

## **How does the HDC Code apply in the context of delays?**

There is no doubt that currently the health and disability sector is under significant pressure. This pressure, together with issues introduced by the COVID-19 pandemic, has been reflected in an unprecedented increase in complaints to HDC. HDC received a 25% increase in complaints in the 2021/22 financial year, and complaint volumes continue to be high in the current year to date.

A number of these complaints reflect concerns by people about delays in care, constrained access to services, and inadequate communication in the context of these delays. Complaints highlight the impact that delays in care can have on people, both physically and psychologically, particularly where their health is deteriorating and there is a lack of certainty about when care will be received.

### **Application of the Code in the context of delays**

My role as the Health and Disability Commissioner is to promote and protect the rights of people using health and disability services, as set out in the Code of Health and Disability Services Consumers' Rights (the Code). The Code gives people a number of rights, including the right to care of an appropriate standard that meets their needs and upholds their dignity and mana; freedom from discrimination; effective communication; the information they need to make an informed decision and give their informed consent; and to complain about the services they receive. The Code places corresponding duties and obligations on providers, and is enforceable by law.

The Code states that a provider is not in breach of the Code if the provider took reasonable actions in the circumstances to give effect to the rights and comply with the duties in the Code. Circumstances in this context include the consumer's clinical circumstances and the provider's resource constraints. The onus is on the provider to prove that it took reasonable actions. When assessing complaints, HDC invariably takes into consideration the relevant broader circumstances and context within which the care occurred.

### **An appropriate standard of care**

The Code does not give people the right to access services, and HDC cannot compel care to be provided to someone. However, providers do owe people waiting for services a duty of care, and the care that is provided must be of an appropriate standard (Right 4), and must minimise potential harm to them and optimise their quality of life (Right 4(4)). This includes minimising delays and providing care within acceptable timeframes where possible, particularly for care that is time-dependent. It is also expected that providers assess and prioritise people on a wait list appropriately, to ensure that those with greater acuity and need are seen first — that is, that prioritisation systems are fair and effective.

Below I outline some cases in which HDC found providers in breach of Right 4 of the Code (an appropriate standard of care) in respect of care delays.

Recently I found Te Whatu Ora Southern (formerly Southern DHB) in breach of Right 4(4) of the Code for delays in the provision of non-surgical cancer services between 2016 and 2022.<sup>1</sup> Due to poor clinical governance systems, including inadequacies in quality measures and indicators, and poor relationships between clinicians and executive leadership, Te Whatu Ora Southern failed to recognise and adequately respond to the clinical risk associated with lack of capacity and consequent delays within its non-surgical cancer service. As a result, people with cancer were harmed. In respect of this case, I commented:

‘Providers owe a duty of care to people waiting for resource constrained specialist procedures, particularly when the intervention is time-critical ... [A]n effective accountability and performance framework where patients are the focus and patient safety concerns are signalled, acted upon and evaluated is a vital component of quality and risk management ... This case is a salutary reminder of the detrimental physical and psychological outcomes for patients when the system does not adequately provide for timely cancer care.’

I also found a district in breach of Right 4(1) of the Code for a failing to provide care with reasonable care and skill in relation to not ensuring that radiology reporting was completed in an acceptable timeframe.<sup>2</sup> In this case there was a delay of 11 days before a chest X-ray image, which showed a mass, was reviewed and reported on by a radiologist. In respect of this case, I noted:

‘I am, of course, aware of the pressure radiology services are under at a national level due to increase in demand paired with workforce shortages and recruitment challenges. Fundamentally, however, it is my view that healthcare consumers have the right to expect X-rays to be read in fewer days than occurred in this case. That such delays are common does not excuse the delays, and I am concerned that if a culture of tolerance of unacceptable delays develops across DHBs, this will become normalised and patients will be put at risk. The passage of time between seeing a patient and reviewing a radiology report does not support good clinical decision-making, and the timely reporting of radiology results is a critical systems issue.’

Deputy Health and Disability Commissioner Dr Vanessa Caldwell found a DHB in breach of Right 4(1) of the Code for delays by the ophthalmology service in providing care to a six-year-old boy with symptoms of reduced vision.<sup>3</sup> Because of the long delays, the boy’s family sought care privately, and he was diagnosed with a brain tumour. In particular, the Deputy Commissioner was concerned that both his referrals were graded incorrectly by an orthoptist without the direct supervision of an ophthalmologist and in the absence of appropriate guidelines, and that the DHB failed to meet Ministry of Health timeframes for a first specialist appointment (FSA). While

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<sup>1</sup> 22HDC01310.

<sup>2</sup> 20HDC00717.

<sup>3</sup> 20HDC00116.

the Deputy Commissioner acknowledged the pressure on ophthalmology services and the associated workforce shortages, she noted that provider accountability to address these issues is not removed by systemic pressures. She also raised concerns that this was not the first time HDC had investigated delays in this ophthalmology service. The Deputy Commissioner commented in respect of this case:

‘I am very critical of the length of time it took for Master A to be seen at the DHB for an FSA, noting that Master A’s symptoms could well have been indicative of a health issue that was time sensitive ... It is concerning that in order to receive treatment within a reasonable timeframe, Master A’s family had to seek care privately.’

### **Communication with consumers about delays**

Right 6(1)(c) of the Code gives people the right to information that a reasonable consumer, in that consumer’s circumstances, would expect to receive, including information regarding the estimated time within which services will be provided.

In the current environment, where pressure on the system can often result in delays, proactive, transparent communication is important for managing patient expectations. Waiting for care can be an anxious time for patients and their whānau, and complaints often reflect their frustration with a lack of information about reasons for delays and time-frame expectations. It is important that consumers are provided with information about reasons for delays, any alternative options for care, and estimated timeframes. Clear safety-netting advice is also important in this context, with patients needing accessible information about when to contact their health professional while waiting for care.

For example, regarding cancer care delays at Southern DHB, I was critical of the level of communication and support provided to people on the waitlist. In that case, patients and their whānau would have benefited from a more consumer-centric approach to communication that included a single point of contact within the district to ensure that patients were well informed and supported, and knew what to do if their circumstances changed.

### **Conclusion**

The Code is the benchmark for consumer-centred care in Aotearoa New Zealand. I am very cognisant of the current pressures on the health and disability system and its workforce, and have been impressed by the dedication providers continue to show in providing high quality, consumer-centred care in spite of these pressures. Notwithstanding such pressures, the Code remains of central importance in this context, and it is critical that we continue to guard against complacency or tolerance of delay, and the potential for patient harm. While I understand that the constraints on the system are complex and will take time to address, all people have the right to services that minimise the potential harm to them and optimise their quality of life.

**Morag McDowell, Health and Disability Commissioner**  
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