HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Home-care services provided to disabled woman

Decision 20HDC01093

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1. The Nationwide Health and Disability Advocacy Service referred a complaint to this Office relating to the care provided to Ms A by Healthvision New Zealand Limited (Healthvision) between July and December 2019. This report focuses on the issues encountered during Ms A's transition to Healthvision.

2. Ms A has a complicated health history, for which she receives 24/7 home care under an 'Integrated Home and Community Support'[1] service agreement with ACC. Healthvision has provided home-help services to Ms A since 2017, and from 15 July 2019 the service agreement was extended to include home-care services.

Referral

3. On 3 July 2019 Healthvision received an urgent ACC referral as Ms A's previous home-care service provider had terminated service provision on short notice. The referral was accepted on 4 July 2019. Healthvision said that it did not follow its standard intake assessment process because of the urgency of the situation, and it accepts that it could have been more proactive in demanding disclosure of health information before acceptance of the referral.

4. The referral stated that Ms A required 24/7 'general home help' and assistance with daily living activities, and that further details would be provided on 5 July 2019. Ms B, Ms A's rehabilitation nurse specialist, and Ms C, Ms A's social worker, told HDC that at the time of the referral, they flagged to Healthvision that Ms A was a complex client who needed experienced staff.

5. On 5 July 2019 a four-hour meeting was held with five Healthvision staff, Ms A, and Ms A's multidisciplinary team (MDT).[2] The following details were discussed:

- A summary of Ms A's clinical history;
- The staffing requirements to manage her care, including that staff needed a Level 5[3] NZQA qualification and that this was not a regular support worker role; and

[1] These services are intended to support clients to return to independence or reach their maximum level of participation in everyday life.
[2] The team included Ms C, Ms A's legal representative, Ms B, and two staff members from ACC.
[3] Level 5 refers to the NZQA tertiary qualification level that provides individuals with theoretical and/or technical knowledge and skills within specific fields of work or study. See Level descriptors for the NZQCF :NZQA for further information.

Names (except Healthvision, the clinical advisor, and ACC) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- That Ms A's current team of support workers would be transitioning from the previous home-care provider to Healthvision.

6. Healthvision provided HDC with conflicting information regarding the information shared with its service. Healthvision told HDC that it was provided with limited information about Ms A's condition, including that Ms A's Support Needs Assessment (SNA)[4] was not shared until 20 November 2019 and that her client records were not shared until October 2019. In contrast, Healthvision records show that the SNA was provided on 7 July 2017,[5] that is, at the time Ms A's home-help services commenced. In addition, the previous home-care provider emailed further documents to Healthvision on 14 July 2019, including handover documents, training-related material, and medication-related documents. Further, multiple meetings were held between Ms A's MDT and Healthvision to share care information between July and September 2019. However, ACC records show that Healthvision struggled with processing the 'volume of information and various sources it [came] from'.

7. Healthvision acknowledged that it could have been more proactive in demanding the disclosure of certain health information and support documentation prior to commencing service for Ms A. Healthvision stated that if it had received information in the early stages, it may not have accepted the referral in the first place, or alternatively, it would have been more prepared.

8. Healthvision did not complete a client service agreement, risk management plan, or support plan for Ms A. Healthvision stated that these documents had been drafted by its organisation, and, despite many attempts by its staff, Ms A never agreed to sign these documents, leaving Healthvision in a difficult position to provide support. In contrast, Ms A stated that the client service agreement was not provided to her until October 2019, and the risk management plan was not provided to her until late August 2019. Ms A stated that she had requested a copy of the service agreement multiple times at multiple meetings, and when it was provided in October 2019, she agreed to sign it, but she needed time to process it. In relation to the support plan, Ms A stated that this was never finalised or presented to her for signing.[6]

Staffing

9. HDC received conflicting information about how the support staff roster was managed. Ms A's SNA states that she has the tendency to take on the role of a staff coordinator, but 'it is important to remember that [Ms A] is the client'. Healthvision told HDC that Ms A wished to coordinate her own support arrangements, and it was restricted in its ability to manage staff changes or staff vacancies without Ms A's consent and agreement.

10. ACC records show that Ms A repeatedly expressed concerns to Healthvision regarding the day-to-day management of her affairs. In addition, she highlighted that there were gaps in

[4] This assessment helps to determine the client's strengths and injury-related needs and identify a range of strategies and options to address those needs.
[5] Further copies of the SNA were sent on 6 and 10 October 2019.
[6] Ms A's account is supported by Ms C and Ms B, who stated that they raised the issue of risk management and care plans with Healthvision during their meetings with Healthvision.

the staff roster, which led to her taking on the role of a staff coordinator, and the stress associated with this made her 'less able to sleep and cope'. Ms C, Ms A's physiotherapist, and Ms B, also advised Healthvision that Ms A had increased fatigue levels and that the transition to Healthvision had been overwhelming.

11. Healthvision considers that Ms A's support could have been provided by support workers with qualifications at NZQA Level 3, as Level 3 is considered a 'high level' for complex clients. Healthvision said that its ability to cover the roster fully was impacted by the exiting provider having pre-approved staff leave until December 2019, and by Ms A's requirements for Level 5 support workers, for staff to undertake 13-hour workdays, and for staff to work no more than three shifts per week.

12. In contrast, Ms A stated that these were not her requirements, but rather an 'assessed need'. Ms A's SNA states the need for 'experienced psychiatric assistants' and does not mention a requirement for an NZQA Level 5 qualification. However, statements from Ms C and Ms B demonstrate that the staffing requirements were in place to prevent staff burn-out. Further, Ms B told HDC that Ms A had a high risk for suicide and self-harm, and therefore support workers need to be able to evaluate these risks, and pre-empt and de-escalate issues. Ms B said that support workers with Level 2 and Level 3 qualifications are 'task driven' and do not have the critical-thinking skills to be able to care for Ms A.

13. Healthvision stated that on reflection it should have taken a more direct management role in terms of working with Ms A regarding her expectations around how staff arrangements were to be managed from the beginning.

Use of friends for overnight support

14. Ms A's SNA states that she requires active support overnight because of her tendency to awaken multiple times overnight, and a lack of such support overnight can lead to increased incidence of self-harm, suicidal intent, and self-neglect. In addition, Ms A needs the support of a mechanical bed to reduce her pain, and she uses a CPAP[7] machine, and these needs could not be met when staying away from her home. Ms A told HDC that the gaps in the staff roster led to her spending several nights a week with a friend (a natural support[8]) at her friend's home, which caused considerable stress and increased self-harm incidents.

15. HDC received conflicting information about the use of Ms A's friends for overnight support. ACC records show that there was an agreement in place to fund Ms A's friends for overnight support prior to Healthvision's service starting.[9] Similarly, Healthvision told HDC that a friend provided support to Ms A during the week of 1 July and 8 July based on Ms A's suggestion. However, ACC records show that on 2 August 2019 Ms C and Ms A told Healthvision that the use of friends for overnight support should be a fall-back option only. ACC records also show that between August and September,[10] repeated concerns were

[7] A machine used to treat sleep apnea (a sleeping disorder in which breathing stops and starts repeatedly). CPAP machines need regular maintenance and may require troubleshooting during the night.
[8] Natural supports are personal associations, relationships, and activities independent from formal services.
[9] Correspondence with Ms A and ACC dated 11 July 2019.
[10] On 2 August, 8 August, 9 August, 18 August, 22 August, 26 August, 27 August, and 29 August.

raised about Ms A having to stay with her friends. Multiple incidents forms[11] were also completed demonstrating self-harm following overnight stays;[12] however, Ms A said that Healthvision continued to send her to her friend's house.

16. ACC's guidelines on the use of natural supports state that it is appropriate to consider a natural support depending on the nature of the care and/or support, whether the tasks require medical expertise, and the capability of the natural support to undertake the required tasks.

Communication and complaint management

17. As stated above, there was a lack of communication regarding day-to-day affairs. Ms A said that communication from Healthvision to other providers was poor and made it difficult to put consistent and reliable supports in place. Ms C said that as many people were involved in Ms A's care, information did not get shared effectively or was missed and/or misinterpreted.

18. Healthvision also told HDC that the overall coordination and management of Ms A's health support was being managed by multiple parties, without one central coordinating party and, while it endeavoured to employ a client service manager, this was unsuccessful. However, Healthvision does not agree that communication from Healthvision to other providers was poor. It told HDC that it tried its best to meet Ms A's very high expectations and demands and that it seemed inevitable from the beginning that her expectations would not be possible to achieve.

19. On 6 September 2019 Ms A made a verbal complaint to Healthvision about her care. This was followed by three meetings with Healthvision.[13] Ms A said that it was agreed that Healthvision would take notes from the meetings, and this would form the basis of Ms A's formal complaint. However, Ms A recalled being told that she could not receive a copy of her complaint as it contained sensitive details about alleged wrongdoing by Healthvision staff, which could lead to staff disciplinary action. While Healthvision attempted to address Ms A's concerns, it appears that Healthvision did not understand the key issues raised by Ms A. In addition, Healthvision did not fully acknowledge the entirety of Ms A's complaint.

20. On 3 December 2019 Healthvision provided formal notification to ACC regarding the withdrawal of its home-care service to Ms A. Healthvision did not communicate the termination of the services to Ms A until 14 December 2019, that is, after Ms A was informed by her general practitioner that Healthvision was terminating its services. Ms A stated that this left her in a vulnerable position. Healthvision stated that it stands by its decision to exit from Ms A's support due to roster gaps and its inability to provide staff to whom Ms A would

[11] 23 July, 11 August, 19 August, 26 August, and 27 August.
[12] On one occasion, the self-harm event led to a serious injury and hospitalisation.
[13] Meetings were held on 25 September 2019, 2 October 2019 and 10 October 2019. The total time of these meetings equated to eight hours. Verbal meetings were held because Ms A experiences fatigue when reading and writing.

agree or accept. Healthvision stated that the health and safety risks arising were too great and were not capable of being resolved.

Independent clinical advice

21. Independent advice was received from disability expert Mr John Taylor (Appendix A). Mr Taylor identified several deficiencies in the care provided by Healthvision.

22. Mr Taylor advised that Healthvision's flawed intake process, sending Ms A to her friend's home overnight in the presence of the concerns raised by Ms A and her MDT, the failure to engage in open communication regarding the termination of services, and the management of Ms A's complaint represented severe departures from the accepted standards of care.

23. In addition, Mr Taylor advised that the lack of a client service agreement and lack of adherence to the Enabling Good Lives (EGL) principles[14] represented moderate departures.

24. Healthvision told HDC that EGL principles do not apply to ACC or ACC services and that none of its contract specifications reference these. It also told HDC that it does not agree with Mr Taylor's statement that Healthvision omitted relevant information. Healthvision considers that it had all appropriate policies and procedures in place at the relevant time.

Decision

25. Having reviewed all the information in this case, I consider that Healthvision breached Rights 4(2),[15] 4(3),[16] 5(2),[17] and 10(3)[18] of the Code of Health and Disability Services Consumers' Rights (the Code).

26. By accepting the ACC referral, Healthvision had a responsibility to provide care that was consistent with Ms A's needs. In my opinion, the lack of personalised care provided to Ms A resulted from the failure by Healthvision to assess Ms A's support needs adequately or set expectations with Ms A, at the point of referral. This resulted in a delayed recognition of Ms A's complex needs, leading to downstream consequences, including the failure to develop a timely and appropriate support plan and risk management plan, and a client service agreement that was personalised to Ms A's needs. This forms the basis of my Right 4(3) breach decision.

27. Secondly, Healthvision did not have an environment conducive to open communication. Specifically, Healthvision failed to address Ms A's concerns adequately relating to the use of friends for overnight support, and it failed to communicate the termination of its services to her openly. As recognised by Healthvision, these risks could have been mitigated somewhat

[14] Principles - Enabling Good Lives.
[15] Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
[16] Every consumer has the right to have services provided in a manner consistent with his or her needs.
[17] Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.
[18] Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

by the appointment of a central coordinator; however, this did not occur. For these reasons, I find that Healthvision breached Right 5(2) of the Code.

28. Thirdly, I find that Healthvision breached Right 4(2) of the Code for its lack of adherence to the EGL principles, ACC service agreement, and Home and Community Support Sector Standards, which stipulate the importance of person-centred care. This is evidenced by Healthvision's lack of understanding of the skill set necessary to care for Ms A. I acknowledge Healthvision's view that the EGL principles do not apply to ACC services; however, as reiterated by Mr Taylor, these principles have been adopted by ACC in delivering person-centred care to disabled people, and the need for compliance against relevant guidelines has been stipulated within the contract between ACC and Healthvision.

29. Finally, I find that Healthvision breached Right 10(3) of the Code for its failure to provide Ms A with a copy of her complaint and for its lack of acknowledgement of the entirety of Ms A's complaint, despite multiple extended meetings being held to discuss these concerns and Ms A repeatedly raising these concerns throughout her care.

Changes made

30. Healthvision stated that since the events it has made the following changes:

- It ensures that appropriate expectations are set in relation to the level of support staff being assigned to a client upon commencement; and
- It seeks to follow its usual intake process and ensure that it has an 'appropriate framework in place from the beginning prior to service commencement'.

Responses to provisional report

31. Healthvision was provided with a copy of the provisional report and given the opportunity to comment on the report. Healthvision told HDC that it accepted the findings and recommendations. However, it was disappointed with the length of time taken to conclude this investigation. Other comments have been included elsewhere in this report.

32. Ms A was provided with a copy of the provisional report and given the opportunity to comment on the report. Ms A stated that she is happy with the outcome and hopes that Healthvision will reflect on the findings with honesty and humility.

Recommendations

33. Further to the changes made by Healthvision, I recommend that Healthvision review its process for accepting referrals, including what information and assessment is necessary prior to accepting referrals. Evidence of this review, including any corrective actions, is to be provided to HDC within three months of the date of this report.

34. In addition, I recommend that Healthvision review its communication practices in light of this report. Evidence of this review, including any corrective actions, is to be provided to HDC within three months of the date of this report.

35. Lastly, I recommend that Healthvision provide a formal written apology to Ms A for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

Follow-up actions

36. An anonymised copy of this decision (naming only Healthvision, my clinical advisor, and ACC) will be placed on the HDC website (www.hdc.org.nz) for educational purposes and forwarded to the Ministry of Social Development, ACC, and Whaikaha.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Mr John Taylor:

'**Re: [Ms A]/Healthvision NZ — C20HDC01093**

I have been asked to provide an opinion on case number C20HDC01093 that relates to the care provided by Healthvision NZ to [Ms A] in 2019. I have read and agree to abide by the Commissioner's Guidelines for Independent Advisors.

I have the following qualifications and experience to fulfil this request.

Qualifications: MPhil (Distinction) in Disability Studies, Education and Evaluation; DipPGArts (Distinction) Social Work; BSc (in ethics and science); LTh.

Experience: 35 years of working within the disability sector including the following roles: direct support worker, agency management (over 15 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the MoH's New Model, National Leadership Team for Enabling Good Lives, a range of contracted roles and I have helped set up a number of support agencies and disability related businesses.

I have been asked to provide my opinion to the Deputy Health and Disability Commissioner as to whether I consider the care provided by Healthvision NZ was reasonable in the circumstances, and why.

The specific areas I have been asked to respond to are:

1. Whether services provided to [Ms A] by Healthvision NZ met acceptable standards.
2. Whether the management of [Ms A's] exit from Healthvision NZ's services was reasonable in the circumstances.
3. The appropriateness of Healthvision NZ's management of [Ms A's] complaint when she raised her concerns directly with the organisation.
4. Any other matters raised in the information provided that I consider warrant comment.

I have based my opinion on the information I have been provided which is listed below:

- Referral of complaint from the Nationwide Health and Disability Advocacy Service dated 22 June 2020, and accompanying letters of support.
- Healthvision NZ's response dated 5 August 2020, including appendices.
- [Ms A's] further comments dated 3 November 2020
- [Ms A's] comments on Healthvision NZ's response to the HDC complaint dated January 2021
- Extract from the ACC personal injury claim summary report

- Two meeting transcripts from the HDC Zoom meeting with [Ms A] held on 3 May 2021; one with and one without [Ms A's] amendments.

By way of preface to my ensuing comments, I will discuss these matters within the context of both acceptable practice and Enabling Good Lives principles as these are increasingly informing acceptable practice.

Enabling Good Lives was accepted as Government policy to guide the support provided to disabled people in 2012. As a result, disability support agencies need to constantly adjust their standards to match the greater level of control and choice disabled people and their families are, quite justifiably, asking for. This was also the case in 2019.

Executive summary

When I read through the material supplied it became evident that there are two very different versions of this situation being described by the two parties. One would normally expect a certain level of variation but, in this case, there are large areas where the views provided don't match at any point. Consequently, my opinion is rather lengthy in its discussion so I have provided this brief overview.

[Ms A] appears to me to be a person who has both complex support needs and a black and white way of processing information. The latter could well lead to misunderstandings. Healthvision NZ is a Home and Community Support agency that is probably used to working with relatively straightforward support situations, is probably not funded to build the infrastructure required to support situations such as [Ms A's] and appears to operate within standard business operating protocols.

As a result, this situation could serve as a primer on how the uncritical adoption of standard business practice fails when applied to disability support. It further provides an interesting case study as to why Enabling Good Lives came into being.

It is my opinion that Healthvision NZ's management had neither the skill nor the will to work with someone like [Ms A]. It appears that they completely underestimated what was required to support her well, failed to work with her and her supporters, and then exited from service provision with extremely short notice just prior to Christmas.

I suspect that their peers would agree with me that Healthvision NZ fell severely short of the expected standards for service provision, complaint management, and service termination.

Discussion on the questions posed by the HDC.

1. Whether services provided to [Ms A] by Healthvision NZ met acceptable standards.

There were many areas of discontent and conflicting versions with the services provided by HealthVision NZ to [Ms A]. I shall discuss four of the specific contested points to provide a platform for my overall opinion.

1a. Intake process

The first Significant departure in views relating to the situation is in the intake process. Healthvision NZ (hereafter referred to as HV) states in their response:

"In hindsight HV recognises that we could have been more proactive in demanding the disclosure of certain health information and support documentation prior to commencing service for [Ms A] …"

Throughout their response HV spoke of having little or no information and struggling to get what they required.

In making my comments below I acknowledge that gathering information and clarifying expectations before support commences is very difficult within the usual time constraints organisations work with. However it is still a critical function and, as the vulnerabilities of the individual increase, its proper execution becomes more important. This information is needed to: determine the client's specific support requirements, identify any particular risks or vulnerabilities they may have, and to accommodate other individual preferences or non-negotiables that the person may have that will influence their experience of the quality of their support.

For this reason, if the situation was as they say, then I agree with their view quoted above. However, it does suggest a seriously flawed intake process that falls severely below the accepted standard for safe service provision. The fact that they proceeded without the necessary information implies that they either had no appropriate intake process to follow or failed to follow their intake process. (No template was provided for an intake process.)

HV should have demanded information before commencing support with an individual with such complex needs and requirements as [Ms A]. The fact that the referral was called urgent should not have distracted them from this fundamental responsibility. (And, I might add, it seems about a third of all complex referrals are rated "urgent" in the current environment so this situation is not an unusual one to have to manage.)

HV's peers would likely see this departure as dangerous and naive. It demonstrated poor knowledge of these types of support situations and set the scene for exactly the type of difficulties that ensued.

The other view on the intake process provided by [Ms A] was, broadly, as follows:

- There was a referral meeting of 5 July 2019 attended by 5 HV staff, [Ms A], her solicitor, her social worker and ACC. At that meeting, which [Ms A] reports lasted 4 hours, huge amounts of information was provided about her care needs and complexities.
- [Ms A] and her supporters note that the HV staff did not appear to take any notes at the meeting.

- Following the meeting, [Ms D] sent 6 emails (11/07/2019 x1, 14/07/2019 x5) with large amounts of information, including HR information that HV specifically claims it never received.
- On 22 July 2019 [Ms A] wrote to HV and asked if someone had read [Ms D's] information but this was not responded to.

HV does appear to make mention of this meeting and subsequent emails in their Client Service Review and Recommendations report on 5 October 2019. So the question then is, where are their notes from the meeting and where is the information supplied in their submission to the HDC?

If HV didn't take notes at a referral meeting for a new client then this is incredibly poor practice. If they did take notes then why were they not supplied to the HDC?

Similarly, did they receive the information [Ms D] sent? And if not, then why didn't the prompt from [Ms A] cause them to look for them in their email system.

I have a great deal of sympathy for the comment [Ms A] made about this:

"The fact that HV don't have any recorded notes from the 5 July 2019 meeting (or not provided to the HDC anyway), and their apparent lack of recall from this meeting, has proven to be very problematic throughout their service provision, and that is coming up [time] and time again in HV's response to the HDC."

1b. The Support Needs Assessment (SNA) from ACC

One of the particular pieces of information that HV say was missing was the Support Needs Assessment. This provided guidance on [Ms A's] needs and the support/ management of those needs. Again, the two accounts are radically different.

HV claim they only got this on 20 November 2019 and prior to that time they had repeatedly asked for it from both ACC and [Ms A] but neither would supply it.

[Ms A] claims HV had it since 2017 as part of another contract they undertook with her. She also states that the SNA was part of the information sent by [Ms D] albeit without the password required to open it.

It is hard to know how to reconcile these two views. What the evidence supplied does show though is that HV did have the SNA prior to 20 November 2019.

- [Ms A] gave an email from 10/10/2019 where she provided the SNA to HV.
- Nearly a month later, on 16/11/2019 [Ms A] provided the correct password for the SNA.
- On 18/11/2019 [Ms F] acknowledges this and says she now has access.
- The copy of the SNA provided to the HDC has 20/11/2019 written on it as the date of receipt.

There is no evidence that HV acknowledged receipt of the SNA on 10/10/2019. Nor is there any evidence that they tried to open it or request the correct password at that time. This is baffling to me given the centrality of this document to safe and successful support for [Ms A].

1c. Overnight support from friends; especially from [Friend E].
The situation where [Ms A] was on occasion required to stay over with a friend because of staffing shortages led to the initial complaint from [Ms A] directly to HV. It is another example of radically differing accounts from the two parties.

HV state that the use of [Friend E] came about at the behest and direction of [Ms A]. They say that it was an arrangement they had not initially been aware of and it was funded directly by ACC. They further state that staying with [Friend E] was used "on a total of 6 occasions during the time [they] engaged in service."

HV, including [Ms F] and [Dr G] claim that staff shortages were what prompted the need for [Ms A] to stay with friends so often. In their response to the HDC they are clear that the reason for the staff shortages was due to the requirements [Ms A] had of staff that hamstrung their attempts at recruitment.

If this account is correct then this appears to be another problematic area of service provision that has its roots in the 5 July 2019 meeting and the lack of notes taken/ attention paid by HV. Having said that, I do think that there is reasonable grounds for HV to be confused as to the efficacy of utilising [Friend E] given that there were somewhat contradictory bits of information ...

However, any confusion should have evaporated following a meeting with [Ms A] and her lawyer (14 August 2019) and an email from her social worker (20 August 2019) stating the significant danger this practice was to [Ms A] and asking for it to cease immediately.

The meeting of 14 August 2019 was attended by [Ms F] and [Ms I] who were the HV staff specifically arranging the support for [Ms A].

After the meeting HV let [Ms A] know that they had rostered overnight stays with [Friend E] on 17, 18, 19, 22, 24 and 25 August. This is what prompted the email from [Ms A's] social worker on 20 August 2019.

On 21 August an email from [Ms F] to [Ms A] was received saying it had been arranged for [Ms A] to stay with [Friend E] for a further 3 days (Thursday, Saturday and Sunday).

[Ms A] then sent a reply email on 21 August 2019 expressing how this was negatively affecting her health. There was no response from HV.

On 22 August [Ms A's] rehab nurse specialist also emailed [Ms F] to emphasise the danger in the current arrangement.

[Ms A] was still rostered with [Friend E] on 24 and 25 August culminating with a hospital admission on 27 August and a formal complaint being lodged by [Ms A] on 31 August 2019 and subsequently provided verbally on 25 September, 2 and 10 October to [Dr G] and accompanied by [Ms A's] social worker and lawyer.

Given the risks that HV was made aware of, it appears a severe departure from accepted practice, one could say unconscionable, that they continued to use [Friend E], or indeed anyone, as roster relief. Even given the fact that they struggled to recruit sufficient staff, there are other options available including nursing pool staff and the like. Within NZDSN, organisations will collaborate with each other to assist in such circumstances if they can. No evidence was offered to indicate they attempted any of these options in preference to using [Friend E].

In [Ms A's] account of the use of [Friend E] as overnight stay for roster shortages, she has this to say: "In addition to the referral meeting on 5 July 2019 where the topic of [Friend E] was discussed, there were multiple emails, teleconferences and meetings with my MDT and eventually my lawyer, trying to get HV to stop sending me away for overnight shifts to people's places where I had no awake overnight support."

At the 5 July 2019 meeting [Ms A] notes that HV said they wouldn't employ [Friend E] given the history expressed.

The real divergence comes through when one analyses the nights that [Ms A] had to "stay at friends" due to roster issues. HV states that there were 6 occasions where [Ms A] stayed with [Friend E] but this ignores the fact that other "stays with friends" also happened. Stays occurred in July — 16, 17, 18, 19, 21, 22 and August — 2, 7, 9, 11, 17, 18, 19, 22, 24, 25. A total of 16 "stays" within a 43 day period. This means that for over one third — 37% — of [Ms A's] nights while supported by HV she stayed "with friends." This is a severe departure from the expected standard of support to someone who expects, and needs, to stay in their own home.

[Ms A] states that the issue with the staffing roster that caused gaps in the roster were due to HV not understanding her needs and not commencing recruitment in a timely manner (the latter was acknowledged by HV who apologised for it to [Ms A] but continued to claim it was [Ms A's] demands that continued to create the problem in their response to the HDC).

1d. Client Service Agreement

HV state: "Unfortunately, despite many attempts to get [Ms A's] approval, she has never agreed to sign [the Client Service] agreement, the risk plan, the communication plan and her Service Support Plan. This was acknowledged by her lawyer in an email to HV's CEO on 21 November 2020." (I think the actual date is 21/11/2019.)

Please note that the email from [Ms A's] solicitor, dated 21/11/2019 and referred to here, says: "At the same meeting I suggest that the client service agreement can be dealt with. [Ms A] accepts that this is something that needs to be signed. She has no real issue with doing so, she just wants to go through it properly beforehand."

I think it is drawing a long bow to say the lawyer is acknowledging that [Ms A] does not agree to sign the Client Service Plan from the email quoted above as HV have claimed.

In [Ms A's] account, it is she who is trying to get various plans written or agreed to and signed off. As with the previous areas of different accounts, [Ms A] supplies more evidence to support her view than does HV.

The fact that HV does not have a Client Service Agreement with [Ms A] is another failure of their intake process. It is their responsibility to ensure this foundational document is both negotiated and signed, preferably before service commences, but certainly as soon after as possible. If there are issues with getting it signed for any reason then there should be a paper trail outlining what the issues are, what and when attempts were made to remedy this and what the current working arrangements are.

HV has not presented any evidence that they attempted to get a Client Service Agreement signed or that it was [Ms A] who was holding up the process. Given this, I think their peers would see this as a moderate departure from the expected standard.

The copies of their Service Agreement HV supplied as drafts for [Ms A] to sign do fall short of current best practice. Current best practice is to have a service agreement that allows for the individual, and their family/guardian as appropriate, to personalise the support to their needs, expectations and preferences.

A personalised Service Agreement has become important over the past few years to accommodate the greater level of autonomy people are asking for with their support arrangements. It has become a critical conversation to clarify differing expectations and understanding. As such, HV's Service Agreement is a traditional "top down" summary of the terms they wish to apply to the support arrangement. I make this comment as I think this approach has been part of the problem between the two parties.

1e. General comment

I discussed the above four of the areas of divergence as examples of how the accounts between the parties differ substantially. I acknowledge that there are other areas of equal difference of account including: staff competence/qualifications, rostering, risk management, communication and others. I will not enter into these domains individually, but rather make some general comments about the quality of service supplied to [Ms A] by HV that encompass these extra domains and the four discussed in more detail.

Reading through this material I could sense the exasperation HV staff felt in their interactions with [Ms A]. This exasperation was also evident in the transcript with the HDC official ... At the same time, [Ms A's] desperate need to have clarity so that she feels safe was quite evident and completely understandable.

It is my opinion that, from the information provided, HV "dropped the ball" at the very beginning of this support situation and never regained sufficient composure to recover from that. What I mean by this is that HV apparently failed to grasp the complexities

inherent in the support for [Ms A], they then attempted to apply their standard operating processes which failed, and were subsequently unable to adapt to the different demands [Ms A's] service required.

Besides not having the competency at a managerial or service level they also demonstrated a concerning disconnect in their communication with [Ms A] and internally. An example of this is as follows.

- On 27 August 2019 [Ms A] was admitted to hospital as a result of harm that occurred during her most recent visit to [Friend E].
- On the morning of 27 August 2019, presumably before [Ms A] was admitted to hospital, [Ms I] sent a message out to staff to ensure they did not pack the hair straightener for overnight stays.
- This communique received a very stern response on the same day 27 August 2019 at 5:36pm from one of [Ms A's] staff reminding [Ms I] that the practice of overnight stays put [Ms A] in a vulnerable position. (Quite likely in the knowledge that [Ms A] was now in hospital due to the previous stay.)
- Also on 27 August 2019 [Ms A] texted [Ms F] saying: "Please don't make me go back to [Friend E's home] to stay the night again. It is extremely harmful to me …"
- On 29 August 2019 [Ms I] replied to the staff person defending her comments and seemingly unaware that [Ms A] had suffered harm from her previous visit and was currently in hospital; or at least she made no reference to it.
- If [Ms I] had been aware of the events of 25 to 27 August (that is the final stay with [Friend E] and the subsequent hospital admission) one would have imagined that she would have some comment to make about it.

So, given their inability to provide safe and effective support to [Ms A] they had no option but to withdraw, although the manner of that withdrawal will be discussed below. I would think that most of their peers would agree that HV's intake processes, problem solving processes, communication and responsiveness all fell significantly below the accepted standard for disability support services. When one brings in the framework for Enabling Good Lives, then I think their approach is severely below the standard required. (I will add detail to this in the final section.)

2. Whether the management of [Ms A's] exit from Healthvision NZ's services was reasonable in the circumstances.

I think the decision to exit from services to [Ms A] was the only reasonable decision given HV's inability to support [Ms A] at a safe level, never mind an acceptable level.

Through their submission to HDC and to the ACC previously, HV claimed there are, largely unspecified, Health and Safety risks that made their withdrawal of support both important and urgent. From the evidence supplied, former staff were unaware of any such risks nor had they been consulted in determining the risks or the level of risk.

There is plenty of evidence presented on both sides that supporting [Ms A] was not straightforward, and that a risk management plan, or better still, a safeguarding plan, was essential. This was never fully developed nor finalised by HV therefore they had no real way to identify and then mitigate risks in an effective manner.

In my opinion, the real issue was inadequate processes, a distinct skills deficit from HV management in dealing with such situations and an intransigence to change how they operated to accommodate [Ms A's] situation. Therefore, exiting was the only way [Ms A] was going to have a safe and stable support service. Something that she apparently does have with her new provider.

(It is interesting to note that the same staff who HV found so problematic are still supporting [Ms A] and, in the opinion of …, are happy with their new employer and working environment.)

[Dr G] took the view that they could not discuss exiting services directly with [Ms A], nor with her solicitor, nor social worker. I do not understand this as that would be the accepted standard and norm.

This reluctance to engage in more open communication then led to a sudden termination of support with the associated risks that was, in my opinion, entirely avoidable. I think their peers would see the way they undertook the exit, and indeed the reason for it, as severely below an acceptable standard.

3. The appropriateness of Healthvision NZ's management of [Ms A's] complaint when she raised her concerns directly with the organisation.

The management of [Ms A's] original complaint to HV is another situation where the actions of [Dr G], seem inexplicable. Having offered to meet with [Ms A] and take notes of the complaint, [Dr G] then maintained she could not share the notes she took of [Ms A's] complaint.

In such circumstances, the expected standard is for transparency and collaboration. [Dr G's] approach showed neither of these. Her reason for this was that various staff names were included in the notes and therefore made them confidential. This appears to be wrong for several reasons.

1. Firstly, the complaint was [Ms A's] complaint and therefore she owns that information.
2. Secondly, [Ms A] had named the people in the complaint, her solicitor and social worker were present, so any immediate issues of confidentiality appear moot.
3. It is possible that [Dr G] did not want the document shared more widely with the names included. In this case she could have simply blacked out the names and identifying information, which would be usual practice.

4. By not allowing [Ms A] to access the notes that [Dr G] had taken on [Ms A's] behalf, it displays very poor judgement on [Dr G's] behalf and an unwillingness to operate with good faith.
5. In the context of the Enabling Good Lives principles, this action completely disregards their intent.

The subsequent response to the complaint that was given to [Ms A] by [HV] was, in my opinion, wholly unsatisfactory. It attempted to compile the issues into three categories, which is reasonable enough. But in so doing, [HV] glossed over most of the complaint and answered questions that had not really been posed.

[Ms A] was clearly dissatisfied with the response and asked the question as to whether [HV] had read the complaint notes taken by [Dr G] or any other documents. This question was not answered but, given the paucity of the complaint response, I think it was a reasonable question to ask. The only other obvious reason for the complaint response being so glib was that HV wasn't that interested in responding or engaging with it seriously.

In my opinion then, HV again fell severely short of the expected standard to resolving complaints.

4. Any other matters raised in the information provided that I consider warrant comment.

There are two main things I will comment on in regards to this situation and one smaller, and disturbing, occurrence.

Missing documents from HV's response to the HDC.
HV provided several thousand pages in their response to the HDC and yet failed to provide very much that spoke specifically to this situation. Much of what was provided appeared to come out of a spreadsheet. It was printed in 8 point typeface in a column about 3 cm wide and was not in chronological order.

As an example, on one particular page the entries were from 23/08/2019 followed by 01/08/2019 and then immediately after 28/08/2019. In other areas the notes went from 05/08/2019 to 30/08/2019 to 06/08/2019 and back to 22/08/2019.

I am not sure what the spreadsheet settings were but I do think HV could have at least arranged this information chronologically so it could be used. I found it impossible to navigate in order to track down any sequence of events and ceased to use it.

Documents that may have been present in the spreadsheet but I would have expected to have been printed out for clarity include:

- Copies of the information [Ms D] sent on July 11 and 14 of 2019.
- Any attempts by HV to have [Ms A's] information provided to them given that they maintain they never received any.

- Evidence of their claim that they had made "many attempts" at getting [Ms A] to sign a Client Service Agreement, a Support Plan, Communication Plan and a Risk Management Plan.
- HV provided an email … to [Ms A] dated 27 November 2019 that cites a letter that was attached to the email. That letter has not been included in the material HV sent.
- Evidence of HV attempting to obtain the SNA.
- Evidence of HV's Intake Process.

It seems to me that there is so much information missing from HV's response that they either have very poor information systems in place or didn't feel the need to supply everything to clarify the situation.

It is my opinion that providing important information such as a complaint response to the HDC, in what is essentially an inaccessible format, or failing to provide it at all, is well below the accepted standard for complaint responses.

HV's management approach

Throughout the material supplied it became clear to me that HV was an agency that had a very transactional view of its role. By this I mean, they appeared to see themselves as a "doer of tasks" rather than a "supporter of people."

The most obvious example of this is HV's proposed structure to resolve the situation around [Ms A]. It introduces a clear hierarchy that sidelines [Ms A's] involvement to a passive recipient of services rather than an agent in her own right. In that restructure proposal they make a number of sensible recommendations. Others though resonate with their seemingly transactional and hierarchical view, as follows:

- "HV has full control and decision making — managing contract and compliance …
- HV enabled to embed best practice and compliance"

This latter statement comes without any intimation as to what those "best practices" are. In my opinion this perhaps demonstrates the nub of the problem; HV's apparent inability to work collaboratively.

In their submission they noted that: "It is not our experience that clients are able to determine policies and procedures in respect of their support — this is usually determined by the service provider (in line with the relevant funder contract specifications)."

My response to that is: right there you have the exact reason EGL was born!

HV's need for control and regularity of response is, in my opinion, the exact opposite of the direction of the EGL principles. This presents an interesting additional problem for the HDC as, since 2012, EGL has been the primary Government policy guiding disability

support. It now informs "accepted practice" to a very large extent and did so in 2019 as well.

The disturbing email from [Ms F] regarding a potential staff member [Ms J].
There is one more observation I will make from the material supplied and this relates to the potential employment of a staff person named [Ms J]. This situation shows HV, and in particular [Ms F], in a very poor light.

Without going into the details, this email of 12 August 2019 is wrong for several reasons.

1. [Ms F] and the other members of HV's management team should have been able to decide what to do about hiring [Ms J] without burdening [Ms A] with the lurid details and the decision. They should have known how damaging such things were to [Ms A].
2. If such topics are discussed at a job interview then, to me, there seems to be only two reasons why. The first is that the applicant is asking for help. The second is that the applicant has no clear boundaries or reasonable knowledge of what is appropriate. In either case, this is [Ms F's] job to sort out, not [Ms A's] nor any other client's.
3. The matter disclosed was potentially abusive to children and possibly also illegal. The interviewers almost certainly should have made the decision to report this to Oranga Tamariki or to the Police, and informed the applicant [Ms J] that they would be doing so.
4. When [Ms F] was challenged on the email that outlined this situation she appeared to think it was appropriate to have sent.
5. Subsequent emails showed that [Ms F] continued to consider this potential staff person — [Ms J] — as a suitable employee and support person for [Ms A].

This incident demonstrates such poor judgement from [Ms F] that I consider it grounds for a complaint all on its own. It speaks of a significant lack of professionalism from [Ms F] and an unwillingness to reflect on the consequences of these actions.

Yours sincerely

John Taylor'

Further independent clinical advice to Health and Disability Commissioner

'Complaint:	**[Ms A]/Healthvision NZ**
Our ref:	**20HDC01093**
Independent advisor:	**Mr John Taylor ONZM**

I have been asked to provide clinical advice to HDC on case number 20HDC01093. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I have the following qualifications and experience to fulfil this request. Qualifications: MPhil (Distinction) in Disability Studies, Education and Evaluation; DipPGArts (Distinction) Social Work; BSc (in ethics and science); LTh. Experience: 37 years of working within the disability sector including the following roles: direct support worker, agency management (over 20 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the MoH's New Model, National Leadership Team for Enabling Good Lives, a range of contracted roles and I have helped set up a number of support agencies and disability related businesses. I have operated contracts from MoH, Whaikaha, ACC, Corrections, Oranga Tamariki and MSD.
Documents provided by HDC:	1. Initial bundle of documents provided on 27 May 2022. 2. Initial advice report received on 8 August 2022. 3. Healthvision NZ's further response dated 16 December 2022. 4. Records from ACC received 13 December 2022. 5. Further information supplied by [Ms A] on 10 August 2023. 6. ACC's correction letter dated 22 August 2023. 7. Healthvision NZ's further response dated 5 March 2024.

	8. ACC and Healthvision Service Agreement in place during the events.
Referral instructions from HDC:	Healthvision NZ 1. Whether any of the further information supplied by [Ms A], Healthvision NZ and ACC causes you to make any changes to the conclusions drawn in your initial report. 2. In your initial report you note that Healthvision NZ's management approach does not reflect Enabling Good Lives principles. If you consider this to be a departure from the accepted standard of care, could you please quantify the departure as set out below. 3. In your initial report you note that the way Healthvision NZ presented documents falls "well below the accepted standard for complaint responses". If you consider this to be a departure from the accepted standard of care, could you please quantify the departure as set out below. 4. Any further matters you consider warrant your comment.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	This complaint concerns the home support services provided by Healthvision NZ to [Ms A]. [Ms A] has a [complicated health history]. Healthvision NZ was contracted by ACC to provide [Ms A] with home support from July 2019–December 2019. [Ms A] has raised a number of concerns about the services provided to her during this period. [Ms A] has also raised issues around the way Healthvision NZ (referred to in this report as "HV") has responded to her complaint, and considers that staff are seeking to discredit her.
Question 1: Whether any of the further information supplied by [Ms A], Healthvision NZ and ACC causes you to make any changes to the conclusions drawn in your initial report.	
The response from HealthVision (HV) dated 16 December 2022 added very little new evidence to bolster their view that they had acted to a reasonable standard throughout the support of [Ms A]. (I will comment more fully on the standard of evidence supplied in question 3 below.) Some of the new information from other sources, though, confirmed my initial view. It may be useful to clarify a couple of contextual issues at this stage as well.	

Firstly, I have been involved in delivering ACC contracted services for over a decade so I am familiar with their expectations.

Secondly, my critique of the support offered to [Ms A] should not be taken as a critique of HealthVision's usual practice. I make no comment about that as I do not know how they usually operate, and it is entirely possible that this situation represents an exception to otherwise very good service delivery.

Thirdly, as an expert advisor I do not rely solely on my own experience. I do, from time to time, check my impressions with other sector leaders. This is done within the guidelines for independent advisors with no identifying details so that the agency in question and the individuals in question are fully protected. By doing this I am able to moderate my own biases and better reflect sector expectations. I have done this in relation to some aspects of this case.

In this current case, that is the support offered to [Ms A] from July 2019 to December 2019, I am still of the opinion that HealthVision (HV) did fall below the expected standard in a number of areas.

[Mr H] … of HealthVision disputes this in his letter of 16 December 2022 so I will try to clarify my previous advice briefly here for a couple of areas not covered in questions 2 and 3 below.

1.1. [Mr H] reiterates that HV had significant difficulty gathering information about [Ms A] and therefore my critique of their intake process was unreasonable. There are two comments here. Firstly, they have again provided no written evidence of this that I could find. In fact, from my reading of the information provided, ACC, [Ms A] and [Ms D] were all very forthcoming with information. Further, ACC does not say this was a problem in the information they provided to the HDC and [Ms A] also denies this point in her response to the HDC.

Secondly, even if these restrictions on collecting information were as they say, I will reiterate that it is the provider's responsibility to collect whatever information they require to do the best job they can do. If they are unable to access information to allow them to safety and appropriately perform their role then they should not accept a referral. This is not just my opinion but also the advice ACC offers in its "Operational Guidelines HCS-MI".

In the words of [Ms A]: "When you took on my care you had a responsibility to get the information you needed to be able to safely, effectively and responsibly provide that care."

The peers that I consulted with agree with me that this aspect of the support was a severe departure from the expected standard which is, as mentioned above, that the agency collects sufficient information to perform their roles safely and well.

1.2. With regard to the initial complaint [Ms A] made to … HealthVision, [Dr G], [Mr H] reiterates HV's previous response and does not appear to acknowledge the points I raised in my original advice.

However, [Mr H] did correctly observe that I had not always stated the specific standards I was using. But to recap, the two issues I was critical of were that [Dr G] met with [Ms A] to write down the complaint and then refused to give [Ms A] a copy of her complaint. Secondly, the subsequent report on the complaint glossed over the key aspects of the complaint. (This view was supported by a document released to the HDC from ACC where [Ms A's] social worker considered the HV complaint report to be "an orchestrated litany of half-truths, misunderstandings and misinterpretation."

So, the standards I did, and I still do, consider they fell severely short of are listed below.

1. That they act according to the Code of Health and Disability Services Consumers' Rights, specifically right 10 the "Right to Complain."
2. That the complaints process meets the expectations of the NZ Ombudsman's advice on complaints processes.
3. That the process meets the Privacy Act's requirement, specifically principles 6 and 7, that all information a person supplies remains their information and should be made available to them.

1.3 [Mr H] discussed my comment about the employment of a staff person [Ms J]. Again, he is quite correct that this was not part of the formal complaint, rather I brought it up under the "Any other comments" section the HDC invited me to use.

I brought it up because it did, and still does, seem such an anomalous situation. In the appendices provided in their 2022 response, HV did provide some clarifying information for this situation.

I was encouraged to note that their HR person … did identify that this was a problem. In an email from her … on 12-08-2019 she says: "I've felt increasingly uncomfortable about [Ms J] over the past few days. What she described at the interview is sexual abuse, I feel that putting her with [Ms A] (with her history) would be very risky."

Despite this warning [Ms F] … did discuss/email employing [Ms J] and the associated disclosure with [Ms A]. [Mr H] claims [Ms F] was "purely the conduit of the information" which appears to me to treat [Ms F] as if she was an office junior rather than as a competent, experienced and, from my reading, caring senior manager who should have applied that knowledge to this interaction.

I have also checked with some peers to see if my original opinion was wrong. Their unanimous view was that this did fall severely outside of the expected standard because:

1. Personal matters discussed at an interview should not be discussed outside of the management line within the organisation.
2. Talking to a person who has [experienced psychological reaction] … a new situation that aligns with their trauma is likely to re-traumatise that person. This is the situation here.
3. By 2019 the accepted standard for most organisations was that any disclosures of child abuse should be reported to the appropriate authorities even if this was not mandated by the contract the organisation operated under. No evidence was supplied to say this occurred.

Therefore, the expectation would have been that HV, at the very least, screened [Ms J] out of contention as suitable as an employee and reported this back to [Ms A]. Beyond that, HV should have reported the family situation to Oranga Tamariki or the Police.

Question 2: In your initial report you note that Healthvision NZ's management approach does not reflect Enabling Good Lives principles. If you consider this to be a departure from the accepted standard of care, could you please quantify the departure as set out below.

In the HV response, … states: "the Enabling Good Lives policy … does not apply to ACC or ACC services — and certainly none of our contract specifications reference this."

… is incorrect to assume EGL does not relate to ACC or ACC services.

HV did not provide a copy of the relevant ACC contract as part of their evidence nor any other ACC documents that might support this view.

ACC was an early adopter of EGL and was specifically named in the Disability Action Plan agreed by the Ministerial Committee on Disability Issues on 11 September 2012, along with 9 other government agencies, as an active participant. (It is a common misunderstanding that EGL only applies to Health — now Whaikaha, and MSD when it was adopted as an all-of-government approach to guide the inclusion of disabled people and whānau in all aspects of their life, not just service provision.)

ACC has adapted the EGL principles into its framework to better suit their purpose. This has led to policies and processes especially focusing on enhancing individual autonomy and supporting tailored rehabilitation and compensation services. These principles inform ACC's more recent person-centered approach which emphasises choice, control, and a holistic view of individual needs and aspirations, aimed at fostering independence and community involvement for those with long term disabling conditions.

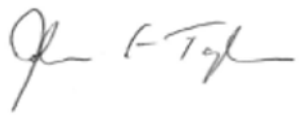
ACC continues to support the UNCRPD, the NZ Disability Strategy and the NZ Disability Action Plan (which integrates the EGL approach).

The departure from this standard, that is EGL practice, was moderate in terms of the sector, but only because the sector has been very slow to integrate EGL into practice, but significant in terms of the impact to the client — [Ms A]. It involved a failure to ensure client autonomy, empowerment through [Ms A's] full involvement in decision-making, and operating in a Mana Enhancing manner (refer [Ms A's] opinion on this).
Question 3: In your initial report you note that the way Healthvision NZ presented documents falls "well below the accepted standard for complaint responses". If you consider this to be a departure from the accepted standard of care, could you please quantify the departure as set out below.
In my previous advice on this complaint I noted that there were significant gaps in the information provided by HV that made it difficult to corroborate their response and I commented that this is below "the accepted standard for complaint responses." As an expert advisor for the HDC I have read and responded to many complaints and, although there may not be an expected standard published by the HDC, my experience is that most respondents provide full information, highlight the evidence that supports their responses and provide all this in a reasonably accessible format. HV failed to do this in their 2020 response. They provided their opinion and then large amounts of additional information without any guidance as to where I, or others, might find the relevant material that would support their view. Much of the material they provided in 2020 was printed in 8 point typeface in a column about 3 cm wide and was not in any chronological order. (NB: this latter issue has been corrected in the current response.) This approach strikes me as a little disrespectful to the HDC process, in that it is akin to saying: "here, find it for yourself!" In their 2022 response HealthVision has provided better documentation but it is still poorly organised in that any references made are to large and diverse appendices rather than to specific documents or parts of documents. As a result it still requires that those reading it search through to find anything that supports HealthVision's opinions; and I failed to find any evidence that did so.
Question 4: Any further matters you consider warrant your comment.
In the HV response of 2022, … says of the difficulties that HV experienced in gathering information that "we expect ACC will confirm this …" ACC did not confirm this issue. What ACC did was offer the following: "… the contents in several documents from the July 2019–December 2019 period that ACC sent to the HDC are now accepted as inaccurate or wrong and have been redacted and marked by ACC as not to be read/used. The information contained in these documents wrongly casts aspersions on [Ms A's] clinical team and their professional judgements … All letters however from Healthvision to ACC during

the July 2019–December 2019 period have been redacted and marked as "not to be read/used". These include:

- Letter from Healthvision to ACC dated 25th November 2019 — with recommendations
- Letter from Healthvision to ACC dated 2nd December 2019 — cessation of service
- Letter from Healthvision to … (GP) dated 12th December 2019

In addition to the above comment from ACC, from my reading of the evidence presented from several sources, [Ms A] (the client), her social worker — [Ms C], some of her key staff and the person providing much of the information for the transition — [Ms D], all agree that HealthVision did not provide the quality of support required. Maybe it is time that HealthVision accepted that despite its good intentions, it did not manage the support for [Ms A] well during the 5–6 month period that it was involved with her.



Signature:

Name: Mr John Taylor ONZM

Date of Advice: 5 November 2024'

Names (except Healthvision, the clinical advisor, and ACC) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.