

61 engagements and

259 submissions

received for Act and Code review consultation[2]

8,399

new registrants accessed HDC's online education modules

64%

of HDC complaints received were closed within **6 months**

96%

of advocacy complaints were closed within **6 months**

123

sector engagements and 20 recommendations made to improve experience of older people

47

hui ā-whānau

354

occasions of issues escalated

843

recommendations made, and

96%

fully complied with to improve quality of services

HDC achieves its strategic objectives through four key functions:

1 **Complaints resolution**

2 **Promotion and education**

3 **System monitoring and impact**

4 **Focus populations (Māori, disabled people, and older people)**

[2] *The public consultation ran from April 2024 to August 2024.*

4.1

Complaints resolution

HDC is tasked with the fair, simple, speedy, and efficient resolution of complaints about the quality of care provided by health and disability services providers.

HDC has several options available to resolve complaints. These options include referring the complaint to the provider or Advocacy Service for direct and early resolution between the parties; electing to take no action where care appears reasonable; making recommendations and educational comments to improve care quality and safety; referring complaints to other agencies; and undertaking a formal investigation, which may result in a provider being found in breach of the Code.

HDC is focused on supporting the timely resolution of complaints between consumer and provider where appropriate. When done well, resolution between the parties can often result in the best outcome for both consumer and provider. It can ensure that people's resolution needs are met quickly, restore trust and build relationships, and ensure that any quality improvement measures are implemented at source. Around 70% of complaints closed in 2023/24 were closed using early resolution pathways.

HDC has experienced significant increases in complaint volume in recent years. In 2023/24 HDC received 3,628 complaints. This is the highest number of complaints ever received by HDC, representing an 8% increase on the previous year and a 52% increase in the volume of complaints over the past five years.

> **'Thank you for your assistance and support ... Your involvement has been crucial in facilitating the steps necessary to improve my condition. The progress made ... is a testament to the collaborative efforts of everyone involved, and I am optimistic about the future.'**

Our focus on finding efficiencies to respond to the growing volume of complaints resulted in HDC closing a record number of 3,148 complaints in 2023/24. This represents a 41% increase in closures over the past five years.

Around 64% of complaints received by HDC are closed within six months. However, the impact of on-going increases in complaint volume in a resource-constrained environment has meant that currently we are not able to close as many complaints as we receive. This has led to a growing number of complaints under assessment, and delays in assessing more complex and/or serious complaints. In this context, HDC has focused our resources on responding to public safety and other urgent issues and closing our older files.

Process improvements

In the context of resource constraints and on-going increases in complaints, HDC's process improvement work has focused on increasing our use of early resolution pathways to ensure that our resources are directed towards those complaints where our powers can be used to greatest effect. We have also prioritised work to ensure that we have strong processes to urgently escalate any public safety issues to those agencies who can take action to protect patients.

Our focus on early resolution has also allowed us to explore ways in which we can use these pathways more effectively and flexibly — for example, using our levers to ensure timely resolution for the individual consumer, while also working with agencies who can effect change to address the issue on a wider scale (some examples of ways we have done this are outlined in the case studies below).

In 2023/24 we also began to implement a mid- to long-term plan to both reduce our aging profile of complaints and to improve the timeliness of our complaints process. We are seeing positive results from this plan in respect of an increase in the number of older complaints closed — for example, in 2023/24 we closed 289 complaints aged over two years, as compared to 198 complaints in the previous year. Unfortunately, we are now experiencing the full impact of the 25% increase in complaints in 2021/22 resulting in an increased number of complaints entering the aged file cohort. As such, 20% of complaints under assessment were aged over two years at the end of 2023/24. Work to reduce our aging profile of complaints will remain a key area of focus in 2024/25.

> **'It is important for people to have their voices heard and this is an avenue for them to do that.'**

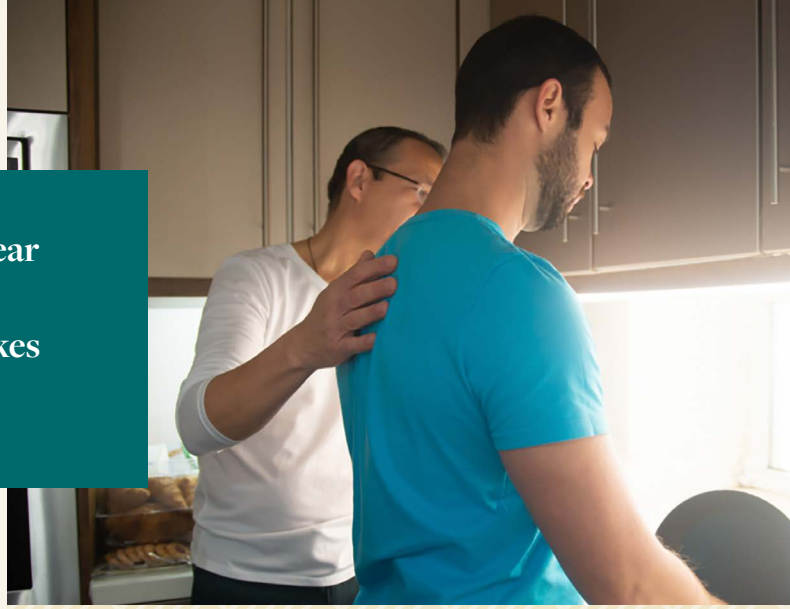
> **'We found the experience very fair and helpful. The positive focus to help resolve was really good.'**

> **'It helped to get the seriousness of my situation understood, and helped me get closure that my concerns were real.'**

Other process improvement initiatives implemented in 2023/24 included:

- Strengthening the focus of our complaint triage process on early resolution where appropriate. This resulted in an increase in complaints being resolved using early resolution pathways — for example, in Quarter 4 of 2023/24 (April to June 2024) we resolved 878 complaints through early resolution pathways compared to 532 complaints in Quarter 4 of 2022/23;
- Improving our triage assessment processes to ensure that we are consistently identifying and addressing urgent and serious issues in a timely way;
- Strengthening relationships with other agencies responsible for quality and patient safety to ensure that we have strong mechanisms for escalating and addressing public safety issues;
- Simplifying and standardising our early resolution closure processes, with the intention of achieving earlier resolution of people's concerns, as well as freeing up staff time to focus on older complaints;
- Improving the messaging on our website to support the resolution of complaints between consumers and providers, as well as providing better information about our complaints process and timeframe expectations; and
- Further expanding our use of tikanga-led approaches to complaints resolution. This work is outlined in the focus populations section.

> ‘We have found the communication clear and easy with the HDC. The process is fair and transparent, and I think it makes us better as a provider.’



HDC is also continuing to see positive impacts from initiatives introduced in the previous year, including the use of clinical navigators to assist people to understand clinically complex aspects of their care, support early resolution where possible, and provide clinical input to the complaint triage process.

HDC’s regular complainant and provider experience surveys are important quality improvement tools, providing insights on how HDC can improve people’s experience, and allowing us to measure the impact of any changes made. For example, in response to survey feedback in 2023/24 we reviewed the way we communicate our decisions in correspondence with complainants; improved the messaging on our website; reviewed our correspondence with providers when asking them for information; and made changes to our complaint triage process.

HDC has identified that the implementation of a modern fit-for-purpose complaints management system would greatly assist us to improve the efficiency of our process; improve the experience of both consumers and providers, particularly in respect of allowing us to communicate more responsively and transparently; and allow us to monitor and share our complaints data more easily. Exploring ways to invest in such a system will be an area of focus in 2024/25.

> ‘Thank you for helping me get some clear answers with my complaint.’

CASE STUDY

Access to Avastin

A man complained to HDC about his access to regular injections of Avastin. Without these injections, he risked losing his sight. Because he did not meet the threshold for funded treatment in the region where he lived, he was forced to move to a district where the threshold for funded treatment was lower. He had to move away from his wider family, support network, and home. He then moved to another district with funded treatment options, all the while trying to persuade his home hospital to fund his care or allow him to live at home and travel each month to the other hospital where currently he was receiving care. These applications were denied. The man found the situation particularly frustrating considering that one of the intents of the health reforms and the nationalisation of the system is to achieve equity of access.

HDC escalated this complaint to the national office of Health New Zealand | Te Whatu Ora (Health NZ) — highlighting the impact that geographical inequities in access thresholds were having on people and their families. The national office took these concerns seriously and acted swiftly to remedy the situation. The man received access to the care he needed in his home region, and inconsistent thresholds for access were discussed at a national level with a view to standardising thresholds across the country and developing a national pathway. The man’s complaint was closed with no further action being taken, given that his situation had been resolved.

CASE STUDIES

Access to care after being displaced by weather event

A woman complained to HDC about her access to surgery. The woman had been on a waitlist to receive care in her home region, but she was forced to move into temporary accommodation in another region due to a weather event. She was informed that she had been removed from the waiting list in her home region and would need to be referred by her GP to receive care in the region of her temporary residence. She reported that the public hospital in her home region had refused to refer her directly for care.

HDC urgently referred this complaint to the providers involved and asked them to take a collaborative approach to facilitating access to care for the woman. The woman was waitlisted and received her surgery. HDC also escalated the issue to the national office of Health NZ highlighting the lack of coordination between districts and the lack of consideration of the woman's personal circumstances. Health NZ highlighted the work underway towards the standardisation of referral processes.

Care provided to a man by prison health services

A man in prison complained to HDC that he was not consistently receiving his regular oral medications and that his mental health needs were not being met.

HDC referred this complaint to the Department of Corrections to resolve with the man. The Deputy Commissioner asked Corrections to provide an outline of the steps taken to ensure the effective and reliable management of the man's medication and mental health needs. Corrections advised HDC that a care plan for the man had been put in place, including weekly welfare checks and tracking of the man's medications, and that a treatment plan had also been formulated for the management of his mental health.

The role of the Advocacy Service in supporting early resolution

HDC contracts the Nationwide Health and Disability Advocacy Service to provide advocacy to support people to resolve their complaints directly with the provider. The Advocacy Service plays a vital role in supporting HDC's focus on early resolution, as well as our strategic priorities around having a timely and people-centred complaints process.

Advocates guide people to clarify their concerns and resolution needs and facilitate effective responses from providers. The advocacy process can assist to mitigate the power imbalance between consumers and providers and helps to restore trust and rebuild relationships. The service also supports timely resolution, with 96% of complaints closed within 6 months and 100% closed within 12 months. HDC will refer complaints to the Advocacy Service where a person may benefit from support to resolve their concerns. The Advocacy Service can also assist people to make a complaint to HDC where appropriate.

In 2023/24 the Advocacy Service received 2,455 complaints – a 14% decrease on the number of complaints received in 2022/23. The reasons for this reduction are likely multifactorial, and may include the reduced capacity of the service resulting in decreases in education and networking visits, disruptions caused by the implementation of a new IT system, and moving to a working-from-home model, as well as complainant behaviour (for example, people choosing to escalate their concerns to HDC in the first instance). The Director of Advocacy will be undertaking a review to better understand the reasons for this decrease in complaints to the Advocacy Service. A focus for HDC in 2024/25 will be working with the Advocacy Service to enhance the reach of this service and support more complaints being directed to advocates in the first instance.

'I would like to thank you for your expertise in the meeting today, they are often difficult when emotions are high and having an expert facilitator makes it so much better for all involved.'

'My Advocate is warm, empathetic, supportive, knowledgeable and professional. Her knowledge and use of te reo and tikanga also helped immensely. Her attributes and experience made such a difficult process a lot easier.'

While complaint numbers may have decreased, the Advocacy Service continues to deal with a high number of enquiries. In 2023/24 advocates made 20,518 contacts with enquirers, helping people to understand their rights under the Code and avenues for complaint, connecting them with appropriate support agencies, and providing education on self-advocacy skills to empower people to resolve concerns with their provider themselves (without the need for further advocacy involvement).

The Advocacy Service achieves high satisfaction rates, with 83% of consumers satisfied or very satisfied with the complaints management processes in 2023/24. The Advocacy Service has undertaken a review of these surveys to improve response rates and information provided to support quality improvement.

Communication with GP

A woman raised concerns with an advocate that she had stopped attending GP visits as she felt that her previous GP had not understood her communication needs. The woman advised that she was having difficulty with face-to-face discussions, and often she was unable to verbalise her concerns. She said that she had asked her GP to read the written concerns she had prepared, but the GP had noted that it was easier to communicate verbally. The woman now felt nervous to attend the GP clinic.

The advocate and the woman discussed communication options and together they wrote a letter to her new GP advising that she would like the GP to book an appointment for a consultation to be undertaken over email rather than in person. The woman noted that she could attend in person if the GP felt it necessary after the email consultation. The woman advised the advocate that she now has a good management plan in place and, importantly, she is receiving appropriate medical oversight, she understands any diagnosis and recommended treatment, and she feels listened to by her new doctor.

Care provided in residential aged-care facility

A consumer who lived in a residential aged-care facility required a bilevel positive airway pressure (BiPAP) machine to support her breathing while she slept. This required staff to connect her to the BiPAP each evening. She was concerned that often this task was completed by multiple different staff who did not always know the correct procedure.

The woman was also concerned about a lack of communication from staff about her husband's care, and several issues regarding her privacy and personal care tasks.

The consumer sought support from the Advocacy Service, which requested that the residential service ensure that all staff were familiar with how to connect the woman's BiPAP, improve communication with her about her husband's care, and ensure that she received appropriate privacy and the opportunity to exercise her independence with her personal cares. The Facility Manager provided a detailed response and apologised for the woman's experience. The Manager reported the steps they would take to improve the woman's care, including providing all staff with a step-by-step guide for connecting the BiPAP machine, implementing a better communication system about her husband's care, and providing guidance to staff around the type of support she required.

Key statistics — HDC

FIGURE 1. Number of complaints received and closed over the past five years

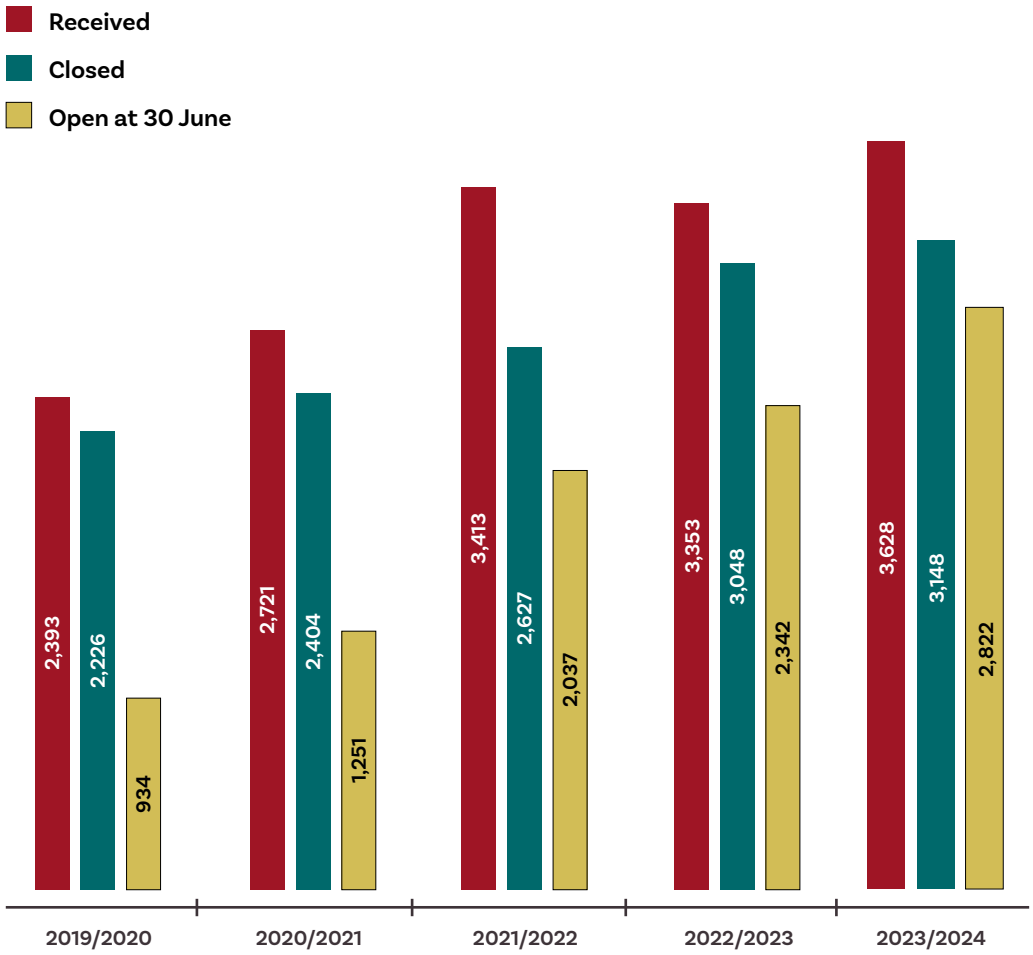
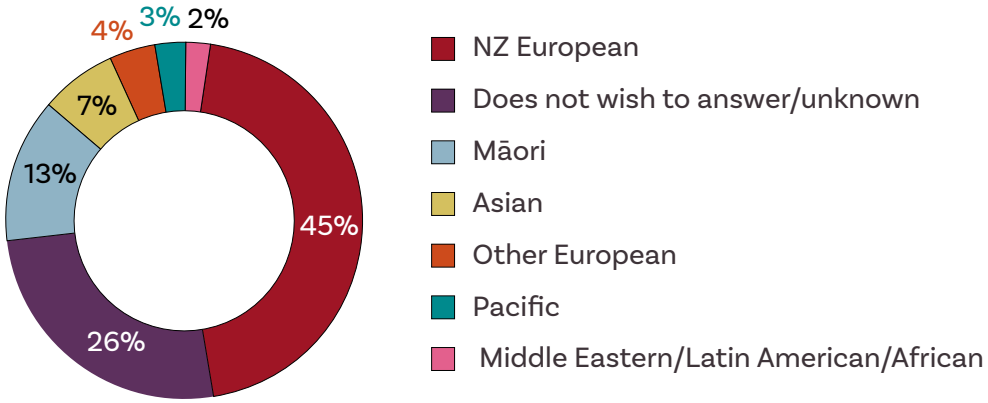


TABLE 1. Outcomes of complaints closed by HDC in 2023/24

Outcome	Number of complaints closed
Investigation	154
Breach finding	127
No breach finding with adverse comment and recommendations	17
No breach finding with recommendations	3
No breach finding	1
No further action with recommendations or educational comment	3
Assessment concluded; no further action needed	3
Other resolution following assessment	2,834
No further action with recommendations or educational comment	252
Referred to regulatory body	37
Referred to other agency	37
Referred to provider	852
Referred to Advocacy Service	268
Assessment concluded; no further action needed	1,265
Withdrawn	123
Outside jurisdiction	160
TOTAL	**3,148**

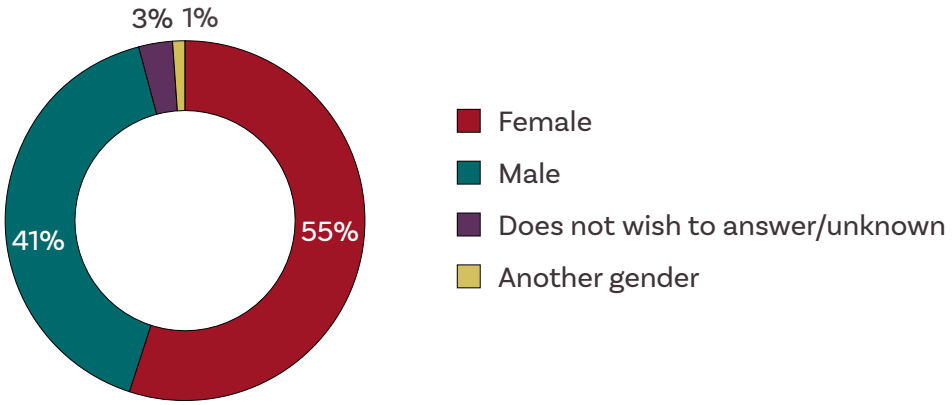
Whose care was complained about?

FIGURE 2. Ethnicity of consumers whose care was complained about in 2023/24



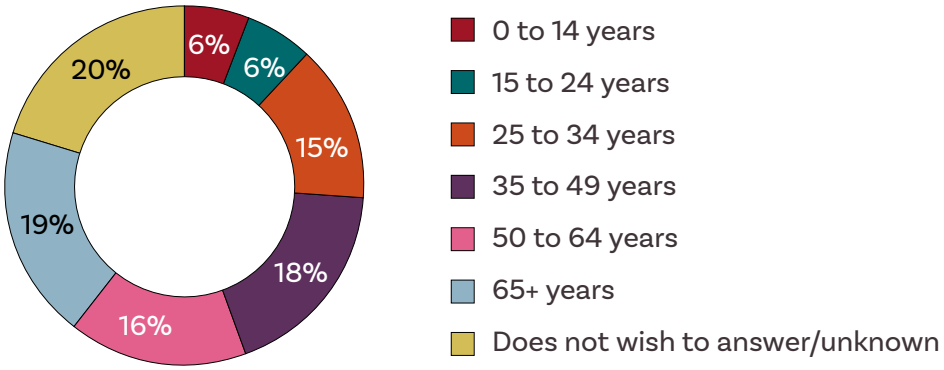
(Similar to previous years' figures)

FIGURE 3. Gender of consumers whose care was complained about in 2023/24



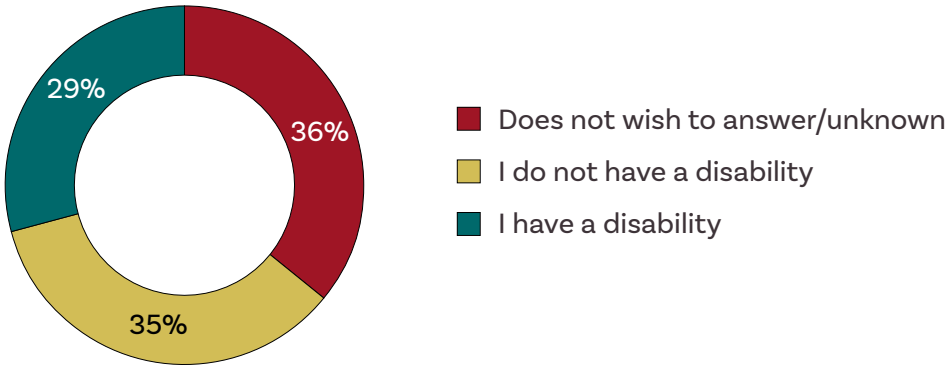
(Similar to previous years' figures)

FIGURE 4. Age of consumers whose care was complained about in 2023/24



(Similar to previous years' figures)

FIGURE 5. Disability status of consumers whose care was complained about in 2023/24



What was complained about?

TABLE 2. Most common primary issues in complaints

Primary issue	20/21	21/22	22/23	23/24
Inadequate/inappropriate treatment	228	186	302	358
Missed/incorrect/delayed diagnosis	205	240	246	228
Delay in treatment	127	116	135	237
Unexpected treatment outcome	92	90	122	179
Failure to communicate effectively with consumer	132	136	151	170
Inadequate/inappropriate examination/ assessment	144	144	131	168
Lack of access to services	97	119	176	156
Disrespectful manner/attitude	127	163	138	152
Waiting list/prioritisation issue	53	70	108	102

We note an increase in complaints about treatment delays

When all issues raised in complaints are considered — not just primary issues — the most common complaint issue categories in 2023/24 were:

74% **Care/treatment**

68% **Communication**

17% **Access/funding**

15% **Consent/information**

13% **Facility issues**

12% **Medication**

Who was complained about?

TABLE 3. Most common organisations complained about

Organisation type	20/21	21/22	22/23	23/24
Health New Zealand district	1,099	1,243	1,377	1,468
Medical centre	595	805	786	745
Aged residential care facility	151	183	185	184
Dental clinic[3]	96	86	98	177
Prison health service	112	73	112	139
Pharmacy	70	111	114	109
Disability support provider	69	60	64	66
Home care services provider	81	103	83	63
Specialist clinic	45	45	70	62

TABLE 4. Most common provider occupations complained about

Occupation	20/21	21/22	22/23	23/24
General practitioner	308	364	371	334
Dentist[3]	58	64	58	186
Midwife	91	79	86	96
Nurse	57	62	74	90
Psychiatrist	46	65	68	71
Psychologist	48	67	46	67
Orthopaedic surgeon	30	51	50	57
Internal medicine specialist	33	58	49	49
Obstetrician and gynaecologist	28	41	39	39

[3] *Please note that this increase was driven by a high number of complaints about a single provider.*

FIGURE 6. Number of complaints received and closed by the Advocacy Service each year

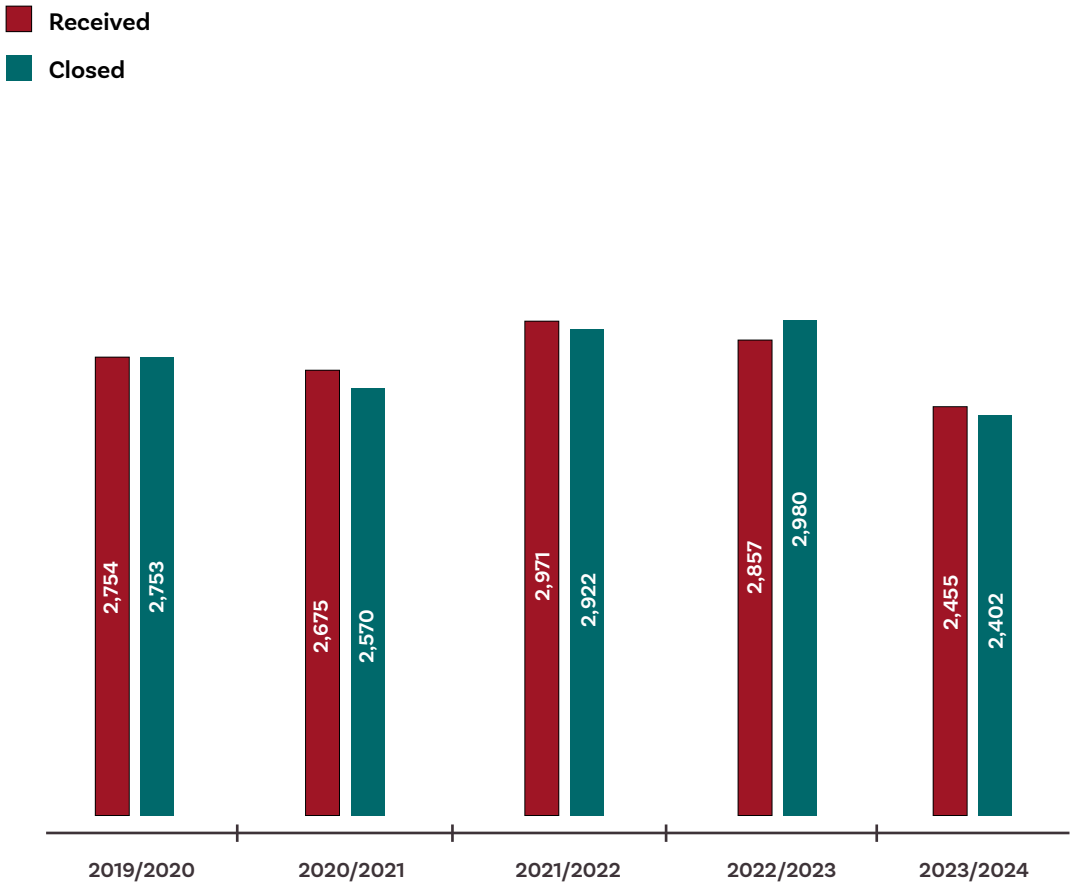


FIGURE 7. Ethnicity of complainants to the Advocacy Service in 2023/24

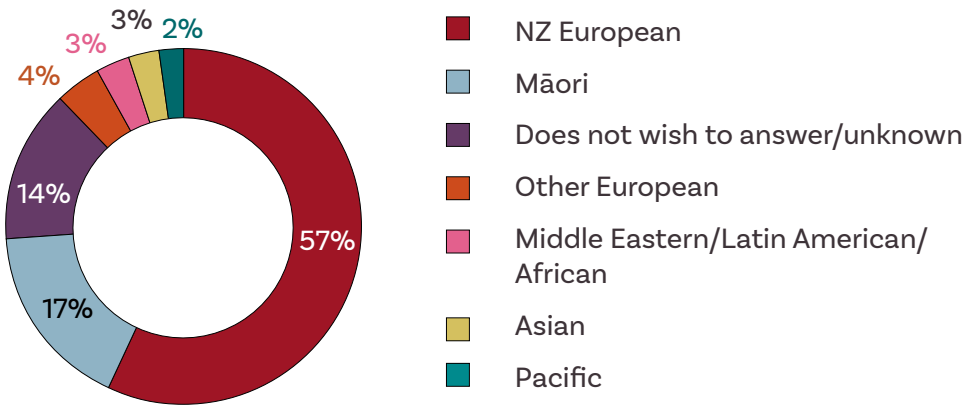


FIGURE 8. Age of complainants to the Advocacy Service in 2023/24

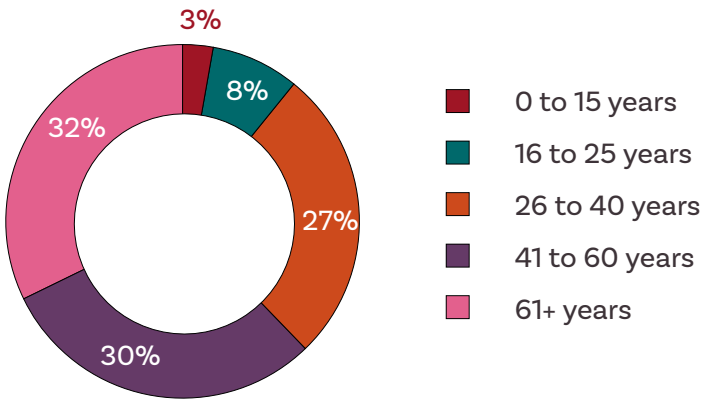
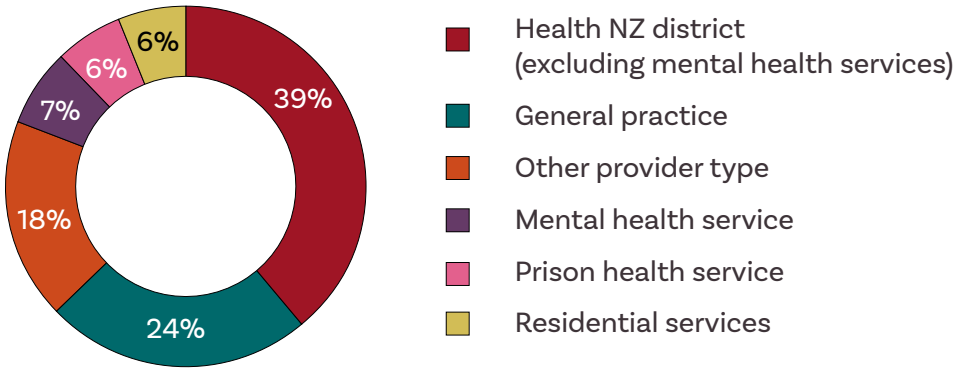


FIGURE 9. Providers complained about in complaints received by the Advocacy Service in 2023/24



Investigations

HDC provides an important mechanism for providers to be held to account for failing to uphold consumers' rights. HDC may formally investigate a complaint where a provider's actions appear to be in breach of the Code. HDC also has the power to undertake an investigation into an issue affecting consumer rights in the absence of a complaint. Investigations tend to focus on more serious departures from acceptable standards or professional boundaries, public safety concerns, and significant systems or equity issues.

Investigations ensure that providers and organisations are held to account where needed, public safety is protected, recurrent behaviour and systemic issues are addressed, preventative action is taken, and public trust is strengthened. HDC's complainant experience survey has found that people who go through the investigations process highlight that the independent inquiry and sense of accountability has helped bring them some closure and restore their trust in the system.

> **'Being heard and validated by way of the investigation process has allowed me to feel that a sense of justice prevailed for our family member.'**

> **'The whole process was fair and reasonable. Thank you for the decisions that you made and for also being so respectful. It has also helped me with my healing.'**

> **'We are grateful to have this complaint so thoroughly investigated and we appreciate the detail and sensitivity evident in your deliberations ... This has helped alleviate our sadness.'**

Around 7–8% of complaints received by HDC proceed to a formal investigation. An investigation is a thorough, quasi-judicial process. Evidence is gathered from multiple parties, including the consumer/complainant, provider/s, and other agencies such as ACC or the Coroner where relevant. We may also seek independent clinical advice from a relevant professional peer of the provider. When all relevant evidence has been gathered and assessed, the Commissioner or Deputy Commissioner prepares a provisional opinion outlining their findings and proposed recommendations. When assessing the care provided, HDC considers the contribution of organisational failings to individual behaviour — that is, our investigations seek to place individual behaviour in its systemic context. Systems and organisations are found in breach of the Code more often than are individuals.

In 2023/24 HDC closed 154 investigations and 276 complaints were transferred to our investigations team. 127 investigations resulted in a finding that the provider had breached the Code, and 136 investigations resulted in recommendations being made.

CASE STUDIES
INVESTIGATIONS

Some examples of breach findings made in 2023/24 include:

- A gynaecologist was found in breach of the Code for failing to obtain a woman's consent to undertake ablation treatment for her endometriosis. The woman had communicated clearly that she did not want ablation, and she did not receive an explanation prior to surgery that ablation may be required in some circumstances. The Commissioner also reminded Health NZ that in the exercise of clinical judgement, a surgeon must ensure that a patient has been fully informed about, and consented to, a particular treatment option.
- A dermatology clinic was found in breach of the Code for providing the wrong dose of phototherapy to a man, resulting in burns. The Deputy Commissioner emphasised the importance of having suitable processes and measures to identify patients correctly and ensure that they receive their own prescribed treatment, as well as ensuring that staff understand the purpose of processes.
- A dentist was found in breach of the Code for providing a young girl with orthodontic treatment outside his scope of practice over a two-year period.
- A GP was found in breach of the Code for undertaking a sensitive examination of a teenager following a circumcision procedure without the teenager's explicit consent. The Deputy Commissioner was particularly critical of the lack of consent given the teenager's vulnerability as a young person, the intimate nature of the examination, and the presence of his family in the room. She noted that consenting is an ongoing process, and care must be taken to protect the privacy and dignity of consumers.
- Health NZ was found in breach of the Code for failing to make relevant referrals and put in place adequate supports for a woman living with dementia mate wareware, particularly in respect of her food intake and medication management, when she was discharged home following hospital admissions.
- Health NZ was found in breach of the Code for delays in its management of significant postoperative complications experienced by a woman after a procedure involving surgical mesh. The Deputy Commissioner was also critical about the information provided to the woman about the risks of the surgery, and the specialist's recognition and response to the woman's complications.
- A community support worker was found to have breached the Code when she took non-consensual photos and videos of several consumers residing in a residential disability support service.
- A private oncology clinic was found in breach of the Code for the care provided to a man who was receiving chemotherapy and died after presenting to the clinic for acute care. The Deputy Commissioner found that the lack of guidelines in place for the assessment and management of patients who presented to the clinic acutely unwell resulted in a heavy reliance on decision-making and coordination by individual clinicians, and gaps in the care provided.

Continued on next page

- Health NZ was found in breach of the Code for inadequate care provided to a woman pregnant with twins, who required regular monitoring at a high-risk antenatal clinic. The Deputy Commissioner was critical that an effective plan was not made for monitoring the woman closely; medical input was not sought when required; and the decision on whether to deliver the babies was not considered in the context of abnormal results and the expressed preference of the woman. The Deputy Commissioner also made adverse comment that support for the woman did not meet her cultural needs.
- A GP was found in breach of the Code for sharing a document containing anti-vaccination misinformation with a woman who had COVID-19, not explaining that certain medications are not recommended for treating COVID-19 in New Zealand, and initially responding to the woman's complaint in an inappropriate and unprofessional manner.
- A residential disability support provider was found in breach of the Code for the quality of care provided to a disabled man — including failing to take appropriate action in respect of his pressure injuries, leading to the man's hospitalisation with sepsis. The Deputy Commissioner also found the provider in breach of the Code for its inadequate management of a complaint made by the man's mother.
- Health NZ was found in breach of the Code for multiple system failures in the management of a woman's echocardiogram, including a delay in triaging her referral and performing the echocardiogram, a delay in communicating the results to both the woman and her GP, and a lack of action when errors were identified.
- A GP was found in breach of the Code for failing to obtain informed consent for an examination and for failing to provide an adequate response to the woman's complaint, including making inappropriate comments about her character, veracity, and mental health.
- A residential aged-care provider was found in breach of the Code for inadequacies in the care provided to an older man who was receiving respite care, including inadequate falls management, and assessments not being undertaken as required. The Aged Care Commissioner was also critical of a failure to establish a positive culture, with residents' wellbeing at the centre of care planning and care delivery.
- A pharmacy was found in breach of the Code for a dispensing error in which a four-year-old boy was dispensed anti-psychotic medication along with his hayfever medication. The boy was administered the anti-psychotic and required admission to hospital.
- Health NZ was found in breach of the Code for an almost eight-month delay in disclosing to a woman who had been diagnosed with stage III cervical cancer that a retrospective review had shown that her previous smear tests had been misread, resulting in her cancer going undetected. This delay in open disclosure affected the woman emotionally, physically, and financially. A lack of clear processes was identified, which had caused confusion as to who had primary responsibility for disclosing the smear review findings.
- A massage therapist was found in breach of the Code and referred to the Director of Proceedings for filming multiple clients without their consent.
- Health NZ was found in breach of the Code for failing to ensure continuity of care, and for shortcomings in the standard of care provided, when a young woman was admitted to an acute mental health respite facility.
- A GP was found in breach of the Code for inadequate care of a man at risk of blood clots. This led to a missed opportunity to identify an acute medical emergency and ensure timely escalation of care.

> ‘HDC provides a safe and appropriate environment for patients to complain, be heard, and have someone investigate whether improvements could be made.’

Director of Proceedings

In very serious cases, HDC may refer a provider found in breach of the Code to the Director of Proceedings (an independent statutory role), who will decide whether to take legal proceedings against that provider. The Director can lay a disciplinary charge before the Health Practitioners Disciplinary Tribunal and/or issue proceedings before the Human Rights Review Tribunal.

In 2023/24 HDC made 9 referrals to the Director (relating to 13 consumers and 8 providers), and the Director issued 10 decisions to take proceedings. The Director concluded two proceedings against providers in the Human Rights Review Tribunal, both of which resulted in a declaration that the provider had breached the Code. The Director also successfully prosecuted a healthcare provider in the Health Practitioners Disciplinary Tribunal, which resulted in a finding of professional misconduct.

CASE STUDY
PROCEEDINGS

The Director of Proceedings filed proceedings by consent against a massage therapist in the Human Rights Review Tribunal. During the massage he massaged a woman’s breasts and abdomen without her consent. Independent advice to the Commissioner confirmed that this massage did not meet accepted practice of professional massages in New Zealand.

The massage therapist now accepts that it was inappropriate for him to massage the woman’s breasts and to expose her breasts and abdomen without providing her with information that this was his intention or seeking her consent. He accepts that it is not sufficient to assume that a client has given informed consent if the client does not object to specific actions. Finally, the massage therapist now accepts that he did not comply with accepted professional and ethical standards. The matter proceeded by way of an agreed summary of facts, and the Tribunal issued a declaration that the massage therapist breached Rights 1(2), 4(2), 6(1) and 7(1) of the Code.

The Tribunal’s full decision can be found at: http://www.nzlii.org/cgi-bin/download.cgi/cgi-bin/download.cgi/download/nz/cases/NZHRRT/2023/30.pdf

4.2

Promotion and education

HDC's promotion and education initiatives help to build the public's understanding of their rights and providers' understanding of their obligations under the Code. Ultimately, this contributes to improved care in the health and disability system and to people's rights being upheld.

Specific educational and promotional activities directed at Māori and disabled communities and older people are detailed in the focus populations section.

Online learning and education sessions

On 16 September 2023, HDC launched an animated video designed to raise people's awareness of their rights under the Code. The video was designed in consultation with consumers and is available in both plain English and Māori. Closed captions are also available in both languages. The launch of this video coincided with World Patient Safety Day and was attended by a range of representatives from consumer and provider organisations. The video was also distributed through a range of media and social media channels and to our stakeholders. Feedback has been positive, for example:

> 'I've just watched this now, it's fabulous, really easy to understand on what could be a legal and jargony topic.'

> 'Wow! Cool video. I will add this link into our induction with staff and information pack for whānau who enrol.'

As at 30 June 2024, the English language version of the animated video had had over 4,000 views, and the te reo Māori version had received 607 views. HDC will be exploring ways to increase the reach of this video further in 2024/25.

In 2022/23 HDC released three online learning modules focused on increasing providers' understanding of the Code, informed consent, and complaints management. These modules continued to be accessed by a considerable number of providers, with 8,399 new registrants recorded in 2023/24. This underscores the value of these modules to providers and reflects the commitment of providers to upholding people's rights.

HDC will be considering possible topics for further provider education modules in 2024/25. Currently we are also developing other methods to support providers' capability in resolving complaints themselves, including by making complaints management resources available on our website.

> ‘Really appreciated the opportunity to be part of the workshop which was well run and engaging … and responsive to the expressed needs of the audience.’

In 2023/24 we also delivered 43 educational presentations to providers and consumers to support their understanding of the Code, factors that support early resolution of complaints, and key themes in complaints. In addition, HDC received 1,645 enquiries about the HDC Act and Code and avenues for complaint.

Act and Code review

HDC is required by law to review the HDC Act and Code periodically. In 2023/24 HDC undertook 88 engagements to inform our current review. These engagements were also used as an opportunity to increase awareness and understanding of the Code and the roles of HDC and the Advocacy Service. The Act and Code review team had a particular focus on engaging with Māori communities and disabled people | tāngata whaikaha, as well as those communities who are under-represented in complaints to HDC (such as Pacific Peoples and migrant communities).

CASE STUDY

ACT AND CODE REVIEW CONSULTATION

As part of public consultation, the team reviewing HDC’s Act and Code met with individuals, groups, and organisations (online and in person) to provide education about the Act and Code and hear feedback about how these can be improved.

One education and feedback session was held in Ōtautahi Christchurch with the Waitaha Enabling Good Lives Regional Leadership Group. Fifteen of their members were present and shared their experiences of navigating health and disability services and complaints processes as disabled people | tāngata whaikaha. Suggestions for improvement included for information about rights and complaint processes to be more accessible, for complaint resolution processes to be less defensive, and for there to be more effective use of the Advocacy Service and supported decision-making to meet the needs of disabled people | tāngata whaikaha.

‘We would like to express our sincere appreciation for your wonderful workshop. The participants had a highly informative and engaging session with you. It significantly raised our elder community’s awareness about advocacy services. Many of our elderly participants, who frequently use medical services, face challenges due to language barriers and cultural differences and are often unaware of their entitlements … all of them felt that this workshop was essential for understanding their rights.’

Role of the Advocacy Service in promotion and education

HDC contracts the Advocacy Service to promote the Code through community-level educational initiatives. There are 28 advocates spread throughout Aotearoa New Zealand (with 4 advocates dedicated to managing the 0800 line). Advocates build and maintain relationships in the community to raise awareness of the Code and avenues for complaints. In their promotional work, advocates focus on those communities with highest need, and services that support people who may be least able to self-advocate and whose welfare may be most at risk, such as those residing in aged-care and disability residential support services.

The Advocacy Service carried out 3,075 networking visits with community groups and provider organisations across New Zealand in 2023/24. Of those visits, 76% focused on priority communities, including people living in residential settings, Māori, Pacific Peoples, refugee and migrant populations, and disabled people. Advocates also delivered 1,151 group education sessions across Aotearoa New Zealand. Feedback on these education sessions has been positive, with 93% of respondents indicating that after the session they had greater knowledge of how the information applied to them. The Advocacy Service also made over 20,000 contacts with enquirers in 2023/24 — helping people to navigate the complaints system, understand their rights under the Code, and develop self-advocacy skills.

While the number of networking and education visits remains in the thousands, the volume has reduced in recent years as rising costs have reduced the size and capacity of the Advocacy Service. In this context, the Advocacy Service has remained focused on prioritising educational activities for those communities with highest need. However, the reduced capacity to undertake networking and education has likely contributed to the recent decrease in complaints to the Advocacy Service. Unfortunately, there are also significant geographical gaps in coverage of the Advocacy Service, particularly in the South Island and upper North Island. This is of concern to HDC, and we will be working with the Advocacy Service and the Government to ensure the future reach of the service.

4.3

System monitoring and impact

HDC has a key role to play in quality and safety, including through the making and monitoring of recommendations and reporting on complaint trend information. HDC works with sector leaders and other agencies who have an interest in quality and safety, to share intelligence, amplify the consumer voice, monitor the implementation of our recommendations, ensure that timely action is taken on public safety concerns and, where appropriate, take a multi-agency approach to areas of shared concern.

Recommendations

HDC made 843 recommendations to health and disability service providers in 2023/24 to improve care quality and consumer experience. HDC closely monitors the implementation of the recommendations we make, and we have a high compliance rate. In 2023/24, 96% of our recommendations were complied with.

Where recommendations are not complied with, HDC may refer a provider to their regulatory body or name them publicly. However, generally the reasons for non-compliance with recommendations is reasonable — for example, common reasons include the provider retiring from practice or significant logistical issues arising after the recommendation was made.

> 'The recommendations are aimed at improving service delivery and quality of care and are well thought out.'

The most common recommendation made by HDC in 2023/24 was for providers to review or develop procedures or policies, followed by recommendations to provide or undergo training/professional development. Common themes in complaints included improving coordination of care, informed consent processes, clinical assessment processes/skills, documentation standards, and communication skills.

In 2023/24 HDC developed training for all staff on making effective recommendations. The training will be rolled out in 2024/25 and become part of our induction programme.

CASE STUDIES

RECOMMENDATIONS

Some examples of recommendations made by HDC in 2023/24 include:

- **HDC released an addendum to our Commissioner-initiated investigation into cancer care delays in the Southern region. The addendum noted that while our recommendations had been met, significant workforce constraints had hindered progress. HDC acknowledged that these were complex issues that do not necessarily have a quick fix; and emphasised the need for urgent national collaborative action and a coordinated programme of work to address the workforce challenges experienced by cancer centres around the country.**
- **In response to a complaint about a lack of care provided to a man seeking HIV post-exposure prophylaxis medication (HIV PEP) by an emergency department (ED), HDC made multiple recommendations to the Health NZ district, including that it amend the proposed guidelines for HIV PEP to reflect the decision by Pharmac to widen funding access; develop and implement a policy for conducting confidential discussions in the ED in private (including taking sexual histories); and provide an update on progress towards ensuring that clinicians have access to infectious disease specialists for advice and that people are being redirected by ED to other healthcare providers appropriately.**
- **In response to a complaint involving delays in communicating a significant incidental finding of a kidney tumour on a scan, HDC recommended that a Health NZ district consider developing a process for ensuring that patients are informed that they need to follow up results with their GP; consider appointing a lead clinician for patients accessing the vascular service as part of its planned regional vascular surgery structure; and review its agreement with the radiology service for communication of significant and unexpected findings.**
- **Following a complaint about the use of an unapproved restraint on a disability service user, HDC recommended that the disability service provider use the complaint as a basis for developing education/training on restraint and incident reporting for staff.**
- **In response to a complaint that involved poor communication about the need to transfer a consumer to another residential aged-care service, HDC recommended that the aged-care provider liaise with Health NZ to jointly develop a policy that outlines the pathway for raising concerns about the ability to provide adequate care to a resident, and the pathway for Health NZ to locate alternative accommodation for a resident.**

Continued on next page

- **Following a complaint about the care provided to a man who died following an incorrect intubation, HDC recommended that all current staff within the ED and the ICU be provided with training on the standard practice in emergency airway management, and that the Health NZ district implement an ongoing programme of regular training on this.**
- **Following a complaint about a dispensing error, HDC made several recommendations to the pharmacy, including to develop guidelines for prioritising workloads and managing workplace pressures, and to put in place a process for registering, managing, and investigating complaints.**
- **In respect of a complaint about the delayed diagnosis of an ectopic pregnancy, HDC recommended that the Health NZ district consider establishing space within the ED/assessment unit for the safe and private review of patients with suspected early pregnancy complications; develop a policy for the management and registration of acute gynaecology patients within the patient management system; and develop information pamphlets about ectopic pregnancy treatment options and safety-netting advice on when consumers should return to hospital for a further review.**

Sharing intelligence and stakeholder engagement

In 2023/24, HDC undertook 373 engagements with sector stakeholders to share intelligence, collaborate on areas of shared concern, and promote people's rights. This included attendance at the National Quality Forum — a multi-agency group of sector stakeholders designed to take a collaborative approach to quality improvement concerns. HDC raised a range of matters at the forum in 2023/24, such as informed consent practices, quality of maternity care, and delays in provider complaints management.

HDC also undertook early notification of systemic and public safety issues to relevant agencies on 354 occasions in 2023/24. Primarily these were made to regulatory agencies, Health NZ, the Ministry of Disabled People | Whaikaha, and the Ministry of Health. In most of these cases, HDC will ask for the agency to report back on the action taken and will monitor progress.

Some examples of systemic issues raised with agencies in 2023/24 include:

- The impacts of emergency department delays on people and the lack of hygiene and other care provided to people in waiting rooms and corridors;
- Cancer care delays, including the impact of delays in stem cell transplants;
- Delays in access to primary care, including difficulties accessing primary care in some areas of the country;
- The experience of people with hypermobile Ehlers-Danlos Syndrome and vascular compression syndromes in the health system;
- Communication with people on waitlists for specialist care, including the importance of providing people with information about expected timeframes for treatment where practicable;

> **'We can all learn from complaints ... to assist the consumer, ensure our practice is robust. If consumers don't complain things cannot be improved.'**

- Geographical disparities in access to specialist care and a lack of coordinated care between districts where people on a waitlist move regions;
- The manner in which changes to disability support funding was communicated to disabled people and their families;
- The information provided to women with dense breast tissue about the limitations of mammograms in this context;
- The lack of psychogeriatric care options in some regions of the country;
- The importance of permanent and transparent national clinical governance systems;
- The safety of radiology systems in use at a Health NZ district; and
- The long-term lack of compliance with safety audits and the Code by Opioid Substitution Therapy services across New Zealand.

Our insights from complaints also inform our submissions on policy and legislation. In 2023/24 we made 17 submissions, including in relation to the Government Policy Statement on Health and the New Zealand Health Plan, as well as a range of professional standards.

We ensure that insights from complaints are shared with the sector and the public by publishing key individual decision reports (107 decisions published in 2023/24). We also work with the media to ensure greater public awareness of HDC decision reports and other matters of public interest affecting consumer rights. In 2023/24, 1,440 stories were generated from our media releases, an increase on the 715 stories generated in the previous year.

> **'Receiving an HDC complaint can be a bit of a heart sink moment however, but it is a valuable service with an eye on improving health services and providing a voice to people with concerns.'**

Complaint trend reporting

HDC continues to review our data collection and reporting to ensure that it aligns with the evolving structure of the health system, as well as Government priorities and our focus populations.

We provided Health NZ with six-monthly complaint trend reports that outline the trends in complaints about public hospital care. We also regularly publish a summary of this information on our website. Feedback on these reports from the sector is positive.

HDC closely monitors complaints about assisted dying services, and we work with the Registrar, Assisted Dying to ensure that we both have oversight of the trends in complaints and that appropriate action is being taken to improve quality and protect public safety. This includes providing the Registrar with complaint trend reporting on a quarterly basis. The themes in complaints about assisted dying services are outlined below.

In 2023/24 we also developed two sector reports with associated recommendations. One was on the support provided to disabled people by residential support providers, and the other outlined the actions required to improve care provided to older people by health and disability services. More information about these reports can be found in the focus populations section.

Review of the Act and Code

In 2024/25, to support a review of the Code and the HDC Act, HDC identified and developed topics for review and sought public feedback on a consultation document.

To develop topics for review, HDC undertook targeted engagement with over 150 stakeholders with expertise in their fields, including with rangatira and Māori health and disability sector leaders; disabled people | tāngata whaikaha; tāngata whai ora | people with lived experience of mental distress and harm from substance use and gambling; consumer and provider groups; and regulatory organisations.

HDC released the public consultation document on 30 April 2024, with submissions open until 13 August 2024. HDC has received 259 submissions from the public. Consultation material is available in accessible formats, Māori, and plain English. Submissions could be made in person/video conference, by email, or by online survey. We have partnered with organisations working with communities that are under-represented in our complaints data (eg, Pacific and migrant communities) to develop opportunities for those communities to have input into the review.

> **HDC also undertook early notification of systemic and public safety issues to relevant agencies on 354 occasions in 2023/24.**

CASE STUDY

THEMES IN COMPLAINTS ABOUT ASSISTED DYING

As at 30 June 2024, HDC had received 18 complaints about assisted dying services since the End-of-Life Choice Act came into force in November 2021.

Themes that have been identified in these complaints include:

- **The readiness of facilities to undertake assisted dying services;**
- **Difficulties for people in accessing appropriate facilities in which to undertake an assisted death, particularly for people who live in aged residential care facilities, and the level of information provided to people about whether facilities allow assisted dying on their premises;**
- **Discriminatory attitudes and approaches by some providers towards those seeking an assisted death;**
- **Variable understanding among providers of their obligations when they have a conscientious objection; and**
- **Variable quality in the assessments undertaken by health professionals to determine a person's eligibility — resulting in people being restricted from accessing assisted dying services.**

HDC is engaging with the Ministry of Health in respect of its current review of the End-of-Life Choice Act.

4.4

Focus populations

HDC has a particular focus on those populations who experience poor health outcomes and who are particularly reliant on the care they are receiving.

Noting our commitment to our responsibilities under Te Tiriti o Waitangi, our focus on equity, as well as our statutory obligations, we have placed particular focus on Māori, disabled people | tāngata whaikaha, and older people. These focus populations may evolve over time.

HDC's Consumer Advisory Group | Whakawaha is an important mechanism by which HDC receives representative advice from a range of communities about strategic issues in the health and disability sector, as well as operational matters. The group includes two iwi representatives, as well as representatives from Pacific, Asian, older people, youth, disability, and rainbow communities. It also includes representation from people with lived experience of mental distress and harm from substance abuse.

In 2023/24 we worked with our Consumer Advisory Group to develop an ingoa Māori for this group — Whakawaha — to better reflect the kaupapa of the group and its important role. The ceremony to 'unveil' the new name was an opportunity for HDC to reset our commitment to empower Whakawaha to advocate on behalf of their communities.

> **Noting our commitment to our responsibilities under Te Tiriti o Waitangi, our focus on equity, as well as our statutory obligations, we have placed particular focus on Māori, disabled people | tāngata whaikaha, and older people.**

4.4.1

Māori

HDC's Kaitohu Mātāmua Māori | Director Māori, together with a small team, is focused on supporting HDC to improve our cultural capability and respond effectively to Māori complainants and complaints with a cultural dimension, as well as supporting effective engagement with Māori communities to increase understanding of the Code.

Complaints resolution

HDC has expanded our use of tikanga-led approaches to complaints resolution. In 2023/24 we undertook 47 hui ā-whānau — a significant increase on the 26 hui ā-whānau undertaken in the previous year . Hui ā-whānau is a whānau gathering (inclusive of the consumer) facilitated using te reo Māori me ngā tikanga (Māori methods of engagement and protocols). Hui ā-whānau is a newly implemented approach within HDC's complaint management process facilitated by Māori. Hui ā-whānau allows whānau voice to be heard and understood in a culturally safe and appropriate environment. Hui ā-whānau takes place in Māori, plain English, or both. It is a process led by tikanga where whānau are the experts of their experience and are supported to decide what resolution looks like for them. Māori whānau continue to speak positively of the hui ā-whānau process in terms of allowing them to share their story and be heard, and providers have also noted the benefits of the process in improving their cultural capability to resolve complaints.

In terms of improving the cultural capability of providers in the management of complaints, our Director Māori team also assists providers to coordinate hohou te rongo (peaceful resolution) processes between the parties to de-escalate situations, re-establish relationships, and create peaceful resolution.

While we have been working to undertake hui ā-whānau earlier in the complaints process, currently demand outstrips the capacity of our small Director Māori team, making it difficult for them to provide timely cultural input. This, in turn, limits our ability to consider the broader application of these hui in complaints resolution. However, HDC continues to explore ways in which the broader application of these hui and restorative practices could be supported.

CASE STUDY

A wahine and her whānau complained to HDC about the care provided to the woman by her midwife and a birthing centre in relation to her baby, who was stillborn. The whānau also raised concerns about communication and a lack of cultural safety after the baby's stillbirth.

HDC formally investigated the complaint and found both the midwife and birthing centre in breach of the Code for the standard of care provided.

The Deputy Commissioner noted that the birthing centre had an obligation to ensure that its practices were culturally safe and upheld the woman's mana and cultural beliefs. Cultural advice from HDC's Director Māori team noted:

> ***'In te ao Māori, the level of tapu surrounding birth and death are heightened. Tikanga is practised to ensure that the rules surrounding tapu are observed. When certain practices are not observed, this can be considered a breach of tikanga. Tikanga underpins culturally safe practices … The tikanga that surrounds the tapu of death acknowledges that te ara wairua (the spiritual pathway followed after death to the afterworld) can involve reciting appropriate karakia and takutaku (incantations).What is clear from the recollections of staff, and the documentation provided, is that there was no offer of karakia and/or guidance by a relevant person, eg, a kaumātua, to the woman and her whānau.'***

The Deputy Commissioner was critical of the birthing centre's cultural response following the baby's delivery and considered that the cultural services and support provided to the woman and her whānau were inadequate and a breach of Right 1(3) of the Code.[4]

[4] *Right 1(3) states that every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.*

Code promotion and education

HDC undertook multiple regional engagements in 2023/24 focused on promoting the Code and the work of HDC and the Advocacy Service within Māori communities. The ultimate objective of our approach is to empower local leaders to become the champions of this work and have the capability to support their communities, with HDC providing oversight and support as required. This included visits to Ika Whenua Hauora (Murupara), Te Paa Harakeke (Taranaki), Te Waipounamu (Christchurch), Te Matau-a-Māui (Hawke's Bay), Te Arawa (Lakes), Te Manawa Taki (Waikato), and Te Pare a Toi (Whakatāne).

HDC's Director Māori team also started to build relationships with Māori health teams within some districts to help strengthen culturally appropriate support and complaints resolution for Māori whānau.

Engagement with Māori was prioritised as part of HDC's review of the Act and Code. This engagement was an important opportunity to hear how the Act and Code could be more effective for, and responsive to, Māori, as well as to raise awareness and understanding of the Code and the role of HDC and the Advocacy Service among Māori communities. The Act and Code review team worked closely with HDC's Māori team to run tikanga-led engagement processes with rangatira, Māori health and disability sector leaders, and Māori communities. The Commissioner and Director Māori also presented to Pou Tangata (from the Iwi Chairs Forum) to raise awareness of the opportunity provided by the review and promote engagement with whānau, hapū, and iwi.

We have also continued to update key HDC resources into te reo Māori. In 2023/24 this included translating our Easy Read resources and complaint forms into te reo Māori.

System monitoring and impact

HDC's Director Māori team regularly share the themes in complaints from Māori whānau with other agencies and support the identification and implementation of recommendations to improve the care provided to Māori whānau in the health and disability system. HDC will be exploring ways to highlight these themes and recommendations to the sector more broadly in the coming year.

In 2023/24 focus was also on HDC's Director Māori team developing partnerships with regulatory bodies to support the development and reinforcement of appropriate cultural standards of care. This included hosting representatives from the Dental Council, the Occupational Therapists Council, and the Pharmacy Council. These relationships help us all to better understand the wider pathways to resolve complaints and work together to raise and resolve issues.

Common primary issues raised in complaints about care provided to Māori

9% Missed/incorrect/delayed diagnosis

8% Inadequate/inappropriate treatment

8% Delay in treatment

5% Disrespectful manner/attitude

5% Inadequate/inappropriate examination/assessment

4.4.2

Tāngata whaikaha
Disabled people

HDC has a key role to play in protecting the rights of disabled people | tāngata whaikaha. The Deputy Commissioner, Disability is focused on the rights of disabled people | tāngata whaikaha when using health and disability services. While our resource in this area remains extremely limited, ultimately our goal is to improve the health and disability system to better meet the individual needs of disabled people | tāngata whaikaha, now and in the future, in line with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the principles of Enabling Good Lives.

Currently almost 30% of complaints to HDC relate to all services and supports (including health care) provided to disabled people, with approximately 4% of complaints relating to disability support services. HDC is aware that there are groups within the disability community who are under-represented in complaints and face multiple barriers to making a complaint, including those receiving residential support, Pacific peoples, and tāngata whaikaha Māori. HDC is committed to improving the accessibility and responsiveness of our complaints process to disabled people | tāngata whaikaha. Therefore, in 2023/24 we began the development of a disability strategy to support the rights of disabled people | tāngata whaikaha to be understood and upheld, and to address key systemic issues identified through engagement and complaints data. This included:

- Conducting a staff survey to identify existing skills and knowledge in disability across the organisation, as well as areas of interest for further development;
- Undertaking a series of engagements with disabled people's organisations and key disability sector agencies to feed into the development of the strategy. This engagement included meetings with Te Ao Marama Aotearoa (a disabled people | tāngata whaikaha Māori leadership group), Te Roopu Waiora (a whānau hauā Māori leadership group), Disabled Older People, Kāpō Māori Aotearoa, the Disabled People's Organisations Coalition (DPO), the New Zealand Disability Support Network (NZDSN), and New Zealand's Independent Monitoring Mechanism of the UNCRPD. The disability team also met with multiple stakeholders at the Ministry of Disabled People | Whaikaha, Health NZ, Oranga Tamariki, ACC, the Health Quality and Safety Commission, and the Advocacy Service; and
- Revising our recruitment material to support recruitment of people with a strong understanding of disability and the disability sector.

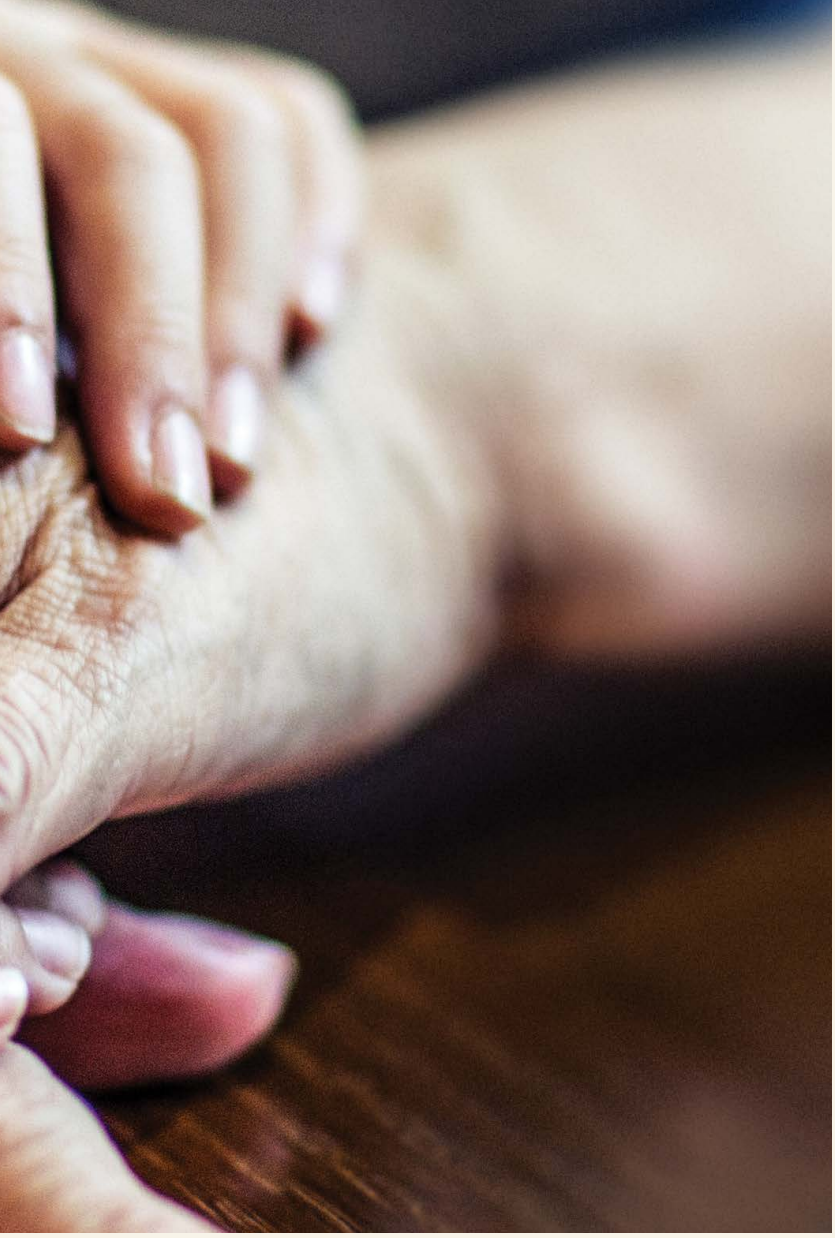
Currently almost 30% of complaints to HDC relate to all services and supports (including health care) provided to disabled people.

Promotion and education

To reduce barriers to people understanding and exercising their rights and making complaints, we continued to update and ensure the accessibility of key HDC resources. In 2023/24 we updated and translated 5 resources, creating 15 new accessible formats, including large print, audio, braille, NZSL video, and Easy Read.

Engagement with disabled people | tāngata whaikaha was prioritised as part of HDC's review of the Act and Code. The review team worked closely with the Deputy Commissioner, Disability to hear from disabled people | tāngata whaikaha (including people with lived experience of mental distress and/or harm from substance use). The team used accessible engagement methods to ensure a diversity of perspectives for how the Act and Code could work better for disabled people | tāngata whaikaha and how it could align more closely with the UNCRPD. This engagement was an important opportunity to raise awareness and understanding of the Code and the role of HDC and the Advocacy Service among disabled people | tāngata whaikaha.

The Act and Code review team also focused on making our public consultation process as accessible as possible. Advice was sought from accessibility experts and disabled people's organisations on options for engagement, our summary document was translated into accessible formats, and we set up a range of avenues for people to contact us through the consultation process.



The team used accessible engagement methods to ensure a diversity of perspectives for how the Act and Code could work better for disabled people | tāngata whaikaha and how it could align more closely with the UNCRPD.

Sector monitoring and impact

HDC has made several improvements to our data collection and analysis in recent years, allowing us to more effectively monitor and report on the experiences of disabled people | tāngata whaikaha in the health and disability system. HDC closely monitors complaints about disability support and works closely with leaders in the disability sector to share this information, with the goal of amplifying people's experience of services and improving the quality of care and support provided to people. In 2023/24, the Deputy Commissioner undertook 76 engagements with stakeholders.

We have developed strong processes to ensure that any issues posing a risk to the safety of disabled people are escalated and addressed by those agencies who can act, including the Ministry of Disabled People | Whaikaha.

In 2023/24 HDC undertook work to analyse five years of complaints to HDC about residential disability support services. A report was published in July 2024 and outlined several recommendations to the sector to improve quality of support, complaints management, and the implementation of community-based alternatives to residential support. The report has been received positively by many stakeholders, and HDC will be focusing on working collaboratively with the sector to monitor the implementation of our recommendations. It is our hope that this report will make a timely contribution to Aotearoa New Zealand's continued work to improve services and deinstitutionalise and transform the disability sector in line with the UNCRPD and the principles of Enabling Good Lives.

HDC will be exploring further opportunities to report on the experience of disabled people. Many of our complaints from disabled people point to their concerns about their experience in the health system, and this may be an area of future interest.

Common issues raised in complaints about care provided to disabled people

10% **Inadequate/inappropriate treatment**

6% **Delay in treatment**

6% **Lack of access to services**

5% **Failure to communicate effectively with consumer**

5% **Missed/incorrect/delayed diagnosis**

CASE STUDY

RESIDENTIAL DISABILITY SUPPORT REPORT

HDC undertook an analysis of five years of complaints to HDC about residential disability support services (363 complaints) and identified several themes that highlight areas of concern. These themes include the following:

- Failure to adhere to support plans
- Inadequate standards of care
- Use of restraint and force
- Concerns about one-size-fits-all approaches to individual disabled people's needs
- Lack of culturally safe and appropriate support services
- Poor coordination with other services, including health services
- Poor communication with disabled people, family, and whānau
- Shortages of skilled staff to support specific needs of individuals
- Poor responses to feedback and complaints

The following broader systemic issues were also identified as contributing to these themes:

- Workforce shortages
- Slow progress in respect of transforming the system in line with Enabling Good Lives
- Geographical inequities in access to services across Aotearoa New Zealand
- Lack of safeguards and quality frameworks
- Sustainable and appropriate funding of services and individual alternatives

Informed by the findings of this analysis, HDC made several recommendations to the Ministry of Disabled People | Whaikaha, including that it:

- Develop and implement a consistent quality framework across all funded disability service provision in consultation with disabled people|tāngata whaikaha, whānau, and disability service providers and funders. Such a framework should include the proactive monitoring and reporting of the experience of disabled people and their family or whānau;
- Progress work on a consistent framework and guidance for complaints management;
- Support the workforce planning programme to remain a priority;
- Consider making the Choice in Community Living programme available nationwide;
- Support development of Māori-led disability services; and
- Communicate with the disability community about progress to roll out Enabling Good Lives systems transformation nationally.

4.4.3

Older people

The Aged Care Commissioner provides a focal point for monitoring and addressing quality and safety issues for older people. Her role includes advocating for better health and disability services for older people, driving quality improvement, reporting on emerging systemic issues and improvements, and supporting the Government's commitment to Te Tiriti o Waitangi.

In March 2024 the Aged Care Commissioner published her first monitoring report, which made 20 recommendations to the health sector to improve the experience of older people. The report was informed by a significant amount of engagement undertaken across Aotearoa New Zealand to understand the challenges experienced by a diverse range of older people, as well as with providers and other relevant agencies. The findings of the report have been shared widely and received broad media coverage. Several organisations issued media releases promoting the report and/or shared the report through their own channels, including Alzheimers New Zealand, the Aged Care Association, Age Concern and Grey Power. The Aged Care Commissioner and her team have developed a monitoring approach to track progress against her recommendations, and this will be reported on at regular intervals in the coming year.

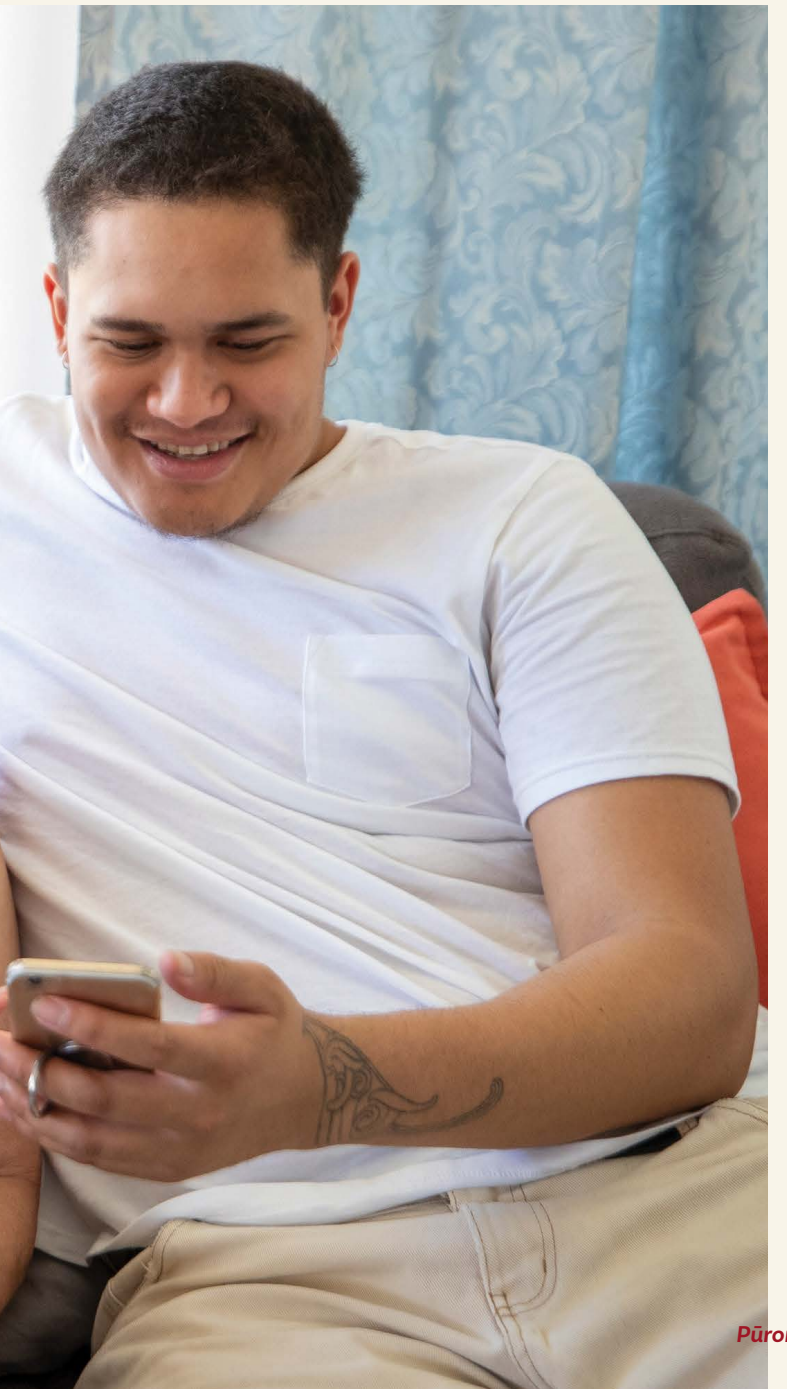
Around 18% of complaints to HDC are about the care provided to older people. The Aged Care Commissioner is a statutory decision-maker on complaints, and complaints management is an important part of the Aged Care Commissioner's overall monitoring role. It provides her with oversight over the issues that older people are concerned about and allows her to effect quality improvement through the making and monitoring of recommendations and holding providers to account where appropriate. It also ensures a focus on promoting and protecting the rights of older people using health and disability services.

> **Around 18% of complaints to HDC are about the care provided to older people.**

Some examples of recommendations made by the Aged Care Commissioner in relation to individual complaints in 2024/25 are:

- A care home was asked to update its Respiratory Care Guide to provide guidance on the steps required if a patient is in respiratory distress, including when a GP should be called and the time within which an ambulance should be called when a GP is not available; and to develop an oxygen administration procedure that can be integrated into its current medication management procedure.
- It was recommended that a care home review its policies on updating care plans, to ensure that changing needs post-discharge from hospital are included adequately.
- Following a complaint about the information provided to an older person about the risks of prolonged use of a medication, Health NZ was asked to provide confirmation that it had produced a written information resource to highlight the side effects of the medication and provide advice about its safe use; and to consider disseminating this information to other relevant services within Health NZ.

- Representatives from HDC's aged care team discussed consumer-centred approaches to feedback and complaints resolution with a care home, and ways in which these could be incorporated into the organisation's complaints policy. The care home was then asked to send its revised policy to HDC.
- Following a complaint about the management of an older person over multiple presentations to an emergency department, including anti-coagulant management, it was recommended that Health NZ develop a patient information sheet with safety-netting information for patients who have sustained injuries and are taking anticoagulation medication and develop a process for patients who re-present to the ED within a short time frame to be flagged for discussion with a clinical colleague for a 'fresh eyes' review.
- A care home was asked to provide additional education to its staff to improve their communication skills with family in respect of cultural safety.
- It was recommended that a pharmacy provide consumers with written guidance on any dosage/medication changes when collecting their medications.
- A home care and community support provider was asked to undertake an audit of missed cares provided to older clients, including timeliness of communication with families when cares were missed, and to outline actions taken to address any identified shortcomings.



A care home was asked to provide additional education to its staff to improve their communication skills with family in respect of cultural safety.

Engagement

The Aged Care Commissioner undertakes a significant amount of engagement with older people, service providers, and government agencies to inform her monitoring work. She also takes a collaborative approach to working with other agencies with an interest in the quality of care provided to older people, for example regularly engaging with the Office for Seniors, HealthCERT, and the Minister for Seniors.

In 2023/24 the Aged Care Commissioner undertook 123 stakeholder engagements. Many of these were with a diverse range of older people to understand their experience of the health and disability system and the issues of most concern to them.

Kaumātua are a priority population for the Aged Care Commissioner and her work. Supported by the Director Māori, the Aged Care Commissioner has planned engagement with kaumātua across Aotearoa New Zealand with a focus on three regions in 2024 — Te Tai Tokerau | Northland; Tāmaki Makaurau | Auckland; and Te Tairāwhiti | Gisborne. Recently the Aged Care Commissioner made visits to kaumātua in Tāmaki Makaurau | Auckland, Te Tairāwhiti | Gisborne, Wairoa, and Hastings.

Common primary issues complained about in complaints about the care of older people

11% Inadequate/inappropriate treatment

8% Unexpected treatment outcome

8% Delay in treatment

6% Missed/incorrect/delayed diagnosis

5% Inadequate/inappropriate care

The Aged Care Commissioner undertakes a significant amount of engagement with older people, service providers, and government agencies to inform her monitoring work.

CASE STUDY

AMPLIFYING THE VOICES OF OLDER PEOPLE ACROSS AOTEAROA NEW ZEALAND

This report draws on the voices of thousands of older people and their whānau|family, including carers, and service providers to outline some core issues in health and disability services for older people. The report focused on:

- The need for better transitions of care for older people from hospital to home and community support services and aged residential care;
- Investing in innovative primary and community care models, including assisting older people to navigate health and disability services;
- Preventative interventions for dementia mate wareware; and
- Ensuring that people can access reliable, quality home care and community support services to age well at home.

The Aged Care Commissioner made 20 recommendations to improve the care provided to older people, including:

- A targeted strategy to ensure quality health and disability services for older people;
- Nationally replicating and upscaling existing roles in Health NZ that support older people to be discharged safely from hospital;
- Any focus on workforce in the aged-care funding and service models review and in future Health NZ workforce plans should have a focus on actions that contribute to a sustainable aged-care workforce;
- Shortages in psychogeriatric care beds across the country must be addressed urgently;
- The aged-care funding and services review must address the significant gap in the provision of kaupapa Māori aged-care services;
- Primary and community care, especially general practitioner clinics, should be valued as critical partners with priority investment in changing models of primary and community care;
- A health worker and/or social care worker in primary care focused on older people's health could have an important navigator role to support people with complex conditions and their whānau to access and transition between services;
- Regular training and development of primary and community care providers and staff on the health and wellbeing of older people and ageing-related health and disability conditions;
- Preventative actions to reduce dementia mate wareware to include increasing hearing-aid subsidies and public health interventions fostering social connection and age-friendly environments;
- The aged-care funding and service models review by Health NZ to consider aspects of home and community support services to improve the sustainability of services and to ensure equity; and
- The development of a comprehensive national Home and Community Support Services workforce dataset to be collated, shared, and regularly updated by Health NZ, as well as accurate data on current and projected demand for Home and Community Support Services.

5

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

People, performance, and capability

The Commissioner is responsible for setting and leading the strategic direction of the organisation. She is supported by an executive leadership team, which is responsible for leading our performance culture, managing operational matters, and risk identification and management.

HDC works collectively to promote and protect the rights of people who use health and disability services. Most of our staff hold professional qualifications and they bring a diverse range of skills and expertise, including in disputes resolution, law, cultural advice, and clinical practice. As at 30 June 2024 we had 129 staff (111.73 FTE equivalent). Almost all our staff are dedicated to carrying out our core statutory functions.

Diversity and inclusion

Developing a workforce that reflects the diversity of Aotearoa New Zealand is a priority. Our commitment to fair and equitable opportunities for employment, promotion, and training are integrated into the recruitment process and throughout the employment cycle. We benefit from a diverse workforce and continue to implement initiatives that positively impact on diversity and ensure a culturally safe workplace. In 2023/24 we:

- Revised our material to support recruitment of people with a strong understanding of disability and the disability sector;
- Undertook a staff survey to understand staff's current knowledge around disability and how well-equipped staff feel to engage with disability-related matters. Currently we are developing a comprehensive training programme for staff to ensure that they have the necessary skills and knowledge in disability. This training programme will be rolled out in 2024/25;
- Continued to deliver our cultural education programme to staff. In 2023/24 this included a focus on enhancing staff understanding of mātauranga Māori with a series of educational initiatives over a six-week period, as well as education around the history and revitalisation of the use of te reo Māori in New Zealand;
- Added a cultural capability component to our staff induction training programme; and
- Continued to further develop our mihi whakatau practice to welcome new colleagues. Mihi whakatau creates further opportunities to enhance whakawhanaungatanga and whanaungatanga for staff.

Oranga taiao, oranga tāngata

Healthy environment, healthy people

Leadership and culture

Our staff work collaboratively to achieve HDC's strategic objectives. Our managers are responsible for leading a positive performance culture. Currently we are working to enhance the capability of our leadership and have begun to roll out several training sessions to help support the professional development of our people leaders. We also provided training to all managers on the new Protected Disclosures Act and handling concerns raised by staff.

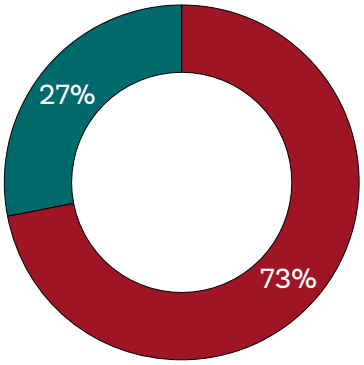
In 2023/24 we launched Tā Tātou Kawenata | Our Charter, which reflects our intentions of being a high-performing organisation while growing our supportive and collaborative internal culture. Central to the charter are the ideas of he tina ki runga, he tāmore ki raro (in order to flourish above, one must be well supported below) and kia tipu, kia hua, kia puāwai (plant the aspirations, nurture the aspirations for all aspirations to flourish). The development and implementation of this charter has been staff-led and supported by development of an HDC karakia that reflects the values.

People who leave HDC primarily do so for further development or personal reasons. Exit surveys are conducted with departing staff, who can offer valuable feedback and support continuous improvements to HDC's culture and work environment.

Health, safety, and wellbeing

Our staff can be exposed to challenging subject matter and behaviour. In 2023/24 frontline staff were supported with professional supervision to help them to debrief and manage difficult behaviours. We also reviewed our Unsafe Visitor process for dealing with on-site unacceptable and abusive communication and behaviour.

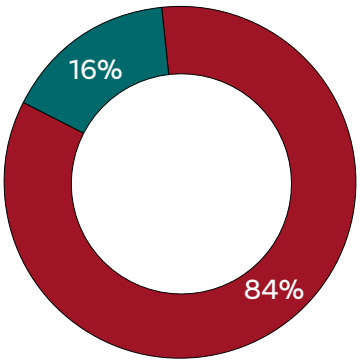
HDC recognises flexible working as an important component of a supportive and productive work environment. In 2023/24 HDC implemented a refreshed policy to ensure that access to flexible working is fair and consistent across all teams. Our flexible working arrangements include supporting working from home with extra IT equipment and tools and providing flexible work times where possible to support family/whānau and other commitments.



Staff in full-time and part-time positions

- Full time
- Part time

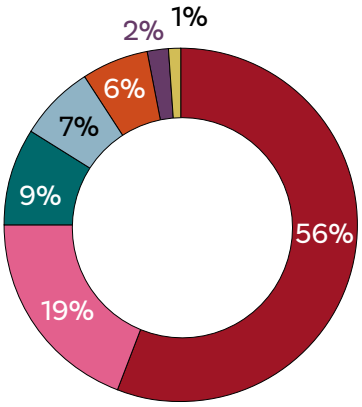
Note: Another four staff were on parental leave as at 30 June 2024.



Gender

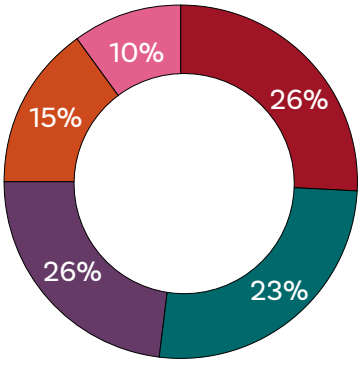
- Female
- Male

Note: Four staff were on parental leave as at 30 June 2024.



Ethnicity

- NZ European
- Asian
- Pacific
- Māori
- Other European
- Undeclared
- Other



Age

- 21-30
- 31-40
- 41-50
- 51-60
- 60+

Other ways we support the safety and wellbeing of staff include:

- Offering Employee Assistance Programme (EAP) confidential counselling services;
- Offering influenza vaccinations;
- Providing sit/stand desks at work;
- Supporting staff to develop and implement wellbeing initiatives;
- Populating our staff intranet with useful tips and guidance on self-care and wellbeing initiatives;
- Having an 'anti-harassment' policy and a zero-tolerance approach to any forms of harassment or bullying;
- Promoting and expecting staff to comply with the State Services Standards of Integrity and Conduct;
- Having our health and safety committee meet regularly to discuss staff health and safety concerns and initiatives and address issues that arise during the year;
- Having 'health and safety' as a regular agenda item for the executive leadership team; and
- Encouraging staff to raise concerns with health and safety representatives.

Recruitment, selection, and induction

Our recruitment policy and practices ensure that the best qualified people are recruited using the principles of equal employment opportunities. In 2023/24 we refined the recruitment system to improve efficiency, reporting, and the candidate experience by moving it online.

We have a comprehensive induction process, and we undertake a fresh eyes survey to obtain feedback from new staff on how we could further improve this process. In 2023/24 we revised our induction training to add a cultural capability component and explored how to support staff understanding of quality and safety and how to make effective recommendations.

Remuneration, recognition, and conditions

HDC has systems and processes in place to ensure that staff who are in the same job band are remunerated fairly and equitably. In May 2024 HDC updated our action plan under Kia Toipoto, the Public Service Commission's Public Service Pay Gaps Action Plan. In 2023/24 work to support pay equity included enhancing pay information transparency, continuing to monitor and report on pay equity, and progressing the development of an improved personnel strategy, including criteria for determining salaries.

Our remuneration is based on position accountability and market movement, while considering affordability. We recognise our people's achievements in several ways, including at weekly all-staff pānui, directly by managers, and through other channels such as internal newsletters and on the HDC intranet.

We support professional development through a co-designed performance objective-setting process. Ongoing professional development for employees is encouraged, and financial assistance and/or study leave may be granted by the Commissioner. We also provide acting-up and internal secondment opportunities to promote the development of our staff.

We offer long-service leave in addition to standard leave to acknowledge the commitment and dedication of our long-serving staff. To contribute to staff wellbeing, discretionary leave days can be provided to staff between Christmas and New Year.

The Health and Disability Commissioner is a Crown entity and is required to disclose certain remuneration information in its annual reports. The information reported is the number of employees receiving total remuneration of $100,000 or more per annum. During the year ended 30 June 2024, one employee received compensation and other benefits in relation to cessation totalling $16,000 (2023: $7,555).

Remuneration of employees over $100,000 per annum

Total remuneration paid or payable:	Actual 2024 No. of employees	Actual 2023 No. of employees
$100,000-$109,999	10	7
$110,000-$119,999	7	5
$120,000-$129,999	8	4
$130,000-$139,999	1	3
$140,000-$149,999	3	-
$150,000-$159,999	3	4
$160,000-$169,999	3	-
$170,000-$179,999	1	1
$190,000-$199,999	-	2
$200,000-$209,999	2	-
$230,000-$239,999	-	1
$240,000-$249,999	1	-
$250,000-$259,999	1	-
$260,000-$269,999	3	4
$370,000-$379,999	-	1
$380,000-$389,999	1	-
Total	44	32

In accordance with the disclosure requirements of sections 152(1)(a) of the Crown Entities Act 2004, the total remuneration paid to the Commissioner during the year from 1 July 2023 to 30 June 2024, including all benefits, is $384,147 (2023: $376,600).

Processes and technology

Technology

HDC proactively manages its IT security arrangements using specialised support as required. Key technology solutions are reviewed regularly, data is backed up frequently, and the IT disaster recovery plan is tested annually. We have a rolling programme of work to review and enhance systems to meet the organisation's requirements and enhance staff experience and productivity. We continue to make investments in our technology to support a 'paperless' working process and hybrid working arrangement.

While HDC has a secure and reliable internal IT platform, an external review of our IT infrastructure found that our digital case management system is out-dated, which creates significant additional time and manual 'workarounds' for staff when managing complaints, as well as obstacles for our interactions with consumers and providers. We will be exploring ways in which we can invest in a new case management system in 2024/25.

In the meantime, we continue to work on technological initiatives where possible that may result in greater efficiency and improve staff satisfaction. At the beginning of 2023/24 we migrated the email system from Lotus Notes to Microsoft Outlook 365. We have also worked to implement SharePoint, to support staff collaboration and communication. We have implemented a new phone system to improve integration with other software applications and a new cybersecurity training platform to strengthen our staff knowledge and awareness on security matters.

Sustainability

We work to reduce our impact on the environment[5] and reduce costs. This includes the use of a recycling programme and review of consumables purchased with a focus on reducing packaging waste; buying locally where possible; close monitoring and reduction of travel; encouraging staff to use public transport where appropriate; and purchasing environmentally friendly products and services where possible.

Physical assets and structures

We manage our assets cost-effectively. For example, we upgraded the memory for appropriate laptops where possible to meet new software requirements instead of purchasing new laptops. We continue to review business requirements for the future and improve the usability of existing workspaces and physical resources. We maintain and care for our assets to ensure that we maximise their useful life.

> **We continue to review business requirements for the future and improve the usability of existing workspaces and physical resources.**

[5] *HDC is not on the Carbon Neutral Government Programme participant list.*

6

Statement of Performance
Tauāki whakatutukitanga

6.1 Output Class — Complaints Resolution

Financial Performance for the year ended 30 June

	Actual 2024 ($000)	Budget 2024 ($000)	Actual 2023 ($000)
Revenue	12,981	12,692	12,269
Expenditure	13,075	13,290	12,403
Net surplus/(deficit)	(94)	(598)	(134)

Output 6.1.1 — Complaints Management (HDC)

Output and Assumptions	Performance Measures and Targets	Actual Performance
Efficiently and appropriately resolve complaints *(which contributes to achievement of Strategic Objective 2)*.	Assume 3,200–3,400 complaints will be received.	3,628 complaints were received (2023: 3,353).
	Close an estimated 2,700–3,000 complaints. The above figure includes an estimated 180–200 investigations.	3,148 complaints were closed, including 154 investigations (2023: 3,048 complaints closed, including 156 investigations). Target achieved.
	Manage complaints so that of closed complaints: • At least 60% are closed within 3 months • At least 80% are closed within 12 months • At least 95% are closed within 24 months	• 70.7% of closed complaints were closed within 3 months (2022: 66.5%). Target achieved. • 80.5% of closed complaints were closed within 12 months (2022: 74.9%). Target achieved. • 90.9% of closed complaints were closed within 24 months (2022: 93.5%). Target substantially achieved.
	Manage complaints so that of open complaints: • No more than 7–9% are over 24 months old	There were 2,822 open files at 30 June 2024. • 20.4% (575)[6] of open complaints were over 24 months old (2023: 11.4%). Target not achieved.

[6] *Around 64% of complaints received are closed within 6 months. However, our assessment processes are thorough, and more complex and serious complaints can take time to resolve. As noted previously, HDC has a backlog reduction plan, and we are prioritising our resources towards reducing our aging profile of complaints and addressing urgent matters. Please note that the cohort of complaints aged over 2 years is now starting to show the impact of an unanticipated 25% increase in complaints in 2021/22.*

Output and Assumptions	Performance Measures and Targets	Actual Performance
Supporting timely and appropriate resolution pathways (HDC) *(which contributes to achievement of Strategic Objective 2).*	Use HDC's levers effectively and appropriately to resolve complaints. Report on: • % of complaints referred for resolution directly between the parties • # of complaints in which recommendations are made • # of complaints notified • # of hui ā-whānau completed (Director Māori) Provide early notification of systemic and public safety issues to the Ministry of Health | Manatū Hauora, the Ministry of Disabled People | Whaikaha, Health NZ, Te Aka Whai Ora and/or other relevant agencies. Report on total number.	For the year ended 30 June 2024 • 35.6% (1,120[7]) of complaints closed were referred for resolution directly between the parties (2023:35%) • 236 complaints had recommendations made (2023:231) • 143 complaints were notified (2023:178) • 47 hui ā-whānau were completed (2023:26) For the year ended 30 June 2024, early notification of systemic issues was made to the Ministry and other relevant agencies on 354 occasions (2023:177).

Output 6.1.2 — Complaints Management (Advocacy Services)

Output and Assumptions	Performance Measures and Targets	Actual Performance
Supporting timely and appropriate resolution pathways (Advocacy Services) *(which contributes to achievement of Strategic Objective 2).*	Assume 2,600–3,100 complaints will be received.	2,455 new complaints were received by the Advocacy Service (2023: 2,857).
	Close an estimated 2,600 to 3,100 complaints.	2,402 complaints were closed by the Advocacy Service (2023: 2,980). Target not achieved.
	Manage complaints so that: • 80% are closed within 3 months • 95% are closed within 6 months • 100% are closed within 9 months	• 76% of complaints were closed within 3 months (2023: 76%). Target substantially achieved. • 96% of complaints were closed within 6 months (2023: 96%). Target achieved. • 99% of complaints were closed within 9 months (2023: 99%). Target substantially achieved.
Consumers and providers are satisfied with Advocacy's complaints management processes *(which contributes to achievement of Strategic Objective 2).*	Undertake consumer satisfaction surveys, with 80% of respondents satisfied with Advocacy's complaints management processes.	83% of consumers who responded to satisfaction surveys were either satisfied or very satisfied with the Advocacy complaints management process (2023: 95%). Target achieved.
	Undertake provider satisfaction surveys, with 80% of respondents satisfied with Advocacy's complaints management processes.	The provider satisfaction survey is on hold as the measure is under review to improve the response rate and the quality of information (2023: 95%). Target not achieved.

[7] *This includes complaints that are referred to the Advocacy Service to support the complainant to resolve their concerns with the provider.*

Output 6.1.3 — Proceedings

Output and Assumptions	Performance Measures and Targets	Actual Performance
On referral of a complaint from the Commissioner, a decision is made whether to take further action (including disciplinary or HRRT proceedings, or resolution by way of a restorative approach) where it is appropriate to do so *(which contributes to achievement of Strategic Objective 4).*	The Director makes decisions on complaints referred to its office. Report on: • The number of providers referred to the Director • The number of decisions made	9 new referrals relating to 13 consumers and 8 providers were received (2023: 21 referrals). 10 decisions to take proceedings were issued (2023: 4).
Proceedings are taken in the relevant forum (HPDT or HRRT) where the Director determines it warranted *(which contributes to achievement of Strategic Objective 4).*	The Director takes proceedings in the HPDT and HRRT in cases determined to be warranted.[8] In relation to both the HRRT and HPDT, report on: • Number of proceedings filed • Number of proceedings concluded • Outcome of proceedings concluded	HRRT proceedings • 1 HRRT proceeding was filed. • 2 HRRT proceedings were completed (declaration that the practitioner had breached the Code was made in both cases). HPDT proceedings • 2 HPDT proceedings were filed. • 1 HPDT proceeding was completed (professional misconduct finding made). (2023: 4 HPDT proceedings and 2 HRRT proceedings were concluded).

[8] *In 2023/24, HDC removed the quantitative measure, i.e. the success rate, which does not represent the nuanced nature of proceedings or how decisions are made by various tribunals.*

6.2 Output Class — Promotion and Education

Financial Performance for the year ended 30 June

	Actual 2024 ($000)	Budget 2024 ($000)	Actual 2023 ($000)
Revenue	1,911	1,966	1,901
Expenditure	1,925	2,059	1,921
Net surplus/(deficit)	(14)	(93)	(20)

Advocacy Output 6.2.1 — Access to Advocacy

Output and Assumptions	Performance Measures and Targets	Actual Performance
Network to promote awareness of the Code and access to the Advocacy Service in local communities *(which contributes to achievement of Strategic Objective 3).*	Advocates carry out 3,500 scheduled visits or meetings with community groups and provider organisations for the purpose of providing information about the Code, HDC, and the Advocacy Service.	For the year ended 30 June 2024, the Advocacy Service had carried out 3,075 networking visits across the motu (2023: 3,351). Target not achieved.
	At least 75% of these visits and meetings are focused on vulnerable consumers (including those in residential aged care and disability services, inpatient mental health services and prisons) and the family/whānau members who support them.	76% (2,359) of these visits were focused on vulnerable consumers (2023: 73.5%). Target achieved.

Output 6.2.2 — Advocacy Education

Output and Assumptions	Performance Measures and Targets	Actual Performance
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 3).*	Advocates provide an estimated 1,500 education sessions. Consumers and providers are satisfied with the education sessions.	For the year ended 30 June 2024, the Advocacy Service had delivered 1,151 education sessions across the motu[9] (2023: 1,314). Target not achieved.
	Seek evaluations on sessions, with 80% of respondents satisfied.	92% of survey respondents were satisfied with the education session they attended (2023: 91%). Target achieved.
Advocacy Services respond to enquiries from consumers, providers, and other agencies about the Act, the Code, and consumer rights under the Code *(which contributes to achievement of Strategic Objective 3).*	Provide responses to enquiries as requested.	For the year ended 30 June 2024, the Advocacy Service had responded to 20,518 enquiries (2023: 21,738).
	Report on the total number.	

[9] *The volume has reduced in recent years as rising costs have reduced the size and capacity of the Advocacy Service.*

Output 6.2.3 — HDC Education

Output and Assumptions	Performance Measures and Targets	Actual Performance
Respond to enquiries from consumers, providers, and other agencies about the Act, the Code, and consumer rights under the Code (HDC) *(which contributes to achievement of Strategic Objective 3).*	Provide responses to enquiries as requested. Report on the total number.	As at 30 June 2024, HDC had received 1,645 enquiries, and responded to 1,499 enquiries (2023: 2,768 were received and 2,246 were responded to).
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 3).*	Provide educational presentations. Report on total number.	During the year ended 30 June 2024, HDC provided 43 educational presentations (2023: 38).
	Monitor reach of online education modules for providers on the application of the Code. Report on number of **providers** who have completed the modules.	<u>Education modules</u> There are three online provider education modules. During 2023/24, 4,718 providers completed Module 1 about the Code, 4,184 providers completed Module 2 about informed consent, and 3,910 providers completed Module 3 about complaints management.
	Develop and implement promotional resources for **consumers,** including an online educational resource.	In September 2023, a whiteboard animated video was launched with the objective of increasing awareness of the Code and empowering individuals to exercise their rights. By 30 June 2024, the English version had garnered over 4,000 views, while the te reo Māori version had received 607 views, reflecting a 25% increase for both versions over the preceding three quarters. Both videos are equipped with closed captions in their respective languages. A plan to further amplify the reach and impact of these videos will be implemented in the upcoming financial year.

6.3 Output Class — System monitoring and impact

Financial Performance for the year ended 30 June

	Actual 2024 ($,000)	Budget 2024 ($,000)	Actual 2023 ($,000)
Revenue	1,506	1,637	1,583
Expenditure	1,517	1,714	1,600
Net surplus/(deficit)	(11)	(77)	(17)

Output 6.3.3 — System impact

Output and Assumptions	Performance Measures and Targets	Actual Performance
Use HDC complaints management processes to facilitate quality improvement *(which contributes to achievement of Strategic Objective 3).*	Make recommendations to improve quality of services, and monitor compliance with the implementation of recommendations by providers: • Providers make quality improvements as a result of HDC recommendations. Verify provider's compliance with HDC's quality improvement recommendations, with a target of 97% compliance.	During the year ended 30 June 2024, a total of 586 recommendations due for completion had been reviewed, of which: • 96.4% had been fully complied with (2023: 96.2%). Target substantially achieved. Of the 4% of recommendations that had not been complied with, the provider either refused to complete the recommendation or did not respond. Where appropriate, these matters were referred to the provider's professional body or governing body. The second leading cause for not complying with recommendations was because the recommendation was no longer practicable — either because the individual provider had ceased practising or because of logistical issues with implementing the recommendations. HDC continues to monitor recommendations that are overdue for response, and those that require further action/information from providers for full compliance.
Monitor complaint trends and provide regular reports to Health NZ and other stakeholders as relevant *(which contributes to achievement of Strategic Objective 3).*	Publish six-monthly complaint trend reports about hospital-level services provided by Health NZ districts.	Two six-monthly complaint trend reports were provided to Health NZ. Target achieved.
	Provide quarterly reports on complaints about assisted dying services to the Registrar (assisted dying).	Four quarterly reports on complaints received by HDC relating to assisted dying were provided to the Registrar. Target achieved.

Output and Assumptions	Performance Measures and Targets	Actual Performance
Engage with key sector stakeholders to promote the Code, share intelligence and insights relating to complaint trends, and collaborate on issues of shared concern *(which contributes to achievement of Strategic Objective 3).*	Maintain engagement with key stakeholders to share intelligence, collaborate on issues of shared concern and promote people's rights. Report on number of engagements.	During the year ended 30 June 2024, HDC undertook 373 engagements with key sector stakeholders (2023: 325). Target achieved.
	Provide briefings, and raise issues or make recommendations, suggestions, or submissions to any person or organisation in relation to the Code and/or trends identified through complaints. Report on activity.	During the year ended 30 June 2024, HDC made 15 submissions on various issues (2023: 17). Target achieved.
	Participate in the National Quality Forum with the purpose of sharing intelligence and collaborating with other agencies to implement systemic improvements. Report on activity towards achieving system impact quarterly.	During the year ended 30 June 2024, HDC attended four National Quality forums. Target achieved.
Review the HDC Act and Code to ensure fit for purpose in a transformed health system *(which contributes to achievement of Strategic Objective 3).*	Undertake review of Code and operation of HDC Act. Report on activity quarterly.	In 2023–2024, to support a review of the Code and the HDC Act, HDC identified and developed topics for review and sought public feedback on a consultation document. To develop topics for review, HDC undertook targeted engagement with over 150 stakeholders with expertise in their fields, including rangatira and Māori health and disability sector leaders; disabled people | tāngata whaikaha; tāngata whai ora | people with lived experience of mental distress and harm from substance use and gambling; consumer and provider groups; and regulatory organisations. HDC released the public consultation document on 30 April 2024, with submissions open until 31 July 2024 (and extensions granted until 13 August). Consultation material is available in accessible formats, Māori, and plain English. Submissions can be made in person/video conference, by email, or by online survey.
Make public statements and publish reports in relation to matters affecting the rights of consumers *(which contributes to Strategic Objective 2).*	Produce and publish key Commissioner decision reports and related articles on the HDC website. Report on total number. Work with the media to generate 200 media stories on HDC decision reports or other matters of public interest that affect consumer rights.	During the year ended 30 June 2024, HDC published 107 decisions on the website (2023: 96). During the year ended 30 June 2024, HDC issued 112 media releases, with 1,440 stories generated from the releases (2023: 103 media releases and 715 media stories generated). Target achieved.

6.4 Output Class — Focus populations

Financial Performance for the year ended 30 June

	Actual 2024 ($,000)	Budget 2024 ($,000)	Actual 2023 ($,000)
Revenue	3,708	3,688	3,565
Expenditure	3,729	3,906	3,645
Net surplus/(deficit)	(21)	(218)	(80)

Output 6.4.1 — Māori

Output and Assumptions	Performance Measures and Targets	Actual Performance
Promote awareness of, respect for, and observance of, the rights of consumers and how they may be enforced *(which contributes to achievement of Strategic Objective 2).*	Partner with other agencies to raise awareness of consumer rights and reduce barriers to resolving complaints for Māori, Pasifika, and other focus communities. Report on activity.	In the 2023/24 year, we developed our relationships with external stakeholders across the country to raise awareness of HDC consumer rights. External stakeholder relationships were established with Kaupapa Māori providers who provide health and disability services, including regulatory authorities, Ministry of Health Māori Health team, public and private health and disability service providers, as well as community social service providers. Through these relationships we took the opportunity to share our tikanga-led complaints process in support of reducing barriers to resolving complaints for Māori and to empower all consumers' understanding of the Code. In addition, HDC delivered a tikanga-led process for the HDC Act and Code review. This tikanga-led process strengthened meaningful engagement and provided space for whānau voice and whānau experience to be heard to influence service improvement. We continue to support whānau and communities to build confidence to advocate on their own behalf directly with providers in the first instance.

Disability Output 6.4.2 — Disabled people | tāngata whaikaha

Output and Assumptions	Performance Measures and Targets	Actual Performance
Promote awareness of, respect for, and observance of, the rights of disability services consumers *(which contributes to achievement of Strategic Objective 2).*	Publish on the HDC website (and make accessible to people who use 'accessible software') educational resources that are written in plain language for disability services consumers and disability services providers. Report on number of resources published.	During the year ended 30 June 2024, 13 new accessible formats of resources were developed for disability services consumers and disability services providers and 2 easy read booklets were updated — making a total of 15 accessible resources (2023: 5). Target achieved.
Monitor complaint trends in relation to disability and collaborate with other agencies to protect and promote the rights of disability services consumers *(which contributes to achievement of Strategic Objectives 3 and 4).*	Develop a monitoring framework to measure the performance of the health and disability sector in relation to disabled people | tāngata whaikaha. Report on activity.	Complaints about disability service providers continued to be monitored monthly. HDC undertook work to produce a report detailing the trends in complaints about residential disability support. The report makes several recommendations towards monitoring and improving the quality of support provided. The report was published on 17 July 2024 and HDC will be monitoring the implementation of its recommendations. HDC is also working with relevant agencies on a collaborative approach to a monitoring framework — including engaging with the Ministry of Disabled People | Whaikaha (as funders and disability systems stewards), the Independent Monitoring Mechanism, and disability support providers.
	Maintain engagement with key sector stakeholders to share intelligence, ensure timely action is taken in response to public safety concerns, collaborate on areas of shared concern and promote the rights of disabled people | tāngata whaikaha. Report on number of engagements and who we are engaging with.	During the year ended 30 June 2024, the Deputy Commissioner, Disability held 76 engagements with sector stakeholders (2023: 89). Target achieved.

Output Class 6.4.3 — Older people

Output and Assumptions	Performance Measures and Targets	Actual Performance
Provide strategic oversight and leadership to drive quality of care improvements for older people *(which contributes to achievement of Strategic Objective 4).*	Develop effective relationships with stakeholders and monitor sector performance. Report on activity.	During the year ended 30 June 2024, the Aged Care Commissioner had undertaken 123 stakeholder engagements with a wide range of stakeholders to keep informed about service issues and trends. These relationships support her mandate of quality improvement of health and disability services for older people (2023: 85). Target achieved.
Monitor the performance of health and disability services for older people and identify emerging issues and priorities *(which contributes to achievement of Strategic Objective 4).*	Test and implement an approach to, and framework for, monitoring and reporting on the performance of the sector in relation to older people's health and disability services. Report on activity. Complete a monitoring report on the performance of health and disability services for older people, with a particular focus on equity.	Priority issues for the Aged Care Commissioner and associated recommendations for the sector are outlined in the inaugural Aged Care Commissioner's report, released on 7 March 2024. A draft monitoring approach[10] is being created for the 20 recommendations in the report, which will be updated regularly. Target achieved.

[10] *The framework will be completed by November 2024, and we will report against 6–12 monthly progress from 2024/25 onwards. A policy think-piece (finalised in August) has been developed on the recommendation to increase hearing aid funding and subsidy schemes across government, alongside engagement with agencies responsible for these schemes — ACC leadership, the Ministry of Disabled People | Whaikaha portfolio managers, the aged-care sector, eg, CE of the NZ Hearing Industry Association, and academia (audiology professor at University of Auckland).*

Output and Assumptions	Performance Measures and Targets	Actual Performance
Provide enhanced advocacy on behalf of older consumers and their whānau and support commitments to Te Tiriti o Waitangi.	Actively engage with older consumers and their whānau from all communities and reflect their perspectives in the Aged Care Commissioner's work. Report on number of engagements.	During the year ended 30 June 2024, 123 engagements were held with older people, their whānau and stakeholders working on older people's health and wellbeing. These included meetings with a diverse range of older people's groups and making visits to, and speaking with, people living in aged residential care (ARC) facilities (2023: 104). Target achieved.
	Make submissions, recommendations, and public statements on issues of relevance to the Aged Care Commissioner's role. Report on total number.	During the year ended 30 June 2024, the Aged Care Commissioner team made 4 submissions, 20 recommendations (published in the March 2024 report), and 27 public statements (outlined elsewhere in this report). The following are examples of this work: • Made a submission to the Law Commission on its second issues paper on adult decision-making capacity law • Presented to the Dementia Mate Wareware Leadership Network on issues outlined in our submission • Made a public statement to bring attention to Elder Abuse Awareness Day Target achieved.
	Develop meaningful and authentic advocacy partnerships with kaumātua, whānau, hapū, and iwi. Report on activity.	The Director Māori | Kaitohua Mātāmua Māori and the Aged Care Commissioner held engagements with kaumātua across Aotearoa New Zealand with visits to stakeholders in Tāmaki Makaurau | Auckland and Te Tairāwhiti | Gisborne in Quarter 4. Engagements included Ngāti Whatua Ōrakei and Eastcliffe Retirement Village, including kaumātua; Ngāti Kahungungu kaumātua — Wairoa and Ngāti Porou leadership — Tairāwhiti. Target achieved.

The following tables set out the assessment of our performance against the targets set out in the Statement of Performance Expectations. The following grading system has been used:

Criteria	Rating
On target or better	Achieved
<5% away from target	Substantially achieved
>5% away from target	Not achieved

7

Ngā tauākī pūtea
Financial statements

Statement of comprehensive revenue and expense for the year ended 30 June 2024

	Notes	Actual 2024 $000	Budget 2024 $000	Actual 2023 $000
Revenue				
Funding from the Crown	2	19,701	19,701	18,944
Interest revenue	2	315	211	227
Other revenue	2	90	71	147
Total revenue		20,106	19,983	19,318
Expenditure				
Personnel costs	3	13,479	13,907	12,685
Depreciation and amortisation expense	8,9	143	161	174
Advocacy services		3,543	3,543	3,588
Other expenses	4	3,081	3,358	3,122
Total expenditure		20,246	20,969	19,569
Surplus/(deficit)		(140)	(986)	(251)
Total comprehensive revenue and expense		(140)	(986)	(251)

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 2024

	Notes	Actual 2024 $000	Budget 2024 $000	Actual 2023 $000
Assets				
Current assets				
Cash and cash equivalents	5	3,199	2,653	3,492
Receivables	6	15	20	21
Prepayments		181	60	148
Inventories	7	9	20	22
Total current assets		3,404	2,753	3,683
Non-current assets				
Property, plant, and equipment	8	279	279	293
Intangible assets	9	1	9	2
Total non-current assets		280	288	295
Total assets		3,684	3,041	3,978
Liabilities				
Current liabilities				
Payables	10	516	676	604
Employee entitlements	11	733	750	799
Total current liabilities		1,249	1,426	1,403
Total liabilities		1,249	1,426	1,403
Net assets		2,435	1,615	2,575
Equity				
Contributed capital	13	788	788	788
Accumulated surplus	13	1,647	827	1,787
Total equity		2,435	1,615	2,575

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 2024

	Notes	Actual 2024 $000	Budget 2024 $000	Actual 2023 $000
Balance at 1 July		2,575	2,601	2,826
Total comprehensive revenue and expense for the year		(140)	(986)	(251)
Balance at 30 June	13	2,435	1,615	2,575

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 2024

	Notes	Actual 2024 $000	Budget 2024 $000	Actual 2023 $000
Cash flows (used in)/from operating activities				
Receipts from the Crown		19,701	19,701	18,944
Interest received		315	211	233
Receipts from other revenue		95[11]	65	134
Payments to suppliers		(6,761)	(6,937)	(6,814)
Payments to employees		(13,545)	(13,907)	(12,643)
GST (net)		34	-	19
Net cash (used in)/from operating activities		(161)	(867)	(127)
Cash flows used in investing activities				
Purchase of property, plant, and equipment		(132)	(136)	(157)
Purchase of intangible assets		-	(10)	-
Net cash used in investing activities		(132)	(146)	(157)
Net increase/(decrease) in cash and cash equivalents		(293)	(1,013)	(284)
Cash and cash equivalents at beginning of the year		3,492	3,666	3,776
Cash and cash equivalents at end of the year	5	3,199	2,653	3,492

Explanations of major variances against budget are provided in Note 17.
The accompanying notes form part of these financial statements.

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

Notes to the financial statements

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1 Statement of accounting policies

Reporting entity

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

The financial statements for the Health and Disability Commissioner are for the year ended 30 June 2024, and were approved by the Commissioner on 18 October 2024.

Basis of preparation

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

Statement of compliance

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

The financial statements have been prepared in accordance with, and comply with, the PBE Standards RDR. The Health and Disability Commissioner is eligible for, and has elected to apply, the PBE Standards RDR because its expenses are less than $33 million and it does not have public accountability as defined by the External Reporting Board (XRB) A1 Application of the Accounting Standards Framework.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values other than related party transaction disclosures in Note 14 are rounded to the nearest thousand dollars ($000). The related party transaction disclosures are rounded to the nearest dollar.

New or amended standards adopted

The Health and Disability Commissioner has adopted the 2022 Omnibus Amendments to the PBE Standards, issued in June 2022.

The 2022 Omnibus Amendments issued by the XRB include several general updates and amendments to several Tier 1 and Tier 2 PBE accounting standards, effective for reporting periods starting 1 January 2023. The adoption of the revised PBE standards did not have any significant impact on the Health and Disability Commissioner's financial statements.

Summary of significant accounting policies

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

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

Goods and services tax (GST)

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

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

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

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

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

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

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

Critical accounting estimates and assumptions
In preparing these financial statements the Health and Disability Commissioner has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are evaluated continually and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are:

- Useful lives and residual values of property, plant, and equipment — refer to Note 8.
- Useful lives of software assets — refer to Note 9.
- Employee entitlements — refer to Note 11.

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

- Leases classification — refer to Note 4.

2 Revenue

Accounting policy

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

Funding from the Crown (non-exchange revenue)

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

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

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

Interest revenue

Interest revenue is recognised by accruing on a time proportion basis the interest due for the investment.

Sale of publications

Sales of publications are recognised as revenue 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 as revenue in proportion to the stage of completion at balance date.

Breakdown of interest revenue

	Actual 2024 $000	Actual 2023 $000
Other interest revenue	315	227
Total interest revenue	315	227

Breakdown of other revenue

	Actual 2024 $000	Actual 2023 $000
Sale of publications	49	67
Advocacy Trust contribution to IT costs	19	59
Sundry revenue	22	21
Total other revenue	90	147

3 Personnel costs

Accounting policy

Defined contribution schemes

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

Breakdown of personnel costs

	Actual 2024 $000	Actual 2023 $000
Salaries and wages	13,219	12,349
Defined contribution plan employer contributions	326	293
Increase/(decrease) in employee entitlements	(66)	43
Total personnel costs	**13,479**	**12,685**

4 Other expenses

Breakdown of other expenses and further information

	Actual 2024 $000	Actual 2023 $000
Advertising	13	17
Audit fees	61	56
Clinical and legal advice	450	460
Communications & IT	791	840
Educational publication & eLearning	74	124
Write-off of property, plant, and equipment	-	5
Operating lease expense	887	719
Policy and operational consultancy	174	276
Staff travel and accommodation	107	130
Other expenses	524	495
Total other expenses	3,081	3,122

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 2024 $000	Actual 2023 $000
Not later than one year	978	853
Later than one year and not later than five years	4,042	3,724
Later than five years	184	1,036
Total non-cancellable operating leases	5,204	5,613

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

A significant portion of the total non-cancellable operating lease commitment relates to the lease of these two offices and office equipment (2023: two office leases and office equipment). The Auckland office lease expires in October 2029 and the Wellington office lease expires in June 2029. Both leases have an option to vacate the premises at the end of the current leases.

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 2024 $000	Actual 2023 $000
Cash on hand and at bank	3,199	3,492
Total cash and cash equivalents	3,199	3,492

As at 30 June 2024, the Health and Disability Commissioner holds no unspent grant funding received that is subject to restrictions (2023: nil).

6 Receivables

Accounting policy

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

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

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

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

The allowance for credit loss in 2024 is $2,472 (2023: $4,173).

	Actual 2024 $000	Actual 2023 $000
Trade receivables	17	25
Less: allowance for credit loss	(2)	(4)
Total receivables	15	21
Total receivables comprise:		
Receivables from the sale of goods (exchange transactions)	15	21

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 2024 $000	Actual 2023 $000
Commercial inventories		
Publications held for sale	9	22
Total inventories	9	22

The write-down of inventories in 2024 amounted to $1,853 (2023: $2,244).

8 Property, plant, and equipment

Accounting policy

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

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

Leasehold improvements	3 years	33%
Furniture and fittings	5 years	20%
Office equipment	5 years	20%
Motor vehicles	5 years	20%
Computer hardware	4 years	25%
Communication equipment	4 years	25%

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

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

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

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

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

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

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

	Computer Hardware $000	Comms equip $000	Furniture and fittings $000	Leasehold improvements $000	Office $000	Total $000
Cost						
Balance at 1 July 2022	913	12	213	675	81	1,894
Balance at 30 June 2023	997	16	239	681	79	2,012
Additions	70	1	56	-	-	127
Disposals	-	-	(28)	-	(16)	(44)
Balance at 30 June 2024	1,067	17	267	681	63	2,095
Accumulated depreciation						
Balance at 1 July 2022	664	9	194	673	68	1,608
Balance at 30 June 2023	746	13	208	677	75	1,719
Depreciation expense	115	4	17	2	4	142
Disposals	-	-	(29)	-	(16)	(45)
Balance at 30 June 2024	861	17	196	679	63	1,816
Carrying amounts						
At 1 July 2022	249	3	19	2	13	286
At 30 June 2023/1 July 2023	251	3	31	4	4	293
At 30 June 2024	206	-	71	2	-	279

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

During the year, the Health and Disability Commissioner disposed of some furniture and fittings that had reached the end of its useful life. The net loss on all disposals was nil (2023: $4,851).

There were no capital commitments for the acquisition of property, plant, and equipment at balance date (2023: nil).

9 Intangible assets

Accounting policy

Software acquisition and development

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

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset where this results in an asset controlled by the Health and Disability Commissioner. Direct costs include software development, employee costs, and an appropriate portion of relevant overheads.

Where software is provided under a Software-as-a-Service (SaaS) arrangement, costs of configuration and customisation are recognised as an intangible asset only if the activities create an intangible asset that the Health and Disability Commissioner controls and asset recognition criteria are met. Costs, including ongoing fees for use of software, that do not result in an intangible asset or a software finance lease are expensed as a service contract as incurred. However, where fees represent payment for future services to be received, the Health and Disability Commissioner recognises these as a prepayment and expenses these as subsequent services as received.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are expensed when incurred.

Costs associated with developing and maintaining the Health and Disability Commissioner's website are expensed when incurred.

Amortisation

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

The useful life and associated amortisation rate of the major class of intangible assets has been estimated as follows:

Computer software	3 years	33%

Movements for each class of intangible asset are as follows:

	Acquired software $000	Total $000
Cost		
Balance at 1 July 2022	766	766
Balance at 30 June 2023/1 July 2023	766	766
Additions	-	-
Balance at 30 June 2024	766	766
Accumulated amortisation		
Balance at 1 July 2022	740	740
Balance at 30 June 2023/1 July 2023	764	764
Amortisation expense	1	1
Balance at 30 June 2024	765	765
Carrying amounts		
At 1 July 2022	26	26
At 30 June 2023/1 July 2023	2	2
At 30 June 2024	1	1

There were no capital commitments for the acquisition of intangible assets at balance date (2023: nil).

10 Payables

Accounting policy

Short-term payables are recorded at their face value.

Breakdown of payables

	Actual 2024 $000	Actual 2023 $000
Payables under exchange transactions		
Creditors	94	200
Accrued expenses	114	147
Total payables under exchange transactions	208	347
Payable under non-exchange transactions		
Taxes payable (GST, PAYE and rates)	308	257
Total payables under non-exchange transactions	308	257
Total current payables	516	604
Total payables	**516**	**604**

11 Employee entitlements

Accounting policy

Short-term employee entitlements

Employee benefits that are expected to be settled wholly before 12 months after the end of the reporting period that the employees provide the related service in 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 but not yet taken at balance date.

Breakdown of employee entitlements

	Actual 2024 $000	Actual 2023 $000
Current liability		
Annual leave	733	799
Total employee entitlements	733	799

12 Contingencies

Contingent liabilities

As at the reporting date there were no contingent liabilities (2023: nil).

Contingent assets

The Health and Disability Commissioner has no contingent assets (2023: 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 2024 $000	Actual 2023 $000
Contributed capital		
Balance at 1 July	788	788
Balance at 30 June	788	788
Accumulated surplus		
Balance at 1 July	1,787	2,038
Surplus/(deficit) for the year	(140)	(251)
Balance at 30 June	1,647	1,787
Total equity	2,435	2,575

14 Related party transactions

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

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

Key management personnel compensation

	Actual 2024	Actual 2023
Leadership Team		
Remuneration ($)	2,715,631	2,674,012
Full-time equivalent members	11.62	11.67

15 Financial instruments

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

	Actual 2024 $000	Actual 2023 $000
Financial assets measured at amortised cost		
Cash and cash equivalents	3,199	3492
Receivables	15	21
Total financial assets measured at amortised cost	3,214	3,513
Financial liabilities measured at amortised cost		
Payables (excluding taxes payable)	208	348
Total financial liabilities measured at amortised cost	208	348

16 Events after the reporting date

There were no significant events after the reporting 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 interest revenue was higher than budgeted due to a higher interest rate.

Total expenditure

Personnel costs were lower than budgeted due to holding staff vacancies during the year.

Other expenses were lower than budgeted mainly because the preparation of public consultation for the Act and Code review was completed with in-house resources.

Statement of Financial Position

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

Statement of Changes in Equity

The closing equity balance was higher than budgeted because of the lower than budgeted deficit.

Statement of Cash Flows

The higher net cash movement was mainly as a result of the favourable variances in interest revenue, personnel costs, and other operating expenses noted above.

8

Tauāki kawenga
Statement of Responsibility

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

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

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Health and Disability Commissioner for the year ended 30 June 2024.

Morag McDowell
Health and Disability Commissioner

Jason Zhang
Corporate Services Manager

18 October 2024

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Pūrongo ōtita
Auditor's report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Health and Disability Commissioner's financial statements and performance information for the year ended 30 June 2024

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

Opinion

We have audited:

- the financial statements of the Health and Disability Commissioner on pages 88 to 103 that comprise the statement of financial position as at 30 June 2024, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information which reports against the Health and Disability Commissioner's statement of performance expectations and appropriation for the year ended 30 June 2024 on pages 16 to 25 and 78 to 87.

In our opinion:

- the financial statements of the Health and Disability Commissioner:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2024; 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 Health and Disability Commissioner's performance information for the year ended 30 June 2024:
  - presents fairly, in all material respects, for each class of reportable outputs:
    - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
  - presents fairly, in all material respects, for the appropriations:
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred as compared with the expenses or capital expenditure appropriated or forecast to be incurred; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 18 October 24. This is the date at which our opinion is expressed.

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

Basis for our opinion

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

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

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

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

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

In preparing the financial statements and the performance information, the Health and Disability Commissioner is responsible for assessing the Crown Entity's ability to continue as a going concern. The Health and Disability Commissioner is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the Crown Entity, or there is no realistic alternative but to do so.
The Health and Disability Commissioner 's responsibilities arise from the Crown Entities Act 2004 and the Public Finance Act 1989.

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

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

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health and Disability Commissioner's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Health and Disability Commissioner.
- We evaluate the appropriateness of the reported performance information within the Health and Disability Commissioner's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Health and Disability Commissioner and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Crown Entity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health and Disability Commissioner to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Health and Disability Commissioner is responsible for the other information. The other information comprises the information included on pages 2 to 15, 26 to 77, and 104, 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 (including International Independence Standards) (New Zealand) (PES 1) issued by the New Zealand Auditing and Assurance Standards Board.

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

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

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

Whakakotahi ai kia tipu,
kia hua, kia puāwai

Working together we will grow,
flourish and prosper

HEALTH & DISABILITY COMMISSIONER
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